ACO Primary Care Flex Model

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

June 2026
Version 3

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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

Revision History (from Version 2 to 3)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
3	May 2026	Replaced previous Section 5 about financial settlement with more details and methodological updates. Some of this went into appendices.	Sections 5 – 6, Appendix E, Appendix F
3	May 2026	Added updated information about 2026 and subsequent Rate Books	Section 3
3	May 2026	Clarifications to criteria to determine PPCP eligibility	Section 2
3	May 2026	Updates to discussion about geographic adjustment factor (GAF)	Section 3
3	May 2026	Risk scores and assignment files to be used for 2026	Section 4

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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.
- **Sections 5** through **6** provide information about Financial Settlement, with **Section 6** specifically focused on early termination.
- **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 Realizing Equity, Access, and Community Health (REACH).
- **Appendix E** explains the first stage of ACO PC Flex Model operations and financial settlement.
- **Appendix F** explains the second stage of ACO PC Flex Model operations and financial settlement.
- **Appendix G** 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] 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”).

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 Quarter (Q) 1 of 2025. The Advance Shared Savings Payment is intended to cover costs 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 Amount, 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 that 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; or • 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 (i.e., 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 Other providers and suppliers. CMS determines the plurality of primary care services by comparing the total Medicare allowed charge 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, their 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, their care focus is RHC). In the event of a tie with other non-FQHC and non-RHC providers/suppliers (i.e., the allowed amount for primary care services for the beneficiary billed by all other non-FQHC and non-RHC providers collectively equals the allowed amount for primary care services billed by FQHCs collectively 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

[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.

performed by a primary care physician for the ACO PC Flex Model, including in the determination of care focus.

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 and non-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 and non-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 and 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 (1) a specialist physician[10] and therefore not included on the PPCP-eligible participant list or (2) 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.
    - Beneficiaries assigned to an organization participating in another capitation-based initiative for which beneficiary overlap with the ACO PC Flex model is prohibited (e.g., Kidney Care First, the Primary Care AHEAD model, and the Geo AHEAD model) are not PPCP-eligible beneficiaries.
    - For Performance Year 2025 only, beneficiaries with a primary provider or supplier that was designated by the ACO as deferring fee reductions until 2026.
    - For Performance Year 2025 only, beneficiaries with a primary provider or supplier that was designated by the ACO as "participation in fee reduction to-be-determined" and who was later confirmed to participate for fee reductions starting July 2025 were not PPCP-eligible beneficiaries for the months of January through June 2025, but became PPCP-eligible starting July 1, 2025, if they met 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.

[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.

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 the performance year if they are assigned to the PC Flex ACO via voluntary alignment or claims-based assigned via Step 1 or Step 3 based on the performance year's Prospective Assignment run (see **Table 1** for an overview of the Shared Savings Program assignment methodology). If a beneficiary dies during the performance year, they are considered a PPCP-eligible beneficiary only for the months during the performance year 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 2** summarizes the scenarios and the implications for determination of PPCP-eligible beneficiaries served by ACOs that select Prospective Assignment.

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

Initial Assignment Run [a]	Subsequent Assignment Eligibility Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	Remains assigned to the ACO.	Eligible.
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 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. [b]

Initial Assignment Run [a]	Subsequent Assignment Eligibility Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	Beneficiary died during the performance year.	Eligible for partial year; eligibility continues until the month following the month of death. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	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. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	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. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	Beneficiary is assigned to the ACO and to an organization participating in another capitation-based initiative for which beneficiary overlap with the ACO PC Flex model is prohibited.	Not eligible for any month in the performance year. [b]
Assigned via CBA only in Step 2	Any outcome.	Not eligible for any month in the performance year. [b]

[a] *Assigned via Voluntary Alignment can mean assigned via Voluntary Alignment only or via Voluntary Alignment and CBA in Steps 1, 2, or 3. Note that both (1) beneficiaries assigned via Voluntary Alignment whose designated primary clinician is a specialist physician or NPP designated as specialty care by the ACO and (2) beneficiaries assigned via CBA only in Steps 1 or 3 whose primary provider or supplier is a specialist physician or NPP designated as specialty care by the ACO are not eligible for any months of the performance year regardless of outcomes of subsequent assignment eligibility runs in the performance year.*

[b] *Recoupment procedure is applied (see Section 4.5 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 the performance year 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 the performance year, 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 3 summarizes the scenarios and the implications for determination of PPCP-eligible beneficiaries for ACOs that select Preliminary Prospective Assignment with Retrospective Reconciliation.

Table 3. PPCP-Eligible Beneficiary Determination in ACOs Who Select Preliminary Prospective Assignment with Retrospective Reconciliation

Initial Assignment Run [a]	Subsequent Assignment Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment	Still assigned to the ACO.	Eligible.
Assigned via Voluntary Alignment	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. [b]
Assigned via CBA only in Step 1 or Step 3	Remain assigned via Step 1 or Step 3 to the same PC Flex ACO for all subsequent assignment runs.	Eligible.
Assigned via CBA only in Step 1 or Step 3	Assigned via Step 2.	Not eligible for any month in performance year. [b]
Assigned via CBA only in Step 1 or Step 3	No longer assigned to the same PC Flex ACO for at least one quarter.	Not eligible for any month in performance year. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA in Step 1 or Step 3	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. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	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. [b]
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	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. [b]

Initial Assignment Run [a]	Subsequent Assignment Run in the Performance Year	PPCP Eligibility
Assigned via Voluntary Alignment *or* Assigned via CBA only in Step 1 or Step 3	Beneficiary is assigned to the ACO and to an organization participating in another capitation-based initiative for which beneficiary overlap with the ACO PC Flex model is prohibited.	Not eligible for any month in the performance year. [b]
Assigned via CBA only in Step 2	Any outcome.	Not eligible for any month in performance year. [b]

[a] Assigned via Voluntary Alignment can mean assigned via Voluntary Alignment only or via Voluntary Alignment and CBA in Steps 1, 2, or 3. Note that both (1) beneficiaries assigned via Voluntary Alignment whose designated primary clinician is a specialist physician or NPP designated as specialty care by the ACO and (2) beneficiaries assigned via CBA only in Step 1 or 3 whose primary provider or supplier is a specialist physician or NPP designated as specialty care by the ACO are not eligible for any months of the performance year regardless of outcomes of subsequent assignment eligibility runs in the performance year.

[b] Recoupment procedure is applied (see Section 4.5 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 PPC Payment Amount.

For Performance Year 2025, two versions of the Rate Book were released: a Preliminary Rate Book and an Updated Rate Book. Note that for Performance Year 2025, CMS created 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. For Performance Year 2026, the Rate Book was updated to reflect changes to the applicable A&D risk score model (see Subsection 3.2.2). CMS currently anticipates that the Performance Year 2026 Rate Book will also be used for Performance Years 2027–2029. CMS will update the financial methodology if it determines that updates for future performance years are warranted.

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 support consistency between the developed rates and the beneficiaries for whom the PPC Payment will be paid. The criteria have 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

[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.

Reference Population excludes both beneficiaries in the ACO PC Flex National Reference 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 Years 2025–2029 are based on historical claims data from the most recent years prior to the start of the model 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 and is trended forward to 2024 in the case of the 2025 Preliminary Rate Book when the most recent BY was 2023. For the 2025 Updated Rate Book and the 2026 Rate Book, there was no need to be trend forward since the most recent BY was 2024. The County Relative Cost Indices are based on experience from all 3 BYs (varies by Rate Book, see **Table 4)**.[13] As part of the PPC Payment calculation for each performance year, County Base Rates and Enhanced amounts (which are in 2024 dollars via the National Conversion Factor) are trended to each performance year (see Subsection 4.1.3). **Table 4** outlines the calendar years (CYs), BYs, and performance years used to develop the Rate Book.

Table 4. Construction of the 2025 Preliminary Book, 2025 Updated Rate Book, and 2026–2029 Rate Book

Performance Year	Calendar Year	Rate Book Bys
Performance Year 2025–Performance Year 2029	2025–2029	CY2021, CY2022, and CY2023 for the 2025 Preliminary Rate Book CY2022, CY2023, and CY2024 for the 2025 Updated Rate Book and 2026–2029 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

[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.

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 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 5**). 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]

[14] Refer to CFR § 425.400(c)(1)(ix) for the list of CPT/HCPCS codes used in assignment for Performance Year 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).

- 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 (**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 5. Assignment Window and Expanded Window for Assignment for the 2025 Preliminary Book, the 2025 Updated Rate Book, and the 2026–2029 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)
2025 Preliminary Rate Book	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
2025 Updated Rate Book and 2026–2029 Rate Book	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

[19] Refer to § 425.401(a)(4).
[20] Refer to § 425.402(b)(1).
[21] Refer to § 425.20.
[22] Refer to § 425.611.

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 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 expenditures included in the development of the Rate Book—referred to as ACO PC Flex expenditures—include all eligible primary care FFS Medicare claim payment amounts billed by

[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.

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, 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 6**.
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 7**.

Table 6. Rate Book BYs Used to Compute ACO PC Flex Expenditures for the 2025 Preliminary Rate Book, the 2025 Updated Rate Book, and the 2026–2029 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 and 2026–2029 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

[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.

Table 7. 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 used, "Rendering" must not be found. For "Attending" to be used, "Other" and "Rendering" must both not 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 8** 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

[25] The 2025 Preliminary ACO PC Flex Rate Book did not add back in adjustments for CAHs, ETA hospitals, and HOPDs.

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 8**.

Table 8. 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	Included [a] – primary care only	Included	Included
Other adjustments for Innovation Center models and other CMS programs (e.g., shared savings and losses)	Not included	Included	Included
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. However, the 2025 Updated ACO PC Flex Rate Book and the 2026–2029 ACO PC Flex Rate Book do 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]

[26] The preliminary version of the 2025 Rate Book used an overall claims completion factor of 1.013. The 2025 Updated Rate Book and the 2026–2029 Rate Book used a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model.

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 1.05114 (representing 5.114 percent growth) for A&D beneficiaries and 1.06588 (representing 6.588 percent growth) for ESRD beneficiaries. For the 2025 Updated Rate Book and 2026 Rate Book, the calculated PBPM figure was based on 2024 data, so no trend factor was required or applied.

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 state having the same value.

[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.

The process of calculating the final County Relative Cost Index for the A&D population is illustrated in **Table 9**.[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. This result is then divided by the national index, which is the national average geographic adjustment.[29]

Table 9. 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
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.

[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.

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

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 Subsection 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 related to use of state versus 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 beneficiaries in the ACO PC Flex National Reference Population in care focus "Other" (that is, beneficiaries who do not have FQHC- or RHC-focused care).

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

- **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.

- **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.
- **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 10** presents the county average percentage of claims eligible for repricing, by claim type and CY.

Table 10. Percentages of Claims Eligible for Repricing, by Year, Claim Type, and PC Flex Population

Claim Types	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%

- **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).
- **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 adjustment is applied to claims eligible for repricing by CY, claim type, and population group, resulting in the Budget Neutral (BN) GAF-Adjusted Expenditure.

- **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 (A&D or ESRD). For the 2025 Preliminary Rate Book, expenditures for 2021–2023 were adjusted to CY2024. For the 2025 Updated Rate Book and the 2026–2029 Rate Book, expenditures for 2022–2024 were adjusted using the most recent geographical practice cost index (GPCI) and Area Wage Index (AWI) data. For the 2025 Preliminary Rate Book, GPCI and AWI data from CY2025 was used; for the 2026–2029 Rate Book, GPCI and AWI data from the prior CY will be used (e.g., the 2027 Rate Book will use CY2026 GPCI data). **Table 11**

shows the differential inputs for the 2025 Preliminary Rate Book as compared to the 2025 Updated Rate Book and the 2026–2029 Rate Book.

Table 11. GAF Indices Used for the 2025 Preliminary Rate Book, the 2025 Updated Rate Book, and the 2026–2029 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	$\frac{\text{[BY]BN GAF Expenditure Adjusted to 2024}}{\text{[BY] PC Flex Expenditure}}$
2025 Updated Rate Book	A&D	County	2022, 2023, 2024	$\frac{\text{[BY] BN GAF Expenditure Adjusted to 2025}}{\text{[BY] PC Flex Expenditure}}$
	ESRD	State	2022, 2023, 2024	$\frac{\text{[BY] BN GAF Expenditure Adjusted to 2025}}{\text{[BY] PC Flex Expenditure}}$
2026–2029 Rate Book	A&D	County	2022, 2023, 2024	$\frac{\text{[BY] BN GAF Expenditure Adjusted to Prior CY}}{\text{[BY] PC Flex Expenditure}}$
	ESRD	State	2022, 2023, 2024	$\frac{\text{[BY] BN GAF Expenditure Adjusted to Prior CY}}{\text{[BY] PC Flex Expenditure}}$

Table 12 provides an example of the GAF process for aggregated claims in three counties.

Table 12. 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	1.006
B	$9,463,582.51	$10,374,090.48	$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 12** 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 a 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 Preliminary and Updated Rate Books, risk scores for A&D beneficiaries 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). For the 2026–2029 Rate Book, risk scores for A&D beneficiaries are based on the 2024 prospective CMS-HCC risk adjustment model V28 (without a blend). Risk scores for ESRD beneficiaries for all versions of the Rate Book 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 Years 2025 and 2026 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 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

[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.

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 is based on FFS data from CY2017–CY2021. The methodology for the study and adjustment is described in more detail in the CY2022 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:

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

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:

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

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

[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.

The credibility-adjusted county rate is then:

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

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.∑

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

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

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

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 **Table 13** and **Table 14**.

[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.

Table 13. 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 14. 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 budget neutrality factor involved in the final rate. As outlined in Subsection 3.3.2, the budget neutrality 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 budget neutrality 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 15**. 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 15. 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 are 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 6** 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 and the 2026–2029 Rate Book, the calculated PBPM figure is calculated in 2024 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.

[35] The 2025 Preliminary Rate Book used an overall claims completion factor of 1.013. The 2025 Updated Rate Book and the 2026–2029 Rate Book used a 3-month completion factor of 1.021, computed specifically to the primary care services used in ACO PC Flex Model.

- **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 Years 2025 and 2026 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 Years 2025 and 2026 is $10.42 PBPM ($125 PBPY). This Enhancement Add-On amount is meant to account for the billing of the Advanced Primary Care Management services codes established by the CY2025 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 16**).

Table 16. 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 5.3, 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 17**.

Table 17. 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); sequestration
	FQHC Add-On; RHC Add-On	Risk adjustment; PCOA; PCPAT; sequestration
	Base Rate Add-On amount	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 Amount	Population Adjustment Amount	Sequestration

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

- **Section 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.
- **Section 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 Amount.
- **Section 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 relevant performance year dollars.
- **Section 4.1.4 Seasonality Adjustment.** Used to account for natural variability in Medicare expenditures for primary care services over the course of a CY.

- **Section 4.1.5 Comparison to Fee Reductions and Additional Payment Amount for Beneficiaries with FQHC- or 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.
- **Section 4.1.6 Limit on Enhanced PPC Payment Amount.** A limit or cap is applied to the enhanced portion of the PPC Payment.
- **Section 4.1.7 Population Adjustment Amount.** Adjusts the amount of PPC Payment payable to a PC Flex ACO to account for relative differences in beneficiary resources.

  Section 4.1.8 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 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 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). For Performance Year 2026, risk scores for A&D beneficiaries reflect the 2024 prospective CMS-HCC risk adjustment model (based on V28). Risk scores for ESRD beneficiaries reflect the 2023 prospective CMS-HCC ESRD risk adjustment model (based on V24).

