ACO Primary Care Flex Model

Financial Methodology: Rate Book Development, Calculation of Monthly Prospective Primary Care Payment, and Financial Settlement

June 2025
Version 2

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Revision History (from Version 1 to 2)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
2	June 2025	Revised the terminology from "Health Equity Adjustment" to "Population Adjustment" to align with the ACO PC Flex Model Participation Agreement.	Overall
2	June 2025	Added language related to Voluntarily Aligned beneficiaries.	2.2.1
2	June 2025	Added language related to Voluntarily Aligned beneficiaries.	2.2.2
2	June 2025	Added the Rate Book Base Years for the 2025 Updated ACO PC Flex Rate Book.	3 and 3.1.4
2	June 2025	Added the exclusion of HCPCS codes G2086, G2087, and G2088.	3.1.1, 4.6, and Appendix D
2	June 2025	Added the assignment windows and expanded windows for assignment for the 2025 Updated ACO PC Flex Rate Book.	3.1.1
2	June 2025	Updated the list of models used for Alternative Payment Adjustments.	3.1.4
2	June 2025	Updated the base years and revised the language for the GAF indices in the 2025 Updated ACO PC Flex Rate Book.	3.2.1
2	June 2025	Added note on ACO PC Flex Model specific 3-month completion factor.	3.5.1
2	June 2025	Updated the Enhancement Add-on amount.	3.7
2	June 2025	Added the formula for applying PCPAT in future performance years.	4.1.3
2	June 2025	Added seasonality adjustment factors for A&D and ESRD.	4.1.4
2	June 2025	Updated the limit on the Enhanced PPC Payment Amount.	4.1.6
2	June 2025	Updated codes used to calculate primary care FFS claims expenditures for the 2025 Updated ACO PC Flex Rate Book.	Appendix B

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1 INTRODUCTION

This document provides Accountable Care Organizations (ACOs) participating in the ACO Primary Care Flex Model (ACO PC Flex Model) with the necessary details to understand the financial aspects of the model. It provides a detailed description of the ACO PC Flex Model financial methodology, including construction of the Rate Book used to establish county-level payment rates, calculation of the two payment mechanisms for the model, and the approach to financial settlement.

- **Section 2** provides information about Shared Savings Program beneficiary assignment and the determination of Prospective Primary Care Payment (PPCP) eligibility[1] for assigned beneficiaries.
- **Section 3** provides an overview of the ACO PC Flex Rate Book, which is used to calculate the Prospective Primary Care (PPC) Payment for PC Flex ACOs.
- **Section 4** describes the calculation of the PPC Payment.
- **Section 5** provides information about financial settlement.
- **Appendix A** goes over expenditure categories.
- **Appendix B** provides Rate Book expenditure codes.
- **Appendix C** lists valid specialty codes for primary care physicians, non-physician practitioners (NPPs), and additional specialties.
- **Appendix D** compares ACO PC Flex Model, the Medicare Shared Savings Program, and ACO REACH.
- **Appendix E** compares the preliminary and updated versions of the ACO PC Flex Rate Book.
- **Appendix F** lists the abbreviations used in this document.

ACOs participating in the ACO PC Flex Model will receive two payments: the Advance Shared Savings Payment and the PPC Payment. Both are designed to support population health management and have an emphasis on flexibility, primary care innovation, and strong monitoring to ensure that beneficiaries receive access to high-quality, person-centered primary care.

1.1 ACO PC Flex Payment Mechanisms

1.1.1 Advance Shared Savings Payment

The Advance Shared Savings Payment is a one-time shared savings advance of $250,000, paid in the Quarter (Q) 1 of 2025. The Advance Shared Savings Payment is intended to cover costs

[1] Prospective Primary Care Payment is referred to as PPC Payment, unless in reference to eligibility, in which case PPCP is used to save space (e.g., “PPCP-eligible beneficiary”).

associated with forming an ACO (where relevant) and administrative costs for required model activities. The Advance Shared Savings Payment will be deducted from shared savings earned each performance year until the full $250,000 is repaid, and any balance owed will be carried over from performance year to performance year.

1.1.2 PPC Payment

The PPC Payment is a per-beneficiary per-month (PBPM) payment for primary care services, which replaces fee-for-service (FFS) payment for eligible primary care services delivered by eligible primary care providers to assigned PPCP-eligible beneficiaries (see Section 2 below). The PPC Payment will allow prospectively determined and more-predictable revenue streams for primary care that are paid monthly to PC Flex ACOs. More-predictable cash flows may offer more flexibility and a stronger incentive for health care providers to coordinate care with the potential to improve outcomes and lower costs. The regionally consistent rate for primary care spending will increase payment for providers that have entrenched patterns of inappropriately low spending for medically underserved communities and populations.

The PPC Payment consists of three main parts: the Base PPC Payment Amount, the ACO Enhanced PPC Payment Amount (i.e., Enhanced Amount), and the Population Adjustment, which are each composed of several payment components and subject to a series of adjustments. These adjustments are explained in detail in Section 4.

2 SHARED SAVINGS PROGRAM BENEFICIARY ASSIGNMENT AND DETERMINATION OF PPCP ELIGIBILITY FOR ASSIGNED BENEFICIARIES

The ACO PC Flex Model will rely on the criteria the Centers for Medicare & Medicaid Services (CMS) uses to determine a beneficiary's eligibility for assignment under the Shared Savings Program.[2] A PC Flex ACO will be paid the monthly PPC Payment, which is based on the PPCP-eligible beneficiary months identified among its ACO-assigned beneficiaries. The identification of PPCP-eligible beneficiary months assigned to a PC Flex ACO will depend on the assignment step (described below) and other eligibility criteria.

2.1 Shared Savings Program Beneficiary Assignment

Per the Shared Savings Program assignment methodology, claims-based assignment (CBA) of beneficiaries to PC Flex ACOs is determined according to the plurality of primary care services[3] (see Appendix B, Table B-1), measured by allowed charges, through a step-wise assignment process, delineated by Assignment Steps 1, 2, and 3 (see Table 1). As a "pre-step" to Steps 1 and 2 in the CBA process, CMS identifies all beneficiaries who had at least one primary care service during the 12-month assignment window with a physician who is an ACO professional[4] and who is a primary care physician (see Appendix C, Table C-1) or who has one of the specialty designations listed in Appendix C, Table C-3.[5] Beneficiaries who do not meet this condition may be eligible for assignment via Step 3, as described in Table 1.

Beneficiaries may also be assigned through voluntary alignment. Beneficiaries who designate an ACO professional participating in an ACO as responsible for coordinating their overall care are prospectively assigned to that ACO, regardless of their assignment methodology based on claims. This takes place annually for the Shared Savings Program at the beginning of each benchmark and performance year based on available data at the time assignment lists are determined for the benchmark and performance year.[6]

[2] Refer to 42 CFR § 425.401.
[3] Note that primary care services under the Shared Savings Program assignment methodology are defined slightly differently from those in the ACO PC Flex Model (as explained in Subsection 3.1.1, with codes in Appendix B, Table B-1).
[4] ACO professional has the meaning given at § 425.20 and refers to an individual who is Medicare-enrolled and bills for items and services furnished to Medicare FFS beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations and who is either (1) a physician legally authorized to practice medicine and surgery by the state in which he or she performs such function or action or (2) a practitioner who is a physician assistant, nurse practitioner, or clinical nurse specialist.
[5] Refer to § 425.402(b).
[6] Refer to § 425.402(e)(1).

Table 1: Overview of Shared Savings Program Beneficiary Assignment

Assignment Step	Assignment Criteria
Voluntary Alignment	Beneficiaries may voluntarily align themselves to an ACO at any time during the year by logging into MyMedicare.gov and designating a provider or supplier who they believe to be responsible for coordinating their overall care (referred to as a "primary clinician"). Beneficiaries who designate an ACO professional participating in an ACO as responsible for coordinating their overall care are prospectively assigned to that ACO annually at the beginning of each performance year. Assignment is based on available data at the time assignment lists are determined for the performance year. Voluntarily aligned beneficiaries will remain voluntarily aligned in future performance years unless the beneficiary either changes their voluntary alignment designation through MyMedicare.gov or no longer meets Shared Savings Program eligibility criteria. Beneficiaries with voluntary alignment selections with a date of death before the performance year are excluded from assignment.
1	Beneficiary is assigned if they met the pre-step for Steps 1 and 2 and received the plurality of primary care services provided by primary care physicians or NPPs (see Appendix C, Tables C-1 and C-2) during the 12-month assignment window from primary care physicians or NPPs within the ACO.
2	Beneficiary is assigned if they met the pre-step for Steps 1 and 2 and: • beneficiary did not receive any primary care services from primary care physicians or NPPs (within or outside the ACO) during the 12-month assignment window; • beneficiary received the plurality of primary care services provided by specialist physicians within the ACO (see Appendix C, Table C-3, for definition of specialist physicians).
3	A beneficiary who does not meet the pre-step criteria for Steps 1 and 2 but meets the following criteria is eligible for assignment via Step 3: the beneficiary received at least one primary care service from a NPP (see Appendix C, Table C-2) in the ACO in the 12-month assignment window *and* received at least one primary care service from a primary care physician (see Appendix C, Table C-1) or a specialist physician (see Appendix C, Table C-3) in the ACO in the 24-month expanded assignment window. For a beneficiary meeting these criteria, the beneficiary is assigned if they received the plurality of primary care services they received from all primary care physicians, specialist physicians, or NPPs within the ACO during the 24-month expanded assignment window.

2.2 Determining Beneficiary Care Focus and Primary Provider/Supplier

Once a beneficiary is assigned under the Shared Savings Program, CMS conducts several steps to determine if the assigned beneficiary is PPCP-Eligible, including determining the beneficiary's care focus and primary provider/supplier. For each beneficiary assigned to a PC Flex ACO under the Shared Savings Program assignment methodology, CMS will determine the beneficiary's care focus, which indicates whether the beneficiary received the plurality of primary care services from Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), or Other non-FQHC and non-RHC providers and suppliers within the ACO. CMS next determines the beneficiary's primary provider or supplier, which represents the individual

provider or supplier within the beneficiary's care focus and within the ACO from which the beneficiary received the plurality of primary care services. CMS considers a beneficiary's primary provider/supplier (among other factors) in determining whether the beneficiary is PPCP-eligible (see Section 2.3 below). For a beneficiary who is determined to be PPCP-eligible for a given month, the beneficiary's care focus dictates whether the PPC Payment for that month will include the FQHC or RHC Add-on Amount. For a PPCP-eligible beneficiary with FQHC-focused care, the FQHC Add-on will apply. For a PPCP-eligible beneficiary with RHC-focused care, the RHC Add-on will apply. For PPCP-eligible beneficiaries with Other care focus, neither the FQHC nor RHC Add-on will apply.

2.2.1 Determining Beneficiary Care Focus

CMS determines an assigned beneficiary's care focus based on whether the beneficiary received the plurality of primary care services from FQHCs,[7] RHCs,[8] or non-FQHC or RHC providers and suppliers. CMS determines the plurality of primary care services by comparing the total Medicare allowed amounts for primary care services during the assignment window billed by the various providers and suppliers participating in the PC Flex ACO.

The plurality logic used for this determination identifies which of three categories (FQHCs, RHCs, or Other) has the highest allowed charge amount billed for an assigned beneficiary among primary care services, as defined for Shared Savings Program beneficiary assignment, delivered by providers and suppliers billing under the PC Flex ACO. Specifically, if the greatest allowed amount for primary care services for the beneficiary is billed by FQHCs collectively compared to RHCs collectively and compared to all other providers collectively, then the beneficiary is considered to have *FQHC-focused care* (that is, care focus is FQHC). Similarly, if the greatest allowed amount is billed by RHCs collectively compared to each of the other two categories, the beneficiary is identified as having *RHC-focused care* (that is, care focus is RHC). In the event of a tie with Other providers/suppliers (i.e., the allowed amount for primary care services for the beneficiary billed by all Other providers collectively equals the allowed amount for primary care services billed by FQHCs or RHCs collectively), the beneficiary is identified as having *FQHC- or RHC-focused care*. In the event of a tie between FQHCs and RHCs (i.e., the allowed amount for primary care services for the beneficiary billed by FQHCs collectively equals the amount billed by RHCs collectively), preference goes to the category (FQHC or RHC) with the most recent date of service billed in the window. Otherwise, the beneficiary is not classified as having FQHC- or RHC-focused care (that is, care focus is *Other*).[9]

According to § 425.404(b), CMS treats any service reported on FQHC or RHC claims as a primary care service performed by a primary care physician for Shared Savings Program beneficiary assignment. Such services are also considered to be primary care services performed by a primary care physician for the ACO PC Flex Model, including in the determination of care focus.

[7] Identified by Institutional claim Type of Bill = 77x.
[8] Identified by Institutional claim Type of Bill = 71x.
[9] If a beneficiary assigned via voluntary alignment did not receive any primary care services from their assigned ACO's providers or suppliers during the assignment window, the beneficiary's care focus is identified as Other.

For PC Flex ACOs that select Preliminary Prospective Assignment with Retrospective Reconciliation, CMS will perform the care focus determination (and determination of primary provider/supplier described in Subsection 2.2.2) with the first Shared Savings Program assignment run of the performance year and will not update the determination in subsequent assignment runs during the performance year. For PC Flex ACOs that select Prospective Assignment, CMS will base the care focus determination on the Prospective Assignment window for the performance year and will not base the determination on claims experience during the performance year.

For U.S. Department of Veterans Affairs (VA) beneficiaries who also have ACO PC Flex primary care claims, their care focus is derived from the claims data, similar to other claims-based beneficiaries. For VA-only beneficiaries, the care focus defaults to Other.

2.2.2 Determining Primary Provider/Supplier

After identifying the care focus for each beneficiary assigned to a PC Flex ACO, CMS determines the provider or supplier within the beneficiary's care focus within the ACO that provided the plurality of primary care services to the beneficiary. This is referred to as the beneficiary's primary provider (for FQHC or RHC care focus) or primary supplier (for Other care focus).

For a beneficiary identified as having FQHC-focused care, CMS will identify the FQHC provider (identified by CMS Certification Number [CCN]) among all FQHC providers inside the PC Flex ACO that has the highest allowed amount billed for primary care services during the assignment window for the beneficiary. In the event of a tie among multiple FQHC CCNs, the preference goes to the CCN with the most recent date of service billed in the window. The FQHC CCN identified by this process is the beneficiary's primary provider (also referred to as primary CCN).

For a beneficiary identified as having RHC-focused care, CMS will identify the RHC provider (identified by CCN) among all RHC providers inside the PC Flex ACO that has the highest allowed amount billed for primary care services during the assignment window for the beneficiary. In the event of a tie among multiple RHC CCNs, the preference goes to the CCN with the most recent date of service billed in the window. The RHC CCN identified by this process is the beneficiary's primary provider (also referred to as primary CCN).

For a beneficiary identified as having a care focus of Other, CMS will identify the primary supplier for each beneficiary using a two-step process. First, CMS will identify the PC Flex ACO's participant Taxpayer Identification Number (TIN) that has the highest allowed charge amount billed for non-FQHC or RHC primary care services during the assignment window for the beneficiary. In the event of a tie among participant TINs, the preference goes to the TIN with the most recent date of service billed in the window. The participant TIN identified by this process is the beneficiary's primary TIN. Second, CMS will identify the individual ACO supplier (identified by the individual National Provider Identifier [NPI]) that had the plurality of primary care services among all of the suppliers in the ACO that billed non-FQHC or RHC primary care services for that beneficiary during the assignment window. In other words, CMS will identify the NPI billing under the primary TIN that has the highest allowed amount billed for non-FQHC or non-RHC primary care services during the assignment window for the beneficiary. In the event of a tie among NPIs, the preference goes to the NPI with the most recent date of service billed

in the window. The NPI identified by this process is the beneficiary's primary supplier (also referred to as primary NPI). For VA beneficiaries who also have ACO PC Flex primary care claims, the primary TIN and NPI are derived from the claims data, similar to other claims-based beneficiaries. For VA-only beneficiaries, the TIN and NPI associated with the designated primary clinician become the primary TIN and NPI.

2.3 Determining PPCP Eligibility for Assigned Beneficiaries

CMS considers the following PPCP eligibility exclusion criteria in determining whether the beneficiary is PPCP-eligible:

- Beneficiaries no longer assigned, as part of the Shared Savings Program annual assignment process, to a PC Flex ACO because of at least one assignment exclusion criteria are not PPCP-eligible beneficiaries.
- Beneficiaries assigned to a PC Flex ACO via Step 2 will not be PPCP-eligible beneficiaries and will not have any PPCP-eligible beneficiary months during the performance year.
- Beneficiaries who select a specialist physician as their primary clinician or an NPP designated as a specialist NPP by the ACO through voluntary alignment will not be PPCP-eligible beneficiaries.
- Beneficiaries who elect to decline data sharing are not PPCP-eligible beneficiaries.
- Beneficiaries who are enrolled in a Medicare health plan or enrolled in Part A–only or Part B–only for at least 1 month of the performance year are not PPCP-eligible beneficiaries.
- Beneficiaries with a death date during the performance year are not PPCP-eligible beneficiaries for any subsequent months after the month of death.
- Beneficiaries not enrolled in both Parts A and B for at least 1 month of the performance year are not PPCP-eligible beneficiaries for that month and any subsequent months.
- Beneficiaries without a valid U.S. address for at least 1 month of the performance year are not PPCP-eligible beneficiaries for that month and any subsequent months of the performance year.
- Beneficiaries with a primary provider or supplier that is not a PPCP-eligible participant are not PPCP-eligible beneficiaries. Therefore, the following beneficiaries would not be PPCP-eligible beneficiaries:

- Beneficiaries with a primary provider or supplier that is a specialist physician[10] and are not included on the PPCP-eligible participant list or an NPP designated as a specialist NPP by the ACO.[11]
- Beneficiaries with a primary provider or supplier associated with a PPCP-eligible participant TIN that is terminated mid-year from the ACO. These beneficiaries are not PPCP-eligible beneficiaries for any months in the performance year after the TIN termination's effective date.
- Beneficiaries with a primary provider or supplier that is enrolled in Periodic Interim Payments.
- For Performance Year 2025, beneficiaries with a primary provider or supplier that is designated by the ACO as deferring fee reductions until 2026.
- For Performance Year 2025, beneficiaries with a primary provider or supplier that were designated by the ACO as "participation in fee reduction to-be-determined" and who are later confirmed to participate for fee reductions starting July 2025 are not PPCP-eligible beneficiaries for the months of January thru June 2025, but may become PPCP-eligible starting July 1, 2025 if they meet all other PPCP eligibility criteria.

- Beneficiaries assigned to a PC Flex ACO under Preliminary Prospective Assignment with Retrospective Reconciliation who are newly assigned to the ACO during quarterly updates to assignment are not PPCP-eligible beneficiaries.
- Beneficiaries assigned to a PC Flex ACO under Preliminary Prospective Assignment with Retrospective Reconciliation who do not meet all of the assignment criteria for assignment to the ACO in at least one quarterly update to assignment are not PPCP-eligible beneficiaries.

Beneficiaries are assigned to a PC Flex ACO using two options: Prospective Assignment or Preliminary Prospective Assignment with Retrospective Reconciliation; each option has specific implications for the determination of a PPCP-eligible beneficiary, as discussed below.

2.3.1 Impact of Shared Savings Program Assignment Methodology on PPCP-Beneficiary Eligibility

Under **Prospective Assignment**, a beneficiary is a PPCP-eligible beneficiary for Performance Year 2025 if they are assigned to the PC Flex ACO via voluntary alignment or claims-based assigned via Step 1 or Step 3 based on Performance Year 2025's Prospective Assignment run (see Table 1 for an overview of the Shared Savings Program assignment methodology). If a

[10] Specialist physicians are all physicians excluding those with the primary care physician specialty codes listed in Appendix C, Table C-3. Note that because all services provided at FQHCs and RHCs are considered primary care services provided by a primary care physician for Shared Savings Program assignment and ACO PC Flex Model, irrespective of the specialty of the individual practitioner performing the service, no specific check is for physician or NPP specialty is necessary for beneficiaries with FQHC- or RHC-focused care.

[11] For a beneficiary assigned via voluntary alignment, the specialty of the beneficiary's selected primary clinician will take precedence over the specialty of the primary provider/supplier identified through the claims-based process described in Subsection 2.2.2 for determining PPCP eligibility.

beneficiary dies, they are considered a PPCP-eligible beneficiary only for the months during the performance in which they were alive. Beneficiaries assigned via Step 2 during the Prospective Assignment run are not PPCP-eligible beneficiaries for the performance year; however, if the beneficiary is then assigned via Step 1 or Step 3 in a future performance year, they would qualify as a PPCP-eligible beneficiary for that performance year. Table 2a summarizes the scenarios and the implications for determination of PPCP-eligible beneficiaries served by ACOs that select Prospective Assignment.

Table 2a: PPCP-Eligible Beneficiary Determination for Beneficiaries in ACOs That Select Prospective Assignment

Initial Assignment Run	Subsequent Assignment Eligibility Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3	Remains assigned to the ACO.	Eligible.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3	No longer assigned to a PC Flex ACO because of at least one assignment exclusion criteria: • Does not have at least 1 month of Part A and Part B enrollment. • Has any months of Part A–only or Part B–only enrollment. • Has any months of Medicare group (private) health plan enrollment. • Did not live in the United States or U.S. territories and possessions, based on the most recent available data in beneficiary records regarding the beneficiary's residence in the last month of the assignment window.	Not eligible for any month in performance year. [a]
Assigned via Voluntary Alignment (designated primary clinician is a *specialist* physician or NPP designated as a specialist by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3	Remains assigned to the ACO.	Not eligible for any month in performance year.
Assigned via Step 1 or Step 3 (assigned via CBA only)	Remains assigned to the ACO.	Eligible.

