	Level A	Level B	Level C	Level D	Level E	Enhanced
Intellation and the first						
Initial program start year Overview	2019 In late 2018, the MSSP was overhauled	In late 2018, the MSSP was overhauled	2019 In late 2018, the MSSP was overhauled	In late 2018, the MSSP was overhauled	2019 In late 2018, the MSSP was overhauled	2019 In late 2018, the MSSP was overhauled
Overview	with the structure of Tracks 1, 2, 3, 1+	with the structure of Tracks 1, 2, 3, 1+	with the structure of Tracks 1, 2, 3, 1+	with the structure of Tracks 1, 2, 3, 1+	with the structure of Tracks 1, 2, 3, 1+	with the structure of Tracks 1, 2, 3, 1+
		replaced with a Basic and Enhanced track.	replaced with a Basic and Enhanced	replaced with a Basic and Enhanced	replaced with a Basic and Enhanced	replaced with a Basic and Enhanced
	Basic provides five levels that graduate	Basic provides five levels that graduate	track. Basic provides five levels that	track. Basic provides five levels that	track. Basic provides five levels that	track. Basic provides five levels that
	ACOs to progressively higher levels of	ACOs to progressively higher levels of	graduate ACOs to progressively higher	graduate ACOs to progressively higher	graduate ACOs to progressively higher	graduate ACOs to progressively higher
	Track 1+ transformed into Level E. Levels	risk. The Enhanced Track replaces Track 3. Track 1+ transformed into Level E. Levels	levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed	levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed	levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed	levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed
	A and B offer one-sided risk and new	A and B offer one-sided risk and new	into Level E. Levels A and B offer one-	into Level E. Levels A and B offer one-	into Level E. Levels A and B offer one-	into Level E. Levels A and B offer one-
	ACOs are allowed two or three years	ACOs are allowed two or three years	sided risk and new ACOs are allowed two	sided risk and new ACOs are allowed two	sided risk and new ACOs are allowed two	sided risk and new ACOs are allowed
	there before being forced to take on risk.	there before being forced to take on risk.	or three years there before being forced	or three years there before being forced	or three years there before being forced	two or three years there before being
	CMS said in rulemaking it believes ACOs	CMS said in rulemaking it believes ACOs	to take on risk. CMS said in rulemaking it	=	to take on risk. CMS said in rulemaking it	forced to take on risk. CMS said in
	need to take on risk faster in order to	need to take on risk faster in order to	believes ACOs need to take on risk faster			rulemaking it believes ACOs need to
	produce greater levels of savings. More details on the changes can be found in	produce greater levels of savings. More details on the changes can be found in	in order to produce greater levels of savings. More details on the changes can	in order to produce greater levels of savings. More details on the changes can	in order to produce greater levels of savings. More details on the changes can	take on risk faster in order to produce greater levels of savings. More details
	this NAACOS resource:	this NAACOS resource:	be found in this NAACOS resource:	be found in this NAACOS resource:	be found in this NAACOS resource:	on the changes can be found in this
		https://www.naacos.com/naacos-analysis		https://www.naacos.com/naacos-	https://www.naacos.com/naacos-	NAACOS resource:
	of-the-final-mssp-pathways-to-success-	of-the-final-mssp-pathways-to-success-	analysis-of-the-final-mssp-pathways-to-	analysis-of-the-final-mssp-pathways-to-	analysis-of-the-final-mssp-pathways-to-	https://www.naacos.com/naacos-
	rule	rule	success-rule	success-rule	success-rule	analysis-of-the-final-mssp-pathways-to-
						success-rule
Number of 2019	Participation in the new Pathways	Participation in the new Pathways	Participation in the new Pathways	Participation in the new Pathways	Participation in the new Pathways	Participation in the new Pathways
organizations	strucuture starts on July 1, 2019.	strucuture starts on July 1, 2019.	strucuture starts on July 1, 2019.	strucuture starts on July 1, 2019.	strucuture starts on July 1, 2019.	strucuture starts on July 1, 2019.
