Accountable Care Organization Primary Care Flex Model (ACO PC Flex Model) Application Overview Webinar

June 6, 2024

>>Haley Moen, SEA: Good afternoon, and thank you for joining us. Next slide, please.

To start us off, this webinar was prepared for informational purposes only, and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents. Next slide, please.

Before we get started, I will share a few brief housekeeping items. During today's presentation, all participants will be in listen-only mode. We recommend that you listen via your computer speakers. For those who prefer to dial in by phone, please see the dial-in information on the screen. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed in the Zoom window. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs on the model's webpage. We also would like you to know that today's presentation is being recorded. If you have any objections, please hang up now. This slide deck, along with a recording and transcript of today's webinar, will be available on the ACO PC Flex Model website in the coming days. Next slide, please.

I'd now like to introduce today's speakers. First, we have Meghan Elrington-Clayton, Director of the CMS Innovation Center's Division of Financial Risk. Meghan O'Connell, ACO PC Flex Model Co-Lead, and Lauren Kuenstner, ACO PC Flex Model Co-Lead. I will now turn it over to Meghan to share some opening remarks.

>>Meghan Elrington-Clayton, CMS: Welcome everyone. As Haley mentioned, my name is Meghan Elrington-Clayton. I'm the Director of the Division of Financial Fisk here at CMS's Innovation Center. We are so excited to have all of you join us today to learn more about our recently announced ACO PC Flex Model. As you know, we released the Requests for Applications, or RFA, for this model on May 30th and are holding today's webinar, really as an opportunity for you to learn more about the model and consider participation.

To that end, we will do a few things. First, we will do a walk-through of the key elements of the ACO PC Flex Model, as outlined in the RFA, such as information regarding eligibility, assignment, and financial methodology. For your reference, the RFA, a link to the application portal, and related model documents are all located on the model's website, for your reference.

Second, during this webinar, we will point you to key resources within the RFA to help you as you consider participation in the model, such as the exhibit and the calculations in the companion workbook titled, "The ACO PC Flex RFA Exhibits and Example Calculations Workbook." Third, we will review the application process so that you can plan for key submissions and due dates. At the end of the webinar, we will want to take an opportunity to open the floor to address any questions you may have. Next slide, please.

Before we dive into the detail provided in the RFA, I just want to take a moment to provide a brief overview of the goals of the ACO PC Flex Model test. The ACO PC Flex Model is a five-year, voluntary model with the goal of strengthening primary care within the Medicare Shared Savings Program. Primary care is the foundation of a high-performing health system, and fundamental to improving the health of the US population. However, primary care delivery has become significantly more complex for providers and patients, contributing to fragmented care. We at CMS are testing ways to strengthen primary care because research has shown that access to primary care is associated with improved patient outcomes, increased equity, and lower mortality and higher life expectancy, at similar or often lower total costs.

Yet, despite being the foundation of our health care delivery system, primary care is currently facing several challenges. ACO PC Flex aims to mitigate those challenges by increasing investments in primary care through ACOs. ACOs in particular, who will promise delivering person-centered care, as evidenced by the success of physician-led ACOs in the Medicare Savings Program. The ACO PC Flex Model builds upon the total cost of care framework that the program provides to boost investment in primary care directly and provide prospective payments to primary care providers.

Through these mechanisms, ACO PC Flex seeks to facilitate the delivery of advanced primary care, improve the beneficiary experience and outcomes, and really reduce program expenditures, while enhancing the quality of care for our beneficiaries. In addition, through this model we seek to encourage the formation and participation of new low revenue ACOs in the Medicare Share Savings Program.

Specifically, the ACO PC Flex Model will provide monthly Prospective Primary Care Payments, or PPCPs, to ACOs in lieu of fee-for-service revenue for primary care services billed by participating primary care providers, thereby providing a stable source of revenue for primary care. These payments include multiple components to advance health equity, such as an equity adjustment. We heard from many about the importance of upfront funding. So ACO PC Flex will also provide a one-time shared savings advance of 250,000 to all PC Flex ACOs to help the finance, to help fund the cost of forming and operating a PC Flex ACO.

So, under this model, we expect the beneficiaries will receive more coordinated, seamless care that really addresses their unique needs. As our primary care clinicians should have more time to really spend with their patients and have additional resources to provide person-centered care. And as a result, we're really excited to have this opportunity to really share more information with you about this initiative. So with that, I'll now pass it to our ACO PC Flex Model Co-Lead Meghan O'Connell to begin discussion of the model's details in the RFA. Meghan.

>> Meghan O'Connell, CMS: Thanks, Meghan. And hello, everyone. Thank you for being here today.

For today's agenda, we just heard opening remarks from our Division Director, Meghan Elrington-Clayton. I will now provide an overview of the ACO PC Flex Model's Request for Applications that was recently released, going into more detail on various model design elements and key considerations, along with my Co-Lead Lauren Kuenstner. Next, I'll share an overview of the application process. And we'll hold a Q&A session where our team will answer common questions from the webinar's registration form, as well as questions from the audience here today. And just to note, we've planned for 90 minutes for today's session in order to dedicate a significant portion of time to question and answers, and making sure that all of your answers on the ACO PC Flex Model are answered. Next slide.

Now I'll share more information about the ACO PC Flex Model's Request for Applications. Next slide.

Here we have listed the eligibility criteria for the ACO PC Flex Model. For those who are following along in the Request for Applications document, you can find this information on page six. An ACO is eligible for the PC Flex Model if CMS determines that the following eligibility criteria are met. The first is related to Shared Savings Program eligibility, as I'll detail in the application process section. ACOs must first apply to the Shared Savings Program in order to participate in the ACO PC Flex Model. So, an ACO must be eligible to participate in the Shared Savings Program in order to be eligible to participate in the ACO PC Flex Model.