Initial Assignment Run	Subsequent Assignment Eligibility Run in the Performance Year	PPCP Eligibility
Assigned via Step 1 or Step 3 (assigned via CBA only)	No longer assigned to a PC Flex ACO because of at least one assignment exclusion criteria: • Does not have at least 1 month of Part A and Part B enrollment. • Has any months of Part A–only or Part B–only enrollment. • Has any months of Medicare group (private) health plan enrollment. • Did not live in the United States or U.S. territories and possessions, according to the most recent available data in beneficiary records regarding the beneficiary's residence in the last month of the assignment window.	Not eligible for any month in performance year. [a]
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or an NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary died during the performance year.	Eligible for partial year; eligibility continues until the month following the month of death.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or an NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary is assigned to the ACO but is not enrolled in both Part A and Part B for at least 1 month of the performance year.	Eligible for partial year; eligibility continues until the month beneficiary is not in enrolled in both Part A and Part B.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or an NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary is assigned to the ACO but does not have a valid U.S. address for at least 1 month of the performance year.	Eligible for partial year; eligibility continues until the month beneficiary does not have a valid U.S. address.

[a] *Recoupment procedure is applied (see Sections 4.5 and 5.3 for details on the recoupment procedure).*

For ACOs who select **Preliminary Prospective Assignment with Retrospective Reconciliation**, only beneficiaries who remain assigned to the same PC Flex ACO from the beginning of Performance Year 2025 through all the quarterly and final assignment runs (via Step 1 or Step 3) and who meet all PPCP eligibility criteria are PPCP-eligible beneficiaries. Specifically, as of the first assignment run of Performance Year 2025, beneficiaries are PPCP-eligible beneficiaries if they were assigned via voluntary assignment or claims-based assigned via Step 1 or Step 3. Beneficiaries assigned via Step 2 as of the first assignment run are not PPCP-eligible beneficiaries.

Table 2b summarizes the scenarios and the implications for determination of PPCP-eligible beneficiaries for ACOs that select Preliminary Prospective Assignment with Retrospective Reconciliation.

Table 2b: PPCP-Eligible Beneficiary Determination in ACOs Who Select Preliminary Prospective Assignment With Retrospective Reconciliation

Initial Assignment Run	Subsequent Assignment Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3	Still assigned to the ACO.	Eligible.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] and NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3	No longer assigned to a PC Flex ACO because of at least one assignment exclusion criteria: • Does not have at least 1 month of Part A and Part B enrollment. • Has any months of Part A–only or Part B–only enrollment. • Has any months of Medicare group (private) health plan enrollment. • Did not live in the United States or U.S. territories and possessions, based on the most recent available data in beneficiary records regarding the beneficiary's residence in the last month of the assignment window.	Not eligible for any month in performance year. [a]

Initial Assignment Run	Subsequent Assignment Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment (designated primary clinician is a *specialist* physician or NPP designated as *specialist* by the ACO who is) and assigned via CBA in Step 1, Step 2, or Step 3	Still assigned to the ACO.	Not eligible for any month in performance year.
Assigned via Step 1 or Step 3 (not voluntarily aligned)	Remain assigned via Step 1 or Step 3 to the same PC Flex ACO for all subsequent assignment runs.	Eligible.
Assigned via Step 1 or Step 3 (not voluntarily aligned)	Assigned via Step 2.	Not eligible for any month in performance year. [a]
Assigned via Step 2 (not voluntarily aligned)	Assigned via Step 1, Step 2, or Step 3.	Not eligible for any month in performance year.
Assigned via Step 1 or Step 3 (not voluntarily aligned)	No longer assigned to a PC Flex ACO for at least one quarter.	Not eligible for any month in performance year. [a]
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary is assigned to the ACO but is not enrolled in both Part A and Part B for at least 1 month of the performance year.	Eligible for partial year; eligibility continues until the month the beneficiary is not in enrolled in both Part A and Part B.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary is assigned to the ACO but died during the performance year.	Eligible for partial year; eligibility continues until the month following the month of death.
Assigned via Voluntary Alignment (designated primary clinician is a primary care physician [Appendix C, Table C-1] or NPP designated as primary care by the ACO) and assigned via CBA in Step 1, Step 2, or Step 3 *or* Assigned via Step 1 or Step 3 (assigned via CBA only)	Beneficiary is assigned to the ACO but does not have a valid U.S. address for at least 1 month of the performance year.	Eligible for partial year; eligibility continues until the month the beneficiary does not have a valid U.S. address.

[a] *Recoupment procedure is applied (see Section 5.3 for details on the recoupment procedure).*

3 OVERVIEW OF THE ACO PC FLEX RATE BOOK

The ACO PC Flex Rate Book (the Rate Book) is used to calculate the PPC Payment for PC Flex ACOs. The Rate Book is broadly similar to the Medicare Advantage (MA) and ACO REACH Rate Books, which establish county-level payment rates for both the aged and disabled (A&D) and end-stage renal disease (ESRD) populations.[12] A summary of differences in key features of the Rate Book for the ACO PC Flex Model, ACO REACH, and the Medicare Shared Savings Program is available at Appendix D, Table D-1. This section describes the construction of the Rate Book used in the ACO PC Flex Model. Specifically:

- **Section 3.1** describes the calculation of the National Conversion Factor.
- **Section 3.2** addresses the construction of the County Relative Cost Indices.
- **Section 3.3** describes additional adjustments to county rates.
- **Section 3.4** describes how the components described in Sections 3.1, 3.2, and 3.3 are combined into the production of the Rate Book.
- **Section 3.5** describes the calculation of the add-on for beneficiaries with FQHC- or RHC-focused care.
- **Section 3.6** describes the Base Rate Add-on Amount.
- **Section 3.7** describes the construction of the Enhanced Amount.

In June 2025 the Rate Book was updated. There are some differences between the 2025 preliminary version of the Rate Book (Preliminary Rate Book) and the 2025 Updated ACO PC Flex Rate Book version (2025 Updated Rate Book). These differences are summarized in Appendix E, Table E-1. Note that for Performance Year 2025, CMS will create a Performance Year 2025 Rate Book Guardrail Provision to determine payable rates for Performance Year 2025 between the preliminary and updated rate books to ACOs as detailed in Subsection 4.8.

The county rates contained in the ACO PC Flex Rate Book are developed based on experience from the ACO PC Flex National Reference Population. This population is similar to the National Assignable Population for the Medicare Shared Savings Program, with primary care services defined slightly differently (as explained in Subsection 3.1.1 below). Inclusion criteria for the ACO PC Flex National Reference Population supports consistency between the developed rates and the beneficiaries for whom the PPC Payment will be paid and has no impact on the assignment methodology used in the Shared Savings Program. Specifically, county rates are based on a subset of the ACO PC Flex National Reference Population referred to in this document as the Rate Book Reference Population. As explained further below, the Rate Book Reference Population excludes beneficiaries in the ACO PC Flex National Reference

[12] MA Rate Books are available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data. The 2023 ACO REACH Rate Book Development document is available at https://www.cms.gov/priorities/innovation/media/document/gpdc-py2023-ratebook-dev.

Population who received the plurality of their primary care services from FQHCs or RHCs and beneficiaries who only received primary care services from specialist physicians.

The county rates established in the Rate Book are the product of (1) a National Conversion Factor, which is an estimate of the PBPM expenditure for eligible primary care services for the Rate Book Reference Population, expressed in 2024 U.S. dollars; (2) a County Relative Cost Index, which reflects the difference between the PBPM primary care expenditure of Rate Book Reference Population living in each county and the national average PBPM primary care expenditure of all beneficiaries in the Rate Book Reference Population; and (3) several adjustments.

The Rate Book contains separate County Base Rates and County Enhancement amounts derived from those rates for the A&D and ESRD populations for each county for use in the beneficiary-level calculation of the PPC Payment. County Base Rates for Performance Year 2025–2029 are based on historical claims data from the most recent years for which complete Medicare FFS claims data are available, known as the Rate Book base years (BYs). The National Conversion Factor is based on experience from the most recent BY, trended forward to 2024. The County Relative Cost Indices are based on experience from all 3 BYs.[13] As part of the PPC Payment calculation for each performance year, County Base Rates and Enhancement amounts (which are in 2024 dollars via the National Conversion Factor) are trended to each performance year (see Subsection 4.1.3). Table 3 outlines the calendar years (CYs), BYs, and performance years used to develop the Rate Book.

Table 3: Construction of the for the 2025 Preliminary Book and the 2025 Updated Rate Book

Performance Year	Calendar Year	Rate Book BYs
Performance Year 2025–Performance Year 2029	2025–2029	CYs 2021, 2022, 2023 for the 2025 Preliminary Rate Book CYs 2022, 2023, 2024 for the 2025 Updated Rate Book

For Performance Year 2026 and each subsequent performance year, CMS shall use the ACO PC Flex Rate Book produced for that year to calculate County Base Rates; any FQHC or RHC Add-on Amounts, if applicable; and the County Enhancement for each PPCP-eligible beneficiary month.

3.1 The National Conversion Factor

The National Conversion Factor is the risk-standardized national average expenditure for services included in the Rate Book for beneficiaries who meet relevant eligibility criteria, as defined in Subsection 3.1.1, and do not receive the plurality of their primary care at an FQHC or RHC. The National Conversion Factor is expressed in 2024 dollars as a PBPM amount. Taken

[13] Because the County Relative Cost Indices are meant to capture relative differences between the county and nation during a given time period rather than absolute dollars, they are not trended to 2024 as the National Conversion Factor is.

together with the County Relative Cost Indices (Section 3.2), it makes up the County Base Rate of the PPC Payment.

3.1.1 Eligibility

Eligibility for the ACO PC Flex National Reference Population is aligned with Shared Savings Program criteria for identifying assignable beneficiaries,[14] with some small differences in how primary care services are defined.[15] These differences include the following:

- Inclusion of Healthcare Common Procedure Coding System (HCPCS) code G0463 in Hospital Outpatient Department (HOPD) settings if billed by a primary care provider
- Exclusion of Current Procedural Terminology (CPT) codes 99304-99318 (professional services furnished in a nursing facility)
- Inclusion for CPT codes 99497 and 99498 (advance care planning services) in all settings (services delivered in inpatient settings are not excluded)
- Exclusion of HCPCS codes G2086, G2087, and G2088 (office-based opioid use disorder services)

To be eligible for inclusion in the ACO PC Flex National Reference Population, beneficiaries must meet the below requirements for assignability under the Shared Savings Program:[16]

- The beneficiary has at least one eligible beneficiary month during the 12-month assignment window (see Table 4). An eligible beneficiary month is one in which the beneficiary is:
    - alive on the first of the month;
    - enrolled in both Part A and Part B;[17] and
    - not enrolled in a Medicare group (private) health plan for the month.[18]
- Lives in the United States or U.S. territories and possessions, based on the most recent available data in beneficiary records regarding the beneficiary's residence at the end of the assignment window.[19]
- The beneficiary has at least one primary care service that meets one of the following definitions:
    - The primary care claim has a date of service during the assignment window and is billed by a primary care physician (Appendix C, Table C-1) or one of the specified specialists

[14] Refer to CFR § 425.400(c)(1)(ix) for the list of CPT/HCPCS codes used in assignment for PY 2025 in the Shared Savings Program.
[15] Refer to § 425.20.
[16] Refer to § 425.654(a)(1)(i).
[17] Refer to § 425.401(a)(1).
[18] Refer to § 425.401(a)(2).
[19] Refer to § 425.401(a)(4).

(Appendix C, Table C-3). All claims by FQHCs and RHCs are considered primary care services regardless of specialty of providers or claim line CPT/HCPCS codes.[20]

- There is a primary care claim with a date of service during the *expanded* window for assignment and is billed by a primary care physician (see Appendix C, Table C-1) or one of the specified specialists (Appendix C, Table C-3) *and* there is a primary care claim with a date or service during the assignment window and is billed by an NPP (Appendix C, Table C-2).[21]

Only eligible beneficiary months (as defined above) that are not part of an episode of coronavirus disease 2019 (COVID-19) as defined under § 425.611 are considered in the County Base Rate calculations.[22]

Table 4: Assignment Window and Expanded Window for Assignment for the 2025 Preliminary Book and the 2025 Updated Rate Book

Rate Book	BY	Assignment Window (same 12 months as BY)	Expanded Window for Assignment (24-month period that includes the assignment window and preceding 12 months)
Preliminary	BY 1	1/1/2021–12/31/2021	1/1/2020–12/31/2021
	BY 2	1/1/2022–12/31/2022	1/1/2021–12/31/2022
	BY 3	1/1/2023–12/31/2023	1/1/2022–12/31/2023
Updated	BY 1	1/1/2022–12/31/2022	1/1/2021–12/31/2022
	BY 2	1/1/2023–12/31/2023	1/1/2022–12/31/2023
	BY 3	1/1/2024–12/31/2024	1/1/2023–12/31/2024

As described above, the Rate Book Reference Population for a given BY is a subset of the ACO PC Flex National Reference Population. It excludes beneficiaries who received the plurality of primary care services from FQHCs or RHCs (see Subsection 3.1.2). Although these beneficiaries are excluded from the population used to calculate the County Base Rates, their experience is used to develop add-on amounts that are applied as part of the PPC Payment calculation (see Sections 3.5 and 4.2). The Rate Book Reference Population also excludes beneficiaries who only received primary care services from specialist physicians during the BY. Such beneficiaries are comparable to those assigned via Step 2 CBA in the Shared Savings Program. Beneficiaries assigned to PC Flex ACOs via Step 2 are ineligible for the PPC Payment and associated claim payment reductions under the ACO PC Flex Model.

3.1.2 Beneficiaries with FQHC- or RHC-focused Care

For each BY, beneficiaries in the ACO PC Flex National Reference Population who received the plurality of primary care services based on allowed amounts at FQHCs are flagged as beneficiaries with FQHC-focused care. Similarly, beneficiaries who received the plurality of

[20] Refer to § 425.402(b)(1).
[21] Refer to § 425.20.
[22] Refer to § 425.611.

primary care services based on allowed amounts at RHCs are flagged as beneficiaries with RHC-focused care. In evaluating whether these criteria are met, primary care services at *any* FQHC or RHC are included; that is, the beneficiary does not need to have received the plurality of care from a single FQHC or RHC.

All services delivered at FQHCs and RHCs will count as primary care services for calculating both allowed charges and expenditures. However, beneficiaries with FQHC- or RHC-focused care will be excluded from both the numerator and denominator for the calculation of the National Conversion Factor and from the County Relative Cost Indices, including their primary care activity outside of FQHCs and RHCs. The primary care activity for these beneficiaries will be used to develop the add-on amounts for beneficiaries with FQHC- and RHC-focused care, which are separate from the County Base Rates in the Rate Book.

3.1.3 ESRD and A&D Beneficiaries

The National Conversion Factor is calculated separately for ESRD and A&D beneficiaries. Beneficiaries are categorized as ESRD or A&D on a monthly basis. Long-term dialysis and transplant statuses are used to determine whether a beneficiary has ESRD status for a given month. Long-term dialysis and transplant statuses are determined through Form 2728 (rather than diagnosis codes on Medicare claims). ESRD facilities submit Form 2728 to CMS through CROWNWeb. This form must be completed within 45 days of the beneficiary beginning or returning to dialysis treatment. Beneficiaries on short-term dialysis and beneficiaries more than 3 months post-graft are not defined as ESRD for these purposes.[23] For purposes of the Rate Book, A&D beneficiary months are not further categorized into disabled, aged/dual, or aged/non-dual enrollment types as they are in the Shared Savings Program.

3.1.4 ACO PC Flex Expenditures

The expenditure included in the development of the Rate Book—referred to as ACO PC Flex expenditures—includes all eligible primary care FFS Medicare claim payment amounts billed by primary care providers,[24] plus sequestration amounts, plus reductions made to provider payments for primary care services because of participation in certain alternative payment arrangements (listed below, following tables). ACO PC Flex expenditures are defined the same way for A&D and ESRD populations.

Eligible primary care services claims and payment amounts: All billing codes used to calculate primary care FFS expenditures for the Rate Book are listed in Appendix B, Table B-1. Claims can be made on behalf of professionals or institutions. Institutional claims can include services delivered at FQHCs, RHCs, HOPDs, Electing Teaching Amendment (ETA) hospitals,

[23] See Appendix E of CMS's *Medicare Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology* (Version 11 2023): https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-2.

[24] Primary care providers include primary care physician specialties (internal medicine, general practice, family practice, geriatric medicine, and pediatric medicine) and non-physician specialties (nurse practitioner, physician assistant, and certified clinical nurse specialist). The codes for these specialties are listed at Appendix C, Tables C-1 and C-2, respectively.

and Critical Access Hospitals (CAHs) Method II. To be included in the development of the Rate Book, claims must meet the following conditions:

1. The beneficiary must be in the Rate Book Reference Population for the BY.
2. The claim date of service must fall within the dates set out in Table 5.
3. The rendering provider must have a specialty as listed in Appendix C, Table C-1 or C-2 (except for claims for FQHCs or RHCs since all services delivered in these settings are classified as primary care services provided by a primary care physician).
4. The claim lines must have the CPT/HCPCS codes listed in Appendix B, Table B-1 (except for claims for FQHCs and RHCs, noting all services delivered in these settings are classified as primary care services provided by a primary care physician).

Further information on institutional claims and payment amounts is in Table 6.

Table 5: Rate Book BYs Used to Compute ACO PC Flex Expenditures for the 2025 Preliminary Rate Book and the 2025 Updated Rate Book

Rate Books	BY	Date of Service Range	Claims Processed Through
2025 Preliminary Rate Book	BY 1	1/1/2021–12/31/2021	3/31/2022
	BY 2	1/1/2022–12/31/2022	3/31/2023
	BY 3	1/1/2023–12/31/2023	3/31/2024
2025 Updated Rate Book	BY 1	1/1/2022–12/31/2022	3/31/2023
	BY 2	1/1/2023–12/31/2023	3/31/2024
	BY 3	1/1/2024–12/31/2024	3/31/2025

Table 6: ACO PC Flex Institutional Claims and Payment Amounts Used to Compute Expenditures

Institutional Claim	Type of Bill	Revenue Codes	Header vs. Line	Evaluate Specialty of Claim NPIs
FQHC	77x	Not applicable (N/A)	Paid amount from header	No
RHC	71x	N/A	Paid amount from header	No
Non-ETA HOPD	13x	N/A	Paid amount from claim lines with CPT/HCPCS code(s) from Appendix B, Table B-1	Yes: Rendering, then Other, then Attending, include only if valid specialty code [a]
CAH method II	85x	096x, 097x, 098x	Paid amount from claim lines with CPT/HCPCS code(s) from Appendix B, Table B-1	Yes: Rendering, then Other, then Attending, include only if valid specialty code [a]
ETA hospital	13x	N/A	Paid amount from claim lines with CPT/HCPCS code(s) from Appendix B, Table B-1	Yes: Rendering, then Other, then Attending, include only if valid specialty code [a]

[a] NPIs are tested in sequence: Rendering, Other, and Attending. This sequence is dependent—for "Other" to be satisfied, "Rendering" must also be found. For "Attending" to be satisfied, "Other" and "Rendering" must both be found.

Alternative payment adjustments: In computing ACO PC Flex expenditures, reductions to provider payments for primary care services associated with certain alternative payment arrangements are added back (see Table 7 below for an exception to this for the 2025 Preliminary Rate Book for CAHs, ETA hospitals, and HOPD).[25] The following are the alternative payment arrangements allowed:

- Next Generation ACO Model
- Vermont All-Payer ACO Model
- ACO REACH
- Kidney Care Choices Model
- Primary Care First Model
- Comprehensive Primary Care Plus (CPC+) Model
- Maryland Total Cost of Care Model
- Making Care Primary

Although adjustments are made for payment reductions for primary care services for the models listed above, the ACO PC Flex expenditures are not adjusted to include other Innovation Payment Adjustments (such as shared savings and losses from other Center for Medicare & Medicaid Innovation and CMS programs) although those are included in the MA and ACO REACH Rate Books. This is because these generally reflect both primary-care-related and non-primary-care-related services, whereas ACO PC Flex expenditures are based on primary care services only. The differences between the expenditures included in the ACO PC Flex Rate Book, ACO REACH Rate Book, and MA Rate Book are presented in Table 7.

Table 7: Differences in Expenditures Included in ACO PC Flex, MA, and ACO REACH

Expenditure Category	PC Flex	ACO REACH	MA
FFS claim payment amounts	Included – primary care only	Included	Included
Sequestration amounts	Included	Included	Included
Payment reductions for primary care services made to providers due to alternative payment arrangement participation	Not included for CAHs, ETA hospitals and HOPD [a]	Included	Included
Other adjustments for Innovation Center models and other CMS programs (e.g., shared savings and losses)	Not included	Included	Included

[25] The Updated ACO PC Flex Rate Book added back in adjustments for additional models introduced in 2024 such as the Making Care Primary Model.

