

Medicare's New ACO Track 1+ Model

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Introduction

The Centers for Medicare and Medicaid Services ("CMS") recently announced the details of the Track 1+ Model, its newest Medicare Accountable Care Organization ("ACO") model.¹ The Track 1+ Model is an interesting addition to the Medicare Shared Savings Program ("MSSP") because it involves *more* risk than the Track 1 model, but *less* risk than Tracks 2 and 3.

Track 1+ is unique because it allows eligible ACOs and participants to experiment with performance-based payment risk while having limited negative financial exposure. This article provides a detailed overview of the new Track 1+ ACO Model by (i) comparing its most important features to other ACO Track models and (ii) discussing the specific opportunities and challenges the Track 1+ Model presents.

Background on ACO Tracks

To understand the details of Track 1+, one must first understand the basics of the MSSP. Congress enacted the MSSP to encourage providers and suppliers of medical services to join ACOs, which are healthcare entities that commit to (i) providing high quality healthcare and (ii) reducing the rate of healthcare spending growth for their population of assigned Medicare beneficiaries.² CMS holds ACOs accountable for these commitments by linking ACO pay to performance.³

To accomplish this, CMS evaluates an ACO's quality and financial performance by comparing the *actual* healthcare outcomes and costs of its assigned beneficiary population with the *expected* healthcare outcomes and costs of its population taken from a historical benchmark.⁴

ACOs that meet or exceed a minimum savings rate and satisfy various quality standards receive a payment that consists of a percentage of the savings the ACO generated. Conversely, ACOs that fail to meet their minimum savings rate and participate in a two-sided performance-based risk model must pay CMS a percentage of its losses relative to the historic benchmark.

The MSSP provides four different "tracks" for entities to participate in an ACO: Track 1, Track 1+, Track 2, and Track 3. Each track possesses a different payment/penalty structure and involves a different level of financial risk. The sections below discuss the new Track 1+ Model by (i) comparing its most important details to other ACO Tracks and (ii) analyzing the opportunities and challenges the Track 1+ Model presents.

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¹ [CMS, Fact Sheet: New Accountable Care Organizational Model Opportunity: Medicare ACO Track 1+ Model \(May 2017\)](#), (last viewed June 15, 2017) (*hereinafter* "Track 1+ Fact Sheet").

² See, e.g., 14 U.S.C. § 1395jjj(b)(2). See also [CMS, Accountable Care Organizations: What Providers Need to Know](#), pg. 2 (March 2016) (last viewed June 15, 2017) (*hereinafter* "ACO Provider Fact Sheet").

³ ACO Provider Fact Sheet at 5.

⁴ ACO Provider Fact Sheet at 4.

Track 1+

The Track 1+ ACO Model can provide participants with the ability to experiment with performance-based payment risk while having limited negative financial exposure because it maintains the structure of Track 1 while including various characteristics from Track 3.⁵ For example, like Track 3, Track 1+ ACOs have prospective beneficiary assignment, the ability to request a Skilled Nursing Facility 3-Day Rule Waiver, and the potential to experience both upside and downside performance-based payment risk.⁶

The three variables that determine an ACO's level of financial risk are: (1) The Minimum Savings Rate/Minimum Loss Rate; (2) The Shared Savings Rate/ Shared Loss Rate; and (3) The Performance Payment Limit/Loss Sharing Limit.

1. Minimum Savings Rate/ Minimum Loss Rate

The minimum savings rate is the minimum amount of money an ACO must save below its population's projected benchmark before CMS will pay the ACO an incentive payment.⁷ Similarly, the minimum loss rate is the minimum amount of money an ACO must lose above its population's projected benchmark before CMS will require the ACO to make a penalty payment.⁸

Track 1 provides different minimum rates than Tracks 2 and 3. Under Track 1, ACOs have a minimum savings rate established by CMS between 2 percent and 3.9 percent, depending on the number of beneficiaries within the ACO.⁹ Under Track 2 and Track 3, ACOs can have *either* (i) minimum rates between 0 percent and 2 percent that increase in increments of 0.5, *or* (ii) minimum rates set by CMS that depend on the number of beneficiaries.¹⁰

Track 1+ ACOs have the same flexibility as Tracks 2 and 3 in establishing minimum savings and loss rates, because they also have the ability to set rates at *either* (i) a rate between 0 percent and 2 percent that increases in increments of 0.5 *or* (ii) a CMS established rate that depends on the number of beneficiaries.¹¹

⁵ Track 1+ Fact Sheet at 1.

⁶ *Id.* at 1.

⁷ See CMS, Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology Version 5, pg. 43 (April 2017) available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V5.pdf>. (last viewed June 15, 2017) (*hereinafter* "MSSP Methodology").

