Navigating the Model Matrix: 101 (REDUX)

The webinar will begin at 2:00 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

Agenda

1. Introductions and Housekeeping
2. Presentations:
   - Timelines and Participation Options
   - Discussion of program overlap
3. Audience Q&A

Housekeeping

1. Speakers will present for around 50 minutes

2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
   - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question.

3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers

	**Dave Ault** Dave is counsel at Faegre Drinker Biddle & Reath LLP where he advises clients on a range of CMS issues including those related to value-based payment. Dave regularly draws on his extensive experience at HHS and CMS, including his tenure leading the Next Generation ACO Model and working as part of the Medicare Shared Savings Program leadership team.
	**David Pittman** David is senior policy advisor at NAACOS where he assists the government affairs team in its legislative and regulatory affairs work, including its work around Direct Contracting. He also works on NAACOS's communications efforts.
	**Alyssa Neumann** Alyssa serves as health policy analyst for NAACOS, providing support for the Government Affairs team. Prior to NAACOS, Alyssa served as Senior Program Associate at the Primary Care Collaborative, providing support for grant projects, policy work, and communications. Alyssa earned her MPH in Health Policy and Management at the George Washington University Milken Institute School of Public Health.

Overview

- CMMI continues to release and refine payment models, especially in the wake of the COVID-19 PHE. As the number of models increase, so does the complexity of the Alternative Payment Model landscape:
  - **Total cost of care models:** Direct Contracting
  - **Bundled payments:** BPCI-A and CJR
  - **Primary care models:** Primary Care First and CPC+
  - **Specialty specific models:** Kidney care and Radiation Oncology

- Overlap continues to be an issue for NAACOS members; understanding how these models interact and overlap is key

- Today's webinar will review key Alternative Payment Models and discuss how each of these models interact with ACO models

Overview

Today's webinar will review the following models

- Direct Contracting and Next Generation ACO Model
- CHART
- Primary Care First
- Important bundled payment programs
- Kidney care models
- And other notable models

NAACOS will also hold a follow-up webinar, Navigating the Model Matrix: 201, which will go into more detail on each of these models

- June 14th 2:30–4 PM ET
- Register today!

Direct Contracting

- Global and Professional Direct Contracting ("GPDC") in the new administration
  - No new applicants for 2022 (except for Next Gen ACOs)
  - No MCO track
  - Future of Direct Contracting?

- Geographic Direct Contracting: Dead but not gone?

“GPDC” Model Timeline

	Implementation Period (PY0) Applicants	PY1 (2021) Applicants	PY2 (2022) Applicants * Next Gen ACOs Only *
LOI	Closed		June 3, 2021
Application Deadline	Closed		June 14, 2021
DCE Selection	Announced Summer 2020	Announced September 2020	Summer 2021
Execute Participation Agreement	Executed September 2020	March 2021	Late 2021
Start Date	October 1, 2020	April 1, 2021	January 1, 2022
End Date	March 31, 2021	December 31, 2026	

Three types of Direct Contracting Entities (DCEs)

	Standard DCE	New Entrant DCE	High Needs Population DCE
Description	• This is the traditional ACO with experience in risk	• For DCEs with limited historical experience delivering care for Medicare FFS beneficiaries • Available to DCEs with fewer than 50% of its providers experienced in fee-for-service risk models	• For DCEs tailored to a high needs population • "High Needs" = impaired mobility and/or complex high needs • DCE can care for specific sub-populations, including patients with a particular diseases, disease at a particular stage, or a combination of diseases
Minimum Beneficiary Requirement	5,000 beneficiaries	1,000 beneficiaries in PY1 (increases to 5,000 by PY5)	250 beneficiaries in PY1 (increases to 1,400 by PY5)

Risk Arrangements

Professional Option

- Shared Savings/Losses: 50%
- Capitation: Primary Care Capitation (up to 7% capitation) → Basic + Enhanced
- Advanced Payment
  - May elect Advanced Payment for non-capitated claims
  - Reconciled at the end of each PY (similar to the Population-Based Payment mechanism in NextGen)

Global Option

- Shared Savings/Losses: 100%
- Capitation: DCE chooses Primary Care Capitation or Total Care Capitation (100% capitation)

- Participant Providers must agree to capitation
- Capitated payments are not reconciled against actual expenditures
- The model will qualify as an AAPM

Either model option is available to each of the three types of DCEs.