Second is related to revenue status. The ACO must be a low revenue ACO, as defined by the Shared Savings Program. And revenue designations are provided by CMS as part of an ACO's Shared Savings Program application. And this is done at a few different points during the application process for the Shared Savings Program. First, with the RFI-1 in July, and again RFI-2 in late August, and lastly during the Shared Savings Program phase 1 final dispositions on October 17th. So, it's just important to note that eligibility for the ACO PC Flex Model will be based on final revenue determinations, provided by CMS during the phase 1 final dispositions in October.

Next, is program integrity. A program integrity review done during the application process, should, of the ACO or other relevant individuals or entities associated with the ACO, must produce satisfactory results. The ACO may not receive prepayments of shared savings or simultaneously participate in another Medicare initiative that involves Shared Savings Program.

And lastly, an ACO must demonstrate their ability to repay. So, all PC Flex ACOs must repay amounts for which, for which they may be liable under the ACO PC Flex Model. And documentation, draft and final, and repayment mechanism documentation is required. And I have a slide that details out the repayment mechanism requirements in more detail. Next slide.

This is a slide that highlights the different types of ACOs that are encouraged to apply to the model. So, if you're asking yourself, "Is my ACO eligible to apply for the ACO PC Flex Model?" ACOs that are existing but renewing ACOs, meaning their current Shared Savings Program agreement period ends in 24, 2024, and they're planning to start a new agreement period for 2025, and they are low revenue. Those ACOs are welcome and eligible to apply. As well as existing ACOs that are early renewal ACOs to the Shared Savings Program. This means they have a current Shared Savings Program agreement period that ends in 2025 or later, but they want to apply early to renew to participate in the ACO PC Flex. And again, low revenue status applies to all of these categories.

Returning ACOs are encouraged to apply, so those that are not Shared Savings Program ACOs in 2024, but have previously participated, and are likely to meet the Shared Savings Program criteria for low revenue. But again, I'll highlight, that those final revenue designations are the eligibility criteria for participation in the model.

And finally, new ACOs. So, ACOs that have formed a new entity that have not previously participated in the Shared Savings Program that think they might be likely to meet the Shared Savings Program criteria for a low revenue designation. And the low revenue definition is listed at the bottom of the slide. It's the definition codified in Shared Savings Program regulations. Next slide.

This slide highlights overlaps, permitted and non-permitted, with other Medicare programs. PC Flex ACOs may not simultaneously receive Advanced Investment Payments under the Shared Savings Program or other prepayments of Shared Savings. If an ACO terminates its Shared Savings Program participation agreement during the period in which it received an Advanced Investment Payment, Shared Savings Program rules for recoupment and recovery of Advanced Investment Payments apply. And there's more detail related to this overlap in the Request for Applications.

Next, our CMS Innovations Center shared savings initiatives and other prohibited overlaps. In general, CMS will not allow organizations and providers to simultaneously participate in the ACO PC Flex Model and another model or Medicare initiative that involves shared savings, aside of course, from the Shared Savings Program. You can see the list of ineligible overlaps here. I'll note that overlap is not allowed with the ACO REACH Model, the Making Care Primary Model, or the Primary Care First Model.

And lastly, there are a set of CMS Innovation Center non-Shared Savings Program, they're non-shared savings initiatives, that are allowed in terms of overlap. And you can see those listed in the eligible column. Next slide.

This slide articulates the ACO PC Flex Model repayment mechanism requirements. And for those who are following along in the RFA, this is on page 18. As I mentioned earlier, a PC Flex ACO must have the ability to repay Other Monies Owed for which it may be liable under the model. To ensure an ACO's ability to repay any Other Monies Owed, each PC Flex ACO that participates in the model must obtain a repayment mechanism. This requirement is separate from, and in addition to, repayment obligations under the Shared Savings Program. And CMS will annually notify the PC Flex ACO of the amount that must be funded by its repayment mechanism.

I will note that the ACO PC Flex Model repayment mechanism must be in one of the following three forms, which are the same as those under the Shared Savings Program: Funds placed in escrow, a line of credit, or a surety bond. And you can see listed in the key considerations here, for ACOs that are considering applying. The repayment mechanism for the ACO PC Flex Model covers liability on the Prospective Primary, Prospective Primary Care Payment Enhanced Amount. In the event of a mid-year termination, and the Advanced Shared Savings Payment, which would be prorated in the event of early termination, given this, the amount should be less than repayment mechanisms for general downside risk that are required under the Shared Savings Program.

A few more considerations. PC Flex ACOs participating in two-sided risk tracks of the Shared Savings Program must secure two repayment mechanisms. This means that a PC Flex ACO participating in a two-sided risk track of the Shared Savings Program may not obtain a single repayment mechanism to meet its obligations to obtain an ACO PC Flex Model repayment mechanism and a Shared Savings Program repayment mechanism. Similarly, PC Flex ACOs participating in one-sided tracks of the Shared Savings program must establish a single repayment mechanism to repay Other Monies Owed under the ACO PC Flex Model. Draft and final repayment mechanisms are due in Phase 2 of the ACO PC Flex application period. And so this means after the phase 1 dispositions are released, after October 17th. And I'll talk more about those dates and the application phase process. Next slide.

This slide covers assignment of beneficiaries under the ACO PC Flex Model. Before calculating a PC Flex ACO’s Prospective Primary Care Payment, beneficiaries must be assigned to a PC Flex ACO. PC Flex ACOs may select either Prospective Assignment or Preliminary Prospective Assignment with Retrospective

Reconciliation. I will note that this is a change from previously released information. And highlight again, that PC Flex ACOs may select either Prospective Assignment or Preliminary Prospective Assignment with Retrospective Reconciliation, as part of their Shared Savings Program application.

You can see, listed under the key considerations, for Preliminary Prospective Assignment with Retrospective Reconciliation, only beneficiaries that are assigned as part of the first assignment run of the performance year, and remain assigned at all subsequent performance year runs, are eligible beneficiaries for the Prospective Primary Care Payment. So, this is highlighting that there is a connection between the assignment methodology selected and the calculation of the Prospective Primary Care Payment. More details about how assignment options affect the Prospective Primary Care Payment can be found in Appendix E of the RFA.

