Accountable Care Organization Primary Care Flex Model (ACO PC Flex Model) Overview Webinar
April 4, 2024

>>Haley Moen, SEA: Good afternoon, everyone, and thank you for joining the Overview Webinar for the Accountable Care Organization Primary Care Flex Model, or ACO PC Flex Model. We have an exciting presentation for you all today. But first we would like to share some brief housekeeping items. Next slide, please.

We would like to start with a disclaimer, stating that all information provided in the Overview Webinar is potentially subject to change. When published, the request for application, or RFA, will be the sole source of information about the ACO PC Flex Model details and the application process. Next slide, please.

We recommend that you listen to today's presentation via your computer speakers. If this does not work, there is also a dial-in option for viewers to listen through their phone. The dial-in number and passcode for today's event are listed on the slide here. Closed captioning is available on the bottom of your screen. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A box displayed on the bottom of your screen. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs.

Today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck, a recording of today's presentation, and a transcript will be made available on the ACO PC Flex website in the coming days. Finally, we will share a brief survey at the end of today's presentation. Please take a few minutes to let us know how we did, and share any questions that you may have about the ACO PC Flex Model. We would love to know your feedback so that we can apply it towards future events. Thank you. Next slide, please.

Now I am pleased to introduce our CMS Innovation Center speakers for today. We have four speakers, including Doug Jacobs, Chief Transformation Officer at the Center for Medicare. Purva Rawal, Chief Strategy Officer at the CMS Innovation Center. Pauline Lapin, Director of the Seamless Care Models Group at the CMS Innovation Center. And last but not least, Meghan O'Connell and Lauren Kuenstner, ACO PC Flex Model Co-Leads. I will now hand it over to Meghan to share the agenda, and some opening remarks.

>> Meghan O'Connell, CMS: Next slide, please. Thank you, Hayley.

We have a packed agenda today. So we'll get started with an overview of the ACO PC Flex Model, followed by several sections that describe important areas of the model, including eligibility, participation, model elements, and payment structure. We'll close the event with some more information on the ACO PC Flex Model application, next steps, and things to look for in the coming weeks. Next slide, please.

We want to take every opportunity to make today's session an engaging one. Throughout the next hour we'll have multiple opportunities for you to provide us feedback and insight. We have a poll here to start. For this first poll question, please select what type of organization you represent. The question

should pop up on your screen, and we'll keep it open for about a minute. I'll give you a few moments to participate before moving on.

For those of you just joining us, we have a poll question up on the screen. We're going to keep it open for just about a minute. Great, about 30 more seconds here for the poll question, please provide your answers. Okay, a few more seconds here. And I think we can go ahead and close the poll. Excellent, thanks for your responses. This information will really help inform our model team's outreach efforts for future events with the ACO PC Flex Model. Next slide, please.

We'd also love to see where you're joining us from today. Please choose the corresponding state or territory on the map. Again, the poll should pop up on your screen. And we'll keep it open for just about a minute here before moving on.

For those of us just joining, we have a poll question here up on the screen. If you could go ahead and select where you're joining us from today, and we'll keep it open for a few more, a little bit longer before moving on. Okay, great. Thank you so much for participating, and thanks again for taking time out of your day today to be here with us for this event. Next slide, please.

CMS announced the ACO PC Flex Model on March 19th, 2024. And we have additional materials coming out over the next several weeks that will provide more detail on the topics we cover today. For today, we'll share a lot of high level information, but don't forget to subscribe to the ACO PC Flex listserv if you're interested in staying updated on new materials as they're released.

With that, I'd like it to pass it over to my colleague Doug, to provide an overview of the three Medicare value-based care priorities. Next slide, please.

>> Douglas Jacobs, CMS: Thank you so much, Meghan. It's great to be with you all here today, and great to see so many people interested in this new model that we're really excited about. I'm in the Center for Medicare, and we've worked really hand-in-hand with the Innovation Center in coming up with this model. And it really fits very nicely into our value-based care priorities, and so going through those very quickly now today.

The first is growth. You folks might have heard that we want to get to 100% traditional Medicare beneficiaries in accountable care relationship with their provider by 2030. And growth and accountable care can improve quality, increase savings for Medicare, and also promote innovative delivery of services that best meets patients' needs.

