

AHLA

# The ACO “Track One+” Model: New Rewards for Risk

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Accountable Care Organization Task Force

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This is an important year for Medicare Accountable Care Organizations (ACO) and their participants. Six years after the Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Shared Savings Program (MSSP), the Track 1 model remains the most popular model for participants in the MSSP.<sup>1</sup> Despite this, many MSSP Track 1 ACOs and their participants will consider transitioning to other ACO risk models in 2018 for various reasons, including time limits imposed on Track 1 and desire to participate in an “Advanced Alternative Payment Model” under the Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act (MACRA).<sup>2</sup>

On January 20, 2017, CMS announced the details of a new Track 1+ ACO Model that may be an attractive opportunity for existing Track 1 ACOs and participating practices. Track 1+ ACOs permit participating providers to test taking on risk while limiting their financial exposure.<sup>3</sup> As such, Track 1+ may be particularly attractive for new ACOs motivated by potential MACRA bonuses, or experienced Track 1 ACOs who are still unsure of their ability to manage downside risk. The initial Notice of Intent to Apply as a Track 1+ ACO with January 1, 2018 start date is May 31, 2017, with more detailed application materials due later in 2017.

This article provides additional information regarding Track 1+ ACOs, including perspective on how the model relates to other ACO options under the Medicare program.

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<sup>1</sup> 438 of the 480 ACOs operating in the MSSP in 2017 are in Track 1. See CMS, CMS Welcomes New and Renewing Medicare Shared Savings Program ACOs, January 18, 2017:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/2017-MSSP-Fact-Sheet.pdf>. (2107 MSSP Fact Sheet).

<sup>2</sup> Consistent with applicable MSSP rules, this article distinguishes the “ACO” (the entity operating under a Participation Agreement with CMS) from a “participant” (an entity identified by a Tax Identification Number operating under an agreement with the ACO).

<sup>3</sup> CMS, Fact Sheet: New Accountable Care Organizational Model Opportunity: Medicare ACO Track 1+ Model, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf>. (Track 1+ Fact Sheet).

## ACO Tracks

ACOs are perhaps the most robust value-based payment model operated by CMS. With the addition of Track 1+, the MSSP has now expanded to four separate tracks,<sup>4</sup> distinguished by the level of financial risk taken by the providers in the ACO and the size of potential bonuses.

The MSSP Track 1 model is the sole “upside-only” model offered by CMS, which means it allows shared savings bonuses without requiring repayment of losses. All other non-Track 1 options—including MSSP Tracks 1+, 2, 3 and the Center for Medicare and Medicaid Innovation (CMMI)-sponsored two-sided Next Generation ACO model<sup>5</sup>--are “two-sided” ACOs that offer both shared savings bonuses and require repayment of losses. Although such models may make it easier to earn savings and retain a larger percentage of these savings, only 42 of the 480 currently-operating MSSP ACOs (or less than 10%) are in a two-sided model.<sup>6</sup>

An ACO can participate in Track 1 for a maximum of two three-year terms (i.e., six years).<sup>7</sup> Because the first MSSP term began in 2012, an increasing number of ACOs must either move to two-sided models starting in 2018 or drop out of the program.

## Who Can Participate

CMS states that the Track 1+ model is “a pathway for ACOs to enter two-sided risk and to transition to higher risk (e.g., Track 2 or 3).”<sup>8</sup> As such, new MSSP ACO participants and existing Track 1 ACO participants may participate in the Track 1+ ACO, but participants in Tracks 2, 3, or the Next Generation ACO models may not transition to Track 1+. <sup>9</sup> In addition, Track 1 ACOs, and their participants, may not use the one-year

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<sup>4</sup> These are Tracks One, One+, Two, and Three.

<sup>5</sup> It also previously operated the Pioneer ACO program, which included two-sided risk. The Pioneer ACO program concluded in 2016. See <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>.

<sup>6</sup> See 2107 MSSP Fact Sheet.

<sup>7</sup> See 42 C.F.R. § 425.600(b).

<sup>8</sup> Track 1+ Fact Sheet at 3.

<sup>9</sup> *Id.*

“deferral period” available to allow transfers to Tracks 2 and 3 to support a transfer to Track 1+. <sup>10</sup>

New Track 1+ ACOs are limited to a single three-year performance period, although Track 1 participants who transition to Track 1+ during an existing term may renew for an additional three years. <sup>11</sup> Further, an ACO may not participate in Track 1+ if it is owned or operated by a health plan, if the ACO legal entity previously participated in a two-sided ACO, or if 40% or more of an ACO’s participants were previously participants in a two-sided ACO. <sup>12</sup>

## Picking Tracks

Track 1+ ACOs combine aspects of Track 1 with the existing “two-sided” risk models. Track 1+ resembles the other two-sided models in many ways, but it includes special rules to reduce the ACO’s exposure to losses. Track 1+ also qualifies as an “Advanced Alternative Payment Model” under MACRA, so participants may be eligible for an automatic bonus to Medicare payment rates. <sup>13</sup>

Participants should understand the key differences between the models as they make ACO participation decisions for 2018. At a high level, under all tracks, CMS evaluates whether an ACO has earned savings or losses by comparing its costs to a benchmark based on the costs of Medicare Part A and B services provided to beneficiaries who

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<sup>10</sup> See e.g., 42 C.F.R. § 425.200(e)(1). See also, CMS, Medicare Accountable Care Organization Track 1+ Model, March 22, 2017 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Medicare-Accountable-Care-Organization-ACO-Track-1+-Model-Webinar-slides.pdf>. (Track 1+ Slides).

