ACO PC Flex FAQs

- These FAQs are based on a live webinar hosted by the AMA, ACP, and AAFP with Center for Medicare and Medicaid Innovation (CMMI) staff on July 17, 2024, a recording of which is available here.
- The Accountable Care Organization (ACO) Primary Care (PC) Flex Model operates within the Shared Savings Program (SSP), applications for which were due June 17, 2024. Supplemental application questionnaires for the ACO Primary Care Flex Model are due **August 23, 2024**.
- ACO PC Flex Request for Applications (RFA)
- ACO PC Flex Model CMMI Webpage
- Contact the CMMI model team at ACOPCFlex@cms.hhs.gov
- Sign up for CMMI email updates.

Eligibility and Application Process

1- **I understand high-revenue accountable care organizations (ACOs) are not eligible for ACO Primary Care (PC) Flex. What is the difference between a high- and low-revenue ACO? How do I know which type of ACO I am in? Will I know that before ACO PC Flex applications are due?** The Shared Savings Program regulations define "low revenue ACO" under 42 CFR § 425.20 as an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35% of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available. One of the key differences is that low revenue ACOs generally exclude hospital participants. Low revenue status is calculated by CMS and provided at three different points throughout the application process. ACOs that applied to the MSSP should have already received their first revenue estimate on July 11th. A second revenue determination will be made in late August and a final determination will be provided on October 17, 2024.

2- **Final TIN participation decisions are due in early September for the Shared Savings Program (SSP), but ACO PC Flex decisions will not be announced until mid-October. Since all primary care practices in a PC Flex ACO must participate, has CMS given any consideration to allowing a special TIN add/removal period for PC Flex ACOs?** CMS is not able to modify the SSP regulations. A special TIN add/removal period is not being considered at this time.

3- **Is CMMI planning to solicit a second round of applicants? Would it consider extending the application deadline or accepting a second round of applicants if it doesn't fill all 130 ACO PC Flex slots?** CMS does not have plans to offer a second round of applications at this time. ACO PC Flex is tied to the operations for the SSP, so it must generally maintain alignment with that schedule. However, CMS recently extended the deadline for ACO PC Flex applications from August 1 to August 23, 2024. Additionally, in order to participate in ACO PC Flex, you have to have first applied to MSSP. Those applications closed in June 2024. That said, existing ACOs are continuing to establish

relationships with physicians so you could still be in the model with an ACO that did apply. The deadline for ACOs to drop practices from their participation lists is Sept. 5, 2024.

4- **Will CMS offer technical assistance (TA) to help ACOs develop payment arrangements with their primary care practices?** CMS plans to look into offering TA on this subject. Many REACH ACOs have entered into downstream arrangements with participating practices since 2021 so this may be an opportunity for CMS to facilitate some type of shared learning. CMS will explore the options and provide more information through the ACO PC Flex listserv and future FAQs.

5- **When will county base rates be released? How will this factor into the general timeline for application materials?** CMS' goal is to release the rate book by August 16, 2024- no later than August 31st. CMS aims to provide a few weeks for ACOs to understand and analyze their population before the September 5th deadline to remove practices from their participation lists.

6- **Is there a minimum number of patients needed to join the ACO PC Flex model?** A PC Flex ACO must have a minimum of 5,000 assigned beneficiaries.

7- **How will ACO PC Flex differ from previous CMMI Primary Care Models?** The Prospective Primary Care Payment (PPCP) in the ACO PC Flex Model is not based on individual ACOs' historic expenditures, but rather on county average spending on primary care services. This PPCP has a different methodology for calculating primary care spend featuring capitation and downside risk compared to FFS with a care management fee added to the top, or partial capitation with bundled, inflated evaluation and management visits and no downside risk under Comprehensive Primary Care Plus. Making Care Primary was focused on primary care practices that may not be ready to move to an ACO or downside-risk based model whereas ACO PC Flex is tested on the SSP, so that's another major difference.

Beneficiary Assignment for Purposes of Making Prospective Primary Care Payments (PPCPs)

8- **It is promising to see CMS address non-physician practitioners (NPPs) practicing in primary care versus specialty settings in ACO PC Flex, which has been an issue with patient assignment in the SSP for a long time. Is CMS planning to make similar changes to the larger SSP assignment methodology for NPPs?** The SSP currently has no proposed changes to the overall assignment methodology. Interested parties are encouraged to provide comments on the Proposed 2025 Medicare Physician Fee Schedule Rule to provide feedback on this issue.

