On December 20, 2016, CMS announced the Medicare ACO Track 1+ Model. As a hybrid of Track 1 and Track 3 of the Medicare Shared Savings Program (MSSP), CMS designed Track 1+ to encourage more providers, especially smaller practices, as well as allow hospitals, including small, rural hospitals, to advance to performance-based risk at a more rapid pace.

How is Track 1+ Different from Current MSSP Tracks?

Track 1+ will have more limited downside risk than MSSP Track 2 or 3 to expand the opportunities for smaller practices and hospitals to participate. The Track 1+ Model will also qualify as an Advanced Alternative Payment Model (APM) under MACRA's Quality Payment Program (QPP), giving an estimated additional 70,000 physicians the opportunity to qualify for the 5 percent lump sum incentive payment beginning in 2018.

Track 1+ is a hybrid of Tracks 1 and 3 of the MSSP. It allows practices to take on some downside risk, but limits exposure with a maximum 50% shared savings rate, which is less than both Track 2 (60%) and Track 3 (75%). While the new model is based on Track 1, it also incorporates certain key elements of Track 3, such as prospective beneficiary assignment, choice of minimum savings and loss rates, and the option to elect the SNF 3-day rule waiver.

The Specifics: Sharing Limits

Track 1+ has a fixed 30% loss sharing rate, and the maximum level of downside risk will vary based on the composition of the ACO. There are two types of risk arrangements available – a revenue-based and a benchmark-based loss sharing limit. Each ACO's arrangement will be determined annually by CMS and any changes would be made prior to the start of the performance year.

In 2018, physician-led ACOs or ACOs that include small, rural hospitals will operate under a revenue-based loss sharing limit with a loss sharing limit capped at 8 percent of their Medicare fee-for-service revenue. In subsequent years, the loss sharing limit may be adjusted to align with updated Advanced APM standards.

An ACO will operate under a benchmark-based loss sharing limit with a loss sharing limit of four percent of the ACO's updated historical benchmark if it meets one of the following criteria:

1. The ACO includes an ACO participant that is or is owned or operated by, in whole or in part, an inpatient prospective payment system (IPPS) hospital, cancer center, or rural

hospital with more than 100 beds;
2. The ACO includes 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; and
3. The ACO includes an ACO participant rural hospital with 100 or fewer beds that is owned or operated by, in whole or in part, a health system.

In addition, for renewing ACOs, the benchmark will incorporate a regional benchmark consistent with the timing and phase-in of the regional benchmark adjustment.

Once again, both the revenue- and benchmark-based loss sharing limits provide lower risk than Track 2 (three-year phase-in period, starting at 5% in year one, 7.5% in year two, and 10% in subsequent years) and Track 3 (15%).

Eligibility and Application Process

The 2018 application cycle will follow the same timeline as the annual MSSP application cycles. Organizations interested in applying should submit the Notice of Intent to Apply in May 2017. Current and renewing Track 1 ACOs, as well as new applicants to the MSSP program, are welcome to apply. Current or former Track 2, Track 3, Pioneer Model, or Next Generation Model are not eligible for the Track 1+ model. If selected, a Track +1 ACO is limited to one full three-year agreement period. CMS also plans to offer opportunities to join the Model during the 2019 and 2020 MSSP application cycles.

For more information: Fact Sheet; General Fact Sheet; HHS Press Release; Final Rule