Our second priority is alignment. I'm a primary care practitioner, and oftentimes practitioners experience this, that when you see patients, you're not necessarily thinking about what, who the payer is for an individual patient. And so alignment on quality and data is certainly a priority and alignment as well, goes across the Center for Medicare and Medicaid Services. And part of our goal is to create a chassis on upon which we can build new models, and the Medicare Shared Savings Program is the largest accountable care program in the country. So the model that we'll describe to you today is just demonstrating this in action, which is really exciting.

And lastly, equity. Profound inequities exist in our health care system today, and the way that we go about designing these value-based care models is really intentional to promote equitable delivery of

care. And we'll go over some of those features of the model as well. Because ultimately, we hope to rectify some of these really long standing disparities in our health care system.

And so, as you'll see, this model fits really nicely into all of our priorities, and it is part of the reason we're so excited about it. And so with that, I will give it, I think, back to Purva. Thank you.

>> Purva Rawal, CMS: Thanks, Doug, we really appreciate you participating today. It really speaks to the partnership with the Shared Savings Program in the design of this model. I also want to thank the ACO Flex team that has worked tirelessly on this model over the last several months, and to all of you for your interest and for joining us today.

Through the ACO PC Flex Model, The Innovation Center is testing another way to strengthen primary care. Many of you are well aware, I'm sorry. Next slide, please. Thank you.

Many of you are well aware of the challenges facing primary care today. So primary care delivery has become significantly more complex for providers and patients, contributing to fragmented care. Access to primary care is associated with improved patient outcomes, increased equity, and lower mortality, and higher life expectancy at similar lower costs, so great results. But we know that fewer people are reporting a regular source of primary care, particularly among underserved populations. And last, primary care needs additional investment and support to coordinate care and to improve health outcomes and close disparities. And value-based payment models like ACO PC Flex have the potential to make the health system, and primary care in particular, more resilient. Next slide, please.

So what guided the design of ACO PC Flex? In 2021, the Innovation Center announced a strategy guided by the vision you see here, to drive a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. And five core objectives guide the implementation of our vision, but I'll focus on two of them today, in particular.

Our first strategic objective is to drive accountable care. You can think of this as making sure patients have a provider that is quarterbacking their care across settings and across other providers to make sure their needs are addressed. CMS has set a goal of having 100% of our Medicare beneficiaries in an accountable care relationship with a clinician who is responsible for their total cost of care and quality by 2030. And ACO PC Flex is a really important part of our ability to achieve this goal.

Our second strategic objective, that I'll spend a second on, is advancing health equity. We can only improve quality by closing disparities in access and outcomes, and this is a strategic priority for CMS. And primary care is the cornerstone for achieving these objectives. And that's why PC, ACO PC Flex, is such an important addition to the Innovation Center's portfolio and CMS's ability to strengthen primary care. And in particular, the model focuses on three dimensions. The first is financing, the second is an emphasis on health equity, and the third is sustainability of transformation.

The first to mention, financing, focuses on increasing the stable revenue that practices receive that my colleagues will describe in more depth. Previous Innovation Center models have demonstrated that in many cases practices benefit from upfront investments to support their care transformation. It helps them, set up workflows and processes that develop advanced primary care capabilities. The second dimension, advancing health equity, which Doug also spoke about, aims to increase safety net provider participation and drives payments, greater payments to underserved areas. And that brings to it brings

me to the third dimension, sustainable transformation. ACO Flex does this by testing the model within the permanent Shared Savings Program to create a permanent pathway of successful.

We are incredibly excited about the pathway ACO PC Flex will create for more primary care providers to join and succeed in value-based care, and to hear questions today and in the future. And with that, I will turn it over to my colleague, Pauline Lapin. Next slide.

>> Pauline Lapin, CMS: Thank you, Purva.

Primary care is the foundation of a high-performing health system and fundamental to improving the health of the United States population. But the experience and the outcome of the Medicare beneficiary today in primary care is inadequate, unequal, and in need of improvement. The National Academies of Sciences, Engineering, and Medicine, in their landmark report on primary care, said "Primary care is a central component of ACOs, and organizations differ in the extent to which they emphasize, incorporate, pay for and support it." This report included several recommendations, and I would like to highlight, too, that inform the design of ACO PC Flex.