Although the same risk models used to adjust Shared Savings Program benchmarks are used to risk adjust the PPC Payment, these risk score values are not identical to those used in benchmarking calculations. The PPC Payment risk scores are 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 is divided into two enrollment types, A&D and ESRD, with risk scores normalized separately for each. This ensures that the risk scores used to calculate payment 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 are used throughout the performance year and updated based on the schedule presented in **Table 18** and **Table 19**. A forecasted normalization factor is 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 CY2022–CY2024 for the 2026 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 19** also provides other information including which assignment run is used for each month.

Table 18. Performance Year 2026 Risk Score Measurement Calendar

Risk Score	CMS-HCC Risk Adjustment Model Diagnostic Measurement Period (Dates of Service)	Claims Run-Out Through
Preliminary	July 2024–June 2025	September 2025
Mid-Year Q1	January 2025–December 2025	March 2026
Mid-Year Q2	January 2025–December 2025	June 2026
Mid-Year Q3	January 2025–December 2025	September 2026
Mid-Year Q4	January 2025–December 2025	December 2026
Final	January 2025–December 2025	January 2026

Table 19. Performance Year 2026 Risk Score and Payment Calendar

Payment Report Month	Monthly Payment Report (MPR) 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-26	1/14/2026	Initial	Preliminary	Nov-25	N/A
Feb-26	1/28/2026	Initial	Preliminary	Dec-25	N/A
Mar-26	2/26/2026	Initial	Preliminary	Jan-26	Jan 2026
Apr-26	3/25/2026	Initial	Preliminary	Feb-26	Jan 2026–Feb 2026
May-26	4/24/2026	Initial	Preliminary	Mar-26	Jan 2026–Mar 2026
Jun-26	5/27/2026	Q1	Mid-Year Q1	Apr-26	Jan 2026–Apr 2026
Jul-26	6/25/2026	Q1	Mid-Year Q1	May-26	Jan 2026–May 2026
Aug-26	7/27/2026	Q1	Mid-Year Q1	Jun-26	Jan 2026–Jun 2026
Sep-26	8/26/2026	Q1	Mid-Year Q1	Jul-26	Jan 2026–Jul 2026
Oct-26	9/25/2026	Q2	Mid-Year Q2	Aug-26	Jan 2026–Aug 2026
Nov-26	10/27/2026	Q2	Mid-Year Q2	Sep-26	Jan 2026–Sep 2026
Dec-26	11/26/2026	Q3	Mid-Year Q2	Oct-26	Jan 2026–Oct 2026
Pre-Final (NCBP)	3/31/2027	Q4	Final	Dec-26	Jan 2026–Dec 2026
Final	5/31/2027	Final	Final	Dec-26	Jan 2026–Dec 2026

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

4.1.2 Adjustment for PCOA

Primary care delivered 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 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, therefore 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 amount. 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 whom 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.

The PCOA adjustment was calculated using BYs comprised of CY2021, CY2022, and CY2023, 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 (defined according to 42 CFR 425.402(b)) is run 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 Section 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 Primary Care Prospective Administrative Trend (PCPAT).

After application of relevant adjustments to the County Base Rate, FQHC and RHC Add-Ons, and Enhanced PPC Payment Amount (see **Table 17** above), the resulting amount is trended forward to the applicable performance year using the PCPAT. For Performance Year 2025 and 2026, 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 Performance Year 2024:

PCPAT associated with Performance Year 20XX= PCPAT^(Performance Year 20XX-2024)

For Performance Year 2025=PCPAT^1

For Performance Year 2026=PCPAT^2

4.1.4 Seasonality Adjustment

For Performance Year 2025, CMS applied a national seasonality adjustment to account for the partial year payment of the County Base Rate and FQHC and RHC Add-Ons (July–December 2025). See the prior version of the ACO PC Flex Model Financial Methodology for details on the Performance Year 2025 seasonality adjustment. The seasonality adjustment is not applicable for Performance Year 2026 because payments will be made for the full CY2026 (January–December 2026).

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 Amount

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 Amount.

The Population Adjustment Amount 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 Amount.

A PPCP-eligible beneficiary's Population Score is determined using a composite methodology consisting of community- and beneficiary-level measures of deprivation. For Performance Years 2025 and 2026, the Population Adjustment Amount 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,[37] 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, then 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 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, then 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, then CMS shall assign a low-income marker of 0.

For Performance Years 2025 and 2026, there are two ADIs, each used in its own way: 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

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

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*. For Performance Year 2026, this calculation is performed for beneficiaries in the CY2024[38] 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 20** and explained below.

Table 20. Population Adjustment Amount to the PPC Payment Amount

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

[38] Performance Year 2025 used CY2023.

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 Application of Medicare Sequestration

After applying the Population Adjustment Amount, 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:

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

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

- **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 (1) the total YTD amount of PPC Payment Fee Reductions for the PPCP-eligible beneficiaries with RHC-focused care and (2) 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 21 summarizes example beneficiary status changes occurring during a given performance year that may result in retrospective adjustments.

Table 21. 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 Amount (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
Risk score and normalization factor	Impact to clinical risk adjustment of PPC Payment components (see Subsection 4.1.1, **Table 18** and **Table 19**)
Change of residence	Impact to assignment of County Base Rate, County Enhancement, and ADI used for Population Adjustment Amount (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 (NCBP) System by March 31 of each CY.

4.4 CALCULATION OF MONTHLY PPC PAYMENT FOR THE 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 22 is an example of how the payment of Monthly PPC Payments will be operationalized at the ACO level.

Table 22. 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 Section 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 that 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).

Professional 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 codes 99206-99210 (office or other outpatient services).

- Primary care services in ACO PC Flex include HCPCS codes 99319-99338 (patient domiciliary, rest home, or custodial care visit).
- Primary care services in ACO PC Flex include HCPCS code 99346 (evaluation and management services furnished in a patient's home).
- Primary care services in ACO PC Flex include HCPCS code G0463 (hospital outpatient clinic visit) if billed by a primary care provider in an HOPD.
- 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.

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 DELAY OF FEE REDUCTIONS

For Performance Year 2025, there was a delay in the application of claims-based fee reductions because the portion of the PPC Payment corresponding to the County Base Rate and FQHC and RHC Add-Ons was not paid for otherwise eligible beneficiary months of January–June 2025 (see the prior version of the ACO PC Flex Model Financial Methodology paper for details on the Performance Year 2025 delay of fee reductions policy). For Performance Year 2026, this delay is not applicable because all components of the PPC Payment were paid starting January 2026 and will be paid through the end of December 2026.

4.8 RATE BOOK GUARDRAIL PROVISION

For Performance Year 2025, there were two Rate Books (Preliminary and Updated) developed to calculate the PPC Payment for each PPCP-eligible beneficiary, which required a guardrail provision to ensure ACOs were not paid any less after transitioning from the Preliminary to the Updated Rate Book. For Performance Year 2026, there is a single Rate Book; therefore, this guardrail provision is not applicable.

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 PERFORMANCE YEAR FINANCIAL RECONCILIATION CALCULATIONS

As part of the performance year financial reconciliation calculations for the Shared Savings Program, CMS compares the updated historical benchmark to an ACO's assigned beneficiaries' per capita expenditures during the performance year to determine whether the ACO may share in savings or losses, if owed. The calculation of the updated historical benchmark for PC Flex ACOs will be unchanged from the Shared Savings Program's methodology for the duration of the ACO PC Flex Model. The ACO PC Flex Model will apply adjustments to the calculation of performance year expenditures and the calculation of shared savings and shared losses under the Shared Savings Program to account for the model's unique features.

Below CMS outlines the performance year financial reconciliation calculations, including the calculation of shared savings and shared losses for PC Flex ACOs and the sub-steps or modifications related to the PC Flex Model. Broadly, these modifications, and their corresponding sections, include:

> ***First Set of Shared Savings Program Processes:*** *Update historical benchmark and determine total updated benchmark and total performance year expenditures in aggregate and per capita.*

(I) **ACO PC Flex Modification A (Section 5.2)**: Include the *Total PPC Payment Amount* for the Performance Year in the calculation of performance year expenditures

> ***Second Set of Shared Savings Program Processes****: Determine gross savings/losses and perform calculations relative to MSR/MLR, shared savings and losses rates, determine shared savings or losses amounts, apply sequestration for shared savings, and apply performance payment limit or loss recoupment limit.*

(II) **ACO PC Flex Modification B (Section 5.3)**: Application of a Total PC Flex Settlement Adjustment to the ACO's shared savings or losses after the application of the Shared Savings cap or the application of the loss recoupment limit. This adjustment is a final, end-of-year calculation that accounts for enhanced primary care payments and population adjustments the ACO received throughout the year. This process occurs in three steps (1) determining the original shared savings or losses (2) determining the counterfactual shared savings or losses, and (3) determining the final Total PC Flex Settlement Adjustment and final shared savings or losses amount.

(III) **ACO PC Flex Modification C (Section 5.5):** Recoupment and Recovery of the Advance Shared Savings Payment

(IV) **ACO PC Flex Modification D (Section 5.6):** Calculation of Other Monies Owed

A discussion of two key model operational steps associated with financial reconciliation is provided in **Appendices E and F.** The final PPC payments during the performance year and the December MPR are described in **Appendix E**. Incorporating updated eligibility information including from Q4 assignment, for inclusion in the Non-Claims Based Payment (NCBP) file, is discussed in **Appendix F**. These steps take place before the calculation of performance year expenditures.

5.1 SUMMARY

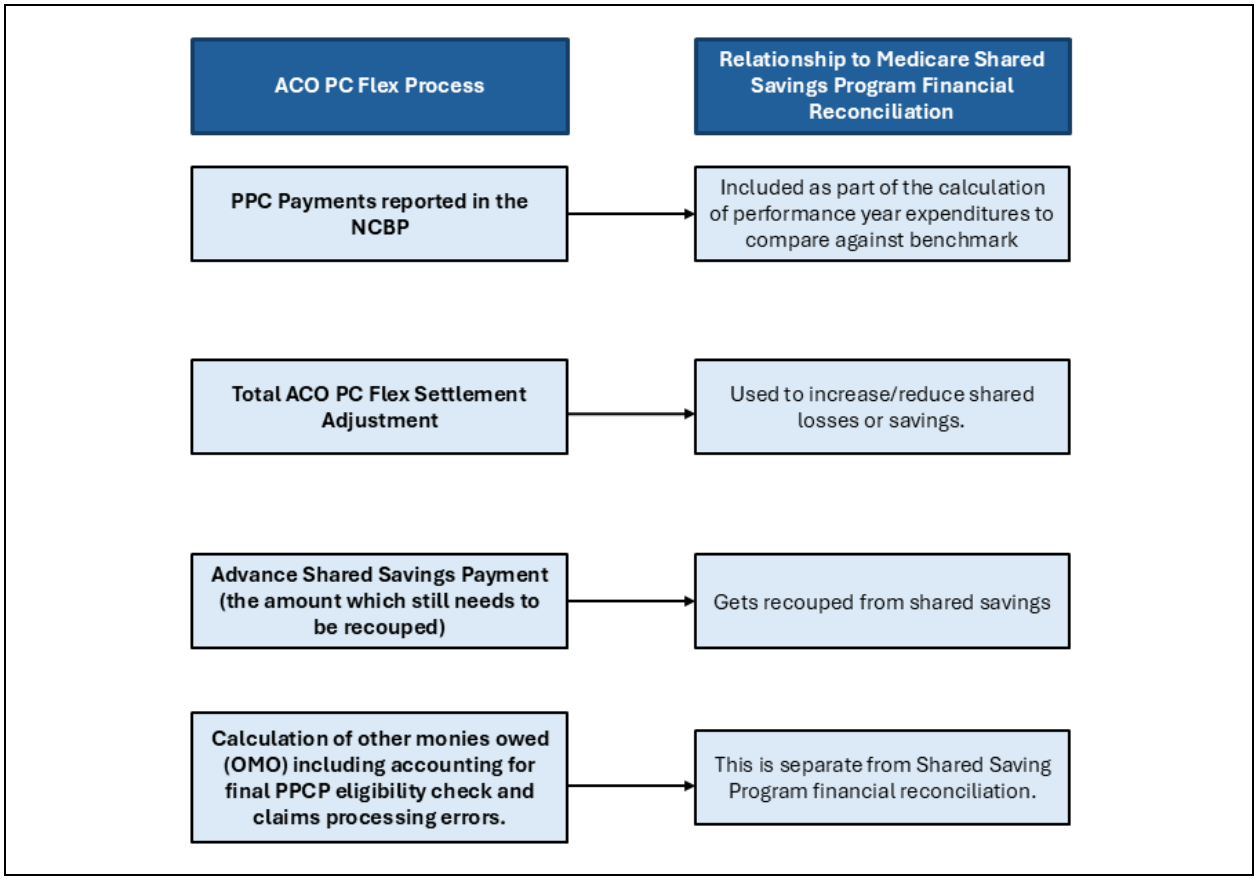
This section will describe the ACO PC Flex Model final settlement process and how this process relates to the Shared Savings Program financial settlement calculations upon completion of a performance year. For Performance Year 2025, ACO PC Flex Model Financial Settlement will be initiated in April 2026, following the completion of the final beneficiary assignment for the performance year. Procedures in the event of early termination are detailed in Section 6, below.

There are three elements of ACO PC Flex Model final settlement that are incorporated into the Shared Savings Program financial reconciliation calculations, as listed in **Figure 1**:

1. Total PPC Payment Amounts for the Performance Year, as reported in the Non-Claims Based Payment file (see Appendix F) and included in the calculation of performance year expenditures
2. The Total PC Flex Settlement Adjustment
3. The recoupment of the Advance Shared Savings Payment.

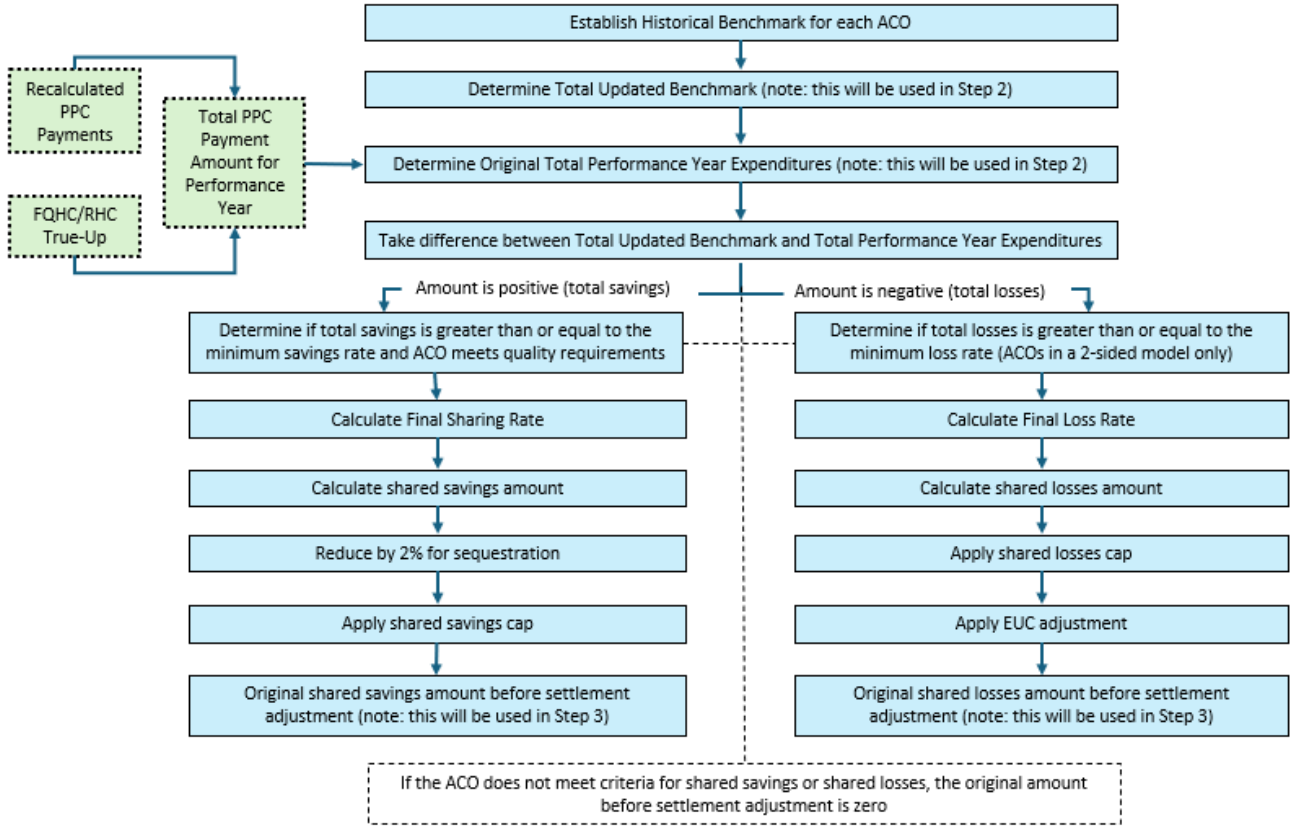
In **Figure 1** we additionally list the calculation of other monies owed (OMO), which is part of ACO PC Flex Model final settlement but is separate from Shared Savings Program financial reconciliation.

