Comparing Direct Contracting and High-Risk ACOS

	MSSP Track 3	MSSP Enhanced	Next Gen ACO Model	Direct Contracting - Professional	Direct Contracting - Global	Direct Contracting - Geographic
Initial program start year	2016	2019	2016	Implementation Period starts on Oct. 2020; Performance Year 1 starts on April 1, 2021	Same as Professional option	CMMI staff said in June 2020 that they were still working on this option and will release more information on it when they can.
Overview	Designed off the Pioneer ACO Model, Track 3 was added to the Medicare Shared Savings Program beginning in 2016.	In late 2018, the MSSP was overhauled with the structure of Tracks 1, 2, 3, 1+ replaced with a Basic and Enhanced Track. More details on the changes can be found in this NAACOS resource: https://www.naacos.com/naacos-analysis-of-the-final-mssp-pathways-to-success-rule	Successor to the Pioneer ACO Model with higher potential rewards and risk than the MSSP Tracks with a goal to transition providers from FFS to capitation. Starting with the 2019 performance year, certain program policies changed, as detailed in this NAACOS summary: https://www.naacos.com/summary-of-next-generation-model-program-methodology-changes-for-2019-and-2020	Successor to the Next Gen ACO Model. Direct Contracting offers a move toward capitation while providing options for organizations that have not previously participated in Medicare FFS. The Professional option is a lower-risk payment model option that will provide a capitated payment for enhanced primary care services.	The Global option of Direct Contracting offers a higher risk sharing arrangement and provides two payment options: Primary Care Capitation and Total Care Capitation. Each are risk-adjusted monthly payments for all services provided by Direct Contracting Participants and preferred providers with whom the Direct Contracting Entity has an agreement.	The Geographic option would be open to organizations, including health plans, healthcare technology companies, and providers and supplier organizations interested in taking on financial responsibility for all FFS patients in an entire geographic region. Entities would enter into arrangements with clinicians in the region.
Number of organizations in 2020	Peaked at 38 in 2018	80	41	-Applications for the Implemention Period were due Feb. 24 -Applications for PY1 due July 6	Same as Professional option	No recent announcement on anticipated application deadlines
Length of contract	3 years	5 years	Based on start year: - 2016 NG ACOs: 5 years - 2017 NG ACOs: 4 years - 2018 NG ACOs: 3 year	5 years	5 years	5 years
Advanced APM status under MACRA	Advanced APM	Advanced APM	Advanced APM	Advanced APM (starting in 2021)	Advanced APM (starting in 2021)	Anticipated to be an Advanced APM
Financial Structure						

Risk-Sharing Arrangement	- Savings: up to 75% based on quality performance, not to exceed 20% of updated benchmark - Losses: at a rate of 1 minus final sharing rate (40-70%), not to exceed 15% of updated benchmark	- Savings: up to 75% based on quality performance, not to exceed 20% of updated benchmark - Losses: at a rate of 1 minus final sharing rate (40-70%), not to exceed 15% of updated benchmark	2 risk arrangement options: - 80% shared savings/losses - 100% shared savings/losses	50% shared savings/losses	100% shared savings/losses	100% shared savings/losses
Discount or MSR/MLR	- Symmetrical MSR/MLR - 3 options: • 0% MSR/MLR • MSR/MLR in 0.5% increment up to 2.0% • MSR/MLR that varies based on the number of assigned beneficiaries	- Symmetrical MSR/MLR - 3 options: • 0% MSR/MLR • MSR/MLR in 0.5% increment up to 2.0% • MSR/MLR that varies based on the number of assigned beneficiaries	- Discount applied to benchmark - 0.5% for 80% risk sharing arrangement - 1.25% for 100% risk sharing arrangement	'- No Discount; Offers “first dollar" savings and losses and no MSR/MLR	- "First dollar savings and Losses; Discount applied to the PY benchmark 2 percent (PY1-2) 3 percent (PY3) 4 percent (PY4) 5 percent (PY5)	- Discount applied to benchmark - Discount amount TBD
Savings/Losses Cap	- Savings: 20% of updated benchmark - Losses: 15% of updated benchmark	- Savings: 20% of updated benchmark - Losses: 15% of updated benchmark	- 5% or 15% of updated benchmark, selected by ACO annually	CMS will employ four risk bands -For gross savings/losses of less than 5%, cap of 50% savings/losses -For gross savings/losses between 5% and 10%, cap of 35% savings/losses -For gross savings/losses between 10% and 15%, cap of 15% savings/losses -For gross savings/losses greater than 15%, cap of 5% savings/losses	CMS will employ four risk bands -For gross savings/losses of less than 25%, 100% savings/losses -For gross savings/losses between 25% and 35%, cap of 50% savings/losses -For gross savings/losses between 35% and 50%, cap of 25% savings/losses -For gross savings/losses greater than 50%, cap of 10% savings/losses	TBD