So, more details here. While the ACO PC Flex Model will follow the Shared Savings Program annual assignment process, CMS will identify beneficiaries receiving a plurality of primary care services based on allowable charges at Federally Qualified Health Centers or Rural Health Clinics to apply the add-on payment to the Prospective Primary Care Payment for beneficiaries with FQHC or RHC Focused Care. And Lauren will talk more about that when she goes over the financial methodology details. Excuse me.

And two more considerations related to the intersection of the payment methodology and assignment of beneficiaries. The Prospective Primary Care Payment will not be paid, will not be paid for beneficiaries assigned via “Step 2” nor will claims be reduced for these beneficiaries. And as a reminder, assignment via Step 2 in the Shared Savings Program is beneficiaries who are assigned, who are assigned to the ACO via Step 2, meaning they're not assigned via Step 1 based on primary care services with primary care physicians. Instead, they were assigned based on primary care services with specialist physicians.

And lastly, non-physician practitioners designated as specialty practice NPPs, or non-physician practitioners, by PC Flex ACOs, will not have claims reduced for assigned beneficiaries. And I'll provide more information on the process for identifying and reporting on physician practitioners designated as specialty practice NPPs in the application section.

And now I’ll pass it over to my colleague Lauren, next slide, please, who will detail the payment mechanisms and financial methodology outlined in the model Request for Applications. Thank you.

>> Lauren Kuenstner, CMS: Thank you, Meghan. Next slide, please.

So, now we'll go into more details on the payment methodology, monitoring and quality, some more details in additional parts of the RFA. So there are two main components to the payment approach. A one-time Advanced Shared Savings Payment, and monthly Prospective Primary Care Payments, or PPCPs.

The model will provide a one-time shared savings advance of $250,000 to all PC Flex ACO’s to help finance the cost of forming and operating a PC Flex ACO. This payment can be used to fund startup costs of creating an ACO as well as covering activities that are required by the model, like health equity data reporting, submitting spend plans and administering prospective payments. This payment will not be risk adjusted or based on the number of beneficiaries assigned to an ACO. So that means that all PC Flex ACOs will receive the same $250,000 Advanced Shared Savings Payment. This payment will be deducted

from shared savings each performance year until the full $250,000 is repaid and any balance that is owed will be carried over from performance year to performance year.

So then, to cover the second piece of the payment mechanism, we'll now talk about the Prospective Primary Care Payments, or PPCP. As a reminder, ACOs will receive their primary care budget prospectively in monthly payments, which are designed to cover primary care services that are provided by primary care providers, for ACO professionals delivering services to the ACO's assigned beneficiaries. PPCP will be made to ACOs, in lieu of fee-for-service reimbursement, directly to ACO Participants for most primary care services. Eligible claims will be reduced in the fee-for-service payment system, which we refer to as zero-pay claims. And ACOs and ACO Participants will enter into agreements reflecting their negotiated payment terms for payment from the ACO to the ACO Participant. One important thing to note is that the PPCP is not treated as a cash advance or a cash float mechanism like the Advanced Payment Option, or APO, in ACO REACH.

The PPCP is built from the four components below: the County Base Rate, the enhanced amount, adjustments, and a prospective trend. And we'll go into each of these building blocks in more detail. Next slide, please.

So, the foundation of the PPCP is based on the County Base Rate. The County Base Rate is based on county-level utilization of primary care services billed by primary care providers, and it's called the County Base Rate. The intent of the County Base Rate is to address historical and current patterns of low spending for underserved groups. So, by creating a payment rate that's based on average county spending for primary care, rather than historical spending, which may be too low for underserved groups for primary care, we can increase the amount of funding and resources available for primary care for underserved communities and break this pattern. By setting primary care payments above current levels of spending for underserved populations, we can reduce some of these resource disparities and encourage ACOs to form to deliver high quality primary care.

So, all ACOs participating in ACO PC Flex will get the same County Base Rate for each county that they are serving beneficiaries in. The process to construct the base rate in ACO PC Flex will be similar to the process to develop the ACO REACH Rate Book. To derive the County Base Rate for each ACO, we will construct a county-level Rate Book of primary care spending for all assignment eligible Medicare beneficiaries in each county. The Rate Book will include county average primary care spending on the CPT and HCPCS codes that we have included in Appendix D of the RFA, and billed by primary care providers. And by this we mean physician specializing in internal medicine, family medicine, general practice, geriatric medicine, pediatric medicine, as well as non-physician providers or practitioners such as nurse practitioners, physician assistants and clinical nurse specialists.

Beneficiaries who receive the plurality of their primary care services based on allowed amounts at FQHCs or RHCs will be excluded from the reference population in the Rate Book construction. And we'll talk about this in more detail later. But we will be making an add-on payment instead to the County Base Rate for beneficiaries who are receiving what we refer to as FQHC or RHC Focused Care.

So, more details on sort of the construction of the Rate Book here. We will use three base years for the Rate Book that's currently in the RFA listed at 21 to 23. We're still exploring the best approach to use

2021 utilization in the Rate Book construction, due to lingering effects of the COVID-19 Public Health Emergency. Some other possible approaches, which we've included in the RFA, are potentially weighting the impact of 2021 less than 2022 and 2023, as well as using a preliminary Rate Book until a final Rate Book can be constructed using 22 to 2024 experience, which would likely be in mid-2025. The final methodology for the Rate Book will be detailed in a methodology paper in late summer 2024, and will be published with the Rate Book.

Each county will receive two County Base Rates, so, an ESRD base rate and a non-ESRD base rate. The county rates will be risk-standardized, and by that we mean expenditures will be calibrated assuming an average risk score of 1.0, and calculated before we apply any model-wide or ACO-specific adjustments. Next slide, please. Thank you.

An ACO's PPCP County Base Rate is subject to two potential enhancements. The first is the County Enhancement, which is applied at the county level in counties that we designate as low spending, relative to standardized spending nationally. The County Enhancement is setting a floor on the base rate to raise the County Base Rate in counties with low primary care spending. And to identify the counties where the County Enhancement will apply, we will calculate each county's primary care utilization, and then group counties into deciles from the lowest to the highest spending, and identify counties with low spending relative to that threshold, which we've defined as the top of the second decile of risk-standardized primary care spending nationally. Counties with average primary care spending less than that national threshold amount will have the County Enhancement applied, and this will be calculated as the difference between the PBPM national threshold amount and the County Base Rate.