Figure 1. ACO PC Flex Model Results Which Are Incorporated into Shared Savings Program Financial Reconciliation, plus OMO



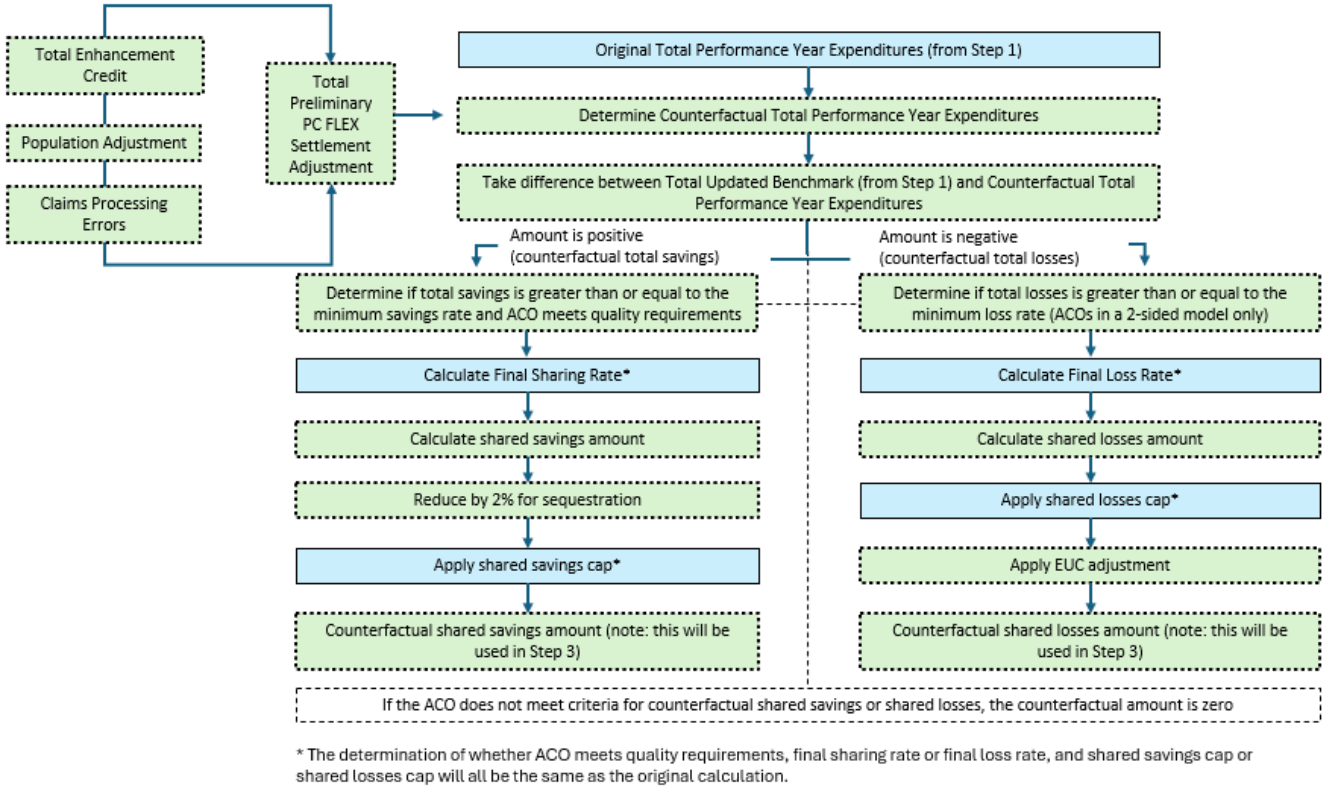
In **Figure 2** through **Figure 4**, we provide a more detailed depiction of how the Shared Savings Program settlement process interacts with (1) the PPC Payments reported in the Non-Claims Based Payment file, (2) the Total PC Flex Settlement Adjustment, and (3) the recoupment of the Advance Shared Savings Payment. In these figures, we break up the process into three steps: determining the original shared savings or losses, determining the counterfactual shared savings or losses, and determining the final Total PC Flex Settlement Adjustment and final shared savings or losses amount.

Figure 2. Detailed Depiction of ACO PC Flex Model Results Inputs for Shared Savings Program Financial Reconciliation Step 1 – Determine Original Shared Savings or Losses



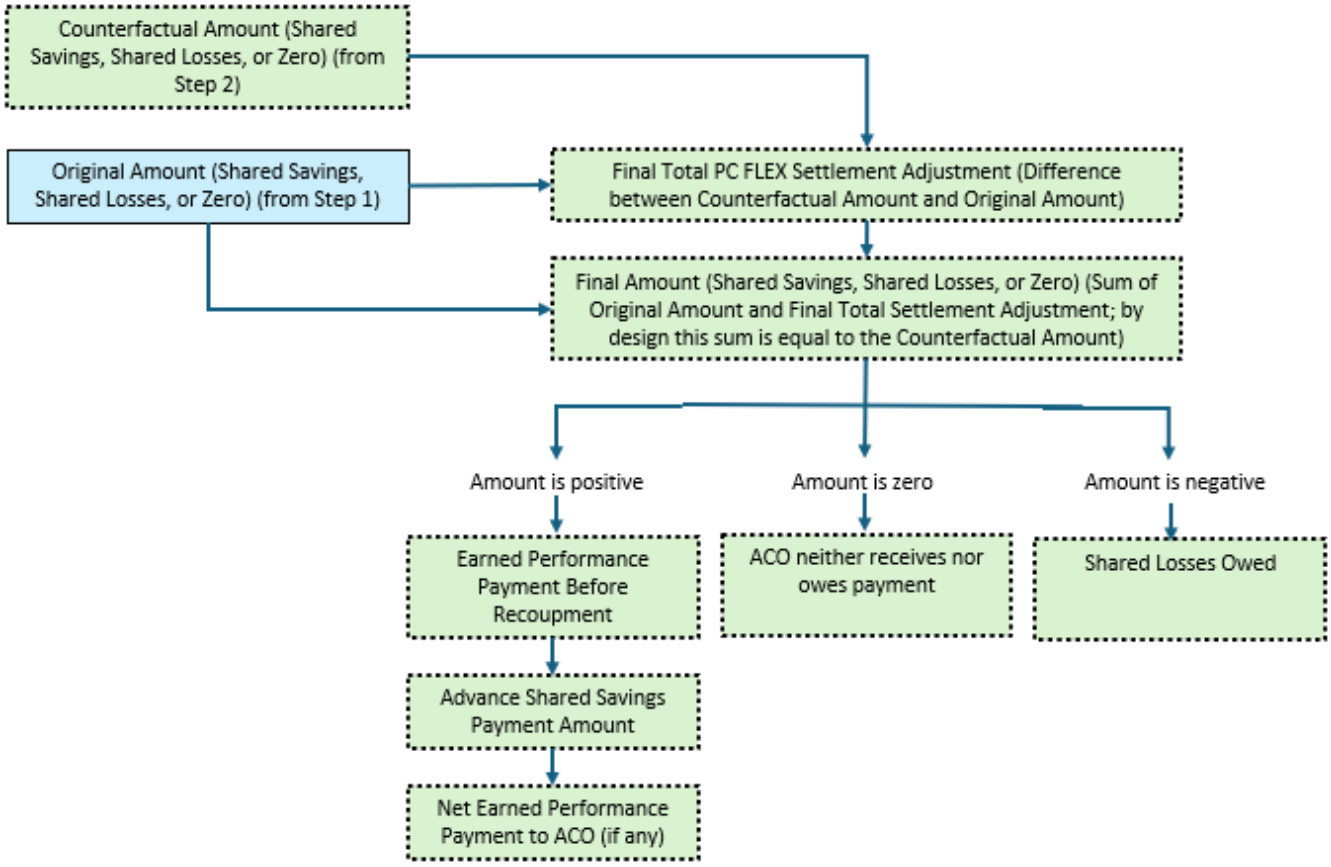
Note: Blue boxes (with solid lines) indicate a standard Shared Savings Program process. Green boxes (with dashed lines) indicate a new PC FLEX process.

Figure 3. Detailed Depiction of ACO PC Flex Model Inputs Used in Shared Savings Program Financial Reconciliation Step 2 – Determine Counterfactual Shared Savings or Losses



Note: Blue boxes (with solid lines) indicate a standard Shared Savings Program process. Green boxes (with dashed lines) indicate a new PC FLEX process or an existing process with modifications related to the PC Flex Model.

Figure 4. Detailed Depiction of ACO PC Flex Model Results Inputs for Shared Savings Program Financial Reconciliation Step 3 – Determine Final Total PC Flex Settlement Adjustment and Final Shared Savings or Losses Amount



Note: Blue boxes (with solid lines) indicate a standard Shared Savings Program process. Green boxes (with dashed lines) indicate a new PC FLEX process.

5.2 INCLUSION OF PPC PAYMENTS IN PERFORMANCE YEAR EXPENDITURES FOR THE ACO PC FLEX MODEL

The calculation of the benchmark and shared savings and losses (before the application of the Total PC Flex Settlement Adjustment and the recoupment of the Advance Shared Savings Payment) 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. 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, in the Assignment and Quality Performance Standard Methodology document.[39]

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, calculated and submitted to the NCBP system as described in **Appendix F**, adjusted for final performance year assignment. That is, if a beneficiary is no longer assigned to an ACO in final assignment, their PPC Payments are not included in the ACO's performance year expenditures.

Note that when a beneficiary is de-assigned from a retrospective PC Flex ACO during final assignment, there are three possible scenarios that may occur:

1. The beneficiary is not assigned to any ACO;
2. The beneficiary is assigned to a non–PC Flex retrospective ACO; or
3. The beneficiary is assigned to a PC Flex retrospective ACO.

Expenditures for the beneficiary will not be included in performance year expenditures for the original ACO under any of the scenarios. Under scenarios 2 and 3, the beneficiary's expenditures would be included in performance year expenditures for the new retrospective ACO, including PPC Payments reflected in the NCBP file (despite the fact that they will eventually be recouped through OMO from the original ACO). However, claims for primary care services for the beneficiary who were correctly reduced to zero will not contribute to the new ACO's performance year expenditures (even though they will eventually be reprocessed as FFS at some point after the claims run-out date). Finally, in scenario 3, enhancement and Population Adjustment Amount payments made on behalf of the beneficiary will not be included in Total PC Flex Settlement Adjustment calculation for the new ACO because the beneficiary is not considered a PPCP-eligible beneficiary for that ACO.

5.3 TOTAL PC FLEX SETTLEMENT ADJUSTMENT

5.3.1 Background

The monthly PPC Payment includes both (1) Non-claims based payments that replace FFS services and payments (e.g., the PPC Base Amount) and (2) Non-claims based payments that are independent of claims (e.g., the Total Enhancement Credit and the Population Adjustment Amount). Non-claims based payment amounts that are not intended to replace FFS payments do not meet the criteria used by the Shared Savings Program to define assignable beneficiary expenditures - articulated at 42 CFR 425.605(a)(5)(ii), 42 CFR 425.610(a)(6)(ii)(B), or 42 CFR 425.652(a)(1) - because they do not correspond to Medicare FFS Parts A and B expenditures. For this reason, the Total Enhancement Credit and the Population Adjustment Amount should

[39] Versions 12 and 13 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

not be included in the calculation of shared savings and shared losses under the Shared Savings Program.

The PPC Payment is accounted for by the Shared Savings Program via the NCBP file (see Section 5.2). For completeness, the NCBP file includes all non-claims based payments, meaning both (1) Non-claims based payments that replace FFS services and payments (e.g., the PPC Base Amount) and (2) Non-claims based payments that are independent of claims (e.g., the Total Enhancement Credit and the Population Adjustment Amount). While valuable for completeness, the requirement for submission of all non-claims based payments means that, in the absence of an adjustment, all PC Flex non-claims based payments (including those that are independent of claims) are used to calculate performance year expenditures and gross savings and losses for PC Flex ACOs. The Total PC Flex Settlement Adjustment, described below, corrects this discrepancy for PC Flex ACOs by effectively removing the Total Enhancement Credit and any positive Population Adjustment Amounts from the calculation of performance year expenditures.

For performance year 2025 the Total PC Flex Settlement Adjustment also accounts for claims processing errors. As is the case for PY 2025, when there are claims processing errors that have not been resolved by the end of the Shared Savings Program run-out period for calculating performance year expenditures, underpayments or overpayments will be incorporated in the performance year expenditures and will impact the calculation of shared savings and losses. The Total PC Flex Settlement Adjustment will therefore also account for these claims processing errors.

5.3.2 Calculation

The Total PC Flex Settlement Adjustment has three main components[40]: the Total Enhancement Credit, the Population Adjustment, and net outstanding claims processing errors (overpayments minus underpayments). The purpose of the Total Enhancement Credit is to remove the portion of their Enhanced PPC Payment amounts, (which for operational reasons are included in the ACO total performance year expenditures) that exceeds the higher of the regional adjustment or prior savings adjustment. The purpose of the Population Adjustment calculated for settlement is to remove the Population Adjustment Amount payments included in ACO total performance year expenditures.[41] Finally, we add overpayments so that performance year expenditures are not inflated. Note that we expect that these overpayments will eventually be addressed through claims reprocessing.

The Enhanced PPC Payment amounts are always positive and the Total Enhancement Credit is designed such that it cannot fall below zero. Although beneficiary-level Population Adjustment

[40] In some years, there may be a fourth and generally smaller component – "Other Payment Adjustments" – described briefly below.

