



May 29, 2024

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: Request for Information on Medicare Advantage Data (CMS–4207–NC)

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our response to the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) on Medicare Advantage (MA) Data. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP is pleased that CMS issued a request for information (RFI) seeking data-related input to improve transparency in the fast-growing MA market. The College strongly believes that refinements to the MA program are necessary to enhance transparency in all aspects of the program, including access to care, prior authorization, supplemental benefits, and clinician (or "provider") networks. We welcome the opportunity to provide insight into common challenges and experiences in the MA program for which limited data is currently available, and we offer our recommendations below.

### **The Role of Data in Promoting Health Equity**

As the number of patients enrolled in MA plans increases, there is an imminent need to ensure that the MA program is structured to meet the needs of those patients and the physicians who care for them. ACP believes that CMS must collect and publish more robust data on the MA program to promote transparency, protect patients, empower beneficiaries, and emphasize health equity. ACP is committed to achieving equity in health care<sup>1</sup>, and we believe that data collection is an instrumental tool for reaching that goal, especially in utilizing data to identify disparities or predatory practices. We acknowledge that CMS has already begun taking steps to collect and report data on race, ethnicity, and social determinants of health. Still, more must be done to address gaps in care based on disability, sexual orientation, gender identity, religion, socioeconomic status, and other demographic data that can inform care decisions. Collecting this information is essential because certain populations are more likely to experience barriers to accessing health care services and have below-average health outcomes. Identifying these populations will allow CMS to drive innovation and reduce disparities through all their programs and would also help inform MA plans in their efforts to enhance care arrangements and promote health equity.

<sup>1</sup> Erickson SM, Outland B, Joy S, et al. Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms. *Annals of Internal Medicine*. 2020;172(2):S33. doi:<https://doi.org/10.7326/m19-2407>

The collection of geographical-based data is also necessary for MA programs to determine potential gaps in access to care, especially in rural populations. According to a report published by the Kaiser Family Foundation, geographic accessibility has improved, with one-third of beneficiaries in counties offering more than 50 Medicare Advantage plans.<sup>2</sup> In metropolitan areas, defined as counties with populations exceeding 50,000 individuals, potential enrollees typically have access to an average of 47 MA plans. However, in rural areas, defined as counties with fewer than 10,000 people, individuals can choose from an average of 27 plans. Beneficiaries in micropolitan areas (10,000-50,000 people) have, on average, 32 plans to choose from. The discrepancies between plan offerings based on geographic regions present both opportunities and challenges, and CMS must decipher potentially important differences across plans, which requires enhanced reporting requirements.

Physicians can also be partners in improving access to equitable health care, especially if electronic health records are leveraged to capture social drivers of health and are technologically equipped to support physicians in acting to address social drivers. CMS can use this information to adopt coverage and reimbursement structures that reward this screening and documentation. Regarding improved data collection, health care settings that primarily serve marginalized populations are likely to have resource constraints already, making it more challenging to collect data. CMS should consider this when considering potential payment structures and physicians' overall administrative burden. In reporting on the MA program, CMS must ensure that collection burdens do not impose upon the physician's responsibility to meaningfully engage with a patient and that these reporting requirements do not result in mere check-box measures.

As a member of the Health IT End Users Alliance<sup>3</sup>, ACP has worked to develop key principles highlighting the importance of data and its role in supporting health equity. One opportunity physicians have is to make referrals to community-based organizations and community health workers to address social drivers of health, with information looping back to the original physician. Other areas where CMS can act include aligning data standards, investing in innovation, and workforce improvements. These contribute to enhanced data collection and advance health equity in the MA program and Medicare.