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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	APM (benefits under MIPS but does not	APM (benefits under MIPS but does not	APM (benefits under MIPS but does not	Advanced APM	Advanced APM
under MACKA	qualify for Advanced APM bonuses)	qualify for Advanced APM bonuses)	qualify for Advanced APM bonuses)	qualify for Advanced APM bonuses)		
	Level A	Level B	Level C	Level D	Level E	Enhanced
Financial structure	W. 4. 400/		L 500/			
Sharing rate Minimum savings rate	Up to 40% Same as Track 1. 2% to 3.9% MSR	Up to 40% Same as Track 1. 2% to 3.9% MSR	Up to 50% Prior to entering a two-sided model, the	Up to 50%  Prior to entering a two-sided model, the	Up to 50% Prior to entering a two-sided model, the	Up to 75% Prior to entering a two-sided model, the
(MSR)/ minimum loss	depending on number of assigned	depending on number of assigned	ACO must select its MSR/MLR as part of	ACO must select its MSR/MLR as part of	ACO must select its MSR/MLR as part of	ACO must select its MSR/MLR as part of
rate (MLR)	beneficiaries. Smaller ACOs have higher	beneficiaries. Smaller ACOs have higher	the application cycle. The choices are: •	the application cycle. The choices are : •	the application cycle. The choices are: •	the application cycle. The choices are: •
	MSR (5,000 assigned beneficiaries = 3.9%	MSR (5,000 assigned beneficiaries = 3.9%	0% MSR/MLR • Symmetrical MSR/MLR in	•	· · · · · · · · · · · · · · · · · · ·	0% MSR/MLR • Symmetrical MSR/MLR
	MSR) and larger ACOs have lower MSR,	MSR) and larger ACOs have lower MSR,	a 0.5 percent increment between 0.5 and		a 0.5 percent increment between 0.5 and	in a 0.5 percent increment between 0.5
	(2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.	(2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.	2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries	and 2.0% • Symmetrical MSR/MLR that varies based on the number of	2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries	and 2.0% • Symmetrical MSR/MLR that varies based on the number of
	beneficialies). Well not applicable.	beneficiality, Well not applicable.	assigned to the ACO	beneficiaries assigned to the ACO	assigned to the ACO	beneficiaries assigned to the ACO
Performance payment	10% (based on total benchmark	10% (based on total benchmark	10% (based on total benchmark	10% (based on total benchmark	10% (based on total benchmark	20% (based on total benchmark
limit	expenditures each year)	expenditures each year)	expenditures each year)	expenditures each year)	expenditures each year)	expenditures each year)
Shared savings rate**	First dollar sharing once MSR is met or	First dollar sharing once MSR is met or	First dollar sharing once MSR is met or	First dollar sharing once MSR is met or	First dollar sharing once MSR is met or	First dollar sharing once MSR is met or
Shared loss rate	exceeded Not applicable	exceeded Not applicable	exceeded  1st dollar losses at 30%, not to exceed	exceeded  1st dollar losses at 30%, not to exceed	exceeded  1st dollar losses at 30%, not to exceed	exceeded 1st dollar losses at 40– 75%, not to
Silareu ioss fate	Inot applicable	Not applicable	2% of revenue capped at 1% of	4% of revenue capped at 2% of	8% of revenue capped at 4% of	exceed 15% of benchmark based on
			benchmark	benchmark	benchmark in 2019 and 2020	quality score
Loss sharing limit	Not applicable	Not applicable	Calculate 2% of the ACO participants'	Calculate 4% of the ACO participants'	Calculate 8% of the ACO participants'	The loss sharing limit is 15% of an ACO's
			total Medicare Parts A and B FFS revenue and 1% of the ACO's updated benchmark	total Medicare Parts A and B FFS revenue and 2% of the ACO's updated	total Medicare Parts A and B FFS revenue and 4% of the ACO's updated benchmark	benchmark.
			expenditures. The loss sharing limit is the		expenditures. The loss sharing limit is the	
			lesser of those two amounts.	sharing limit is the lesser of those two	lesser of those two amounts.	
				amounts.		