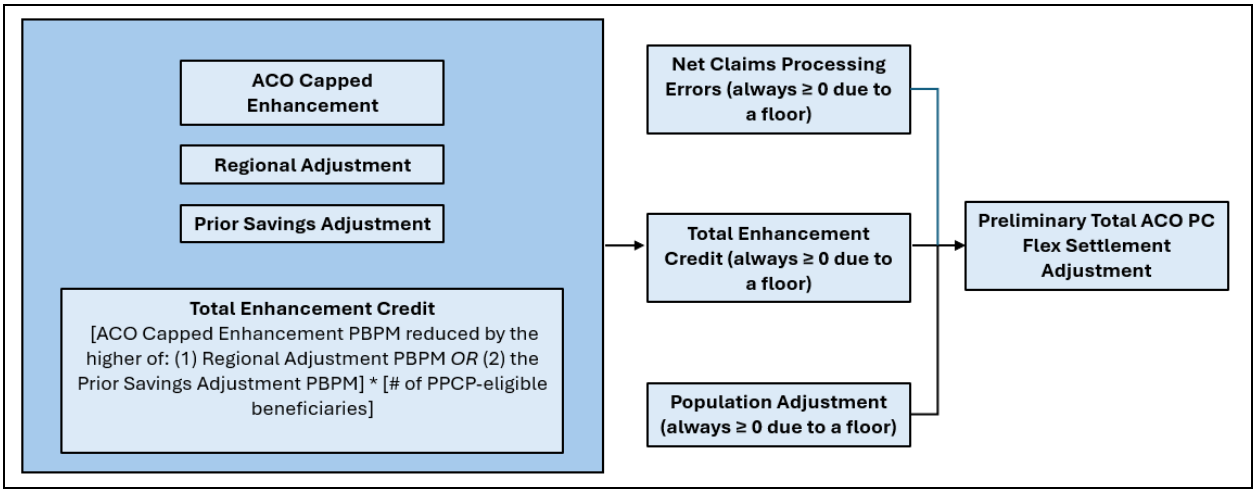
[41] Both Enhanced PPC Payment Amount and the Population Adjustment are included in the Total PPC Payments used in the NCBP data for expenditure calculations. As a result, they are incorporated into the ACO's performance year expenditures.

Amount[42] payments can be either positive or negative, the ACO-level Population Adjustment calculated for settlement will aggregate only positive beneficiary-level payments amounts. While claims processing errors can be overpayments or underpayments, the net amount used in the settlement adjustment is not allowed to fall below zero. Thus, the overall settlement adjustment will either reduce an ACO's shared losses or increase its shared savings. It cannot negatively impact an ACO by increasing shared losses or reducing shared savings.

5.3.3 Calculation of Preliminary Total PC Flex Settlement Adjustment

The calculation of the Preliminary Total PC Flex Settlement Adjustment—which is based on the Total Enhancement Credit, the Population Adjustment, and net claims processing errors—is depicted at a high level in **Figure 5**.

Figure 5. Calculation of Total PC Flex Settlement Adjustment



5.3.3.1 Total Enhancement Credit

The Total Enhancement Credit will be calculated in four steps:

1. **Calculate the ACO Capped Enhancement PBPM.** This is done by summing the Capped Enhanced PPC Payment Amount across all PPCP-eligible beneficiary months for the performance year and dividing this by the sum of the PPCP-eligible beneficiary months for the performance year based on the final assignment MPR. The ACO Capped

[42] Note that **Population Adjustment Amount** means the beneficiary-level adjustment applied to the ACO's PPC Payment. Corresponds to the percentile in which the PPCP-Eligible Beneficiary's Population Scores falls, as set forth to Appendix A, Section 5.B.25 of the Agreement. **Population Adjustment** means an amount used during financial settlement to determine the Preliminary Total ACO PC Flex Settlement Adjustment. Calculated as the sum of the Population Adjustment Amounts across all PPCP-Eligible Beneficiary Months for PC Flex Beneficiaries where the Population Adjustment Amount corresponds with $Population\ Score_b \geq P_{70}$, as set forth in Appendix A, Section 5.B.25 of the Agreement. Refer to the forthcoming Participation Agreement PY 2026 Amended and Restated version (anticipated June 2026).

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:

a. 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.

b. 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.

c. The calculation of the ACO Capped Enhancement PBPM will adjust PPCP-eligible beneficiary months determined for the March NCBP submission and related payments for those months to exclude all months for beneficiaries who are de-assigned in final assignment. Note that we will use pre-sequestration amounts for these enhanced payment amounts when calculating the total enhancement credit.

2. **Determine the offset to the ACO Capped Enhancement PBPM on a PBPM basis.** In this step, the regional adjustment and prior savings adjustment (on a PBPY basis)[43] are evaluated to determine which is greater and divided by 12 to convert the PBPY value to a PBPM value. This is an ACO-level calculation. Note that if an ACO is not eligible for the prior savings adjustment the PBPY and PBPM amounts for this adjustment will be set to zero.

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

4. **Convert the ACO Capped Enhancement PBPM after offset to a total dollar value.** This is done by multiplying the ACO Capped Enhancement PBPM value from step 3 by the total number of PPCP-eligible beneficiary months assigned to the PC Flex ACO for the performance year (adjusted for final assignment). The result from this step is the Total Enhancement Credit. Note that this amount does not include the Population Adjustment or any adjustment for claims processing errors.

[43] These are provided in the Shared Savings Program historical benchmark report in Tables 1A and 1B, respectively

5.3.3.2 *Using the Total Enhancement Credit, the Population Adjustment, and Claims Processing Errors to Calculate the Preliminary Total PC Flex Settlement Adjustment*

CMS will compute the Population Adjustment by summing all positive beneficiary-level Population Adjustment amounts (pre-sequestration) across all PPCP-eligible beneficiary months for the performance year (adjusted for final assignment). To compute the adjustment for claims processing errors, CMS will first calculate total overpayments (claims that were not reduced that should have been reduced) and total underpayments (claims that were reduced that should not have been reduced) still outstanding at the end of the three-month runout window used for Shared Savings Program expenditure calculations. CMS will calculate the total amount of net claims processing errors as the difference between overpayments and underpayments (adjusted for sequestration and claims completion[44]), with the difference subject to a floor of zero. CMS will sum together the Total Enhancement Credit (from step 4 above), Population Adjustment, and the net claims processing errors to obtain the Preliminary Total PC Flex Settlement Adjustment.[45] As described in **Section 5.3.4**, the preliminary adjustment will be used to determine the final adjustment.

The summary of Preliminary Total PC Flex Settlement Adjustment calculation follows with some numerical examples shown in **Table 23**. In this table we provide a detailed look at the calculation of the preliminary adjustment. In **Table 24**, we describe possible scenarios of how the settlement adjustment can impact shared savings and losses. In **Table 25** and **Table 26** below, we provide less detail on the calculation of the preliminary adjustment and show the calculation of the preliminary adjustment as part of the calculation of the final adjustment. The steps listed in brackets below correspond to the steps as listed in the first column of **Table 23**.

- 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) [Step 1]
- Total Enhancement Credit PBPM = ACO Capped Enhancement PBPM − (greater of regional adjustment and prior savings adjustment / 12) [Steps 2 and 3]
- Total Enhancement Credit = Total Enhancement Credit PBPM x ∑ (PPCP-Eligible beneficiary months for the performance year) [Step 4]
- Preliminary Total PC Flex Settlement Adjustment = Total Enhancement Credit + Population Adjustment + Outstanding claims processing errors [Step 5]

[44] The reason for adjusting for sequestration and claims completion is because these adjustments are applied as part of calculating performance year expenditures in the Shared Savings Program, so CMS must account for them when removing these claims processing errors.

[45] If applicable, the preliminary total settlement adjustment will also include a separate adjustment (referred to as "Other Payment Adjustments") for updates to PPC payment amounts made at the time of settlement to correct for data or computation issues identified after the submission of the final NCBP file and prior to settlement. The adjustment will be calculated as the sum of the differences between the payment amounts submitted to the NCBP file and the updated payment amounts for beneficiary months that remain PPCP eligible as of final assignment, with the sum subject to a floor of zero.

Table 23. Preliminary Total PC Flex Settlement Adjustment Calculation Examples

Step	Based on March NCBP Submission (Adjusted for Final Assignment)	Example 1	Example 2
Step 1	Capped Enhancement Amount [1]	$2,396,625	$1,611,600
	PPCP-Eligible Months [2]	115,500	102,000
	ACO Capped Enhancement PBPM [3] = [1] / [2]	$20.75	$15.80
Step 2	Regional Adjustment (PBPY) [4]	$185	$480
	Prior Savings Adjustment (PBPY) [5]	$150	$615
	Greater of Regional Adjustment and Prior Savings Adjustment (PBPY) [6] = Max of [4] and [5]	$185	$615
	Offset Amount (PBPM) [7] = [6] / 12)	$15.42	$51.25
Step 3	Total Enhancement Credit (PBPM) [8] = Max ([3] − [7]) and 0	$5.33	0.00
Step 4	Total Enhancement Credit [9] = [8] x [2]	$616,000	0.00
Step 5	Population Adjustment Amount [10]	$265,650	$122,400
	Outstanding Claims Processing Errors [11]	$1,000	$500
	Preliminary Total PC Flex Settlement Adjustment [12] = [9] + [10] + [11]	$882,650	$122,900

5.3.4 Calculation of Final Total PC Flex Settlement Adjustment

The Preliminary Total PC Flex Settlement Adjustment is not directly applied to an ACO's shared savings or losses. Instead, it is used in conjunction with other elements of the original shared savings and losses calculation to determine the final settlement adjustment. It is the final settlement adjustment that is applied directly to the original shared savings or losses to yield the final shared savings and losses. The aim of the final total settlement adjustment is to return the ACO to the Financial Settlement position it would have been in had the amount of the preliminary settlement adjustment been excluded from its performance year expenditures.

Specifically, after calculating the preliminary settlement adjustment, the next step is to recalculate shared savings and losses in a slightly different way. We consider a counterfactual reality where the portion of the PPC Payment corresponding to the amount of the preliminary settlement adjustment is not included in the ACO's performance year expenditures. We operationalize this by subtracting the preliminary settlement adjustment from the ACO's original total performance year expenditures.[46] We then take the difference between the ACO's total updated benchmark expenditures and the counterfactual total performance year expenditures to calculate the counterfactual total savings or losses. Based on the counterfactual **total** savings or

[46] Note that because the preliminary total settlement adjustment amount is computed at the ACO-level and subtracted from aggregate total expenditures (which reflect post-truncation values), the final impact on an ACO's financial performance may be slightly different than if only "at risk" components of the PPC payment had been incorporated in beneficiary-level expenditures via the NCBP data prior to truncation.

losses, we calculate a counterfactual **shared savings** or (if applicable) **shared losses** amount. The counterfactual shared savings or losses calculation will use the following elements from the original shared savings or losses calculation, as applicable:

- Minimum savings rate (MSR) or minimum loss rate (MLR) (%)
- Determination of whether ACO met quality requirements
- Final Sharing Rate or Shared Loss Rate (%)
- Shared Savings Cap or Shared Losses Cap (%)
- Sequestration Adjustment (%, applies to shared savings only)
- Share of Beneficiaries in Counties Affected by an Extreme and Uncontrollable Circumstance (EUC) (%, applies to shared losses only)
- Share of Year in Counties Affected by an EUC (%, applies to shared losses only)

The final Total PC Flex Settlement Adjustment is calculated as the difference between the ACO's counterfactual shared savings or losses and original shared savings or losses. The final Total PC Flex Settlement Adjustment is then added to the ACO's original shared savings or losses amount to obtain the final shared savings or losses amount (which, by design, is mathematically equivalent to the counterfactual shared savings or losses amount).

Because the preliminary total settlement adjustment will be non-negative by design, the application of the final Total PC Flex Settlement Adjustment could cause an ACO to see increased shared savings, decreased shared losses, or to go from having shared losses to not having shared savings or losses or having shared savings. In **Table 24** below, we explain the possible scenarios and how each could occur.

Table 24. Possible Scenarios of How Total Settlement Adjustment Can Impact Shared Savings and Losses

Original Outcome (before application of Total Settlement Adjustment)	Final Outcome (after application of Total Settlement Adjustment)		
	Shared Savings [a]	Neither	Shared Losses
Shared Savings [a]	Only possibility	Can not happen	Can not happen
Neither	1. Can only happen if preliminary total adjustment is positive 2. Can happen for one-sided ACOs or two-sided ACOs with a nonzero MSR/MLR	3. Can happen if preliminary total adjustment is positive or zero 4. Can happen for one-sided ACOs or two-sided ACOs with a nonzero MSR/MLR	Can not happen
Shared Losses	5. Can only happen if preliminary total adjustment is positive 6. Can only happen for two-sided ACOs	7. Can only happen if preliminary total adjustment is positive 8. Can only happen for two-sided ACOs with a nonzero MSR/MLR	9. Can happen if preliminary total adjustment is positive or zero 10. Can only happen for two-sided ACOs

[a] Note that under Shared Savings Program regulations certain (BASIC)–track ACOs that fail to meet their MSR can earn shared savings at a reduced rate; for the purpose of this table, this would function similarly to shared savings.

We share two examples, side by side, of the calculation of the preliminary and final Total PC Flex Settlement Adjustment in **Table 25** and **Table 26** below. We use two tables to highlight the different parts of the calculations using the same two examples. In Example 1, the ACO earns shared savings with or without the settlement adjustment but earns more shared savings because of the adjustment. In Example 2, the ACO earns shared savings only because of the adjustment.

In **Table 25**, we show side by side the shared savings and losses calculations when including the full PPC Payments used in the original shared savings/losses compared to when only including components used in the counterfactual shared savings/losses. These two different methods result in two different PPC Payment amounts, and thus two different performance year expenditures. These lead in turn to different total and shared savings/losses.

Table 26 shows how we calculate the final settlement adjustment for each example, which is the difference between the original shared savings/losses and the counterfactual shared savings/losses.