Note: In the future, CMS may offer a third model option, the "Geographic Option," where a DCE would assume financial risk for the entire population of a particular geographic area.

faegre drinker

Direct Contracting

	MSSP Enhanced	Next Gen	Direct Contracting - Professional	Direct Contracting - Global
MACRA	Advanced APM			
Risk-Sharing Arrangement	savings: 75% losses: 1 minus final sharing rate (40-70%)	2 options: - 80% or 100% shared savings/losses	50% shared savings/losses	100% shared savings/losses
Savings/Losses Cap	20% (savings) 15% (losses)	5% or 15% (selected by ACO)	Risk Bands: 50% for savings/losses < 5% 35% for savings/losses 5-10% 15% for savings/losses 10-15% 5% for savings/losses >15%	Risk Bands: 100% for savings/losses < 25% 50% for savings/losses 25-35% 25% for savings/losses 35-50% 10% for savings/losses > 50%
Stop/Loss Arrangement	n/a	Optional		

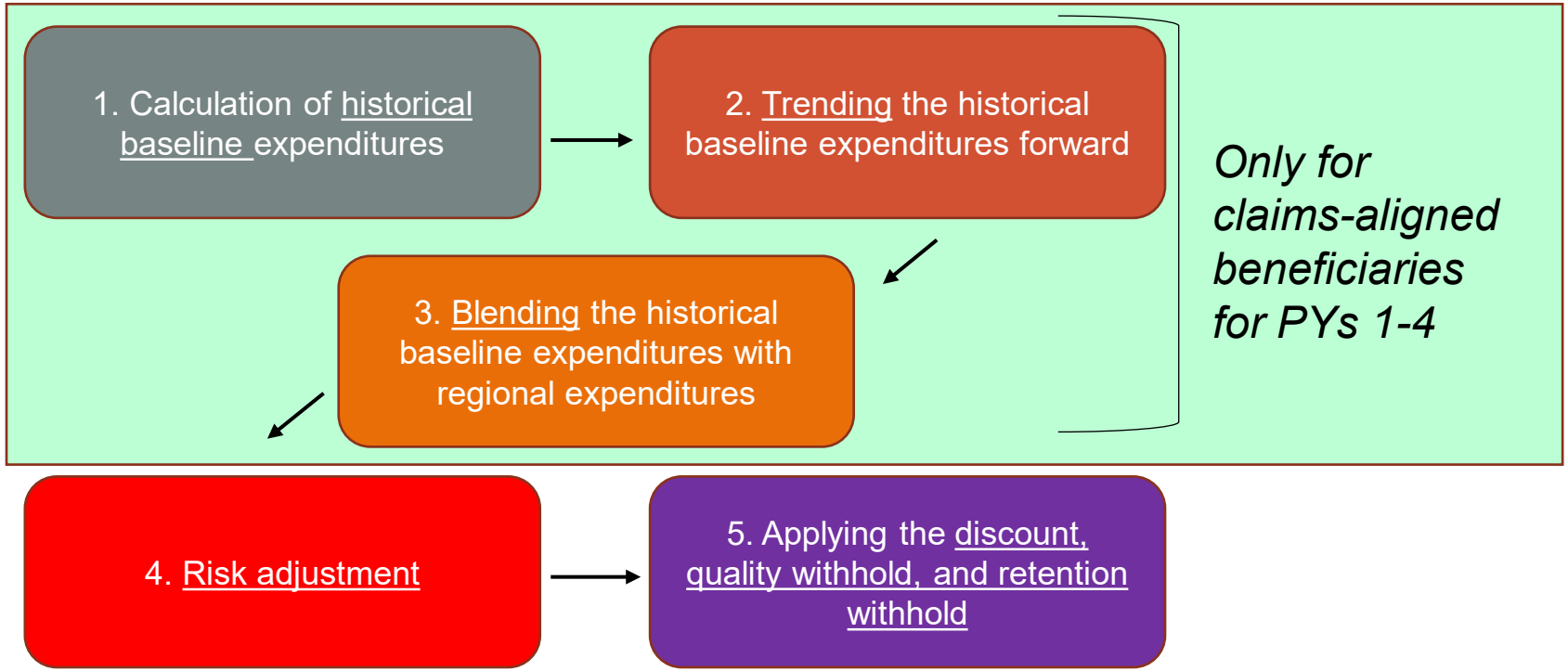
faegre drinker

Direct Contracting

	MSSP Enhanced	Next Gen	Direct Contracting - Professional	Direct Contracting - Global
Payment Options	CMS makes all FFS payments	Optional Population-Based Payments, reconciled to claims	Primary Care Capitation (7%) - CMS pays claims for all other services - Optional Advanced Payment, reconciled to claims	2 Options: - Primary Care Capitation - Total Care Capitation: (100%)
Reconciliation	Full performance year reconciliation following full claims run out period			
			Optional provisional reconciliation	