### **Transparency and Beneficiary Empowerment**

ACP strongly believes in providing MA beneficiaries with clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare (TM). The process of "seamless conversion" into these plans should be stopped entirely and be reevaluated to ensure that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding that they may opt-out.<sup>4</sup>

MA program transparency at the consumer level, which involves the enrollment process, details regarding available benefits, cost-sharing arrangements and premium costs, and clinician (or "provider")

<sup>2</sup> Freed M, Damico A, Biniek JF, Neuman T. Medicare Advantage 2024 Spotlight: First Look. Kaiser Family Foundation. Published November 8, 2023. <https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/>

<sup>3</sup> Consensus Statement on Data to Support Equity. Health IT End Users Alliance. Published May 15, 2023. [https://hitenduser.org/wp-content/uploads/2023/05/HIT-Template4\\_5.15.23.pdf](https://hitenduser.org/wp-content/uploads/2023/05/HIT-Template4_5.15.23.pdf)

<sup>4</sup> Senate Finance Committee Hearing: Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences. American College of Physicians. Published October 23, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp\\_statement\\_to\\_sfc\\_re\\_hearing\\_on\\_medicare\\_advantage\\_annual\\_enrollment\\_cracking\\_down\\_on\\_deceptive\\_practices\\_and\\_improving\\_senior\\_experiences\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp_statement_to_sfc_re_hearing_on_medicare_advantage_annual_enrollment_cracking_down_on_deceptive_practices_and_improving_senior_experiences_2023.pdf)

directories, is essential for informed decision-making and should be readily available to all Medicare beneficiaries. Comparing MA plan networks and available benefits remains challenging for beneficiaries due to the lack of readily available plan information. Variations in plan offerings, such as supplemental benefits, can be restricted to specific subgroups of beneficiaries. Since plans are not required to report the utilization and costs, individuals cannot adequately assess these when making plan decisions. These supplemental benefits can range from in-home support services to food and produce and can be attractive to MA enrollees.<sup>5</sup> ACP encourages CMS to extend reporting guidelines regarding the utilization of supplemental benefits and address challenges in reporting for situations where a benefit lacks a procedure code.

Beneficiaries and clinicians should be fully aware of any differences in coverage that could result in delays to appropriate care, such as limits on prescription drug coverage and any access to criteria used by the plan for making prior authorization determinations.

MA plans can also significantly change benefit options, cost-sharing arrangements, clinician networks, and other details from year to year, making comparison even more difficult. ACP supports the MA program and its ability to provide beneficiaries with a choice of health coverage if benefit requirements and essential consumer protections are ensured, including providing valid and reliable information, in easily accessible formats, to facilitate informed decision-making.

### **Increased Data Collection for Provider Directories**

As ACP commented in December 2022 in our response to the Request for Information, National Directory of Healthcare Providers and Services (NDH), we reiterate that the current state of health care professional (HCP) directories is flawed due to barriers and fragmentation that make information exchange and interoperability difficult.<sup>6</sup> Not only is it challenging for physicians to maintain these directories, but patients are often receiving inaccurate or incomplete information when seeking care. ACP remains supportive of CMS fostering the development of a centralized, national directory of HCP information that minimizes the financial and administrative burden for physicians and health care systems. This NDH also needs to be accessible for all types of patients, including those with limited English proficiency, low digital literacy, and those with disabilities.

Generalized data elements features should also be featured as part of a directory. In our 2022 RFI response, we outlined key elements that should be in physician (or “provider”) directories, at a minimum: (1) information on which clinicians are accepting new patients, (2) the clinician’s location, (3) contact information, (4) specialty, (5) medical group, and (6) any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM. Other data elements that would be helpful include state licensure information and plan participation for HCPs, data elements reflecting the same spectrum of information for allied health professionals, and, eventually, price and quality information. ACP acknowledges that standardizing and collecting some data elements will be challenging. Still, we encourage CMS to streamline, standardize, and manage

<sup>5</sup> Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization. U.S. Government Accountability Office; 2023. <https://www.gao.gov/products/gao-23-105527>

<sup>6</sup> Request for Information; National Directory of Healthcare Providers & Services. American College of Physicians. Published December 5, 2022. [https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp\\_letter\\_to\\_cms\\_regarding\\_national\\_directory\\_of\\_healthcare\\_providers\\_and\\_services\\_rfi\\_2022.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp_letter_to_cms_regarding_national_directory_of_healthcare_providers_and_services_rfi_2022.pdf)

these data elements to minimize the administrative burden for physicians and develop a well-rounded, comprehensive directory for patients.

