Congress of the United States

Washington, DC 20515

July 11, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

We write to express our strong support for innovative payment models that reduce costs for health care consumers and the federal government while improving care and enhancing patient experiences. Advanced Alternative Payment Models (advanced APMs) that require accountability for both reducing costs and improving quality have demonstrated promising success and we strongly encourage the Centers for Medicare & Medicaid Services (CMS) to consider expanding options and ensure continuity for beneficiaries to receive the benefits of these proven, innovative delivery system reforms. Recent Health Subcommittee hearings at both the Ways and Means and Energy and Commerce Committees highlighted opportunities for CMMI to improve on financial savings and accountability of models and the need for more providers to participate in models.

There is strong evidence that these advanced APMs save money while simultaneously improving care for beneficiaries:

- Advanced APM accountable care organization (ACO) portfolio. ACOs that take on two-sided risk, including two-sided risk Medicare Shared Savings Program and CMS Innovation Center ACOs, saved $4.2 billion in traditional Medicare in 2022,[1] and a total of $8.4 billion in gross savings after taking into account spillover effects in Medicare Advantage.
- The Pioneer ACO was one of the first ACO programs. It is one of six CMMI models to result in statistically significant savings, totaling $134 million over the first two years and $99 million subsequently. The model was also successful at lowering emergency department and inpatient utilization. [2]
- The ACO Investment Model encouraged the formation of new ACOs, and 45 participants transitioned to greater financial risk. A study estimated that this model produced net savings of $381.5 million over three years, driven by reduced inpatient admissions, emergency department visits, post-acute care, and readmissions.
- Certain specialty care models, such as the Comprehensive End Stage Renal Disease (ESRD) Care Model, coordinating care for individuals with ESRD, demonstrated cost savings and improved care. The model reduced Medicare spending by $217 million in traditional Medicare.[1] The Oncology Care Model (OCM) generated gross savings of $499 per episode. Gross savings increased over the life of the model, and notably the level of savings accelerated over the last two performance periods. OCM led to a reduced probability of intensive care unit admission and reduced the number of emergency department visits.[2]

In addition to saving money, these innovative payment arrangements have improved the patient experience. Examples include expanding access by offering more timely appointments, streamlining communication with patients, better care coordination, receiving more chronic care management as compared to fee-for-service, increasing access to behavioral health services, and reducing preventable emergency room utilization.

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[1] https://www.cms.gov/priorities/innovation/data-and-reports/2022/cec-annrpt-py5-fg

[2] https://www.cms.gov/priorities/innovation/data-and-reports/2023/ocm-evaluation-pp1-9-exec-sum

In light of these successes and our collective desire to move away from inefficient fee-for-service medicine, we strongly urge you to consider building on, or extending, successful model designs to solidify care delivery and payment system improvements to benefit providers and patients. This will enhance financial and clinical accountability in CMS's model portfolio. It will ensure smooth transitions and transfer of innovation to next generation models when existing models conclude, taking care to continue successful cost-saving features and designs into the next generation to pursue more sophisticated and effective value-based care models.

We also encourage the Center to prioritize the development and successful implementation of rural-focused models that promote payment stability and care coordination for providers in rural areas, while improving health outcomes for Americans living in rural areas. Rural Americans may experience significant health disparities, such as a higher likelihood of having chronic conditions, and are more likely to experience delays in care delivery and gaps in coordination. This worsens health outcomes and serves as a prime opportunity for CMMI to develop models that address rural disparities and improve care delivery.

Creating additional advanced APM options, especially ones focused on improving care options and coordination for rural Americans, while ensuring continuous participation options for existing participants, will help to achieve our shared goals of greater participation in advanced APMs by reducing administrative burden and improving ease of provider assimilation into models. This was a focus at the recent Ways and Means Health Subcommittee hearing, where witnesses emphasized a need for reduced provider burden, tailored resources, and better educational outreach. As CMS's stated goal is to move nearly all fee-for-service beneficiaries into accountable care organizations by the end of this decade, prioritizing APM designs that encourage broad-based participation, while recognizing the unique needs of rural and underserved providers and using tailored and effective quality measurement that focuses on improving health outcomes and accurate benchmarking is imperative.

Thank you for your attention to these important matters. We share your commitment to improving health care delivery and advancing accountable care and look forward to continued work with you.

Sincerely,

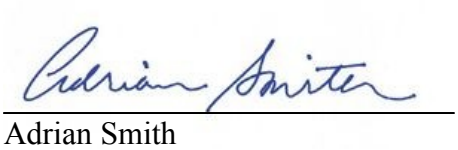
Darin LaHood
Member of Congress

Kim Schrier, M.D.
Member of Congress

Carol D. Miller
Member of Congress

Mike Carey
Member of Congress

Scott H. Peters
Member of Congress



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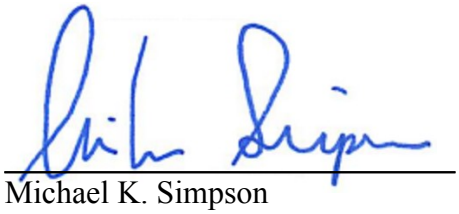

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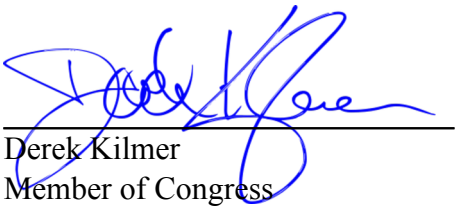

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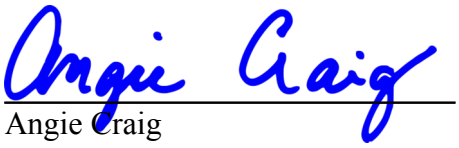

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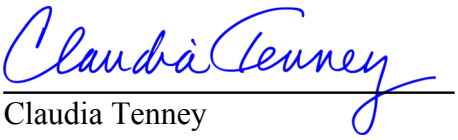

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