faegre drinker

Financial Methodology - Benchmarking



faegre drinker

Direct Contracting Benchmarks

	MSSP Enhanced	Next Gen ACO Model	Direct Contracting - Professional	Direct Contracting - Global
Baseline	Fixed 3-year historical baseline period, rebased for each agreement period	Rolling 2-year historical baseline period, no rebasing	Fixed 3-year (2017, 2018, 2019) historical baseline period, no rebasing	
Trend/Risk, GAF Standardization	Blending of regional and national trends.	Prospective trend, based on the adjusted USPCC; also reflects changes in regional FFS Geographic Adjustment Factors		
Regional Blend	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 weight)	10% maximum upward adjustment (if baseline is less than average expenditure occurred by beneficiaries in the region); 2% maximum downward adjustment	- Based on Adjusted Medicare Advantage Rate Book - Historical/Regional Blend: 65 /35 (PY1-2) to 50/50 (PY6) - Standard DCEs using voluntary alignment, New Entrant DCEs, and High Needs DCEs: regional rates for PY1-4 and will add in historical baseline expenditures for PY5-6; PY5 has two-year historical baseline (2021, 2022, 2022); PY6 has three-year historical baseline (2022, 2023, 2024)	

Direct Contracting

	MSSP Enhanced	Next Gen ACO Model	Direct Contracting - Professional	Direct Contracting - Global
Risk adjustment	- Prospective coding adjustment - HCC risk score cap of 3% over length of the agreement period - No limit on risk score decreases	- Prospective coding adjustment - HCC risk score cap of 3% for risk score increases or decreases (annual)	For **Standard and New Entrant DCEs** → CMS will use the existing CMS-HCC A&D model and CMS-HCC ESRD risk adjustment model CMMI will use a 4-step risk adjustment process: 1.Prospective estimated normalization 2.Normalization correction adjustment factor 3.Risk score cap (symmetric 3% cap on DCE-level risk score grow (per PY)) 4.Retrospective Coding Intensity Factor (CIF) For **High Needs Population DCEs** → CMS will use a new CMMI-HCC risk adjustment model and the existing CMS-HCC ESRD risk adjustment model	
Discount or MSR/MLR	- Symmetrical MSR/MLR - 3 options: 0%, choose in 0.5% increment up to 2.0%, variable based on the number of assigned beneficiaries	Discount applied to benchmark: 0.5% for 80% risk sharing arrangement 1.25% for 100% risk sharing arrangement	No Discount	Discount applied to benchmark: 2 percent (PY1-2) 3 percent (PY3) 4 percent (PY4) 5 percent (PY5-PY6)
		- Quality withhold = 3%	- Quality withhold = 5% - Retention withhold = 2%	

faegre drinker

Direct Contracting - Quality Measures

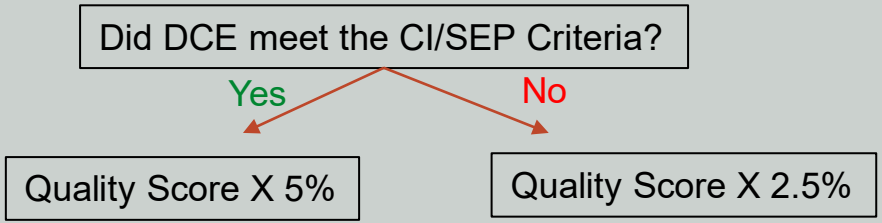
Quality Measures and Performance

Quality Measures

- Measures (no DCE-reported measures):
  - Risk-Standardized All-Condition Readmission
  - All-Cause Unplanned Admissions for Patients with MCC
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Timely Follow-Up (Standard and New Entrant DCEs only)
  - Days at home for Patients with Complex Chronic Conditions (High Needs DCEs only)