The first is that primary care payment should shift from fee-for-service to hybrid payment, part fee-for-service, part prospective payment. And the second is that sufficient resources and incentives should flow to primary care within ACOs to provide team-based care, to risk-adjust for medical and social complexity, and to support infrastructure, including digital health. ACOs whole promise in delivering person-centered care as evidenced by the success of physician, led ACOs in the Shared Savings Program. Total-cost-of-care frameworks, such as the Shared Savings Program, provide an opportunity to CMS to boost investment in primary care and provide prospective payments to primary care providers, which we believe will improve beneficiary outcomes and access to care and provide stable revenue for primary care.

ACO Primary Care Flex seeks to facilitate the delivery of advanced primary care, improve the beneficiary experience with health care and health outcomes, reduce program expenditures while enhancing the quality of care for Medicare beneficiaries in the Shared Savings Program, and encourage the formation and participation of new low revenue ACOs in the Shared Savings Program. The ACO PC Flex Model would provide prospective primary care payments to ACOs in lieu of fee-for-service revenue for primary care services billed by primary care providers participating in the ACO. Payments would be made on a monthly basis, and we know that prospective payments were a lifeline for primary care during the pandemic. Offering prospective primary care payments within the Shared Savings Program should improve beneficiary access outcomes and experience.

The ACO Primary Care Flex Model will also provide a one-time shared savings advance of $250,000 to all Primary Care Flex ACOs to finance the cost of forming and operating a PC Flex ACO. The model will test a common risk-adjusted, capitated, county rate for primary care. This does not exist in other ACO models. Past ACO models based their primary care capita, capitated rate on each ACOs' historical claims experience. So this will be a different setting, a different way of setting the payment rate in ACO PC Flex than we've had in, for example, the ACO REACH Model or the Next Generation ACO Model.

The financial flexibility offered by prospective primary care payments supports the formation of multi-disciplinary care teams by shifting resources towards team-based care and non-fee-for-service services, enabling practices to invest in collaboration between various health care providers, including specialists

like behavioral healthcare specialists, cardiologists, and others. This integrated approach enables providers to consider all aspects of wellbeing, including behavioral health, health-related social needs, without the pressure of revenue generation through volume. Under the ACO PC Flex Model, beneficiaries should receive more coordinated seamless care that addresses their unique needs, as primary care clinicians should have more time to spend with patients and additional resources to provide person-centered care.

I'll now pass it to the ACO PC Flex Model Co-Lead, Megan O'Connell, to discuss the model design in more detail.

Meghan O'Connell, CMS: Great thanks, Pauline. Next slide, yep.

This slide gives an overview of the ACO PC Flex Model goals. So, first to reduce disparities in access to high quality primary care and outcomes. As Purva said, the Innovation Center really believes that equitable care is a key component of achieving high quality care for Medicare beneficiaries, and it's therefore critical to the ACO PC Flex Model success.

Second, to improve individuals' experience and access to care. Theory and evidence have really shown that payment methods matter because of the incentives that they create. This model will test if a new way for paying for primary care within the Shared Savings Program can better align the financial incentives for delivery of advanced primary care.

Third, the ACO PC Flex Model aims to lower costs, while enhancing quality of care for individuals in the Shared Savings Program. Fourth, we know that practices need some flexibility from payers to adapt payment models to their circumstances. The flexibility afforded by the model payment mechanisms aim to empower participating ACOs and their providers to use more innovative care delivery approaches that are team-based, person-centered, and proactive rather than visit-driven to improve health outcomes and quality of care.

Lastly, the increased flexibility in the use of funds for primary care providers and increased resources for primary care strengthens incentives for organizations to participate that have not typically participated in ACOs, in the Shared Savings Program, or both. So the model aims to grow participation in the Shared Savings Program, especially for newly formed ACOs and ACOs that do not have experience with performance-based risk arrangements. Next slide, please.

The Innovation Center has invested significant time and resources over the years, testing models to strengthen primary care, improve care coordination, and address social determinants of health. This slide shows the Innovation Center models focused on primary care payment along with their timelines. These include the ACO REACH Model, the Primary Care First Model and three of our newer Innovation Center models: Making Care Primary, AHEAD, and of course, ACO PC Flex.

