ACO Primary Care Flex (ACO PC Flex) Model

Frequently Asked Questions

Version 3

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Contents

Model Purpose

1. What is the Accountable Care Organization Primary Care Flex (ACO PC Flex) Model?

The ACO PC Flex Model is a 5-year voluntary primary care payment model that is tested within the Medicare Shared Savings Program (Shared Savings Program), which began January 1, 2025. ACOs that participate in the ACO PC Flex Model (PC Flex ACOs) are jointly participating in the Shared Savings Program.

The ACO PC Flex Model seeks to reduce program expenditures and improve quality of care and health care outcomes for Medicare beneficiaries through the alignment of financial incentives for primary care, an emphasis on flexibility and primary care innovation, and strong monitoring to ensure that beneficiaries receive access to high-quality, person-centered primary care. The model is testing whether alternative payment for primary care services will empower ACOs participating in the Shared Savings Program and their primary care providers to use more innovative, team-based, person-centered, and proactive approaches to care that positively impacts health care outcomes, quality, and costs of care.

The model provides more flexibility in the use of funds for primary care providers, increases resources for primary care, and strengthens incentives for organizations to participate in the Shared Savings Program. This includes, for example, newly formed low revenue ACOs and ACOs that include federally qualified health centers (FQHCs) or rural health clinics (RHCs) as ACO Participants.

2. How does the ACO PC Flex Model support the Innovation Center's goal to drive accountable care?

Improving primary care is a cornerstone of the Innovation Center's strategy to increase access to high-quality, person-centered care. The ACO PC Flex Model strengthens incentives for more providers to form ACOs in areas that are underresourced and increase the number of people with Medicare who are in an accountable care relationship.

Model Features

1. How will ACOs and their primary care providers benefit from participating in the ACO PC Flex Model?

Primary care is the foundation of a high-performing health care system and fundamental to improving the health of the United States. ACOs have been limited in their ability to provide advanced primary care because of visit-based payment mechanisms and financial incentives in fee-for-service Medicare. The ACO PC Flex Model will test enhanced and prospective primary care payments to enable more team-based, proactive, and person-centered care by ACOs and their primary care providers. These payments include a one-time Advance Shared Savings Payment and monthly Prospective Primary Care (PPC) Payments.

The Advance Shared Savings Payment is intended to cover costs associated with forming an ACO (where relevant) and administrative costs for required model activities. This payment will not be risk adjusted or based on the number of beneficiaries assigned to an ACO. All ACOs will receive the same Advance Shared Savings Payment amount.

2. How does the ACO PC Flex Model impact Medicare beneficiaries?

Beneficiaries with Original Medicare retain all of their rights, coverage, and benefits, including the freedom to see any Medicare health care provider. Like previous ACO models, ACO PC Flex Model requires ACO Participants to make medically necessary covered services available to beneficiaries in accordance with applicable law and prohibits restricting a beneficiary's freedom to choose where he

or she receives care. Even if a beneficiary is assigned to an ACO participating in the ACO PC Flex Model, they always have the freedom to see any Medicare-enrolled provider or supplier.

CMS expects that beneficiaries whose primary care provider is part of an ACO participating in the ACO PC Flex Model will see and feel improvements in the quality and experience of care they are getting because of the ACO PC Flex Model. We refer to this model test as the ACO PC Flex Model given the flexibility in care delivery enabled by the Prospective Primary Care (PPC) Payments. This includes flexibility to coordinate primary care delivery and enhance coordination with specialists. The PPC Payment rate is derived from the average county primary care spending and amplified by payment enhancements based on characteristics of the ACO and the assigned patient population. Deriving the rate from average county spending rather than the historical volume of services rendered by an ACO is a critical feature for increasing payment for primary care and supporting flexibility in how services are delivered. The model tests whether this flexibility would improve the beneficiary experience by allowing providers to arrange for services in a manner that best serves Medicare patients and pays for care management, patient navigation, behavioral health integration, and other care coordination services. Moreover, the model's payment design are expected to provide greater access for reaching beneficiaries who have not previously received coordinated care.