Quality Performance

- PY1-2: 4% pay-for-reporting/1% pay-for performance (so all DCEs should get the 5% withhold back so long as they report)
- PY3-6: 5% pay-for-performance. The amount of the quality withhold a DCE earns back is a product of --
  (1) Its score on the quality measures; and
  (2) Whether the DCE meets continuous improvement/sustained exceptional performance (CI/SEP) criteria



Direct Contracting - Benefit Enhancements

	MSSP Enhanced	Next Gen ACO Model	Direct Contracting
SNF 3-day rule	- SNF must have a quality rating of 3+ stars		
Telehealth	- Prospective assignment only	Available	
Beneficiary Incentive Program	- Can provide CMS-approved incentive payments to eligible beneficiaries who receive qualifying primary care services.	- Can make direct payments to beneficiary who receives certain services from the Next Gen ACO's Participants and Preferred Providers - Can provide in-kind items or services to beneficiaries	
Post-Discharge Home Visits	N/A	Available	
Care Management Home Visits	N/A	Available	
Part B Cost-Sharing Support	N/A	Available	
Home Health	N/A	N/A	- Nurse Practitioners to certify that a patient is eligible for home health services - May provide home health services to beneficiaries who are not "homebound" for certain conditions
Palliative and Hospice Care	N/A	N/A	Patients may receive concurrent curative and palliative/hospice care

NAACOS Advocacy

- NAACOS continues to meet with CMMI on shaping Direct Contracting
- Examples of formal letters we've written
  - NAACOS letter to CMMI provides detailed program recommendations
  - NAACOS writes HHS Secretary Becerra on policy priorities for the new administration
    NAACOS calls for changes to Direct Contracting's financial methodology
  - NAACOS urges announced plans for the future of the Direct Contracting Model
  - NAACOS calls for changes to Direct Contracting and seeks more information
- We continue to address concerns around financial specifications
  - In setting benchmarks, CMS should give greater weight to the least recent year
  - CMS should add shared savings earned by a DCE back in the PY benchmark
  - CMS should give more weight to the regional rates for all DCEs
  - CMS should expand the concurrent risk adjustment model beyond the High Needs Population DCEs
- ***What else concerns or excites you about this model?***
- **Reach out to DirectContracting@naacos.com**

NAACOS Resources

- Stand-alone webpage with CMS and NAACOS resources
- Frequently Asked Questions on Direct Contracting
- In-depth analysis of Direct Contracting
- Chart comparing Direct Contracting to other high-risk ACOs
- Chart on the overlap of CMMI models and ACOs
- Summary of Direct Contracting Financial Specifications
- Overview of Direct Contracting Quality Measurement Methodology
- Hosted several webinars, town halls and learning discussions
- To continue today's discussion, we encourage use of our Direct Contracting Listserv. You must sign up first and can do so here.
  - DirContractListServ@naacos.com
- NAACOS staff is also available at DirectContracting@naacos.com

Next Generation ACO Model

- Final performance year
  - No extension
- What's next for Next Gen?
  - "Expansion"?
- What's next for Next Gen ACOs?
  - Direct Contracting
    - LOI: June 3, Application June 14 (Standard DCE only)
    - More options for ACOs that deferred
  - MSSP Enhanced
  - MSSP "Enhanced Plus"

faegre drinker

Next Generation ACO Model

- NAACOS Advocacy

  - NAACOS supported the extension of Next Gen

  - NAACOS is advocating for the “expansion” of Next Gen
    - Permanent track of MSSP; Requires rulemaking
    - MSSP Enhanced Plus Model

Community Health Access Rural Transformation (CHART) Model

Two tracks:

- ACO transformation track
  - Rural ACOs (up to 20) receive advanced shared savings payments
  - Similar to ACO Investment Model (AIM)
  - Application period delayed to Spring 2022
- Community Transformation Track
  - Upfront grant funding for 15 lead organizations with capitated payments to participating hospitals
  - NOFO closed May 11; Selection September 10, 2021
  - Runs through 2030
  - Moving forward
- NAACOS Advocacy
  - NAACOS continues to support the ACO transformation track and has advocated for it to move forward
  - Advance payments to ACOs have proven to be successful and important to bringing value-based care to underserved areas

faegre drinker

Primary Care First

- Primary Care First (PCF) is a voluntary, five-year model to test if innovative payment options for advanced primary care can reduce total cost of care.
  - There are 827 practices and 14 payers in Cohort 1 of standard PCF
  - The Seriously Ill Population (SIP) model option was paused by CMS
- Builds off the Comprehensive Primary Care Models (CPC and CPC+)
- Cohort 1 began Jan. 2021. Cohort 2 will begin Jan. 2022
- Qualifies as an Advanced Alternative Payment Model (Advanced APM)
- NAACOS webpage includes model news/information and resources
- CMS webpage includes Request for Applications and FAQs

Primary Care First

- Key timelines:
  - The practice solicitation period for PCF Cohort 2 closed May 21, 2021
  - The payer solicitation period for PCF Cohort 2 closes June 18, 2021
  - Practice and payer selections will take place in Summer—Fall 2021
  - CMS will onboard participating practice and payer partners Fall—Winter 2021
  - Cohort 2 will begin January 2022
- Practices participating in MSSP ACOs will be eligible to participate
- While CPC+ practices were not eligible to apply for Cohort 1, CMS created Cohort 2 for CPC+ practices to be able to participate in the model, later extending to non-CPC+ practices as well
- Participant Providers in Direct Contracting Entities (DCEs) are not eligible to participate in PCF

PCF: Payment Structure

- Total Primary Care Payment (TPCP): includes two elements—a lump-sum professional population-based payment (PBP) based on average HCC risk scores paid on a quarterly basis, and a flat $40.82 primary care visit fee
- Performance-Based Adjustment (PBA): In performance year 2 and subsequent years, a practice's TPCP will be adjusted based on performance on five quality measures as well as an additional quality measure of acute hospital utilization.
  - Must meet a minimum threshold of performance in the Quality Gateway and Acute Hospitalization Utilization measure in order to be eligible for a positive PBA. Cab earn up to 50% additional revenue through a Regional Performance Bonus and Continuous Improvement Bonus.
  - A practice that fails to meet with the Quality Gateway or AHU Benchmark will receive a maximum penalty of -10% (beginning in PY 3).

PCF Expenditures & ACOs

- MSSP ACO expenditures and PCF:
  - All PCF payment amounts will be treated as non-claims-based expenditures by the MSSP in the concurrent performance period and will be included when comparing ACO spending to the benchmark in the shared savings or losses calculation
  - The flat primary care visit fee will be treated as a claims-based expenditure
- This approach follows the policy used for dual participation in CPC+ and ACO models. Additional expenditures can be a challenge for ACOs; however, the model can also serve as an engagement tool for primary care practices

CJR Model

Comprehensive Care for Joint Replacement (CJR) Model

- A bundled payment program for hip and knee replacements with episodes covering inpatient stays and ends 90 days post-discharge.
- A May 3 final rule extends the model for an additional three years, through 2024
  - Will only operate in 34 “mandatory” metropolitan areas, dropping participation option for hospitals in the 33 areas where it was previously voluntary
  - Includes some outpatient procedures
  - Changes to how target prices are calculated
- CMS will move from two reconciliation periods to one
  - Will no longer have a 2nd reconciliation at 14 months after the end of the PY
  - Because CMS won’t have necessary data from ACO models, the agency is altering its overlap policy that adjusts for ACOs’ shared savings payments

BPCI Advanced Model

Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

- A voluntary model which builds upon the original BPCI model
- A single, retrospective bundle payment with a 90-day clinical episode duration
- Qualifies as an Advanced Alternative Payment Model (APM)
- ACOs may simultaneously participate in both the BPCI Advanced and ACO models
- Model runs through December 31, 2023
- NAACOS webpage includes news updates/information and resources
- CMMI webpage includes pricing methodology papers and other key model details

BPCI Advanced Model

- 30 inpatient clinical episodes, 3 outpatient clinical episodes, and 1 multi-setting Clinical Episode
- Participants must meet prospectively established target prices for episodes of care which will include a standard three percent discount
- Payment is also tied to Participants' performance on certain quality measures. Participants will be responsible for total Medicare FFS spending on all items and services furnished during the 90-day episode, except for certain excluded costs
- BPCI-A episodes begin either at the start of an inpatient admission to an Acute Care Hospital (the Anchor Stay) identified by MS-DRGs, or at the start of an outpatient procedure (the Anchor Procedure) identified by Healthcare Common Procedure Coding System (HCPCS) codes