Table 25. Example Calculations of Shared Savings and Losses Before Settlement Adjustment

Steps in Calculation	Example 1		Example 2	
	Original Shared Savings/ Losses	Counterfactual Shared Savings/ Losses	Original Shared Savings/ Losses	Counterfactual Shared Savings/ Losses
PPC Payments to ACO During Performance Year				
Components Used in Both Original and Counterfactual Shared Savings/Losses				
Base Payments [1]	$5,760,000	$5,760,000	$5,760,000	$5,760,000
Portion of Enhancement up to Regional/Prior Savings Adjustment [2] (= [18])	$1,800,000	$1,800,000	$1,800,000	$1,800,000
Components Used in Only the Original Shared Savings/Losses				
Portion of Enhancement in Excess of Regional/Prior Savings Adjustment [3] (= [19])	$600,000	0	$600,000	0
Population Adjustment [4]	$240,000	0	$240,000	0
Total PPC Payment (NCBP) [5] = [1] + [2] + [3] + [4]	$8,400,000	$7,560,000	$8,400,000	$7,560,000
Net Claims Processing Errors Used in Counterfactual Calculation [6] (= [23])	$0	$8,000	$0	$8,000
Shared Savings Program Settlement				
Total Updated Benchmark Expenditures [7]	$130,000,000	$130,000,000	$130,000,000	$130,000,000
Performance Year Expenditures				
Claims [8]	$120,000,000	$120,000,000	$120,800,000	$120,800,000
Total PPC Payment (NCBP) and Net Claims Processing Errors [9] = [5] - [6]	$8,400,000	$7,552,000	$8,400,000	$7,552,000
Total [10] = [8] + [9]	$128,400,000	$127,552,000	$129,200,000	$128,352,000
Total Savings [11] = [7] - [10]	$1,600,000	$2,448,000	$800,000	$1,648,000
Total Savings as % of Benchmark [12] = [11]/[7]	1.2%	1.9%	0.6%	1.3%
MSR (assumed) [13]	1.0%	1.0%	1.0%	1.0%
Outcome [14] = Shared Savings if [12] >= [13], Shared Losses if [12] <= -[13], Otherwise Neither	Shared savings	Shared savings	Neither shared savings nor shared losses	Shared savings
Sharing Rate [15] = 75% if [14] = Shared Savings, 40% if [14] = Shared Losses, Otherwise NA	75.0%	75.0%	N/A	75.0%
Shared Savings/Losses (Before Settlement Adjustment) [16] = [11] x [15]	$1,200,000	$1,836,000	0	$1,236,000

Table 26. Example Calculations to Determine the Preliminary and Final Settlement Adjustment

Steps in Calculation	Example 1	Example 2
Determine Flex Settlement Adjustment		
Total Enhancement Payment [17]	$2,400,000	$2,400,000
Higher of Positive Regional Adjustment/Prior Savings Adjustment [18] (= [2])	$1,800,000	$1,800,000
Enhancement Credit (cannot be negative) [19] = Max ([17] - [18], 0] (= [3])	$600,000	$600,000
Population Adjustment (cannot be negative) [20]	$240,000	$240,000
Claims Processing Error Overpayments [21]	$10,000	$10,000
Claims Processing Error Underpayments [22]	$2,000	$2,000
Net Claims Processing Error [23] = [21] - [22] (cannot be negative, positive indicates overpayments)	$8,000	$8,000
Preliminary Total Settlement Adjustment (cannot be negative) [24] = [19] + [20] + [23]. The reason we add overpayments is so that performance year expenditures are not inflated. Note that we expect that these overpayments will eventually be addressed through claims reprocessing.	$848,000	$848,000
Counterfactual Total Savings [25] = [11] + [24]	$2,448,000	$1,648,000
Counterfactual Total Savings as % of Benchmark [26] = [25]/[7]	1.9%	1.3%
Counterfactual Outcome [27] = Shared Savings if [26] >= [13], Shared Losses if [26] <= -[13], Otherwise Neither	Shared Savings	Shared Savings
Counterfactual Sharing Rate [28] = 75% if [27] = Shared Savings, 40% if [27] = Shared Losses, Otherwise NA	75.0%	75.0%
Counterfactual Shared Savings/Losses [29] = [25] x [27]	$1,836,000	$1,236,000
Final Total Settlement Adjustment [30] = [29] - [16]	$636,000	$1,236,000
Shared Savings/Losses (After Settlement Adjustment) [31] = [16] + [30]	$1,836,000	$1,236,000

[a] Bracketed numbering continued from prior table.

Note that in the examples above, we do not show the determination of whether the ACO met quality requirements, the sequestration adjustment, the guardrail determination for ACOs with realized losses, the determination of whether the ACO met criteria to share in savings at a reduced rate, the application of the shared savings or losses cap, or the EUC adjustment. In practice, we would include these steps in both the original and counterfactual calculations, as applicable.

5.4 SETTLEMENT RESULTS USED IN DOWNSTREAM SHARED SAVINGS PROGRAM DETERMINATIONS

There are several Shared Savings Program policies that consider or rely on an ACO's settlement results (e.g. total savings or losses or total savings or losses relative to the MSR or MLR) from prior performance years. These include policies for monitoring ACO financial

performance (425.316(d)), reviewing applications for renewing or re-entering ACOs (425.224(1)(ii)(b), calculating the prior savings adjustment to the historical benchmark (425.658) and calculating prepaid shared savings (425.640(f)). For these policies, CMS will use the results of the **original** shared savings or losses calculation, that is total shared savings or losses that do not incorporate the Preliminary Total Settlement Adjustment.

5.5 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. Note that CMS will not recoup the Advance Shared Savings Payment from OMO. 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, then 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 from the ACO PC Flex Model prior to the end of Performance Year 2025, then the ACO must repay the total amount of the Advance Shared Savings Payment as OMO. See additional detail on the recoupment and recovery of the Advance Shared Savings Payment for ACOs that terminate early from the ACO PC Flex Model in Section 6 below.

CMS will perform recoupment of the Advance Shared Savings Payment and calculate the remaining outstanding balance that will be carried forward to the next performance year, if any, as follows:

1. Determine the Outstanding Balance Before Recoupment. This is the total amount that the ACO still owes CMS prior to the current performance year reconciliation. For Performance Year 2025, this will be $250,000 for all ACOs that did not terminate from the ACO PC Flex Model at the end of the performance year (for special rules for terminated ACOs, see Section 6).
    - Outstanding Balance Before Recoupment = Original Advance Shared Savings Payment − Amounts Recouped in Prior Performance Years
2. Determine the amount recouped for current performance year. This is the amount that is recouped from the current performance year's earned performance payment (after application of the Total PC Flex Settlement Adjustment).
    - Amount Recouped in Current Performance Year = Minimum of Earned Performance Payment Before Recoupment and Outstanding Balance Before Recoupment
3. Determine the earned performance payment after recoupment. This is the earned performance payment the ACO will actually be paid for the performance year.
    - Earned Performance Payment After Recoupment = Earned Performance Payment Before Recoupment − Amount Recouped in Current Performance Year

4. Determine the outstanding balance after recoupment. This is the remaining outstanding balance that will get carried forward to the next performance year.
    - Outstanding Balance After Recoupment = Outstanding Balance Before Recoupment − Amount Recouped in Current Performance Year

In **Table 27**, we provide three examples of recoupment of Advance Shared Savings Payments.

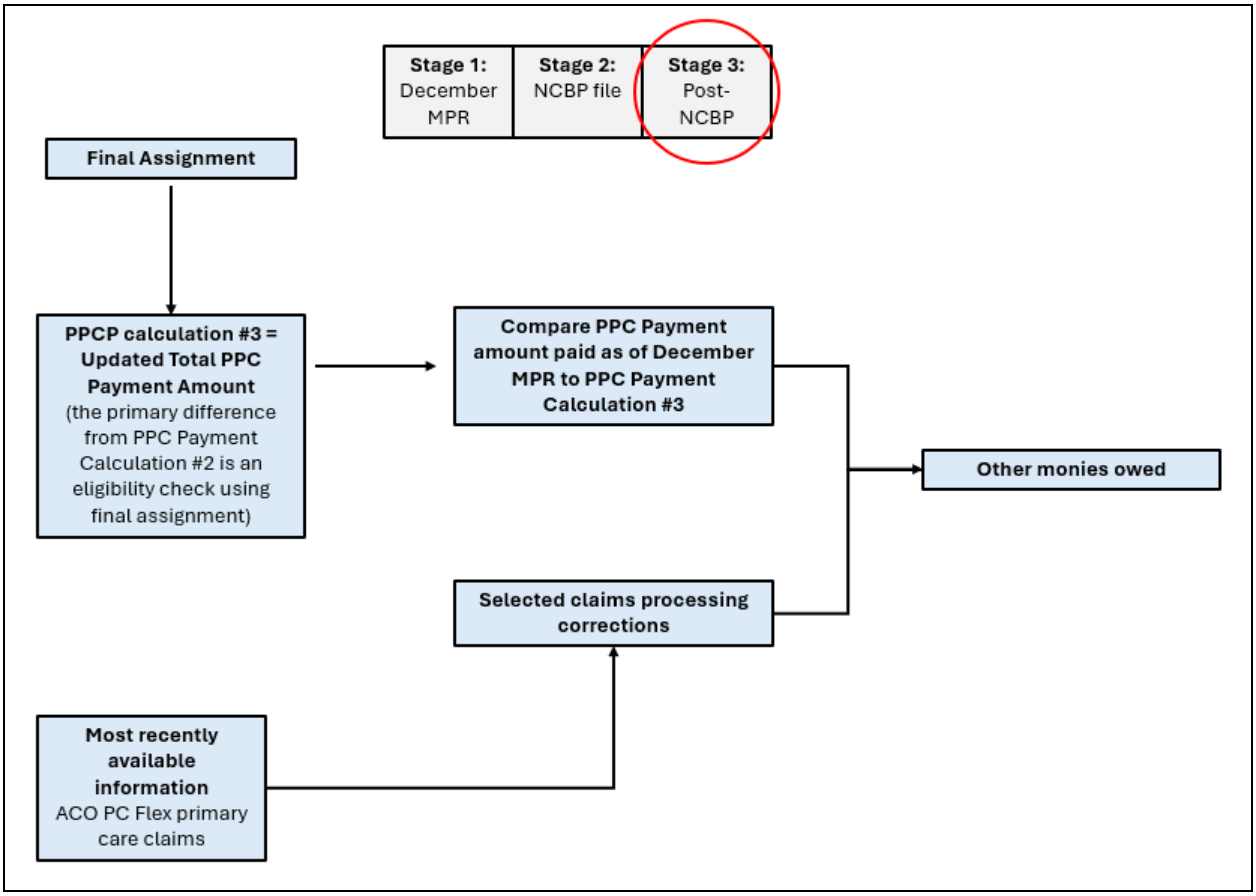
Table 27. Advance Shared Savings Payment Recoupment Examples

No.	Original Advance Shared Savings Payment	Amounts Recouped in Prior Performance Years	Outstanding Balance Before Recoupment	Earned Performance Payment Before Recoupment	Amount Recouped in Current Performance Year	Earned Performance Payment After Recoupment	Outstanding Balance After Recoupment
	[1]	[2]	[3] = [1] − [2]	[4]	[5] = Min of [3] and [4]	[6] = [4] − [5]	[7] = [3] − 5]
1	$250,000	$0	$250,000	$1,000,000	$250,000	$750,000	$0
2	$250,000	$0	$250,000	$200,000	$200,000	$0	$50,000
3	$250,000	$0	$250,000	$0	$0	$0	$250,000

5.6 CALCULATION OF OTHER MONIES OWED

In **Figure 6** we depict how OMO is calculated based on recalculated PPC Payment and claims processing errors.

Figure 6. Final Settlement



5.6.1 PPC Payment Calculation #3[47]: PPC Payment Adjustments for Final Beneficiary PPCP Eligibility

In this stage, CMS will update PPCP eligibility for beneficiaries included in the final NCBP file (submitted in March 2026 for Performance Year 2025). Specifically, beneficiaries who are no longer assigned to the same ACO in final assignment or who are not voluntarily-aligned beneficiaries and are assigned to the same ACO, but under Assignment Step 2, will have their PPCP eligibility status changed from eligible to ineligible for all months of the performance year. Aside from this assignment-based check, no additional PPCP eligibility checks are performed during this stage. Also, there will be no other changes made at this stage such as for county of residence or ESRD status.[48] Based on this final eligibility check, we can calculate the Total PPC Payment for the Performance Year, or *PPC Payment Calculation #3.*

[47] See Appendix E and Appendix F for an explanation of earlier PPC Payment Calculations performed as part of the settlement process

[48] An exception to this may occur to correct for data or computation issues identified after the submission of the final NCBP file. In this case, CMS would update the monthly PPC Payment amounts at the time of settlement to address the identified issue(s) only.

The ACO will be required to repay the difference between the sum of PPC Payments received as of the December payments and the Total PPC Payment for the performance year. If the amount the ACO received was lower, CMS will be required to pay the difference to the ACO. These payments are considered OMO.

5.6.2 Claims Processing Corrections

Using claims data from July 1–December 31, 2025 with a claims run-out through at least the end of March 2026, CMS will identify any claims that have not been reprocessed, appear to reflect a processing error, and are not expected to be reprocessed in the CY following the performance year.

We will classify claims processing errors as either Type 1 or Type 2 errors. Type 1 errors are claims that were reduced that should not have been reduced (i.e., underpayments to ACOs), and Type 2 errors are claims that were not reduced that should have been reduced (i.e., overpayments to ACOs).

CMS expects these types of claims processing errors to be rare and low volume. In general, we expect that processing errors, including those arising from updated PPCP eligibility information, will be addressed during the performance year they arise. However, there are some situations that could require being addressed at this stage:

1. A minor processing error in the implementation of the ACO PC Flex Model Change Request (CR) by the Shared System Maintainers or Medicare Administrative Contractors (MACs) that leads to a small number of claim lines being processed in a manner inconsistent with model intent. Errors of this nature may not be reprocessed if the root cause of the inconsistency is unknown, or if the impact is sufficiently small[49], such that a Technical Direction Letter to direct the MACs to reprocess the claims is not warranted.
2. Type 1 errors are where a beneficiary loses PPCP eligibility and the claim has not been correctly reprocessed. If Type 1 error claims are not reprocessed as FFS by the time of settlement, they may need to be accounted for through OMO.

Note that the process described above (Section 5.3) of addressing claims processing errors through the Total PC Flex Settlement Adjustment for PY 2025 is distinct from the more general process of addressing selected claims processing errors through OMO discussed in the present section. The former process is a way to calculate performance year expenditures for Financial Settlement in a way that accounts for the errors, regardless of whether these errors will eventually be resolved through reprocessing (because subsequent reprocessing will not help with the calculation of performance year expenditures so needs to be addressed through the adjustment). The latter processes addresses selected claims processing errors that will not be addressed through reprocessing but does not apply where reprocessing is likely to address it.

[49] As defined, for example, by a *di minimus* clause in a future Participation Agreement

5.6.3 Example Other Monies Owed Calculation

In the example below in **Table 28**, we illustrate the calculation of OMO based on recalculated PPC Payment, claims processing errors, and FQHC/RHC True-up. Additionally, we show what amounts would be included in the NCBP files.

Table 28. Example to Illustrate Calculation of OMO Based on PPCP Eligibility, Claims Processing Errors, and True-up

Stage of Calculation	As of December 2025 MPR	As of Pre-NCBP file Calculations March 2025	PC Flex Final Settlement (post-NCBP when calculating OMO)
PPCP-eligible beneficiaries	100	94	92
PPCP-eligible beneficiary months	950	910	895
PPC Payment for 2025	$80,000	$75,300	$73,900
Selected claims overpayments (Type 2): Claims that were paid FFS that should have been reduced	N/A	$80	$120
Selected claims underpayments (Type 1): Claims that were reduced that should have been paid FFS	N/A	$60	$70
Net claims processing errors (positive represents overpayments)	N/A	$20	$50
FQHC/RHC True-up amount	0	$200	N/A
Total PPC Payment amount (reflected in NCBP)	N/A	$75,500	N/A
Total PPC Payment for the performance year (total amount which should be paid in PPC Payment as of ACO PC Flex Model final settlement; includes True-up calculated pre-NCBP file)	N/A	N/A	$74,100
Calculation of OMO (positive indicates money owed by ACO to CMS)	N/A	N/A	$5,950

Note: In this example we are ignoring sequestration.

In the example in **Table 28**, we calculate OMO as follows:

[(amount actually paid as of Dec MPR) + (net claims errors as of final settlement [overpayments − underpayments])] –

[amount that should have been paid based on beneficiaries assigned as of final settlement including True-up calculated pre-NCBP file]

In our example in **Table 28**, this simplifies to

$(\$80{,}000 + \$50) - (\$74{,}100) = \$5{,}950$

In this example, we assume that the beneficiaries who became ineligible based on final assignment do not have FQHC- or RHC-focused care. If they did, the True-up amount ($200 in the example above) would decrease slightly between the time of the NCBP file creation and ACO PC Flex Model final settlement, because the True-up is paid at the beneficiary-month level and the ACO would lose the True-up Payments for beneficiary months that become ineligible.

