

Differences between Medicare ACO Tracks that may impact ACO financial results

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Executive Summary

For accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP), selecting which track to participate in is a critical decision. Although each ACO's track selection depends on organizational preferences, including risk tolerance, it is critical that ACO leadership have a full understanding of the differences among each of the four tracks. The differences between tracks can have a material effect on an ACO's financial results. This paper, which discusses the differences that can impact ACO financial results, is intended to be an educational resource for ACOs contemplating their own MSSP track selection.

Gross savings and losses for an ACO may differ between Tracks 1 and 2 versus Tracks 1+ and 3 due to the use of different beneficiary assignment windows. Tracks 1 and 2 use a retrospective assignment window that is the 12 months concurrent with the calendar year, while Tracks 1+ and 3 use a prospective assignment window that is the 12 months ending three months prior to the beginning of the calendar year. The number of assigned beneficiaries will typically be 5% to 10% lower using a prospective assignment window.¹ Larger differences in the number of assigned beneficiaries will often occur in geographic areas with higher Medicare Advantage penetration. Although fewer assigned beneficiaries reduces the total expenditures at risk for an ACO, this will likely be partially offset by higher per capita benchmark expenditures for beneficiaries assigned using a prospective assignment window.

The different assigned beneficiary populations for Tracks 1+ and 3 versus Tracks 1 and 2 can have a materially different profile for savings opportunities and impact trends for an ACO. ACOs should analyze their historical experience to quantify the savings opportunities. Prioritizing actionable and financially meaningful savings opportunities can increase the likelihood that the ACO will generate gross savings. Savings opportunities may differ between prospectively versus retrospectively assigned beneficiary populations, which is due to the timing of when assigned beneficiaries are identified, leakage of services to non-ACO providers, prevalence of types of patients or services that the ACO has been able to successfully manage, and other factors. ACOs participating in Tracks 1+ and 3 have an additional savings opportunity if they apply for a waiver of the requirement for a three-day inpatient hospital stay prior to a Medicare-covered stay at an eligible skilled nursing facility (SNF).

There is potential for bias in gross savings and losses among the tracks because of the assignable fee-for-service (FFS) beneficiary population values used in the calculation of an ACO's updated benchmark for a performance year. This bias could occur if the same values are used for beneficiary populations assigned using a prospective versus a retrospective assignment window. Any biases will be mitigated through risk adjustment, but risk adjustment has limitations and may not perfectly reflect differences in the characteristics of beneficiary populations assigned using a prospective versus retrospective assignment window. Therefore, some bias could potentially remain.

Finally, the sharing percentages and limits that are applied to gross savings and losses are different for each track. CMS has designed the tracks to provide the potential for greater shared savings when an ACO accepts greater downside risk. ACOs should model how these parameters will affect the final dollar amount of savings or losses it shares in. The regulations are nuanced and ACOs should develop a thorough understanding of how shared savings and losses could vary depending on certain factors, such as quality scores and minimum sharing/loss rates (MSR/MLR).

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¹ In a March 2013 study that simulated ACOs from 2008 and 2009 100% Medicare fee-for-service claims, it was estimated that the number of assigned beneficiaries was approximately 6.7% lower on average under prospective assignment than under retrospective assignment. See <http://content.healthaffairs.org/content/32/3/587.full.pdf> for more information.

Introduction

Over 95% of the ACOs that have joined the MSSP since its inception in April 2012 chose the Track 1 model initially, primarily because it does not expose the ACO to downside risk, i.e., financial loss. Because ACOs are currently limited to remaining in Track 1 for two three-year agreement periods and Track 1 is not designated an Advanced alternative payment model (APM),² many ACOs are now considering Medicare ACO tracks that have downside risk. Which Medicare ACO track should an ACO choose?