BPCI Advanced Model

- Semi-annually, CMS compares aggregate Medicare FFS expenditures for all items and services included in the episode against the target price for the episode to determine whether the Participant is eligible to receive a payment from CMS or must make a repayment to CMS.
- Clinical Episodes will be attributed at the Episode Initiator level. The hierarchy for attribution of a Clinical Episode among different types of EIs is as follows, in descending order of precedence:
  1. the Physician Group Practice that submits a claim that includes the NPI for the attending physician;
  2. the Physician Group Practice that submits a claim that includes the NPI of the operating physician; and
  3. the Acute Care Hospital where the services that triggered the Clinical Episode were furnished

BPCI Advanced Model

- CMS in September 2020 created several changes to the model starting in 2021
  - Summarized in this fact sheet
  - Altering target price calculations using an adjusted retrospective element
  - Requiring participants to chose clinical episode groups versus individual episodes
  - Addressing clinical episode overlap
  - Removing the physician group practice offset
  - Alter risk adjustment for major joint replacement episodes
- Changes come after formal evaluations show net losses to Medicare

Kidney Care Choices

- Two payment models collectively referred to as Kidney Care Choices
  - Kidney Care First
  - Comprehensive Kidney Care Contracting
- Builds upon the Comprehensive ESRD Care Model and designed to improve the care of patients with chronic kidney disease and ESRD
- CMMI released an RFA in 2019
- NAACOS published this resource to help ACOs better understand each model
- Delayed to start in 2022 and run five years or 2026
- No word on another application cycle

Kidney Care Choices

Kidney Care First

- Designed for nephrologists and nephrology practices
- Builds on the current Comprehensive ESRD Care Model
- Prospective alignment, which is updated quarterly, is based on nephrology E&M services, not dialysis facility
  - Patients are fee-for-service beneficiaries with stages 4 or 5 of CKD, ESRD, or a transplant recipient who was previously aligned to a KCF practice
- Advanced Alternative Payment Model starting in 2022
- Simultaneous Participation is allowed for MSSP providers

Kidney Care Choices

Kidney Care First

- *Quarterly Capitation Payment* – Combines payment for several different E&M and other care management codes for patients for stages 4 and 5 of CKD. Will not be risk adjusted.
- *Adjusted Monthly Capitation Payment* – Based on the current monthly capitation payment for managing an in-center dialysis patient with two to three visits a month.
- *Transplant Bonus* – Delivered for aligned beneficiaries who receive a kidney transplant to incentivize keeping patients healthy. Will be up to $15,000 per transplant, if the transplant remains successful.

Kidney Care Choices

Comprehensive Kidney Care Contracting

- Nephrologists and nephrology practices partner with transplant providers, dialysis facilities and other providers to become Kidney Contracting Entities
- Total-cost-of-care for assigned patients
- Three tracks with increasing levels of risk and reward
- Prospective, claims-based alignment through nephrologists
- 1,000 aligned Medicare beneficiaries with late-stage kidney disease and 350 ESRD beneficiaries
- Advanced Alternative Payment Model starting in 2022
- Simultaneous Participation is NOT allowed for MSSP providers

Kidney Care Choices

Key Considerations for ACOs

- Are nephrologists in your ACO participating?
- In Kidney Care First, payments will be counted as ACO expenditures
- What impact will this have on patient attribution?
- Changes could impact an ACO's benchmark and performance year spending – broadly speaking an ACO's ability to earn shared savings
- Medicare Advantage began enrolling ESRD patients starting in 2021

Innovation Center Models

- **ESRD Treatment Choices (ETC) Model**
  - Participation mandatory for about 30 percent of ESRD patients
  - January 2021 start date
- **Radiation Oncology Model**
  - Delayed to start January 2022
  - 30 percent of all eligible Medicare FFS radiotherapy episodes nationally
- **Oncology Care Model**
  - Extended by a year because of COVID-19; Anticipated to end on June 30, 2022
  - Additional details on Oncology Care First haven't been released
- **Emergency Triage, Treat, and Transport (ET3) Model**
  - Tests paying ambulance services for treating patients at a scene, transporting to non-emergency department, or treating via telemedicine
  - Started on Jan 1, 2021
  - 184 ambulance providers participating