If at any time a Medicare beneficiary or their caregiver has concerns about the ACO PC Flex Model, the Innovation Center has a model liaison that is part of the Medicare Beneficiary Ombudsman team in the Offices of Hearings and Inquiries. The model liaison can be reached through 1-800 Medicare and will assist in facilitating communications with the Medicare Quality Improvement Organizations (QIOs), the CMS regional offices, and ACO PC Flex Model team to ensure the beneficiary's concerns are heard.

3. **Can beneficiaries opt-out of CMS data sharing with ACOs?**
   Yes, beneficiaries can opt out of having CMS share their claims data with an ACO PC Flex Model ACO for care coordination and quality improvement purposes at any time by contacting 1-800-MEDICARE and indicating their preference that CMS does not share such with the ACO.

Eligibility and Participation

1. **Are Medicare Shared Savings Program ACOs that elect to be under preliminary prospective assignment with retrospective reconciliation able to participate in the ACO PC Flex Model, or is this limited to ACOs that elect prospective assignment?**
   Yes, both assignment methodologies are permitted in the ACO PC Flex Model. More information about assignment options and impact on the Prospective Primary Care (PPC) Payment may be found in Appendix A Section V of the ACO PC Flex Participation Agreement.

2. **Must all ACO Participants and ACO Providers/Suppliers in an ACO participate in claims reduction and prospective payment if the ACO participates in the ACO PC Flex Model? Must all National Provider Identifiers (NPIs) under a Tax Identification Number (TIN) participate or may a TIN elect specific NPIs to participate in ACO PC Flex?**
   Similar to the Shared Savings Program requirement for "whole TIN" participation, PC Flex ACOs cannot select which ACO Participants and ACO Providers/Suppliers participate in the ACO PC Flex Model. The ACO PC Flex Model fee reductions for primary care services will apply to each PC Flex ACO Participant that includes a primary care provider. CMS will identify the PC Flex ACO Participants and their primary care providers based on the ACO Participant List and ACO Provider/Supplier List, submitted as part of the ACO's Shared Savings Program application, to determine providers eligible for fee reduction. To

apply fee reductions, CMS will identify the TIN and CMS Certification Number (CCN), if applicable, of each Prospective Primary Care Payment (PPCP)-Eligible Participant and PPCP-Eligible Provider/Supplier and NPI of each eligible primary care provider, such that CMS understands each primary care provider as a TIN/CCN or TIN/NPI combination. Such combinations are identified on the PPCP-Eligible Participant List.

3. **Are all non-physician practitioners (NPPs) included in the model, regardless of their specialty?**
   Only NPPs designated as primary care NPPs by PC Flex ACOs will be included in the model and therefore eligible for fee reductions. NPPs designated as specialty practice NPPs by PC Flex ACOs will not have claims reduced for assigned beneficiaries. This designation is identified during the submission of the Proposed Updated Prospective Primary Care Payment (PPCP)-Eligible Participant List for the upcoming Performance Year.

4. **Can providers participate in other Innovation Center models if they also participate in the ACO PC Flex Model?**
   Health care providers participating in another Innovation Center model that involves shared savings will not be allowed to participate at the same time in the ACO PC Flex Model, unless otherwise permitted by CMS. Visit the Innovation Center's model webpage for more information about models focused on other aspects of care.

5. **Is the model affiliated with HRSA's Medicare Rural Hospital Flexibility (Flex) program?**
   No. HRSA's Flex program provides funds to states for technical assistance to Critical Access Hospitals (CAHs). HRSA's Flex program has no relation to the ACO PC Flex Model.

6. **Can ACOs participating in the ACO PC Flex Model receive Advance Investment Payments (AIP) or Prepaid Shared Savings (PSS)?**
   ACOs may not participate in the ACO PC Flex Model and also receive Advance Investment Payments (AIP) or Prepaid Shared Savings (PSS) under the Shared Savings Program.

7. **Will this model qualify as an Advanced or Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM)?**
   Advanced APM status in the ACO PC Flex Model will be consistent with CMS' Advanced APM determination for each Shared Savings Program risk track, where CMS has determined that Level E of the BASIC track and the ENHANCED track are Advanced APMs for the performance year. Eligible providers who are included on the participant list participating in the Level E of the BASIC track or the ENHANCED track will be eligible for Quality Payment Program (QPP) Qualifying APM Participant (QP) determinations.