### **Prior Authorization**

ACP believes additional data collection is needed around MA prior authorization determinations and utilization management. We are encouraged by the current data reporting requirements on prior authorization determinations, appeals, and outcomes at the contract level. While traditional Medicare rarely requires prior authorization, virtually all Medicare Advantage enrollees (99 percent) were enrolled in a plan that required prior authorization for some services in 2022. Data reporting efforts must keep pace and government agencies and Congress must have access to this information. Still, while steps have been taken to improve data reporting, some of the current data limitations include a lack of information on requests, denials, and appeals across types of services and differences in prior authorization across plan type.<sup>7</sup> In the Contract Year 2025 Medicare Advantage and Part D Final Rule, CMS finalized a proposal requiring plans to establish and publish annual health equity analyses of prior authorization policies and procedures.<sup>8</sup> This is instrumental in providing transparency around utilization management, and ACP believes this will help identify those whose prior authorization policies might disproportionately impact.

Earlier this year, CMS also published the Interoperability and Prior Authorization Final Rule.<sup>9</sup> We are encouraged by the requirements to streamline prior authorization processes and improve the electronic exchange of data and look forward to the implementation of this rule in the coming years.<sup>10</sup>

Last year, ACP also strongly supported the Improving Seniors' Timely Access to Care Act of 2023, which would require that all MA plans establish an electronic prior authorization process to streamline approvals and denials and the Department of Health and Human Services (HHS) to establish a process for MA plans to provide "real-time decisions" for prior authorization requests of items and services that are routinely approved.<sup>11</sup> This legislation also would require that MA plans report approval and denial rates to provide transparency on using prior authorization.

ACP applauds CMS for using its regulatory authority to make meaningful changes to prior authorization processes to promote transparency, minimize the burden on physician practices, and hold payers

<sup>7</sup> Sroczyński N, Biniek JF. Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021. Kaiser Family Foundation. Published February 2, 2023. <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>

<sup>8</sup> Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F). Centers for Medicare & Medicaid Services. Published April 4, 2024. <https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f>

<sup>9</sup> CMS Interoperability and Prior Authorization Final Rule CMS-0057-F. Centers for Medicare & Medicaid Services. Published January 17, 2024. <https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>

<sup>10</sup> Letter to CMS Regarding Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule. American College of Physicians. Published March 13, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp\\_letter\\_to\\_cms\\_regarding\\_advancing\\_interoperability\\_and\\_improving\\_prior\\_authorization\\_processes\\_proposed\\_rule\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp_letter_to_cms_regarding_advancing_interoperability_and_improving_prior_authorization_processes_proposed_rule_2023.pdf)

<sup>11</sup> Improving Seniors' Timely Access to Care Act of 2023. American College of Physicians. Published October 18, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp\\_letter\\_of\\_support\\_for\\_seniors\\_timely\\_access\\_to\\_care\\_act\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp_letter_of_support_for_seniors_timely_access_to_care_act_2023.pdf)

accountable for their utilization management processes. One of ACP's significant concerns about prior authorization is the administrative burden it places on physicians and the time it takes away from providing care to patients. The burden placed on physicians is also likely to be higher in smaller, independent practices that are less likely to have support staff that can handle the volume of necessary prior authorization paperwork. CMS, in partnership with the Office of the National Coordinator for Health Information Technology (ONC) and stakeholder input, should adopt a single set of certification criteria for prior authorization. In the long term, harmonization would save physicians from performing duplicative work and prevent delays in patient care.