So, the second enhancement is the Flex Enhancement, which is applied at the ACO level to all participating ACOs, regardless of location or utilization, and is designed to increase resources for primary care. The Flex Enhancement is $125 per-beneficiary-per-year.

So together, the County Enhancement and the Flex Enhancement form what we refer to as the Enhanced Amount. And the Enhanced Amount refers to the value of the County Enhancement and the Flex Enhancement after we've adjusted it for clinical risk, primary care delivered outside of the ACO, which we'll talk about later, and application of the cap on the enhancement. The cap on the enhancement is limited to $200 per-beneficiary-per-year.

The Enhanced Amount is intended to provide additional resources to ACOs to support increased access to primary care, provision of care, and care coordination. And, the Enhanced Amount is not a risk-based payment. So, to the extent that it exceeds the positive regional adjustment and prior savings adjustment, it will not be recouped by CMS. But we'll talk about this more in the settlement section that will follow.

One important thing to keep in mind, is that not all ACOs will receive both enhancements. So, all ACOs will get the Flex Enhancement, but the County Enhancement is dependent on where the ACO's beneficiaries reside. Next slide, please.

So, there are a series of adjustments that will be applied to the PPCP, we've listed them here. Many of these are common in population-based payment arrangements. But, we've added some additional ones, with the focus on health equity. So, to go through some of these here, we will apply a Payment Precision Withhold to the PPCP, which will create a buffer, again, non-reduction of PPCP eligible claims. This is the prospective discount and it will not be more than 3%. We will also risk adjust the PPCP using the same

CMS-HCC prospective risk adjustment model version or version blend that's used to address benchmarks in the Shared Savings Program. The County Base Rate, the County Enhancement, and the Flex Enhancement will all be risk adjusted using the CMS-HCC risk adjustment model.

We also have an add-on payment for beneficiaries with FQHC or RHC Focused Care. We will discuss this, some more, at a later point, we'll do that later. And then additionally, we will have an adjustment for Primary Care Delivered Outside of the ACO, or what we refer to as the PCOA adjustment. This adjustment will be based on historical experience of the amount or the rate of primary care that's delivered by providers outside of the PC Flex ACO in a historical period. This will be fixed for 2025 to 2026. During this period, CMS will observe care delivery patterns and impact on care delivery to see whether or not we would be updating this adjustment for the remainder of the model. Next slide, please.

So, there are two additional adjustments here. The first is In-Year Retrospective Adjustments, which will be made to the PPCP, which will account for things like changes in beneficial eligibility status, changes in risk scores, and normalization factors, and beneficiary county of residence. The last adjustment is the Health Equity Adjustment. This will be a PBPM dollar adjustment that will be made for the assigned beneficiaries in the model with the highest and lowest equity scores. All beneficiaries assigned to a PC Flex ACO will receive an equity score. A beneficiary's equity score will be determined by three factors. So that's the national ADI score, state ADI score, and then dual eligibility or low-income subsidy status, either partial or full. CMS will compare the equity scores of beneficiaries that are assigned to a PC Flex ACO, which we refer to as ACO-assigned beneficiary, to the distribution of equity scores in the assignable population.

The total health equity adjustment policy in ACO PC Flex will be budget neutral. And by that we mean that all dollars given to PC Flex ACOs for the care of highly underserved beneficiaries will be offset by reduction for PC Flex ACOs who are serving the least underserved beneficiaries. This adjustment will increase resources for the care of underserved communities and encourage Flex ACOs to attract more underserved beneficiaries. We've also included the chart here, which you may notice from the RFA, that details the specific adjustment by decile that would apply. Next slide, please.

So, after we've applied all of these adjustments, we will then trend the PPCP forward, to the corresponding performance year, based on the Primary Care Prospective Administrative Trend, or what we prefer to as the PCPAT, to produce the final trended adjusted PBPM rate used to set the total PCPP. For PY 2025, the PCPAT will be based on projected growth and reimbursement per fee-for-service enrollee for Physician Fee Schedule services. We will be combining the separate aged and disabled projections into a single trend, for a single PCPAT. Next slide, please.

So, we've alluded to some of this before, but we have special design pieces in the model for ACOs with FQHC and RHC Participants. So, we will be identifying beneficiaries who receive the plurality of primary care services based on allowable charges at FQHCs or RHCs, in order to apply the add-on payment to the base rate for beneficiaries with FQHC or RHC Focused Care. And this is really accounting for the fact that these providers are paid under different payment systems. It doesn't lend itself to comparison with a lot of the other primary care services that would be included in the Rate Book, so we've account, we're accounting for this separately. The add-on payment will reflect the average difference in national historical spending for beneficiaries with FQHC or RHC Focused Care and the average County Base Rate.

The final values will be finalized with the Rate Book, but we've provided some current estimates in the RFA. For beneficiaries with FQHC Focused Care, it's estimated at $249 per-beneficiary-per-year and for beneficiaries with RHC Focused Care, it's estimated at $256 per-beneficiary-per-year. We will be monitoring the PPCP compared to actual fee reduction on a quarterly basis to ensure that ACOs are appropriately funded for assigned beneficiaries with FQHC or RHC Focused Care. If PPCP payments for beneficiaries with FQHC or RHC Focused Care are less than actual fee reductions on year-to-date basis, we will make additional payment in the next available monthly PPCP.

Page 27 of the RFA shows the calculation that we will be using, at the ACO level, for beneficiaries who are receiving the plurality of their primary care at safety net providers to determine whether an additional payment is needed. So if you want more detail on that, you can refer to the RFA. Next slide, please.

