June 21, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Inequity of Repayment Mechanisms for Track 1+ Revenue-Based ACOs

Dear Administrator Verma:

The undersigned organizations appreciate the opportunity to alert you to a key issue that could undermine the new Track 1+ ACO model by impeding ACOs from applying to participate. Specifically, the repayment mechanism requirements typically used for two-sided ACOs, including Medicare Shared Savings Program (MSSP) Track 2 and 3, are not appropriate for Track 1+ ACOs with a revenue-based risk arrangement. We urge the Centers for Medicare & Medicaid Services (CMS) to swiftly modify the repayment mechanism requirements for these ACOs so they are able to participate in Track 1+. We strongly support Track 1+ and look forward to working with CMS on a solution that will allow broad Track 1+ participation, which is a common goal for CMS and the signatories to this letter, which include organizations representing physicians, medical group practices and nearly all existing Medicare ACOs.

Our recommendations reflect our unified expectation and desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program. Specifically, our key goals for the MSSP include encouraging increased participation, enabling existing ACOs to continue in the program and creating a successful, long-term ACO model for Medicare. It is in Medicare's interest for ACOs to continue in the program in order to provide high quality care for Medicare beneficiaries and to reduce the growth rate of Medicare spending.

Modifying the repayment mechanism requirement for Track 1+ ACOs in the revenue-based risk arrangement

As with other two-sided ACO models, should Track 1+ ACOs incur losses beyond their minimum loss rate (MLR) they are required to pay CMS a portion of the losses. As part of the MSSP application process, two-sided ACOs must demonstrate their ability to repay losses by establishing a sufficient repayment mechanism. While there are few details on Track 1+ repayment mechanisms in this CMS Factsheet, the agency provided more information about Track 1+ repayment mechanisms during a March 22, 2017 webinar, "Medicare Accountable Care Organization Track 1+ Model". Specifically, on slide 27 of the presentation, CMS explained the requirements for Track 1+ ACOs to demonstrate their ability to repay losses should they occur. These requirements mirror those for other two-sided ACO models and Track 1+ ACOs must demonstrate their ability to repay CMS for potential losses by demonstrating an adequate repayment mechanism including funds in escrow, a line of credit, a surety bond, or a combination of those mechanisms.

These requirements are specified in the Code of Federal Regulations at Title 42 §425.204 and further detailed in this CMS resource. While the repayment mechanism requirements are the same across two-sided tracks, it is important to note that the two-sided MSSP tracks include very different levels of risk and loss sharing limits. These maximum potential losses are as follows:

- Track 1+ revenue-based standard: 8 percent of ACO participant Medicare fee-for-service (FFS) revenue
- Track 1+ benchmark-based standard: 4 percent of the ACO's updated historical benchmark
- Track 2: 5 percent in year one, 7.5 percent in year two, 10 percent in year three and beyond. These percentages are based on the ACO's updated historical benchmark
- Track 3: 15 percent of the ACO's updated historical benchmark

Given these variances in the loss sharing limits, it makes little sense for Track 1+ ACOs evaluated under the revenue-based risk arrangement to have to meet the same repayment mechanism requirements as the other two-sided MSSP tracks. Track 1+ ACOs under the revenue-based risk arrangement have their maximum risk capped at 8 percent of Medicare FFS revenue, not total expenditures for assigned beneficiaries which is the basis of the loss sharing limit for the other two-sided MSSP tracks. For example, suppose an ACO has annual Part A and B expenditures for assigned beneficiaries totaling $100 million. According to page 170 of the June 2017 MedPAC Report to Congress, a primary care group's revenue through an ACO would likely account for only about 5 percent of the Part A and Part B benchmark. Thus, benchmark spending in an ACO would be a large multiple of a clinician group's revenue through the ACO. Using a hypothetical benchmark of $100 million, this ACO would have to demonstrate ability to repay $1 million even though its revenue through the ACO is only $5 million.