Expenditure Category	PC Flex	ACO REACH	MA
FFS expenditure for beneficiaries enrolled in a managed care plan	Not included	Not included	Not included
Uncompensated care payments	Not included [b]	Not included	Included
Hospice Care for FFS Beneficiaries	Included [c]	Included	Not Included

[a] The 2025 Preliminary ACO PC Flex Rate Book does not adjust for payment reductions for alternative payment arrangements for primary care services at CAHs, ETA hospitals, or non-ETA HOPDs (see Appendix E, Table E-1). However, the 2025 Updated ACO PC Flex Rate Book does adjust for payment reductions for alternative payment arrangements for primary care services at CAHs, ETA hospitals, or HOPDs.
[b] Uncompensated Care payments under the inpatient prospective payment system are not found in the claim types used to identify primary care services for purposes of ACO PC Flex expenditures. Therefore, no explicit adjustment is necessary to exclude them.
[c] Hospice care billed through professional claims with a hospice place of service, that otherwise meet the criteria used to identify primary care services for ACO PC Flex expenditures are included. Hospice services billed through institutional hospice claims are not included.

Completion factor: In calculating expenditures, CMS allows up to 3 months after the end of the BY for claims to run out. The claims run-out period is the time between when a Medicare-covered service has been furnished to a beneficiary and when the final payment is actually issued for the respective service. Generally, claims will be approximately 98–99 percent complete after a 3-month claims run-out. CMS applies an adjustment, known as a completion factor, to ACO PC Flex expenditures to account for the remaining 1–2 percent.[26]

3.1.5 Construction of the National Conversion Factor

The National Conversion Factor is constructed using a combination of the ACO PC Flex Expenditure data and the ACO PC Flex eligibility data.

The calculation of the National Conversion Factor is performed for the most recent BY used to construct the ACO PC Flex Rate Book and is conducted separately for the A&D and ESRD populations. The National Conversion Factor is calculated by dividing the ACO PC Flex Primary Care Expenditures for the Rate Book Reference Population for primary care services provided in eligible beneficiary months (as defined in Subsection 3.1.1) divided by total eligible beneficiary months for this population. For example:

$$National\ Conversion\ Factor = \frac{Sum\ of\ ACO\ PC\ Flex\ expenditures\ for\ beneficiary\ eligible\ months}{Total\ number\ of\ beneficiary\ eligible\ months} \times Trend\ Factor$$

For the 2025 Preliminary Rate Book, the resulting PBPM figure was calculated for 2023 and then trended to 2024 using a factor of 5.114 percent for A&D beneficiaries and 6.588 percent for ESRD beneficiaries. For the 2025 Updated Rate Book, the calculated PBPM figure was based on 2024 data, so no trend factor was required or applied.

[26] The preliminary version of the 2025 Rate Book will use an overall claims completion factor of 1.013. The 2025 Updated Rate Book used a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model (see Appendix E, Table E-1).

3.2 County Relative Cost Indices

The County Relative Cost Indices account for differences between the PBPM primary care expenditure of the Rate Book Reference Population beneficiaries living in each county and the national average PBPM primary care expenditure of the overall Rate Book Reference Population. Separate County Relative Cost Indices are calculated for the A&D and ESRD populations.

For the A&D population, county-level PBPM expenditures used to develop the indices are computed in a similar manner to the National Conversion Factor, except that sums of expenditures and eligible months are taken at the individual county level and the resulting ratio is not trended.[27] Geographic Adjustment Factors (GAFs), discussed in Subsection 3.2.1, are used to adjust each county's ACO PC Flex PBPM expenditures to reflect changes over time in the geographic variations in the cost of doing business. Risk scores, discussed in Subsection 3.2.2, are used to "standardize" county rates. Standardization removes differences in expected expenditures accounted for by the average risk of beneficiaries living in each county.

A similar approach is used for the ESRD population, but ACO PC Flex PBPM expenditures, GAF Trend Indices, and risk scores are computed at the state level. Therefore, the County Relative Cost Indices for ESRD reflect state averages, with each county in a given state having the same value.

The process of calculating the final County Relative Cost Index for the A&D population is illustrated in Table 8.[28] For each BY, the county-level ACO PC Flex expenditure PBPM is multiplied by the GAF Index for that county for that BY and divided by the Rate Book Reference Population PBPM for that BY. The result is the County Index. These county indices are then averaged and this average is divided by the 3-year weighted average of the renormalized risk scores, and then the result is divided by the national index, which is the national average geographic adjustment.[29]

Table 8: Illustration of County Relative Cost Indices for Three Counties, Performance Year 2025 (A&D Population)

Inputs	County A	County B	County C
2021 County ACO PC FLEX Expenditure PBPM	$41	$47	$30
Multiply by: 2021 GAF Trend Index	0.982	0.984	0.986
Divide by: Rate Book Reference Population PBPM 2021[a]	$40	$40	$40
Equals: 2021 County Index	1.007	1.156	0.740

[27] As with the National Conversion Factor, eligible months that are part of a COVID-19 episode are excluded from both the numerator and denominator of the calculation.
[28] The relative cost index for ESRD is calculated similarly, but, as noted, uses the same state-level values for all counties within a given state for expenditure PBPMs, GAF trend indices, and risk scores.
[29] National Index is the national average geographic adjustment, calculated as a weighted average of all the County Relative Cost Indices (uses BY 3 enrollment). Dividing by this factor will ensure that the national average geographic adjustment is 1.0 across the 3 years.

Inputs	County A	County B	County C
2022 County ACO PC FLEX Expenditure PBPM	$45	$50	$29
Multiply by: 2022 GAF Trend Index	1.036	1.038	1.040
Divide by: Rate Book Reference Population PBPM 2022[a]	$42	$42	$42
Equals: 2022 County Index	1.110	1.236	0.718
2023 County ACO PC FLEX Expenditure PBPM	$45	$55	$29
Multiply by: 2023 GAF Trend Index	0.991	0.993	0.995
Divide by: Rate Book Reference Population PBPM 2023[a]	$44	$44	$44
Equals: 2023 County Index	1.014	1.241	0.656
Average: 2021, 2022, and 2023 County Indices (calculated above)	1.044	1.211	0.705
Divide by: 3-Year Weighted Average Renormalized Risk Scores	0.830	1.060	0.982
Divide by: National Index[b]	1.002	1.002	1.002
Equals: County Relative Cost Index	**1.255**	**1.140**	**0.716**

[a] Rate Book Reference Population PBPM is similar to the National Conversion Factor for a single ACO PC Flex Rate Book BY.
[b] National Index is the national average geographic adjustment, calculated as a weighted average of all the County Relative Cost Indices (uses 2023 BY 3 enrollment). Dividing by this factor will ensure that the national average geographic adjustment is 1.0 across the 3 years.

A county's County Relative Cost Index is multiplied by the National Conversion Factor (Section 3.1) and then adjustments are applied (Section 3.3) to give the A&D County Base Rate.

$$Pre-adjusted\ A\&D\ County\ Base\ Rate = (National\ Conversion\ Factor) \times (County\ Relative\ Index)$$

For the ESRD population, because the County Relative Cost Indices represent state-level values, there is a subsequent step applying a county GAF to account for differences in geographic payment rates within each state, leading to county-specific base rates for each county. See Section 3.2.1 for discussion of the computation of the county GAF for ESRD and Section 3.4 for discussion of the application of these adjustments in computing the ESRD county-specific base rates.

3.2.1 Construction of GAF Indices

Medicare FFS primary care claim payment amounts are adjusted in various ways to reflect geographic differences in the cost of doing business. These adjustments are updated annually and vary by FFS payment system. For example, area Wage Indices are used by the various Prospective Payment Systems and the Geographic Practice Cost Indices are applied by the Physician Fee Schedule.

To account for these differences, the Rate Book includes a GAF Trend Index for each county that estimates the combined impact of changes in the geographic adjustments between the BY and performance year. The GAF Trend Index is calculated separately for each of the 3 BYs used to construct the Rate Book. Separate GAF Trend Indices are also calculated for ESRD

and A&D, and as explained below, there are important differences between them about when to use the state or the county indices.

To develop the GAF Trend Index, primary care claims data for each of the Rate Book's BYs are repriced using the most recently published FFS geographic price adjustments. In developing the 2025 Preliminary Rate Book, claims for 2021, 2022, and 2023 were repriced using the FFS geographic adjustments applied in 2024 (which serve as a proxy for data from Performance Year 2025). The GAF Trend Indices used in the 2025 Preliminary Rate Book were constructed using only professional claims, because these make up the majority of ACO PC Flex–eligible expenditures. In developing the 2025 Updated Rate Book, both physician and outpatient claims for 2022, 2023, and 2024 were repriced using the FFS geographic adjustments for 2025. The GAF Trend Indices used in the 2025 Updated Rate Book were constructed using professional, FQHC, RHC, ETA, CAH, and HOPD claims related to ACO PC Flex Model primary care services among the ACO PC Flex Model population in care focus "Other."

The repricing of claims and generation of the GAF Indices is a multi-step process outlined below.

1. **Adjustment for ACO PC Flex–Relevant Expenditures.** The observed payment amount—Claim Line Expenditure—is adjusted to reflect ACO PC Flex–relevant expenditures, accounting for payments associated with other CMS Center for Medicare and Medicaid Innovation models and sequestration. Because most other CMS Center for Medicare and Medicaid Innovation models adjust only professional payments, adjustments related to participation in these models are limited to professional claims—consistent with the ACO REACH GAF methodology. The resulting value, ACO PC Flex Expenditure, represents the net payments after adjustments.

2. **Removal of Geographic Adjustments.** Geographic adjustments applied at the time of payment are removed to calculate a Standardized Expenditure. This variable represents what the payment would have been in the absence of any geographic adjustments.

3. **Application of Current Geographic Adjustments.** The most recent FFS GAFs are applied to the standardized payment to produce the GAF-Adjusted Expenditure. These adjustments reflect geographic variation but are held constant across years to facilitate comparability.

   The proportion of each claim eligible for GAF-adjusted repricing depends on the share of the payment attributed to geographically sensitive factors such as wages, malpractice premiums, and practice expenses. For professional claims, 100 percent of the payment is considered geographically sensitive and eligible for repricing. For outpatient claims, 60 percent of the payment is considered geographically sensitive and eligible for repricing.

   Claims from FQHCs and RHCs are excluded from GAF-based repricing due to their alternative payment methodologies under the Prospective Payment System. In addition, any claims lacking essential geographic service location data—such as a valid zip or county code—are excluded from repricing. For claims excluded from geographic repricing, the GAF-standardized and GAF-adjusted payment amounts are set equal to the ACO PC Flex

expenditure value. Table 9 presents the county average percentage of claims eligible for repricing, by claim type and CY.

Table 9. Percentages of Claims Eligible for Repricing, by Year, Claim Type, and PC Flex Population

	2022	2023	2024
All Claims	86.3%	86.5%	86.8%
A&D	86.3%	86.5%	86.8%
ESRD	85.6%	86.4%	86.6%
Outpatient Claims	50.3%	51.4%	51.9%
Physician Claims	94.8%	95.1%	95.7%

4. **Aggregation of Expenditure Variables.** After generating the necessary expenditure variables, we aggregate the four payment amounts—Claim Line Expenditure, ACO PC Flex Expenditure, Standardized Expenditure, and GAF-Adjusted Expenditure—by CY, county, claim type, and population group (A&D or ESRD).

5. **Application of Budget Neutrality Adjustment.** Consistent with CMS guidance on budget neutrality related to geographic adjustments, we apply a final adjustment to GAF-Adjusted Expenditure to ensure that the total GAF-adjusted payments equal the total ACO PC Flex Expenditure within each subgroup and year. This budget neutrality adjuster is applied to claims eligible for repricing by CY, claim type, and population group, resulting in the Budget Neutral (BN) GAF-Adjusted Expenditure.

6. **Calculation of the GAF Trend Index.** The GAF Trend Index is calculated as the ratio of the BN GAF-Adjusted Expenditure to the ACO PC Flex Expenditure, inclusive of non-repriced claims.

$$GAF\ Trend\ Index = \frac{BN\ GAF\ Adjusted\ Expenditure}{ACO\ PC\ Flex\ Expenditure}$$

For the A&D population, the GAF Index is produced by CY and county.

For the ESRD population rates, we calculate the GAF Trend Index only at the state level instead of at the county level due to small sample sizes. In addition to this state-level GAF Trend Index, we also calculate a cross-sectional point-in-time county GAF Index and a county GAF adjustment for the ESRD population. The county GAF Index calculates the expected impact of the performance year GAFs by comparing Medicare PBPM expenditures during a CY to what they would have been if no performance year geographic adjustment had been applied during the year. This is calculated for each county as follows:

$$County\ ESRD\ GAF\ Index = \frac{ESRD\ BN\ GAF\ Adjusted\ Expenditure}{ESRD\ BN\ GAF\ Standardized\ Expenditure}$$

The county ESRD GAF adjustment calculates cross-sectional variation in Medicare FFS PBPM expenditures by county, based on BY 3 experience and performance year GAFs, and therefore

allows the state-based payment rate for the ESRD population to vary for each county. The cross-sectional GAF adjustment is applied at the stage of computing the Updated County Base Rate for ESRD (see Section 3.4). The county ESRD GAF adjustment is calculated as follows:

$$County\ ESRD\ GAF\ Adjustment = \frac{County\ ESRD\ BN\ GAF\ Index}{Statewide\ Average\ ESRD\ PY\ GAF\ Index}$$

For certain smaller counties, there may not be available baseline data to calculate a county-level GAF for the ESRD rate. In these scenarios, the following hierarchy is used to determine the ESRD county rate:

1. If the county is part of a Core-Based Statistical Area (CBSA), a CBSA rate is assigned to the county. This CBSA rate is calculated as the eligible-month-weighted average of the GAF-adjusted County Rates for other counties within the CBSA.
2. If the county is not part of a CBSA, the county rate is equal to the state rate for the county.

A total of six GAF Trend Indices are produced each year, one for each BY and ACO PC Flex Model population. For the 2025 Preliminary Rate Book, expenditures for 2021–2023 were adjusted to CY 2024. For the 2025 Updated Rate Book, expenditures for 2022–2024 were adjusted to CY 2025. Table 10 shows the differential inputs for the 2025 Preliminary Rate Book as compared to the 2025 Updated Rate Book.

Table 10: GAF Indices Used for the 2025 Preliminary Rate Book and the 2025 Updated Rate Book

Rate Book	Population	Level	BY	GAF Trend Index		
2025 Preliminary Rate Book	A&D	County	2021, 2022, 2023	$\frac{\text{[BY]BN GAF – Adjusted Expenditure 2024}}{\text{[BY]PC Flex Expenditure}}$		
	ESRD	State	2021, 2022, 2023	$\frac{\text{[BY] Expenditure Adjusted to 2024}}{\text{[BY]PC Flex Expenditure}}$		
2025 Updated Rate Book			A&D	County	2022, 2023, 2024	$\frac{\text{[BY] Expenditure Adjusted to 2025}}{\text{[BY]PC Flex Expenditure}}$
			ESRD	State	2022, 2023, 2024	$\frac{\text{[BY] Expenditure Adjusted to 2025}}{\text{[BY]PC Flex Expenditure}}$

Table 11 provides an example of the GAF process for aggregated claims in three counties.

Table 11. GAF Example, A&D Population

County	Claim Line Expenditure	PC Flex Expenditure	Standardized ACO PC Flex Expenditure	GAF-Adjusted ACO PC Flex Expenditure	BN GAF-Adjusted Expenditure	GAF Index
A	$312,998.29	$318,321.03	$324,843.73	$320,711.65	$320,173.76	1.010
B	$9,463,582.51	$10,354,090.48	$10,852,719.55	$10,373,504.09	$10,372,340.09	1.000
C	$6,708,450.79	$7,790,055.55	$7,042,488.26	$7,782,494.40	$7,780,508.38	0.999

In County A, the GAF results in a slightly higher payment relative to the observed value. County B shows minimal change, indicating little geographic impact. In County C, the adjustment results in a slightly lower payment than the original expenditure. If Table 11 were expanded to all counties, the total sums of ACO PC Flex Expenditure and BN GAF-Adjusted Expenditure would be identical, illustrating the effect of the budget neutrality adjustment.

3.2.2 Risk Scores Used for Rate Book Standardization

To develop the ACO PC Flex Rate Book, risk scores are used to standardize expenditures so that the County Relative Cost Indices do not reflect differences in the health status of beneficiaries residing in each county. Using the CMS Hierarchical Condition Category (CMS-HCC) prospective risk adjustment model applicable for the performance year, the county-level expenditures are risk-standardized so that they reflect the estimated expenditure PBPM of beneficiary in the Rate Book Reference Population with a risk score of 1.0 in each year for the ESRD or A&D population. For the 2025 Updated Rate Book, risk scores for A&D beneficiaries will reflect a blend of 67 percent of the risk score calculated using the 2024 prospective CMS-HCC risk adjustment model Version 28 (V28) with 33 percent of the risk score calculated using the 2020 prospective CMS-HCC risk adjustment model Version 24 (V24). Risk scores for ESRD beneficiaries will reflect the 2023 prospective CMS-HCC ESRD risk adjustment model (based on V24). This aligns with the risk score models used in the Shared Savings Program for Performance Year 2025 for A&D and ESRD beneficiaries, respectively.

Risk standardization of the Rate Book is achieved by dividing the county rates by the 3-year weighted average risk score for each county. Prior to performing risk standardization, we renormalize risk scores in a similar manner as done for the Shared Savings Program.[30] For each CY used in the Rate Book construction, risk scores are renormalized by dividing by the national average risk score for the Rate Book Reference Population for that year, with the calculation done separately for ESRD and A&D. This is done to account for any difference in the average risk score within this specific population and to ensure that the risk scores used to develop County Base Rates will reflect the cost of beneficiary care relative to the average cost of a beneficiary eligible for the model. Note that like ACO PC Flex expenditures, we consider

[30] For information on the Shared Savings Program's risk score calculations, see Section 3.2 in CMS's *Medicare Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology* (Version 12), https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-3.

only eligible beneficiary months that are not part of a COVID-19 episode when computing county (or state, for ESRD) and national average risk scores.

3.3 Adjustments to County Rates

In calculating the A&D County Base Rate, two additional adjustments are applied to achieve policy goals and improve accuracy for the model. These are the VA and Department of Defense (DoD) adjustments (i.e., the VA/DoD adjustment; see Subsection 3.3.1) and the credibility adjustments (Subsection 3.3.2). These adjustments are applied at the county level. Consistent with MA and ACO REACH, the VA/DoD and credibility adjustments are not applied when calculating ESRD rates. As described above, County Relative Indices for ESRD are based on state-level data, and therefore are based on larger sample sizes than the county-level data used for A&D, removing the need for a separate credibility adjustment.

The Rate Book does not include other adjustments that are included in the MA and ACO REACH Rate Books, including an adjustment for beneficiaries with zero claims and a kidney acquisition cost adjustment. This is because the Rate Book is based on primary care spending and does not include beneficiaries who have no primary care services (and thus, zero expenditures) during the BY.

3.3.1 VA/DoD Adjustment

The ACO PC Flex Rate Book applies the same VA/DoD (U.S. Family Health Plan) adjustments to the county-level PBPM FFS rates using the ratios reported in the MA Rate Book corresponding to BY 3. This adjustment removes the impact of VA/DoD beneficiaries' experience on the county-level rates because these beneficiaries have care expenditure patterns that vary from FFS beneficiaries who are not covered by VA/DoD benefits. This is included in the ACO PC Flex Rate Book because the same logic applies to the ACO PC Flex Model as to MA. The VA/DoD adjustment for the 2025 rates will be based on FFS data from CYs 2017–2021. The methodology for the study and adjustment is described in more detail in the CY 2022 Advance Notice Part II.[31] To calculate the VA adjustment, CMS analyzed the impact of removing VA dual-benefit eligible beneficiaries from claims and enrollment by calculating the ratio of standardized per capita costs of all non-veteran Medicare beneficiaries to all beneficiaries (veteran and non-veteran) for each county. Similar analysis was undertaken for DoD beneficiaries. Adjustments were made to counties with at least 10 members in the Uniformed Services Family Health Plan, because only these ratios were significant.

To calculate the pre–credibility-adjusted County Base Rate for the A&D population, the VA/DoD adjustment is multiplied by the National Conversion Factor and the County Relative Index as illustrated in the following equation:

$$\begin{aligned} Pre-credibility-adjusted\ A\&D\ County\ Base\ Rate \\ = (National\ Conversion\ Factor) \times (County\ Relative\ Index) \\ \times (VA/DoD\ adjustment) \end{aligned}$$

[31] CMS, (2020, October), *2022 Advance Notice – Part I*, https://www.cms.gov/files/document/2022-advance-notice-part-ii.pdf

3.3.2 Credibility Adjustments

Similar to the MA Rate Book, a credibility adjustment is applied to small counties in the ACO PC Flex Rate Book when calculating the A&D base rates. The credibility adjustment is intended to address expenditure volatility in small counties. For counties with fewer than 1,000 beneficiaries, county experience is blended with experience from the applicable Medicare CBSA. If a county is not associated with a CBSA, the county experience will be blended with statewide experience.

The credibility formula[32] defines credibility (denoted by "Z") as:

$$Credibility\ (Z) = \sqrt{\frac{Average\ A\ \&\ B\ Beneficiaries}{1000}}$$

The credibility-adjusted county rate is then:

$$Credibility - Adjusted\ A\&D\ County\ Base\ Rate\ PBPM = Pre - credibility - adjusted\ A\&D\ County\ Base\ Rate\ PBPM^{33} \times Z + CBSA\ PBPM \times (1 - Z)$$

Once the county-level rates are adjusted to account for credibility, a second adjustment is applied to counties with credibility less than 1.0 in order to maintain budget neutrality relative to the pre–credibility-adjusted rates (shortened to "pre-credibility PBPM" in equation below).[34] These budget neutrality factors are calculated at the state level.