Innovation Center Models

Home Health Value-Based Purchasing (HHVBP) Model

- On January 8, CMS announced its plan for "expansion" of the model into a permanent program
- Launched in 2016 to incent home health agencies to improve quality and reduce spending
- Mandatory in nine states (Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington)
- Payments for agencies adjusted based on quality performance relative to peers in the state. Medicare payments to agencies are adjusted (upwards and downwards) as much as 8% based on performance
- Expansion done through regulation, but the new administration could alter the timeline
- Questions remain including whether the expansion would be to all 50 states and whether it would be mandatory

Model Overlap

	Direct Contracting Model (DC)	
	Providers	Beneficiaries
MSSP	Participant Providers cannot particpate in MSSP (and vice-versa). Preferred Providers may participate in both models	Beneficairies aligned to a DCE will not be aligned to a MSSP ACO
Bundled Payments for Care Initiative - Advanced (BPCI-A)	Providers may participate in both DC and BPCI-A	DC beneficiaries cannot participate in BPCI-A (beneficiaries cannot trigger an episode)
Comprehensive Joint Replacement (CJR)	DC participants may be either CJR collaborators or collaborator agents	DC beneficiaries cannot participate in CJR (beneficiaries cannot trigger an episode)
Oncology Care Model (OCM)	Providers may participate in both DC and OCM	OCM beneficiaries are not excluded from participation in DC
Comprehensive ESRD Care Model (CEC)	DC Professionals cannot participate in both CEC and DC. DC Participants who are not primary care specialsts and DC Preferred Providers may participate in both CEC and DC.	CEC beneficiaries are excluded from participation in DC
Comprehensive Primary Care + (CPC+)	Providers cannot participate in both DC and CPC+	DC beneficiaries may not participate in CPC+. (DC has alignment preference over CPC+)
Primary Care First (PCF)	Providers cannot participate in both DC and PCF	DC beneficiaries may not participate in PCF. (DC has alignment preference over PCF).

Model Overlap

	Medicare Shared Savings Program (MSSP)	
	Providers	Beneficiaries
Direct Contracting	Participant Providers cannot participate in MSSP (and vice-versa). Preferred Providers may participate in both models	Beneficairies aligned to a DCE will not be aligned to a MSSP ACO
Bundled Payments for Care Initiative - Advanced (BPCI-A)	Providers may participate in both MSSP and BPCI-A.	(for Model Year 3, beginning 1/1/2020) MSSP beneficiaries can participate in BPCI-A regardless of MSSP track (beneficiaries can trigger an episode).
Comprehensive Joint Replacement (CJR)	MSSP participants may be either CJR collaborators or collaborator agents.	MSSP Track 3 beneficiaries are excluded from CJR (beneficiaries cannot trigger an episode); All other MSSP beneficiaries are included in CJR (beneficiaries can trigger an episode).
Oncology Care Model (OCM)	Providers may participate in both MSSP and OCM.	OCM beneficiaries are not excluded from participation in MSSP.
Comprehensive ESRD Care Model (CEC)	Providers (full TIN) cannot participate in both CEC and MSSP.	CEC beneficiaries are excluded from participation in MSSP.
Comprehensive Primary Care + (CPC+)	Providers can participate in both CPC+ and MSSP.	MSSP beneficiaries may participate in CPC+ regardless of MSSP track.
Primary Care First (PCF)	Providers can participate in both PCF and MSSP (any track).	MSSP beneficiaries may participate in PCF regardless of MSSP track.

Model Overlap

- BPCI-A and ACO financial reconciliation
  - BPCI Advanced Participants aligned with an ACO will have the portion of the BPCI Advanced discount paid out as the ACO's shared savings payment recouped. This step prevents duplicate payment from overlapping savings achieved for the same beneficiary's care

- **NAACOS Resources**
  - Understanding BPCI-A and MSSP Reconciliation
  - NAACOS Medicare ACO-APM Overlap Chart
  - NAACOS chart of CMS Innovation Center models and their overlap with ACOs
  - NAACOS chart comparing Direct Contracting and other high-risk ACOS
  - NAACOS ACO Comparison Chart updated for 2019 to reflect the new Pathways structure and old MSSP structure

Questions

If you did not get a chance to ask your question, or if you have additional questions in the future, please email advocacy@naacos.com