The ACO REACH Model encourages health care providers to come together to form an ACO and provides alternative payment options for ACOs outside of the Shared Savings Program, compared to ACO PC Flex Model, which will be tested as part of the Shared Savings Program, along with other differences in the design of the payment arrangements. As Pauline alluded to, the Primary Care First model supports primary care practices as opposed to ACOs in managing their patients' health and aims to simplify payment, to improve comprehensive care. While, Making Care Primary improves care management,

community connections, and care integration, and offers a progressive care delivery and payment design to move practices slowly, more slowly from fee-for-service to value-based payment over time.

The AHEAD Model creates a new pathway to invest in primary care. The model's goal is to affect change in primary care delivery at the state level. States Participating in AHEAD, for example, will be held accountable for state-specific Medicare and all payer growth, all payer cost growth and primary care investment targets. And lastly, as I've said, ACO PC Flex focuses on improving primary care funding within low revenue ACOs in the Shared Savings Program and strengthens participation incentives for new ACOs. Next slide, please.

The ACO PC Flex Model includes several design features that I'd like to highlight on this slide. And first, it's important to note that this model concept is part of broader momentum towards increased funding and stronger incentives for high-quality primary care, as Pauline and Purva noted. This is evidenced by the 2021 National Academies of Science Engineering and Medicine report on implementing high-quality, primary care. And, the 2023 changes to the Shared Savings Program to, among other goals, increase participation and advance equity.

We heard from many stakeholders in the design of this model that the, on the importance of upfront funding, so the model will provide a one-time shared savings advance of $250,000 to all PC Flex ACOs. And this includes both new and existing low revenue ACOs that participate, regardless of the Shared Savings Program Track in which they participate. These funds can be used to finance the cost of forming and operating a PC Flex ACO, where relevant, as well as covering potentially costly activities required by the model, such as health equity data reporting, administering prospective payments, and submitting detailed spend plans.

As others have mentioned, a cornerstone of the model design is the Prospective Primary Care Payments, which align with recommendations from the National Academies and others to mix fee-for-service payment mechanisms with per-person payments to encourage team-based, proactive, and person-centered advanced primary care. The foundation of the prospective payment, Prospective Primary Care Payments will be based on average county primary care spending. Meaning, average county-level, historical utilization of primary care services billed by primary care providers. And we refer to this as the "County Base Rate."

This design, of the County Base Rate, is unique among Innovation Center models, as Pauline noted, which have tended to use providers' historical spending, at least in part, to set payment rates. And using a regionally consistent rate for primary care, divorces targets, target primary care spending from an ACO's historical primary care expenditures, which for many providers are below the levels required for patient- centered, coordinated care delivery.

Another important design feature is the enhanced amount of the Prospective Primary Care Payment, for which, which for many ACOs will be guaranteed revenue increases for primary care. The enhanced amount of the Prospective Primary Care Payments are not risk-based payments, and are not recouped by CMS as part of performance-based risk arrangements to the extent that they exceed positive regional adjustments and prior savings adjustments of the Shared Savings Program. And more details on this will be included as part of the forthcoming RFA. There will be guardrails to ensure money is used to support improvements in primary care.

And lastly, the model includes several health equity promoting design components, including the rate setting approach for the County Base Rate, the Prospective Primary Care Payments' enhanced amounts that I just described, and others that will be covered in more detail by Lauren. Next slide, please.

This slide highlights several potential benefits to participation for organizations considering applying to the ACO PC Flex Model. CMS designed the model to increase investments in person-centered primary care and to invite new players to value-based care delivery via a supported payment and care delivery structure. ACO PC Flex offers an on ramp to value-based care for new, low revenue ACOs, increased resources, flexibility and use of funds, opportunities to advance health equity, and an overall improved patient experience. Next slide.

Great. Now we'll talk through the model's eligibility and participation requirements. Next slide.

The ACO PC Flex Model is open to all low revenue ACOs that participate in the Shared Savings Program. Regarding the low revenue designation, CMS provides all applicant ACOs with information applicable for the upcoming performance year, including revenue status designations, as part of the Shared Savings Program application process. Eligible applicants include initial applicants to their shared, to the Shared Savings Program, meaning both new applicants and re-entering ACOs that may have had a break in participation, as well as renewal applicants meaning both regular renewal applicants and early renewal applicants. ACOs participating in either the basic or enhanced tracks of the Shared Savings Programs are eligible to participate.