To help ACOs make an informed decision, this paper discusses how an ACO's results may differ among the four tracks in which ACOs in the MSSP can choose to participate: MSSP Track 1, MSSP Track 2, MSSP Track 3, and the Track 1+ Model offered by the Center for Medicare and Medicaid Innovation (CMMI). As the focus is on differences among the tracks, this paper does not discuss all aspects and readers should previously be familiar with the MSSP Shared Savings and Losses and Assignment Methodology Specifications for performance years beginning with 2017.³ This paper addresses the following areas that may cause an ACO's gross and shared savings and losses to vary between the tracks:

- Number of assigned beneficiaries
- Savings opportunities and trend
- Benchmarks and gross savings
- Sharing savings/losses

Number of assigned beneficiaries

There are two different assignment windows used with the claims-based algorithm to assign beneficiaries to ACOs in the Medicare ACO programs. Tracks 1 and 2 use a retrospective assignment window, in which beneficiaries are assigned based upon their utilization of primary care services during the performance year. This assignment window more accurately reflects the beneficiaries who receive care from ACO providers during the calendar year. However, it presents a significant operational challenge because beneficiaries are added and removed during the performance year as an ACO's list of assigned beneficiaries is updated quarterly. Tracks 1+ and 3 use a prospective assignment window, in which beneficiaries are assigned based upon their utilization of primary care services during the 12-month period ending three months prior to the start of the calendar year. This allows an ACO to know who is assigned to it early in a performance year but can result in the ACO being financially responsible for beneficiaries who did not receive care from any ACO providers during the performance year.

National Association of ACOs (NAACOS) members should refer to the paper "The Impact of Retrospective Versus Prospective Attribution on Your ACO"⁴ for a discussion of the pros and cons of retrospective and prospective assignment windows. This information can be useful in assessing operational implications for an ACO. An ACO should also consider that it will likely have fewer assigned beneficiaries if it participates in Tracks 1+ or 3, rather than Tracks 1 or 2. This is because, under prospective assignment, beneficiaries cannot be added to an ACO's list of assigned beneficiaries during a performance year, but they can be removed for various reasons, such as enrolling in a Medicare Advantage plan. We have seen that Medicare ACOs typically have 5% to 10% fewer assigned beneficiaries under prospective assignment than under retrospective assignment, with the larger differences occurring in geographic areas with higher Medicare Advantage penetration.

An ACO with experience in Tracks 1 or 2 can estimate the assigned beneficiaries it would have under Tracks 1+ and 3. The ACO can start with its first preliminary prospective assignment list for a performance year, then remove beneficiaries who died prior to the beginning of the performance year or were not included in subsequent quarterly updated assignment lists due to the prospective assignment exclusion criteria. To illustrate with an example, an ACO participating in Track 1 had 7,563 beneficiaries included in its first preliminary prospective assignment list for a performance year. Then 481 beneficiaries died or became ineligible for assignment during the year. The ACO ended its Track 1 performance year with 7,460 beneficiaries assigned, which is approximately 5% higher than the estimated 7,082 beneficiaries they would have been assigned under the prospective assignment algorithm.⁵

² Participating in an Advanced APM is one of the requirements a physician must meet to qualify for a 5% bonus and higher fee schedule increases beginning in 2026 under the Medicare and CHIP Reauthorization Act (MACRA).

³ The MSSP Shared Savings and Losses and Assignment Methodology Specifications document for performance years beginning with 2017 is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V5.pdf>. Specifications for earlier performance years are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications.html>.

⁴ Available at <https://www.naacos.com/mssp-and-next-generation-acos>.

⁵ This result is consistent with a study by Hsu of patient population loss from Partners Healthcare, an ACO that participated in the Pioneer ACO program. The Pioneer ACO program used prospective assignment of beneficiaries. The study reported that 2.5% to 3.6% of beneficiaries died during a performance year and 0.7% to 6.2% of beneficiaries moved to Medicare Advantage or left the service area by the end of the performance year. See <http://content.healthaffairs.org/content/35/3/422.full.pdf> for more information (subscription required).

FIGURE 1: ILLUSTRATIVE COMPARISON OF PROSPECTIVE AND RETROSPECTIVE ASSIGNMENT

	Prospective	Retrospective
Preliminary assignment	7,563	7,563
Deaths/exclusions during the year	481	481
Increase in assignment during the year*	0	378
Final assignment	7,082	7,460

* This reflects the net changes, which includes both the removal of some preliminarily assigned beneficiaries and adding new beneficiaries.

Figure 2 presents a summary of the 481 beneficiary deaths and exclusions based upon analysis of the quarterly updated assignment lists for the performance year. Consistent with other ACOs we have reviewed, most of the beneficiary exclusions occur by early in the performance year because of death or enrollment in a group health plan, such as a Medicare Advantage plan. Note that beneficiaries who die during the performance year remain assigned through their dates of death, with the exception of retrospectively assigned beneficiaries who do not seek care with the ACO during the performance year.