This budget neutrality factor is multiplied by the credibility-adjusted A&D County Base Rate for those counties with credibility less than 1.0.

$$Credibility\ Budget\ Neutral\ Factor_{State} = \frac{a}{b}, where$$

$$a = \sum_{all\ ctys\ cred<1} (Pre\text{-}Credibility\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment)$$

$$b = \sum_{all\ ctys\ cred<1} Credibility\ Adjusted\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment$$

[32] In the credibility formula, "average A & B beneficiaries" corresponds to the average number of FFS beneficiaries enrolled in Parts A and B in a given county during the applicable year. For purposes of the credibility adjustment, we consider only beneficiaries in the Rate Book Reference Population classified as A&D.

[33] Pre–credibility-adjusted A&D County Base Rate PBPM = (National Conversion Factor) x (County Relative Index) x (VA/DoD Adjustment)

[34] The budget-neutrality adjustment is needed to prevent the credibility adjustment from resulting in rates that would, if applied to the entire A&D Rate Book Reference Population, result in a national average payment rate that is higher or lower than the average payment rate prior to applying the credibility adjustment.

3.4 Construction of the Final County Base Rate

The ACO PC Flex Rate Book contains two rates for each county. There is one rate for the A&D population (including disabled, aged/dual, and aged/non-dual enrollment types) and one rate for the ESRD population.

As described in Section 3.3, A&D county rates are the product of the National Conversion Factor, the County Relative Cost Index, and the VA/DoD adjustment, and then the credibility adjustment is applied. This is illustrated in Tables 12 and 13.

Table 12: Construction of Pre–credibility-Adjusted A&D PBPM County Rate

County	County Relative Cost Index	National Conversion Factor	VA/DoD Adjustment	Calculation	Pre–credibility-adjusted A&D Rate
County A	0.9537	$46.15	1.0026	= $46.15 x 0.9537 x 1.0026	$44.13
County B	1.1901	$46.15	0.9718	= $46.15 x 1.1901 x 0.9718	$53.37
County C	0.9363	$46.15	0.9931	= $46.15 x 0.9363 x 0.9931	$42.91
County D	0.8339	$46.15	1.0035	= $46.15 x 0.8339 x 1.0035	$38.62
County E	0.9095	$46.15	1.0268	= $46.15 x 0.9095 x 1.0268	$43.10

Table 13: Construction of Final A&D PBPM County Rate

County	Average Enrollment	Pre–credibility-Adjusted Rate	Credibility (Z)	CBSA/State Rate	Credibility-Adjusted A&D Rate[a]
County A	8,000	$44.13	1	N/A	$44.13
County B	7,000	$53.37	1	N/A	$53.37
County C	6,000	$42.91	1	N/A	$42.91
County D	800	$38.62	0.8944	$46.82	$39.47
County E	300	$43.10	0.5477	$42.35	$42.74

[a] There is also a BN factor involved in the final rate. As outlined in Subsection 3.3.2, the BN factor is multiplied by the credibility-adjusted A&D County Base Rate for counties with credibility less than 1.0. This table uses an arbitrary value of 0.9995 for the BN factor.

ESRD county rates are the product of the National Conversion Factor, the County Relative Cost Index (which is the same for all counties in a given state), and the county-specific ESRD GAF, as illustrated in Table 14. In this example, Counties F, G, and H are assumed to be in State 1 and Counties I and J are assumed to be State 2.

Table 14: Construction of ESRD PBPM County Rate

County, State	County Relative Cost Index	National Conversion Factor	County ESRD GAF	Calculation	County Rate
County F, State 1	0.9533	$65.86	0.9839	= $65.86 x 0.9533 x 0.9839	$61.77
County G, State 1	0.9533	$65.86	0.9616	= $65.86 x 0.9533 x 0.9616	$60.37
County H, State 1	0.9533	$65.86	1.0215	= $65.86 x 0.9533 x 1.0215	$64.13
County I, State 2	1.0196	$65.86	0.9950	= $65.86 x 1.0196 x 0.9950	$66.82
County J, State 2	1.0196	$65.86	1.0152	= $65.86 x 1.0196 x 1.0152	$68.17

3.5 Add-ons for Beneficiaries for FQHC- or RHC-Focused Care

As discussed in Subsection 3.1.2, beneficiaries in the ACO PC Flex National Reference Population with FQHC- or RHC-focused care excluded from the calculation of the County Base Rates (and the County Enhancement amounts) in the ACO PC Flex Rate Book. These beneficiaries are excluded because FQHCs and RHCs are paid under different payment systems (FQHCs under FQHC prospective payment system and RHCs under RHC all-inclusive rates) and because these providers receive all-inclusive per-visit payments. Therefore, the historical claims for FQHCs and RHCs do not lend themselves to standardization and inclusion in the calculation of the County Base Rates. As a result, CMS includes an add-on payment to the PPC Payment for beneficiaries with FQHC- or RHC-focused care. These add-ons are model-level variables: one for beneficiaries who receive the plurality of primary care services at FQHCs and, separately, one for beneficiaries who receive the plurality of primary care services at RHCs. The add-ons are fixed dollar amounts added to the PPC Payment for these beneficiaries based on the average difference between (1) national historical spending for beneficiaries who receive the plurality of primary care services at FQHCs or RHCs and (2) the average County Base Rates based on the Rate Book Reference Population that excludes these beneficiaries. The add-ons are not geographically adjusted.

3.5.1 PPC Payment Add-on for Beneficiaries with FQHC-Focused Care

The add-on for beneficiaries with FQHC-focused care described in this section accounts for the exclusion of these beneficiaries' experience from the ACO PC Flex County Base Rates. The resulting payment add-on factor accounts for the average observed difference in expenditures for FQHC-focused care beneficiaries and what would be predicted by the ACO PC Flex Rate Book alone. The following steps are used to compute the FQHC Add-on factor, but Steps 2 through 10 are computed separately for each BY and enrollment type (A&D or ESRD):

- **Step 1.** Identify the beneficiaries in the ACO PC Flex Reference Population with FQHC-focused care. See Subsection 3.1.1 for details on eligibility for the ACO PC Flex Reference Population and Subsection 3.1.2 for the identification of beneficiaries with FQHC-focused care, respectively.

- **Step 2.** Calculate the average County Base Rate for beneficiaries with FQHC-focused care. The average County Base Rate is an eligible-month weighted average of the risk-standardized County Base Rates in each BY applied to the FQHC-focused care population. The average County Base Rates are calculated separately for ESRD and A&D FQHC-focused care beneficiaries using the analogous Rate Book rates for each population. The result is a predicted average PBPM expenditure amount reflecting the distribution of ACO PC Flex Model eligible FQHC-focused care beneficiaries across counties in each BY and a mean risk score of 1.0 and is expressed in 2024 dollars. See Table 5 in Subsection 3.1.4 of this document for information on the BYs included in the Rate Book.

$$Average\ County\ Base\ Rate = \frac{\sum_c (County\ Base\ Rate_c \times Eligible\ Months_c)}{\sum_c Eligible\ Months_c}$$

- **Step 3.** Calculate the national ACO PC Flex expenditure PBPM for the FQHC-focused care population by applying a completion factor[35] to the total observed ACO PC Flex Expenditure incurred within a BY, then dividing by the FQHC-focused care population total eligible months.

- **Step 4.** Calculate the national average risk score for the FQHC-focused care population. This is a weighted average national risk score constructed by weighting each county's average FQHC-focused care beneficiary population raw risk score by the number of FQHC-focused care eligible beneficiary months.

- **Step 5.** Calculate the national average risk score for the Rate Book Reference Population (i.e., neither FQHC- nor RHC-focused care population). This is a weighted average national risk score constructed by weighting each county's average Rate Book Reference Population raw risk score by the number of eligible beneficiary months.

- **Step 6.** Calculate the normalized FQHC-focused care population risk score by dividing the national average risk score for the FQHC-focused care population from (product of Step 4) by the national average risk score for the Rate Book Reference Population from (product of Step 5).

- **Step 7.** Calculate the risk-standardized national PBPM by dividing by the national PBPM from (the result from Step 3) by the normalized risk score from (the result from Step 6).

- **Step 8.** For the 2025 Preliminary Rate Book, calculate the applicable trend factor to trend each BY spending amount to 2024. We apply a separate trend factor for each enrollment type and BY. The trend factors are derived from observed change in the national average ACO PC Flex expenditure PBPM for the Rate Book Reference Population between each BY and that of BY 3, and BY 3 (i.e., 2023) is then trended to 2024 dollars using a 5.114 percent A&D growth rate and 6.588 percent ESRD growth rate. For the 2025 Updated Rate Book, the calculated PBPM figure is calculated in 2024

[35] The 2025 Preliminary Rate Book used an overall claims completion factor of 1.013. The 2025 Updated Rate Book used a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model (see Appendix E, Table E-1).

dollars. Therefore, no trend factor is required, and a neutral trend factor of 1.0 is applied in the calculations.

- **Step 9.** Calculate a risk-standardized, trended national PBPM by multiplying the risk-standardized PBPM from (result from Step 7) by the trend factor from (result from Step 8).
- **Step 10.** Take the difference between the risk-standardized, trended national PBPM for the FQHC-focused care population from (result from Step 9) and the average County Base Rate from (result from Step 2).
- **Step 11.** For each enrollment type, take a simple average of the differences (from Step 10) across the 3 BYs.
- **Step 12.** To obtain the final single FQHC Add-on, take a weighted average of the 3-year average differences for ESRD and A&D enrollment types (from Step 11), using total eligible beneficiary months across the 3 BYs for each enrollment type as weights.

3.5.2 PPC Payment Add-on for Beneficiaries with RHC-Focused Care

The add-on for beneficiaries with RHC-focused care corrects for the exclusion of RHC claims from the county rates. The add-on calculation for beneficiaries with RHC-focused care follows the same steps as detailed in Subsection 3.5.1 above but uses the RHC-focused care population in place of the FQHC-focused care population.

3.6 Base Rate Add-on Amount

The PPC Payment includes a Base Rate Add-on Amount, which is a fixed amount PBPM for a performance year. The Base Rate Add-on may be used to increase the base rate for underlying changes in the Medicare Physician Fee Schedule that are not reflected in the Rate Book. Annually, CMS may examine relevant changes to the Medicare Physician Fee Schedule and may release an amendment to the ACO PC Flex Model financial methodology with adjustments to the Base Rate Add-on Amount. The Base Rate Add-on Amount for Performance Year 2025 is $0 PBPM.

3.7 Construction of the Enhanced PPC Payment Amount

The PPC Payment includes an Enhanced Amount that consists of three components:

1. **Flex Enhancement:** A fixed amount of $125 per-beneficiary per-year (PBPY), applied at the ACO level to all PC Flex ACOs. It is designed to increase primary care funding and encourage investment in in primary care.
2. **County Enhancement:** Applied to counties designated as low-spending counties relative to standardized spending nationally. It is designed to increase payment in counties with historically low levels of primary care spending. When combined with the County Base Rate, the County Enhancement brings the county-specific amount up to a national threshold of primary care spending. The County Enhancement is calculated separately for ESRD and A&D populations.

3. **Enhancement Add-on:** A fixed amount PBPM for a performance year. As with the Base Rate Add-on Amount, the Enhancement Add-on may be used to increase the Enhanced PPC Payment Amount for underlying changes in the Medicare Physician Fee Schedule that are not reflected in the Rate Book. Annually, CMS may examine relevant changes to the Medicare Physician Fee Schedule and may release an amendment to the ACO PC Flex Model financial methodology with adjustments to the Enhancement Add-on Amount. The Enhancement Add-on amount for Performance Year 2025 is $10.42 PBPM ($125 PBPY). This Enhancement Add-on amount is meant to account for the billing of the 2025 Advanced Primary Care Management services codes established by the Calendar Year 2025 Medicare Physician Fee Schedule Final Rule.

To determine eligible counties and calculate the County Enhancement, CMS groups County Base Rates into deciles from lowest to highest spending and identifies counties with low spending relative to a national threshold.[36] "Low-spending" counties are defined as those with average primary care spending less than the top of the second decile of risk-standardized primary care spending nationally (i.e., the national threshold amount). For low-spending counties as defined, the County Enhancement is calculated as the difference between the PBPM national threshold amount and the county's County Base Rate. The Final Enhanced County Rate is determined by adding this amount to the pre-enhanced rate for each eligible county (see Table 15).

Table 15: County Enhancement Calculations

County	County Base Rate	Below National Threshold Amount ($40.51) [a]	County Enhancement Calculation [b]	County Enhancement
County A	$44.13	No	N/A	N/A
County B	$53.37	No	N/A	N/A
County C	$42.91	No	N/A	N/A
County D	$39.47	Yes	= $40.51 − $39.47	$1.04
County E	$42.74	No	N/A	N/A

[a] In this example, the 20th percentile is $40.51.
[b] The County Enhancement is calculated as the difference between the national threshold amount and the County Base Rate.

As described in Section 5.2, the Enhanced PPC Payment Amount is not subject to recoupment by CMS based on the PC Flex ACO's performance in achieving shared savings, to the extent that it exceeds the greater of the ACO's positive regional adjustment and prior savings adjustment. This approach aims to encourage investments in primary care. At the time of the performance year settlement, CMS will reduce the value of the payment enhancement by no more than the dollar value of the PC Flex ACO's positive regional adjustment or prior savings adjustment.

[36] The deciles are computed based on the final County Base Rates after the application of all applicable adjustments.

4 CALCULATION OF THE PPC PAYMENT

This section describes how the County Base Rates and County Enhancement amounts for the A&D and ESRD populations in the Rate Book are used in the beneficiary-level calculation of the PPC Payment and the calculation of the monthly PPC Payment for an ACO.

4.1 Payment and Operational Adjustments to PPC Payment

The components comprising the PPC Payment, as described in Section 3, are subject to a series of payment and operational adjustments, though not all adjustments are applied to each component, as shown in Table 16.

Table 16: Summary of Adjustments Applied to PPC Payment Components

PPC Payment	Payment Component	Adjustments
Base	County Base Rate	Risk adjustment; Primary Care Delivered Outside of the ACO (PCOA); Primary Care Prospective Administrative Trend (PCPAT); seasonality adjustment, Payment Precision Withhold; sequestration
	FQHC Add-on; RHC Add-on	Risk adjustment; PCOA; PCPAT; seasonality adjustment Payment Precision Withhold; sequestration
	Base Rate Add-on Amount	Payment precision withhold; sequestration
Enhanced PPC Payment Amount	County Enhancement	Risk adjustment; PCOA; PCPAT; sequestration
	Flex Enhancement	Risk adjustment; PCPAT; sequestration
	Enhancement Add-on Amount	Risk adjustment; PCPAT; sequestration
Population Adjustment	Population Adjustment	Sequestration

The adjustments are briefly summarized below and described in detail in the following subsections:

- **Subsection 4.1.1: Risk Adjustment.** Uses the CMS-HCC prospective risk adjustment model to adjust for variation in the clinical risk among a given PC Flex ACO's PPCP-eligible beneficiaries.
- **Subsection 4.1.2: Adjustment for PCOA.** Accounts for ACO PC Flex assigned beneficiaries' receipt of primary care from providers not participating in a PC Flex ACO; this adjustment is not applied to the Flex Enhancement, Enhancement Add-on Amount or the Population Adjustment .
- **Subsection 4.1.3: Primary Care Prospective Administrative Trend.** Used to trend forward the County Base Rate, County Enhancement, Flex Enhancement, Enhancement Add-on Amount, and FQHC and RHC Add-ons to Performance Year 2025 dollars.

- **Subsection 4.1.4: Seasonality Adjustment.** Used to account for natural variability in Medicare expenditures for primary care services over the course of a CY.
- **Subsection 4.1.5: Comparison to Fee Reductions and Additional Payment Amount for Beneficiaries with FQHC- and RHC-Focused Care:**
  - **FQHC True-up Payment PBPM:** Used to ensure that ACOs are appropriately funded for assigned beneficiaries with FQHC-focused care; and
  - **RHC True-up Payment PBPM:** Used to ensure that ACOs are appropriately funded for assigned beneficiaries with RHC-focused care.
- **Subsection 4.1.6: Limit on Enhanced PPC Payment Amount.** A limit or cap is applied to the enhanced portion of the PPC Payment.
- **Subsection 4.1.7: Population Adjustment.** Adjusts the amount of PPC Payment payable to a PC Flex ACO to account for relative differences in beneficiary resources.
- **Subsection 4.1.8: Operational Payment Precision Withhold.** A prospective discount withheld from the PPC Payment that buffers against potential non-reduction of PPCP-eligible beneficiary claims.
- **Subsection 4.1.9: Application of Medicare Sequestration.** Application of 2 percent Medicare sequestration as required by federal rulemaking.

4.1.1 Risk Adjustment

Components of the PPC Payment are adjusted to account for variation in the clinical risk among a given PC Flex ACO's PPCP-eligible beneficiaries. The County Base Rate, County Enhancement, Flex Enhancement, FQHC and RHC Add-ons, and Enhancement Add-on are risk-adjusted using the CMS-HCC prospective risk adjustment model. The County Base Rate, described in Section 3.4, is also risk-standardized based on the same approach. For each performance year, the PPC Payment is risk-adjusted using the same CMS-HCC prospective risk adjustment model version or version blend that is used to adjust benchmarks in the Shared Savings Program. Specifically, for Performance Year 2025, risk scores for A&D beneficiaries will reflect a blend of 67 percent of the risk score calculated using the 2024 prospective CMS-HCC risk adjustment model (based on V28), with 33 percent of the risk score calculated using the 2020 prospective CMS-HCC risk adjustment model (based on V24). Risk scores for ESRD beneficiaries will reflect the 2023 prospective CMS-HCC ESRD risk adjustment model (based on V24). These two processes align with the risk score models used in the Shared Savings Program to adjust benchmarks for Performance Year 2025 for A&D (i.e., disabled, aged/dual, and aged/non-dual) and ESRD beneficiaries.

Although the same risk models used to adjust Shared Savings Program benchmarks will be used to risk adjust the PPC Payment, these risk score values will not be identical to those used in benchmarking calculations. The PPC Payment risk scores will be normalized to the ACO PC Flex Rate Book Reference Population. This is to maintain consistency with the ACO PC Flex Rate Book county rate calculations, which express County Base Rates on a risk-standardized basis relative to the Rate Book Reference Population. Similar to the County Base Rate calculations, the population will be divided into two enrollment types, A&D and ESRD, with risk

scores normalized separately for each. This will ensure that the risk scores used to calculate payment will reflect the expected cost of beneficiary care relative to the average cost of a PPCP-eligible beneficiary.

To support more precise PPC Payments than would be calculated using prior years' final scores and to minimize the impacts of retrospective updates to the PPC Payment due to risk adjustment, interim risk scores will be used throughout the performance year and updated based on the schedule presented in Tables 17 and 18. A forecasted normalization factor will be used throughout the performance year. The normalization factor is calculated as a linear projection based on average risk scores among the Rate Book Reference Population in CY 2021 through CY 2023 for the 2025 Preliminary Rate Book, and CY 2022 through CY 2024 for the 2025 Updated Rate Book, calculated separately for each enrollment type (A&D and ESRD). In addition to showing which risk scores are used for each month, Table 18 also provides other information including which assignment run is used for each month.

Table 17. Performance Year 2025 Risk Score Measurement Calendar

Risk Score	CMS-HCC Risk Adjustment Model Diagnostic Measurement Period (Dates of Service)	Claims Run-out Through
Preliminary	July 2023–June 2024	September 2024
Mid-Year Quarter (Q) 1	January 2024–December 2024	March 2025
Mid-Year Q2	January 2024–December 2024	June 2025
Mid-Year Q3	January 2024–December 2024	September 2025
Mid-Year Q4	January 2024–December 2024	December 2025
Final	January 2024–December 2024	January 2026

Table 18: Performance Year 2025 Risk Score and Payment Calendar

Payment Report Month	Monthly Payment Report Distribution	Assignment Run Used for ACO Assignment and PPCP Eligibility	Interim Risk Score	Month Used to Prospectively Determine Beneficiary Status for Report Month	Previous Payment Months Evaluated for Retrospective Adjustments
Jan-25	1/10/2025	Initial	Preliminary	Sep-24	N/A
Feb-25	1/28/2025	Initial	Preliminary	Dec-24	N/A
Mar-25	2/27/2025	Initial	Preliminary	Jan-25	Jan 2025
Apr-25	3/26/2025	Initial	Preliminary	Feb-25	Jan 2025–Feb 2025
May-25	4/24/2025	Initial	Preliminary	Mar-25	Jan 2025–Mar 2025
Jun-25	5/27/2025	Initial	Preliminary	Apr-25	Jan 2025–Apr 2025
Jul-25	6/26/2025	Q1	Mid-Year Q1	May-25	Jan 2025–May 2025
Aug-25	7/23/2025	Q1	Mid-Year Q1	Jun-25	Jan 2025–Jun 2025
Sep-25	8/26/2025	Q1	Mid-Year Q1	Jul-25	Jan 2025–Jul 2025
Oct-25	9/25/2025	Q2	Mid-Year Q2	Aug-25	Jan 2025–Aug 2025

Payment Report Month	Monthly Payment Report Distribution	Assignment Run Used for ACO Assignment and PPCP Eligibility	Interim Risk Score	Month Used to Prospectively Determine Beneficiary Status for Report Month	Previous Payment Months Evaluated for Retrospective Adjustments
Nov-25	10/27/2025	Q2	Mid-Year Q2	Sep-25	Jan 2025–Sep 2025
Dec-25	11/26/2025	Q3	Mid-Year Q2	Oct-25	Jan 2025–Oct 2025
Mar-26	2/28/2026	Q4	Mid-Year Q4	N/A	Jan 2025–Dec 2025
Apr-26	4/30/2026	Final	Final	N/A	Jan 2025–Dec 2025

Note that dates listed in this table are estimates and are subject to change.