5.7 ISSUING FINAL PAYMENTS AND DEMANDS

In this subsection we outline the governing principles for issuing payments and demands to account for the components discussed above, including the Shared Savings Program financial reconciliation, the Total PC Flex Settlement Adjustment, the Advance Shared Savings Payment, and OMO. Key principles include:

1. The Shared Savings Program financial reconciliation results and the results of the Total PC Flex Settlement Adjustment are fully integrated. Specifically:
    a. Calculations related to the PC Flex Total Settlement Adjustment are integrated into the ACO Settlement Report. Final Shared Savings/ Shared Loss amounts fully account for the Total PC Flex Settlement Adjustment.
    b. ACO Status under the Shared Savings Program accounts for the Total PC Flex Settlement Adjustment, meaning an ACO may move from shared losses to shared savings or meet the MSR as a result of the Total PC Flex Settlement Adjustment.[50]
    c. Shared saving and losses reflected in the ACO Settlement Report account for recoupment of the Advance Shared Savings Payment.
    d. The Advance Shared Savings Payment is recouped from shared savings only (after the application of the Total PC Flex Settlement Adjustment) and not recouped from OMO.
    e. Final Payments/ demands incorporating the Total PC Flex Settlement Adjustment follow Shared Savings Program processes and regulations (e.g., time at which debts begin to accrue interest).
2. Shared savings and losses are kept separate from OMO, that is, they will not be combined or used to offset one another.
3. Final Payments/ demands related to OMO follow processes and regulations of the CMS Innovation Center (e.g., time at which debts begin to accrue interest) and will be settled separately from shared savings and losses.

[50] As noted in Section 5.4, CMS will use an ACO's results that do not incorporate the Total PC Flex Settlement Adjustment for certain downstream policies that consider settlement results from prior performance years.

6 FINANCIAL SETTLEMENT IMPLICATIONS OF EARLY TERMINATION FROM ACO PC FLEX MODEL

6.1 SUMMARY

An early termination from the ACO PC Flex Model occurs when an ACO voluntarily terminates its participation in the model prior to the end of the 5-year model performance period (voluntary termination) or when CMS terminates the ACO's participation (involuntary termination). A PC Flex ACO that is terminated from the Shared Savings Program will also be terminated from the ACO PC Flex Model, but there may be cases where an ACO terminates early from the model while continuing to participate in the Shared Savings Program.

Each ACO that early terminates from the ACO PC Flex Model, whether voluntarily or involuntarily, will undergo Financial Settlement for the ACO PC Flex Model for the performance year in which the termination is effective, regardless of whether the ACO will also be financially reconciled for the Shared Savings Program. However, the Financial Settlement processes and calculations for early terminating ACOs may differ from those for non-terminating ACOs depending on factors such as

- the nature of the termination (voluntary or involuntary),
- when in the performance year the termination is effective (e.g., mid-year or end of year), and
- whether the ACO will be subject to Shared Savings Program reconciliation (it would be eligible either because the ACO is not terminating from the Shared Savings Program or the ACO is terminating from the program and is subject to reconciliation under the program's termination policy, see **Table 29**).

Table 29. Summary of Shared Savings Program Termination Policy

Type of Termination	Shared Savings Program Risk Model	Effective Termination Date from Shared Savings Program		
		January 1–June 30	July 1–December 30	December 31
Voluntary	One-sided	Not subject to Shared Savings Program reconciliation	Not subject to Shared Savings Program reconciliation	Subject to Shared Savings Program reconciliation, eligible for shared savings but not liable for shared losses
Voluntary	Two-sided	Not subject to Shared Savings Program reconciliation	Subject to Shared Savings Program reconciliation, not eligible for shared savings but liable for prorated shared losses	Subject to Shared Savings Program reconciliation, eligible for shared savings and liable for shared losses

Type of Termination	Shared Savings Program Risk Model	Effective Termination Date from Shared Savings Program		
		January 1–June 30	July 1–December 30	December 31
Involuntary	One-sided	Not subject to Shared Savings Program reconciliation	Not subject to Shared Savings Program reconciliation	Not subject to Shared Savings Program reconciliation
Involuntary	Two-sided	Subject to Shared Savings Program reconciliation, not eligible for shared savings but liable for prorated shared losses	Subject to Shared Savings Program reconciliation, not eligible for shared savings but liable for prorated shared losses	Subject to Shared Savings Program reconciliation, not eligible for shared savings but liable for shared losses

In general, the following principles govern cases of early termination from the ACO PC Flex Model:

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. OMO may be impacted.

This section describes how Financial Settlement will be operationalized for ACOs terminating early from the model. Note that within the remainder of this section, any month of the performance year up to and including the month of an ACO's effective termination date is referred to as a "pre-termination month," and any month after the ACO's effective termination date is referred to as a "post-termination month."

6.2 METHODOLOGY BY TERMINATION CATEGORY

6.2.1 Voluntary End-of-Year Termination

An ACO that voluntarily terminates with an effective date of December 31 of the performance year will be subject to the same Financial Settlement processes and calculations applicable to non-terminating ACOs (as described in Section 5.1 of this document) except regarding the recoupment and recovery of the Advance Shared Savings Payment. Recoupment and recovery of the Advance Shared Savings Payment for all early terminating ACOs is described in Section 6.2.5.

6.2.2 Voluntary Mid-year Termination Subject to Shared Savings Program Financial Reconciliation

An ACO's voluntary termination with an effective date on or before December 30 of the performance year is considered a mid-year termination. As described in **Table 29**, an ACO that voluntarily terminates from ACO PC Flex Model mid-year **will** be subject to Shared Savings

Program financial reconciliation under the Shared Savings Program termination policy (and will receive a Shared Savings Program settlement report) if any of the following are true:

1. The ACO is in a one- or two-sided model and is not terminating from the Shared Savings Program.
2. The ACO is in a one- or two-sided model and is voluntarily terminating from the Shared Savings Program effective December 31.
3. The ACO is in a two-sided model and is voluntarily terminating from the Shared Savings Program with an effective date between July 1 and December 30.
4. The ACO is in a two-sided model and is involuntarily terminating from the Shared Savings Program.

6.2.2.1 Remaining Performance Year Monthly Payment Reports

Once an ACO notifies CMS of its intention to terminate from the model effective as of a certain date, CMS will use this date to set the monthly PPCP eligibility flag for the next MPR. All post-termination months will be PPCP-ineligible. Pre-termination months will remain PPCP-eligible so long as they meet other eligibility criteria.

Depending on the timing of the termination notification and effective dates, it may not be possible to stop prospective payment for the month immediately following an ACO's termination date.[51] For example, assume an ACO notifies CMS in late July that it intends to terminate with an effective date of August 31. In this situation CMS may choose to proceed with the delivery of the September reports and payments as originally prepared. The ACO's termination would be incorporated in the October MPR production cycle commencing in early August. By contrast, if the ACO notified CMS in late June of its intention to terminate from the ACO PC Flex Model on August 31, this information could be incorporated into the September MPR and prospective payment for September would be avoided.

The following processes will apply for the remainder of the performance year:

1. The terminating ACO will continue to receive an informational MPR for all remaining months of the performance year, including the December MPR.
2. The informational MPRs will include redetermined PPCP eligibility and payments as follows:
    a. All post-termination months will be PPCP-ineligible and consequently all base payments for post-termination months will be set to zero.
    b. Base PPC Payments for each pre-termination month will be recalculated based on updated information (same process as for non-terminating ACOs).

[51] It is expected that this scenario would be unlikely as there are mechanisms available to prevent payments from being made with short notice. This may result in a divergence of the MPR report and payments for the month in question, which would need to be addressed in the next MPR.

c. Enhanced PPC Payment amounts and Population Adjustments for both pre- and post-termination months will be set to zero.

3. The ACO will **not** receive any further PPC Payments or PPC Payment adjustments or recoupments beginning with the payment cycle associated with the MPR for the ACO's first post-termination month (or the following month, if the termination notification is not received in time). Any payment adjustments or recoupments will be addressed as OMO during settlement.
4. Claims for beneficiary months identified as losing PPCP eligibility—up to and including the claims in the December MPR—that had been reduced under the model will be reprocessed.
5. Only base payments for PPCP-eligible months will be reflected in data captured in the NCBP system.

See an example of this process in the following text box.

Example:

1. An ACO notifies CMS on July 25 of intention to terminate from the ACO PC Flex Model, effective August 31. Because of the timing of the notification, termination will not be accounted for in the September MPR. ACO will receive prospective payment for September in late August along with any payment adjustments for the months of January–August.
2. CMS will account for the termination for the first time when assessing eligibility for the October MPR. The ACO will receive informational MPRs for October, November, and December that show the following:
    a. Redetermined PPCP eligibility for January–August
    b. Recalculated base payments for January–August
    c. Enhancement payments of 0 for January–August
    d. PPCP eligibility flags, base payments, enhancement payments, and population adjustment amounts will all equal to 0 for months of September–December for all beneficiaries.
3. The ACO will receive no payments or payment recoupments/adjustments in the payment cycle associated with the October, November, or December MPRs.
4. Claims for the following months that were originally reduced will be reprocessed:
    a. Any claims for September–December (though in theory, only September claims are likely to require reprocessing)
    b. Any claims in months of January–August that are newly ineligible
5. Data submitted to the NCBP system based on the December MPR will reflect the following:
    a. Adjustments to cancel any enhancement payments/population adjustment amounts for January–August
    b. Adjustments to cancel any base or enhanced payments for September
    c. Adjustments to reflect recalculated base payments for January–August
    d. No base or enhanced payments for October–December

6.2.2.2 March NCBP File (Voluntary Mid-year Terminations with Shared Savings Program Financial Reconciliation)

As with non-terminating ACOs, CMS will re-determine PPCP eligibility and recalculate payments in March following the end of the performance year. Any new eligibility changes will be reflected in the next scheduled FFS file and will trigger claims reprocessing.

The total PPC Payment for each pre-termination PPCP-eligible month that will be included in the NCBP file will be based on the **base PPC Payment** (not the Enhancement amount or Population Adjustment) and will be calculated as follows:

1. Use the recalculated PPC Payment amounts along with payment reduction amounts for beneficiaries with FQHC- and RHC-focused care to compute FQHC and RHC True-up amounts, expressed on a PBPM basis across all PPCP-eligible pre-termination months for the FQHC- or RHC-focused care population, respectively.

- Note that for non-terminated ACOs, the PPC Payment used to compute the True-up reflects not only the base payment but also the county enhancement and Enhancement Add-On. However, because mid-year terminating ACOs must pay back any enhancement payments received, these Enhancement amounts are not included in their True-up calculations, which increases the likelihood of a positive True-up.

2. Add the True-up amounts, expressed on a PBPM basis, to the recalculated base PPC Payments for each PPCP-eligible pre-termination month for beneficiaries with FQHC- or RHC-focused care.

6.2.2.3 *Final Settlement (Voluntary Mid-Year Terminations w/ Shared Savings Program Financial Reconciliation)*

Final ACO PC Flex Model settlement for this category of early terminating ACOs will occur at the same time as Shared Savings Program financial reconciliation and will include the calculation of the following components as OMO:

Components of OMO for terminating ACOs:

(1) Enhanced Amounts

(2) Base amounts for post-termination months

(3) Difference between base amounts paid and the Total PPC Payment for the performance year

(4) Net claims processing errors

(5) Portion of the Advance Shared Savings Payment

1. Enhanced payments and population adjustments. The ACO will be required to repay any enhancement payments and Population Adjustments received for the performance year for both pre- and post-termination months.

2. Base payments post-termination. The ACO will be required to repay any base payments received for post-termination months.

3. PPC Payment discrepancy. The ACO will be required to repay the difference between the sum of base payments received for all pre-termination months and the Total PPC Payment for the performance year (as calculated for the March NCBP file and subsequently adjusted to remove beneficiaries not assigned in final assignment). If the amount the ACO received was lower, CMS will be required to pay the difference to the ACO.

   - Note that this is similar to the calculation done for non-terminating ACOs but based only on base payments and only for pre-termination months.

4. Net claims processing errors. For those claims processing errors not expected to be reprocessed in the CY following the performance year, the ACO will be required to repay any FFS payments received for ACO PC Flex Model primary care services provided by primary care providers or primary care NPPs that should have been fee-reduced (Type 2 errors), offset by the amount of payments that were reduced, but should have been paid (Type 1 errors). If the amount of Type 1 errors is larger, CMS will be required to pay the difference to the ACO.

   - Note that this is similar to the calculation done for non-terminating ACOs.

5. The ACO may be required to repay a portion of the Advance Shared Savings Payment after accounting for recoupment from any current year shared savings as determined under the methodology described in Section 6.2.5.

To help illustrate some of the OMO calculations, **Table 30** shows hypothetical data for the example ACO that terminated effective August 31 for the September MPR (last MPR for which ACO received payments) and what would be included in the final NCBP file in March for that ACO.

Table 30. Hypothetical Payment Data for OMO Calculations

Month	September MPR (last payments made)			Calculated for March NCBP File		
	PPCP-Eligible Beneficiaries	Enhancement & Population Adjustment Payment	Base Payment	PPCP-Eligible Beneficiaries	Enhancement & Population Adjustment Payment	Base Payment
Jan	12,000	$120,000	$660,000	10,800	0	$680,400
Feb	11,900	$119,000	$654,500	10,700	0	$674,100
Mar	11,800	$118,000	$649,000	10,600	0	$667,800
Apr	11,700	$117,000	$643,500	10,500	0	$661,500
May	11,600	$116,000	$638,000	10,400	0	$655,200
Jun	11,500	$115,000	$632,500	10,300	0	$648,900
Jul	11,400	$228,000	$627,000	10,200	0	$642,600
Aug	11,300	$226,000	$621,500	10,100	0	$636,300
Sep	11,200	$224,000	$616,000	0	0	0
Oct	—	—	—	0	0	0
Nov	—	—	—	0	0	0
Dec	—	—	—	0	0	0
Total	**104,400**	**$1,383,000**	**$5,742,000**	**83,600**	**0**	**$5,266,800**

Table 30's example ACO received enhancement payments (including the Population Adjustment) for the months of January–September totaling $1,383,000 as of the September MPR and would be required to repay this full amount as part of OMO. The ACO would also be required to repay the base payment it received for September of $616,000.

To determine OMO related to base payments for pre-termination months (January–August), CMS would calculate the difference between what the ACO actually received in base payments for those months ($5,742,000 − $616,000 = $5,126,000) and the base payments for those months as calculated for the March NCBP file (including any FQHC/RHC True-up amounts) adjusted to remove payments for beneficiaries no longer assigned in final assignment (assumed to be $5,000), which would be $5,126,000 − ($5,266,800 − $5,000) = −$135,800. In this case, the ACO was actually paid less than it should have been, therefore CMS would owe ACO

$135,800 as part of OMO. So, in total, the ACO would be required to pay $1,383,000 + $616,000 − $135,800 = $1,863,200 in OMO along with any amounts associated with claims paid that should have been reduced (that are not offset by claims reduced that should have been paid) or Advance Shared Savings payments owed.

6.2.2.4 Shared Savings Program Settlement (Voluntary Mid-Year Terminations w/ Shared Savings Program Financial Reconciliation)

The ACO's total PPC Payment (as reflected in the NCBP file) will be incorporated in the ACO's performance year expenditures as described in Section 5.2. The total PPC Payment included in performance year expenditures will not include any enhancement amounts or Population Adjustment amounts. This is because an ACO that voluntarily terminates mid-year is **not** eligible to receive the Total PC Flex Settlement Adjustment (with the exception being that CMS may use the Total PC Flex Settlement Adjustment to address claims processing errors) and must repay any enhancement payments and Population Adjustments received for the performance year.

6.2.2.5 Recoupment of the Advance Shared Savings Payment for Early Terminating ACOs

Recoupment of the Advance Shared Savings Payment for early terminating ACOs will be handled as described in Section 6.2.5.