FIGURE 2: ILLUSTRATIVE EXAMPLE OF ESTIMATING BENEFICIARIES UNDER PROSPECTIVE ASSIGNMENT DEATHS AND EXCLUSIONS PER QUARTERLY UPDATED ASSIGNMENT LISTS

Death/Exclusion	1Q	2Q	3Q	4Q	Total
Deaths prior to beginning of performance year	231				231
Beneficiary had at least one month of Part A-only or Part B-only coverage	1	1	1	1	4
Beneficiary had at least one month in a group health plan	201	8	16	21	246
Beneficiary does not reside in the United States	0	0	0	0	0
Total Deaths/Exclusions					481

Note: In addition to these exclusion criteria, additional criteria must be met for the beneficiary to be initially assigned to the ACO.⁶

For an ACO with experience in Track 3, its first preliminary prospective assignment list for a performance year will usually serve as a reasonable proxy for assignment under Track 2 for the prior performance year if the ACO's participating provider list is stable.

When developing estimates of the number of assigned beneficiaries under the prospective and retrospective assignment algorithms, there are two additional considerations to note. First, prospective assignment takes precedence over retrospective assignment. Thus, ACOs choosing a track with retrospective assignment may have fewer beneficiaries than expected if there are other ACOs or programs within their service areas that have chosen prospective assignment. Second, beginning with performance year 2018, beneficiaries who designate a provider as responsible for coordinating their overall care will be prospectively assigned to the provider's ACO.⁷ This will preempt claims-based assignment of beneficiaries for ACOs participating in all tracks. We expect that initial impacts of this voluntary alignment will be better assessed as preliminary assignment lists for the 2018 performance year become available.

Savings opportunities and trend

In addition to there being fewer assigned beneficiaries under prospective assignment (Tracks 1+ and 3) than under retrospective assignment (Tracks 1 and 2), the savings opportunities of the assigned beneficiaries may differ and impact the trend an ACO is able to achieve for its assigned beneficiary population. Savings opportunities may differ related to the following areas:

- Services performed by ACO versus non-ACO providers
- Prevalence of target patients or services
- Skilled nursing facility three-day rule waiver

⁶ In addition to the criteria outlined in Figure 2, to be assigned beneficiaries must also have a record of enrollment, have the majority of their primary care services from the participating ACO during the assignment period, and not be assigned to any other Medicare shared savings initiatives. For more information please read section 3.1 at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V5.pdf>.

⁷ Beneficiaries must also meet assignment eligibility and other criteria. NAACOS has a resource available for ACOs to learn more about voluntary alignment at <https://naacos.memberclicks.net/naacos-essentials-for-mssp-voluntary-alignment?servId=7312>.

There are a smaller percentage of services performed by ACO providers for a prospectively assigned population than for a retrospectively assigned population because the assignment period is prior to, rather than concurrent with, the performance period.⁸ Higher leakage may make it more difficult for ACOs to manage care and control costs. However, leakage can work in an ACO's favor if providers outside the ACO are more efficient than ACO providers. The degree of leakage will vary by ACO depending upon availability of providers outside the ACO and general turnover in the patient population.

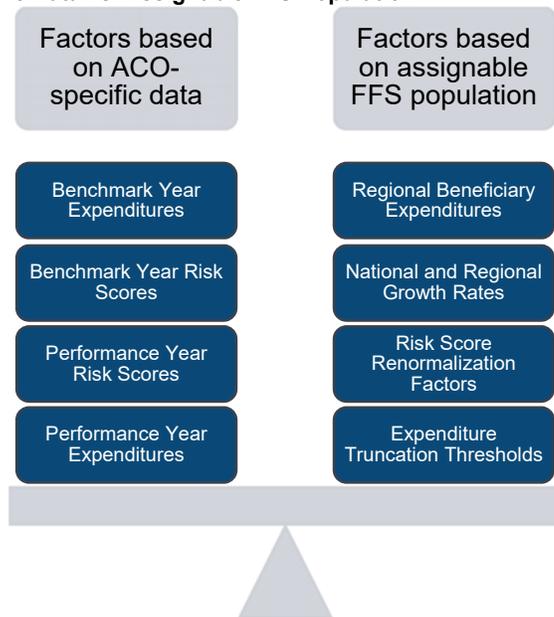
ACOs that have identified certain types of patients or services they have been able to successfully manage will want to consider whether the prevalence of these target patients or services varies materially for prospectively versus retrospectively assigned populations. An ACO can analyze its historical claims experience, differentiating the prospectively versus retrospectively assigned populations, to assess the effect that leakage and the prevalence of target patients or services might have on the ACO's ability to generate savings.