8. **What is a low revenue ACO? How does my ACO know if it is low or high revenue?**
   The Shared Savings Program regulations define "low revenue ACO" under 42 CFR § 425.20 as an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO Participants, based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35% of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available. These low revenue ACOs often face greater financial challenges than high revenue ACOs with expanding access to high-quality primary care, because they tend to be less capitalized, more risk-averse, and less likely to take on performance-based risk than high revenue ACOs.

   The Shared Savings Program provides revenue determinations to ACOs in the ACO Management System (ACO-MS) as part of the Shared Savings Program application process. Eligibility for the ACO PC

Flex Model will be based on final revenue determinations provided by CMS during Phase 1 Final Dispositions in October.

9. **What is the model timeline?**
   The ACO PC Flex Model will be tested over five performance years, from January 2025 – December 2029. Performance years will occur in the calendar years of 2025, 2026, 2027, 2028, and 2029, respectively. A Shared Savings Program ACO participating in the ACO PC Flex Model will start a new Shared Savings Program agreement period and will enter into a new Shared Savings Program participation agreement for the performance years January 2025 through December 2029. In addition, the ACO will have a separate ACO PC Flex Participation Agreement for performance years January 2025 through December 2029.

10. **Will there be another application cohort in the future?**
    No additional application round is planned at this time. For more information on upcoming CMS Innovation Center Models, please visit: https://www.cms.gov/priorities/innovation/models.

Financial Model

1. **How does the Prospective Primary Care (PPC) Payment work?**
   The PPC Payment is a monthly payment, paid to ACOs, for primary care services provided by primary care providers who participate in the ACO and provide primary care to the ACO's assigned beneficiaries. The PPC Payment is made up of two parts, a County Base Rate to cover PPCP-eligible services (Prospective Primary Care Payment County Base Rate) and an Enhanced Amount for providing enhanced primary care services (Prospective Primary Care Payment Enhanced Amount).

   The amount of payment made by CMS to the ACO will depend on the County Base Rate, which is derived from county average primary care spending, and the Enhanced Amount based on characteristics of the ACO and its assigned patient population. For most model participants, CMS expects that the PPC Payment will increase primary care funding relative to ACOs' historical expenditures.

2. **ACOs that participate in the Shared Savings Program receive the Prospective Primary Care (PPC) Payment for primary care services in lieu of fee-for-service payments. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not receive fee-for-service payments. How will the ACO PC Flex Model drive participation in the Shared Savings Program for RHCs and FQHCs? Are there special considerations for FQHCs and RHCs, who are not paid fee-for-service like other primary care providers?**
   The ACO PC Flex Model includes special considerations for RHCs and FQHCs, who are not paid fee-for-service like other primary care providers. A beneficiary level add-on payment to the PPC Payment is included for beneficiaries who receive the plurality of primary care services based on allowable charges at FQHCs or RHCs (beneficiaries with FQHC or RHC focused care). Because the all-inclusive payment rate is different for FQHCs and RHCs, there will be a different primary care per-beneficiary per-month (PBPM) add-on amount for each of these settings to encourage FQHCs and RHCs to participate in the ACO PC Flex Model.

   Additionally, CMS is providing a guardrail for PPC Payment amounts for beneficiaries with FQHC or RHC focused care. If the ACO's paid PPC Payment (excluding Flex Enhancement) for these beneficiaries is less than the actual claims reductions (evaluated YTD on a quarterly basis), we will make additional payment in the next available payment cycle to make up the difference. This means

that the payment for these beneficiaries will not be less than actual fee reductions while preserving the Flex Enhancement. Note that this calculation is done at the ACO level and not at the beneficiary level.

3. **How will FQHC Prospective Payment System (PPS) rates be impacted if they participate in ACO PC Flex? Will FQHCs still be able to bill for Care Management Services?**
   All claims billed by Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) for beneficiaries assigned to the PC Flex ACO in which the FQHC or RHC is participating will be considered primary care services and zero-paid. Claims billed by FQHCs or RHCs for other beneficiaries will be paid normally.