4.1.2 Adjustment for PCOA

Primary Care Outside of the ACO (PCOA) is the value of primary care services provided to a given set of beneficiaries by primary care providers or suppliers who are not participants in a PC Flex ACO. Examples of PCOA may include the following:

- Office-based acute or urgent care at an after-hours or retail clinic
- Beneficiary transition to a new, non-ACO primary care provider
- Care delivered while traveling or while at an alternate residence

Because base components of the PPC Payment include all primary care services provided to beneficiaries residing in a county by primary care providers and suppliers, payment rates to ACOs must be adjusted to account for PCOA. This adjustment is applied to County Base Rates, add-ons for beneficiaries with FQHC- or RHC-focused care, and the County Enhancement. This adjustment is not applied to the Flex Enhancement, Base Rate Add-on Amount, Enhancement Add-on Amount, or the Population Adjustment. The PCOA is an ACO specific adjustment that is applied to all PPCP-eligible beneficiary months for that ACO.

In the PCOA calculation, primary care services are defined according to the same list of services as used in the ACO PC Flex Rate Book development (see Appendix B, Table B-1). The list of primary care providers is identified by the primary care physicians listed in Appendix C, Table C-1, and the NPPs listed in Appendix C, Table C-2. Notably, primary care services performed by NPPs who the PC Flex ACO has designated as specialist NPPs are treated as care outside the PC Flex ACO for the purpose of calculating the PCOA adjustment.

For Performance Year 2025, the PCOA adjustment is calculated using BYs comprised of CYs 2021, 2022, and 2023, each with claims run-out through March 31 of the year following the CY. The BYs are weighted as follows, so that the more recent years have higher weight:

- 2021 (10 percent weight)
- 2022 (30 percent weight)
- 2023 (60 percent weight)

The PCOA adjustment is calculated using the Medicare Paid Amount, which is determined before the application of any claim reductions related to other models or program and before the application of Medicare sequestration, similar to the determination of expenditures used in the ACO PC Flex Rate Book calculation.

The PCOA Calculation Methodology is as follows:

- **Step 1.** PPCP-eligible beneficiaries are identified for each PCOA BY. Only PPCP-eligible beneficiary months will be used in the PCOA Adjustment.
    - **Step 1a.** For each PCOA BY, Shared Savings Program assignment logic is run (defined according to 42 CFR 425.402(b)) using the methodology (Prospective or Preliminary Prospective with Retrospective Reconciliation ["Retrospective"]) elected by the ACO for the ACO PC Flex performance year. This includes running the subsequent logic to determine impact of quarterly and final assignment runs for the retrospective ACOs, as well as terminations due to mortality, any months of Medicare group (private) health plan enrollment, residency outside of the United States and its territories, any months with only Part A or Part B, and lack of at least 1 month with both Part A and Part B.
    - **Step 1b.** For Prospective ACOs, PPCP-eligible beneficiaries for each PCOA BY are identified based on the performance year participant list and the methodology for *Prospective Assignment ACOs* (defined according to 42 CFR 425.400(a)(3)). See Section 2.1 for details on assignment criteria.
    - **Step 1c.** For retrospective ACOs, PPCP-eligible beneficiaries for each PCOA BY are determined based on the performance year participant list and the methodology for *Retrospective Assignment ACOs* (defined according to 42 CFR 425.400(a)(2)). See Subsection 2.1 for details on assignment criteria.
- **Step 2.** Determine the total Medicare Paid Amount for each PCOA BY of Primary Care Services provided by *all Primary Care Physicians and NPPs* for PPCP-eligible beneficiaries.
- **Step 3**. Determine the total Medicare Paid Amount for each PCOA BY of Primary Care Services provided by *Primary Care Physicians and NPPs billing under ACO Participants* for PPCP-eligible beneficiaries.
- **Step 4.** Determine the total Medicare Paid Amount for each PCOA BY of Primary Care Services provided by *Specialist NPPs billing under ACO Participants* for PPCP-eligible beneficiaries.
- **Step 5.** Calculate PCOA BY Percentages *for each PCOA BY* as follows:

$$PCOA\ BY\ Percentage = 1 - \frac{(Step\ 3 - Step\ 4)}{Step\ 2}$$

$$PCOA\ BY\ Percentage = 1 - \frac{(\text{Primary Care within the ACO delivered by Primary Care Providers})}{All\ Primary\ Care}$$

Where the second term, [(Step 3 – Step 4) / Step 2], represents the Medicare Paid Amount for primary care services (excluding primary care services delivered by specialist NPPs) billed *within* the ACO as a proportion of all primary care services provided by all primary care providers (both within and outside of the ACO) for PPCP-eligible beneficiaries. Subtracting this quantity from 1 then represents the amount of primary care services delivered outside of the ACO.

Operationally, for a given BY, the *PCOA BY percentage* reflects

- the sum of the Medicare paid amounts before claim reductions for primary care services billed by primary care providers or suppliers that are not billing under an ACO Participant TIN/CCN in the ACO PC Flex Model

  divided by

- the sum of Medicare paid amounts before claim reductions for primary care services billed by *all* primary care providers and suppliers.

- **Step 6.** Calculate the Weighted Baseline PCOA Percentage.

$$\begin{aligned} &Weighted\ Baseline\ PCOA\ Percentage \\ &= (PCOA\ Baseline\ Year\ Percentage_{2021}\ X\ 10\%) \\ &+ (PCOA\ Baseline\ Year\ Percentage_{2022}\ X\ 30\%) \\ &+ (PCOA\ Baseline\ Year\ Percentage_{2023}\ X\ 60\%) \end{aligned}$$

- **Step 7.** Calculate the PCOA Adjustment Factor, which represents the value of primary care services retained by the ACO:

$$PCOA\ Adjustment\ Factor = 1 - Weighted\ Baseline\ PCOA\ Percentage$$

  This is the value used in PPC Payment calculations. This factor is applied to the relevant base components of the PPC Payment (County Base Rates, Add-ons for beneficiaries with FQHC- or RHC-focused care, and the County Enhancement) to reduce payment for the proportion of primary care that is delivered by the ACO.

  Although the adjustment is at the ACO level, it is applied to the PPC Payment at the beneficiary level as a single multiplier to the monthly beneficiary-specific PPC Payment Amount. This ensures that all PPC Payment amounts are at the beneficiary-month level and can be used in settlement calculations and future benchmarking where appropriate.

4.1.3 Primary Care Prospective Administrative Trend

The County Base Rate, Enhanced PPC Payment Amount, and FQHC and RHC Add-ons described above are expressed in 2024 dollars and trended forward to performance year dollars using the PCPAT.

After application of relevant adjustments to the County Base Rate, FQHC and RHC Add-ons, and Enhanced PPC Payment Amount (see Table 16 above), the resulting amount is trended forward to the applicable performance year using the PCPAT. For Performance Year 2025, the PCPAT factor is equal to the compound annual growth rate between 2019 and 2023 for primary care services provided to beneficiaries in the ACO PC Flex National Reference Population, excluding beneficiaries who only received primary care services from specialists. For

Performance Year 2026 and subsequent performance years, the PCPAT used to calculate the PPC Payment Amount is the PCPAT raised to an exponent equal to the difference between the current performance year and 2024:

$$\text{PCPAT associated with PY20XX} = \text{PCPAT}^{(\text{PY20XX-2024})}$$

$$\text{For PY2025} = \text{PCPAT}^{1}$$

$$\text{For PY2026} = \text{PCPAT}^{2}$$

4.1.4 Seasonality Adjustment

The County Base Rates and the FQHC and RHC Add-on Amounts are calculated using 12 calendar months of data for the applicable BYs. For Performance Year 2025, the portion of the PPC Payment corresponding to the County Base Rate and FQHC and RHC Add-ons will commence with the July 2025 payment and will be paid for beneficiary months between July and December 2025. To account for the partial year payment of these portions of the PPC Payment in Performance Year 2025, CMS will apply, national seasonality adjustment, separately for A&D and ESRD beneficiaries to the County Base Rates and FQHC and RHC Add-on Amounts paid for PPCP-eligible beneficiary months between July and December 2025. The seasonality adjustment accounts for natural variability in Medicare expenditures for primary care services over the course of a CY. Examples of seasonality in Medicare expenditures include the following:

- Average Medicare expenditures for primary care are typically lower in earlier months of the CY until beneficiaries reach their deductible.
- Certain types of services, such as visits for flu, may be more prevalent during certain months of the year.

The seasonality adjustment will be calculated separately for the A&D and ESRD populations using historical data as follows:

- **Step 1.** Separately for each CY of 2021 to 2023, determine the national average Medicare expenditures for eligible primary care services (see list of codes in Appendix B, Table B-1) delivered by eligible providers (see list of specialty codes in Appendix C) by month of service.[37] Table 19 provides an illustrative example.

[37] For institutional claims at FQHC and RHCs, all claims and claim lines are considered eligible primary care services delivered by eligible providers. Expenditures are defined the same way as those used to construct the National Conversion Factor for the County Rate Book development.

Table 19: Illustrative Example of Medicare Expenditures by Month of Service in Step 1

	Medicare Expenditures (millions)											
Month of Service	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2021	$6,900	$7,340	$9,390	$9,040	$8,620	$9,310	$8,790	$9,210	$9,400	$9,640	$9,180	$8,800
2022	$6,870	$7,530	$9,190	$8,570	$8,890	$9,080	$8,280	$9,500	$9,270	$9,730	$9,200	$8,660
2023	$7,430	$7,930	$9,440	$8,590	$9,620	$9,330	$8,610	$9,890	$9,530	$10,980	$9,890	$8,910

- **Step 2.** Separately for each CY of 2021 to 2023, determine the number of beneficiaries associated with an eligible primary care service (see list of codes in Appendix B, Table B-1) delivered by eligible providers (see list of specialty codes in Appendix C) for each month of service. Table 20 provides an illustrative example.

Table 20: Illustrative Example of Beneficiary Counts by Month of Service in Step 2

	Beneficiary Counts (millions)											
Month of Service	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2021	30	30	30	31	32	32	32	32	32	32	32	32
2022	29	29	29	30	31	31	31	31	31	31	31	31
2023	28	28	28	29	30	30	30	30	30	30	30	30

- **Step 3.** Separately for each CY, determine the total Medicare expenditures and the total number of beneficiary months for the *full 12-month CY*:
  - **Step 3a.** Sum the total Medicare expenditures in Step 1 across all 12 months of the CY. **Using the illustrative example, this value is $105,620 (in millions) for CY 2021.**
  - **Step 3b.** Sum the total number of beneficiaries in Step 2 across all 12 months of the CY to determine the number of beneficiary months. **Using the illustrative example, this value is 377 (in millions) for CY 2021.**
- **Step 4.** Separately for each CY, determine the total Medicare expenditures and the total number of beneficiary months for the *last 6 months of the year*:
  - **Step 4a.** Sum the total Medicare expenditures in Step 1 for months 7 to 12 (i.e., the total Medicare expenditures during the last 6 months of the year). **Using the illustrative example, this value is $55,020 (in millions) for CY 2021.**
  - **Step 4b.** Sum the number of beneficiaries in Step 2 for months 7 to 12 (i.e., the total beneficiary months during the second half of the year). **Using the illustrative example, this value is 192 (in millions) for CY 2021.**
- **Step 5.** Separately for each CY, determine average PBPM Medicare expenditures for the full 12-month CY and the last 6 months of the year, separately:

  - **Step 5a**: Calculate the average PBPM Medicare expenditures for the full 12-month CY as: (Result from Step 3a) / (Result from Step 3b). **Using the illustrative examples, this value is calculated as $105,620/377 = $280.16 for CY 2021.**
  - **Step 5b**: Calculate the PBPM Medicare expenditures for the last 6 months of the year as: (Result from Step 4a) / (Result from Step 4b). **Using the illustrative examples, this value is calculated as $55,020/192 = $286.56 for CY 2021.**

- **Step 6.** Separately for each CY, calculate the annual ratios as the ratio of PBPM Medicare expenditures for the last 6 months in the CY (result from Step 5b) to the PBPM Medicare expenditures for the full 12 months in the CY (result from Step 5a). **Using the illustrative examples, this value is calculated as $286.56/$280.16= 1.023 for CY 2021.**

- **Step 7.** Take the average of the annual ratios for CY 2021, CY 2022, and CY 2023 to calculate the final seasonality adjustment factors for the A&D and ESRD populations. **Using the illustrative examples, this value is calculated as the mean of (1.023, 1.023, and 1.029) = 1.025.** Note: this is *not* the final seasonality adjustment factor; it is only shown for purposes of demonstrating the calculation. The final seasonality adjustment factors are calculated separately for the A&D and ESRD populations. For PY2025, the final ESRD Seasonality Adjustment Factor will be 1.024, and the final A&D Seasonality Adjustment Factor will be 1.098.

Comparison to Fee Reductions and Additional Payment Amount for Beneficiaries with FQHC- or RHC-Focused Carefinal ESRD Seasonality Adjustment Factor will be 1.024, and the final A&D Seasonality Adjustment Factor will be 1.098.

4.1.5 Comparison to Fee Reductions and Additional Payment Amount for Beneficiaries with FQHC- or RHC-Focused Care

To ensure that ACOs are appropriately funded for PPCP-eligible beneficiaries with FQHC- or RHC-focused care, CMS will monitor the PPC Payment compared to actual fee reductions on a quarterly basis. Should PPC Payments for these beneficiaries be less than actual fee reductions on a year-to-date (YTD) basis, additional payment will be made. This will be evaluated on an individual ACO basis for the ACO's total population that received the plurality of their primary care services at an FQHC or RHC. Each quarter, CMS will calculate the YTD difference between the relevant PPC Payment components, including any prior adjustment for the performance year, and the actual FFS fee reductions to determine an additional payment amount.

CMS will calculate an additional payment amount, if applicable, for PPCP-eligible beneficiaries with FQHC-focused care as follows:

- **Step 1.** CMS calculates the FQHC True-up Amount as the difference between the YTD amount of PPC Payment Fee Reductions for the PPCP-eligible beneficiaries with FQHC-focused care and the sum of the total YTD Base PPC Payment Amount, Adjusted County Enhancement, and Adjusted Enhancement Add-on Amount.

$$\text{FQHC True-up Amount} = \sum(\text{YTD PPC Payment Fee Reductions for PPCP-eligible beneficiaries with FQHC-Focused Care}) - \sum(\text{YTD Base PPC Payment Amount} + \text{Adjusted County Enhancement} + \text{Adjusted Enhancement Add-on Amount})$$

- **Step 2.** If the value of the FQHC True-up Amount is positive, CMS will increase the PPC Payment Amount by the FQHC True-up Payment up to amount equal to the FQHC True-up Amount. If CMS has paid any previous FQHC True-up Payment to the ACO, CMS will then subtract the sum of any previous FQHC True-up Payments made for the performance year from the increased PPC Payment Amount.

  If FQHC True-Amount is greater than zero;

  $$\text{FQHC True-up Payment} = \text{FQHC True-Amount} - \text{previously paid FQHC True-up Payment for performance year}$$

- **Step 3.** CMS calculates the FQHC True-up Payment PBPM to allocate the FQHC True-up Payment by dividing the FQHC True-up Payment by the total number of months that PPCP-eligible beneficiaries with FQHC-focused care were assigned to the ACO. CMS increases the PPC Payment Amount by the FQHC True-up Payment PBPM.

  $$\text{FQHC True-up Payment PBPM} = \text{FQHC True-up Payment} / \sum(\text{YTD PPCP-Eligible beneficiary months with FQHC-focused care})$$

CMS will not recover all or a portion of prior FQHC True-up Payments paid to the ACO if the FQHC True-up Payment calculated each quarter is less than any prior FQHC True-up Payments paid to the ACO. CMS will calculate an additional payment amount, if applicable, for PPCP-eligible beneficiaries with RHC-focused care. The additional payment amount calculation for beneficiaries with RHC-focused care follows the same steps as detailed above, but uses the RHC-focused care population in place of the FQHC-focused care population.

4.1.6 Limit on Enhanced PPC Payment Amount

A limit is applied to the aggregate Enhanced PPC Payment Amount described in Section 3.7. The combined value of the County Enhancement, Flex Enhancement, and Enhancement Add-on for a PC Flex ACO is limited to $300 PBPY (or $25 PBPM) after adjustments for clinical risk, PCOA (for the County Enhancement only) and the PCPAT. This limit is not applied at the individual beneficiary level. Rather, it is an aggregate average applied at the individual ACO level, based on total enhancement dollars divided by the ACO's total average PPCP-eligible beneficiary months. The impact of the limit, if any, will be allocated to the ACO's PPCP-eligible beneficiary months based on share of the ACO's total PPCP-eligible beneficiary months.

For instance, consider a PC Flex ACO determined to have $3,520,000 in adjusted total enhancement dollars (before application of the limit), and 120,000 PPCP-eligible beneficiary months. As a result, the PC Flex ACO has $29.33 in adjusted total enhancement dollars PBPM, exceeding the $25 PBPM limit. The amount in excess of the limit ($4.33 PBPM) is then deducted from the adjusted total enhancement amount determined for each individual PPCP-eligible beneficiary month assigned to the PC Flex ACO.

The Limit on Enhancement Calculation and Application is as follows, using the above example's amounts:

$$\text{Enhancement Limit Amount PBPM} = \$300 / 12 \text{ or } \$25$$

$$\text{ACO Enhancement Amount PBPM} = \sum (\text{YTD Enhancement Amount for all PPCP-eligible beneficiaries}) / \sum (\text{YTD PPCP-eligible beneficiary months})$$

The Enhancement Limit Adjustment is calculated as follows:

$$\text{Enhancement Limit Adjustment} = (\text{ACO Enhancement Amount PBPM} - \text{Enhancement Limit Amount PBPM}); \text{ where the minimum value for the Enhancement Limit Adjustment is } \$0 \text{ PBPM}$$

4.1.7 Population Adjustment

The ACO PC Flex Model adjusts the amount of PPC Payment payable to a PC Flex ACO to account for relative differences in beneficiary resources, referred to as the Population Adjustment.

The Population Adjustment is a beneficiary-level adjustment that is intended to encourage PC Flex ACOs to attract more medically underserved communities by accounting for historically suppressed spending levels for these populations. It is a critical step toward strengthening resources for the care of medically underserved communities enabling ACOs to serve these communities in a manner that reflects their health needs.

In the ACO PC Flex Model, a PBPM dollar adjustment (summarized in Table 21 below) is made for the PPCP-eligible beneficiaries in the model with the highest Population Scores (resulting in a positive adjustment) and those with the lowest Population Scores (which result in negative adjustments). All PPCP-eligible beneficiaries in a PC Flex ACO receive a Population Score, although not all may receive a Population Adjustment.

A PPCP-eligible beneficiary's Population Score is determined using a composite methodology consisting of community- and beneficiary-level measures of deprivation. For Performance Year 2025, the Population Adjustment includes four measures: the National Area Deprivation Index (ADI) and State ADI, as well as Dual Eligibility Status and Low-Income Subsidy, which are both used to determine the low-income marker.

- **The National ADI** is a composite measure of several social determinant of health (SDOH) factors,[38] collected at the census block group level. CMS determines the National ADI that corresponds to the census block in which the PPCP-eligible beneficiary resides on the first day of each month of assignment to the ACO in the applicable performance year.

  If the PPCP-eligible beneficiary does not have an address on the first day of the current month as of assignment to the ACO in the applicable performance year, has a suppressed National ADI, or has incomplete data such that their census block group, census tract, county, and state cannot be determined, CMS uses the average of the National ADIs for all PPCP-eligible beneficiaries assigned to the PC Flex ACO (found by dividing the sum of the

[38] Full documentation on the ADI can be found here: https://www.neighborhoodatlas.medicine.wisc.edu/.

National ADIs for all PPCP-eligible beneficiaries assigned to the ACO by the number of all PPCP-eligible beneficiaries who have addresses on the first day of the month of assignment to the ACO).

- **The State ADI** is a composite measure of several SDOH factors, collected at the census block group level. CMS determines State ADI that corresponds to the census block in which the PPCP-eligible beneficiary resides on the first day of each month of assignment to the ACO in the applicable performance year.

  If the PPCP-eligible beneficiary does not have an address on the first day of the month as of assignment to the ACO in the applicable performance year, has a suppressed State ADI, or the PPCP-eligible beneficiary has incomplete data such that their census block group, census tract, county, and state cannot be determined, CMS uses the average of the State ADIs for all PPCP-eligible beneficiaries assigned to the ACO by dividing the sum of the State ADIs for all PPCP-eligible beneficiaries assigned to the ACO by the number of PPCP-eligible beneficiaries who have addresses on the first day of the month of assignment to the ACO.

- The low-income marker is determined through **Dual Eligibility Status** and **Low-Income Subsidy** Status and determined at the beneficiary-month level. If a PPCP-eligible beneficiary is fully or partially dually eligible for both Medicare and Medicaid (i.e., Medicare-Medicaid Dual Eligibility Code of 01, 02, 03, 04, 05, 06, 07, or 08) or determined eligible for a Medicare Part D low-income subsidy during any month of the performance year, CMS shall assign a low-income marker of 1. If a PPCP-eligible beneficiary is not dually eligible nor determined eligible for a Medicare Part D low-income subsidy at any point in the performance year, CMS shall assign a low-income marker of 0.

