ACO Comparison Chart

This chart details the main elements of Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (REACH) ACOs

Reflects policies in effect for 2023

	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Number of ACOs	27	124	9	10	125	161	24	108
Length of contract	Five years						2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.						No future application cycles planned at this time.	
Status under MACRA	MIPS APM				Advanced APM			
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.						Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.	
Financial Structure								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40– 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%
Shared savings cap	10% of updated benchmark					20% of updated benchmark	Gross (S/L): < 5% 5%-10% 10%-15% > 15%	Cap (S/L): 50% 35% 15% 5%	Gross (S/L): < 25% 25%-35% 35%-50% > 50%	Cap (S/L): 100% 50% 25% 10%
Shared losses cap	Not applicable		Lesser of 2% of total Medicare Parts A & B FFS revenue or 1% of updated benchmark	Lesser of 4% of total Medicare Parts A & B FFS revenue or 2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark				
Discount or MSR/MLR	MSR will be 2% to 3.9% 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.		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.				• No MSR/MLR • No discount	○ No MSR/MLR ○ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)

	Beginning in 2024, low revenue ACOs in the Basic Track may share in a portion of savings if the MSR is not exceeded; Levels A & B at 20%; Levels C, D, & E at 25%			
Transition to two-sided model	New, inexperienced ACOs may participate in Basic Level A for a full 5-year agreement period. In a subsequent agreement period, inexperienced ACOs that remain eligible are permitted to progress through Basic Levels A-E, which provides 2 additional years under upside-only (7 years total before downside risk). If ineligible to continue in the glidepath for the second agreement period, ACOs can participate in Level E for all 5 years of the agreement period.	Optional for all ACOs. ACOs may transition back to Level E from Enhanced.	No one-sided model under ACO REACH.	
Benchmark	CMS establishes and rebases MSSP ACO benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual, and aged/non-dual). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs with spending higher than their region have a regional adjustment weight of 15%, ACOs with spending lower than their region receive a weight of 35% in the first agreement year. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement. Beginning in 2024, CMS will: • Incorporate a prospective administrative growth factor based on US per capita cost to update an ACO's benchmark each performance year, creating a new three-way blend. The new update factor would look as follows: ▪ Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 – National Weight)) ▪ Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)] • Account for an ACO's prior savings when establishing benchmarks for renewing and re-entering ACOs. • Reduce the cap on negative regional adjustments from -5 to -1.5 percent.		Prospective blend of historical spending and adjusted Medicare Advantage Rate Book • Standard ACOs using claims-based alignment: fixed 3-year baseline period (2017-19), with application of a trend adjustment and geographic adjustment • Standard ACOs using voluntary alignment, New Entrant ACOs, & High Needs ACOs: only regional expenditures through PY2024 (historical expenditures incorporated beginning PY2025) A health equity benchmark adjustment will be applied based on aligned beneficiaries' social risk. Additional details on benchmark calculations	
Risk adjustment	CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period. Beginning in 2024, CMS will account for changes in demographic risk scores before applying the 3 percent cap and the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual, and aged/non-dual)		CMS will risk adjust historical baseline, regional expenditures, and capitated payments • For Standard & New Entrant ACOs: CMS-HCC prospective risk adjustment model • High Needs ACOs: CMMI-HCC concurrent risk adjustment model for aged & duals, CMS-HCC prospective risk adjustment model for ESRD To control potential increases in coding intensity and risk score growth, CMS will use a normalization factor, a Coding Intensity Factor, and a risk score cap. Additional details on risk adjustment	
Payment options	CMS makes all FFS payments		Primary Care Capitation (PCC) = monthly payments for certain primary care services ~2-7% of TCOC (CMS pays	Optional PCC or Total Care Capitation (TCC) = 100% Parts A & B services for aligned beneficiaries

							claims for all other services) • Fee reduction required for Participant Providers, optional for Preferred Providers • Optional Advanced Payment (APO) up to 100% of benchmark w/ reconciliation	• Fee reduction required for Participant Providers, optional for Preferred Providers
Reconciliation	Full performance year reconciliation following full claims run out period						Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC withhold against actual expenditures incurred by aligned beneficiaries for services provided outside of TCC arrangement.	
Beneficiaries and Alignment								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Minimum number of beneficiaries	5,000						**Standard ACOs:** 5,000 (≥ 3,000 "alignable" beneficiaries in at least one base year) **New Entrant ACOs**: 2,000 in PY23, 3,000 in PY24, 5,000 in PY25-26 (max. 3,000 "alignable" beneficiaries in any base year) **High Needs Population ACOs**: 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26	
Beneficiary alignment	• Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary ○ Voluntary alignment takes precedence over claims-based						• Prospective • Claims-based and voluntary (may market voluntary alignment) ○ Voluntary alignment takes precedence over claims-based ○ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ○ Option to add voluntarily aligned beneficiaries quarterly	