4. **How is the Enhancement PPC Payment calculated? Will CMS provide ACOs with the data sources used to calculate the PPC Payment?**
   The Prospective Primary Care (PPC) Payment consists of several components, including the PPC Payment County Base Rate, Add-on for beneficiaries with FQHC- or RHC-Focused Care, the Total Enhanced Amount (which includes the Flex Enhancement, the County Enhancement, and the Enhancement Add-on), PPC Payment Adjustments, and Primary Care Prospective Administrative Trend (PCPAT).

   The ACO PC Flex Model Financial Methodology paper, as well as model-wide variables has been published. ACO-specific variables, such as the Primary Care Outside of ACO (PCOA) Adjustment factor, will be made available to PC Flex ACOs in advance of the performance year.

   Each month, PC Flex ACOs will receive a payment detail report that includes the detailed build up of the PPC Payment at the beneficiary-month level.

5. **Is the rate for the prospective payment that is paid to ACO Participants by the ACO established by CMS or by the ACO?**
   The prospective payment will be paid by CMS to PC Flex ACOs based on the methodologies described in the ACO PC Flex Model Financial Methodology paper. PC Flex ACOs will be required to report quarterly the total amount paid to ACO Participants at the Tax Identification Number (TIN) or CMS Certification Number (CCN) level, and for what purpose.

6. **What are the shared savings or shared losses rates in ACO PC Flex?**
   PC Flex ACOs are simultaneously participating in the Shared Savings Program, which governs the shared savings and losses rates based on the participation option (BASIC track levels A through E and ENHANCED track) that is selected.

7. **How does the county rate get established for multistate ACOs?**
   The County Base Rate and County Enhancement, where applicable, are used at the beneficiary level based on the beneficiary's county of residence. For PC Flex ACOs that span multiple counties or states, the average county rate for the PC Flex ACO is the beneficiary-month weighted average of the county rates of the PC Flex ACO's assigned, Prospective Primary Care (PPC) Payment eligible beneficiaries. In practice, the PPC Payment is calculated at the beneficiary-month level. PC Flex ACO-level averages are not used to calculate payment but may be of interest to PC Flex ACOs for informational purposes.

8. **Can the ACO retain a portion of the Prospective Primary Care (PPC) Payment to invest in infrastructure or does all the PPC Payment money need to be paid out to Participant Providers?**
   So long as PC Flex ACOs satisfy the minimum spend requirements described below (e.g., at least 90% of PPC Payment must be spent on Category 1 during performance year 1, at least 95% spent on

Category 1 in subsequent performance years), there are no additional restrictions or limitations on when PPC Payment needs to be spent by PC Flex ACOs. PC Flex ACOs are not required to spend all PPC Payments each performance year.

Allowable uses of the PPC Payment are detailed in Appendix A of the ACO PC Flex Model Financial Methodology paper. There are three expenditure categories, each with requirements about how much of the PPC Payment must be used for that category:

Expenditure Category	First Payment Year	Subsequent Payment Years
1. Provision and Support of Advanced Primary Care	At least 90%	At least 95%
2. Operations of PC Flex ACO	Not more than 10%	Not more than 5%
3. Prohibited Uses	0%	0%

9. **What will financial settlement look like under the ACO PC Flex Model?**
Because PC Flex ACOs are still participating in the Shared Savings Program, PC Flex ACOs will be subject to the Shared Savings Program financial settlement process, as codified in federal regulations. At a high level, financial settlement for PC Flex ACOs will compare the performance year benchmark to performance year expenditures to calculate gross savings or losses. The calculation of the total cost of care benchmark for PC Flex ACOs will be unchanged from the Shared Savings Program's methodology (as codified at 42 C.F.R. Part 425 Subpart G).

   Financial Settlement in ACO PC Flex will generally follow the procedures in the Shared Savings Program; however, several adjustments to Shared Savings & Losses calculations are required for ACO PC Flex. Any Other Monies Owed, or portion of the Advance Shared Savings Payment determined to be owed as a result of a settlement report or revised settlement report upon reopening, shall be paid in accordance with Section 8.06B of the ACO PC Flex Participation Agreement.