For Performance Year 2025, the ADI is used in two ways: the National ADI, which measures deprivation relative to all block groups across the nation, and the State ADI, which measures deprivation relative to all block groups in the state in which the PPCP-eligible beneficiary resides. The Population Score is calculated as 0.5 times the National ADI for the block group a PPCP-eligible beneficiary resides in, plus 0.5 times the State ADI for the block group a PPCP-eligible beneficiary resides in, plus 50 times the low-income marker. From these three components, a beneficiary-level Population Score is calculated according to the equation below for every beneficiary *b* and their corresponding geography *g*. This calculation is performed for beneficiaries in the CY 2023 ACO PC Flex National Reference Population (excluding beneficiaries who only received primary care services from specialists) and among PPCP-eligible beneficiaries:

$$Population\ Score_{b,g} = 0.5\left(National\ ADI_{b,g}\right) + 0.5\left(State\ ADI_{b,g}\right) + (50 \times LIM_b)$$

In the above formula, $National\ ADI_{b,g}$ and $State\ ADI_{b,g}$ are the ADI scores of the block group in which a given beneficiary resided. LIM_b is a low-income marker comprised of two low-income indicators: Dual Eligibility and Low-Income Subsidy. If a beneficiary has been fully or partially Dual Eligible or enrolled in the low-income subsidy for any month in the CY, LIM_b will be equal to 1, else 0. Therefore, $Population\ Score_{b,g}$ can range from 1 through 150.

CMS compares the Population Scores of PPCP-eligible beneficiaries to the distribution of Population Scores in the ACO PC Flex National Reference Population, excluding beneficiaries who only received primary care services from specialists. This is used to calculate the Population Adjustment Amount. More specifically, the percentile, P_x, of a given PPCP-eligible beneficiary's Population Score relative to the Population Scores among the reference population translates to a corresponding PBPM Population Adjustment Amount, as shown in Table 21.

Table 21: Population Adjustment to the PPC Payment Amount

Population Score Range (Percentile)	PBPM Adjustment
$Population\ Sc_b \geq P_{90}$	$3
$P_{80} \leq Population\ Sc_b < P_{90}$	$2
$P_{70} \leq Population\ Sc_b < P_{80}$	$1
$P_{30} \leq Population\ Sc_b < P_{70}$	$0
$P_{20} \leq Population\ Sc_b < P_{30}$	-$1
$P_{10} \leq Population\ Sc_b < P_{20}$	-$2
$Population\ Sc_b < P_{10}$	-$3

For each PPCP-eligible beneficiary month for each beneficiary with a score at or above the 90th percentile of Population Scores, CMS will add $3 to the PPC Payment. For each PPCP-eligible beneficiary month for each beneficiary with a score at or above the 80th percentile but below the 90th percentile, CMS will add $2 to the PPC Payment. For each PPCP-eligible beneficiary month for each beneficiary with a score at or above the 70th percentile but below the 80th, CMS will add $1 to the PPC Payment. For each PPCP-eligible beneficiary month for each beneficiary with a score below the 30th percentile but above the 20th percentile, CMS will deduct $1 from the PPC Payment. For each PPCP-eligible beneficiary month for each beneficiary with a score below the 20th percentile but above the 10th percentile, CMS will deduct $2 from the PPC Payment. For each PPCP-eligible beneficiary month for each beneficiary with a score below the 10th percentile, CMS will deduct $3 from the PPC Payment.

4.1.8 Operational Payment Precision Withhold

CMS will apply a prospective discount, known as the Payment Precision Withhold, to the Base PPC Payment Amount of not more than 3 percent to create a buffer against potential non-reduction of PPCP-eligible services claims (i.e., claims for CPT/HCPCS codes listed in Appendix B, Table B-1 billed by primary care providers for PPCP-eligible beneficiaries which should be reduced by 100 percent but are not; see also Subsection 4.6 for more details on fee reductions). Non-reduction of PPCP-eligible services claims can occur as a result of implementation of payment mechanism and claims processing issues. Examples include the following:

- Reprocessing of non-reduced claims after a claims run-out period specified by CMS
- Processing errors that remain unresolved after a claims run-out period specified by CMS

- Claims incurred in the performance year but not submitted prior to the end of a claims run-out period specified by CMS
- Performance year claims that are suppressed from data sharing and fee reductions due to inclusion of substance use disorder information

The Payment Precision Withhold would allow for up to a 3-percent non-reduction rate on claims for primary care services without needing to reprocess claims such that they match remitted PPC Payment amounts. The Payment Precision Withhold is applied to a PC Flex ACO's Base PPC Payment, before Medicare sequestration. For PY2025, no Payment Precision Withhold will be applied.

4.1.9 Application of Medicare Sequestration

After applying the Population Adjustment and the Payment Precision Withhold, the resulting total PPC Payment is subject to 2-percent Medicare sequestration as required by federal rulemaking.

4.2 Calculation of Monthly PPC Payment for a Beneficiary

For a given PPCP-eligible beneficiary, the monthly PPC Payment Amount prior to sequestration is calculated as follows:

$$\begin{aligned} PPC\ Payment = {} & (PPW \times Base\ PPC\ Amount) \\ & + (Enhancement\ Amount - Enhancement\ Limit\ Adjustment) \\ & + FQHC\ True - Up\ Payment\ PBPM + RHC\ True - Up\ Payment\ PBPM \\ & + Population\ Amount \end{aligned}$$

Each component of the pre-sequestration monthly PPC Payment calculation for a given PPCP-eligible beneficiary is defined below.

- **Payment Precision Withhold** (PPW above): Defined in Subsection 4.1.8.
- **Base PPC Payment Amount:** The sum of the Adjusted County Base Rate, Adjusted FQHC and RHC Add-on, and Base Rate Add-on.
  - Adjusted County Base Rate is the amount of the County Base Rate after adjusting for seasonality, risk, PCOA, and PCPAT.
  - Adjusted FQHC and RHC Add-on (if applicable) is the amount of the FQHC and RHC Add-on after adjusting for seasonality, risk, PCOA, and PCPAT.
  - Base Rate Add-on: Defined in Section 3.6.
- **Enhancement Amount:** The sum of the Adjusted County Enhancement, Adjusted Flex Enhancement, and Enhancement Add-on.
  - Adjusted County Enhancement (if applicable) is the amount of the County Enhancement after adjusting for risk, PCOA, and PCPAT.

- Adjusted Flex Enhancement is the amount of the Flex Enhancement after adjusting for risk and PCPAT.
- Adjusted Enhancement Add-on is the amount of the Enhancement Add-on after adjusting for risk and PCPAT.

- **Enhancement Limit Adjustment:** Defined in Subsection 4.1.6.
- **FQHC True-up Payment PBPM:** CMS will calculate the difference between (1) the total YTD amount of PPC Payment Fee Reductions for the PPCP-eligible beneficiaries with FQHC-focused care and (2) the sum of the total YTD Base PPC Payment Amount, Adjusted County Enhancement, and Adjusted Enhancement Add-on Amount, then pay this difference.
- **RHC True-up Payment PBPM:** CMS will calculate the difference between the total YTD amount of PPC Payment Fee Reductions for the PPCP-eligible beneficiaries with RHC-focused care and the sum of the total YTD Base PPC Payment Amount, Adjusted County Enhancement, and Adjusted Enhancement Add-on Amount and pay this difference.
- **Population Adjustment Amount**: Defined in Subsection 4.1.7.

4.3 In-Year Retrospective Adjustments

In some cases, the PPC Payment must be updated retroactively for individual beneficiary months to reflect changes in beneficiary eligibility status, risk scores, and normalization factors, beneficiary county of residence, and other changes. This ensures appropriate payment as well as accurate recording of the PPC Payment at the beneficiary level.

For each month of a performance year, CMS will recalculate the monthly PPC Payment Amount for all prior months of the performance year in accordance with, using updated risk scores and normalization factors, beneficiary eligibility and assignment status, beneficiary county of residence, and any other applicable updated information available to CMS at the time of the recalculation.

Table 22 summarizes example beneficiary status changes occurring during a given performance year that may result in retrospective adjustments.

Table 22: Potential Retrospective Adjustments and Implications

Status Change Resulting in Retrospective Adjustment [a]	Potential Implication of Change
Beneficiary Mortality	Retroactive termination under Prospective Assignment; recoupment procedure applied under Preliminary Prospective Assignment with Retrospective Reconciliation (see Section 4.5 for details on the recoupment procedure)
Enrollment in MA	Retroactive termination under Prospective Assignment; recoupment procedure applied under Preliminary Prospective Assignment with Retrospective Reconciliation
Dual eligibility	Impact to Population Adjustment (see Subsection 4.1.7)
ESRD status	Impact to assignment of ESRD vs. A&D County Base Rate, County Enhancement, and risk scores used for risk adjustment

Status Change Resulting in Retrospective Adjustment [a]	Potential Implication of Change
Risk score and normalization factor	Impact to clinical risk adjustment of PPC Payment components (see Subsection 4.1.1, Table 17: Performance Year 2025 Risk Score Measurement Calendar and Table: 18 Performance Year 2025 Risk Score and Payment Calendar)
Change of residence	Impact to assignment of County Base Rate, County Enhancement, and ADI used for Population Adjustment (see Subsection 4.1.7)

[a] CMS Center for Medicare and Medicaid Innovation will check for updates to all of the status changes listed above no less than every 3 months and will incorporate status updates into the earliest possible subsequent monthly payment.

Adjustments to past payments for which information is known within the performance year will be retrospectively applied to the earliest possible subsequent monthly payment. Reporting and settlement timelines will require a final cut-off date for adjustments earlier than March 31 following the performance year to accommodate incorporation of final PPC Payment data into the Non-Claims-Based Payment System by March 31 of each CY.

4.4 Calculation of Monthly PPC Payment ACO

At the ACO level, the PPC Payment paid to the ACO will equal to the sum of Monthly PPC Payments for all PPCP-eligible beneficiaries as of the monthly PPC Payment Report, minus any Monthly PPC Payments previously paid to the ACO.

Table 23 is an example of how the payment of Monthly PPC Payments will be operationalized at the ACO level.

Table 23. Example of Monthly PPC Payments at the ACO Level

Payment Period	January PPC Payment Report	February PPC Payment Report
January	$250,000	$251,000
February	-	$249,000
YTD PPC Payment for ACO	$250,000 (January PPC Payment)	$500,000 = $251,000 + $249,000 (January PPC Payment + February PPC Payment)
PPC Payment Paid to ACO (YTD PPC Payment for ACO minus Previous PPC Payment Paid to ACO)	$250,000	($500,000 − $250,000) = $250,000

4.5 Recoupment

Recoupment is the process of recovering money from ACOs that was originally paid and later calculations reveal should not have been paid. When the recoupment procedure is triggered for

a beneficiary (for example due to ineligibility as explained in Subsection 2.3), the following occur:

- All PPC Payment will be recouped for any payments made YTD for the beneficiary by reducing the PC Flex ACO's total PPC Payment for the month in which the recoupment is made (except in those cases of ineligibility which only apply going forward such as ineligibility due to death, which although they could result in recoupment, do not go back for the entire YTD).
- Claim reductions for the beneficiary will stop.
- Claims already reduced for the year will be reprocessed and paid to the billing provider normally as FFS.
    - Note that it is mathematically possible that PPC Payment recoupment resulting from a quarterly assignment run could exceed the next month's Total PPC Payment Amount. For example, there may be a situation where, for an ACO that selected Preliminary Prospective Assignment with Retrospective Reconciliation, a number of beneficiaries who were assigned via Step 1 or Step 3 in the initial assignment run are assigned via Step 2 in a subsequent quarterly assignment run. Because these beneficiaries are no longer PPCP-eligible beneficiaries for the full performance year, all PPC Payment funds paid YTD for these beneficiaries would need to be recouped in the next available monthly report; it may be the case that this recoupment amount is larger than the total PPC Payment to be paid for the ACO's remaining PPCP-eligible beneficiaries in that report month.

4.6 Fee Reductions

The PPC Payment will be paid to PC Flex ACOs in lieu of reimbursement for claims billed for most primary care services provided to PPCP-eligible beneficiaries by participating primary care providers. PC Flex ACOs will determine and distribute payments to participating primary care providers. Primary care providers within a participating PC Flex ACO will continue to submit claims to CMS for services provided to assigned beneficiaries.

4.6.1 Primary Care Services Subject to Fee Reductions

CMS will reduce claims payment amounts according to the standards detailed below for primary care services furnished to PPCP-eligible beneficiaries, by primary care providers participating in a PC Flex ACO (i.e., PPCP-eligible participants).

Profession and institutional claims for primary care services subject to PPC Payment fee reductions are identified as follows:

- **Professional claims:** Claims for certain evaluation and management office services for both new and established beneficiaries using the CPT and HCPCS codes listed in Appendix B, Table B-1 and billed by a primary care provider, defined as the specialty codes listed in Appendix C, Tables C-1 and C-2. See Subsection 4.6.4 below for details related to NPPs designated as specialty practice NPPs.

- **Institutional claims**: All services billed by FQHCs (type of bill = 77x) and RHCs (type of bill 71x, respectively). Claims for non-ETA HOPD (type of bill = 13x), ETA hospital (type of bill = 13x), and CAH method II (type of bill = 85x with revenue codes 096x, 097x, or 098x) for certain evaluation and management services for both new and established beneficiaries using the CPT/HCPCS codes described in Appendix B, where the rendering provider has one of the primary care specialist codes listed in Appendix C.

The CPT and HCPCS codes that correspond to primary care services used to calculate the County Base Rate and fee reductions are listed in Appendix B, Table B-1. Note that they are the same as codes used for beneficiary assignment in the Shared Savings Program, with the following exceptions:

- Primary care services in ACO PC Flex include HCPCS code G0463 (hospital outpatient clinic visit) if billed by a primary care provider.
- Primary care services in ACO PC Flex include CPT codes 99497 and 99498 (advance care planning services).[39]
- Primary care services in ACO PC Flex exclude CPT codes 99304-99318 (professional services furnished in a nursing facility) because the ACO PC Flex Model considers these services to be post-acute care rather than primary care.
- Primary care services in ACO PC Flex exclude HCPCS codes G2086, G2087, and G2088 (office-based opioid use disorder services)

4.6.2 Claims Excluded from Fee Reduction

Primary care services provided to PPCP-eligible beneficiaries will not be subject to a 100 percent fee reduction under certain circumstances. These include the following:

- Claims payments where Medicare is not the primary payer;
- Claims payments for providers enrolled in the periodic interim payments program or other Medicare programs or initiatives specified by CMS prior to the start of the performance year;
- Quarterly Medicare Health Professional Shortage Area Bonus Payments; and
- Claims payments for services related to the diagnosis and treatment of substance use disorder.

4.6.3 Fee Reduction for Primary Care Services Performed by Specialists

Primary care services performed by specialist physicians are not included in the calculation of PPC Payment or subject to fee reduction because it is not possible to distinguish between primary and specialty services provided by specialist physicians in claims.

All claims from FQHCs and RHCs are subject to fee reduction.

[39] See Appendix B, Table B-1, for the list of valid primary care CPT/HCPCS codes.

As described in Section 2, the Shared Savings Program beneficiary assignment methodology uses a step-wise process that considers the plurality of primary care services, measured by allowed charges, for different categories of providers. Although beneficiaries are assigned to PC Flex ACOs using the Shared Savings Program methodology, the PPC Payment will not be paid for beneficiaries assigned via Step 2 (beneficiaries who only received primary care services from specialist physicians) nor will claims be reduced for these beneficiaries. PPC Payment will also not be made for beneficiaries who, through voluntary alignment, identified as their primary clinician a specialty physician whose specialty is included in the Step 2 list of specialties. All claims by FQHCs and RHCs are considered primary care claims and are included in Step 1 of assignment. Additionally, all claims will be reduced for PPCP-eligible beneficiaries at an FQHC or RHC that is on the PPCP-eligible participant list for the ACO to which the beneficiary is assigned.

4.6.4 Fee Reduction for Primary Care Services Performed by NPPs in a Specialty Practice

It is not possible to identify the clinical specialty of NPPs or to distinguish primary care from specialty care provided by an NPP. NPPs designated as specialty practice NPPs by PC Flex ACOs in their PPCP-eligible participant list will not have claims reduced for PPCP-eligible beneficiaries whose NPIs are specialty NPPs.

Note that during the application process and PPCP-eligible participant list process, PC Flex ACOs designate by their NPI each ACO professional that is an NPP as either a “primary care” NPP or a “specialty care” NPP. Once an NPI has been designated as one of those categories by the PC Flex ACO, a change of designation for that provider NPI will not be permitted unless documentation is provided to support a change of clinical practice. Acceptable documentation includes but is not limited to a change in the NPI’s National Plan and Provider Enumeration System taxonomy registration. In the event that an NPP ACO professional’s designation is successfully changed, it will become effective for the purposes of fee reductions and other PPC Payment adjustments on January 1 of the next performance year. Because all claims submitted by FQHCs and RHCs are considered primary care claims, there will be no exclusion of any ACO professionals for these claims for the purposes of fee reductions. For NPPs who exclusively submit claims through an FQHC or RHC, PC Flex ACOs do not need to designate the NPP as “primary care” or “specialty care.” If the NPP also submits claims under a TIN or CCN that is not an FQHC or RHC, however, the PC Flex ACO will be required to provide the designation.

4.7 Performance Year 2025 Delay of Fee Reductions

For Performance Year 2025, the start date of claim reductions for primary care services billed by ACO Participants for PPCP-eligible beneficiaries in the ACO PC Flex Model begins July 1, 2025, and is applied for dates of service on or after July 1, 2025. As a result, the portion of the PPC Payment corresponding to the County Base Rate and add-ons for beneficiaries with FQHC- or RHC-focused care (i.e., FQHC and RHC Add-ons) is not paid for otherwise-eligible beneficiary months between January and June of 2025.

Payments that are administered starting January 2025 are as follow:

- Payment of the one-time Advance Shared Savings Payment; and
- Partial payment of the PPC Payment, including the County Enhancement (where eligible) and the Flex Enhancement with adjustments for risk, PCOA, and trend (i.e., PCPAT), as well as the Population Adjustment. These components of the PPC Payment will be subject to the same retrospective updates described in Section 4.5 above.

Payment of the full PPC Payment, including the County Base Rate FQHC and RHC Add-ons, Flex Enhancement, and Enhancement Add-on commences with the July 2025 payment and will be paid for beneficiary months between July and December 2025. The seasonality adjustment is applied to the County Base Rates and FQHC and RHC Add-on Amount accounts for partial year payment of the PPC Payment portions in Performance Year 2025.

4.8 Performance Year 2025 Rate Book Guardrail Provision: Determination of Applicable Rate Book for Performance Year 2025 PPC Payment Calculations

Once the 2025 Updated ACO PC Flex Rate Book is published, CMS will employ the methodology described in this section to determine which Rate Book (Preliminary or Updated) to use to calculate the PPC Payment for each PPCP-eligible beneficiary for each month of Performance Year 2025. This methodology will serve as a guardrail to make sure ACOs are not paid any less after transitioning from the Preliminary to the Updated Rate Book.

For Performance Year 2025, for each month from January through June, CMS will use whichever Rate Book (Preliminary or Updated) that results in the greater County Enhancement amount for the month for each PPCP-eligible beneficiary. In other words:

- **If the amount of the County Enhancement for the 2025 Preliminary Rate Book is greater than the amount of the County Enhancement for the 2025 Updated Rate Book** , then CMS will use enhancement amount from the 2025 Preliminary Rate Book to calculate the PPC Payment for the beneficiary for the month.
- **If the amount of the County Enhancement for the 2025 Preliminary Rate Book is less than the amount of the County Enhancement for the 2025 Updated Rate Book** , then CMS will use enhancement amount from the 2025 Updated Rate Book to calculate the PPC Payment for the beneficiary for the month.

For Performance Year 2025, for each month July through December, CMS will first compute the 2025 Preliminary Rate Book Amount and 2025 Updated Rate Book Amount for each PPCP-eligible beneficiary as follows:

- The **2025 Preliminary Rate Book Amount** is the sum of the County Enhancement for the beneficiary's county, the FQHC or RHC Add-on (if applicable), and County Base Rate for the beneficiary's county, all from the 2025 **Preliminary** Rate Book.

- The **2025 Updated Rate Book Amount** is the sum of the County Enhancement for the beneficiary's county, the FQHC or RHC Add-on (if applicable), and County Base Rate for the beneficiary's county, all from the 2025 **Updated** Rate Book.

CMS will then use these two amounts to determine the County Enhancement, FQHC or RHC Add-on (if applicable), and County Base Rate to use for each PPCP-eligible beneficiary for the month as follows:

- **If the 2025 Preliminary Rate Book Amount is greater than 2025 Updated ACO PC Flex Rate Book Amount**, CMS will calculate the beneficiary's PPC Payment for the month using all values (County Enhancement, County Base Rate, and, if applicable, FQHC or RHC Add-on) from the Preliminary County Rate Book.
- **If the 2025 Preliminary Rate Book Amount is less than 2025 Updated ACO PC Flex Rate Book Amount**, CMS will calculate the beneficiary's PPC Payment for the month using the following values:
  - **County Enhancement:** The greater of 2025 Preliminary Rate Book County Enhancement and 2025 Updated Rate Book County Enhancement.
  - **County Base Rate:** Value equal to the 2025 Updated Rate Book Amount minus the sum of (1) the greater of 2025 Preliminary Rate Book County Enhancement and 2025 Updated Rate Book County Enhancement and (2) the FQHC or RHC Add-on (if applicable) from the 2025 Updated Rate Book. Note that the sum of the County Enhancement, FQHC or RHC Add-on, and County Base Rate will be equal to the 2025 Updated Rate Book Amount.
  - **FQHC or RHC Add-on (if applicable):** The add-on value from the 2025 Updated Rate Book.

Table 24 presents 2025 Preliminary Rate Book Values (actual) and 2025 Updated Rate Book values (hypothetical) for a hypothetical beneficiary with RHC-focused care who is PPCP-eligible and classified as ESRD for all 12 months of Performance Year 2025.

