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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 heathcare 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]

* The authors would like to thank Bernard Miller for his contribution to this article.

[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.

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 minimumsavings 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.

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.

[4] ACO Provider Fact Sheet at 4.

[5] Track 1+ Fact Sheet at 1.

[6] *Id.* at 1.

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Kenya Woodruff

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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]

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+	*Same as Track 2*	*Same as Track 2*

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]

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.

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[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-ServicePayment/sharedsavingsprogram/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.

[12] MSSP Methodology at 7-8.

[13] *Id.* at 8.

[14] Track 1+ Fact Sheet at 1.

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+	*Up to 50 percent, based on quality performance*	*30 percent, regardless of quality performance*

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]

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]

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[15] *See*, MSSP Methodology at 7.

[16] *See id.*

[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.

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]

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*	*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*

Eligibility

First, a prospective Track 1+ ACO can only include eligible participants[26] 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+ 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.

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[23] *Id.*

[24] *Id.*

[25] *Id.*

[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.

[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.

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.

[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.

CMS Reconsiders Pre-Dispute Arbitration Ban at Long Term Care Facilities after Injunction

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After a rocky start, the Centers for Medicare & Medicaid Services ("CMS") is reconsidering its October 4, 2016 final rule that sets forth requirements for long-term care ("LTC") facilities that offer arbitration agreements to residents.[1] Under the rule, LTC facilities are barred as parties to pre-dispute arbitration agreements.

Shortly after the rule's adoption, the American Health Care Association challenged the rule by filing a complaint in federal court seeking a preliminary and permanent order enjoining enforcement of the rule's prohibition on pre-dispute arbitrations.[2] On November 7, 2016, the district court granted the preliminary injunction, and a month later, CMS issued a nationwide directive that halted enforcement of the rule while the injunction was in effect.[3]

In the ongoing effort to strike the balance between the rule's financial, practical, and legal implications on LTC facilities, residents, and their families, and after reconsidering the policy goals underlying the rule, CMS published a new proposed rule earlier this month.[4]

Summary of the Main Provisions under the Newly Proposed Rule

CMS recognizes that arbitration provides an alternative avenue to litigation that often leads to low-cost and efficient dispute resolution. By prohibiting pre-dispute arbitration agreements, LTC facilities are likely to face increased financial burdens from litigating cases in federal court that take away from resources that can improve resident care. The proposed rule's revisions include the following:

* The authors would like to thank Erica Santamaria for her contribution to this article.

[1] 81 Fed. Reg. 68,688 (Oct. 4, 2016).

[2] **Complaint for Declaratory and Injunctive Relief at 1, Am. Health Care Ass'n v. Burwell, No. 3:16-00233 (N.D. Miss. filed Oct. 17, 2016), ECF No. 1.**

[3] **Order on Motion for Preliminary Injunction at 1, Am. Health Care Ass'n v. Burwell, No. 3:16-00233 (N.D. Miss. filed Oct. 17, 2016), ECF No. 44. Ctr. for Clinical Standards & Quality/Survey & Certification Grp. Memorandum at 1, U.S. Dep't of Health & Human Servs. (2016).**

[4] 82 Fed. Reg. 26,649 (June 8, 2017).

- A removal of the prohibition on LTC facilities that prevented them "from entering into pre-dispute agreements for binding arbitration with any resident or resident's representative" and which barred them from requiring that "residents sign arbitration agreements as a condition of admission to a facility."[5]

In allowing residents to retain control over the administration of their care while still ensuring their rights are fully protected, CMS hopes to retain some provisions from the original rule including the following:

- The provision requiring LTC facilities to explain arbitration agreements to a resident or his or her representative in a form and manner that he or she understands, including language, and obtain acknowledgment of that understanding.

- The provision that bars LTC facilities from using language in their arbitration agreements "that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman."

- The provision that LTC facilities preserve "a copy of the signed agreement for binding arbitration and the arbitrator's final decision" when LTC facilities and residents resolve a dispute through arbitration, including making the documents available for inspection by CMS or designee request.

CMS also proposes additional requirements so residents are better able to make well-informed decisions in light of medical conditions that may hinder such decision-making, including the following:

- A provision that LTC facility agreements for binding arbitration be in plain language in the admission contract if such an agreement is a condition of admission.