10. **Are Prospective Primary Care (PPC) Payments for the ACO PC Flex Model risk-adjusted payments?**
Components of the PPC Payment are adjusted to account for variation in the clinical risk among a given PC Flex ACO's Prospective Primary Care Payment (PPCP)-Eligible Beneficiaries. The County Base Rate, County Enhancement, Flex Enhancement, FQHC and RHC Add-ons, and Enhanced Add-on are risk-adjusted using the CMS-Hierarchical Condition Category (HCC) prospective risk adjustment model. 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.

11. **Will the capitation of the ACO PC Flex Model replace all reimbursement for participating practices?**
Fee reductions under the model will be applied to claims for Prospective Primary Care Payment (PPCP)-Eligible Beneficiaries billed by PPCP-Eligible Providers/Suppliers using a Primary Care or Non-Physician Practitioner PECOS code for primary care services identified by the list of Healthcare Common Procedure Coding System (HCPCS) codes in the Participation Agreement for the relevant performance year. Claims for services not meeting these criteria will not be reduced and will be paid to the billing provider normally. For claims meeting these criteria, CMS will apply a 100 percent fee reduction of the claims-based payment.

12. **If a beneficiary is not Prospective Primary Care (PPC) Payment-Eligible because they declined data-sharing, would the attributed provider receive Fee-for-Service (FFS) payments?**
CMS will not reduce Fee-for-Service (FFS) payments on claims for PPC Payment-Eligible Services furnished to PC Flex Beneficiaries who elect to decline data sharing. Providers will receive FFS

payments for services provided to these beneficiaries.

13. **Can you please clarify if our ACO needs a separate financial guarantee for the ACO PC Flex Model?**
PC Flex ACOs participating in both one sided and two-sided risk tracks of the Shared Savings Program must secure a separate financial guarantee for the ACO PC Flex Model. Therefore, PC Flex ACOs participating in two-sided risk tracks of the Shared Savings Program must secure two repayment mechanisms. The repayment mechanism established as part of the Shared Savings Program application ensures the ACOs ability to repay shared losses for which it may be liable under a two-sided performance-based Risk arrangement. The ACO PC Flex Model repayment mechanism ensures the PC Flex ACO's ability to repay Other Monies Owed to CMS, which may include the Advance Shared Savings Payment and the Prospective Primary Care (PPC) Payment Enhanced Amounts.

14. **Can ACOs modify the Fee Reduction Agreement?**
PC Flex ACOs must use the Prospective Primary Care (PPC) Payment Fee Reduction Agreement Template, as provided by CMS. Additional modifications are not allowed.

15. **When can ACOs expect to receive the monthly Prospective Primary Care (PPC) Payment?**
CMS will make a monthly PPC Payment to the ACO for each month of the Performance Year a few days prior to each month. Please allow 3-5 business days for the payment to transfer. Payments are made prospectively for the next month, with the exception of the January payment. For estimated PPC Payment dates, PC Flex ACOs can visit the Integrated ACO PC Flex Calendar on the Knowledge Library in ACO-MS.

16. **What is the impact of the Prospective Primary Care (PPC) Payment on beneficiary cost-sharing responsibility?**
Participation in the ACO PC Flex Model does not change the cost-sharing responsibilities of beneficiaries or supplemental payers, regardless of how providers are paid or whether the provider is participating in fee reductions. Regarding the PPC Payment amounts, PPC Payments replace the part that Medicare pays in Fee-for-Service. Practices should continue to submit claims to Medicare and to also submit claims or bills for patient responsible portions to secondary payers or patients, as appropriate.