Benchmark in initial	CMS will maintain the overall approach to	CMS will maintain the overall approach to	CMS will maintain the overall approach			
agreement period	establishing and rebasing benchmarks	establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks
	based on expenditures from three	based on expenditures from three	based on expenditures from three	based on expenditures from three	based on expenditures from three	based on expenditures from three
	benchmark years leading up to an	benchmark years leading up to an	benchmark years leading up to an	benchmark years leading up to an	benchmark years leading up to an	benchmark years leading up to an
	agreement period using four beneficiary	agreement period using four beneficiary	agreement period using four beneficiary	agreement period using four beneficiary	agreement period using four beneficiary	agreement period using four beneficiary
	categories (ESRD, disabled, aged/dual	categories (ESRD, disabled, aged/dual	categories (ESRD, disabled, aged/dual	categories (ESRD, disabled, aged/dual	categories (ESRD, disabled, aged/dual	categories (ESRD, disabled, aged/dual
	eligible, and aged/non-dual eligible). As	eligible, and aged/non-dual eligible). As	eligible, and aged/non-dual eligible). As	eligible, and aged/non-dual eligible). As	eligible, and aged/non-dual eligible). As	eligible, and aged/non-dual eligible). As
	finalized in the December 2018 Pathways	finalized in the December 2018 Pathways	finalized in the December 2018 Pathways	finalized in the December 2018 Pathways	finalized in the December 2018 Pathways	finalized in the December 2018
	rule, CMS will incorporate regional	rule, CMS will incorporate regional	rule, CMS will incorporate regional	rule, CMS will incorporate regional	rule, CMS will incorporate regional	Pathways rule, CMS will incorporate
	expenditures into benchmarks starting in	expenditures into benchmarks starting in	expenditures into benchmarks starting in	expenditures into benchmarks starting in	expenditures into benchmarks starting in	regional expenditures into benchmarks
	an ACO's initial performance year. ACOs	an ACO's initial performance year. ACOs	an ACO's initial performance year. ACOs	an ACO's initial performance year. ACOs	an ACO's initial performance year. ACOs	starting in an ACO's initial performance
	have a regional adjustment weight of 15%	have a regional adjustment weight of 15%	have a regional adjustment weight of	have a regional adjustment weight of	have a regional adjustment weight of	year. ACOs have a regional adjustment
	or 35% in their first agreement year. ACOs	or 35% in their first agreement year. ACOs	15% or 35% in their first agreement year.	15% or 35% in their first agreement year.	15% or 35% in their first agreement year.	weight of 15% or 35% in their first
	with spending higher than their region	with spending higher than their region	ACOs with spending higher than their	ACOs with spending higher than their	ACOs with spending higher than their	agreement year. ACOs with spending
	would receive the lower weight, and	would receive the lower weight, and	region would receive the lower weight,	region would receive the lower weight,	region would receive the lower weight,	higher than their region would receive
	ACOs with spending lower than their	ACOs with spending lower than their	and ACOs with spending lower than their	and ACOs with spending lower than their	and ACOs with spending lower than their	the lower weight, and ACOs with
	region would receive the higher weight. If	region would receive the higher weight. If	region would receive the higher weight.	region would receive the higher weight.	region would receive the higher weight.	spending lower than their region would
	an ACO is considered a re-entering ACO,	an ACO is considered a re-entering ACO,	If an ACO is considered a re-entering	If an ACO is considered a re-entering	If an ACO is considered a re-entering	receive the higher weight. If an ACO is
	CMS will apply the regional adjustment	CMS will apply the regional adjustment	ACO, CMS will apply the regional	ACO, CMS will apply the regional	ACO, CMS will apply the regional	considered a re-entering ACO, CMS will
	weight that was used in the most recent	weight that was used in the most recent	adjustment weight that was used in the	adjustment weight that was used in the	adjustment weight that was used in the	apply the regional adjustment weight
	agreement.	agreement.	most recent agreement.	most recent agreement.	most recent agreement.	that was used in the most recent
						agreement.
Benchmark in	CMS will maintain the overall approach to	CMS will maintain the overall approach to	CMS will maintain the overall approach			
Benchmark in subsequent agreement	CMS will maintain the overall approach to establishing and rebasing benchmarks	CMS will maintain the overall approach to establishing and rebasing benchmarks	CMS will maintain the overall approach to establishing and rebasing benchmarks	· · ·		CMS will maintain the overall approach to establishing and rebasing benchmarks
	· · ·	· ·		· · ·		· · · · · · · · · · · · · · · · · · ·
subsequent agreement	establishing and rebasing benchmarks	establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks	to establishing and rebasing benchmarks
subsequent agreement	establishing and rebasing benchmarks based on expenditures from three	establishing and rebasing benchmarks based on expenditures from three	to establishing and rebasing benchmarks based on expenditures from three	to establishing and rebasing benchmarks based on expenditures from three	to establishing and rebasing benchmarks based on expenditures from three	to establishing and rebasing benchmarks based on expenditures from three
subsequent agreement	establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an	establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an
subsequent agreement	establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary	establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary	to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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	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	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	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	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	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
subsequent agreement	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%	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%	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	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	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	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
subsequent agreement	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	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	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.	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.	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,	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
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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 most new ACOs to start their participation in Basic Level B for an additional year, giving them three years in shared savings-only models. New, high 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 in the Basic Track.  CMS will allow most new ACOs to start their participation in Basic Level B for an additional year, giving them three years in shared savings-only models. New, high 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 in the Basic Track.	