<sup>11</sup> Track 1+ Fact Sheet at 3. For example, a Track 1 ACO in Performance Year 2 could transition to Track 1+ in 2018, complete Performance Year 3 (2019) under Track 1+, and then renew for another three year term under Track 1+.

<sup>12</sup> *Id.* at 4. See also Track 1+ Slides at 23.

<sup>13</sup> Under the Advanced APM rules, any group participating in a Track 1+ ACO, and included on a Participant List submitted by the ACO to CMS, will receive a bonus equal to 5% of its prior year’s Medicare reimbursement if the ACO’s clinicians see a sufficient percentage of their patients through the ACO. For 2018, this will be met if 25% of the clinicians’ Medicare Part B payments come from patients attributed through the ACO, or if 20% of the clinicians’ Medicare Part B patients are attributed through the ACO. This increases to 50% of payments or 35% of patients in 2019 and 2020. 42 C.F.R. §§ 1430-1435. Participants in Track 1+ ACOs are also eligible for special scoring as under the MACRA “MIPS APM” rules. See 42 C.F.R. § 414.1370.

received primary care services from the ACO's participants. The financial attractiveness of any ACO can be determined through three measures:

- (1) the **minimum savings/loss rate**, reflecting the ease of earning savings or losses;

To account for natural variation outside the control of the ACO, CMS does not pay a bonus or require repayments unless savings or losses exceed a corridor around the benchmark amount. For Track 1 ACOs, CMS assigns a Minimum Savings Rate and Minimum Loss Rate of 2-3.9% based on the number of beneficiaries assigned to the ACO.<sup>14</sup> Track 1+ ACOs may choose to use this policy. Alternatively, Track 1+ ACOs may use the approach of Tracks 2 and 3 ACOs and choose a corridor between 0-2%.<sup>15</sup> Using a CMS-defined corridor may be helpful for smaller ACOs as it shields them from losses, but it may also prevent them from benefiting from savings they earn. Conversely, defining a lower corridor may make it easier to earn savings, but provides less protection against losses.

- (2) the **shared savings rate/shared loss rate**, reflecting the size of the potential bonus payment or loss;

ACOs only receive part of the savings they generate for the program, but they also must only repay a portion of losses. The maximum sharing and loss rates differ across tracks. Track 1 ACOs can share in a maximum of 50% of the savings they generate, while Track 2 ACOs can share in a maximum of 60% and Track 3 ACOs can share in a maximum of 75%. The actual sharing of savings rate depends on the ACO's performance on quality measures.

The loss sharing rate will be between 40-60% for Track 2 and 40-70% for Track 3 (again depending on quality performance).<sup>16</sup> Next Generation ACOs may select

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<sup>14</sup> 42 C.F.R. § 425.604(b).

<sup>15</sup> See 42 C.F.R. §§ 425.606(b); 425.610(b). Note that Next Generation ACOs use a different methodology in which they apply a 0-3.75% adjustment to the baseline based on the ACO's quality performance and its relative "efficiency" compared to regional and national costs.

<sup>16</sup> See 42 C.F.R. §§ 425.606(d), (f); 425.610(d), (f).

either 80-85% or 100% sharing of risk.<sup>17</sup> Quality scores do not impact the shared savings or loss rate for Next Generation ACOs, but they do impact the benchmark calculation.

Track 1+ uses a 50% maximum sharing rate, consistent with Track 1. However, this relatively lower share of savings is offset by a 30% set shared loss rate, regardless of quality. In other words, Track 1+ ACOs are relatively more insulated from sharing losses in any given year than comparable Track 2 and 3 ACOs (which must share a minimum of 40% of losses).<sup>18</sup>

(3) the “**performance payment limit**” establishing an *overall cap* on payments, and the equivalent “**loss sharing limit**” capping financial losses.

In addition to the maximum sharing/loss **rates**, ACO models place additional overall **limits** on savings or loss payments. Track 1 ACOs may not be paid more than 10% of their benchmark. The limit for savings in Track 2 is 15% of the benchmark, while the cap on *losses* increases from 5% of the benchmark to 10% over the course of the performance period. For Track 3 the overall limit for savings is 20% of the benchmark and the limit on losses is 15%.

Track 1+ ACOs may share in savings up to 10% of the benchmark. However, the cap on losses may apply based *either* on the benchmark or the ACO participants’ actual revenue in a given year. If the ACO includes an acute care hospital, cancer center, certain entities that own hospitals, or certain rural hospitals, the cap will be 4% of the benchmark. ACOs with other compositions (such as physician-only ACOs), may use a cap based on the *lower* of: (1) 8% of actual Medicare fee-for-service revenues; or (2) 4% of their benchmark.<sup>19</sup> This provides additional protection if collections vary from year to year.