Participant Management

1. **What is a PPCP-Eligible Participant List?**
The Prospective Primary Care Payment (PPCP)-Eligible Participant List reflects the individuals and entities that CMS determines to be eligible for PPC Payment Fee Reductions of claims-based payments for PPCP-Eligible Services provided to PPCP-Eligible Beneficiaries. The ACO Participant List, due in Phase 1 RFI-2 of the Shared Savings Program application process, is used to create the Proposed PPCP-Eligible Participant List. The PC Flex ACO updates the Proposed PPCP-Eligible Participant List to select non-physician practitioners (NPP) designations and add any ACO Provider/Suppliers billing through a Tax Identification Number (TIN) included on the ACO Participant List that may not be on the Proposed PPCP-Eligible Participant List. CMS reviews the ACO's revisions to create the final PPCP-Eligible Participant List.

   Beneficiaries must receive the plurality of their care from PPCP-Eligible Providers/Suppliers, as shown on the final PPCP-Eligible Participant List, to be considered PPCP-Eligible Beneficiaries. For more information, please see the ACO PC Flex Model Financial Methodology paper.

2. **What is the difference between the PPCP-Eligible Participant List and the ACO Participant List or ACO Provider/Supplier List that I send to participate in the Medicare Shared Savings Program?**

The ACO PC Flex Model Prospective Primary Care Payment (PPCP)-Eligible Participant List is derived from the Shared Savings Program ACO Participant List and includes ACO providers and suppliers associated with ACO Participants (a) in the Provider Enrollment, Chain and Ownership System (PECOS) and/or (b) billing for primary care services used in assignment of beneficiaries to Shared Savings Program ACOs. The list is restricted to providers and suppliers who will be subject to a 100% fee reduction of their claims-based payments for primary care services provided to PPCP-Eligible Beneficiaries as part of the ACO PC Flex Model. This includes ACO Participants that are federally qualified health centers (FQHCs) or rural health clinics (RHCs) and ACO suppliers who are identified as primary care physicians or non-physician practitioners in either PECOS or claims data. Primary care physicians have specialty designations of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine, while non-physician practitioners include specialty designations of nurse practitioner, clinical nurse specialist, or physician assistant.

The specialty restriction described above means that the PPCP-Eligible Participant List is not the same as the list of ACO providers and suppliers used in Shared Savings Program beneficiary assignment, which includes additional specialist physicians in Step 2 of the assignment methodology. Additional information on the Shared Savings Program assignment methodology can be found on the Program Guidance & Specifications webpage (https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations).

PECOS data used to construct the PPCP-Eligible Participant List are sourced from the ACO Provider/Supplier List data that are also used in the beneficiary assignment process that determines whether Shared Savings Program applicant ACOs have at least 5,000 assigned beneficiaries in the ACO's third benchmark year to be eligible to participate in the Shared Savings Program, which CMS performs at the end of Phase 1 of the Shared Savings Program application cycle. Claims data used to construct the PPCP-Eligible Participant List align with the claims used in the same beneficiary assignment process.

3. **Do beneficiaries retain freedom of choice in this model? Can beneficiaries switch primary care providers?**

   Beneficiaries aligned to a participant in the Model are in Original Medicare and retain all of their rights, coverage, and benefits, including the freedom to see any Medicare-enrolled provider or supplier. They may switch healthcare providers at any time.

4. **If a Participant or Provider/Supplier on the Performance Year (PY) 2026 ACO Participant List for the Shared Savings Program declines the ACO PC Flex Model Fee Reduction Agreement before the signing event, can the ACO remove the individual participant from the Performance Year (PY) 2026 ACO Participant List (before the start of PY 2026), while maintaining entity participation in the ACO PC Flex Model?**

   For PY 2026, Providers/Suppliers on the PY 2026 ACO Participant List that remain on the list after the Shared Savings Program's final opportunity to withdraw or delete ACO Participants (the end of Phase 1 RFI 2, or September 8, 2025) are subject to the terms of the model Participation Agreement. An ACO may not remove the individual participant from the Performance Year (PY) 2026 ACO Participant List (before the start of PY 2026) while maintaining entity participation in the ACO PC Flex Model.

5. **If an ACO intends to withdraw from the ACO PC Flex Model, can the entity continue in its MSSP Participation Agreement?**

   Should a PC Flex ACO terminate from the ACO PC Flex Model during the terms of the Participation Agreement, their participation in the Medicare Shared Savings Program will be reviewed on a case by

case basis.

