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Is PC Flex Right for Your ACO?

The Primary Care Flex (PC Flex) model is a new Center for Medicare and Medicaid Innovation (CMMI) model developed to further test how alternative payments for primary care services (PCS) can empower Accountable Care Organizations (ACOs) to use more innovative, team-based, person-centered, and proactive approaches to care that positively impact health care outcomes, quality, and costs of care.

The two main financial components of the model are the one-time, upfront Advanced Shared Savings Payment of $250,000 and the Prospective Primary Care Payment (PPCP).

Who is Eligible?

1. Must be an ACO eligible to participate in the Medicare Shared Savings Program (MSSP), starting a new agreement period in 2025.
2. Must be considered a Low Revenue ACO (total part A and B spend for **ACO participants** is less than 35% of **total** part A and part B spend)
3. Must not be participating in other CMS/CMMI shared savings programs.
4. Must demonstrate an ability to repay any liabilities.

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An important distinction is that PC Flex is operated under CMMI and is an add on option for eligible MSSP ACOs. Interested ACOs must complete the application process for MSSP by June 17th and must indicate interest in the PC Flex model as part of that application.

Why Is This An Important Program?

This is the first time that prospective capitation payments have been included as part of the MSSP program. Other CMMI programs have included capitation, but this is a first for MSSP. This is important because MSSP is by far the largest ACO program with over 13.7 million participants as of 2024[1]

Capitation offers reliable monthly payments and reduces a primary care provider's need to bill fee for service (FFS). Breaking away from FFS allows provider groups and clinics to separate the care delivered from the financial reimbursement mechanics.

[1] https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024

Who Does This Program Target The Most?

CMMI's main targets for PC Flex are provider groups new to taking risk, federally qualified health centers (FQHCs) and rural health clinic (RHCs). The one time "Advanced Shared Savings Payment" is an upfront $250,000 payment from CMS to the new PC Flex MSSP ACO. This payment will need to be repaid but securing the payment in advance can mitigate some barrier to entering MSSP.

In addition to the capitation, PC Flex continues CMS's focus on health equity and addressing underserved populations. Underserved populations have a history of lower than average spend on primary care services due to access or other issues. By focusing on the county's total population to set the capitation the pattern of historically low spend can be broken.

What Are The New Financial Arrangements?

Advance Shared Savings Payment: A one-time payment of $250,000 to help ACOs cover initial costs, repayable through shared savings.

Prospective Primary Care Payment: Consists of a County Base Rate and an Enhanced Amount, designed to increase primary care funding relative to historical expenditures.

Breakdown of the components of the PPCP:

County Base Rates: All PC Flex participants receive the county base rates based on the counties in which their beneficiaries reside. The county base rate represents the average monthly cost for all primary care designated services in the county for all assignable Medicare beneficiaries, regardless of what services are provided by the ACO. FQHC and RHC services are carved out of this base rate and included as a separate adjustment outlined below.

This rate will be risk adjusted using the CMS hierarchical condition category (HCC) prospective risk adjustment model and will be applied at the member level.

Add-on for beneficiaries with FQHC or RHC Focused Care: For beneficiaries that receive a plurality of care at an FQHC or RHC a separate add on payment will be included in addition to the county base rate. These add-ons will be a fixed dollar amount added to the PPCP for these beneficiaries based on the average difference in national historical spending for beneficiaries who receive the plurality of primary care services at FQHCs or RHCs and the average County Base Rates that exclude these beneficiaries.

This amount will also be risk adjusted using the CMS HCC model and will be applied at the member level.

County Enhancement: An additional payment will be made for counties with risk-standardized PCP spend in the bottom two deciles relative to the national average. The payment will bring the county up to the national threshold, thereby enhancing payment to PC Flex ACOs in counties with historically low levels of primary care spending, evidence of underuse of medical services, and socioeconomic disadvantage.

This amount will also be risk adjusted using the CMS HCC model and will be applied at the member level.

Flex Enhancement: An additional payment of $125 per beneficiary per year (PBPY) or $10.42 per month is applied to each beneficiary to increase primary care funding to all PC Flex ACOs and encourage investment in primary care.

This amount will also be risk adjusted using the CMS HCC model and the combined Enhanced payment will be capped at $200 PBPY. This amount will be applied at the ACO level.

