The Physicians Advocacy Institute’s
Medicare Quality Payment Program (QPP)
Physician Education Initiative

Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) Tracks 1, 1+, 2, and 3 Overview
An Advanced Alternative Payment Model (APM) is one of two pathways physicians can choose under the Quality Payment Program (QPP), which was established as part of the Medicare Access and CHIP Reauthorization Act (MACRA). Under the Advanced APM pathway, physicians may be exempt from participation in the Merit-based Incentive Payment System (MIPS) and be eligible to receive a 5% incentive payment. For successful participation in an Advanced APM, physicians need to consider three core building blocks:

- Understanding the basic principles of population health models
- Understanding the variables and rules impacting performance under specific Advanced APMs
- Understanding the relevant QPP rules relating to participation thresholds and requirements

This resource focuses on the second of these three building blocks: understanding the variables and rules impacting performance under specific Advanced APMs, specifically the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) Tracks 1, 1+, 2, and 3. The Centers for Medicare and Medicaid Services (CMS) established the MSSP under the authority of the Affordable Care Act (ACA).
As of March 2018, the program has four different “Tracks:” 1, 1+, 2, and 3. The different tracks correspond to the potential level of risk and shared savings an ACO may receive. As this potential for sharing in savings due to increased efficiencies and improved outcomes increases (“shared savings”), MSSP Tracks 1+, 2, and 3 also require that ACOs also maintain a certain level of financial responsibility for when costs increase (“shared losses”) beyond a determined cost benchmark.¹

The following is an overview of the four different tracks which summarizes their key features and includes a description of the application process and timeline, who can apply to become an MSSP ACO, the types of risk arrangements, the payment mechanisms, and other unique features of this model. Additional details and resources are available on the MSSP website.²

**Goal of the MSSP**

The goal of the MSSP is to “promote accountability for a patient population and coordinate items and services under Medicare Parts A and B and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” In the process of achieving these goals, it is believed that ACOs will be able to achieve better outcomes, decrease costs, and produce savings for Medicare that can then be shared with participating ACOs.

**Establishing a New ACO – Application Process**

The past process of forming an ACO and participating in MSSP for the 2018 performance year is outlined below. CMS plans to release information in the Spring of 2018 for information on the 2019 application cycle.

Generally, you must submit a notice of intent to apply (NOIA) followed by an application. CMS will then proceed through three Request for Information (RFI) periods to clarify and refine the contents of an application. The timeline for the for the 2018 cycle is available here.³

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¹ The concepts of risk and shared savings are explained in additional resources available on the PAI QPP website.  
² https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram  
³ https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/for-acos/application-types-and-timeline.html#Application%20Cycle:%20Request%20for%20Information%20(RFI)%20Response%20Actions%20and%20Deadlines

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Joining an Existing ACO

As of March 2018, MSSP includes 561 ACOs⁴ which serve approximately 10.5 million beneficiaries. Physicians can contact one of these ACOs and inquire about joining.

Figure 1 below provides a breakdown of the participating ACOs by which track they are currently a part of, while Figure 2 provides information on the types of organizations that have formed ACOs.

**Figure 1**⁵

<table>
<thead>
<tr>
<th>Track</th>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Risk Based: Track 1</td>
<td>460</td>
<td>82%</td>
</tr>
<tr>
<td>Risk Based: Track 1+ Model</td>
<td>55</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>5%</td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Track 2</td>
<td>38</td>
<td>7%</td>
</tr>
<tr>
<td>Track 3</td>
<td>30</td>
<td>6%</td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>30</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Figure 2**⁶

<table>
<thead>
<tr>
<th>Type</th>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians Only</td>
<td>171</td>
<td>30%</td>
</tr>
<tr>
<td>Physicians, Hospitals, &amp; Other Facilities</td>
<td>324</td>
<td>58%</td>
</tr>
<tr>
<td>FQHCs / RHCs</td>
<td>66</td>
<td>12%</td>
</tr>
</tbody>
</table>

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⁶ Ibid

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Eligibility of Providers/Suppliers

In order for participating providers to form an ACO, they must serve a plurality of evaluation and management (E&M) services to at least 5,000 Medicare fee-for-service (FFS) beneficiaries and participate in the program for at least 3 years. A provider participating in MSSP is defined as “...an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants.”

The following groups of providers and suppliers of Medicare-covered services are eligible to form an ACO:

- ACO professionals (i.e., physicians and certain non-physician practitioners) in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint ventures arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Certain critical access hospitals
- Federally qualified health centers, and
- Rural health clinics

If an ACO is formed by more than one provider or supplier, the ACO must be a separate legal entity from the providers or suppliers that formed it (i.e., the ACO must have its own tax identification number (TIN)).

