This NAACOS ACO comparison chart details the main elements of the tracks in the Medicare Shared Savings Program and Next Generation ACO Model

ISSUE	TRACK 1	TRACK 1+	TRACK 2	TRACK 3	NEXT GENERATION ACO MODEL
Initial program start year	2012	2018	2012	2016	2016
Overview	MSSP ACO Tracks 1 and 2 were included in the original MSSP. The program stems the Affordable Care Act and is designed to enhance care coordination and cooperation among healthcare providers with the overall goals of improved quality and patient outcomes as well as lower costs.	Track 1+ represents a new option for ACOs that is available starting with the 2018 performance year. This model includes elements of other tracks and represents a new two-sided risk model with less risk than Track 2, 3 or the Next Generation ACO model. Track 1+ is available for new ACOs and those in Track 1. ACOs in Track 1+ will actually concurrnetly participate in Track 1.	Same as Track 1	Track 3 was added to the MSSP beginning in 2016. This model takes successful aspects of the MSSP and Pioneer model to create a new MSSP Track with higher shared savings opportunities and greater downside risk.	Similar to the Pioneer Model with higher potential rewards and risk than the MSSP Tracks. Next Gen aims to transition providers from fee-for-service to capitation. Next Gen ACOs must also mote to operating under outcomes-based contracts with other purchasers.
Number of 2018 organizations	460	55	8	38	58
Length of contract	3 years (may remain in Track 1 for 6 years). Starting with the 2017 performance year, Track 1 ACOs selected for MSSP Track 2,3 may defer their start in Track 2 or 3 and remain in Track 1 for an additional fourth year of their initial agreement period. Their Track 2 or 3 agreement period remains three years.	3 years. New ACOs would be permitted to participate for one three-year agreement period. Track 1 ACOs that transition to Track 1+ during their existing agreement period could have the opportunity to renew for a subsequent agreement period in Track 1+.	3 years	3 years	Varies based on NG start year: - 2016 NG ACOs: 3 years - 2017 NG ACOs: 2 years - 2018 NG ACOs: 1 year There is the potential for an extension of up to two additional performance years, regardless of start date. As of Jan. 2018, it unlikely that a new class of NGACOs will be available for 2019.
Advanced APM Staus Under MACRA	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	Advanced APM	Advanced APM	Advanced APM	Advanced APM
FINANCIAL STRUCTURE					
Sharing Rate	Up to 50%	Same as Track 1	Up to 60%	Up to 75%	2 risk arrangement options. Arrangement A offers shared savings/losses of up to 80% in Years 1 through 3, then up to 85% in Years 4 and 5. Arrangement B offers shared savings/losses of up to 100%.
Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR)	2% to 3.9% MSR depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR, (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.	Same as Track 2	ACOs have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0%; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)	Same as Track 2	Next Gen does not utilize MSRs/MLRs. Instead, CMS applies a discount to the benchmark once the baseline has been calculated, trended, and risk adjusted. NGACOs can achieve first dollar savings for spending below the benchmark and are accountable for first dollar shared losses for spending above the benchmark.
Performance Payment Limit	10% (based on total benchmark expenditures each year)	Same as Track 1 (based on total benchmark expenditures each year)	15% (based on total benchmark expenditures each year)	20% (based on total benchmark expenditures each year)	5 to 15%, selected annually (based on total benchmark expenditures each year)
Shared Savings**	First dollar sharing once MSR is met or exceeded	Same as Track 1	Same as Track 1	Same as Track 1	First dollar savings for spending below benchmark (which includes a discount)
Shared Loss Rate	Not applicable	Fixed 30%, regardless of quality performance, applied to first dollar losses once MLR is met or exceeded.	First dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 60%	First dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%	First dollar shared losses for spending above the benchmark
Loss Sharing Limit	Not applicable	For 2018: Either 8% of ACO participant TINs' FFS revenue (revenue-based standard) OR 4% of an ACO's updated historical benchmark (benchmark-based standard). Based on three criteria about ACO participant composition, CMS decides which loss sharing limit for a particular ACO applies. If an ACO is under the revenue-based standard but its loss sharing limit would actually be lower under the benchmark-based standard, that ACO would have the benchmark-based standard apply.	Limit on the amount of shared losses phases in over 3-years, starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and beyond (percentages are based on expected expenditures for which the ACO is responsible - a benchmark-based standard)	15% (percentages are based on expected expenditures for which the ACO is responsible - a benchmark-based standard)	5 to 15%, selected annually (percentages are based on expected expenditures for which the ACO is responsible - a benchmark-based standard)