Benchmark	- CMS weights three historical years equally and incorporates a component of regional expenditure data along with ACO historical expenditure data - Regional methodology is implemented gradually as ACOs enter new agreement periods - Methodology is outlined in detail in our NAACOS resource: https://naacos.memberclicks.net/summary-of-final-mssp-benchmarking-rule?servId=7312	- CMS establishes and rebases benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) - CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year - ACOs have a regional adjustment weight of 15% or 35% in their first agreement year ACOs with spending higher than their region would receive the lower weight, and ACOs with spending lower than their region would receive the higher weight - If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement	- 2-year baseline period - Prospective regional trend, based on the adjusted USPCC - Attained performance adjustment: a regional adjustment blend; 10% maximum upward adjustment (if baseline is less than average expenditure occurred by beneficiaries in the region); 2% maximum downward adjustment - Methodology is summarized in this NAACOS resource: https://www.naacos.com/summary-of-next-generation-model-program-methodology-changes-for-2019-and-2020	- Prospective blend of historical spending and adjusted Medicare Advantage Rate Book -For Standard DCEs using claims-based alignment, the baseline period will be a fixed 3-year period (2017, 2018, 2019) -For Standard DCEs using voluntary alignment, CMS will only use regional expenditures for PY1-3 and will add in historical baseline expenditures for PY4-5, using a two-year historical baseline (2020, 2021) -For New and High Needs DCEs, CMS will only use regional expenditures for PY1-3 and will add in historical baseline expenditures for PY4-5, using a two-year historical baseline (2020, 2021). - More details TBD	Same as Professional option	- Based on one-year historical Parts A and B per capita FFS spend in the target region trended forward (no historical/regional blend) with negotiated discounts and a geographic adjustment factor. - More details TBD; CMS sought feedback on the methodology in its Request for Information.
Risk adjustment	- Treats beneficiaries differently depending on whether they are considered newly or continuously assigned - Annual benchmark update caps the risk ratio for continuously assigned beneficiaries to the demographic-only risk ratio	- Benchmark risk-adjusted with a prospective coding adjustment with a HCC risk score cap of 3% over length of the agreement period - No limit on risk score decreases	- Benchmark risk-adjusted with a prospective coding adjustment with a HCC risk score cap of 3% for risk score increases or decreases	- TBD - "will capitalize on Medicare Advantage rate calculations" - CMMI considering new alternatives to risk adjustment	Same as Professional option	- TBD - "will capitalize on Medicare Advantage rate calculations" - CMMI considering new alternatives to risk adjustment

Payment Options	CMS makes all FFS payments	CMS makes all FFS payments	- CMS makes all FFS payments - Option: All-Inclusive Population-Based Payments (AIPBP); CMS does not make FFS payments; CMS pays ACO a monthly AIPBP payment that reflects estimated expenditures for care furnished to aligned beneficiaries	- Primary Care Capitation: DCE is paid a monthly capitated payment for estimated enhanced primary care expenditures (equal to 7% of estimated TCOC) - CMS pays claims for all other services -May elect Advanced Payment for any portion of the remaining 93%; reconciled at the end of the PY, similar to the AIPBP payment mechanism in Next Gen.	2 Options: - Primary Care Capitation - Total Care Capitation: 100% capitation; providers submit claims but all payments go to the DCE	Full capitation with option to pay claims for contracted providers
Reconciliation	Full performance year reconciliation following full claims run out period	Full performance year reconciliation following full claims run out period	Full performance year reconciliation following full claims run out period	- Full performance year reconciliation following full claims run out period - Optional provisional reconciliation: CMMI will distribute interim shared losses/savings based on the first 6 mo. of that PY, with final reconciliation taking place once full data are available	Same as Professional option	- If DCE opts to have CMS pay FFS claims to all providers in the target region, expenditures would be reconciled against the benchmark as part of final settlement - DCE given access to a "notional" account to track expenditures
Beneficiary Alignment						
Minimum number of beneficiaries	5,000	5,000	10,000 (Unless in a rural area in which they must have a minimum of 7,500)	- Standard DCEs: 5000 - New Entrant DCEs: 1,000 in PY1 (increases by 1,000 each year); maximum 3,000 beneficiaries aligned via claims in any baseline year - High Needs Population DCEs: 250 beneficiaries in PY1 (increases to 1,400 by PY5)	Same as Professional option	75,000