6.2.3 Voluntary Mid-year Termination Not Subject to Shared Savings Program Financial Reconciliation

An ACO that voluntarily terminates from the ACO PC Flex Model mid-year **will not be** subject to Shared Savings Program financial reconciliation under the Shared Savings Program termination policy if either of the following are true:

1. The ACO is in a one- or two-sided model and is voluntarily terminating from Shared Savings Program with an effective date between January 1 and June 30.
2. The ACO is in a one-sided model and is voluntarily terminating from Shared Savings Program with an effective date between July 1 and December 30.

The settlement procedures for ACOs in this category will generally mirror those of mid-year terminating ACOs that are subject to Shared Savings Program financial reconciliation, except that they will not be subject to shared savings or shared losses calculations or receive an Shared Savings Program settlement report and any required remaining repayment of the Advance Shared Savings Payment will occur exclusively as OMO as described in Section 6.2.5 (because there will be no shared savings for the current performance year to potentially recoup from).

CMS may consider having two separate settlement cycles for a given performance year for ACOs in this category: one for ACOs terminating from ACO PC Flex Model in the first half of the year (the cycle would be performed in the summer/fall of the performance year itself) and one for ACOs terminating from the ACO PC Flex Model in the second half of the performance year

(the cycle would be performed at the same time as Shared Savings Program reconciliation for the performance year).

6.2.4 Involuntary Terminations

Involuntary terminations from the ACO PC Flex Model will generally follow the same processes as for voluntary terminations. One exception is that an involuntarily terminated ACO must repay the full Advance Shared Savings Payment amount as OMO, if not already recouped via shared savings, as opposed to repaying a prorated amount (see Section 6.2.5). A one-sided ACO that is also involuntarily terminated from the Shared Savings Program will not be subject to Shared Savings Program financial reconciliation regardless of when in the performance year the termination is effective. By contrast, involuntarily terminated two-sided ACOs will subject to Shared Savings Program financial reconciliation regardless of when in the performance year the termination is effective.

6.2.5 Recovery and Recoupment of Advance Shared Savings Payment for Early Terminating ACOs

An ACO that voluntarily terminated from the ACO PC Flex Model before December 31, 2025, would have been required to repay the entire $250,000 Advance Shared Savings Payment. If the ACO was to be financially reconciled for Shared Savings Program for Performance Year 2025, CMS would attempt to recoup up to the full amount from any shared savings earned. The ACO would be required to repay any amount not recouped from shared savings as OMO. If the ACO was not to be reconciled for Shared Savings Program, the ACO would have to repay the entire $250,000 as OMO. In practice, no ACOs fell into this category.

An ACO that voluntarily terminates from the ACO PC Flex Model on or after December 31, 2025, will be required to repay, as OMO, a prorated amount of the Advance Shared Savings Payment, minus any recoupments from shared savings for prior or current performance years up to the prorated amount. The prorated amount shall equal 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 ACO PC Flex Model multiplied by one-fifth of the amount of the total Advance Shared Savings Payment. See **Table 31**.

Table 31. Prorated Amounts by Effective Termination Date

Effective Termination Date	Prorated Amount
Before 12/31/2025	Not applicable, ACO must repay full $250,000
12/31/2025–12/30/2026	$200,000
12/31/2026–12/30/2027	$150,000
12/31/2027–12/30/2028	$100,000
12/31/2028–12/30/2029	$50,000

If, heading into the current performance year's financial reconciliation, CMS has already recouped more than prorated amount, the ACO will not receive any credit for the difference.

To operationalize this policy, CMS will do the following:

1. Determine the applicable prorated amount based on the ACO's effective termination date.
2. Determine the outstanding balance before current performance year recoupment reflecting the prorated amount. This is the total amount that the ACO still owes CMS prior to the current performance year reconciliation.
    - Restated Outstanding Balance Before Recoupment = Maximum of (Prorated Amount − Amounts Recouped in Prior Performance Years) and 0.
3. Determine the amount recouped for current performance year. This is the amount that is recouped from the current performance year's earned performance payment (after application of the Total PC Flex Settlement Adjustment, if applicable).
    - Amount Recouped in Current Performance Year = Minimum of Original Earned Performance Payment for the Current Performance Year and the Restated Outstanding Balance Before Recoupment
4. Determine the earned performance payment for the current performance year after recoupment. This is the earned performance payment the ACO will actually be paid for the performance year.
    - Earned Performance Payment for Current Performance Year After Recoupment = Original Earned Performance Payment for Current Performance Year − Amount Recouped in Current Performance Year
5. Determine OMO. This is the remaining outstanding balance that ACO must repay to CMS as OMO.
    - Advance Shared Savings Component of OMO = Restated Outstanding Balance Before Recoupment − Amount Recouped in Current Performance Year

Table 32 shows several examples of these calculations where an ACO had completed 2 performance years at the time of its termination and therefore has a prorated amount of $150,000.

Table 32. Examples of Advance Shared Savings Payment Recoupment and Repayment for Voluntarily Terminating ACO Subject to Shared Savings Program Financial Reconciliation

No.	Amounts Recouped in Prior Performance Years	Restated Outstanding Balance Before Current Performance Year Recoupment	Original Earned Performance Payment for Current Performance Year	Amount Recouped in Current Performance Year	Earned Performance Payment for Current Performance Year After Recoupment	Advance Shared Savings Payment Component of OMO
	[1]	[2] = Max of ($150,000 − [1]) and 0	[3]	[4] = Min of [2] and [3]	[5] = [3] − [4]	[6] = [2] − [4]
1	$250,000	$0	$1,000,000	$0	$1,000,000	$0
2	$175,000	$0	$500,000	$0	$500,000	$0
3	$100,000	$50,000	$200,000	$50,000	$150,000	$0
4	$50,000	$100,000	$175,000	$100,000	$75,000	$0
6	$0	$150,000	$0	$0	$0	$150,000

If the ACO voluntarily terminates on or after December 31, 2025, and will not be financially reconciled for Shared Savings Program for the performance year in which it terminates from the ACO PC Flex Model, then CMS will calculate the difference between the applicable prorated amount and amounts recouped in prior performance years. If the difference is positive, the ACO will owe this amount as OMO. If the difference is negative (i.e., CMS has already recouped more than the prorated amount), no payment will be made in either direction (i.e., CMS will not credit back to the ACO the difference between the amount already recouped and the prorated amount).

If an ACO is involuntarily terminated from the ACO PC Flex Model at any time during the 5-year agreement period, it is required to repay the full $250,000 either via shared savings recoupment or OMO.

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.

HRSN = Health-related social needs.

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 [a]	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 [b]	G0463

Service	Code(s)
Chronic care management	G0506
Cardiovascular risk assessment and risk management services	G0537 and G0538
Individual behavior management or modification caregiver training services	G0539 and G0540
Direct care caregiver training services	G0541, G0542, and G0543
Advanced primary care management (APCM) services	G0556, G0557, and G0558
Safety planning interventions	G0560
Post-discharge telephonic follow-up contacts intervention	G0544
Cervical or vaginal cancer screening	G0101
APCM behavioral health add-ons [c]	G0568, G0569, and G0570
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

[a] These three codes ended on December 31, 2024, so they are not be applicable for fee reductions for claims billing beginning Calendar Year (CY) 2025.
[b] 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.
[c] These three codes are new for CY2026, so they are not applicable to the 2025 Updated Rate Book. These codes will be applicable for fee reductions for claims billing in CY2026.

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 Realizing Equity, Access, and Community Health (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.	N/A.	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.

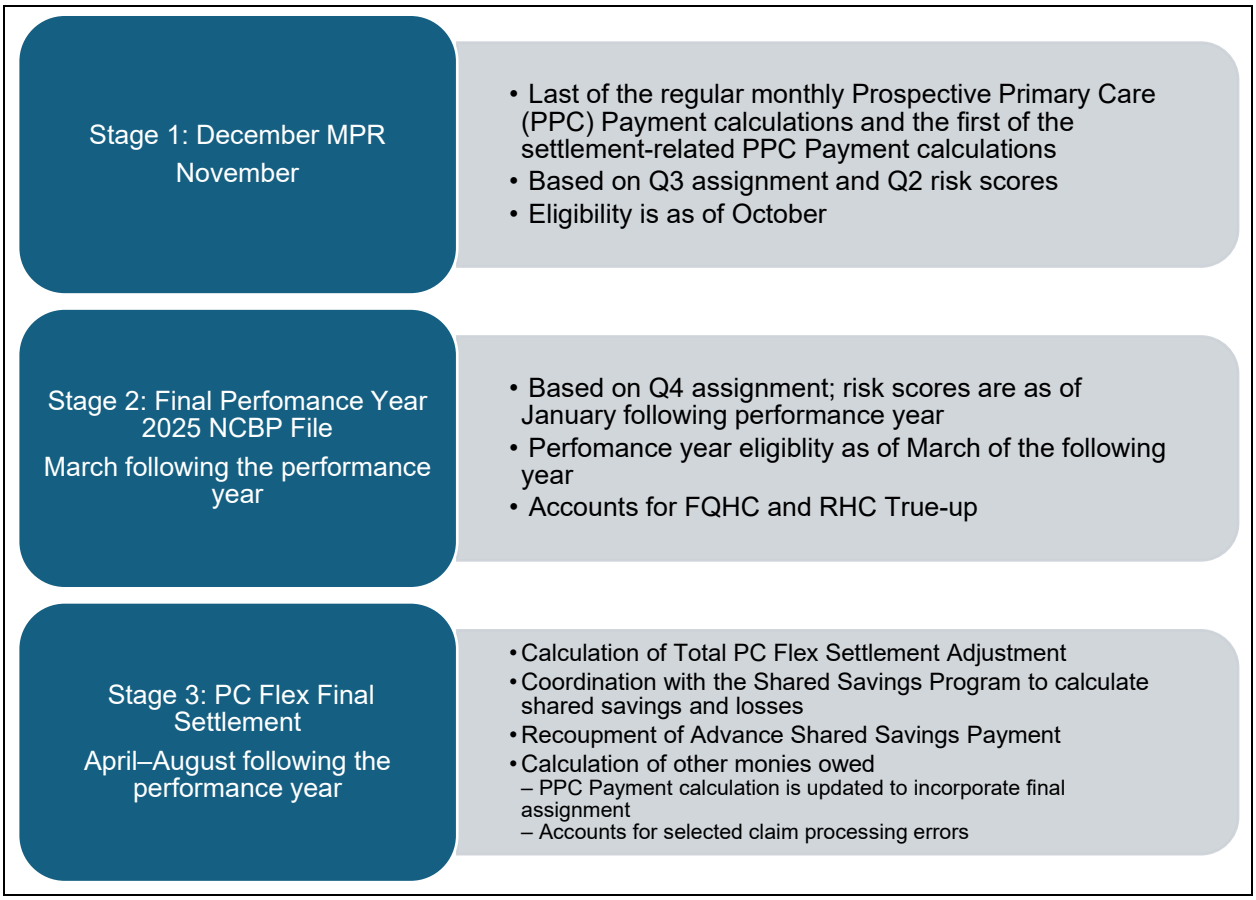
Feature	ACO PC Flex Model	Medicare Shared Savings Program	ACO Realizing Equity, Access, and Community Health (ACO REACH)
Expenditure	Expenditures are defined the same way for A&D and ESRD populations.	Expenditures are calculated separately for ESRD, disabled, aged/dual eligible and aged/non-dual eligible 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 2026 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. 3 months of run-out is considered final.
Credibility adjustment	Credibility adjustment applied to small counties for A&D.	N/A.	Credibility adjustment applied to small counties for A&D.

APPENDIX E: MODEL OPERATIONS AND FINANCIAL SETTLEMENT STAGE 1: FINAL PPC PAYMENTS AND THE DECEMBER MONTHLY PAYMENT REPORT

A summary of the Financial Settlement stages and the primary activities associated with each is provided in **Figure E-1**. Broadly, the stages aim to achieve the following:

- **Stage 1**: Final monthly PPC Payment calculation via the December Monthly Payment Report (MPR)
- **Stage 2**: Calculation of inputs for the Shared Savings Program financial reconciliation via submission of the final Non-Claims-Based Payment (NCBP) File
- **Stage 3**: Final Financial Settlement for ACOs participating in the ACO PC Flex Model

Figure E-1. Stages of ACO PC Flex Model Financial Settlement Activities



Similar to other MPRs, the December MPR contains beneficiary-level information, including demographics, beneficiary assignment, risk adjustment, PPCP eligibility, Population Adjustment

Amount, and final PPC Payment. The December MPR provides PPC Payment calculations for every month during the performance year, using the latest available data. Every month is recalculated during the creation of December MPR, and this is the final time these calculations are run as part of the regular MPR process. This is also the final time these calculations are run during the performance year. The December MPR serves as both the last regular monthly PPC Payment calculation and the first settlement-related PPC Payment calculation. Following the close of the performance year, reconciliation of all final monies, including final PPC Payment amounts and OMO, is done as part of Financial Settlement. No further payments or recoupments occur outside of settlement.

As shown in **Table E-1** the December MPR is based on performance year Q3 assignment, Q2 risk scores, and the other variables, including those related to eligibility, which are current as of October of the performance year (e.g., October 2025 for Performance Year 2025). As is typical of MPRs, the variables for the 2 most recent months (in this case November and December) are estimated based on earlier data. Specifically, in the December MPR, November and December variables are calculated based on information current as of October of the performance year, as shown below in **Table E-1**. When the PPC Payment is recalculated for November and December for settlement purposes (as described in later sections of this plan), it will be based on the most current information as of a later point in time (e.g., March of the CY following the performance year).