Finally, to go along with the prospective assignment window, ACOs in Tracks 1+ and 3 can apply for a waiver of the requirement for a three-day inpatient hospital stay prior to a Medicare-covered stay at an eligible skilled nursing facility (SNF). This potential opportunity can be quantified using an ACO's historical claims experience by limiting it to inpatient admissions for beneficiaries on the estimated beneficiary assignment list for Tracks 1+ and 3. The inpatient admissions must also be limited to ones that preceded an admission at an ACO-affiliated SNF and otherwise met the criteria for the three-day SNF waiver. Additional criteria specific to how the ACO expects to employ the three-day SNF waiver can be applied to further quantify the potential opportunity. An ACO may identify few admissions that meet the criteria for the three-day SNF waiver or otherwise determine that the operational complexities and other factors associated with the waiver overshadow the potential opportunity.⁹

Benchmarks and gross savings

The methodology used to calculate benchmarks and gross savings is the same across the Medicare ACO tracks. However, the values used in the calculations will vary for an ACO between Tracks 1+ and 3 versus Tracks 1 and 2 due to the use of different beneficiary assignment windows. In this section, we discuss the ACO-specific and assignable beneficiary population values used to calculate benchmarks and gross savings and how they may impact an ACO's gross savings under prospective versus retrospective assignment.

Figure 3: Factors for ACO-Specific Data vs. Assignable FFS Population



⁸ In a March 2013 study that simulated ACOs from 2008 and 2009 100% Medicare fee-for-service claims, it was estimated that approximately 68% of assigned patients' performance year visits occurred within the ACO under prospective assignment in comparison to approximately 74% under retrospective assignment. See <http://content.healthaffairs.org/content/32/3/587.full.pdf> for more information.

⁹ Findings from CMMI's Pioneer ACO program, which included the three-day SNF waiver, are available at <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>.

ACO-specific values

ACO-specific beneficiary expenditures and risk scores are used in the calculation of benchmarks and gross savings for a performance year. Both tend to be a little higher for a prospectively assigned population than for a retrospectively assigned population. This is because new beneficiaries cannot be added after the beginning of the calendar year under prospective assignment, which results in a population that is a little older with more clinical conditions and a higher mortality rate than a retrospectively assigned population. Higher beneficiary expenditures will lead to a higher benchmark, which can partially offset the fewer beneficiaries that ACOs typically have under prospective versus retrospective assignment. However, higher beneficiary expenditures and risk scores under prospective assignment will not consistently lead to higher or lower gross savings. Rather, gross savings is a function of the *change* in risk-adjusted expenditures of the assigned beneficiary population between the benchmark and performance periods.

The benchmark calculation includes a risk adjustment factor, intended to adjust for changes in morbidity between the performance year and benchmark year 3. This morbidity adjustment, however, has an unusual feature. For the continuously assigned population, the Centers for Medicare and Medicaid Services (CMS) will recognize a *decrease* in the risk score. However, if the risk score increases, CMS will only make a demographic adjustment for the aging of this population. In doing this, the risk score is effectively capped for the continuously assigned population in all MSSP tracks. It is worth noting that the proportion of continuously versus newly assigned members is about the same among all four tracks, and therefore we do not expect that this will have a material effect.

Assignable FFS beneficiary population values

Beginning with performance year 2017, the non-ACO-specific values used to adjust an ACO's historical expenditures to arrive at its updated benchmark for the performance year are all based upon the assignable FFS beneficiary population. These values include:

- Expenditure truncation thresholds
- Risk score renormalization factors
- National and regional growth rates and trends
- Regional beneficiary expenditures (for ACOs entering their second or later agreement periods in 2017 or later)

Assignable beneficiaries are those who received a primary care service during the 12-month assignment window. As CMS has noted, this is an improvement over the prior methodology, which used the entire FFS beneficiary population, because it avoids biases in the determination of the factors that could result from including beneficiaries who have not utilized primary care services.