Beneficiary Attribution and Alignment

In order to assign the cost of a patient to a provider or providers, CMS uses a “beneficiary attribution” methodology. Tracks 1 and 2 use a preliminary prospective assignment with retrospective reconciliation. Tracks 1+ and 3 use a prospective attribution. Additionally, a “voluntary alignment” option is also in the process of becoming available to beneficiaries for all MSSP Tracks, allowing them to elect to be aligned with an MSSP ACO. The infographic on the next page provides a summary of these methodologies.

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7 42 CFR 425.20

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A beneficiary is attributed to the ACO if he or she receives the plurality of his or her primary care services from primary care practitioners. If a beneficiary has not received a primary care service from a primary care practitioner inside or outside the ACO then the beneficiary is attributed to the ACO if he or she receives a plurality of his or her primary care services from certain ACO professionals within the ACO. The infographic on the next page provides an overview of this methodology.

<table>
<thead>
<tr>
<th>Attribution Method</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective Attribution</td>
<td>Assigns beneficiaries based on historical claims data, typically from the prior year. Allows patient and physician notification. Assumption that most patients will use the same providers in the future as they have in the past. Advantage: quality and cost reports available on a timely basis. Disadvantage: if something occurs that substantially changes the mix of patients served by clinicians affiliated with the model from one year to the next there can be a material mis-match between the patients actually cared for and those assumed under the model.</td>
</tr>
<tr>
<td>Retrospective Attribution</td>
<td>Assigns beneficiaries based on their actual utilization during the performance period. Advantage: Could increase efficiency. Disadvantage: Inability to provide timely reporting to providers. Timely reporting could allow for adjustments that increase likelihood of model success.</td>
</tr>
<tr>
<td>Hybrid Attribution</td>
<td>Preliminarily assigns beneficiaries based on prior year's data, but reconciles the patient attribution list based on performance year data to arrive at final attribution. Hybrid approach seeks to strike a balance between purely prospective and retrospective attribution approaches.</td>
</tr>
<tr>
<td>Voluntary Beneficiary Alignment</td>
<td>Beneficiaries are allowed to voluntarily align themselves with an MSSP ACO for a subsequent performance year.</td>
</tr>
</tbody>
</table>
**Payment Mechanisms**

Medicare will continue to pay individual ACO providers and suppliers for covered items and services as it currently does under the Medicare Fee-For-Service payment systems. However, as discussed above, ACOs will be eligible to receive shared savings, or be responsible for shared losses, based on their performance compared to their established benchmarks.

**Risk Arrangements**

As part of the different tracks offered through MSSP, there are a series of differences between how much risk (shared losses) and reward (shared savings) each track provides and the limits on either.

**Minimum Savings Rate (MSR)**

Track 1 is the only model with “upside risk” only. Upside risk refers to the amount of shared savings a participating ACO may receive. In order to receive any amount of shared savings, an ACO must satisfy minimum quality performance standards. These performance standards are calculated in the form of a minimum savings rate (MSR), which is a percentage of the ACO’s benchmark and is adjusted by the number of assigned beneficiaries (smaller ACOs have higher MSRs). Once a Track 1 ACO achieves savings beyond its MSR, it is eligible to receive up to 50% of those savings. The amount of savings a Track 1 ACO receives is capped at 10% of its updated benchmark.
Minimum Loss Rate (MLR)
Tracks 1+, 2, and 3 also incorporate “downside risk” in addition to upside risk. Downside risk refers to the amount of losses a participating ACO will be responsible for if its costs exceed a threshold referred to as the minimum loss rate (MLR). Similar to the MSR, the MLR is also a percentage of the ACO’s benchmark.

Track 1+, 2, and 3 ACOs have the choice of symmetrically setting their MSR and MLR (meaning the MSR and MLR will be set at the same level above and below the benchmark) in increments of 0.5% between 0% and 2% (e.g. if an ACO sets its MLR at 1.5% it must also set its MSR at 1.5%). Once an ACO exceeds its MLR, it will be responsible for a certain portion of the losses based on which track it selected. These losses are capped at a certain percentage (which gradually increases over time) of an ACO’s benchmark.

The table on the next page provides a summary of all of the shared savings, losses, MSR, and MLR for each of the MSSP tracks. Participating in an arrangement with more than nominal downside risk exposure will require a well-considered understanding of the cost structure, maturity of the population health initiatives available and planning for repayment in case losses are incurred.

Additionally, please see the following CMS resource for more details on the MSR and MLR: Accountable Care Organizations: What Providers Need to Know. 9

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9 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf
Benchmark Calculation

In order to calculate an ACO’s shared savings or shared loss payments, CMS first establishes a cost, or expenditure, benchmark during the initial agreement period based on three years of historical data, using risk-adjusted average per capita expenditures for Medicare Parts A and B FFS.
beneficiaries. The beneficiaries are divided into the following enrollment types: end stage renal
disease (ESRD), disabled, aged/dual eligible and aged/non-dual eligible.