Level A Level B Level C Level D Level E  Beneficiaries and data	Enhanced
reports	
Minimum number of 5,000 5,000 5,000 5,000 5,000	0 5,000
beneficiaries	
Emeficiary 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.  CMS will provide all Basic and Enhanced Track ACOs the choice between prospective assignment or preliminary 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.  CMS will provide all Basic and Enhanced Track ACOs the choice between prospective assignment or preliminary 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.  CMS will provide all Basic and Enhanced Track ACOs the choice between prospective assignment or preliminary prospective assignment or preliminary 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.  CMS also finalized in the final	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.
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.  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.  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.  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.	ACO professional, regardless of specialty, as his or her primary clinician. Previously, CMS required the designated
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.  CMS previously used a risk adjustment methodology that treated beneficiaries differently depending on whether they 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.  CMS previously used a risk adjustment methodology that treated beneficiaries differently depending on whether they 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.  CMS previously used a risk adjustment methodology that treated beneficiaries differently depending on whether they 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.	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.

Quality reporting requirements						
Quality measures	set from 31 measures in 2018 to 23 required measures in 2019. Specifically,	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	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	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	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.

Telehealth	Not permitted	Not permitted	Medicare will waive its typical	Medicare will waive its typical	Medicare will waive its typical	Medicare will waive its typical
			geographic restrictions for telehealth	geographic restrictions for telehealth	geographic restrictions for telehealth	geographic restrictions for telehealth
			originating sites and count patients'	originating sites and count patients'	originating sites and count patients'	originating sites and count patients'
			homes as originating sites for ACOs	homes as originating sites for ACOs	homes as originating sites for ACOs	homes as originating sites for ACOs
			under two-sided models. This provision is	under two-sided models. This provision	under two-sided models. This provision is	under two-sided models. This provision
			applicable only to ACOs who have	is applicable only to ACOs who have	applicable only to ACOs who have	is applicable only to ACOs who have
			elected prospective assignment.	elected prospective assignment.	elected prospective assignment.	elected prospective assignment.
Beneficiary Incentive	Not permitted	Not permitted	ACOs can establish a CMS-approved	ACOs can establish a CMS-approved	ACOs can establish a CMS-approved	ACOs can establish a CMS-approved
Program			beneficiary incentive program to provide	beneficiary incentive program to provide	beneficiary incentive program to provide	beneficiary incentive program to provide
			incentive payments to eligible	incentive payments to eligible	incentive payments to eligible	incentive payments to eligible
			beneficiaries who receive qualifying	beneficiaries who receive qualifying	beneficiaries who receive qualifying	beneficiaries who receive qualifying
			primary care services. Through this	primary care services. Through this	primary care services. Through this	primary care services. Through this
			program, ACOs may provide limited	program, ACOs may provide limited	program, ACOs may provide limited	program, ACOs may provide limited
			"cash equivalent" incentive payments to	"cash equivalent" incentive payments to	"cash equivalent" incentive payments to	"cash equivalent" incentive payments to
			qualifying patients. The beneficiary	qualifying patients. The beneficiary	qualifying patients. The beneficiary	qualifying patients. The beneficiary
			incentive program is available to two-	incentive program is available to two-	incentive program is available to two-	incentive program is available to two-
			sided risk ACOs with preliminary	sided risk ACOs with preliminary	sided risk ACOs with preliminary	sided risk ACOs with preliminary
			prospective assignment with	prospective assignment with	prospective assignment with	prospective assignment with
			retrospective reconciliation or	retrospective reconciliation or	retrospective reconciliation or	retrospective reconciliation or
			prospective assignment starting July 1,	prospective assignment starting July 1,	prospective assignment starting July 1,	prospective assignment starting July 1,
			2019.	2019.	2019.	2019.
Other benefit	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted	Not permitted
enhancements						
** Shared savings payments are subject to 2% sequestration cut						