- A provision requiring LTC facilities to "post a notice in plain language that describes its policy on the use of agreements for binding arbitration in an area that is visible to residents and visitors."[6]

Because the district judge in the pending federal suit believes plaintiffs are likely to prevail on their claim[7], CMS is taking initiative and reconsidering its rule to meet the immediate needs of LTC facilities, residents, and their families as promptly as possible. CMS is currently accepting comments on the proposed amendments until August 7, 2017.

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[5] *Id.*

[6] *Id.*

[7] 82 Fed. Reg. 26,649, 26,650 (June 8, 2017)

Recent Texas Telemedicine Legislation

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Neil Issar

On May 27, 2017, Texas Governor Greg Abbott signed into law Texas Senate Bill 1107, which provided long anticipated updates to state laws concerning telehealth and telemedicine.[1] Nationally, Texas is the last state to update key telehealth and telemedicine provisions in accordance with national trends. The changes are anticipated to allow greater development and innovation in an industry many viewed as significantly limited by regulation within

Texas. Of greatest note, the new legislation removed the requirement for practitioners to have a face-to-face meeting with the patient before the patient can use telemedicine. This change is anticipated to increase service accessibility to patients across the state and encourage providers to expand services. With 35 Texas counties without a family physician, this provision is aimed at giving the rural population, and to some extent suburban populations, more opportunities to access healthcare services that otherwise would be difficult to access with the face-to-face requirement.[2] Location of physicians is not the only problem; Texas also faces a serious projected shortage of over 17,000 primary care physicians, with that number projected to grow to over 23,000 by 2030.[3] Though the impact of the bill is still unclear, industry parties are hopeful it will improve both access and physicians' availability within Texas.

The bill establishes that medical and allied-profession boards cannot impose higher standards of care on telemedicine practitioners than for in-person practitioners. However, the bill retains boards' supervisory power over practitioners through rule-making. This change is notable because over the past two years, a case between Teladoc and the Texas Medical Board regarding regulation of telemedicine has caused uncertainty in the industry.[4] The change gives some positive reassurance to telehealth and telemedicine companies operating in Texas, who have closely monitored the Teladoc case, about the broader future of telehealth and telemedicine regulation. Following passage of the bill, providers have issued statements expressing the intent to expand telehealth and telemedicine services throughout the state.[5]

The new law requires joint development of new prescribing rules among medical and allied-profession boards. Among prescription portions of the bill, the bill places significant restrictions on prescribing drugs or devices which induce abortion, and puts any practitioner who does so at risk of discipline by the Texas Medical Board. Further, the bill retains the current insurance coverage parity requirement that requires insurance companies not to deny service solely because it is not an in-person service. However, the bill narrows this exception by allowing for exclusion of telemedicine services that are only by synchronous or asynchronous audio interaction. Additionally the bill states that copayment, deductible or coinsurance cannot exceed the amount of a procedure for an in-person service. Lastly, the bill allows for direct Medicaid program billing without prior approval. The bill became effective immediately upon signature by the Governor, with the exception that sections regarding the insurance code will go into effect Jan. 1, 2018.[6]

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* The authors would like to thank Nick Nash for his contribution to this article.

1 Tex. S.B. 1107, 85th Leg., R.S. (Tex. 2017).

2 Jonah Comstock, ***In-Depth: What Texas's landmark telemedicine legislation means for the industry and the nation*** **MOBIHEALTHNEWS (2017)** (last visited June 20, 2017).

3 Statewide Health Coordinating Council, Update to the State Health Plan (2015-2016).

4 Neil Issar & Michelle "Missy" D. Apodaca, ***The Tide in Texas is Turning Toward Telemedicine*** HAYNES AND BOONE, LLP (last visited June 20, 2017).

5 **Teladoc Expands Virtual Care Capabilities in Texas, Teladoc, Inc. - Teladoc Expands Virtual Care Capabilities in Texas TELADOC (2017)** (last visited June 20, 2017).

6 Notably, the bill does not apply to mental health services.

We'd like to hear your feedback and suggestions for future newsletters. Please contact:

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