Appendix A. Financial Parameters for MSSP Risk Tracks (changes from proposals in NPRM marked in blue)

	Track 1: One-Sided Risk Starter ACO Model	**Track 2: Two-Sided Risk Model**	**Track 3: Advanced Two-Sided Risk Model**	**Track 4: Population-Based Payment Model**
Transition to Two-Sided Model	Allow ACOs to remain in a one-sided risk model for an additional performance period (not to exceed a total of 6 years in one-sided risk) before being required to transition into a two-sided risk model	ACOs may elect Track 2 without completing a prior agreement period under a one-sided model ACOs cannot switch into Track 1 for subsequent agreement periods	ACOs may elect Track 3 without completing a prior agreement period under a one-sided model ACOs cannot switch into Track 1 for subsequent agreement periods	ACOs may elect Track 4 without completing a prior agreement period under a one-sided model ACOs cannot switch into Tracks 1, 2, or 3 for subsequent agreement periods
Capitated Payments	N/A			Population-based payment of up to 50% of ACO's historical part A & B revenue
Quality Sharing Rate	Up to 50% based on quality performance in the first performance period Reduced by 10 percent (40%) in second performance period, if ACO remains in Track 1	Up to 60% based on quality performance	Up to 75% based on quality performance	Up to 70% of savings for services not included in the capitated payment, based on quality performance
Shared Savings	First dollar sharing once MSR is met or exceeded			First dollar sharing once MSR is met or exceeded for payments outside of capitated payment
Minimum Savings Rate (MSR)	2.0% to 3.9% depending on number of assigned beneficiaries.	Fixed 2.0% Explore extending the lower bound to one percent for organizations with over 80,000 beneficiaries, if there is evidence that these organizations are statistically less significant to reach the MSR		Fixed 1.0% for savings outside of the capitated payment
Minimum Loss Rate (MLR)	N/A	Fixed 2.0%		Fixed 1.0% for losses outside of the capitated payment
Shared Loss Rate	N/A	One minus final sharing rate applied to first dollar losses once	One minus final sharing rate applied to first dollar losses once	One minus final sharing rate applied to first dollar losses once

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		MLR is met or exceeded; Shared loss rate not to exceed 60% Consider creating a sliding scale for the shared loss rate (15 percent to 60 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience	MLR is met or exceeded; Shared loss rate not to be less than 40% or exceed 75% Consider creating a sliding scale for the shared loss rate (15 percent to 75 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience	MLR is met or exceeded; Shared loss rate not to be less than 40% or exceed 70%
Performance Payment Limit	10%	15%	20%	15% of savings outside of capitated payment
Loss Sharing Limit	N/A	Limit on the amount of losses increases annually over 3 years (5% in year 1, 7.5% in year 2, 10% in year 3 and subsequent years); Losses in excess of the annual limit would not be shared	15% Losses in excess of annual limit would not be shared	15% of losses outside of capitated payment Losses in excess of annual limit would not be shared
Beneficiary Assignment	Maintain existing beneficiary assignment process: preliminary prospective beneficiary assignment, followed by retrospective reconciliation at the end of each performance year based on whether the patient received a plurality of services from ACO providers	Prospective patient assignment for reports and financial reconciliation at the beginning of each performance year Limited reconciliation at the end of each performance year to remove ineligible beneficiaries, including those that joined MA plans or moved outside of the ACO provider network region		

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Patient Choice in Assignment	N/A	Allow patients to opt-in or opt-out of assignment to an ACO as a supplement to the existing patient assignment process, which occurs simultaneously with beneficiary decision about data sharing opt-out • Opt-in or opt-out may occur during a 3-month period at beginning of each performance year • ACOs must inform patients of the option to attest ACO via signage in patient waiting areas • CMS administers the process and collects all patient choices • Patient opting into the ACO are eligible for eliminated or reduced copays for primary care services furnished by providers in the ACO provider network		
Benchmark	Continue to use existing historical methodology	Continue to use existing historical methodology in first agreement period Beginning in second agreement period, transition the benchmark to a blended historical-regional methodology: • Second contract: gradual transition to 40 percent historical benchmark/60 percent regional benchmark • Third contract: transition from 20 percent historical/80 percent regional to 100 percent regional benchmark after the first year • Fourth and any subsequent periods: 100 percent regional		
Adjustments for health status and demographic changes	In conjunction with revised benchmark methodology transition, use CMS-HCC risk adjustment model on an annual basis to account for the risk profile and health status of the patient population. Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted on an annual basis using demographic and health status factors, which can result in both a decreased and increased risk score			
Waivers for Existing FFS Payment Requirements	N/A	Allow the use of waivers (SNF 3-day Rule, Billing and Payment for Telehealth Services, Homebound Requirement, and Referrals to Post-Acute Care Settings), with greater flexibility from traditional FFS restrictions for ACOs that are bearing more substantial downside risk Consider use of waivers for co-pays of beneficiaries of the CCM code, and to allow ACOs to cover additional costs that deemed necessary for chronic care management, particularly for ACOs bearing downside risk		
Quality Measures	• Continue to shift toward more outcome oriented quality measures, particularly those that are patient reported • Require more sophisticated quality measures for larger ACOs and those taking on higher risk • Consider providing payment bonuses for reporting on more advanced measures and for better performance on quality measures, as in the Medicare Advantage program			