9- **Can CMS elaborate on its reasoning for not allowing a patient that rolls off assignment during the performance year to be added back on later in the year for PC Flex ACOs electing retrospective assignment since it differs from the regular MSSP assignment methodology?** For assignment purposes, the ACO PC Flex Model uses the same methodologies as the Shared Saving Program for both Prospective Assignment and Preliminarily Prospective Assignment with Retroactive Reconciliation. Of the assigned beneficiaries, however, only those assigned at the beginning of the performance year are included in the payment of the PPCP to the ACO. Please see Appendix E in the Request for Applications for more information on what would happen to PPCPs in various scenarios for ACOs with retrospective assignment.

10- **For patients that end up being retrospectively unassigned from a PC Flex ACO, can you explain more how recouping monthly PPCP payments will work? The RFA says "it is mathematically**

possible that PPCP recoupment resulting from a quarterly assignment run could exceed the next month's total PPCP payment amount." Can you explain that a little further? Will CMS offer any recoupment limits or other strategies such as allowing practices to spread out recoupments over multiple months or defer to the end of the year to help smooth cashflow disruptions for primary care practices? To illustrate how this would work, say a practice has a set of beneficiaries starting in January, so for January, February, and March, CMS pays PPCPs for all of those beneficiaries. In April, assignment is reassessed and your ACO has lost two percent of its beneficiaries. The April payment would then be 98 percent of the beneficiaries you started with, minus two percent for each of the three months' worth of PPCPs paid for beneficiaries that were retroactively terminated. So, 98 percent minus six percent to get a rough net of 92 percent of your previous monthly payment. After that, assignment would go back to 98 percent for April through June until the next quarterly assignment. Here, we are using percentages to simplify the example, but the PPCP is calculated and paid each month at the beneficiary-month level and recoupment of previously paid PPCP related to retroactive ineligibility for the PPCP is based on what was actually paid for those beneficiary-months. Claim reductions for those unassigned patients that happened in those first three months would be reprocessed, and the practices would be paid normally as FFS by Medicare. Additionally, because later in the year you would have a gradually smaller assigned population due to more patients being unassigned throughout the year, it is possible that the amount of recoupment could exceed the monthly payment later on in the performance year. Putting in place recoupment limits or spreading out or deferring settlement is something CMS will consider. One of the goals of this model is to create stable, predictable cashflow for primary care and CMS will monitor for this, particularly for potentially greater risks for cashflow disruptions later in the year.

Prospective Primary Care Payments (PPCPs)

11- **Can you explain more how the payment precision withhold of three percent will work? Will those ever be paid back? If so, when?** CMS has learned through other models that claims payment reductions do not always work perfectly and statutorily CMS is not allowed to pay a claim that has already been paid as part of a capitated payment. To solve for this, CMS is going to withhold up to three percent of the PPCP. At the end of the performance year, CMS will release that withhold back to the payment mechanism and offset by the value of any claims that were paid inappropriately at a beneficiary level throughout the performance year. This reconciliation will likely show up in the PPCP for the following March, since it is the last PPCP for the preceding performance year.

12- **I appreciated seeing that CMMI wants to ensure PC Flex payments are flowing to physicians. Can you please provide more information about how CMS intends to carry that out?** As part of the participation agreement process, the ACO must attest that they have a written and signed agreement with each participating TIN attesting that they agreed to the claims reductions under the model. Those agreements can be audited for cause or randomly. Additionally, before each year, each ACO will report to CMS how they intend to spend additional payments received under the model to downstream participants on a percentage and category basis. While the decision for the type of payment arrangement is between the ACO and its participants, CMS prefers these payments to be some type of downstream value-based arrangement, such as downstream capitation or a per beneficiary per month payment, but it could also be based on fee-for-service (FFS) claims. On a quarterly basis, ACOs report to CMS what they have actually spent in each category. This includes what has been paid to the participating practices to ensure that the money is flowing to them. Once a year, the ACO in coordination with the participant practices will provide more granular reporting on what each practice spent those payments on, which can include workforce; payroll; new

interfaces; etc. CMS is not planning to implement a new survey or mandate reporting at the individual provider level, but they do plan to monitor this data and work with specific participants on a case-by-case basis.