So, so far we've talked about the construction of the prospective payment, but the other piece of that, is that we're making these payments in lieu of fee-for-service reimbursement for primary care providers, FQHCs and RHC's in the ACO. So fee reduction is an important piece of that. Providers will continue to submit claims in ACO PC Flex, and the Medicare payment system will zero-out claims for primary care services billed that meet certain criteria. Certain professional and institutional claims will be subject to fee reductions, which we've included below. And for the sake of time, you can refer to what's on the screen or what's in the RFA.

But one important thing to note, is that just because the service is included on the list of codes in Appendix D, does not mean that it will always be reduced. So, it has to be the right match of assigned beneficiary, either assigned through Step 1 or Step 3, it's got to be an eligible service provided by primary care provider in the ACO, and a service that's not exempt from reduction. So, if you want more details on that, page 30 at the RFA specifies the claim payments that are excluded from reduction to help give you a better sense of what will not have reductions applied. Next slide, please.

So, given that all PC Flex ACOs will still be participating in the Shared Savings Program, PC Flex ACOs will be subject to Shared Savings Program financial settlement processes, which are codified in federal regulations. At a high level, we'll still be doing a lot of the same things. So, financial settlement for PC Flex ACOs will still be comparing the performance year benchmark, the performance year expenditures to calculate growth savings and losses. We'll be following SSPs general procedures for determining the updated benchmark, for risk and renormalization, trend and update, and MSR and MLR.

But we will need to make several adjustments to the savings and losses calculations for PC Flex, which we've included here. So, we will be adding the full paid PPCP to performance year expenditures. We will need to determine the Total Enhancement Credit, and by that we mean the total performance year value of the enhancement portion of the PPCP, after offsetting for the higher the positive regional adjustment or prior savings adjustment. We will be adding the Total Enhancement Credit to the ACO share of savings or losses. And lastly, also recouping Advanced Shared Savings Payment, from any payment owed to the ACO, if there is a balance.

We've detailed this in the methodology, beginning, the methodology has been detailed in the RFA, beginning on page 31. There's an example calculation of the Total Enhancement Credit in the companion workbook that we've released with the RFA entitled "ACO PC Flex Exhibits and Example Calculation."

So, depending on ACO's circumstance, adding a positive Total Enhancement Credit during settlement can result in four different outcomes, which you'll see on the right of the screen here. So, it could potentially increase the earned performance payment, reduce payment owed to CMS. It could result in moving from a payment due to CMS to an earned performance payment due to the ACO, or an earned performance payment equal to the Total Enhancement Credit.

One important thing to note here, is that new and inexperienced ACOs may experience a greater benefit from the Enhanced Amount, as they are less likely to have a positive regional adjustment or prior savings adjustment which would trigger an offset to the Enhanced Amount. And we'll talk about this a little bit more in a future slide. Next slide, please.

So, now shifting gears a little bit away from finance and towards monitoring. The RFA contains a detailed discussion of monitoring and oversight in the PC Flex Model, but here we're really focusing on Spend Plan reporting, and allowed and prohibited uses of both the PPCP and Advanced Shared Savings Payments. So we've outlined, and this all comes from the RFA, three categories of uses that funds in PC Flex. The first two categories are allowed, and the third category is prohibited. With the exception of startup costs, everything that's listed in Category 3 is a prohibited use of the Advanced Shared Savings Payment.

We've also included the table below here, that describes the required allocation proportions by spend category for the first and then subsequent performance years. And as long as an PC Flex ACO satisfies the minimum spend requirements, and by that we mean at least 90% of the PPCP must be spent on Category 1 during the first performance year and then at least 95% spent on Category 1 in subsequent performance years, there are no other additional restrictions or limitations on when the PPCP needs to be spent by ACOs. PC Flex ACOs are also not required to spend all PPCP each performance year.

So, some things to keep in mind, in terms of reporting and due dates. ACOs will need to submit their initial Spend Plans to CMS by October 29th. Once the model starts, ACOs will also be required to submit a quarterly and annual Spend Plans to CMS detailing how the funds were spent. And we will be providing more information and guidance on this in the future. One additional thing to keep in mind here is that PC Flex ACOs must have a separate bank account restoring and dispersing both the PPCP and Advanced Savings Payments. And we will provide more guidance on this in the future. Next slide, please.

So quality, we will be aligning with the Shared Savings Program quality performance standard. We will be adding one quality measure in PC Flex and that's the PCPCM, or the Person-Centered Primary Care Measure. CMS will be funding and managing the administration of the PCPCM Survey and we will be fielding this for all PC Flex ACO Participants. This quality measure will not be included as part of the existing Shared Savings Program quality performance standard that's used to determine shared savings and shared losses. Meaning, that it will not inform the quality scoring or savings and losses calculations. But it is an important piece of information in how the model is helping to impact quality and the beneficiary experience. Next slide, please.

So, we've addressed a lot of this before. I'll go through it very quickly, but health equity has been embedded into the design of the entire model, with the payment methodology. And we also are taking a close look at it, when we get to application scoring, this will be part of the scoring. And ACOs will also need to be submitting health equity data. Next slide, please.

So, as I mentioned before, we released the companion workbook with the RFA, that has two important examples detailed in it. So one, a calculation of the PPCP at a beneficiary level. And then the second, is an example of the enhancement offset calculation that results in the enhancement credit during the settlement process. Next slide, please.

So, this just outlines the appendices in the RFA. We've referred to both Appendix D and Appendix E in this presentation. But there's plenty more information in all of those appendices for you to refer to. Next slide, please.

So, when you're thinking about evaluating the model, reading through the RFA, determining whether or not you want to apply to PC Flex, we want to stress it's really important that all organizations should be evaluating the model for their own situations and circumstances when considering participation. But there are some key points that we'd like to call out for you as you are considering whether or not to participate.

So, ACOs that do not have a positive regional adjustment or prior savings adjustment to the benchmark will retain the model enhancement. And by that we mean that the enhancement value will be fully credited in the settlement process, we referred to this a bit before. ACOs that do, on the other hand, have a positive regional adjustment or prior savings adjustment to the benchmark can still benefit from the stable cash flow created by the PPCP.

