	Track 1	Track 1+	Track 2	Track 3	Next Generation
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 from 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 became Basic Levels A and B under the new Pathways to Success structure.	Track 1+ represented a new option for ACOs starting in 2018. This Center for Medicare and Medicaid Innovation model included elements of other tracks and represented a new two-sided risk model with less risk than Track 2, 3 or the Next Generation ACO model. The track was discontinued and folded into MSSP in 2019, becoming Basic Level E in the new Pathways to Success structure.	Same as Track 1. There is no comparable track under the Pathways structure.	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. Track was transitioned to become the Enhanced Track under the Pathways structure.	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 begin operating under outcomes-based contracts with other purchasers. NOTE: the program rules below are effective through 2018. Starting with the 2019 performance year, certain program policies change, as detailed in this NAACOS summary: https://naacos.memberclicks.net/summary-of-next-generationmodel-program-methodology-changes-for-2019-and-2020
Number of 2019 organizations	394	49	7	37	51* (As of 2/28/2019, CMS hasn't updated the 2019 participant list for the Next Gen program)
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 were 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+. Under the Pathways rule, CMS granted a very limited, one-time exception to allow high revenue ACOs that transitioned to Track 1+ within their current agreement period a one-time option to participate in Basic Level E for a five-year agreement period.	Three years	Three 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. There will not be a new Next Generation Model class for 2019, and the program is scheduled to end Dec. 31, 2020.
Advanced APM status under MACRA	APM (benefits under MIPS but does not qualify for Advanced APM bonuses)	Advanced APM	Advanced APM	Advanced APM	Advanced APM
	Track 1		**Track 2**	**Track 3**	**Next Generation**
Financial structure					
Sharing rate	Up to 50%	Up to 50%	Up to 60%	Up to 75%	2 risk arrangement options. Partial risk offers shared savings/losses of up to 80%. Full risk 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.	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)	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)	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)	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. The discount is applied to the benchmark depending on the shared savings rate selected by the ACO. The performance-adjusted benchmark will be discounted by 0.5% if an ACO chooses a shared savings rate of 80 percent and will be discounted by 1.25% if an ACO chooses a shared savings rate of 100%. Under the new methodology, the discount will be based on the savings rate and not on quality, and the quality bonus will be handled as a withhold independent of the discount.
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 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 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	In 2018 and 2019: 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)	15% (percentages are based on expenditures for which the ACO is responsible - a benchmark-based standard)
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 Track 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 period	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/NAACOSSummaryofFinalMSSP-BenchmarkingRule061016.htm	Same as Track 1	Same as Track 1	Same as Track 1	The Innovation Center will utilize expenditure data from two calendar years to set the financial benchmark. Baseline year one is three years prior to the performance year and baseline year two is two years prior to the performance year. The average expenditure PBPM for each base year will be risk-standardized, standardized for the impact of the geographic adjustment factors that were used in the base year(s) to calculate fee-for-service (FFS) provider payments, and trended to the performance year. In March 2018, the Innovation Center released financial methodology changes for the final 2 years of the program, 2019 and 2020. The revised methodology is summarized in this NAACOS resource: https://naacos.memberclicks.net/summary-ofnext-generation-model-program-methodology-changes-for-2019and-2020
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+ was folded into the MSSP under the Pathways structure to become Basic Level E. Track 1+ ACOs were 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-ServicePayment/sharedsavingsprogram/Downloads/NewAccountable-Care-Organization-Model-Opportunity-FactSheet.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.
	Track 1	**Track 1+**	**Track 2**	**Track 3**	**Next Generation**
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 they must have a minimum 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. 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 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. Determine percent of each patient's outpatient E&M services delivered by Next Gen ACO providers in select primary care specialties. 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 subspecialties are central to the patient's care, which can result in alignment for the subsequent year. In 2019 and 2020, alignment-eligibility and service-area exclusion procedures will be modified to allow an aligned beneficiary to accrue a partial-year of experience. In these instances, a beneficiary will remain aligned and will accrue experience through the last month of continuous eligibility.

Voluntary alignment	Permitted beginning with PY 2018. CMS incorporates 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 Next Gen 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.
Risk adjustment	Under current policy, CMS uses an MSSP risk adjustment methodology that treats beneficiaries differently depending on whether they are considered newly or continuously assigned. Specifically, the current method of updating the benchmark for each performance year within an agreement period involves capping the risk ratio for continuously assigned beneficiaries to the demographic-only risk ratio.	Same as Track 1	Same as Track 1	Same as Track 1	The 2019 benchmark will be risk adjusted to reflect the difference between the baseline risk score and the average risk score of the performance year aligned beneficiaries. A prospective coding adjustment will be applied to performance year risk scores. The benchmark risk score for the performance year will be not less than 100% and not more than 103% of the baseline risk score. The method will continue to include an explicit coding adjustment.
	Track 1	**Track 1+**	**Track 2**	**Track 3**	**Next Generation**
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.	Same as Track 1	Same as Track 1	Same as Track 1	After discussions with internal and external stakeholders, the Next Gen ACO Model in 2019 will continue to mirror the MSSP Quality Measure set, as in past years.
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	CMS will withhold a percentage of a Next Gen ACO's Performance Year Benchmark that can be earned back by hitting quality scores. The quality withhold will replace the standard discounts in the first three years of the NGACO program as the mechanism to recognize providers' quality. In 2019, 2% of the ACO's benchmark will be 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.
EHR use	At least 50% of ACO's eligible clinicans as defined under MACRA must meet requirements for use of certified electronic health records (EHR) per Advancing Care Information requirements.	Same as Track 1	Same as Track 1	Same as Track 1	Prior to 2017, certified EHR use was a prerequisite for participation. Beginning in 2017, Next Gen ACOs were required to attest whether or not their ACO is in compliance with Participation Agreement and certified EHR 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

	Track 1	Track 1+	Track 2	Track 3	Next Generation
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 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.
SNF 3-day rule	Not permitted	Allowed since the track started in 2018. During initial application, ACOs may apply for the waiver. 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	Not permitted	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.	As it has since the beginning of the program, 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.
Telehealth	Not permitted	Permitted starting in 2020 and onward under the Pathways rule for Track 1+ ACOs using prospective assignment.	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. Please note this provision is applicable only to ACOs who have elected prospective assignment.	As it has since the beginning of the program, CMS is waiving the requirement that beneficiaries be located in a rural area and at a specified originating site when telehealth services provided by Next Gen ACO providers/suppliers or preferred providers to aligned beneficiaries.
Beneficiary Incentive Program	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.	Same as Track 1+	Same as Track 1+	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.

Other benefit enhancements	Not permitted	Not permitted	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://naacos.memberclicks.net/summary-of-next-generation-model-program-methodology-changes-for-2019-and-2020

*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