When considering the assignable beneficiary population, it is worth noting that the 12-month assignment window is different for prospective assignment (the 12 months ending three months prior to the performance year) than for retrospective assignment (the 12 months concurrent with the performance year). However, it is not yet clear if CMS will use different assignable FFS beneficiary population values in the calculation of gross savings and losses under prospective versus retrospective assignment. There may be bias in gross savings and losses if the same assignable FFS beneficiary population values are used under prospective and retrospective assignment. Any biases will be mitigated through risk adjustment, but risk adjustment has limitations and may not perfectly reflect differences in the characteristics of prospectively versus retrospectively assigned populations. Therefore, a relatively small amount of bias could remain. A study that examines how well risk adjustment is able to account for differences in the characteristics of prospectively versus retrospectively assigned populations would be needed to quantify the magnitude and direction of any potential impact on gross savings and losses.

Other factors impacting gross savings and losses

The topics discussed thus far have focused on areas contributing to different gross savings and losses under Tracks 1 and 2 in comparison to Tracks 1+ and 3. There are numerous other factors, such as a change in providers included in an ACO's participant list, random variation in beneficiary expenditures and risk scores, and rebasing the historical benchmark for second and later agreement periods, that will affect the gross savings and losses an ACO achieves. Additionally, as noted previously, starting in 2017, CMS began using the assignable FFS beneficiary population for the non-ACO-specific values used to update the benchmark. This change will cause ACO results to differ from previous performance years, although the magnitude and direction is not yet clear. We encourage ACOs to analyze and carefully assess these impacts because they can be significant.

Sharing savings/losses

An ACO choosing among the four Medicare ACO tracks will also need to consider that shared savings/losses will differ because of the varying financial parameters of the tracks, summarized in Figure 4.¹⁰ The financial parameters create different risk/reward profiles for each track.

FIGURE 4: SELECT FINANCIAL PARAMETERS BY MEDICARE ACO TRACK

	Track 1	Track 1+	Track 2	Track 3
Shared Savings Percentage	Up to 50%*	Up to 50%*	Up to 60%*	Up to 75%*
Shared Loss Percentage	N/A	30%	40%-60%*	40%-75%*
Minimum Savings Rate (MSR)	2%-3.9%, varies by number of assigned beneficiaries	0%, 0.5%, 1.0%, 1.5% or 2.0%, depending on ACO choice; or 2%-3.9%, varies by number of assigned beneficiaries		
Minimum Loss Rate (MLR)	N/A	Symmetrical with MSR		
Percentage Payment Limit (upside)	10% of benchmark expenditures	10% of benchmark expenditures	15% of benchmark expenditures	20% of benchmark expenditures
Loss Sharing Limit (downside)	0%	8% of FFS revenue or 4% of benchmark expenditures	PY1 5%, PY2 7.5% PY3+ 10% of benchmark expenditures	15% of benchmark expenditures

* Note: Final sharing percentage will reflect adjustment for quality score.

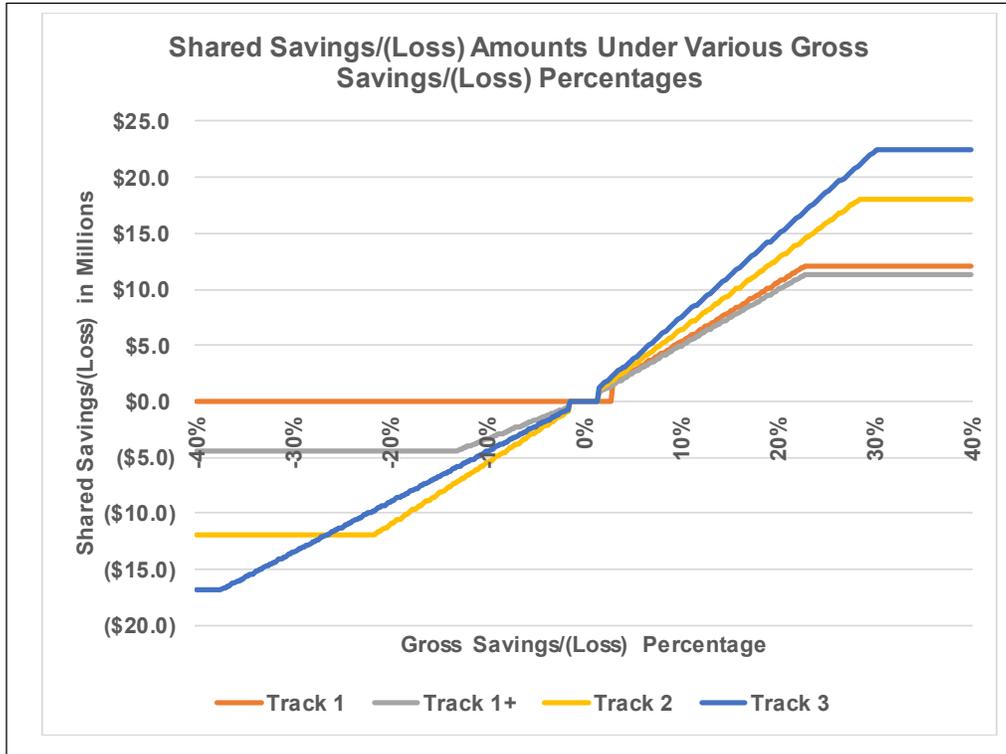
In choosing among the Medicare ACO tracks, an ACO is likely to find it insightful to estimate the dollars of shared savings and losses it would be responsible for at various gross savings and loss rates. An ACO can review this analysis to observe how much shared savings/(loss) amounts vary by track for a given gross savings/(loss) rate and how much maximum shared savings/(loss) amounts vary by track. Figure 5 provides an illustrative example of such an analysis, in both table and graphical presentations. The illustrative example reflects a single performance year using a uniform set of assumptions:

- Regionally adjusted benchmark expenditures per beneficiary per year (PBPY) of \$12,000 for Tracks 1 and 2 and \$12,500 for Tracks 1+ and 3¹¹
- Quality score of 90%
- Assigned beneficiary person-years of 10,000 for Tracks 1 and 2 and 9,000 for Tracks 1+ and 3
- Selection of a 1.5% minimum savings/(loss) rate for Tracks 1+, 2, and 3, and a minimum savings/(loss) rate of approximately 3.0% for Track 1 based upon the number of assigned beneficiaries
- A 4% loss-sharing limit for Track 1+ and a 10% loss-sharing limit for Track 2

¹⁰ See the Appendix of <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf> for a comparison of the Medicare ACO tracks.

¹¹ For our illustration, we use a higher PBPY benchmark for Tracks 1+ and 3 than Tracks 1 and 2, because for the same ACO we generally expect prospective assignment to lead to a higher benchmark and a higher cost than retrospective assignment. This is primarily due to the closed nature of the prospective assignment list.

**FIGURE 5: ILLUSTRATIVE EXAMPLE REFLECTING A SINGLE PERFORMANCE YEAR
 SHARED SAVINGS/(LOSS) AMOUNTS UNDER VARIOUS GROSS SAVINGS/(LOSS) PERCENTAGES
 TABLE PRESENTS SELECTED VALUES FROM GRAPH**



Gross Savings/ (Loss) Percentage	Approximate Shared Savings/(Losses) in Millions			
	Track 1	Track 1+	Track 2	Track 3
Maximum Loss	\$0.0	(\$4.5)	(\$12.0)	(\$16.9)
(10%)	\$0.0	(\$3.4)	(\$5.5)	(\$4.5)
(8%)	\$0.0	(\$2.7)	(\$4.4)	(\$3.6)
(6%)	\$0.0	(\$2.0)	(\$3.3)	(\$2.7)
(4%)	\$0.0	(\$1.4)	(\$2.2)	(\$1.8)
(2%)	\$0.0	(\$0.7)	(\$1.1)	(\$0.9)
(1%)	\$0.0	\$0.0	\$0.0	\$0.0
0%	\$0.0	\$0.0	\$0.0	\$0.0
1%	\$0.0	\$0.0	\$0.0	\$0.0
2%	\$0.0	\$1.0	\$1.3	\$1.5
4%	\$2.1	\$2.0	\$2.5	\$3.0
6%	\$3.2	\$3.0	\$3.8	\$4.5
8%	\$4.2	\$4.0	\$5.1	\$6.0
10%	\$5.3	\$5.0	\$6.4	\$7.4
Maximum Savings	\$12.0	\$11.3	\$18.0	\$22.5

Note: If an ACO generates savings, its financial settlement for the performance year will be reduced for advanced payments elected by the ACO.

As an ACO reviews such an analysis, it should consider the maximum loss it is willing and able to incur as well as the trade-off in shared savings potential that complements the shared loss protection under each track. For example, in Figure 5, we can observe the following:

- Track 3 offers the greatest shared savings opportunity overall and for a given level of gross savings
- Track 3 has the largest exposure to shared losses, but Track 2 shared losses are higher for a given level of gross savings until the ACO hits the loss-sharing limit
- Maximum losses and savings under Track 1+ are significantly less than under Tracks 2 and 3

It may be beneficial for an ACO to develop multiple versions of this analysis if there is a material amount of uncertainty in some of the assumptions, such as the regionally adjusted benchmark expenditures PBPY. The analysis can also be expanded to reflect three performance years in an agreement period. In doing so, the lower loss-sharing limits for the first two performance years under Track 2 can be reflected.