Beneficiary notification requirements	ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in MSSP. Each agreement period, ACOs must furnish a written notice to beneficiaries prior to or at the first primary care visit: • For ACOs under preliminary prospective assignment—send to all FFS beneficiaries prior to or at the first primary care visit during the first performance year that the beneficiary is seen by an ACO participant. • For ACOs under prospective assignment—send to all assigned beneficiaries prior to or at the firs primary care visit. Within 180 days of providing the notice or at the next primary care visit, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.						Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.	
Quality								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Measures	GPRO Web Interface (WI) reporting will sunset after PY 2024. Now through PY 2024, ACOs may report WI, eCQMs/MIPS CQMs, or both (those reporting both will receive the higher of the two scores). The WI will no longer be a reporting option for PY 2025 or later. • WI reporting: 10 total measures (7 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) • eCQMs/MIPS CQMs: 6 total measures (3 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) *Note: CMS may suppress certain measures in certain performance years* NAACOS remains concerned with the timeline and strategy to shift to all payer/eCQM reporting and the NAACOS Digital Quality Measurement Task Force has provided recommendations to CMS on this issue.						• Standard & New Entrant ACOs: assessed on 4 measures (3 administrative claims measures and the ACO CAHPS Survey) • High Needs ACOs: Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions	
Scoring	In order to earn maximum shared saving, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. ACOs that do not meet this threshold may share in a portion of savings by achieving a quality performance score equivalent to the 10th percentile (individual measure performance benchmark) or higher on at least one outcome measure. The ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points.						• 2% benchmark withhold can be earned back through quality scores • Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SE) and health equity data reporting (HEDR) • Highest performers eligible for a bonus	
EHR use	At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT), using an annual attestation process.						ACOs must document that at least 75% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT)	
Compliance and Waivers								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Compliance programs	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.							
Monitoring efforts	CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers through: • Analysis of financial and quality data reported by the ACO as well as aggregate annual and quarterly reports • Analysis of any beneficiary/provider complaints • Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews)						In addition to MSSP monitoring, CMS will monitor REACH ACOs for: • Beneficiaries being shifted to MA • Excessive risk score growth/ inappropriate coding practices • Service use over time Full list of monitoring efforts	

Available waivers	Not applicable	• **SNF 3-day Rule**—Waives 3-day inpatient stay requirement prior to SNF admission. CMS waives 3-star quality rating requirement for providers under swing bed arrangements. • **Telehealth**—Waives typical geographic restrictions count patients' homes as originating sites. (O*nly available to ACOs under prospective assignment*)	• **SNF 3-day Rule**—SNF must be Participant or Preferred Provider and have quality rating of 3+ stars • **Telehealth**—Same as MSSP • **Home visits –** care management and post-discharge • **Chronic Disease Management Reward Program** • **Provision of home health** services to beneficiaries not "homebound" • **Nurse Practitioner Services Benefit** **Hospice Benefit**—Waive requirement to give up curative care (***only for Global*)
Allowable beneficiary incentives	Not applicable	**Beneficiary Incentive Program** —Allows ACOs to provide a limited "cash equivalent" incentive to eligible beneficiaries who receive qualifying primary care services. May not be limited to a subset of beneficiaries or services. **In-kind incentives** — There must be a reasonable connection between items/services and beneficiary's medical care; must be preventive care items/services or advance a clinical goal of the beneficiary; must not be a Medicare-covered item/service	• **Cost sharing support** for Part B services tailored to specific categories of services and/or beneficiaries • **In-kind items or services**—may include home blood pressure monitors, vouchers for OTC medications, transportation vouchers, wellness programs, etc.
Policies to promote health equity	**Health equity quality adjustment:** Beginning PY2023, CMS will award up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. Bonus points are only available to ACOs reporting eCQMs/MIPS CQMs. Additional details on the bonus calculation can be found on p. 14-15 here. **Advance Investment Payments (AIPs):** Beginning PY2024, CMS will provide advance shared savings payments to new, inexperienced, low revenue ACOs, modeled after the ACO Investment Model (AIM). AIPs will consist of a one-time upfront payment $250,000 and quarterly payment calculated per beneficiary over the first 2 years of an ACO's agreement period. ACOs will be able to apply for AIPs as part of the MSSP application cycle. More information can be found on p. 9-12 here.		• Health Equity Plan requirement • Health equity benchmark adjustment • Requirement to collect and report beneficiary-reported demographic and SDOH data • Application scores include ACOs' demonstrated ability to provide high quality care to underserved communities

Additional Resources								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
NAACOS resources	NAACOS MSSP webpage, NAACOS Analysis of the 2023 MPFS, NAACOS Quality webpage						NAACOS ACO REACH webpage, Summary of REACH Financial Specifications, REACH FAQs	
CMS resources	Shared Savings Program webpage, Information for ACOs, Information for Providers, Program Guidance & Specifications, Program Data, MSSP News						REACH Model webpage, Model Factsheet, Financial operating guide, Quality measurement methodology, Provider management guide	