Assuming that 75 percent of this ACO's overall Part B revenue goes through the ACO (i.e., revenue for ACO professionals furnishing care to ACO assigned beneficiaries), this would mean that the providers in the ACO's Participant TINs are billing $6.7 million for Medicare Part B covered professional services for all Medicare beneficiaries, both assigned and unassigned. The loss sharing limit for this ACO would be 8 percent of the $6.7 million Medicare Part B revenue, or $536,000. This maximum amount of losses is significantly lower than what the ACO has to demonstrate an ability to repay, which is 1 percent of the benchmark or in this example, $1 million.

If another ACO with the same overall expenditures of $100 million is evaluated under the Track 1+ benchmark-based standard, its maximum loss sharing limit would be 4 percent of total per capita Part A and B expenditures for assigned beneficiaries, or $4 million. If a Track 2 or Track 3 ACO with the same benchmark expenditures owed losses the maximum amounts would be even higher, with Track 2 loss sharing limits ranging from $5 million to $10 million depending on performance year and a Track 3 loss sharing limit of $15 million. Despite the large disparities in maximum potential losses, all of these two-sided ACOs are required to demonstrate an ability to repay 1 percent of their benchmark expenditures ($1 million). This represents greater than 100 percent of the total maximum losses the revenue-based Track 1+ ACO could be required to repay but a much smaller fraction of the maximum losses the other two-sided ACOs would potentially have to repay.

Requiring revenue-based Track 1+ ACOs to demonstrate the ability to repay such a significant amount and proportion of total maximum losses creates an unfair hurdle that these ACOs may not be able to overcome, thus preventing them from even applying for Track 1+. These ACOs are new to taking on risk and to

securing CMS required repayment mechanisms. This additional unnecessary barrier could prevent a number of them from even applying, thus undermining Track 1+.

RECOMMENDATION: We urge CMS to modify the repayment mechanism requirements so they reflect an appropriate portion of potential losses. Specifically, CMS should modify the repayment mechanism requirements for Track 1+ ACOs evaluated under the revenue-based risk arrangement to be commensurate with the threshold of the repayment mechanism for benchmark-based Track 1+ ACOs. Therefore, revenue-based Track 1+ ACOs should only have to demonstrate the ability to repay losses equaling 25 percent of their 8 percent loss sharing limit, which equates to 2 percent of their Participant TINs' Medicare Part B FFS revenue. Setting the revenue-based repayment mechanism at this level would be reflective of the actual risk the ACO is taking on and is a much more appropriate threshold than using 1 percent of their benchmark. Track 1+ is a new initiative from the CMS Innovation Center and is designed to test a new ACO model as part of the effort to expand opportunities for clinicians to participate in Advanced APMs under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We recommend the Innovation Center use this same authority to quickly modify the Track 1+ repayment mechanism requirements for revenue-based Track 1+ ACOs by implementing a revenue-based repayment mechanism.

Reinsurance as a Repayment Mechanism

As noted above, the current acceptable repayment mechanisms include placing funds in escrow, obtaining a surety bond, establishing a line of credit, or establishing a combination of these approved repayment mechanisms. We urge CMS to restore reinsurance as a qualifying repayment mechanism. Reinsurance was a permissible repayment mechanism for MSSP ACOs until CMS removed this option in the June 2015 final MSSP rule. The agency's rationale for doing so was that few ACOs were using this option. However, we question that logic considering how few two-sided ACOs there were at that time. Further, despite limited initial use of reinsurance for demonstrating ability to repay losses to CMS, this continues to be an option which some ACOs pursue separate from their CMS obligations. We see no harm in CMS reinstating reinsurance as an option, and we urge CMS to do so for all two-sided ACO tracks/models, including Track 1+.

Conclusion

We appreciate your consideration of revising the ACO repayment mechanism requirements. We are available to further discuss this issue and can be reached by contacting Allison Brennan, Vice President of Policy, at abrennan@naacos.com or 202-640-2685.

Sincerely,

National Association of ACOs
American College of Physicians
American Medical Association
Medical Group Management Association