Another thing to consider is that, ACOs that, with beneficiaries who reside in counties with historically low primary care spend, will benefit from the County Enhancement. The counties that will be eligible for the County Enhancement, which will be around 20% of counties, will be specified when we publish the Rate Book for PC Flex.

Two additional considerations. It's also important to understand how your historical primary care spending compares to county averages to understand the impact on cash flow in moving to a population-based payment like PC Flex. Lastly and not least, but organizations that have some experience with population-based payments or capitation may find it easier to implement the PPCP. And so this should be part of your holistic process as you're considering whether or not to apply to the model. But we would just point you to those considerations.

And now I will pass it back to Meghan for a discussion of the application process.

>> Meghan O'Connell, CMS: Great, thanks so much Lauren. Next slide, please.

Okay, so now I will share an overview of the ACO PC Flex Model application process. Next slide.

In addition to applying to participate in the Shared Savings Program, an applicant ACO must submit supplemental ACO PC Flex Model application information. I know we've mentioned this several times throughout the webinar, but we'll continue to reiterate this very important requirement of applying to the Shared Savings Program before application to the ACO PC Flex Model. Submission of supplemental ACO PC Flex Model application information will consist of three phases and those phases are listed here.

The first phase is the phase 1 application submission process, which has begun, as of May 31st with the release of the RFA, and will continue through August of this year. The second, phase 2 application submission period will go from October when ACOs, selected ACOs, are notified, until November of this

year. And there will be a final submission period in December. CMS will offer one application cycle for the ACO PC Flex Model.

And, again, important to reiterate that applications for the model is not the same as the application to the Shared Savings Program. It's a separate application portal. The graphic to the right shows the application portal and the process to start a new application for the ACO PC Flex Model. And we've disseminated, and will continue to disseminate, materials and the links to access the ACO PC Flex RFA, companion materials, and the application portal to submit the application questionnaire. Next slide, please. And just advance one more time, great.

Here we have important dates for the ACO PC Flex Model application. I'm going to focus on the first two boxes here, which are highlighted in red. These provide a snapshot of the period of submission of the model application questionnaire. And the date that CMS anticipates announcing selection, selection decisions for the model. Steps 3 through 6 highlight the later stages of the application process, starting in October of this year. And this is for ACOs that have been selected to participate in the model. I'll also provide more details in these steps. Next slide.

So first, and to reiterate again, a prerequisite for participation in this model is to apply to the Medicare Shared Savings Program. Initial applicant ACOs, reentering applicant ACOs, renewal applicants, and early renewal applicants must first apply to the Shared Savings Program for a January 1, 2025 agreement start date if they wish to apply to the ACO PC FLEX Model. The Shared Savings Program phase 1 submission period is open now and it closes on June 17th of this year.

The first step to initiate application to the PC Flex Model is to submit the application questionnaire. An ACO that has applied to the Shared Savings Program for a January 1, 2025 agreement start date and is interested in participating in the model can submit the model application questionnaire, which is available at the link in the slides. And again, these slides will be posted to the model website and this link is also available on the homepage for the model. The ACO PC Flex phase 1 application submission period, which is the period to submit the application questionnaire opened on May 29th and will close on August 1st.

Step 2 is what we call, to align with the Shared Savings Program, the phase 1 final dispositions. An applicant ACO will be notified by CMS whether CMS has selected them for participation in the model by October 17th. CMS anticipates that the monthly Prospective Primary Care Payment estimates and the final repayment mechanism and amounts will be released by or before October 17th. And again, the phase 1 final dispositions will be communicated by or before October 17th. Next slide.

Step 3 is the, of the application and submission process, for ACOs that are selected, those ACOs that are selected will see a participation question in their ACO PC Flex application portal. ACOs that wish to participate in the model should answer yes to the participation question and will then be prompted to submit supplemental materials. This includes the ACO PC Flex Model Spend Plan that Lauren reviewed, and the non-physician practitioners roster by the submission deadline of October 29th. So again, for those that are selected to participate, the initial supplemental materials include the model Spend Plan and a roster of non-physician practitioners that have been designated as specialty practice NPPs. And additional information related to the process, and a definition for that roster, is in the RFA.

CMS will request information, okay, step 4, sorry. After an ACO selects “yes” to the participation question and submits supplemental materials, there will be a request for information period. This is an

opportunity for CMS to request information necessary to complete phase 1 and phase 2 applications. So any deficiencies or clarifications or additional materials, CMS will be requesting those from application, applicant ACOs. This is also the time when draft ACO PC Flex Model repayment mechanism documentation is due, at the close of this RFI period on November 18th.

Step 5 is the final application dispositions. This aligns with the final application dispositions of the Shared Savings Program, and is when CMS will communicate the final decisions related to applications for the model on December 5th. Following the final application dispositions, there is a, there will be the signing event, which aligns with the Shared Savings Program signing event and a final submission period. The final submission period is for final documentation of ACO compliance with the model repayment mechanisms due on December 12th. And then of course the signing event is related to signing of the model Participation Agreement. Next slide, please.

This is a checklist. It reiterates the details that I just reviewed. This initial phase 1, which is currently open and active, apply to the Shared Savings Program. Submit your PC Flex Model application questionnaires, those are due August 1st. And then for ACOs, CMS will communicate selection decisions by October 17th. And then there's a series of supplemental application materials required after that point, including the Spend Plan, and the non-physician practitioner roster due October 29th, the draft repayment mechanism documentation due later on November 18th, and then the final repayment mechanism documentation due on December 12th. Next slide. Next slide, please. Great.

So just a couple of final key points for ACOs interested to apply to the model. All organizations should evaluate their individual circumstances when deciding to apply to the model, but some key points to consider in the evaluation.

Again, there will only be one application cycle for the ACO PC Flex Model. So, after the application cycle for 2025 agreement periods, there will not be, there is not at this time planned a subsequent application period. I said this before, I'll say it again, all ACOs that are interested to participate must apply for a new agreement period for the Shared Savings Program starting January 1st, 2025, the agreements, agreement period start date.

