

# Repayment Mechanism Arrangements Guidance

## Appendix B: Letter of Credit Template

The letter of credit template satisfies the repayment mechanism requirements for an Accountable Care Organization (ACO) participating in the Medicare Shared Savings Program. Use of the letter of credit template may expedite CMS' review and should minimize the potential need for revision, but does not guarantee CMS approval of the ACO's letter of credit (particularly if it has been modified). If the ACO and/or issuing institution chooses to modify the template, the ACO and/or issuing institution should use Track Changes in a Word document when submitting the draft to CMS for review. Note that any changes made to the template will lengthen the CMS review time.


### Instructions:

- Complete fields marked in bracketed and bolded text as instructed.
- According to the preferences of the institution issuing the letter of credit, provide documentation on letterhead or security paper with the issuing institution's logo.

For additional information, review the [Repayment Mechanism Arrangements Guidance](#).

*Disclaimers: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.*

*This communication material was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of its contents.*

A decorative wavy line at the bottom of the page, consisting of a blue wave on the left and a yellow wave on the right, both curving upwards towards the center.

IRREVOCABLE STANDBY LETTER OF CREDIT NUMBER:

ISSUING INSTITUTION ("Issuer") Name & Address:

**[Issuing Institution Name]**

**[Issuing Institution Address]**

BENEFICIARY Name & Address:

CENTERS FOR MEDICARE & MEDICAID SERVICES ("CMS")

ATTN: KAREN MCVEARRY, CM/PERFORMANCE-BASED PAYMENT POLICY GROUP

7500 SECURITY BLVD

MAIL STOP: C5-15-12

BALTIMORE, MD 21244

Phone: 410-786-5604

Email: [sharesavingsprogram@cms.hhs.gov](mailto:sharesavingsprogram@cms.hhs.gov)

APPLICANT Accountable Care Organization ("ACO") Legal Entity Name & Address:

**[ACO Legal Entity Name]**

**[ACO Legal Entity Address]**

AMOUNT: Not exceeding

**[required Written Dollar amount]** USD (\$

**[Numerical dollar amount])**

ISSUANCE DATE:

**[Issuance Date of Letter of Credit]**

EXPIRATION DATE: (select one)

☐ The expiration date of this letter of credit is \_\_\_\_\_, which is 12 months following the conclusion of the last performance year of the Applicant's agreement period in the Medicare Shared Savings Program.

☐ The initial expiration date of this letter of credit is 12/31/\_\_\_\_\_ **[that is the last day of the ACO's second performance year under a two-sided model covered by this letter of credit, i.e., the second calendar year from the issuance date of this letter of credit]**, provided that this letter of credit will be automatically extended for an additional 12-month period from the initial expiration date and annually thereafter, such that the term of this letter of credit will eventually cover all remaining performance year(s) of the Applicant's agreement period under a two-sided model and end on 12/31/\_\_\_\_\_ **[Final expiration year]**, which is 12 months following the conclusion of the last performance year of the Applicant's agreement period. If Issuer elects not to automatically extend this letter of credit for any additional period, it must provide Beneficiary with at least ninety (90) days advance written notice of non-extension. The Issuer's written notice must be sent by traceable carrier to Beneficiary's above-stated address.

We hereby issue this irrevocable standby Letter of Credit Number \_\_\_\_\_  
in your favor, as the sole beneficiary, for the Account of **[ACO legal entity name]**

for up to an aggregate amount of USD **[numerical dollar amount]** \$ \_\_\_\_\_.

Issuer shall pay Beneficiary's demand for payment for an amount available under this Letter of Credit presented to Issuer at the following place for presentation: **[address of place for presentation]**

at or before the close of business on the expiration date. The demand is a dated statement signed by an authorized signatory of the Beneficiary on the Beneficiary's letterhead that includes the following information: Standby Letter of Credit Number; issuance date of the letter of credit; issuing institution name; the amount demanded by the Beneficiary from the Applicant as provided under the Medicare Shared Savings Program regulations at 42 CFR Part 425; and the method of payment to the Beneficiary.

The demand must be accompanied by the following:

1. The original letter of credit and all amendments thereto, if any.
2. A copy of the written notice from the Beneficiary to the Applicant of the amount owed.

Partial or multiple drawings are allowed.

**[Optional – Specify if Issuer permits electronic presentation and the circumstances for electronic presentation. An electronic presentation clause, if added, is subject to CMS approval.]**

If any portion of this Letter of Credit is used to pay shared losses owed by the Applicant to the Beneficiary, the Applicant may request an amendment to this Letter of Credit to replenish the amount of funds available through this Letter of Credit within 90 days.

All of Issuer's charges and fees are for the Account of the Applicant and shall not be deducted from any payment Issuer makes under this Letter of Credit.

This Letter of Credit is issued subject to the International Standby Practices 1998 (ISP98), International Chamber of Commerce Publication No. 590.

If you require any assistance or have any questions regarding this transaction, contact **[issuing institution contact (first and last name) phone number]**

**[Issuing institution name]**

By:

\_\_\_\_\_  
Authorized signature

Printed Name:

\_\_\_\_\_

Title:

\_\_\_\_\_