CMS applies a national average growth rate to account for inflation and uses national data to trend
forward benchmark years. CMS uses a similar approach with expenditures for beneficiaries in the
four categories, but there are some notable differences in setting benchmarks for subsequent
agreement periods. Benchmarks may be adjusted during a performance period due to changes in
the providers or suppliers participating in the ACO.

Beginning with benchmarks that reset in 2017 and beyond, CMS will incorporate a component of
regional expenditure data along with ACO historical expenditure data.

**Quality Measures**

ACOs are required to report quality data used to calculate and assess their performance. In order
to be eligible to share in any savings generated, an ACO must meet the established quality
performance standard that corresponds to its performance year. In the first performance year of
the first agreement period, an ACO meets the quality performance standard and qualifies for the
maximum sharing rate when it completely and accurately reports on all quality measures.

In subsequent performance years, quality performance benchmarks are phased-in for
performance measures and the quality performance standard requires ACOs to continue to report
quality data on all measures, but the ACO’s final sharing rate is determined based on its
performance compared to national benchmarks.

A full list of the quality measures for performance years 2018 and 2019 can be found in Appendix
A of the [MSSP Quality Measure Benchmarks for the 2018 and 2019 Reporting Years resource]\(^\text{10}\).

**Waivers**

For performance years 2017 onward, Tracks 1+ and 3 ACOs can apply and be approved for use of
the SNF 3-Day Rule Waiver. CMS will waive the requirement for a 3-day inpatient hospital stay
prior to a Medicare-covered post-hospital extended care service for eligible beneficiaries who are

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\(^{10}\) [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-
and-2019-quality-benchmarks-guidance.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-
prospectively assigned to an ACO participating in Track 1+ or 3. To learn more about this waiver, please see the following resource on the SNF 3-Day Waiver.\textsuperscript{11}

**MSSP ACOs and the Quality Payment Program (QPP)**

Under the QPP, physicians and other eligible clinicians who are in an MSSP Track 1+, 2, or 3 ACO are considered to be participating in an Advanced APM. Physicians and other eligible clinicians\textsuperscript{12} on the Participant List for MSSP Track 1+, 2, or 3 ACOs can receive one of three Advanced APM determinations for their participation.

![Qualifying Advanced APM Participant (QP)](image1)

- Eligible to receive a 5% incentive payment
- Exempt from MIPS

![Partially Qualifying Advanced APM Participant (PQ)](image2)

- Not eligible to receive a 5% incentive payment
- Exempt from MIPS (however, the APM Entity could elect to participate in MIPS using the MIPS APM scoring standard and be eligible to receive a positive payment adjustment)

![Neither a QP or PQ](image3)

- Subject to MIPS participation using the MIPS APM scoring standard

Unlike QPs, PQs would not be eligible to receive a 5% incentive payment for their participation, but they would be exempt from MIPS participation. However, the MSSP Track 1+, 2, or 3 ACO may elect to participate in MIPS using the MIPS APM scoring method. Under the MIPS APM scoring method option, all physicians and other eligible clinicians in the MSSP Track 1+, 2, or 3 ACO would be evaluated in three of the four MIPS categories: quality would be 50% of the MIPS score, advancing care information would be 30%, and improvement activities would be 20%. The cost category is reweighted to 0% because physicians are already subject to a cost assessment.

MSSP Track 1 is considered a MIPS APM and will be scored according to the MIPS APM scoring standard. Track 1 ACOs and their physicians and other eligible clinicians may be eligible to receive

\textsuperscript{11} http://innovation.cms.gov/Files/x/pioneeraco-snfwaiver.pdf

\textsuperscript{12} For 2018, eligible clinicians are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists.

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a positive payment adjustment based on their performance in MIPS using the MIPS APM scoring method.

To learn more about the MIPS APM scoring methodology, please see PAI’s MIPS APM Scoring Overview resource.

While the QP and PQ determinations apply at the individual level, they are determined at the APM Entity level. In this case the APM Entity is the MSSP Track 1+, 2, or 3 ACO, and all physicians and other eligible clinicians on the MSSP Track 1+, 2, or 3 ACO’s Participant List must collectively meet the thresholds for becoming a QP or PQ.

Where can I go for more information?

For additional information on the QPP requirements for Advanced APM participation please see the QPP Advanced APM Overview resource, available on PAI’s website under the Advanced APM Pathway page. Additional resources are available on the MSSP website.

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13 http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Advanced-APM-Pathway/MIPS-APM-Scoring-Overview.pdf
14 http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Advanced-APM-Pathway/QPP%20Advanced%20APM%20Overview.pdf
15 http://www.physiciansadvocacyinstitute.org/MACRA-QPP-Center/Advanced-APM-Pathway
16 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram