This NAACOS MSSP vs ACO REACH Comparison Chart details the main elements of Advanced Alternative Payment Model (APM) ACOs. This chart reflects policies that will be in effect for 2023.

	MSSP Basic Level E	MSSP Enhanced	REACH – Professional	REACH – Global
Initial program start year	2019*	2019*	2023^	2023^
Overview	MSSP started with two participation options or "tracks," one with risk and one without. Over the years, the program and its participation options have evolved and in late 2018, the MSSP was overhauled with the structure of Tracks 1, 2, 3, 1+ replaced with a Basic and Enhanced track. Basic provides five levels that graduate ACOs to progressively higher levels of risk. The Enhanced Track replaces Track 3. Track 1+ transformed into Level E. More details on the changes can be found in this NAACOS resource.		ACO REACH is an evolution of GPDC, the successor to the Next Gen ACO Model. REACH offers a move toward capitation while providing options for organizations that have not previously participated in Medicare FFS. It also represents an effort by CMMI to embed health equity into payment models. The Professional option is a lower-risk payment model option that will provide a capitated payment for enhanced primary care services.	The Global option of ACO REACH offers a higher risk sharing arrangement and provides two payment options: Primary Care Capitation and Total Care Capitation. Each are risk-adjusted monthly payments for all services provided by REACH Participants and preferred providers with whom the ACO has an agreement.
Number of organizations	98 (in 2022)	146 (in 2022)	TBA	TBA
Length of contract	Five years	Five years	Based on start year: 2021: 5 years, 9 months 2022: 5 years 2023: 4 years	
Status under MACRA	Advanced APM	Advanced APM	Advanced 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; this beneficiary representative must have full voting rights.		Participating providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a consumer advocate, which must be two distinct individuals each with full voting rights.	

Policies to promote health equity	Not applicable		• ACO must develop and implement a Health Equity Plan that explains work to improve access to and quality of care for underserved communities • A health equity benchmark adjustment will be applied at the beneficiary-level to increase benchmarks for ACOs that serve a higher proportion of underserved patients • REACH ACOs are required to collect and report certain beneficiary-reported demographic and SDOH data for their aligned beneficiaries Application scores include the ACO's demonstrated ability to provide high quality care to underserved communities	
Financial Structure				
	MSSP Basic Level E	**MSSP Enhanced**	**REACH – Professional**	**REACH – Global**
Risk-sharing arrangement	• Savings: 1st dollar savings at 50% • Losses: 1st dollar losses at 30%	• Savings: 1st dollar savings at 75% • Losses: 1st dollar losses at 40–75%	• 50% shared savings/losses • 1st dollar savings and losses	• 100% shared savings/losses • 1st dollar savings and losses
Discount or MSR/MLR	Three options: • 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)
Savings/Losses cap	• Savings: 10% of updated benchmark • Losses: Calculate 8% of the ACO participants' total Medicare Parts A and B FFS revenue and 4% of the ACO's updated benchmark expenditures; loss sharing limit is the lesser of the two	• Savings: 20% of updated benchmark • Losses: 15% of updated benchmark	For gross savings/ losses: < 5% 5% - 10% 10% - 15% > 15% Savings/ losses capped at: 50% 35% 15% 5%	For gross savings/ losses: < 25% 25% - 35% 35% - 50% > 50% Savings/ losses capped at: 100% 50% 25% 10%
Benchmark	CMS establishes and rebases benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs have a regional adjustment weight of 15% or 35% in their first agreement year. ACOs with spending higher than their region would receive the lower weight, and ACOs with spending lower than their region would receive the higher		Prospective blend of historical spending and adjusted Medicare Advantage Rate Book (established by CMS as the ACO REACH/KCC (Kidney Care Choices) Rate Book) • For Standard ACOs using claims-based alignment: the baseline period will be a fixed 3-year period (2017, 2018, 2019) • For Standard ACOs using voluntary alignment, New Entrant ACOs, and High Needs ACOs: CMS will only use regional expenditures through PY2024 and will incorporate historical expenditures beginning in PY2025	

	weight. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement.		A health equity benchmark adjustment will be applied to increase the benchmark for ACOs serving higher proportions of historically underserved communities (additional details in health equity section)	
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.		CMS will risk standardize the historical baseline by applying an ACO's risk score to each base year • For Standard and New Entrant ACOs, CMS will use the CMS-HCC prospective risk adjustment model • High-Needs Population ACOs use the CMMI-HCC concurrent risk adjustment model To control potential increases in coding intensity and risk score growth, CMS will use: 1. Prospective estimated normalization factor, retrospectively adjusted 2. Application of retrospective Coding Intensity Factor 3. Application of ACO-level +/3% risk score cap Beginning in PY2024, CMS will modify the +/-3% cap to adopt a static reference year population and cap the ACO's risk score growth relative to demographic risk score growth	
Payment options	CMS makes all FFS payments	CMS makes all FFS payments	Primary Care Capitation (PCC): ACO is paid a monthly capitated payment for estimated enhanced primary care expenditures • Payment amount will generally equal 7% of TCOC • Claims reduction is flexible through PY2024 and increases to 100% of primary care claims by PY2025 • CMS pays claims for all other services May elect Advanced Payment for up to 100% of the benchmark, reconciled at the end of the PY (similar to the AIPBP payment mechanism in Next Gen)	May choose between PCC and TCC Total Care Capitation (TCC): 100% capitation for all Medicare Part A & B services for aligned beneficiaries • Providers submit claims but all payments go to the ACO • Participant Providers required to take a 100% fee reduction to claims • Optional fee reduction for preferred providers (1-100%)
Reconciliation	Full performance year reconciliation following full claims run out period	Full performance year reconciliation following full claims run out period	Capitation Payment Mechanisms in ACO REACH are not reconciled against actual claims expenditures with the exception of the Advanced Payment Option for Enhanced PCC, which is recouped in its entirety by CMS.	

			For ACOs electing TCC: Following the conclusion of the PY, CMS will reconcile the TCC Withhold against actual expenditures incurred by aligned beneficiaries for services provided by providers and suppliers not participating in TCC Payment.	
Beneficiary Alignment				
	MSSP Basic Level E	**MSSP Enhanced**	**REACH – Professional**	**REACH – Global**
Minimum number of beneficiaries	5,000	5,000	• Standard ACOs: 5,000; at least 3,000 "alignable" beneficiaries in at least one base year (CY2017, 2018, or 2019) • New Entrant ACOs: 2,000 in PY2023; 3,000 in PY2024; 5,000 in PY2025-2026; max. 3,000 "alignable" beneficiaries in any base year • High Needs Population ACOs: 500 in PY2023; 750 in PY2024; 1,200 in PY2025; 1,400 in PY2026	
Beneficiary assignment	• 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 alignment • Ability to market voluntary alignment • Voluntary alignment will take precedence over claims-based • Voluntary alignment completed through MyMedicare.gov takes precedence over paper-based voluntary alignment • Option to add voluntarily aligned beneficiaries quarterly	
Quality reporting				
	MSSP Basic Level E	**MSSP Enhanced**	**REACH – Professional**	**REACH – Global**
Quality measures	For years 2021 through 2024, ACOs in all tracks will have the option of reporting via the Web Interface (WI), reporting Advanced Performance Pathway (APP) measure set via eCQMs/MIPS CQMs, or both. Those which report both will be awarded the higher of the two scores. Those reporting WI will be scored on 10 total measures, including 7 WI quality measures, 2 administrative claims measures, and CAHPS for MIPS. Those reporting eCQMs/MIPS CQMs will be scored on 6 total measures, including 3 APP clinical quality measures, 2 administrative claims measures, and CAHPS for MIPS. Note that CMS may suppress certain measures in certain performance years due to issues establishing a benchmark, or other measure issues.		• Standard and New Entrant ACOs will be assessed on 4 measures, 3 administrative claims measures and the ACO CAHPS Survey • For High Needs ACOs, the Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions	
Reporting requirements	In order to be eligible to earn shared savings, 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. If an ACO meets this minimum standard, it will share in the maximum shared savings rate prescribed in a particular track, regardless of its final quality score. Details about determining shared losses and		• CMS will withhold 2% of ACO's benchmark that can be earned back through quality scores • ½ of the withhold is tied to the CI/SEP threshold: if the ACO meets the threshold, multiply the total quality score by 2% to determine how much of the withhold is earned back (multiply by 1% if threshold not met)	

	other quality reporting and scoring details are available in this NAACOS resource.		• CMS will also employ a "High Performers Pool" funded by quality withholds • Application of CI/SEP and High Performers Pool will begin in PY2024 for ACOs beginning model participation in PY2023	
EHR use	At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT)		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 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 using a range of methods, including: • Analysis of specific financial and quality data reported by the ACO as well as aggregate annual and quarterly reports • Analysis of beneficiary and provider complaints • Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews)		In response to stakeholder feedback, the CMS Innovation Center implemented additional monitoring and compliance efforts in ACO REACH to: • Assess whether REACH beneficiaries are being shifted to MA • Examine ACO risk score growth to identify inappropriate coding practices • Increase use of data analytics to monitor service use over time to prevent stinting of care, and more—a detailed list of these efforts can be found in this comparison chart.	
SNF 3-day rule	Open to ACOs who use either prospective assignment or preliminary prospective assignment with retrospective reconciliation. CMS will waive its three-star quality rating requirement for providers furnishing SNF services under swing bed arrangements.		• For prospectively assigned beneficiaries that receive otherwise covered post-hospital extended care services by an eligible SNF • SNF must have a quality rating of 3+ stars • SNFs must be either Participant or Preferred Providers • ACOs may be asked to describe how the SNFs can carry out proposed coordination activities	
Telehealth	Waives geographic and originating site requirements. This provision is applicable only to ACOs under two-sided models who have elected prospective assignment.		Waives geographic and originating site requirements	
Beneficiary Incentive Program	ACOs can establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying primary care services. Through this program, ACOs may provide limited "cash equivalent" incentive payments to qualifying patients. The beneficiary incentive program is available to two-sided risk ACOs with preliminary prospective assignment with retrospective reconciliation or prospective assignment starting July 1, 2019.		ACOs may provide in-kind items or services to beneficiaries, including blood pressure monitors to patients with hypertension, vouchers for over-the-counter medications, transportation vouchers, wellness program memberships, among other things	
Other benefit enhancements	Not permitted	Not permitted	• Cost sharing support for Part B services • Care management home visits	• In addition to what Professional ACOs are allowed, CMS allows Global ACOs to waive the

			• Chronic Disease Management Reward Program • Provision of home health services to beneficiaries who are not "homebound" for certain conditions • Nurse Practitioner Services Benefit—allows NPs to certify that a patient is eligible for home health services, certify the need for hospice care and for diabetic shoes, order and supervise cardiac rehab, establish, review, and sign home infusion therapy care plans, and refer patients for medical nutrition therapy	requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care as a condition of electing the hospice benefit • Allows nurse practitioners to assume more responsibilities without physician supervision
Protections for Medicare beneficiaries	• All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician • Beneficiaries are proactively notified on an annual basis of their alignment to an ACO and that their benefits have not changed • Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints		• Same as MSSP • In addition, CMS will monitor for ACOs for inappropriate coding practices, stinting of care, and whether or not patients are moving into MA	
* The Medicare Shared Savings Program (MSSP) began in 2012 and participation in the "Pathways to Success" structure began on July 1, 2019 More information about the program is available on this CMS webpage.				
^ The Global and Professional Direct Contracting (GPDC) Model began in 2021 and on February 24, 2022, CMS announced an evolution of GPDC with key changes to governance, risk adjustment, and health equity. These changes go into effect for PY2023 under the new name, "ACO Realizing Equity, Access, and Community Health (REACH) Model." CMMI has published a comparison table to highlight policy changes, which are intended to improve the model for beneficiaries and address health equity. In response to these changes, NAACOS has launched the ACO REACH Coalition and published a summary of the updated model elements. For more information, you can contact ACOREACH@naacos.com.				