And again, participation is limited to new and existing ACOs that participate in the Shared Savings Program. ACOs that are not part of the Shared Savings Program are not eligible to participate. And ACOs designated by CMS as high revenue ACOs are also ineligible. Lastly, PC Flex ACOs may not simultaneously receive Advanced Investment Payments, or AIP, under the Shared Savings Program. And I'll provide a few more details here on the overlap slide. Next slide, please.

Agreement periods in the ACO PC Flex Model will begin on January 1st, 2025, and the model will consist of five performance years from 2025 until the end of 2029. The model will be tested with Shared Savings Program ACOs that are, that apply and are selected to participate. The model will follow Shared Savings Program provider eligibility requirements and participation requirement criteria. And participating ACOs will jointly participate in the Shared Savings Program.

So participation in the model is at the ACO level. The Prospective Primary Care Payments will be made to ACOs in lieu of fee-for-service reimbursement for most primary care services. ACO participants will submit claims as usual, and the Medicare payment systems will zero out claims for primary care services billed and delivered by the ACO's primary care providers, federally qualified health centers, and rural health clinics to assigned Medicare patients.

ACOs will distribute Prospective Primary Care Payments to primary care providers. And in doing so, CMS encourages ACOs to move away from fee-for-service, visit-based payment approaches in their downstream payment arrangements with providers, towards more population-based mechanisms, such as capitation. And as part of the ACO PC Flex Model application process, applicants will be asked questions specific to their proposed implementation of the model payment mechanisms. CMS will also assess the degree to which an applicant promotes the model goals of enhancing the predictability amount of funding and flexibility for primary care providers.

And when we say primary care providers, this includes physicians with a primary care specialty designation, physician assistants, nurse practitioners, and clinical nurse specialists. And I did already see one question about this in the chat. So the ACO PC Flex Model prospective payments are intended for primary care practitioners. Details on operational processes related to specialist, non-physician practitioners will be included in the forthcoming RFA. Next slide, please.

Oh, sorry. Sorry, not yet. Can we go back to the previous? Yeah, participants must select prospective assignment as part of their Shared Savings Program application. And participation in the model is limited to 130 ACOs. Next slide, please.

Okay, as I noted earlier, the PC Flex Model, ACO PC Flex Model, ACOs may not simultaneously receive Advanced Investment Payments, or AIP, under the Shared Savings Program. If an ACO began a new agreement period in 2024 to start AIP, but wants to participate in the ACO PC Flex Model beginning in 2025, they must apply to enter into a new agreement period beginning in 2025. They would not receive Advance Investment Payments, beginning in 2025 if they agree to participate in the ACO PC Flex Model, and the Shared Savings Program policies for recruitment and recovery of Advanced Investment Payments would apply.

CMS will not allow organizations and providers to simultaneously participate in the ACO PC Flex Model and another model or Medicare initiative that involves shared savings, aside from the Shared Savings Program, of course, unless otherwise permitted by CMS. This includes the ACO REACH Model and the Making Care Primary Model, among others. Overlap is also not allowed with the Primary Care First Model, given the similarities and payment approaches used by the two models.

PC Flex Model ACOs can participate in CMS Innovation Center initiatives that do not involve shared savings. And more information on the full overlap policies will be listed in the forthcoming RFA. Next slide, please.

I will now pass it off to my model colleague, Lauren, to talk more about the payment methodology in more detail. Thank you.

>> Lauren Kuenster, CMS: Thanks, Megan. We will now talk more about the payment structure in ACO PC Flex. Next slide, please.

So there are two main components to the payment approach. As mentioned earlier, there's a one-time Advanced Shared Savings Payment, as well as monthly Prospective Primary Care Payments, or what we refer to as PPCPs.

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

ACOs will receive their primary care budget prospectively, and monthly payments designed to cover primary care services provided by primary care providers, who are ACO professionals for the ACO's assigned beneficiaries. Prospective Primary Care Payments would be made to ACOs in lieu of fee-for-

service reimbursement directly to ACO participants for most primary care services. Eligible claims would be reduced in the fee-for-service payment system, or what we refer to as zero-pay claims.