### **Reduce Fraudulent Activity in MA Plans**

ACP urges the Senate Finance Committee, the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG,) and external independent bodies to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans. When fraudulent activity is identified, the responsible Medicare Advantage Organization (MAO) or MA plan should be held accountable for that activity, not the physicians participating in the MA plan.

CMS must also address issues of fraud and abuse in the MA Program. Reports from organizations such as The Center for Public Integrity discuss allegations that some MA plans overbill CMS by exaggerating illness severity in some patient populations by inflating their risk scores. The amount of fraud in Medicare is unknown: the Government Accountability Office (GAO) stated that the Risk Adjustment Data Validation process takes too long and fails to focus on health plans with the greatest potential for recovery of overcharges.<sup>12</sup> Requiring transparency and specifically requiring publication of how the plan captures illness severity through use of the Health and Human Services-Hierarchical Condition Categories (HHS-HCC) risk adjustment methodology could help in identifying areas of potential fraud and promote a more cohesive method of capturing severity across all MA plans.<sup>13</sup> To further promote and maintain program integrity, the CMS's Center for Program Integrity, the OIG, and such external independent organizations such as MedPAC and the GAO should take the lead in investigating potential situations of fraud or "gaming the system" by MA plans to increase profitability by misusing the risk-stratification process. Requiring transparency in how MA plans capture illness severity and investigating potential fraud by MA plans are essential steps for improving program integrity.

### **Protection from Deceptive Marketing Tactics**

ACP recommends investigating and prohibiting fraudulent marketing tactics some MA plans use during enrollment. ACP strongly supports CMS' intent to increase the transparency of MA plans and their respective marketing policies.<sup>14</sup> The College also supports the Agency's goal of ensuring that MA

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<sup>12</sup> Schulte F. Fraud and billing mistakes cost Medicare — and taxpayers — tens of billions last year. Center for Public Integrity. Published July 19, 2017. <https://publicintegrity.org/health/fraud-and-billing-mistakes-cost-medicare-and-taxpayers-tens-of-billions-last-year/>

<sup>13</sup> Statement from American College of Physicians Senate Finance Committee Hearing Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences. Published October 18, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp\\_statement\\_to\\_sfc\\_re\\_hearing\\_on\\_medicare\\_advantage\\_annual\\_enrollment\\_cracking\\_down\\_on\\_deceptive\\_practices\\_and\\_improving\\_senior\\_experiences\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp_statement_to_sfc_re_hearing_on_medicare_advantage_annual_enrollment_cracking_down_on_deceptive_practices_and_improving_senior_experiences_2023.pdf)

<sup>14</sup> ACP Comments on CMS' Proposed Changes to Medicare Advantage and Part D. Published February 13, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp\\_comments\\_on\\_cms\\_proposed\\_changes\\_to\\_medicare\\_advantage\\_and\\_part\\_d\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/letters/acp_comments_on_cms_proposed_changes_to_medicare_advantage_and_part_d_2023.pdf)

enrollees receive the same access to medically necessary care they would receive in traditional Medicare. To that end, we believe agents must be required to explain the effect of a beneficiary's enrollment choice on their current coverage whenever the beneficiary makes an enrollment decision. It is a great safeguard of traditional Medicare and protection against current abusive marketing tactics. ACP also appreciates the Agency tightening MA marketing rules to protect beneficiaries from misleading advertisements and pressure campaigns. Prohibiting ads that do not mention a specific plan name and use words, imagery, and logos in a confusing way is a critical step in ensuring information disseminated to beneficiaries is accurate and not misleading.

