# Comparing the Options

## Medicare Shared Savings Program (MSSP) Tracks 1 and 3

<table>
<thead>
<tr>
<th></th>
<th>Track 1</th>
<th>Track 3</th>
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<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>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.</td>
<td>Track 3 was added to the MSSP beginning in 2016. This model takes successful aspects of the MSSP and Pioneer models to create a new MSSP track with higher shared savings opportunities and greater risks.</td>
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<tr>
<td><strong>Length of contract</strong></td>
<td>3 years (may remain in Track 1 for 6 years)</td>
<td>3 years</td>
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<tr>
<td><strong>FINANCIAL STRUCTURE</strong></td>
<td></td>
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<tr>
<td><strong>Sharing Rate</strong></td>
<td>Up to 50%</td>
<td>Up to 75%</td>
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<tr>
<td><strong>Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)</strong></td>
<td>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.</td>
<td>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).</td>
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<tr>
<td><strong>Performance Payment Limit</strong></td>
<td>10%</td>
<td>20%</td>
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<tr>
<td><strong>Shared Savings</strong></td>
<td>First dollar sharing once MSR is met or exceeded</td>
<td>Same as Track 1</td>
</tr>
<tr>
<td><strong>Shared Loss Rate</strong></td>
<td>Not applicable</td>
<td>First dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%.</td>
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<tr>
<td><strong>Loss Sharing Limit</strong></td>
<td>Not applicable</td>
<td>15%</td>
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<tr>
<td><strong>Benchmark in initial agreement period</strong></td>
<td>Established based on three years of historical ACO costs, using risk-adjusted average per capita expenditures for Parts A and B Medicare FFS beneficiaries who would have been assigned to the ACO. Benchmark years are weighted 10% Year 1, 30% Year 2 and 60% Year 3. CMS applies a national average growth rate for later years to account for inflation. Benchmarks may be adjusted during a performance period as a result of ACO participant TIN changes. Trending forward accounts for changes in beneficiary characteristics, and updating the benchmark. Risk and costs calculated for four beneficiary categories (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).</td>
<td>Same as Track 1</td>
</tr>
<tr>
<td><strong>Benchmark in subsequent agreement periods</strong></td>
<td>Same as general approach with as first agreement period but uses equally weighted historical benchmark years (33% each year) and accounts for savings generated by the ACO in its prior agreement period.</td>
<td>Same as Track 1</td>
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### Transition to Two-Sided Model

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<td>Shared savings only option with no downside risk is available for a maximum of two 3-year agreement periods.</td>
<td>ACOs may elect Track 3 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.</td>
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### Beneficiaries and Date Reports

| Minimum number of beneficiaries | 5,000 | 5,000 |

### Beneficiary Assignment

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<td>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.</td>
<td>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.</td>
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### Adjustments for Beneficiary Health Status and Demographic Changes

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<td>Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores results in a lower risk score. Historical benchmark expenditures based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the assigned beneficiary population for the performance year.</td>
<td>Same as Track 1</td>
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### Quality Reporting Requirements

| Quality measures | Must report on and/or meet performance thresholds for 34 quality measures. Many measures are pay-for-reporting initially then transition to pay-for-performance in later years | Same as Track 1 |
| Reporting requirements | Quality performance impacts eligibility to share in savings, and poor performance can result in the ACO being ineligible for shared savings. | Same as Track 1 |
| EHR use | At least 50% of ACO’s PCPs must meet requirements for meaningful use of certified electronic health records (EHR). This measure is double weighted. | Same as Track 1 |
| 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 |

### Waivers

| SNF 3-day rule waiver | Not permitted | Permitted |
| Telehealth waiver | Not permitted | No earlier than 2017, CMS may begin to phase-in a waiver of certain billing and payment requirements for telehealth services, but only after testing occurs through the Innovation Center. |
| Home bound waiver | Not permitted | Not permitted |
| Primary care co-pay waiver | Not permitted | Not permitted |

Source: National Association of ACOs (NAACOS)