6. **Are ACOs able to change NPP (Non-Physician Practitioner) designations of 'primary care' or 'specialty care'?**
   During the PY, once a NPI (National Provider Identifier) has been designated as a Primary Care NPP or Specialty Care NPP 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.

   During the annual update of the PPCP-Eligible Participant List, when an ACO updates their Proposed PPCP-Eligible Participant List for the following PY, the ACO may change an NPP's designation for the following PY.

7. **What is the overlap of ACO Participants in the Shared Savings Program and the PC Flex Model?**
   For PC Flex ACOs, all ACO Participants on the Shared Savings Program Participant List identified as providing primary care are also ACO Participants in the ACO PC Flex Model. Therefore, PC Flex Model ACOs cannot select which ACO Participants, ACO providers/suppliers, or ACO professionals participate in the ACO PC Flex Model. This is consistent with the Shared Savings Program requirements for "whole TIN" participation. ACO Participants identified on the Prospective Primary Care Payment (PPCP)-Eligible Participant List will be subject to PPC Payment Fee Reductions for PPCP-Eligible Services provided to PPCP-Eligible Beneficiaries by PPCP-Eligible Providers/Suppliers. PPCP-Eligible Participant means an ACO Participant (as defined at 42 CFR § 425.20) (1) for which the ACO Providers/Suppliers (as defined at 42 CFR § 425.20) billing Medicare under the TIN of the ACO Participant include one or more PPCP-Eligible Provider/Supplier (defined below); (2) identified on the PPCP-Eligible Participant List; and (3) is subject to a PPC Payment Fee Reduction for PPCP-Eligible Services provided to PPCP-Eligible Beneficiaries.

8. **How do changes to the ACO Participant List for the next PY impact PPC Payment and Repayment Mechanism (RM) amounts for that PY?**
   In the Participation Options Report, which ACOs receive at the beginning of each Request for Information (RFI) phase of the annual application cycle, ACOs will receive an estimate of their monthly Prospective Primary Care (PPC) Payments and their ACO PC Flex Repayment Mechanism (RM) amount. These estimates will be based on estimated assignment for the base year based on the proposed ACO Participant List for the upcoming performance year. The final PPC Payment and RM amounts will be determined by the final PPCP-Eligible Participant List.

Public Reporting

1. **Are PC Flex ACOs subject to public reporting requirements?**
   PC Flex ACOs are subject to Shared Savings Program public reporting requirements and additional PC Flex requirements, including but not limited to posting spend plans and reports and termination notices on public websites before disabling the website. The Shared Savings Program requires ACOs to create and maintain a dedicated webpage to publicly report required organizational and programmatic information, such as organizational contact information and performance results. A separate URL from MSSP public reporting is not required for ACO PC Flex Model public reporting. For additional information on public-facing reporting, please refer to the guidance provided by CMS here: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations.

2. **Can ACOs modify the Annual Spend Plan that was submitted and approved by CMS and post an updated version on the ACO's public website?**
   Each year, CMS will provide model participants with a 508-compliant PDF version of the relevant Performance Year's Annual Spend Plan for use in public reporting. Approval of modifications can be requested via the Shared Savings Program helpdesk.

3. **When submitting Quarterly and Annual Spend Reports, can ACOs allocate funds differently than the Annual Spend Plan?**
   The Annual Spend Plan is non-binding and may differ from actual expenditures as reported in ACOs' Quarterly and Annual Spend Report submissions. Quarterly and Annual Spend Reports must reflect actual spending of the Prospective Primary Care (PPC) Payment and Advance Shared Savings Payment. This includes itemization of how the PPC Payment and Advance Shared Savings Payment were actually spent, the dollar amounts spent on each Expenditure Category and Subcategory, the distribution of funds to ACO Participants, the type of payee that received such funds, if the funds were used for Expenditure Category 1.A, and such other information as may be specified by CMS through written communication and as defined in the ACO PC Flex Model Participation Agreement. ACOs will submit an updated Spend Plan prior to the start of each Model Performance Year; they may adjust the plan at that time to reflect where the ACO will focus its spending pursuant to the allowable and prohibited uses set forth in the Participation Agreement.