Table 24: Hypothetical Example Where 2025 Preliminary Rate Book Amount Is Greater than 2025 Updated Rate Book Amount

Row	PPC Payment Component	Values from 2025 Preliminary Rate Book	Values from 2025 Updated Rate Book
[A]	County Enhancement [A]	$5.15	$6.00
[B]	RHC Add-on [B]	$38.78	$38.00
[C]	County Base Rate [C]	$53.50	$52.00
[D]	Rate Book Amount [D] = [A] + [B] + [C]	$97.43	$96.00

Note that while values in the Preliminary Rate Book Column are drawn from the actual 2025 Preliminary Rate Book, values in the Update Rate Book Column are purely hypothetical and shown for illustrative purposes only.

For each month of January through June, CMS will calculate the beneficiary's PPC Payment Amount using the greater of the two County Enhancement values from row [A] in Table 24 above which, in this case, is the value from the 2025 Updated Rate Book ($6.00).

For each month of July through December, CMS will determine which values to use for the beneficiary's PPC Payment Amount calculation based on the higher of the two Rate Book Amount values from row [D]. In this case, the Preliminary Rate Book Amount ($97.43) is greater than the Updated Rate Book Amount ($96.00), so CMS will use the following values to compute the PPC Payment:

- For the County Enhancement, CMS will use the value from the Preliminary Rate Book in row [A] ($5.15).
- For the RHC Add-on, CMS will use the value from the Preliminary Rate Book from row [B] ($38.78).
- For the County Base Rate, CMS will use the value from the Preliminary Rate Book from row [C] ($53.50).

Table 25 presents 2025 Preliminary Rate Book values (actual) and 2025 Updated Rate Book values (hypothetical) for a different hypothetical beneficiary who has FQHC-focused care, is PPCP-eligible, and is classified as A&D for all 12 months of Performance Year 2025.

Table 25: Hypothetical Example Where 2025 Preliminary Rate Book Amount Is Less than 2025 Updated Rate Book Amount

PPC Payment Component	Values From 2025 Preliminary Rate Book	Values From 2025 Updated Rate Book
County Enhancement [A]	$2.46	$2.00
FQHC Add-on [B]	$32.22	$34.00
County Base Rate [C]	$38.05	$39.00
Rate Book Amount [D] = [A] + [B] + [C]	$72.73	$75.00

Note that while values in the 2025 Preliminary Rate Book Column are drawn from the actual 2025 Preliminary Rate Book, values in the 2025 Update Rate Book Column are purely hypothetical and shown for illustrative purposes only.

For each month of January through June, CMS will calculate the beneficiary's PPC Payment Amount using the greater of the two County Enhancement values from row [A] which, in this case, is the value from the 2025 Preliminary Rate Book ($2.46).

For each month July through December, CMS will determine which values to use for the beneficiary's PPC Payment Amount calculation based on the higher of the two Rate Book Amount values from row [D]. In this case, the Preliminary Rate Book Amount ($72.73) is less than the Updated Rate Book Amount ($75.00), so CMS will use the following values to compute the PPC Payment:

- For the County Enhancement, CMS will use the greater of the two values from row [A] which, in this case, is the value from the 2025 Preliminary Rate Book ($2.46).

- For the FQHC Add-on, CMS will use the value from the 2025 Updated Rate Book from row [B] ($34.00).
- For the County Base Rate, CMS will use a value equal to the Updated Rate Book Amount from row [D] ($75.00) minus the sum of (1) the greater of the two County Enhancement values ($2.46) from row [A] and (2) the FQHC Add-on value from the 2025 Updated Rate Book from row [B] ($34.00). Thus, the base rate value CMS will use for the calculation will equal $75.00 – ($2.46 + $34.00) or $38.54.

In this case the values used for these three components will still sum to greater of the two Rate Book Amounts ($75.00), but the value used for the County Enhancement will be higher than the value in the 2025 Updated Rate Book and the value used for the County Base Rate will be lower than the value in the 2025 Updated Rate Book.

4.9 Permitted Uses of the Advance Shared Savings Payment and PPC Payment

There are two types of permitted expenditure categories in the ACO PC Flex Model:

- **Category 1 expenditures** are for the provision and support of advanced primary care ("Advanced Primary Care Expenditures"). Advanced Primary Care Expenditures include replacement of FFS revenue, provision of other advanced primary care, health-related social needs (HRSN) screening and supports, behavioral health integration, expansion and retention of primary care workforce, health care practice infrastructure, and implementation of evidence-based protocols and guidelines for primary care.
- **Category 2 expenditures** are for the cost of operating the PC Flex ACO ("Operations Expenditures"). Operations Expenditures include legal, actuarial, analytic or other professional services, spend plan reporting, support to ACO Participants to incorporate PPC Payment into revenue cycles, and other administrative costs. Additional detail on spend categories is provided in Appendix A.

Although the Advance Shared Savings Payment and PPC Payments may be used for either of the two permitted expenditure categories, each payment mechanism has different requirements regarding the proportion of funds that may be allocated to each expenditure category. A PC Flex ACO may use the Advance Shared Savings Payment for both Advanced Primary Care Expenditures and Operations Expenditures and, unlike the PPC Payment, there is no maximum percentage that can be used on Operations Expenditures. The requirements for the PPC Payment are as follow:

- During the first performance year, PC Flex ACOs must spend at least 90 percent of PPC Payments on items and services that fall within Advanced Primary Care Expenditures, and not more than 10 percent on items and services that fall within Operations Expenditures. See Appendix A for detail on expenditure categories.

During subsequent performance years, PC Flex ACOs must spend at least 95 percent of PPC Payment on Advanced Primary Care Expenditures and not more than 5 percent on Operations Expenditures. PC Flex ACOs may use more of the PPC Payment on Operations Expenditures

in the first performance year because some items require one-time implementation or development expenditure.

5 FINANCIAL SETTLEMENT

PC Flex ACOs will be subject to the Shared Savings Program financial settlement process codified in federal regulations as described in 42 CFR Part 425 Subpart G. In order to calculate and determine gross savings and losses and to make adjustments for ACO PC Flex payment mechanisms and policies, financial settlement for PC Flex ACOs will compare each ACO's updated historical benchmark to expenditures based on the performance year. The updated benchmark represents the average Medicare beneficiary total cost of care for assigned beneficiaries and refers to the target expenditure amount that will be compared to Medicare expenditures for items and services furnished to PC Flex ACO–assigned beneficiaries during a performance year.

For an overview of the settlement process, see the flowchart in Figure 1 in Subsection 5.6.

5.1 Inclusion of PPC Payments in Performance Year Expenditures for ACO PC Flex

The calculation of the benchmark for PC Flex ACOs will be unchanged from the Shared Savings Program methodology as described in 42 CFR Part 425 Subpart G and 88 FR 78818. Benchmarks are constructed using nationally and regionally adjusted historical expenditures. As per the methodology in the Shared Savings Program, CMS will update the historical benchmark and determine the total updated benchmark. For details on the calculation and updating of the historical benchmark, see the Performance Year 2023 and subsequent years' Shared Savings and Losses, Assignment and Quality Performance Standard Methodology document.[40]

The calculation of the total performance year expenditures in aggregate and per capita under the Shared Savings Program will include the Total PPC Payment Amount. By a date specified by CMS during Q1 of the following performance year, CMS recalculates the PPC Payment for all PPCP-eligible beneficiaries for the performance year and completes the following calculations:

- CMS calculates the Non-release Amount as the sum of the net amount of any applicable claims processing errors and the amount of Payment Precision Withhold applied for any PPC Payments paid to the ACO for PPCP-eligible beneficiaries who are no longer assigned to the ACO as of a date specified by CMS.
- CMS calculates the Preliminary Release Amount as the difference between the sum of the Payment Precision Withhold applied throughout the performance year and the Non-release Amount. CMS divides the Preliminary Release Amount by the sum of PPCP-eligible beneficiary months to calculate the PBPM Preliminary Release Amount.

[40] Versions 11 and 12 of CMS's *Medicare Shared Savings Program Shared Savings and Losses, Assignment Methodology and Quality Performance Standard Specifications* available at: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations

- CMS calculates the Total PPC Payment Amount PBPM as the sum of the PBPM Preliminary Release Amount and the sum of the recalculated PBPM PPC Payment for the performance year.

PPC Payments are non-claims-based payments, which are included in the calculation of total performance year expenditures under the Shared Savings Program.

The ACO PC Flex inclusion of the PPC Payment in performance year expenditures will impact the resulting calculations of total savings and losses.

Summary of inclusion of PPC Payments in performance year expenditures:

- **Step 1.** CMS recalculates the PPC Payment for all PPCP-eligible beneficiaries for the performance year (Section 4.2)
- **Step 2.** CMS calculates the Non-release Amount
  - Non-release Amount = ∑ (Payment Precision Withhold applied for performance year for PPCP-eligible beneficiaries who are no longer assigned to the ACO) + net amount of any applicable claims processing errors
- **Step 3.** CMS calculates the Preliminary Release Amount
  - Preliminary Release Amount = ∑ (Payment Precision Withhold applied for performance year) – Non-release Amount
- **Step 4.** CMS calculates the PBPM Preliminary Release Amount
  - PBPM Preliminary Release Amount = Preliminary Release Amount / ∑ (PPCP-Eligible Beneficiary Months for performance year)
- **Step 5.** CMS calculates the Total PPC Payment Amount for all PPCP-eligible beneficiaries for the performance year for all PPCP-eligible beneficiary months
  - PBPM Total PPC Payment Amount = PBPM Recalculated PPC Payment + PBPM Preliminary Release Amount

5.2 ACO PC Flex Modification to Apply the Total ACO PC Flex Settlement Adjustment

CMS calculates and applies the Total ACO PC Flex Model Settlement Adjustment in five steps:

- **Step 1.** Calculate the ACO Capped Enhancement PBPM by dividing the sum of Capped Enhanced PPC Payment Amount for all PPCP-eligible beneficiaries for the performance year by the sum of the PPCP-eligible beneficiary months for the performance year. The ACO Capped Enhancement PBPM is subject to offset by the greater of the positive regional

adjustment and prior savings adjustment at settlement. This is an ACO-level calculation. Note the following:

- An ACO's regional adjustment is determined in the Shared Savings Program based on whether the ACO has lower or higher spending compared to the ACO's regional service area and the agreement period subject to the regional FFS adjustment.
- For the prior savings adjustment, for agreement periods beginning on January 1, 2024, and in subsequent years, CMS calculates an adjustment to the historical benchmark to account for savings generated in the 3 years prior to the start of the ACO's current agreement period for renewing or re-entering ACOs that were reconciled for 1 or more performance years in the Shared Savings Program during this period.

- **Step 2.** Determine the offset to ACO Capped Enhancement PBPM on a PBPM basis. In this step, the regional adjustment and prior savings adjustment (on a PBPY basis), which are provided in the Shared Savings Program benchmark report on Tables 1A and 1B respectively, are evaluated to determine which is greater and then divided by 12 to convert the PBPY value to a PBPM value. This is an ACO-level calculation.

- **Step 3.** Reduce the ACO Capped Enhancement PBPM amount from Step 1 by the offset amount determined in Step 2. The resulting value is the Total Enhancement Credit PBPM to settlement, after offsetting for the greater of positive regional adjustment and prior savings adjustment on a PBPM basis. The floor for this value is $0.00 PBPM. This is an ACO-level calculation.

- **Step 4.** Convert the PBPM value in Step 3 to a total dollar value by multiplying by the total number of PPCP-eligible beneficiary months assigned to the PC Flex ACO for the performance year, which is the Total Enhancement Credit.

- **Step 5.** CMS sums the Population Adjustment Amount for all PPCP-eligible beneficiaries for the performance year. The Total Enhancement Credit to Settlement after offset for positive regional adjustment and prior savings adjustment does not include the Population Adjustment The Population Adjustment Amount dollars are added to the dollar value from Step 4 to determine the Total ACO PC Flex Settlement Adjustment. This is an ACO-level calculation. CMS adds the Total ACO PC Flex Settlement Adjustment to the ACO's Shared Savings after the application of the Shared Savings cap or the ACO's Shared Losses after the application of the loss recoupment limit, as applicable. The summary of Total ACO PC Flex Settlement Adjustment calculation follows:
  - ACO Capped Enhancement PBPM = ∑ (Capped Enhanced PPC Payment Amount for all PPCP-eligible beneficiaries for the performance year) / ∑ (PPCP-Eligible Beneficiary months for the performance year)
  - Total Enhancement Credit PBPM = ACO Capped Enhancement PBPM – (greater of regional adjustment and prior savings adjustment / 12)

- Total Enhancement Credit = Total Enhancement Credit PBPM x ∑ (PPCP-Eligible beneficiary months for the performance year)
- Total ACO PC Flex Settlement Adjustment = Total Enhancement Credit + Population Adjustment

Adding a positive Total ACO PC Flex Settlement Adjustment to the ACOs' financial settlement will have four possible outcomes (before the application of sequestration):

- **Outcome 1.** When the PC Flex ACO has an earned performance payment before total settlement credit, a positive Total ACO PC Flex Settlement Adjustment will increase the earned performance payment.
- **Outcome 2.** When the PC Flex ACO has a payment due to CMS before total settlement credit that is greater than or equal to the positive Total ACO PC Flex Settlement Adjustment, the payment due to CMS will be reduced by the amount of the positive Total ACO PC Flex Settlement Adjustment.
- **Outcome 3.** When the PC Flex ACO has a payment due to CMS before total settlement credit that is less than the positive Total ACO PC Flex Settlement Adjustment, the PC Flex ACO will have an earned performance payment equal to the positive Total ACO PC Flex Settlement Adjustment minus the payment due to CMS.
- **Outcome 4.** When the PC Flex ACO has neither an earned performance payment nor a payment due to CMS, the PC Flex ACO will have an earned performance payment equal to the positive Total ACO PC Flex Settlement Adjustment.

5.3 Recoupment and Recovery of the Advance Shared Savings Payment

CMS will recoup the Advance Shared Savings Payment from any shared savings earned by the ACO until CMS has recouped in full the amount of the Advance Shared Savings Payment. CMS will carry forward any remaining balance owed to subsequent performance years in which the ACO achieves shared savings. If the ACO has an outstanding balance of the Advance Shared Savings Payment after the calculation of shared savings or shared losses for the ACO in the final performance year of the model performance period, CMS will continue to recoup the remaining balance of the Advance Shared Savings Payment from any shared savings the ACO earns for as long as the ACO participates in the Shared Savings Program. If an ACO terminates the Participation Agreement prior to the end of Performance Year 2025, the ACO must repay the total amount of the Advance Shared Savings Payment as Other Monies Owed.

If CMS terminates the Participation Agreement, the ACO shall repay the entire amount of the Advance Shared Savings Payment as Other Monies Owed.

5.4 Calculation of Other Monies Owed

CMS will calculate Other Monies Owed at the same time as the regular Shared Savings Program financial settlement process as described above. Other Monies Owed includes the following amounts, if applicable:

1. Difference between Total PPC Payment Amount for the performance year and the PPC Payment Amount for all PPCP-eligible beneficiaries CMS previously paid to the ACO for the performance year.
2. Sum of all paid amounts for claims submitted by a date specified by CMS for the set of services listed in Appendix C, Tables C-1 and C-2 provided to PPCP-eligible beneficiaries by ACO Professionals for a performance year, billed with specialties internal medicine, family medicine, general practice, geriatric medicine, pediatric medicine, nurse practitioner, physician assistant, or clinical nurse specialist, excluding nurse practitioners, physician assistants, and clinical nurse specialists.
3. CMS calculates the Aggregate Final Release Amount by reducing the product of the number of PPCP-eligible beneficiaries who are no longer assigned to the ACO and the PBPY Release Amount by the Preliminary Release Amount. In equation form: Aggregate Final Release Amount = Preliminary Release Amount - (# of PPCP-eligible beneficiaries no longer assigned to the ACO x PBPY Release Amount)

In the case of early termination, CMS will include the following amounts as Other Monies Owed, if applicable:

1. Repayment of Advance Shared Savings Payment upon voluntary termination. If an ACO terminates the Participation Agreement prior to the end of Performance Year 2025, the ACO must repay the total amount of the Advance Shared Savings Payment as Other Monies Owed. If the ACO voluntarily terminates the Participation Agreement after the end of Performance Year 2025, the ACO must repay the amount of the Advance Shared Savings Payment on a pro rata basis. The ACO must repay the amount equal to the difference between (1) the total amount of the Advance Shared Savings Payment and (2) the number of complete performance years the ACO participated in the model multiplied by one-fifth of the amount of the total Advance Shared Savings Payment. If CMS terminates the Participation Agreement, the ACO shall repay the entire amount of the Advance Shared Savings Payment as Other Monies Owed.
2. If CMS terminates the Participation Agreement, or the Participation Agreement is terminated by either party, with an effective date range from January 1 to June 30 of a performance year, then Other Monies Owed include any PPC Payment paid to the ACO for any months after the month of the effective termination date.
3. If CMS terminates the Participation Agreement, or the Participation Agreement is terminated by either party, with an effective date from January 1 to June 30 of a performance year, then Other Monies Owed include the total Capped Enhanced PPC Payment Amount paid to the ACO for the performance year.

4. If CMS terminates the Participation Agreement, or the Participation Agreement is terminated by either party, with an effective date from July 1 to December 31 of a performance year, then Other Monies Owed include any Capped Enhanced PPC Payment Amounts paid to the ACO for the performance year.
5. If CMS terminates the participation agreement, or the participation agreement is terminated by either party, with an effective date from July 1 to December 31 of a performance year, then Other Monies Owed may include Base PPC Payment Amounts paid to the ACO for the performance year.
6. If CMS makes an FFS payment for a PPCP-Eligible Service furnished to a PPCP-Eligible Beneficiary by a primary care professional for a claim submitted by an ACO Participant, then Other Monies Owed include the total amount of such FFS payments.

5.5 Early Termination

The following principles govern cases of early termination:

1. For months prior to termination, fee reductions are not reversed.
2. For months following termination, claims are no longer reduced and the PPC Payment is no longer paid.
3. Other Monies Owed may be impacted as defined in Subsection 5.4.

Based on the Shared Savings Program termination policy[41] CMS *does not* perform financial settlement for the Shared Savings Program for a particular performance year in these cases:

- When a one- or two-sided ACO voluntarily terminates on or before June 30
- When a one-sided ACO voluntarily terminates on or after July 1 but before December 31

Under the Shared Savings Program termination policy CMS *does* perform financial settlement for the Shared Savings Program for a particular performance year in these cases:

- When CMS involuntarily terminates a two-sided ACO (not eligible for shared savings, liable for pro-rated shared losses)
- When a two-sided ACO voluntarily terminates on or after July 1 but before December 31 (not eligible for shared savings, but liable for pro-rated shared losses)
- When a one-sided or two-sided ACO voluntarily terminates on December 31 (eligible for shared savings or, if two-sided, also liable for shared losses)

When financial settlement does not take place, there will be immediate recoupment of any applicable Other Monies Owed (as defined in Subsection 5.4).

If CMS terminates the Participation Agreement, or the Participation Agreement is terminated by either party, with an effective date from July 1 to December 31 of performance year, any Base

[41] Refer to § 425.221.

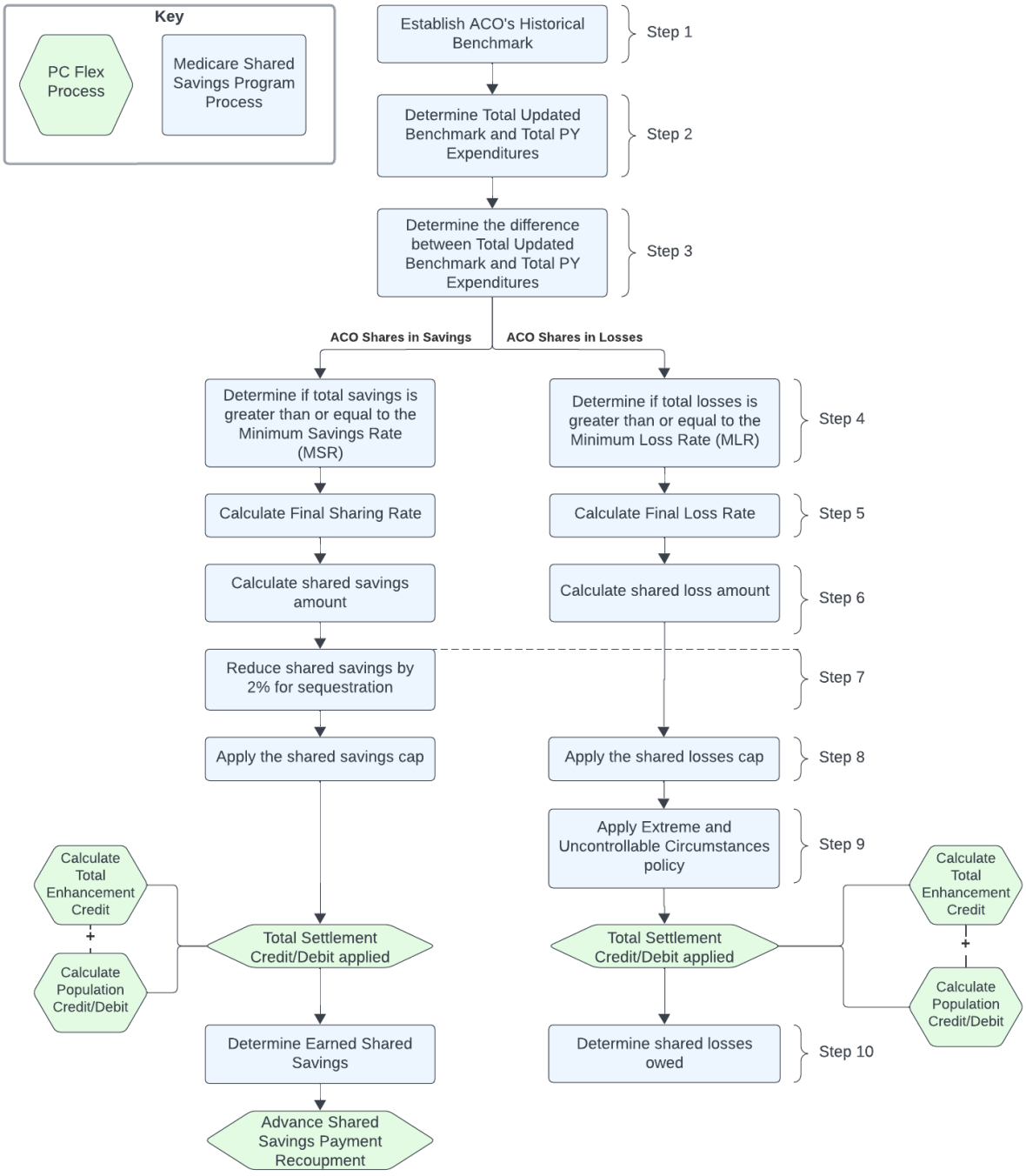
PPC Payment Amounts paid to the ACO for the performance year shall be included on the settlement report for the performance year.

