This NAACOS ACO Comparison Chart details the main elements of the tracks in the Medicare Shared Savings Program as changed by the Pathways to Success rule
This chart reflects policies in place for 2019

	Level A	Level B	Level C	Level D	Level E	Enhanced
Initial program start year	2019	2019	2019	2019	2019	2019
Overview	In late 2018, the MSSP was overhauled with the structure of Tracks 1, 2, 3, 1+ replaced with a Basic and Enhanced track. Basic provides five levels that graduate ACOs to progressively higher levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed into Level E. Levels A and B offer one-sided risk and new ACOs are allowed two or three years there before being forced to take on risk. CMS said in rulemaking it believes ACOs need to take on risk faster in order to produce greater levels of savings. 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	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A
Number of 2019 organizations	Participation in the new Pathways strucuture starts on July 1, 2019.	Participation in the new Pathways strucuture starts on July 1, 2019.	Participation in the new Pathways strucuture starts on July 1, 2019.	Participation in the new Pathways strucuture starts on July 1, 2019.	Participation in the new Pathways strucuture starts on July 1, 2019.	Participation in the new Pathways strucuture starts on July 1, 2019.
Length of contract	Five years	Five years	Five years	Five years	Five years	Five years

Advanced APM status under MACRA	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	Advanced APM	Advanced APM
	Level A	**Level B**	**Level C**	**Level D**	**Level E**	**Enhanced**
Financial structure						
Sharing rate	Up to 40%	Up to 40%	Up to 50%	Up to 50%	Up to 50%	Up to 75%
Minimum savings rate (MSR)/ minimum loss rate (MLR)	Same as Track 1. 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 Level A	Prior to entering a two-sided model, the ACO must select its MSR/MLR as part of the application cycle. The choices are : • 0% MSR/MLR • Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO	Same as Level C	Same as Level C	Same as Level C
Performance payment limit	10% (based on total benchmark expenditures each year)	10% (based on total benchmark expenditures each year)	10% (based on total benchmark expenditures each year)	10% (based on total benchmark expenditures each year)	10% (based on total benchmark expenditures each year)	20% (based on total benchmark expenditures each year)
Shared savings rate**	First dollar sharing once MSR is met or exceeded	First dollar sharing once MSR is met or exceeded	First dollar sharing once MSR is met or exceeded	First dollar sharing once MSR is met or exceeded	First dollar sharing once MSR is met or exceeded	First dollar sharing once MSR is met or exceeded
Shared loss rate	Not applicable	Not applicable	1st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of benchmark	1st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of benchmark	1st dollar losses at 30%, not to exceed 8% of revenue capped at 4% of benchmark in 2019 and 2020	1st dollar losses at 40– 75%, not to exceed 15% of benchmark based on quality score
Loss sharing limit	Not applicable	Not applicable	Calculate 2% of the ACO participants' total Medicare Parts A and B FFS revenue and 1% of the ACO's updated benchmark expenditures. The loss sharing limit is the lesser of those two amounts.	Calculate 4% of the ACO participants' total Medicare Parts A and B FFS revenue and 2% of the ACO's updated benchmark expenditures. The loss sharing limit is the lesser of those two amounts.	Calculate 8% of the ACO participants' total Medicare Parts A and B FFS revenue and 4% of the ACO's updated benchmark expenditures. The loss sharing limit is the lesser of those two amounts.	The loss sharing limit is 15% of an ACO's benchmark.

Benchmark in initial agreement period	CMS will maintain the overall approach to establishing and rebasing 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). As finalized in the December 2018 Pathways rule, CMS will incorporate 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.	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A

Benchmark in subsequent agreement period	CMS will maintain the overall approach to establishing and rebasing 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). As finalized in the December 2018 Pathways rule, CMS will incorporate 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.	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A

Transition to two-sided model	CMS will allow most new ACOs to start their participation in Basic Level A. While CMS will automatically advance ACOs over time along the Basic Track's levels, ACOs could elect annually to move to higher risk levels in the Basic Track for a quicker transition than what is required.	CMS will allow new, low revenue ACOs to stay in Basic Level B for an additional year, giving them three years in shared savings-only models. New, high revenue ACOs will be required to move to Level C in their third year.	See Levels A and B	See Levels A and B	ACOs that enter in Level E of the Basic Track must stay in that level for the length of the five-year agreement period. Low revenue ACOs can participate in the Basic Track for up to two agreement periods. This participation option would mean the ACO remains at Basic Level E for the entire second, five-year agreement period. High revenue ACOs could have at most a single agreement period in the Basic Track.	ACOs will not be permitted to switch from the Basic Track to the Enhanced Track during their five-year agreement period.
	Level A	**Level B**	**Level C**	**Level D**	**Level E**	**Enhanced**
Beneficiaries and data reports						
Minimum number of beneficiaries	5,000	5,000	5,000	5,000	5,000	5,000
Beneficiary assignment	CMS will provide all Basic and Enhanced Track ACOs the choice between prospective assignment or preliminary prospective assignment with retrospective reconciliation for agreements beginning July 1, 2019. ACOs can switch their selection annually prior to the start of a new performance year. CMS also finalized in the final 2019 Medicare Physician Fee Schedule Rule revisions to the definition of primary care services included in the assignment methodology.	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A

Voluntary alignment	CMS will allow patients to select any ACO professional, regardless of specialty, as his or her primary clinician. Previously, CMS required the designated ACO professional be a primary care physician, a physician with a specialty designation specified in §425.402(c), a nurse practitioner, physician assistant, or clinical nurse specialist.	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A
Risk adjustment	CMS previously used a risk adjustment methodology that treated beneficiaries differently depending on whether they are considered newly or continuously assigned. CMS finalized a policy to eliminate the distinction between these two beneficiary types. The agency will instead use a positive 3% risk ratio cap between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries.	Same as Level A	Same as Level A	Same as Level A	Same as Level A	Same as Level A
	Level A	**Level B**	**Level C**	**Level D**	**Level E**	**Enhanced**
Quality reporting requirements						

Quality measures	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.	CMS reduced the current quality measure set from 31 measures in 2018 to 23 required measures in 2019. Specifically, CMS removed 10 measures while adding two measures as part of the agency's Meaningful Measures Initiative to reduce duplication and focus more on outcomes measures.
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.	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.	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.
EHR use	At least 50% of ACOs' eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process)	At least 50% of ACOs' eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process)	At least 50% of ACOs' eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process)	At least 50% of ACOs' eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process)	At least 75% of ACO's eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process).	At least 75% of ACO's eligible clinicans as defined under MACRA must meet requirements for use of cerified EHR per Advancing Care Information requirements (criteria will be met through an annual attestation process).
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.	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.
	Level A	**Level B**	**Level C**	**Level D**	**Level E**	**Enhanced**
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.	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.	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.	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.	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.	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.
SNF 3-day rule	Not permitted	Not permitted	CMS will allow 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 will allow 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 will allow 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 will allow 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.
Telehealth	Not permitted	Not permitted	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.	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.	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.	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.

Beneficiary Incentive Program	Not permitted	Not permitted	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.	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.	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.	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.
Other benefit enhancements	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted

*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