ISSUE	TRACK 1	TRACK 1+	TRACK 2	TRACK 3	NEXT GENERATION ACO MODEL
Benchmark in initial agreement period	Established based on three years of historical ACO data, using risk-adjusted average per capita expenditures for Parts A and B Medicare FFS beneficiaries for these enrollment types: ESRD, disabled, aged/dual eligible and aged/non-dual eligible. Benchmark years are weighted 10% Year 1, 30% Year 2 and 60% Year 3. CMS applies a national average growth rate to account for inflation and uses national data to trend forward benchmark years. Benchmarks may be adjusted during a performance period due to ACO participant TIN changes.	Same as Track 1	Same as Track 1	Same as Tracks 1	Established prior to each performance year and incorporates historical and regional costs. Initially, the prospective benchmark is established through the following steps: (1) determine the ACO's historical baseline expenditures; (2) apply regional projected trend; (3) risk adjust using the CMS-HCC model; (4) apply the discount, which is derived from one quality adjustment and two efficiency adjustments. CMS makes calculations for populations of beneficiaries in two categories (ESRD and Aged/Disabled). Initial benchmark is rolled forward after each PY for actual trend rates, HCC, and discount factors.
Benchmark in subsequent agreement periods	CMS uses a similar approach with expenditures for beneficiaries in the four categories, but there are some notable differences in setting benchmarks for subsequent agreement periods. Beginning with benchmarks that reset in 2017, CMS weights three historical years equally and incorporates a component of regional expenditure data along with ACO historical expenditure data. This regional methodology is implemented gradually as ACOs enter new agreement periods and this methodology is outlined in detail in our NAACOS resource: https://www.naacos.com/news/NAACOS-SummaryofFinalMSSP-BenchmarkingRule061016.htm	Same as Track 1	Same as Track 1	Same as Track 1	CMS intends to develop an alternative benchmark methodology for PY4 (2019 for ACOs that began in 2016)
Transition to Two-Sided Model	Shared savings only option with no downside risk is available for a maximum of two 3-year agreement periods. Starting with the 2017 performance year, Track 1 ACOs selected for MSSP Track 2,3 may defer their start in Track 2 or 3 and remain in Track 1 for an additional fourth year of their initial agreement period. Under this option, ACOs retain their same benchmark for the 4th year before moving to the two-sided risk model. Their Track 2 or 3 agreement period remains three years.	Track 1+ ACOs are required to transition to higher risk tracks/models after 3 to 5 years (see participation limits in the CMS factsheet: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf	ACOs may elect Track 2 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.	Same as Track 2	Program requires two-sided risk for participation. Next Gen ACOs must also move to operating under outcomes-based contracts with other purchasers.
BENEFICIARIES AND DATA REPORTS					
Minimum number of beneficiaries	5,000	5,000	5,000	5,000	10,000 (unless in a rural area in which case they must have a min. of 7,500)
Beneficiary assignment	Preliminary prospective assignment with retrospective reconciliation. 2 step process to assign beneficiaries: 1) assign beneficiary to an ACO if the beneficiary receives the plurality* of their primary care services from an ACO's PCP. 2) (only for beneficiaries who did not receive any PC services from a PCP), these beneficiaries are assigned to an ACO if they receive the plurality of PC services from ACO professionals in the ACO.	Same as Track 3	Same as Track 1	Similar evaluation of where beneficiaries receive plurality of PCP services, but under Track 3 there is prospective beneficiary assignment. Beginning in 2017, beneficiaries may attest that their main doctor is participating in a T3 ACO and be assigned to that ACO. Beneficiaries who die during the performance year remain on the assigned beneficiary list.	Prospective beneficiary assignment using a two-step process. 1) Determine percent of each patient's outpatient E&M services delivered by Next Gen ACO providers in select primary care specilaites. Those with a plurality of their total care are aligned to the ACO for the subsequent year. 2) Focuses on patients with less than 10 percent of E&M services delivered by Next Gen ACO PCPs to determine whether Next Gen providers in select subspecialities are central to the patient's care, which can result in alignment for the subsequent year. Effective in 2017, CMS will also use voluntary beneficiary alignment.