ACOs and ACO Participants will enter into agreements reflecting their individually negotiated payment terms for payment from the ACO to the ACO Participant. Importantly, PPCP will not be treated as a cash advance or a cash flow mechanism, such as the Advanced Payment Option, or APO, in ACO REACH, in which CMS reconciles prospective payments made to ACOs against claims-based payments, and either recoups any excess payments made or pays any shortfall. Next slide please.

The PPCP is a monthly payment composed of two main parts. So here we're getting into more of the mechanics of how we arrived at the PPC payment, or the PPCP. The two main pay parts are the base rate and payment enhancements. The base rate is intended to cover primary care services furnished to assign beneficiaries by primary care providers in the ACO. And really the foundation of the PPCP is based on this county-level utilization of primary care services billed by primary care providers, and is what we refer to as the "County Base Rate."

The County Base Rate addresses historical and current patterns of low spending for underserved groups. Payments based on historically observed primary care spending may be inequitable by reflecting inequities in access to, and the provision of high quality primary care, and may actually entrench inappropriately low levels of primary care spending. The ACO PC Flex Model seeks to break this pattern by using a County Base Rate for primary care rather than ACO-specific historical spending as the basis for payment. By setting primary care payments above current levels of spending for underserved populations, we can reduce resource disparities and encourage ACOs to form, to deliver high quality primary care to underserved populations, increasing access.

So how do we get at the County Base Rates? To derive a pre-enhanced County Base Rate for each ACO, CMS will construct a county-level Rate Book of performance year primary care, spending and associated spending for all assigned, eligible Medicare beneficiaries in each county. The county rates in this Rate Book will be risk-standardized, and by that we mean that expenditures would be calibrated to an average risk score of 1.0 and calculated before we apply any model-wide or ACO-specific adjustments.

We will publish the Rate Book before the performance year, so ACOs can assess their likely primary care County Base Rates for the model. The process to construct the County Base Rate in the ACO PC Flex Rate Book will mirror the ACO REACH Rate Book development approach. ACO PC Flex will use three base years for the Rate Book, for the Rate Book. And each county will receive two County Base Rates, an ESRD base rate and a non-ESRD base rate. All ACOs participating in the model will receive the same County Base Rate for each county in which they are serving beneficiaries. Next slide, please.

An ACO's PPCP County Base Rate is then subject to a series of potential enhancements and an administratively set trend. The PPCP includes two types of payment enhancements, which we outlined here. The first is the County Enhancement, which is applied, which is applied at the county-level and counties designated as low-spending counties relative to standardized spending nationally. The County Enhancement essentially sets a floor on the base rate, to raise the County Base Rate in counties with low primary care spending.

The second is the Flex Enhancement which is applied at the ACO level to all participating ACOs, regardless of their location or utilization to increase resources for primary care. The enhanced amount, and by that we are referring to both the County Enhancement, and the Flex Enhancement, is intended

to provide additional resources to ACO, to ACOs, to support increased access to primary care, provision of care, and care coordination. The enhanced amount is not a risk-based payment so to the extent that it exceeds positive, positive regional adjustment and prior savings adjustments, it will not be recouped by CMS. Next slide, please.

For every county, the county-specific components of the PPCP are determined. Once this is done, the county-specific components of the PPCP for each beneficiary month that is assigned to an ACO will be determined. And these county-specific components are based on the beneficiary county of residence. The county-specific components, as we referred to earlier, are the County Base Rate and the County Enhancement.

The Flex Enhancement is added to the county-specific components before a set of adjustments are applied to the PPCP. And these adjustments address multiple goals regarding payment, equity, and operational goals for the model. The PPCP will be adjusted to account for clinical and social risk as well as care received outside of the ACO. ACO PC Flex will also include a beneficiary-level adjustment for beneficiaries who receive the plurality of primary care services based on allowable charges at FQHCs or RHCs to help support the participation of safety of providers in this model. Next slide, please.

After the payment has been adjusted for the factors described above, the resulting PPCP will be trended forward to the corresponding performance year based on a primary care prospective administrative trend, or what we are calling the PCPAT. Using a prospectively determined trend increases predictability and stability at primary care revenue. Next slide, please.