13- **How, if at all, are ACO PC Flex payments designed to support integration of primary care with specialty care and engage specialty clinicians?** In the ACO PC Flex Model, CMS is providing increased funding for primary care to help practices move to advanced primary care delivery. Allowable uses of the increased funding include SDOH referral screenings to community-based organizations, investing in technology, or care managers who can help coordinate care with specialists. ACO PC Flex is intended to provide flexibility for ACOs to design how they can use this money (within limits) to best meet the needs of their specific patient populations, and specialty integration is an option for how to use this money. CMS has also started sharing data with SSP and REACH ACOs on shadow bundles and CMS plans to build on that data sharing within ACO PC Flex so ACOs can be thoughtful about the participation and integration of specialists in providing whole-person care.

14- Primary care practices in ACOs may have higher primary care spending than other non-ACO primary care practices since ACOs are focused on prevention and care management. Does CMS plan to account for this at all in the county base rates? It is possible that a PC Flex ACO's own historical spending on primary care is greater than the average rates in their county or counties. This would result in the county base rate portion of the PPCP being less than historical collections. However, in many such cases, the enhanced portion of the PPCP as well as the adjustments made to the PPCP for clinical risk, primary care outside of ACO (PCOA), and trend (PCPAT) will overcome that shortfall. All ACOs who are interested in participating in the ACO PC Flex Model should assess how their own population, how it will translate into PPCP payment compared to historical collections for the capitated services and understand how the enhancements will impact their performance year settlements.

Health Equity Adjustment

15- **Can you please explain more how the health equity adjustment will work? The RFA says it can be up to +$3 but also -$3. How does CMS decide which practices get a negative health equity adjustment? Will practices know what their health equity adjustment is before signing their ACO PC Flex contracts?** The health equity adjustment is done at the beneficiary level, not the practice or ACO level, so based on national- and state-normalized area deprivation index (ADI) score plus their dual or low-income subsidy (LIS) status, each beneficiary gets a health equity score and an adjustment. For the ACO, it's just the aggregation of those individual beneficiary adjustments.

16- **How often will the health equity adjustment be adjusted?** For ADI, home address will be evaluated on at least a quarterly, if not monthly basis, so if a beneficiary moves that would be reflected on a rolling basis. For beneficiaries that become dual or LIS eligible in July for example, CMS reasons that the disparity or socioeconomic challenge did not start July 1, so once CMS has a valid month at any point in the performance year that includes either of those statuses, CMS will credit the beneficiary for all months of the performance year as if they had that status the entire time.

17- **Health equity adjustments get added to the monthly prospective primary care payments, which are reconciled against ACOs' benchmarks. In a way, doesn't that work against primary care practices serving greater amounts of underserved populations when it comes to their ACO's benchmarks and ability to achieve shared savings payments? Does CMS have any plans in place to**

help balance this out? On August 9, 2025, CMS announced clarifications in the "ACO Primary Care Flex (ACO PC Flex) Model: Financial Methodology Updates and Information" on the treatment in settlement of the Health Equity Adjustment: The entire paid PPCP, including the Health Equity Adjustment, is included in Total Expenditures. The Total Enhancement Credit to Settlement after offset for Positive Regional Adjustment and Prior Savings Adjustment does not include the Health Equity Adjustment. The Health Equity Credit / (Debit) is equal to the PC Flex ACO's total Health Equity Adjustment for the performance year. The Total ACO PC Flex Settlement Credit / (Debit) is the sum of the Total Enhancement Credit and the Health Equity Credit / (Debit). This amount is added to the Earned Performance Payment or Payment Due to CMS before sequestration or recoupment of Advance Shared Savings balance as relevant. CMS has also updated the example calculation in "ACO PC Flex RFA Exhibits and Example Calculations Workbook (XLSX)" to illustrate this calculation. The workbook can be downloaded from the model website. The August 9 announcement also includes important updates on timing of claims reductions and related PPCP payments and the application of the preliminary and updated rate books for PY 2025.