Voluntary beneficiary alignment	Permitted beginning with PY 2018. CMS incoprorates voluntary alignment into the assignment algorithm which allows beneficiaries to designate an ACO professional as responsible for their overall care. Certain criteria must be met and the alignment remains in place for the PY if it is made by a certain deadline (ex. Oct. 31, 2017 for 2018). Alignments remain in place as long as criteria are met for each year, but the beneficiary does not have to make the designation each year.	Same as Track 1	Same as Track 1	Same as Track 1	Permitted. The NG Model includes a beneficiary attestation policy similar to the updated manual process used under the Pioneer ACO model for the 2016 performance year. In order for a beneficiary to be eligible to voluntarily align with a Next Generation ACO, the beneficiary must have had at least one paid claim for a qualified E/M service on or after January 1, 2014, with an entity that was a Next Generation Participant during performance year one, among other requirements.
Adjustments for beneficiary health status and demographic changes	Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the performance year assigned population. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model. If the overall risk scores for continuously aligned benes (on average across categories) increases, then the year-over-year change in demographic-only risk score is applied to the updated benchmark, which effectively removes the coding-based portion of a change in risk score.	Same as Track 1	Same as Track 1	Same as Tracks 1	Historical benchmark expenditures are risk adjusted using the CMS-HCC model to compare average risk between the baseline and performance year. Initially this was limited to a 3% cap on average risk score increases or decreases, but the decrease was removed for PY 2018.
ISSUE	**TRACK 1**	**TRACK 1+**	**TRACK 2**	**TRACK 3**	**NEXT GENERATION ACO MODEL**
QUALITY REPORTING REQUIREMENTS					
Quality measures	Must report on and/or meet performance thresholds for 31 quality measures. Many measures are pay-for-reporting initially then transition to pay-for-performance in later years.	Same as Track 1	Same as Track 1	Same as Track 1	Same as Track 1 except, the Next Gen ACOs are exempt from ACO measure 11: Percent of ECs Who Successfully Meet Advancing Care Information Requirements.
Reporting requirements	Quality performance impacts eligibility to share in savings, and poor performance can result in the ACO being ineligible for any shared savings.	Same as Track 1	Same as Track 1	Same as Track 1	A better quality score results in a smaller, more favorable benchmark discount for the Next Gen ACO; conversely, a poorer quality score leads to a larger discount, beginning for an NGACO's PY 2.
EHR use	At least 50% of ACO's ECs as defined under MACRA must meet requirements for use of certified electronic health records (EHR) per Advancing Care Information requirements. This measure is double weighted.	Same as Track 1	Same as Track 1	Same as Track 1	Prior to 2017, CEHRT use was a prerequisite for participation. Beginning in 2017 NG ACOs were required to attest whether or not their ACO is in compliance with Participation Agreement and CEHRT requirements by completing a "Next Generation ACO CEHRT Compliance Attestation Form."
Patient satisfaction	Must report on patient experience/ satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for ACOs	Same as Track 1	Same as Track 1	Same as Track 1	Same as Track 1
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 1	Same as Track 1	Same as Track 1	The vast majority of the requiremetns 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.

SNF 3-day rule waiver	Not permitted	Same as Track 3. Permitted (requires separate application).	Not permitted	Permitted beginning 2017; During initial application, T3 ACOs may apply for a waiver of the SNF 3-Day Rule. Only for prospectively assigned beneficiaries that receive otherwise covered post-hospital 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.	Permitted; 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.
Telehealth waiver	Not permitted	Not permitted	Not permitted	No earlier than 2017, CMS may begin to phase-in a waiver of certain billing and payment requirements for telehealth services, but only after testing occurs through the Innovation Center	Permitted; Waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site when telehealth services provided by NGACO providers/suppliers or preferred providers to aligned beneficiaries in specific facilities or at their residence.
Home bound waiver	Not permitted	Not permitted	Not permitted	Not permitted	Permitted; Waiver permits "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision of NGACO providers/suppliers or preferred providers, following discharge from an inpatient facility. Benefit limited to one visit in the first 10 days following discharge and one additional visit in the subsequent 20 days. Starting in 2018, CMS will allow up to 9 medically necessary post-discharge home visits within 90 days of discharge.
Primary care co-pay waiver	Not permitted	Not permitted	Not permitted	Not permitted	CMS may make direct payments to an NGACO beneficiary who receives certain services from the NGACO'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 NGACO Participant or Preferred Provider.
***pluarlity of PC services means a greater proportion of PC services as measured in allowed charges wihtin 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.**					