And an applicant ACO may apply to the model without impact to their Shared Savings Program application. And what this means is an ACO can withdraw consideration for the model without impacting their overall Shared Savings Program application. So if an ACO initiates a PC Flex application and subsequently does not complete the application or decides to withdraw their consideration from the model, excuse me, there will be no impact to their Shared Savings Program application.

Another example is an ACO that is not selected for the model. That ACO can then choose to either complete or withdraw their Shared Savings Program application. And we have a question in the Q&A session populated related to withdrawal of early renewal applications and some details there.

And then lastly, existing Shared Savings Program policies for renewals, early renewals, and progression to downside risk apply. And by this I mean, for ACOs that make the choice to end their existing agreement period and start a new agreement period for January 1st, 2025, the existing policies related to progression to downside risk, renewal, and early renewals apply there. So the ACO PC Flex Model is not changing or introducing new regulations related to Shared Savings Program policies for determination of their agreement period. Next slide.

Okay, great. So this has been a lot of information. You know, we really wanted to provide enough to answer a lot of questions. We've received a lot of questions, and there are still questions coming through. We're trying our best to respond to those.

There are some resources listed here. We have an upcoming event, which we're calling CMS Office Hours, on July 16th, which is focused on answering questions and providing clarifications for ACOs that have applied or are in the middle of their, submitting their model application questionnaire. So, stay tuned for more information in terms of timing and the registration link for that office hours for the model.

We're also updating our model FAQs. We have a host of questions populated at the end of this slide deck, so you'll see those, those will be posted to the website. But we'll also provide an updated FAQ factsheet. And then of course, we have here linked the model website, the application portal, the Model Overview Factsheet, which was released when the model was announced, along with the first set of frequently asked questions. And some resources related to comparison of the different Innovation Center primary care models, for ACOs that are deciding between one or more models to participate in.

Please sign up for our listserv. That's where you get notifications related to things like the office hours timing, date, registration link, etc. And then if you have additional questions, please feel free to send questions to the ACO PC Flex mailbox. And we're working through those, and we'll respond to the mailbox. Next slide.

Okay, so we have a series of questions populated here. We have been trying our best to answer questions as they come in through the Q&A. If your question hasn't been answered, it probably means that we've answered a similar question. So please take a look in the answered, the questions that have been answered and see if you can, see your question there. It could also mean that we don't yet have the answer, or it requires a, it's not conducive to answering in the chat. But we'll do our best to incorporate these questions into the updated FAQs. Excuse me, thank you.

And I think we can go to the Q&A session now and, my colleagues from the model will, I think, help to answer some of these questions. And please continue if you have additional questions to populate the Q&A function of the chat. Next slide.

Okay, the first one here is related to renewals, early renewals, and terminations. And this sort of speaks to what I was reviewing in the application section. The question is: If a currently participating ACO is not selected for the ACO PC Flex Model, can they revert back to their existing agreement for performance year 2025?

And the short answer is “yes”, in general, existing Shared Savings Program policies for renewals, early renewals, and progression to downside risk apply, as I noted. I've copied a blurb here from the Shared Savings Partner Application Reference Manual, on page 28, which states that early renewal applicants can withdraw their application and return to their current agreement period. ACOs will be automatically returned to their current agreement period upon making this withdrawal, until final application dispositions have been released. However, there are varying impacts on an ACO’s ACO Participant and SNF Affiliate Lists, depending on when in the application cycle that application withdrawal is made. So please, I believe this is linked but, please do reference the Shared Savings Program Application and Reference Manual to ensure that you have all the details needed to make decisions related to renewals or early renewals and terminations. Next slide.

Okay, this is a question that we get frequently, and so provided some additional information here. What is a low revenue ACO? How does my ACO know if it's low or high revenue? And the low or high low, or the high or low revenue designation is determined by CMS from the ACO participant list submitted by the ACO during phase 1 of the Shared Savings Program. So the Shared Savings Program provides this revenue, revenue determinations information to ACOs in the ACO Management System with the release of each Shared Savings Program application. Phase 1 request for information, which is in July. And the second RFI, RFI 2 from phase 1, which is in August. And then again, finally, during the phase 1 final disposition on October 17th.

So the low revenue definition is established by the Shared Savings Program. That definition was provided earlier in the slides, and can be found in the RFA. And the ACO-specific revenue determination is provided by CMS as part of the application process to the Shared Savings Program. Next slide.

How is provider participation determined, must all iNPIs assigned to one TIN participate, or can an ACO or ACO Participant select the specific iNPIs to participate? So the short answer is, all primary care providers, which we define as physicians with a primary care specialty designation as well as the non-physician practitioners, that definition is in the RFA, will be participants in the model. So the ACO PC Flex Model fee reductions for primary care services will apply to each PC Flex ACO Participant that includes a primary care provider.

So CMS will identify, for fee reductions, the PC Flex ACO Participants and their primary care providers, based on the participant list that submitted as part of the Shared Savings Program application. And to apply the fee reductions, CMS will identify the TIN, and CCN if applicable, of each PC Flex ACO Participant and the National Provider Identifiers, or NPI, of each eligible primary care provider, such that CMS understands each primary care provider as a TIN-NPI combination. So in ACO, our ACO Participant is not, not able to selectively indicate participation for the primary care providers. I will note that the one, it's not an exception to the rule, but the one design feature is that, as I noted earlier, non-physician practitioners that are designated by the ACO as specialty care NPPs are flagged through the NPP roster that's submitted to CMS and those NPPs do not have claims reduced. Next slide, please.

Okay, what is the shared savings rate in ACO PC Flex? So because ACO PC Flex is being tested as part of the Shared Savings Program, and PC Flex ACOs are simultaneously participating in the Shared Savings Program, this is what governs the shared savings and losses rates, based on the participation options that have been selected by the ACO. So BASIC A-E or ENHANCED, as selected by the ACO during their Shared Savings Program application applies to the participation in the Shared Savings Program. Oh, sorry, participation in the ACO PC Flex Model. Next slide.

Okay. I hope this is helpful. Sorry, there's a lot of information here and hopefully this is clarifying these some of your questions. Do the PPCPs and one-time payment amounts come out of the shared savings payment during reconciliation?