In summary, Track 1+ ACOs are limited to the 50% maximum sharing rate and 10% payment limit present in Track 1, with a special 30% loss sharing rate and loss sharing

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<sup>17</sup> CMS, CMMI, Next Generation ACO Model Request for Applications – 2018 Model Starters, January 28, 2017, <https://innovation.cms.gov/Files/x/nextgenaco-rfa2018.pdf>.

<sup>18</sup> Track 1+ Fact Sheet at 1.

<sup>19</sup> *Id.* at 1-2.

limit of either 4% of the benchmark or 8% of revenues. This means both the possible upside and downside are lower than in Tracks 2 and 3. Track 1+ ACOs also may choose between different options to trigger bonuses or losses—either a conservative CMS-defined “Track 1” approach or a more aggressive ACO-defined target (as in Tracks 2 and 3).

### **Other Flexibility**

Track 1+ incorporates a number of flexibilities that were previously only available to Next Generation, Track 2, or Track 3 ACOs (such as waivers of certain Medicare rules). This is notable given the much more aggressive financial risk required by these models.

First, Track 1+ includes prospective assignment of ACO beneficiaries. The prospective assignment methodology used in Track 1+ is the same one used in Track 3, in that CMS will develop a list of assigned beneficiaries at the start of the program and update this list quarterly.<sup>20</sup> Track 1+ does not involve voluntary patient opting-in (or “voluntary alignment”), as is used in the Next Generation ACO. This should provide Track 1+ ACOs with additional clarity regarding their assigned patient population. As a result, it will be important for ACOs to be able to certify a fairly stable list of participants at the start of the program.

Second, Track 1+ ACOs also provide for a waiver of the so-called “three day” rule regarding the minimum length of hospital admission to support Medicare coverage for admission to a skilled nursing facility.

Finally, Track 1+ ACOs may also use waivers of the fraud and abuse laws created by CMS for purposes of the MSSP.<sup>21</sup>

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<sup>20</sup> CMS, Medicare Shared Savings Program, Shared Savings and Losses Assignment Methodology Specifications v.5, April 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V5.pdf>.

<sup>21</sup> See 80 Fed. Reg. 66726.

## Challenges and Opportunities

Track 1+ creates an important opportunity for existing Track 1 ACOs and new entities participating in ACOs to test the waters of risk-sharing. By combining the lower threshold to earn shared savings bonuses of Tracks 2 and 3 ACOs with more generous limits on loss-sharing, Track 1+ creates a more gradual transition into Medicare risk-sharing models.

With that said, the introduction of downside risk creates its own unique challenges. For example, many states require entities absorbing downside risk to obtain some form of insurance license (which may trigger substantial requirements for financial reserves).<sup>22</sup> CMS also requires two-sided ACOs to establish a “repayment mechanism” such as a surety bond, escrow account, or line of credit in favor of the Medicare program.<sup>23</sup> In addition, ACOs will need to consider how best to manage any losses; if they allocate these losses to physicians, this may require modifications to participating physician contracts that carry fraud and abuse compliance considerations. As a result, providers should work closely with legal counsel as they transition to Track 1+ or another downside-risk ACO model.

ACOs have become an established, critical part of the health care delivery system. Today, the MSSP covers 9 million Medicare beneficiaries (roughly a quarter of the Medicare Part A and B population) and contains ACOs in all 50 states, Washington D.C., and Puerto Rico.<sup>24</sup> Yet CMS has repeatedly expressed its commitment to encourage providers to migrate away from the upside-only model currently used by 90%

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<sup>22</sup> For example, depending on the composition and structure of the ACO, the California Knox-Keene Act may require ACOs or participants that accept financial risk to obtain a “limited” or “restricted” insurance license, or obtain other registration. See Berkeley Forum for Improving California’s Healthcare Delivery System, University of California Berkeley School of Public Health, *Accountable Care Organizations in California: Promise & Performance*, pp. 19-20, February 2015, available at:

[http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForumACOExpBrief3\\_feb16.pdf](http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForumACOExpBrief3_feb16.pdf).

<sup>23</sup> See e.g., CMS, Medicare Shared Savings Program Repayment Mechanism Arrangements Guidance, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Repayment-Mechanism-Guidance.pdf>.

<sup>24</sup> See CMS, Medicare Shared Savings Program Fast Facts, January 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>. Cf. CMS, Medicare Enrollment Dashboard (last accessed May 9, 2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>.

of the nation's ACOs.<sup>25</sup> The 2018 program year represents a significant year in the agency's efforts to encourage this transition, as mandatory non-renewals and MACRA incentives create significant pressure for practitioners to adopt a two-sided model. Track 1+ presents a useful opportunity for providers to explore downside risk starting in 2018 while maintaining clear caps on the losses that must be repaid, ACO entities, participants, and providers considering joining or forming an ACO should consider this model as they craft their strategy for 2018 and beyond.

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<sup>25</sup> See e.g., 80 Fed. Reg. 32804, "[W]e continue to believe that the long term effectiveness and sustainability of the program depend on encouraging ACOs to progress along the performance-based risk continuum."

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