MA plans also use TV advertising, print, and other marketing activities<sup>15</sup>, to attract and retain enrollees during the open enrollment period. An increase in third-party marketing organizations, such as agents and brokers, lead generation businesses, and media firms, is concurrent with a steep rise in beneficiary complaints<sup>16</sup> related to the marketing of private Medicare plans. From less than 16,000 complaints in 2020 to nearly 40,000 in the first eleven months of 2021, many of these concerns centered on the marketing activities of these third-party entities. To ensure program integrity, MA organizations must also be transparent in how they (and other third parties) market their plans. CMS' policy to prohibit the use of superlatives (e.g., "best" or "most") in marketing is a great start to protecting beneficiaries. Previously, CMS generally required plans to provide substantiating data to support the Agency's use of a superlative only. Currently, the beneficiary has no knowledge of how the superlative is determined, potentially misleading the beneficiary to believe a statement that may be partially or primarily true but lacking context and important specificity. ACP agrees that this is potentially misleading and supports the Agency prohibiting this practice unless the material provides documentation to support the statement and the documentation is for the current or prior year.

Due to the predatory nature and increasing role of third parties in the marketplace, it is imperative that CMS addresses the increasing number of beneficiaries misled into thinking an entity is the Federal Government or a product is endorsed by Medicare. While CMS is simultaneously building a health system to support health equity, trust in the Federal Government and the health system is paramount. ACP greatly appreciates the Agency's recognition of this relationship and the impact that revising its own Medicare-related marketing requirements may have on fostering trust across all populations, particularly those most vulnerable. Therefore, we firmly believe that as enrollment in MA continues to grow and physicians and beneficiaries are presented with more opportunities to participate, maintaining open lines of communication with the physician and beneficiary population is essential to building solid relationships.

ACP additionally strongly supports<sup>17</sup> CMS' efforts to increase the transparency of MA plans and their respective marketing policies. The College supports the Agency's goal of ensuring that MA enrollees

<sup>15</sup>Findlay S, Jacobson G, Leonard F. The Role of Marketing in Medicare Beneficiaries' Coverage Choices. [www.commonwealthfund.org](https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices). Published January 5, 2023. <https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices>

<sup>16</sup>Biniek JF, Cottrill A, Sroczynski N, et al. How Health Insurers and Brokers Are Marketing Medicare - Report - 10203. KFF. Published September 20, 2023. <https://www.kff.org/report-section/how-health-insurers-and-brokers-are-marketing-medicare-report/>

<sup>17</sup>Statement from American College of Physicians Senate Finance Committee Hearing Medicare Advantage Annual Enrollment. Published October 18, 2023. [https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp\\_statement\\_to\\_sfc\\_re\\_hearing\\_on\\_medicare\\_advantage\\_annual\\_enrollment\\_cracking\\_down\\_on\\_deceptive\\_practices\\_and\\_improving\\_senior\\_experiences\\_2023.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/testimony/acp_statement_to_sfc_re_hearing_on_medicare_advantage_annual_enrollment_cracking_down_on_deceptive_practices_and_improving_senior_experiences_2023.pdf)

receive the same access to medically necessary care they would receive in TM. To that end, the Agency's policy should require agents to explain the effect of a beneficiary's enrollment choice on their current coverage whenever the beneficiary makes an enrollment decision is an excellent safeguard of TM and protection against current abusive marketing tactics. ACP also appreciates the Agency tightening MA marketing rules to protect beneficiaries from misleading advertisements and pressure campaigns.

Since releasing our Promoting Transparency and Alignment in Medicare Advantage policy paper in 2017, ACP has sought to inform CMS' policymaking regarding MA. As we stated, MA organizations must be transparent in their processes, policies, and procedures for developing and administering their MA plans and portfolios. ACP reaffirms its support for CMS' efforts to enhance transparency and protect beneficiaries within the MA program. Addressing these concerns can strengthen trust in the Medicare Program and promote equitable access to healthcare for all enrollees.