The ACO PC Flex Model will align with the existing Shared Savings Program quality reporting requirements and performance standards. So, in addition to reporting the Shared Savings Programs existing quality measure set, which is includes but is not limited to the CAHPS for MIPS survey. ACO PC Flex will also include an additional patient reported experience measure called the Person-Centered Primary Care Measure, or the PCPCM for short. Use of the PCPCM is an important component of the ACO PC Flex model quality strategy given its focus on person centeredness and care aspects related to the integrating, prioritizing, and personalizing functions of primary care.

The PCPCM Survey will be fielded for all PC Flex ACO Participants. To reduce the burden of PCPCM reporting CMS will fund and manage the administration of the survey. The PCPCM will not be included as part of the existing Shared Savings Program quality performance standard used to determine shared savings and shared losses, which means that the PCPCM Survey will not import shared savings, program quality scoring or savings and losses calculations. And to facilitate the accurate and complete collection of the survey, ACO Participants may be asked to submit supportive information, for example, this may include things such as patient roster data. Next slide, please.

The ACO PC Flex Model seeks to address underserved communities that are underrepresented in ACO initiatives by increasing the participation of safety net providers in Shared Savings Program ACOs, which we think should align more underserved beneficiaries to ACOs and help provide enhanced primary care to the populations which need it. So key components of the payment methodology, which we described before, including the County Base Rate, the county enhancement, equity adjustment and beneficiary-level adjustment for beneficiaries who receive the plurality of their primary care services at FQHCs, or RHCs, or what we refer to as safety net adjustment, really help to promote equity by providing more resources for primary care for populations which need it most.

We will include health equity related questions in the model application, and will score applicants for health equity experience. While CMS will not determine whether a given applicant is selected for participation in the model based solely on these criteria, we hope to ensure that selected ACOs are well positioned to improve quality outcomes for all aligned beneficiaries, including those in underserved communities. Lastly, the ACO PC Flex Model will include a health equity data reporting requirement which represents a policy initiative that emerged from the 2021 update of the Innovation Center's Strategic Plan and derives from the CMS Framework for Health Equity. Next slide, please.

Now that you've heard about the model's design, we'd like to cover a few next steps. Next slide.

If you're interested in participating in the model, here are the key steps for you to follow. The first is to apply to SSP. The SSP application opens on May 20th, and closes on June 17th. Please ensure to indicate interest in the model when submitting the SSP application in order to receive the ACO PC Flex application.

To stay informed about important updates and announcements related to the model, we encourage you to sign up for our listserv. The ACO PC Flex Listserv will notify you when the Request for Applications or RFA becomes available, as well as provide information about additional events and resources. You can sign up for it here via the link in the chat. And lastly, the ACO PC Flex RFA will be released in the second quarter of 2024. Interested stakeholders can prepare for application by using the resources at the end of this presentation and submitting questions to the model mailbox. Next slide, please.

I will now pass back to Meghan for questions.

>>Meghan O'Connell, CMS: Excellent thanks so much, Lauren. We have received many questions through the Q&A feature of the webinar so we're going answer a few questions that have been submitted through the registration and throughout today's session. You can continue to submit questions via the Q&A box at the bottom of your screen. The model team has been working to answer questions as they come through, and we'll continue to do that. Next slide, please.

And, next slide. You can see the email address for the model help desk is listed here, and it's also been in place in the chat. Next slide, please.

Like, I said, we received many questions submitted through the webinars registration process, and we'll cover a few of the more common ones now.

The first question: Could a practice join under the umbrella of an Independent Physician Association, or IPA, or is the creation of an ACO required? I saw this come up a few times in the chat. If selected, does every TIN in an ACO have to participate in claims reduction advanced payment, or can some providers opt out or choose not to participate.

So first, creation of an ACO and participation in the Shared Savings Program is required for model eligibility. If selected, an ACO must enter fee reduction agreements with each ACO participant, so that means each TIN confirming that the ACO participant fee-for-service, fee-for-service payments, as previously described, will be reduced under the model. So selective participation of TINs or providers is not permitted in the model. Next slide, please.

Will the one-time payment amount and prospective payments impact Shared Savings Program benchmarks, and how will the enhanced amounts be calculated? So no, the calculation of the total-cost-of-care benchmark for ACOs participating in the ACO PC Flex Model will be unchanged from the Shared Savings Program methodology, and the one time advance shared savings payment will not affect benchmarks.