In general, if CMS or the ACO terminates the Model Participation Agreement, financial settlement is conducted in accordance with the terms of the Participation Agreement (Section 13.04). Upon termination, repayment is required in accordance with the terms of the Participation Agreement for PPC Payments (see Participation Agreement, Appendix A. VIII. G), Advanced Shared Savings Payments (see Participation Agreement, Appendix A. VIII. F), and Other Monies Owed (see Participation Agreement, Section 13.04). Upon termination from the ACO PC Flex Model, an ACO's participation status in the Shared Savings Program will be reviewed on a case-by-case basis.

5.6 Overview of Financial Settlement

See Figure 1 below for an illustration of financial settlement.

Figure 1. Determining Shared Savings and Losses for ACO PC Flex and the Shared Savings Program



APPENDIX A: EXPENDITURE CATEGORIES

There are two types of permitted expenditure categories. Category 1 expenditures are for the provision and support of advanced primary care ("Advanced Primary Care Expenditures"). Category 2 expenditures are for the cost of operating the PC Flex ACO ("Operations Expenditures"). Expenditures that do not fall under Advanced Primary Care or Operations Expenditures will fall under Category 3 ("Prohibited Uses"). Advanced Primary Care and Operations Expenditures are summarized in Table A-1 and explained in detail in this section.

Table A-1: Summary of Expenditure Categories and Subcategories

Category 1: Advanced Primary Care Expenditures	Category 2: Operations Expenditures
a. Replacement of FFS Revenue b. Provision of Other Advanced Primary Care c. HRSN Screening and Supports d. Behavioral Health Integration e. Expansion and Retention of Primary Care Workforce f. Health Care Practice Infrastructure g. Implementation of Evidence-based Protocols/Guidelines for Primary Care	a. Legal, Actuarial, Analytic or Certain Other Professional Services b. Spend Plan Reporting Activities c. Support to Participants to Incorporate PPC Payments into Revenue Cycle d. Other Administrative Costs, as defined in this appendix.

Category 1: Advanced Primary Care Expenditures

Category 1 expenditures are expenditures for the provision and support of an advanced level of primary care services covered by Medicare to an ACO's PPCP-eligible assigned beneficiaries. These expenditures reflect important components for improving primary care and may be divided into the following subcategories.

1.A. Replacement of FFS Revenue (Category 1.A): This subcategory is expected to be the largest subcategory of expenditures. This includes payments to PPCP-eligible Participants and PPCP-eligible professionals who have entered into a payment arrangement with the ACO and whose primary care claims are being reduced, to cover the set of primary care service billing codes paid under the Physician Fee Schedule. This subcategory has two types:

- 1.A.i) Prospective Population-Based Payment or Capitation, and
- 1.A.ii) Payment Based on FFS Billings.

1.B. Provision of Other Advanced Primary Care (Category 1.B): Items in this subcategory include: costs of third-party services for provision of advanced primary care such as care management, referral management, and beneficiary event alert management.

1.C. HRSN Screening and Supports (Category 1.C.): Items in this subcategory include costs of implementation of HRSN screening and referrals to community-based organizations (CBOs) to address HRSNs. PPC Payments may be used for screening and referral to CBOs to provide coordination services to address HRSNs; PPC Payments may not be used to fund the delivery

of HRSN services. For example, PPC Payments may be used to identify that a PPCP-eligible assigned beneficiary has need for legal services to establish a living will and make referral for such legal services but not for the provision of legal services directly to the beneficiary. Funding for items under this Category 1.C. may flow to (1) primary care practices that are part of the PC Flex ACO (PC Flex ACO Participants and ACO providers/suppliers as defined under the Shared Savings Program regulations), or (2) by the ACO to hire staff or contract with a third party to engage in these activities for PPCP-eligible assigned beneficiaries.

1.D. Behavioral Health Integration (Category 1.D.): Expenditures in this subcategory include: hiring behavioral health providers and case managers to integrate behavioral health care into the primary care setting; referrals to behavioral health services; investments to support access to behavioral health services and specialists including those co-located within primary care settings and care teams; investments in primary care behavioral health integration and scope of practice including screening, intervention, referrals, and treatment. PPC Payments may not be used under this Category 1.D. for services that are covered Medicare benefits and are not included in the set of PPCP-eligible services described in the Participation Agreement.

1.E. Expansion and Retention of Primary Care Workforce (Category 1.E.): Expenditures in this subcategory include:

- Expansion of primary care workforce: Examples include hiring practice nurse case managers, medical assistants, or other relevant support staff; hiring community health workers, certified peer recovery specialists, other health care professionals with training in delivering culturally and linguistically tailored services. The increased staffing could be both within the primary care practices that are part of the ACO (ACO Participants and ACO providers/suppliers as defined under the Shared Savings Program regulations) or at the ACO level to provide primary care staffing services and supports across ACO Participants and primary care practices through contractual arrangements. Staffing support may be through a health professional staffing agency/company. Funds used for staffing must be used to support the provision of primary care services provided under the model.

- Retention of primary care workforce: Examples include higher compensation rates or performance-based bonuses (bonuses tied to performance on outcomes or quality; not volume based).

1.F. Health Care Practice Infrastructure (Category 1.F.): Items in this subcategory include: spending on certified electronic health record technology (including system enhancements and upgrades); connections to clinical data registries and networks that support health information exchange across disparate providers and systems involved in beneficiary care; integration of ACO Participant systems including tools to share and analyze operational and quality data; remote access technologies; telemonitoring; screening tools; case management to improve care coordination operations across the health and social care continuum including coordination with CBOs; systems to provide and track beneficiary referrals, as well as enable coordination and measurement of health; and integration of systems to support coordination between primary care and specialty care including e-consults and data to support referral decisions.

The funding could go directly to the primary care practices that are part of the ACO (ACO Participants, ACO providers/suppliers as defined under the Shared Saving Program regulations) or at the ACO level to provide health care practice infrastructure across ACO Participants through contractual arrangements.

1.G. Implementation of Evidence-based Protocols/Guidelines for Primary Care (Category 1.G.): Items in this subcategory include: the implementation of standing orders and protocols for uncomplicated acute illnesses and chronic disease management, as well as encouraging non-clinician team members to use standardized workflows for beneficiary care without requiring direct clinician intervention. Expenditure required to acquire, lease, or subscribe to evidence-based protocols from a third party would also be included in this subcategory.

Category 2: Operations Expenditures

Category 2 expenditures are administrative expenses of the ACO that are related to a PC Flex ACO Participant's provision of primary care services but are not Category 1 expenditures. The allowed Category 2 expenditures below include professional services that the PC Flex ACO provides to support its ACO Participants, workforce expenses, and expenditures for certain professional services. Category expenditures may be divided into the following subcategories.

2.A. Legal, Actuarial, Financial, Analytic, or Other Professional Services (Category 2.A.): Expenses under this subcategory include those necessary to implement and maintain payment arrangements between the ACO and PC Flex ACO Participants, including for the development and execution of agreements necessary for participation in the ACO PC Flex Model, determination of payment amounts under the model, processing of payments made under the model, and development and operation of reporting to support such payment arrangements. Legal services do not include litigation to initiate, respond to, or resolve disputes.

2.B. Spend Plan Reporting Activities (Category 2.B): Expenses under this subcategory include those for the development, maintenance, and operations related to required spend plan reporting.

2.C. Support to Participants to Incorporate PPC Payments into Revenue Cycle (Category 2.C.): Expenses under this subcategory include those for support to ACO Participants to facilitate incorporation of prospective payments into the revenue cycle or other financial systems of the ACO Participant.

2.D. Other Administrative Costs (Category 2.D): Expenses under this subcategory include other administrative costs required to operate the PC Flex ACO other than those prohibited in Category 3.

Category 3: Prohibited Uses

Category 3 expenditures consist of any expenditures other than those within Category 1 and Category 2, including the following:

- Management company, parent organization, affiliate, or similar business profit, markup, or fees;

- ACO executive bonuses;
- Items or services that are not reasonably related to one or more purposes of the PC Flex ACO and the Shared Savings Program;
- Expenses incurred prior to the start of the PC Flex ACO or incurred outside of the period they have been submitted for review (funding should be tracked and reported on a cash basis except as otherwise described as permitted);
- Imaging equipment or other revenue generating equipment;
- Interest or fees related to securing the repayment mechanism or payment of the repayment mechanism;
- Financial or gainsharing arrangements in which PPC Payments are tied to performance-based arrangements with conveners or other third parties;
- Litigation to initiate, respond to, or resolve disputes;
- Taxes other than sales taxes incurred via Category 1 or Category 2 expenditures;
- Payment of shared losses; and
- Any use not otherwise specified.

Funding Distribution Requirements

Advance Shared Savings Payment: The Advance Shared Savings Payment can be used for Advanced Primary Care and Operations Expenditures, with no maximum percentage that can be used on Operations. The Advance Shared Savings Payment cannot be used for items in Expenditure Category 3 (see Category 3: Prohibited Uses above). The full amount does not need to be spent in the first performance year.

PPC Payments: During the first performance year, the ACO must spend at least 90 percent of PPC Payments on Advanced Primary Care Expenditures (i.e., not more than 10 percent on Operations Expenditures). During subsequent performance years, PC Flex ACOs must spend at least 95 percent of PPC Payments on Advanced Primary Care Expenditures (i.e., not more than 5 percent on Operations Expenditures). The ACO may use more of the PPC Payments on Operations Expenditures in the first performance year because some items require one-time implementation or development spend. As long as the ACO satisfies these minimum spend requirements, there are no additional restrictions or limitations on when PPC Payments need to be spent (see Table A-2).

Table A-2: Required Allocation of Expenditures across Categories

Expenditure Category	PPC Payment		Advance Shared Savings Payment
	First Performance Year	Second Performance Year & Subsequent Performance Years	
Advanced Primary Care (Category 1)	At least 90%	At least 95%	Unlimited
Operations (Category 2)	Not more than 10%	Not more than 5%	Unlimited
Prohibited Uses (Category 3)	0%	0%	0%

APPENDIX B: RATE BOOK EXPENDITURES CODES

Table B-1: Codes Used to Calculate Primary Care FFS Claims Expenditures for ACO PC Flex Rate Book

Service	Code(s)
Administration of health risk assessment	96160 and 96161
Caregiver Behavior Management Training	96202 and 96203
Caregiver Training Services	97550, 97551, and 97552
Virtual Check-in Service	98016
Office or other outpatient visit for the evaluation and management of a patient	99201 through 99215
Patient domiciliary, rest home, or custodial care visit	99319 through 99340
Evaluation and management services furnished in a patient's home	99341 through 99350
Add-on codes, for prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure; when the base code is also a primary care service code in this list	99354 and 99355
Smoking and Tobacco-use Cessation Counseling Services	99406 and 99407
Online digital evaluation and management	99421, 99422, and 99423
Principal care management services	99424, 99425, 99426, and 99427
Telephone evaluation and management services	99441, 99442, and 99443
Chronic care management	99437, 99487, 99489, 99490 and 99491
Non-complex chronic care management	99439
Interprofessional Consultation Services	99452
Assessment of and care planning for patients with cognitive impairment	99483
Behavioral health integration services	99484, 99492, 99493 and 99494
Transitional care management services	99495 and 99496
Advance care planning; services identified by these codes furnished in an inpatient setting are excluded	99497 and 99498
Community Health Integration services	G0019 and G0022
Principal Illness Navigation services	G0023 and G0024
SDOH Risk Assessment	G0136
The Welcome to Medicare visit	G0402
The annual wellness visits	G0438 and G0439
Alcohol misuse screening service	G0442
Alcohol misuse counseling service	G0443
Annual depression screening service	G0444
Services furnished in ETA hospitals	G0463
Services furnished in HOPD setting [a]	G0463
Chronic care management	G0506

Service	Code(s)
Cardiovascular risk assessment and risk management services	G0537 and G0538
Individual behavior management/Modification caregiver training services	G0539 and G0540
Direct care caregiver training services	G0541, G0542, and G0543
Advanced primary care management services	G0556, G0557, and G0558
Safety planning interventions	G0560
Post-discharge telephonic follow-up contacts intervention	G0544
Cervical or Vaginal Cancer Screening	G0101
The remote evaluation of patient video/images	G2010
Virtual check-in	G2012 and G2252
Non-complex chronic care management	G2058
Principal care management services	G2064 and G2065
Complex Evaluation and Management Services Add-on	G2211
Prolonged office or other outpatient visit for the evaluation and management of a patient	G0317, G0318, and G2212
Psychiatric collaborative care model	G2214
Chronic pain management	G3002 and G3003

Note: This list of codes is what is planned for use for the 2025 Updated Rate Book. There were slight differences for the 2025 Preliminary Rate Book. See Appendix E.
[a] G0463 – Services furnished in HOPD setting (non-ETA HOPD setting) are included in the PPC Payment but not used for assignment in the Shared Savings Program.

APPENDIX C: VALID SPECIALTY CODES FOR PRIMARY CARE PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, AND ADDITIONAL SPECIALTIES

Table C-1: Primary Care Physicians – Valid Specialty Codes for Inclusion of Claims in ACO PC Flex Rate Book Development

Specialty Code	Specialty
11	Internal Medicine
01	General Practice
08	Family Practice
38	Geriatric Medicine
37	Pediatric Medicine

Table C-2: Non-Physician Practitioners (NPPs) – Valid Specialty Codes for Inclusion in Rate Book Development

Specialty Code	Specialty
50	Nurse Practitioner
97	Physician Assistant
89	Certified Clinical Nurse Specialist

Table C-3: Additional Specialty Codes Used to Identify ACO PC Flex Reference Population

Specialty Code	Specialty
06	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonary disease
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventive medicine
86	Neuropsychiatry
90	Medical oncology
98	Gynecology/oncology

APPENDIX D: COMPARISON BETWEEN ACO PC FLEX, SHARED SAVINGS PROGRAM, AND ACO REACH

Table D-1: Differences between the ACO PC Flex Model, Shared Savings Program, and ACO REACH

Feature	ACO PC Flex Model	Medicare Shared Savings Program	ACO REACH
Enrollment types	Two enrollment types (end-stage renal disease [ESRD] and aged and disable [A&D]). Establishes separate county-level payment rates for A&D population and state-level payment rates for ESRD population.	Four enrollment types (ESRD, disabled, aged/dual eligible and aged/non-dual eligible).	Two enrollment types (ESRD and A&D). Establishes separate county-level payment rates for A&D population and state-level for ESRD population.
Base years (BYs) used to develop County Relative Cost Indices	BYs (2022–2024 for the 2025 Updated ACO PC Flex Rate Book) will remain fixed for the duration of the model.	Not applicable.	3 BYs, 1-year interval between BY 3 and the performance year (BYs roll forward every year).
Reference population	Alive on the first of the month, enrolled in Parts A and B, not enrolled in Medicare Advantage (MA), is a U.S. resident, meets primary care service requirement. Three exceptions to the list of primary care services used in Shared Savings Program: 1. Inclusion of HCPCS Code G0463 2. Exclusion of CPT Codes 99304–99318 3. Inclusion of CPT Codes 99497 and 99498 4. Exclusion of HCPCS codes G2086, G2087, and G2088 Medicare is not required to be the primary payer.	Alive on the first of the month, enrolled in Parts A and B, not enrolled in MA, is a U.S. resident, meets primary care service requirement. Referred to as the “national assignable population” in Shared Savings Program. Medicare is not required to be the primary payer.	Alive on the first day of the month, enrolled in Parts A and B, not enrolled in MA, Medicare listed as primary payer, is a U.S. resident. Referred to as “ACO REACH National Reference Population.” No primary care service requirement.

Feature	ACO PC Flex Model	Medicare Shared Savings Program	ACO REACH
Expenditure	Expenditures are defined the same way for A&D and ESRD populations.	Expenditures are calculated separately for ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations.	Expenditures are defined the same way for A&D and ESRD populations.
	Includes hospice care billed through professional claims with a hospice place of service that otherwise meet the criteria used to identify primary care services for ACO PC Flex expenditures (does not include hospice services billed through institutional hospice claims).	Includes hospice claims at any provider.	Includes hospice care at any provider.
	Indirect Medical Education is not applicable to ACO PC Flex.	Excludes Indirect Medical Education payments from expenditures.	Indirect Medical Education is included in county rates.
	Does not truncate or adjust for outlier expenditures.	Truncates outlier expenditures.	Uses stop loss payouts to exclude outlier expenditures.
	The preliminary version of the Rate Book uses the Shared Savings Program multiplicative completion factor of 1.013 (equivalent to an increase of 1.3 percent), with claims processed through the last calendar day of the month. The 2025 Updated Rate Book used a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model.	Uses an overall 3-month claims completion factor of 1.013, with claims processed through the last Friday of the month.	Does not use a completion factor. Three months of run-out is considered final.
Credibility adjustment	Credibility adjustment applied to small counties for A&D.	Not applicable.	Credibility adjustment applied to small counties for A&D.

APPENDIX E: PRELIMINARY AND UPDATED VERSIONS OF ACO PC FLEX RATE BOOK

Table E-1: Key Differences between Preliminary and Updated Versions of ACO PC Flex Rate Book

Component	Preliminary	Updated	Justification
Base years (BYs)	Uses 2021, 2022, and 2023 for BYs and uses CMS trend factor to trend 2023 to 2024.	Uses 2022, 2023, and 2024 for BYs, with 2023–2024 trend factor not required.	2024 data was not yet available when the 2025 Preliminary Rate Book was drafted.
Completion factor	Uses the overall 3-month claims completion factor from Shared Savings Program of 1.013.	The 2025 Updated Rate Book uses a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model.	Additional time is required to calculate a completion factor specific to the primary care services used in the ACO PC Flex Model.
Geographic Adjustment Factor (GAF)	Uses ACO REACH GAF, based on all professional claims.	Uses a GAF based on claims from the ACO PC Flex National Reference Population.	Additional time is required to calculate a GAF specific to primary care services and the ACO PC Flex National Reference Population.
Adjustments for payment reductions	Does not adjust for payment reductions for alternative payment arrangements for primary care services at critical access hospitals (CAHs), Electing Teaching Amendment (ETA) hospitals, or non-ETA HOPDs.	Adjusted for payment reductions for alternative payment arrangements at CAHs, ETA hospitals, or non-ETA HOPDs.	Primary care services for these providers are identified at the line level but reduction amounts are currently only available at the claim level.
Codes for primary care	Some codes were missing from list in Appendix B.	Uses updated list of codes in Appendix B.	One code was incorrectly entered (99407), other codes were added to list for PC Flex based on codes added for the Shared Savings Program.

APPENDIX F: LIST OF ABBREVIATIONS

Abbreviation	Definition
A&D	Aged and disabled
ACO	Accountable Care Organization
ACO PC Flex Model	Accountable Care Organization Primary Care Flex Model
ADI	Area Deprivation Index
BN	Budget neutral/budget neutrality
BY	Base year
CAH	Critical Access Hospital
CBA	Claims-based assignment
CBO	Community-based organization
CBSA	Core-Based Statistical Area
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Hierarchical Condition Category
COVID-19	Coronavirus disease 2019
CPT	Current Procedural Terminology
CY	Calendar year
DoD	Department of Defense
ESRD	End-stage renal disease
ETA	Electing Teaching Amendment
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
GAF	Geographic Adjustment Factor
HCPCS	Healthcare Common Procedure Coding System
HOPD	Hospital Outpatient Department
HRSN	Health-related social needs
MA	Medicare Advantage
N/A	Not applicable
NPI	National Provider Identifier
NPP	Non-physician practitioner
PBPM	Per-beneficiary per-month
PBPY	Per-beneficiary per-year
PCOA	Primary care delivered outside the Accountable Care Organization
PCPAT	Primary Care Prospective Administrative Trend
PPC Payment	Prospective Primary Care Payment
PPCP-eligible	Prospective Primary Care Payment–eligible
Q	Quarter (i.e., Q1, Q2, Q3, or Q4)
RHC	Rural Health Clinic
SDOH	Social determinant of health
TIN	Taxpayer Identification Number
V	Version (i.e., V24 or V28)
VA	U.S. Department of Veterans Affairs
YTD	Year to date