Beneficiary assignment	- Prospective - Claims-based and voluntary alignment	- Prospective or preliminary prospective with retrospective reconciliation; elected annually - Claims-based and voluntary	- Prospective - Claims-based and voluntary alignment	- Prospective - Claims-based and voluntary alignment - ability to market voluntary alignment - Voluntary alignment will take precedence over claims-based; Voluntary alignment completed through MyMedicare.gov takes precedence over paper-based voluntary alignment -Option to add voluntarily alignment beneficiares quarterly	Same as Professional option	- TBD, expected to be a combination of automatic enrollment (with option to drop out) and voluntary assignment
Quality Reporting						
Quality measures	- 23 required measures	- 23 required measures	- 23 required measures	- 14 required measures -9 CAHPS measures, 5 claims measures	Same as Professional option	- Selection of participants will include "the applicant's selection of quality measures and quality improvement goals"
Reporting requirements	- Quality performance impacts eligibility to share in savings, and poor performance can result in the ACO being ineligible for any shared savings	- Quality performance impacts eligibility to share in savings, and poor performance can result in the ACO being ineligible for any shared savings	- CMS withholds a percentage of benchmark that can be earned back by hitting quality scores - In 2019, 2% of the ACO's benchmark is held back with all of it earned back with a full quality score - In 2020, 3% will be withheld and adjusted back on quality performance. If a NGACO receives a quality score of 95 percent, it will receive 95 percent of the withheld amount back	- CMS will withhold 5% of DCE's benchmark that can be earned back through quality scores -PY1 will be pay-for-reporting -Withholds the DCE earns back will be determined by multiplying the quality score by 5% if the DCEs meet or exceed the "continuous improvement/sustained exceptional performance" criteria or 2.5% if the DCE doesn't meet the criteria -CMS will also employ a "High Performers Pool" funded by quality withholds not earned back	Same as Professional option	TBD
EHR use	- At least 50% of ACO's eligible clinicians as defined under MACRA must meet requirements for use of certified electronic health records (EHR) per Advancing Care Information requirements	- At least 75% of ACO's eligible clinicians as defined under MACRA must meet requirements for use of certified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process)	- ACOs must be in compliance with Participation Agreement and certified EHR requirements	- DCEs must document that at least 75% of Participant Providers that are eligible clinicians use certified electronic health record technology (CEHRT)	Same as Professional option	TBD

Patient satisfaction	- Must report on patient experience/ satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs	- Must report on patient experience/ satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs	- Must report on patient experience/ satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs	-Nine of the 14 quality measures are from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs	Same as Professional option	TBD
Compliance and waivers						
Compliance program	- ACO must have a compliance plan including: a designated compliance official, anonymous reporting of suspected compliance violations, and compliance training	- ACO must have a compliance plan including: a designated compliance official, anonymous reporting of suspected compliance violations, and compliance training	- ACO must develop a compliance plan including: designation of a compliance official; mechanisms to identify and address non-compliance; compliance training programs; anonymous reporting of suspected compliance violations; and a quality assurance strategy	-Similar requirements of Next Gen ACOs	-Similar requirements of Next Gen ACOs	TBD
SNF 3-day rule	- For prospectively assigned beneficiaries that receive otherwise covered post-hospital extended care services furnished by an eligible SNF - SNF must have a quality rating of 3+ stars	- Open to ACOs that use either prospective assignment or preliminary prospective assignment with retrospective reconciliation. - CMS will waive its three-star quality rating requirement for providers furnishing SNF services under swing bed arrangements	- For prospectively assigned beneficiaries that receive otherwise covered post-hospital extended care services furnished by an eligible SNF - SNF must have a quality rating of 3+ stars	- Largely mirrors the Next Gen waiver -SNFs must be either Participant or Preferred Providers -DCEs may be asked to describe how the SNFs can carry out proposed coordination activities	Same as Professional option	TBD
Telehealth	- Waives geographic and originating site requirements - Available only to ACOs that have elected prospective assignment	- Waives geographic and originating site requirements - Available only to ACOs that have elected prospective assignment	- Waives geographic and origininating site requirements	- Mirrors the Next Gen waiver	Same as Professional option	TBD
Beneficiary Incentive Program	- Can provide CMS-approved incentive payments to eligible beneficiaries who receive qualifying primary care services. - Available to ACOs that elected preliminary prospective assignment with retrospective reconciliation or prospective assignment	- Can provide CMS-approved incentive payments to eligible beneficiaries who receive qualifying primary care services. - Available to ACOs that elected preliminary prospective assignment with retrospective reconciliation or prospective assignment	- Can make direct payments to beneficiary who receives certain services from the Next Gen ACO's Participants and Preferred Providers	- Similar to Next Gen, DCEs may provide in-kind items or services to beneficiaries, including blood pressure monitors to patients with hypertension, vouchers for over-the-counter medications, transportation vouchers, wellness program memberships, among other things	Same as Professional option	TBD

Other benefit enhancements	None	None	- Cost-sharing support for Part B services - Care management home visits - Chronic Disease Management Reward Program - Post-discharge home visits - More information on these benefit enhancements can be found in this NAACOS resource: https://www.naacos.com/summary-of-next-generation-model-program-methodology-changes-for-2019-and-2020	- In addition to the enhancments Next Gens are allow, CMS is proposing to allow: - Nurse Practitioners to certify that a patient is eligible for home health services - The provision of home health services to beneficiaries who are not "homebound" for certain conditions - CMS is exploring additional enhancements and payment rule waivers	-In addition to what Professional DCEs are allowed, CMS would allow Global DCEs to waive the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care as a condition of electing the hospice benefit.	TBD
*plurality of PC services means a greater proportion of PC services as measured in allowed charges within the ACO than from services outside the ACO (such as services from other ACOs, individual providers or provider organizations. The plurality can be less than a majority of total services.						
** Shared savings payments are subject to 2% sequestration cut						
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