The prospective payments will not affect the historical spending component of the benchmark for PC Flex ACOs while they are in the ACO PC Flex Model, but in subsequent agreement periods the prospective payments would be incorporated as historical spending. And more detailed information about how the Prospective Primary Care Payment is calculated, including the enhanced amounts, I know there's a lot of interest in understanding the breakdown of how those payments are being calculated, that will all be provided in the forthcoming RFA. Next slide please.

Do ACOs need to select prospective assignment for the ACO PC Flex Model or can they select retrospective assignment? I also saw this question come up a few times. Although the Shared Savings Program does offer ACOs a choice of preliminary prospective assignment with retrospective reconciliation, or prospective assignment, ACOs that participate in the ACO PC Flex Model will be limited to prospective assignment only. And this is because retrospective assignment may undermine the intent of the model which is to pay prospectively for primary care delivery for pre-defined patient population.

It looks like we have a few more minutes, so I'll just speak to a few more of the questions that I saw come through in the chat. One is on model overlap. So, as I noted earlier, ACOs participating in the ACO PC Flex Model will not be permitted to simultaneously participate in the ACO REACH Model, the Making Care Primary Model, or the Primary Care First Model.

And I'm also seeing a lot of questions related to the definition of low revenue. The official definition, as outlined by the Shared Savings Program regulations, is available both in these materials, the link to those regulations, and it's also included in our Frequently Asked Questions which are posted on the website and all of those materials will be made available on the model website. And again, the Shared Savings Program provides this information, including revenue designation to ACO applicants as part of the Shared Savings Program application. Next slide, please.

Great, so next slide. We have one more poll for you. So far we have a 140 questions and still coming in. So I know there's a lot of interest. We'd love to know what you'd like to learn more about, specific areas. If you could select the topic you'd like to learn more about, you can select more than one. The poll should pop up on your screen now and we'll keep it open for just a minute for folks to respond.

Okay, we'll give you just a few more moments to participate before moving on. Great, and just another moment to select the topics you'd like to learn more about. And I think we can go ahead and close the poll. Great, thank you. So thank you for your responses. Again, this information is really going to help inform our model team’s outreach efforts for future events with the ACO PC Flex Model. And these resources, these slides and the recording of the webinar today, like Haley noted, will be posted on the webinar, or on the model website, following the event. So I'd now like to, next slide, please.

I'd like to mention a few ways to get additional information and resources to stay informed about upcoming ACO PC Flex events and more detailed information. You can visit our website, you can also sign up for the listserv, email the help desk, that email address has been posted in the chat, or check our Model Overview Factsheet, which is listed on the website.

Thank you so much for joining, and I'd love to pass it to Pauline for closing remarks. Thanks again.

>>Pauline Lapin, CMS: Thank you, Meghan. I would like to thank our speakers today. Our colleagues, Meghan O'Connell and Laura Kuenstner, our Chief Strategy Officer at the Innovation Center Purva Rawal, and our Chief Transformation Officer in the Center for Medicare, Dr. Doug Jacobs. Thanks so much for presenting today.

I would also like to thank a few folks who did not present today, but you may hear from in future webinars. Pablo Cardenas, our Value-Based Care Senior Advisor in the Innovation Center, and John Pilotte and Joe Otto in the Shared Savings Program in the Center for Medicare, who we work very closely with in the design of ACO Primary Care Flex.

We are really excited to bring another opportunity to support primary care with this model. We are excited to work with ACOs and see how our ACOs and their primary care clinicians work together to provide person-centered, proactive, and team-based care to their patients. And we know some of you will have questions after today's webinar and encourage you to continue to send your questions to the model help desk, and we will try to provide updated information in future webinars and documents that you will see regarding the model.

Thanks for joining us today and thank you for your commitment to value-based care. I'll turn the call back to our facilitator.

>>Meghan O'Connell, CMS: Excellent, thanks so much, Pauline.

Please be sure to take a few minutes to provide feedback on today's session through the short post event survey. You can see the link here, the link is being posted in the chat now. And this concludes today's webinar. Thank you for joining, and I hope you have a good rest of your day. Thanks so much.

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