⁸ *Id.* at 43.

⁹ 42 C.F.R. § 425.604(b).

¹⁰ See 42. C.F.R. §§ 425.606(b); 425.610(b).

¹¹ See Track 1+ Fact Sheet at 6-7.

Track	Minimum Savings Rate	Minimum Loss Rate
Track 1	2 percent to 3.9 percent, depending on number of assigned beneficiaries	n/a
Track 2	Choice of (i) 0 percent; (ii) symmetrical MSR/MLR between .5 percent and 2 percent that can only increase in 0.5 increments; or (iii) minimum rates set by CMS that depends on the number of beneficiaries	Choice of (i) 0 percent; (ii) symmetrical MSR/MLR between .5 percent and 2 percent that can only increase in 0.5 increments; or (iii) minimum rates set by CMS that depends on the number of beneficiaries
Track 3	Same as Track 2	Same as Track 2
Track 1+	<i>Same as Track 2</i>	<i>Same as Track 2</i>

2. Shared Savings Rate/ Shared Loss Rate

The shared savings rate is the percentage that CMS will pay an ACO from every dollar that an ACO saves below the projected cost benchmark. Similarly, the shared loss rate is the percentage that CMS will require an ACO to pay from every dollar that its care costs above the projected cost benchmark.

Track 1 ACOs can share a maximum of 50 percent of the savings they generate, Track 2 ACOs can share a maximum of 60 percent of savings they generate, and Track 3 ACOs can share a maximum of 75 percent of savings they generate.¹²

Further, while Track 1 ACOs share no losses, Track 2 ACOs share between 40 percent and 60 percent of losses, and Track 3 ACOs share between 40 percent and 70 percent of losses.¹³

¹² MSSP Methodology at 7-8.

¹³ *Id.* at 8.

Track 1+ ACOs represent a middle ground. Track 1+ ACOs can share a maximum of 50 percent of savings, but have a set 30 percent shared loss rate that does not depend on performance.¹⁴ Because of this design, Track 1+ ACOs have a modest amount of upside potential, but a limited amount of downside risk.

Track	Shared Savings Rate	Shared Loss Rate
Track 1	Up to 50 percent, based on quality performance	n/a
Track 2	Up to 60 percent, based on quality performance	Between 40 percent and 60 percent, depending on quality performance
Track 3	Up to 75 percent, based on quality performance	Between 40 percent and 75 percent, depending on quality performance
Track 1+	<i>Up to 50 percent, based on quality performance</i>	<i>30 percent, <u>regardless</u> of quality performance</i>

3. Performance Payment Limit/ Loss Sharing Limit

The performance payment limit is the maximum amount of money CMS will pay an ACO for spending less than the projected cost benchmarks.¹⁵ The loss sharing limit, similarly, is the maximum amount of money CMS will require an ACO to pay for exceeding its projected cost benchmark.¹⁶

Each of the original tracks provide a different performance payment limit. CMS will pay Track 1 ACOs a maximum of 10 percent of their benchmark, Track 2 ACOs a maximum of 15 percent of their benchmark, and Track 3 ACOs a maximum of 20 percent of their benchmark.¹⁷

¹⁴ Track 1+ Fact Sheet at 1.

¹⁵ See MSSP Methodology at 7.

¹⁶ See *id.*

Each original track also provides a different loss sharing limit. Track 1 ACOs, again, do not have a loss sharing limit because they are one-sided models. For Track 2 ACOs, CMS phases in the loss limit over three years. Specifically, CMS sets the Track 2 loss limit at 5 percent of the benchmark in year one, 7.5 percent of the benchmark in year 2, and 10 percent of the benchmark in all future years.¹⁸ Under Track 3, CMS sets the loss limit at 15 percent of the benchmark.¹⁹

Track 1+ ACOs combine elements of the other ACO Models for both of its limits. For Track 1+ ACO Models, CMS sets the **performance payment limit** at 10 percent of the benchmark.²⁰ The Track 1+ ACO Model **loss sharing limit**, on the other hand, will depend on the organizations included within the ACO.

Specifically, Track 1+ ACO Models that meet *any* of the following criteria have a benchmark-based loss sharing limit:²¹

- (1) **Include** an inpatient prospective payment system hospital, cancer center, or rural hospital with more than 100 beds, or **is owned or operated by**, in whole or in part, such a hospital or by an organization that owns or operates such a hospital;
- (2) **Include** an ACO participant that is owned or operated by, in whole or in part, a rural hospital with 100 or fewer beds that is not itself included as an ACO participant;
- (3) **Include** an ACO participant rural hospital with 100 or fewer beds that is owned or operated by, in whole or in part, a health system.