Additionally, an ACO should determine if it qualifies for the alternative Track 1+ loss-sharing limit of 8% of ACO participants' total Medicare FFS revenue.¹² This alternative loss-sharing limit can be significantly lower than the 4% of benchmark expenditures loss-sharing limit. For example, assume an ACO made up of primary care physicians has Medicare FFS revenue is 10% of total Medicare FFS expenditures for the ACO's assigned beneficiaries. This ACO would have a downside limit of approximately 0.8% of benchmark expenditures (10% times 8%), which is one-fifth of the 4% limit.

For ACOs considering Tracks 2 and 3, the two tracks with the highest exposure to losses, there is one noteworthy (and somewhat counterintuitive) difference in the sharing percentages between the two tracks. Because the shared loss percentage is equal to 1 minus the shared savings percentage for each track, the higher shared savings percentages for Track 3 generally result in lower shared loss percentages for Track 3, unless the ACO has a quality score below about 55%. Figure 6 shows the resulting shared savings and loss percentages under Track 2 and Track 3 at various quality scores. Note that Track 3 still has a higher loss-sharing limit, but ACOs would need a very high gross loss rate (about 10% in the first year and up to about 20% in the third year) to approach the loss-sharing limit under either Track 2 or Track 3.

FIGURE 6: SHARING PERCENTAGES FOR TRACK 2 AND 3, BY QUALITY SCORE

Quality Score	Shared Savings Percentage		Shared Loss Percentage	
	Track 2	Track 3	Track 2	Track 3
100%	60%	75%	40%	40%
90%	54%	68%	46%	40%
80%	48%	60%	52%	40%
70%	42%	53%	58%	48%
60%	36%	45%	60%	55%
50%	30%	38%	60%	63%
40%	24%	30%	60%	70%
30%	18%	23%	60%	75%
20%	12%	15%	60%	75%
10%	6%	8%	60%	75%
0%	0%	0%	60%	75%

¹² An explanation of how CMS will determine an ACO's loss-sharing limit under Track 1+ may be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf>.

Conclusion

As ACOs consider which Medicare ACO track to choose, it's important to assess how results may differ among the four tracks for each ACO. In addition to differences in sharing percentages and limits, gross savings and losses are likely to differ for an ACO if it participates in Tracks 1 or 2 versus Tracks 1+ or 3. The differences result from the use of the two different assignment windows in the assignment of beneficiaries to ACOs. The assignment windows impact the number of beneficiaries assigned to the ACO as well as the savings opportunities and trends the ACO might be able to achieve.

An ACO's risk tolerance is likely to be a key decision factor, so it should thoughtfully consider the maximum loss it is willing and able to incur, as well as the trade-off in shared savings potential that complements the protection in shared loss under each track. ACOs that find Tracks 1 and 1+ their best option now should also consider whether Tracks 2 or 3 will be the more attractive long-term option for them, because ACOs can only participate in Track 1 for up to two three-year agreement periods and Track 1+ for one full three-year agreement period.¹³ The points discussed in this paper, along with financial modeling using an ACO's historical experience, can help provide insights for ACOs to make the optimal decisions for their organizations regarding Medicare ACO tracks.

¹³ An ACO can participate in Track 1+ for up to five years by transitioning to Track 1+ during a Track 1 three-year agreement period and remaining in Track 1+ for one full three-year agreement period thereafter. Further details are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf>.

Limitations and qualifications

This paper was prepared on behalf of the National Association of ACOs (NAACOS) to provide education regarding how an ACO's results under the Medicare ACO programs may have differed depending on which track the ACO chooses to participate in. It may not be appropriate for other purposes.

This paper is based upon the authors' current understanding of the MSSP Shared Savings and Losses and Assignment Methodology Specifications for performance years beginning with 2017. To the extent that the specifications continue to evolve or clarifications are provided by CMS, our work may be subject to change.

In performing the analyses for this paper, we relied upon data and information made available by the Centers for Medicare and Medicaid Services (CMS) and ACOs participating in the MSSP. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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