	MSSP Track 3	MSSP Enhanced	Next Generation ACO	Direct Contracting - Professional	Direct Contracting - Global	Direct Contracting - Geographic
Initial program start year	2016	2019	2016	Performance year 0 starts 2020 Performance year 1 starts 2021	Performance year 0 starts 2020 Performance year 1 starts 2021	Performance year 0 anticipated to start mid 2020 Performance year 1 anticipated to start 2021
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 NGACO Model. Direct Contracting offers a move toward capitation while providing options for organizations that have not previously participated in Medicare FFS. CMS promises a heightened focus on complex chronic, seriously ill, and dually eligible beneficiaries. 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, health care 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 2019 organizations	37	Participation in the new Pathways to Success structure starts on July 1, 2019.	41	Letters of intent due in Summer 2019; Requests for Applications anticipated in Summer/Fall 2019	Same as the Professional option.	Letters of intent will be sought later with requests for applications anticipated in the Fall 2019
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)	Advanced APM (starting in 2021)
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	Same as Track 3	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	Same as Track 3	- Discount applied to benchmark - 0.5% for 80% risk sharing arrangement - 1.25% for 100% risk sharing arrangement	- Symmetrical MSR/MLR - MSR/MLR rate TBD	- Discount applied to benchmark - Discount amount TBD	- 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	TBD	TBD	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 regional expenditures segmented by Aged & Disabled and ESRD - Historical baseline expenditures will be trended forward by U.S. per capita cost growth, with adjustments to account for population risk and geographic price factors - More details TBD	Same as the 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 the Professional option	Same as the Professional option
Payment Options	CMS makes all FFS payments	Same as Track 3	- 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	2 Options: - Primary Care Capitation - Total Care Capitation: Full capitation	Full capitation with option to pay claims for contracted providers

Reconciliation	Full performance year reconciliation following full claims run out period	Same as Track 3	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, with final reconciliation taking place once full data are available.	Same as the 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)	5000, with exception for newly participating DCEs and those taking on chronic or MCC populations	5,000	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 - Option for Medicaid Managed Care Organization alignment for dual when DCE affiliates with MCO - allows mid-year additions for	Same as the 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	Mirrors the MSSP measure set	- TBD - CMS promises a "small set of core quality measures" - will be MIPS comparable and include at least one outcome measure	Same as the Professional option	In its RFI on the Geographic option, CMS indicates that its criteria for the 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.	- TBD; Quality performance will impact an entity's final shared savings or losses.	- TBD; Quality performance will impact discounted benchmark amounts.	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	TBD	TBD	TBD
Patient satisfaction	Must report on patient experience/ satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs.	Same as Track 3	Mirrors MSSP	TBD	TBD	TBD
Compliance and waivers						
Compliance program	ACO must have a compliance plan that meets the requirements of 42 C.F.R. § 425.300, including: a designated compliance official who is not legal counsel to the ACO; anonymous reporting of suspected compliance violations, both by ACO members, employees and contractors regarding internal ACO matters and to law enforcement where the law may be violated; and compliance training.	Same as Track 3	The vast majority of requirements are the same as MSSP ACOs. Differences include: the ACO's governing body must include at least one person with training or professional experience advocating for the rights of consumers. There are also some changes to the descriptive materials that CMS will require to be reviewed before distribution. Participating ACOs must develop a compliance plan with minimum attributes, such as: designation of a compliance official who is not legal counsel to the ACO; mechanisms to identify and address non-compliance; compliance training programs; anonymous reporting of suspected compliance violations; and a quality assurance strategy.	TBD	TBD	TBD

SNF 3-day rule	Permitted beginning 2017; During initial application, Track 3 ACOs may apply for a waiver of the SNF 3-Day Rule. Only for prospectively assigned beneficiaries that receive otherwise covered posthospital extended care services furnished by an eligible SNF that has entered into a written agreement with the ACO for purposes of this waiver. SNF must have a quality rating of 3+ stars.	CMS allows ACOs participating in a two-sided model to use the SNF Three-Day Waiver effective July 1, 2019. The waiver is open to ACOs who 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.	CMS allows beneficiaries to be admitted directly to a SNF from their home, a physician's office, an observation status of the ER, or when they have been in the hospital for fewer than three days. SNF must have a quality rating of 3+ stars.	CMS is considering the same benefit enhancements and payment rule waivers provided Next Gen ACOs, such as • 3-Day SNF Rule Waiver; • Telehealth Expansion Waiver; • Post-Discharge Home Visits Rule Waiver; and • Care Management Home Visits Rule Waiver.	Same as the Professional option	TBD
Telehealth	Medicare will waive its typical geographic restrictions for telehealth originating sites and count patients' homes as originating sites for ACOs under two-sided models. Please note this provision is applicable only to ACOs who have elected prospective assignment.	Medicare will waive its typical geographic restrictions for telehealth originating sites and count patients' homes as originating sites for ACOs under two-sided models. This provision is applicable only to ACOs who have elected prospective assignment.	CMS waives the requirement that beneficiaries be located in a rural area and at a specified originating site when telehealth services are provided by Next Gen ACO providers/suppliers or preferred providers to aligned beneficiaries.	See above	See above	TBD
Beneficiary Incentive Program	ACOs can establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying primary care services. Through this program, ACOs may provide limited "cash equivalent" incentive payments to qualifying patients. The beneficiary incentive program is available to two-sided risk ACOs with preliminary prospective assignment with retrospective reconciliation or prospective assignment starting July 1, 2019.	Same as Track 3	CMS may make direct payments to an ACO beneficiary who receives certain services from the Next Gen ACO's Participants and Preferred Providers. Beneficiaries may automatically be eligible for this reward payment should they receive the applicable services. Ex., for the 2017 PY, this reward was a $25 check to all beneficiaries who received a Medicare Annual Wellness Visit from a Next Gen ACO Participant or Preferred Provider.	TBD	TBD	TBD

Other benefit enhancements	Not permitted	Not permitted	Next Gen ACOs are allowed several additional benefit enhancements not included in MSSP. In 2019, CMS is adding Cost Sharing Support for Part B Services, Care Management Home Visits, and a Chronic Disease Management Reward Program. This is on top of the existing Post-Discharge Home Visits Next Gen ACOs are allowed. 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	- Allowing Nurse Practitioners to certify that a patient is eligible for home health services; and • Allowing the provision of home health services to beneficiaries who are not "homebound." - CMS is exploring additional enhancements and payment rule waivers.	Same as the Professional option	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						