Under the benchmark-based loss sharing limit, CMS sets the Track 1+ ACO loss limit at 4 percent of the benchmark.²²

Track 1+ ACOs that meet *none* of the criteria listed above have a revenue-based loss sharing limit.²³ The revenue-based limit provides Track 1+ ACOs with significant flexibility. Under this limit, CMS caps losses at the lower of either (i) 8 percent of Medicare fee-for-service revenues, or (ii) 4 percent of their historical benchmark.²⁴

CMS will determine the loss sharing limit for Track 1+ ACOs under this two-pronged structure at the beginning of an ACO's agreement period, and will re-evaluate it regularly based on an annual certification process. For ACOs that renew their participation agreements, the Track 1+ benchmark will also incorporate a regional benchmark adjustment consistent with the timing and phase-in of their regional benchmark adjustment.²⁵

¹⁷ *Id.* at 7-8.

¹⁸ *Id.* at 9.

¹⁹ *Id.* at 9.

²⁰ Track 1+ Fact Sheet at 7.

²¹ *Id.* at 1-2.

²² Track 1+ Fact Sheet at 2.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

Track	Performance Payment Limit	Loss Sharing Limit
Track 1	10 percent of benchmark	n/a
Track 2	15 percent of benchmark	Limit is phased in over three years. 5 percent of benchmark in year one; 7.5 percent of benchmark in year two; 10 percent of benchmark in year three and beyond.
Track 3	20 percent of benchmark	15 percent of benchmark
Track 1+	10 percent of benchmark	<i>The lower of either (i) a benchmark based limit at 4 percent of benchmark or (ii) a revenue-based limit at 8 percent of Medicare FFS revenue</i>

Eligibility

First, a prospective Track 1+ ACO can only include eligible participants²⁶ and cannot be “owned or operated” by a health plan.²⁷ Second, a prospective Track 1+ ACO must concurrently participate in Track 1 of the Shared Savings Program to join a Track 1+ model.²⁸ This means that CMS limits Track 1+ participation to (i) Track 1 ACOs within their current agreement; (ii) Track 1 ACOs seeking to renew their agreement; and (iii) new applicants. Track 2 and Track 3 ACOs are not eligible to participate in this model. Third, a prospective Track 1+

²⁶ See Track 1+ Fact Sheet at 5 (explaining that only combinations of the following participants are eligible to form an ACO: 1) ACO professionals in group practice arrangements; 2) Networks of individual practices of ACO professionals; 3) Partnerships or joint venture arrangements between hospitals and ACO professionals; 4) Hospitals employing ACO professionals; 5) Critical Access Hospitals that bill under Method II; 6) Rural Health Clinics; 7) Federal Qualified Health Centers; 8) Electing teaching amendment hospitals).

²⁷ *Id.* at 5.

²⁸ *Id.* at 2.

ACO should submit a Notice of Intent to Apply (NOIA) and complete the other application materials once CMS releases them.²⁹ Clinicians interested in forming an ACO should seek the assistance of counsel.

Additionally, because CMS hopes Track 1+ serves as a pathway to transition ACOs into higher risk arrangements, CMS limits how long ACOs can participate in model. Because of this, CMS limits new applicants and renewing ACOs to one three-year Track 1+ agreement period.³⁰ Current Track 1 ACOs that transition during an existing agreement to Track 1+, however, have the ability to renew for an additional three-year Track 1+ agreement.

Challenges and Conclusion

Overall, Track 1+ ACO Models involve *more risk* than Track 1 ACOs, but *less risk* than Track 2 and Track 3 ACOs. The development of the Track 1+ ACO model constitutes an important step for CMS in realizing its goal of encouraging more clinicians to embrace performance-based payment risk.³¹

Clinicians considering forming Track 1+ ACOs should note, however, that CMS will require Track 1+ participants to establish a repayment mechanism to ensure that the ACO can pay CMS should the ACO fail to meet its benchmarks.³² Despite this challenge, however, clinicians should consider embracing the Track 1+ ACO model, because it provides an opportunity to experiment with performance-based payment risk while having limited negative financial exposure.

²⁹ *Id.* at 2. Note that CMS required participants interested in joining Track 1+ for 2018 to submit an NOIA by May 2017.

³⁰ Track 1+ Fact Sheet at 2.

³¹ See, e.g., 80 Fed. Reg. 32804 (explaining that CMS believes that the long term success of the Shared Savings Program depends on “encouraging ACOs to progress along the performance-based risk continuum”).

³² Track 1+ Fact Sheet at 3. An adequate repayment mechanism can include a surety bond, escrow account, or credit line.