### **Improving Value-Based Payment and Alternative Payment Models**

Over the past decade<sup>18</sup>, the adoption of value-based payment (VBP) models has increased substantially, and commercial payers have structured almost one-third of their payments as alternative payment models (APMs). Public information about value-based payment is often confusing and can lead to skepticism over these efforts. Future models should assess how to build off patient-focused incentives<sup>19</sup> and extend these incentives to patients. In advancing APMs, it is important to note that reducing costs is not the only goal of care reforms. As payment reforms give physicians more flexibility in how they deliver care, some interventions will likely add to costs. The main barriers<sup>20</sup> to current APM participation are the ability to readily operationalize and the financial risk of participating. An analysis of ACO data<sup>21</sup> demonstrates that organizations often need at least three years to generate consistent savings. Not all data from APM's<sup>22</sup> have demonstrated whether participation in these models leads to better quality. Given the investment, commitment, and resources necessary to thrive in the current value-based payment models, providing transparency and more data would allow organizations to predict their performance in the model more accurately.

ACP encourages CMS innovation in the creation of new models. The ACO PC Flex model<sup>23</sup> which will test how prospective payments and increased funding for primary care in Accountable Care Organizations (ACOs) impact health outcomes, quality, and care costs; however, there is potential for misuse. Some of the benefits of the introduction of the new ACO PC Flex model is its focus on increasing the number of participating ACOs in the Medicare Shared Savings Program (MSSP). This may improve access to care, particularly in existing underserved areas, and provide underserved populations with accountable care

<sup>18</sup> A Decade of Value-Based Payment: Lessons Learned And Implications For The Center For Medicare And Medicaid Innovation, Part 1. *Forefront Group*. Published online June 9, 2021. doi:<https://doi.org/10.1377/forefront.20210607.656313>

<sup>19</sup> Vulimiri M, Bleser WK, Saunders RS, et al. Engaging Beneficiaries In Medicaid Programs That Incentivize Health-Promoting Behaviors. *Health Affairs*. 2019;38(3):431-439. doi:<https://doi.org/10.1377/hlthaff.2018.05427> <sup>20</sup>APM MEASUREMENT EFFORT. <https://hcp-ian.org/workproducts/apm-infographic-2019.pdf>

<sup>21</sup> Bleser WK, Saunders RS, Muhlestein DB, McClellan M. Why Do Accountable Care Organizations Leave The Medicare Shared Savings Program? *Health Affairs*. 2019;38(5):794-803. doi:<https://doi.org/10.1377/hlthaff.2018.05097>

<sup>22</sup> Kona M. Adoption of Value-Based, Alternative Payment Models: Where Are We Today and Where Do We Go from Here? CHIRblog. Published January 31, 2022. Accessed May 28, 2024. <https://chirblog.org/adoption-value-based-alternative-payment-models-today-go/>

<sup>23</sup> ACO Primary Care Flex Model | CMS. [www.cms.gov](https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model). <https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model>



benefits. However, there are some concerns about the program's construction and how its potential misuse may undermine access to timely, high-quality care. Considering the numerous financial incentives offered by the program (e.g., one-time Advanced Shared Savings Payment of \$250,000, Prospective Primary Care Payments), organizations affiliated with profit-driven enterprises (i.e., private equity) may take advantage of these incentives without applying them toward the improvement of high-quality patient care.

The deficiencies in the current APMs and VBP, especially within organizations that care for MA patients, highlight the need to reform the MA program. ACP recommends that Medicare and other payers progressively adopt population-based, prospective payment models for primary and comprehensive care that are structured and sufficient to ensure access to care. ACP calls for research in creating a validated way to measure and monitor the cost of caring for patients who are experiencing health care disparities and inequities based on personal characteristics and are disproportionately impacted by social drivers of health.

ACP appreciates the opportunity to provide feedback on this RFI. We look forward to working with you to refine the MA program, including additional reporting and data collection requirements. Please contact Dejah Johnson, JD, MPA, Manager, Regulatory Affairs for the American College of Physicians, at [djohnson@acponline.org](mailto:djohnson@acponline.org) or (202) 261-4506 with questions or comments about the contents of this feedback.

Sincerely,

A handwritten signature in blue ink that reads "Leslie F. Algase MD, FACP".

Leslie F. Algase, MD, FACP  
Chair, Medical Practice and Quality Committee  
American College of Physicians