Table E-1. Data Sources Used in Each Stage of Settlement-Related PPC Payment Calculations for Performance Year 2025

Component of PPC Payment Calculation	December MPR Stage	Final NCBP Data Stage	PC Flex Final Settlement Stage
Assignment: Shared Savings Program assignment for retrospective ACOs and assignment eligibility updates for prospective ACOs	Q3 assignment	Q4 assignment	Final Performance Year 2025 assignment
Eligibility: Data pull for ESRD and A&D statuses, county of residence, health maintenance organization, death, enrolled in Part A-only or Part B-only, not enrolled in Part A or Part B	October 2025	Performance year data as of March 2026	Performance year data as of March 2026
Declined data sharing	October 2025	Performance year data as of March 2026	Performance year data as of March 2026
Terminated TIN	October 2025	Performance year data as of March 2026	Performance year data as of March 2026
Risk adjustment variables	Q2 file	Special run for the ACO PC Flex Model with claims run-out through January 2026	Special run for the ACO PC Flex Model with claims run-out through January 2026

Component of PPC Payment Calculation	December MPR Stage	Final NCBP Data Stage	PC Flex Final Settlement Stage
Low-income subsidy status (for Population Adjustment Amount)	October 2025	Performance year data as of March 2026	Performance year data as of March 2026
Dual status (for Population Adjustment Amount)	October 2025	Performance year data as of March 2026	Performance year data as of March 2026
ADI (State and National) (for Population Adjustment Amount)	October 2025	Performance year data as of March 2026	Performance year data as of March 2026

APPENDIX F: MODEL OPERATIONS AND FINANCIAL SETTLEMENT STAGE 2: PPC PAYMENT UPDATES AND MARCH NON-CLAIMS-BASED PAYMENT FILES

Summary of Non-Claims-Based Payment Files

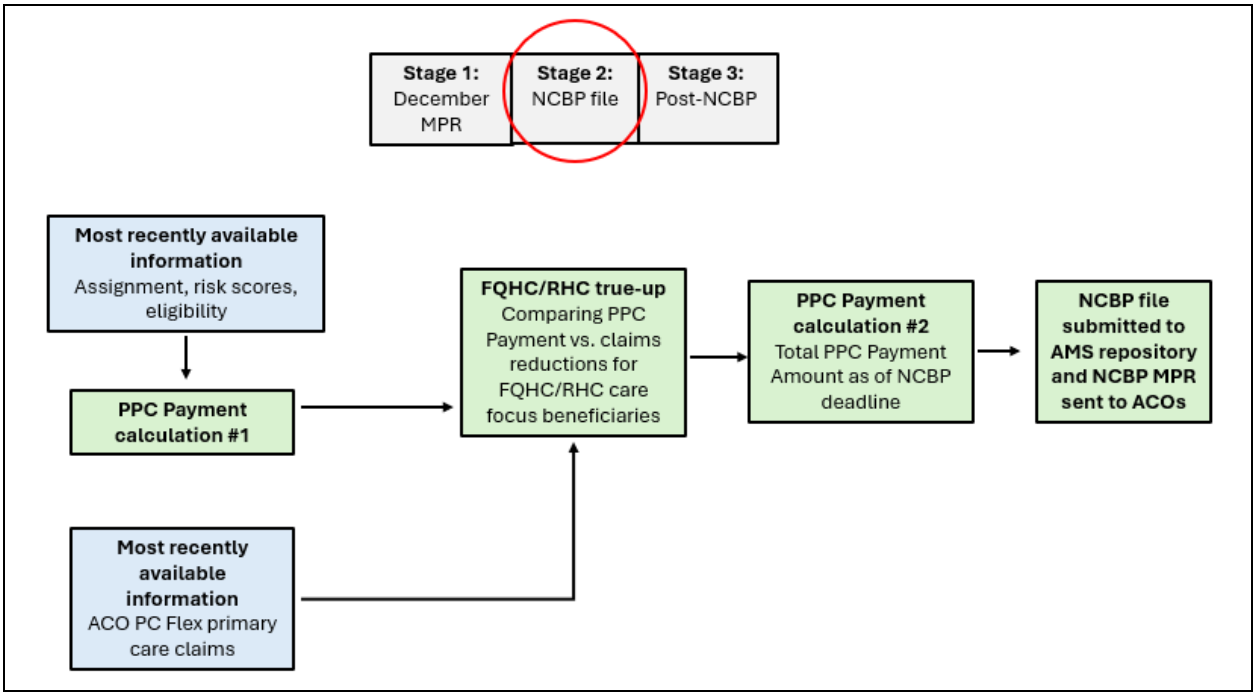
Both the Advance Shared Savings Payment and the PPC Payment are made by CMS to a PC Flex ACO as an NCBP, meaning a payment that does not rely solely on traditional FFS claims. For all Innovation Center payment models participating in shared savings initiatives, CMS requires that beneficiary-level data on all NCBPs for the ACO's assigned population are accounted for via a consolidated NCBP file submitted to the Analysis & Management System (AMS) repository. As described in 42 CFR Part 425 Subpart G, CMS uses a 3-month claims run out period ending on March 31 of the CY following the PY to calculate an ACO's per capita expenditures for each PY. Accordingly, final payment data for the performance year must be submitted by the same date, March 31 of the CY following the PY.

The ACO PC Flex Model submits PPC Payments amounts as NCBP data to the repository quarterly during each performance year and submits one final payment file to the repository by the March 31 deadline. This data is included by the Shared Savings Program in the calculation of performance year expenditures for PC Flex ACOs.

The process which results in the final payment file submission builds on the December MPR, incorporating updated components and introducing new elements. The final file includes Total PPC Payments occurring between January 1 and December 31, recalculated in March to reflect more recent data as described in **Appendix E**, **Table E-1** and the FQHC/RHC True-up adjustment. At this stage, all months, including December, are calculated using eligibility information current as of March of the CY following the performance year. This data is also used to compile the PY 2025 Final NCBP MPR, sent to ACOs on March 31 of the CY following the performance year.

The steps in the March calculations needed for these final payment files (NCBP file submitted to the Shared Savings Program and the PY 2025 Final NCBP MPR sent to ACOs) are the same, and are depicted below in **Figure F-1**.

Figure F-1. Inputs and Processes Leading to the Final Performance Year NCBP File



March Non-Claims-Based Payment Files

Non-Claims-Based Payment File Inputs and Processing

Multiple data elements are pulled from the Integrated Data Repository Cloud (IDR-C) to support development of the March NCBP files. CMS first identifies the ACO PC Flex Model National Reference Population for the performance year for the purpose of calculating risk score normalization factors for the ESRD and A&D populations. This data pull occurs slightly earlier in March than the others due to the time required to generate the normalization factors and because a slightly shorter run-out is not expected to meaningfully impact the resulting normalization factor values. That is, there is no expected relationship between a beneficiary's risk score and the length of the claims run-out period. The normalization factor for the ESRD and A&D populations is the national average risk score among beneficiaries for that sub-population in the Rate Book Reference Population (that is, National Reference Population excluding beneficiaries with FQHC or RHC care focus and beneficiaries who only received primary care services from specialist physicians).

CMS then uses the latest available data to update the PPC Payment calculations and FQHC/RHC True-up calculation. The availability of date and timing of calculations is outlined below in **Table F-1**.

Table F-1. Availability of Data and Timing of Claims Data Pulls for Total PPC Payment Included in the NCBP File Creation

Date	Milestone
January	Q4 assignment data are available
Mid February	Special run of risk score data with claims run-out through mid-January
Late February	Claims data available for ACO PC Flex Model National Reference Population to calculate risk score normalization factors
Early March	Claims data with late February run-out available for FQHC/RHC True-up calculation
Early March	Eligibility data available for PPC Payment calculations

PPC Payment Calculation #1: March Update of PPCP Eligibility and Payment Amounts for January–December 2025

CMS recalculates the PPC Payment amount for all PPCP-eligible beneficiaries for the performance year using updated assignment, eligibility, and risk scores, along with other elements described in **Table E-1** and **Table F-1**Table. The payment calculations are performed in a manner consistent with the PPC Payment calculations conducted for the MPRs. The result is a beneficiary-month–level file with updated PPCP eligibility and payments for January–December. We refer to this as *PPC Payment Calculation #1*, while considering the December MPR PPC Payment calculation to be *PPC Payment Calculation #0*.

Elements of the updated PPC Payment are then used for the FQHC/RHC True-up calculations. Subsequently, CMS adjusts the PPC Calculation #1 results for the FQHC/RHC True-up to calculate the total PPC Payment for the final NCBP data for the performance year (*PPC Payment Calculation #2*), as explained further below.

Calculating the FQHC/RHC True-up Amount

To ensure ACOs are appropriately funded for beneficiaries receiving FQHC- and RHC-focused care, CMS monitors the PPC Payment compared with PPC Fee Reductions for focused care beneficiaries within each ACO Participant and adjusts ACO Participant payments if necessary. This is the “FQHC/RHC True-up” calculation.

For settlement of Performance Year 2025, CMS will use claims from July 1, 2025–December 31, 2025, with a run-out through the end of February to calculate the total fee reduction amount for ACO PC Flex PPCP-eligible services for each ACO. As noted above, all final data must be submitted by March 31, which is the end of the 3-month run out period for claims to calculate an ACO's per capita expenditures for each PY. To have the FQHC/RHC True-up Amount finalized by March 31, a shorter run-out period is required. This amount is then compared to the PPC Payment amount determined by *PPC Payment Calculation #1,* above. The PY 2025 True-up Analysis will include FQHC- and RHC-focused care beneficiaries that are PPCP eligible as of March 2026. For Performance Year 2025, the True-up calculation pertains only to payments made in Q3 and Q4 of 2025.

The True-up calculation will be conducted separately for FQHC-focused care and RHC-focused care beneficiaries, however, the underlying calculations will be the same for both types of care focus. The True-up Amount is calculated by subtracting the YTD PPC Payment components that approximate FFS spending for eligible services—including the Base Rate amount, FQHC and RHC add-on amounts, Adjusted County Enhancement, and Adjusted Enhancement Add-on amount—from the YTD fee reductions. CMS does not include the PC Flex Enhancement or the Population Adjustment Amount when determining PPC Payment amounts for the True-up calculation because these components are not intended to replace FFS payments for eligible services.

For 2025, the analysis will only include July–December in these calculations. In future performance years, the True-up Analysis will be conducted quarterly with a 3-month run-out period for claims data. For Q1 of future performance years, the first True-up calculation will compare PPC Payments with fee reductions from January–March. Any True-up payments will be included as part of the September MPR cycle. For Q2 of future performance years, the True-up calculation will compare PPC Payments with fee reductions from January–June and, where relevant, will be paid as part of the December MPR cycle. True-up calculations and payment for Q3 and Q4 will always occur as part of the financial settlement process.

A positive True-up value means the value of reduced primary care claims exceeds the amount of PPC Payment. A positive value therefore indicates that the ACO has not been fully compensated for PPCP-eligible beneficiaries with FQHC- or RHC-focused care and thus, a True-up PPC Payment amount is appropriate. The amount of claims data used – or the claims run-out period - plays an important role in determining if an ACO has or has not been appropriately compensated as part of the True-up calculation.

For both Q3 and Q4 Performance Year 2025 claims, CMS will use the same claims run-out period, which ends at the end of February, 2026. This means that the claims run-out period for each quarter will differ. For Q3, five months of run-out are used, whereas Q4 has a two-month run-out period. Shorter run-out periods produce a less robust comparison of reductions to amounts paid. With a shorter run-out period, the calculation includes fewer claims, and associated fee reductions, while simultaneously including all PPC Payments during the quarter. As a result, shorter run-outs may bias towards no True-up Payment (i.e., True-up amount is not positive).

To increase the likelihood that results of the True-up calculation accurately reflect claims reductions relative to PPC payments in Performance Year 2025, CMS conducts the True-up calculations separately for Q3 and Q4. This avoids combining the shorter run-out period of Q4 with the Q3 calculations, effectively “diluting” the number of reduced claims and potentially biasing the outcome toward a negative value and no True-up payment, when one may in-fact be appropriate when calculated separately.

For Q3, CMS compares the PPC Payment amounts from July–September 2025 to fee reduction amounts on claims with dates of service from July–September 2025 among FQHC- or RHC-focused care beneficiaries. In future performance years we will subtract out any prior True-up Amounts paid in Q1 or Q2 from any final positive True-up payment amount to avoid double payment. For Performance Year 2025 Q3 and Q4 calculations, Q1 and Q2 True-up amounts are

zero. If the Q3 fee reductions on eligible claims exceed total PPC Payment amounts and prior paid True-up Amounts ($0 in 2025), CMS will increase the PPC Payment amount by the difference between reductions and payments. This will be referred to as the *Q3 True-up Payment Amount*. For negative True-up calculation values - meaning the fee reduction amount is less than or equal to the PPC Payment amount - no change is made to the PPC Payment amount (i.e., the Q3 True-up Payment amount equals zero).

Similarly, for PY 2025 Q4 calculations CMS compares the PPC Payments from July–December 2025 (including any Q3 True-up payment amount) to fee reductions on claims with dates of service from July 2025 to December 2025 among FQHC- or RHC-focused care beneficiaries. If the final True-up amount, less the *Q3 True-up Payment Amount,* is positive, CMS will increase the PPC Payment amount by this difference. No changes will be made to the PPC Payment amount if this difference is not positive. This will be referred to as the *Q4 True-up Payment Amount*.

For Performance Year 2025, the *FQHC/RHC True-up Payment Amount* is calculated as the sum of the *Q3 True-up Payment Amount* and *Q4 True-up Payment Amount.* The *FQHC/RHC True-up Payment Amount* is included as part of Total PPC Payments calculated for the final Performance Year 2025 NCBP files.

In **Table F-2**, we illustrate FQHC/RHC True-up calculations for Q3 and Q4 with two examples.

Table F-2. Example FQHC/RHC True-up Calculations

True-up Calculation Steps	Example 1	Example 2
Q3 YTD Reductions [1]	$6,200,000	$6,200,000
Q3 YTD PPC Payments [2]	$6,000,000	$6,000,000
Q3 True-up Amount [3] = Max ([1] − [2], 0)	$200,000	$200,000
Q4 YTD Reductions [4]	$10,000,000	$12,100,000
Q4 YTD PPC Payments [5]	$11,800,000	$11,800,000
Q4 True-up Amt Before Accounting for Q3 True-up Amount [6] = Max ([4] − [5], 0)	$0	$300,000
Q4 True-up Amt After Accounting for Q3 True-up Amount [7] = Max ([6] − [3], 0)	$0	$100,000
Combined Q3 and Q4 True-up Amount [8] = [3] + [7]	$200,000	$300,000

PPC Payment Calculation #2: Adding the FQHC/RHC True-up Amount to the PPC Payment Amounts for January–December 2025

CMS will update the PPC Payment to account for the *FQHC/RHC True-up Payment Amount*. The *FQHC/RHC True-up Payment Amount* will be converted to a *PBPM value* by dividing the aggregate *FQHC/RHC True-up Payment Amount* for a given ACO by the number of eligible beneficiary months (July–December) among FQHC- or RHC-focused care beneficiaries within

that ACO. This PBPM result will be combined with PPC Payment Calculation #1 in creating PPC Calculation #2.

To reflect payment of the True-up to ACOs, CMS will adjust the value of the variable B_ALLOC_FQHC_RHC_TRUE_UP_AMT in the NCBP MPR so that the sum of the True-up Amounts for all eligible FQHC- or RHC-focused care beneficiaries across July to December is equal to the overall FQHC*/RHC True-up Payment Amount*.

Because beneficiaries cannot receive both FQHC-focused care and RHC-focused care, the B_ALLOC_FQHC_RHC_TRUE_UP_AMT field will include both the FQHC and RHC True-up amounts. For FQHC-focused care beneficiaries, this field will contain the ACO-specific PBPM FQHC True-up. For RHC-focused care beneficiaries, it will contain the ACO-specific PBPM RHC True-up.

Delivery of Non-Claims-Based Payment Files

By March of the CY following the performance year the NCBP files will be submitted to the Shared Savings Program as an input for the calculation of performance year expenditures in the Medicare Shared Savings Program Financial Reconciliation, and to ACOs as the final performance year NCBP Monthly Payment Report. The NCBP files reflect the updated PPC Payment for January–December of the performance year, as of March of the following calendar year. Money will not change hands at this stage. Any additional amounts owed or due as a result of the March calculations will be reconciled as part of the financial settlement process.

APPENDIX G: 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
ACO REACH	ACO Realizing Equity, Access, and Community Health
ADI	Area Deprivation Index
AHEAD	Achieving Healthcare Efficiency through Accountable Design
AMS	Analysis & Management System
BN	Budget neutral
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
CR	Change Request
CY	Calendar year
DoD	Department of Defense
ESRD	End-stage renal disease
ETA	Electing Teaching Amendment
EUC	Extreme and Uncontrollable Circumstance
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
GAF	Geographic Adjustment Factor
GPCI	Geographical practice cost index
HCPCS	Healthcare Common Procedure Coding System
HOPD	Hospital Outpatient Department
HRSN	Health-related social needs
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MLR	Minimum loss rate
MPR	Monthly payment report
MSR	Minimum savings rate
N/A	Not applicable

Abbreviation	Definition
NCBP	Non-claims-based payment
NPI	National Provider Identifier
NPP	Non-physician practitioner
OMO	Other monies owed
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 (e.g., V24 or V28)
VA	U.S. Department of Veterans Affairs
YTD	Year to date