So Lauren went through the financial settlement process for both the payment arrangements under the model, but just to clarify here, the $250,000 one-time payment will be recouped from the ACO shared savings until it is fully repaid. But the total value of the paid Prospective Primary Care Payment, before sequestration, will be added to per capita expenditures and total expenditures and will be included in resulting calculations of total savings and total losses.

So it's included upfront later in the settlement calculation after shared savings and shared losses have been determined, the Total Enhancement Credit to settlement will be added to increase shared savings, reduce shared losses or shift shared losses to shared savings. So this is relatively dense, complex and depends on the ACO's specific circumstances. This is why we've included the companion workbook alongside the RFA, which provides very useful examples of how each payment, the flow of each payment, under different circumstances, example scenarios, so that ACOs can review the different examples and understand the mechanisms, under specific scenarios. Next slide.

Okay, this is related to the administration of the prospective payment. And the question is: Is a prospective payment that's paid to ACO Participants, the payment that is paid to the ACO Participants by the ACO, is that payment established by CMS or by the ACO? Does CMS provide guidance on efficient payment processes for providers?

So, the Prospective Primary Care Payment will be paid by CMS to PC Flex ACOs based on the methodologies described in the RFA. Payment, however, payment terms between the ACO and ACO Participants will be negotiated between the PC Flex ACO and the ACO Participants, and must be detailed in writing in an ACO participant agreement. CMS does not provide guidance on these arrangements. PC Flex ACOs will be required to report annually the amount of payment that's flowed to ACO Participants at the TIN or CCN level, and for what purposes. So this is the Spend Plan reporting.

CMS will provide monthly reporting that details the PPCP at the beneficiary-month level, along with other beneficiary characteristics to support distribution of PPCP to ACO Participants. So I saw this question come through several times in the chat. So I just want to reiterate that CMS will provide monthly reporting that details out the Prospective Primary Care Payments at the beneficiary-month level. Next slide, please.

Okay, how does the country rate get, county rate get established from multistate ACOs? I also saw this one come through in the chat, a few times. The County Base Rate and County Enhancement, where applicable, are applied at the beneficiary level based on the beneficiaries count, the beneficiaries' county of residents. So for PC Flex ACO that span counties or states, the average county rate for the PC Flex ACO is the beneficiary-month weighted average of the county rates of the PC Flex ACOs assigned, PPCP eligible beneficiaries. In practice, the PPCP is calculated at the beneficiary-month level and PC Flex ACO level averages are not used to calculate payment, but maybe of interest to PC Flex ACOs for informational purposes. Next slide.

Can the ACO retain a portion of the PPCP to invest in infrastructure or does all the PPCP money need to be paid out to the ACO Participants? So Lauren detailed out allowable uses of the PPCP, and this can also be found in section 5A of the RFA. There are three expenditure categories, each with requirements about how much of the PPCP must be used for that category. And those three categories are: Provision and Support of Advanced Primary Care, Operations of PC Flex ACOs, and Prohibited Uses. And again, those, the allowed amounts per year are detailed earlier in the slides and are also available in the RFA. Next slide, please.

When will rate information be available to begin financial modeling for potential applicants? This question has been asked a lot. I know folks are eager to have this information, and CMS is working to provide this information as early as possible. CMS anticipates the information will be provided to ACOs as a report prior to phase 1 final dispositions on October 17th. I think we've also answered a few of

these questions in the chat, in saying late summer of this year. Again, we're working to provide this information as soon as we can. We know that it's important for making participation decisions and doing the analytical modeling necessary to have informed decision making and so we will continue to work towards that goal.

I think this might be the last one. Next slide, or well, anything additional, from others on the model team to say related to any of these questions or any comments? Okay.

This was a great question that came through. What is the typical difference between reimbursement using county based, county based capitation rates versus rates based on an ACO historical spending? Essentially, how is the construction of the County Base Rate different from how it's been done historically and what are the benefits an ACO can expect?

And so, like Lauren detailed in earlier slides, it's really important to understand how historical primary care spending compares to county averages in order to understand the impact to a specific ACO's cash flow. For example, for ACOs participating in regions for which the average level of primary care spending is higher than the ACO provider's historical primary care spending, for these ACOs, the PPCP will increase primary care funding relative to what they've seen historically. Next slide.

Okay, that's what we were able to get pre-populated. I know there, it looks like there's a host of open questions, and also a lot that have already been answered. I think we'll take some time to continue answering these questions via the chat. And if Lauren or Pablo or Meghan have any other comments based on the questions that have come through, please feel free.

Okay, great. So let me just close out the slides and then like I said, the model team will stay on the line and work to answer these questions as best as we can. We probably won't be able to answer every single question, but the ones that we have answers to, we will send those through. Next slide.

Okay, great. So we just have one, one poll that we would love for you to answer. We've provided a lot of information. There is a lot more in the RFA, we hope that you see that. But, we have a poll question here: What topics would you like to learn more about? So if you can let us know any topics that are, continue to be of interest, and we'll keep the poll open for about a minute here.

Okay, just a few more seconds here. Again, the poll is: What topics would you like to learn more about? Just let us know your feedback, and as we're working to plan for the question and answer session and update our frequently asked questions, and we'd love to incorporate your feedback. Okay great. I think we can wrap up the poll. Thank you so much for participating. Next slide.

Excellent. So this concludes today's webinar. Thank you so much for joining us today. We hope that the information was helpful. As always, we look forward to continuing to connect with you. And please stay tuned with a follow-up email that will let you know when the materials have been posted to the website. Thanks so much.

And like I said, the model team will stay on the line to answer, wrap-up any questions that we can answer. So if you have an outstanding question that you're waiting for an answer for, you can stay on the line. Otherwise, thanks so much.

Great, thanks so much for everyone who stayed on the line. It looks like we've gone through almost all the questions I can see. Pablo and Lauren are responding to a few more, but I think we'll wrap up here.

And we'll continue to answer questions to the helpdesk mailbox and in the updated frequently asked questions document. Again, thanks so much for your participation today.

###