Health Equity Adjustment: All beneficiaries will receive a health equity score. The beneficiaries in the top three deciles will receive a positive adjustment between $1-3 per beneficiary per month (PBPM), while those in the bottom three deciles will receive a negative adjustment between $1-3 PBPM.

Steps for calculating the ACO's final PPCP payment each month:

1. For each beneficiary calculate the monthly value for the county base rate, FQHC/RHC add on, county enhancement, flex enhancement.
2. Risk adjust each component based on the beneficiary's risk score.
3. Apply the Primary Care Outside ACO (PCOA) factor for primary care services not provided by the ACO.
4. Trend to current performance year based on the Primary Care Prospective Administrative Trend (PCPAT).
5. Apply the enhancement cap.
6. Add on the health equity adjustment PBPM.

How does the PPCP impact the MSSP shared savings reconciliation?

Benchmark

The calculation of the benchmark for PC Flex ACOs will be unchanged from the Shared Savings Program's methodology codified in federal regulations[2].

[2] https://www.cms.gov/files/document/aco-pc-flex-rfa.pdf page 31

Expenditures

The total value of the paid PPCP before sequestration will be added to per capita expenditures and total expenditures and be included in resulting calculations of total savings and total losses[3].

Primary care services that are covered under the PPCP will be zeroed out and replaced by the value of the PPCP. There is no true up against actual FFS.

The PPCP will be an expenditure in the shared savings reconciliation, but there is no change to the MSSP benchmark methodology. The benchmark includes historical PCS spend while the expenditures reflect the PPCP in lieu of the historical PCS spend. If an ACO's historical PCS spend was $40 PBPM and the PPCP payment is $50 PBPM, the benchmark will include the $40 but the $50 will be included in the settlement. This difference will need to be "earned" back through additional shared savings or through the Total Enhancement Credit.

Only a portion of this will need to be earned back since the ACO is paid the full PPCP but is only responsible for 40-75% (depending on the risk track) after sharing gains/losses with CMS.

Total Enhancement Credit

For most ACOs, the county base rate plus the enhanced payments will make the PPCP payment higher than their historical PCS send. This higher payment would be reflected in the shared savings calculation and results in less shared savings at reconciliation. The ACO gets the additional payments upfront but must pay them back at reconciliation.

To offset some of this repayment, CMMI calculates a Total Enhancement Credit. The credit is the difference between the County Enhancement + Flex enhancement less ACO's regional adjustment or prior savings adjustment.

Annotation	Adjustment	Value
A	County Enhancement	$9.65
B	Flex Enhancement	$10.94
C = A+B	**Total Enhancement**	**$20.58**
D	Max Enhancement	$16.67
E = MIN (C, D)	**Minimum**	**$16.67**
F	Regional Adjustment	$10.00
G	Prior Savings	$5.00
H = MAX (F, G)	**Max**	**$10.00**
I = MIN (0, E-H)	**Enhancement Credit**	**$6.67**

[3] https://www.cms.gov/files/document/aco-pc-flex-rfa.pdf page 32

If this value is positive it is added to the MSSP ACO's settlement. Based on the wording in the RFA and the accompanied excel example, this credit is added after the normal MSSP settlement methodology and is not subject to sharing with CMS. This credit could be very impactful if CMS does not apply their shared savings percentage. For example, if a track A MSSP generated $6.67 PBPM in gross savings they would get $2.67 in net savings ($6.67 * 0.40 = $2.67). If the MSSP generated $0 in MSSP savings but had an Enhanced Credit of $6.67, they would keep 100%. This is 2.5x more savings.

Conclusion

There are still a lot of unknowns about the new PC Flex model design. The initial review seems to indicate CMS is focused on supporting ACOs that are new to risk, ACOs that have historically performed worse than the risk-adjusted region, or ACOs that focus on underserved populations. Stay tuned for a follow up white paper diving deeper into the financial implications.

Please contact Zach Davis at zach.davis@wakely.com or Craig Cartossa at craig.cartossa@wakely.com with any questions or to follow up on any of the concepts presented here.

OUR STORY

Wakely's History

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Expanding footprint, top talent. We have grown to several offices across the country specializing in various aspects of actuarial work. Why open new offices? We go where the talent is. Top talent means better service for our clients. Currently, we have offices in Atlanta, Denver, Minneapolis, New York, Omaha, Phoenix, and Tampa.

Learn more about Wakely Consulting Group at www.wakely.com