United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

April 26, 2023

Sean Cavanaugh
Chief Policy Officer, Aledade
[redacted]

Chairman Guthrie, Ranking Member Eshoo and members of the Committee, thank you for inviting me to discuss strategies for increasing transparency and competition in health care.

My name is Sean Cavanaugh, Chief Policy Officer for Aledade, a health care company that helps independent primary care practices, health centers, and clinics deliver better care to their patients and thrive in value-based care. Previously, I served at the Centers for Medicare & Medicaid Services (CMS) for six years, as the Deputy Director of the Center for Medicare and Medicaid Innovation (CMMI) and then as Director of the Center for Medicare. In those capacities, I supported the movement toward value-based payment and service delivery models in Medicare and Medicaid, and I'm proud to continue that work in the private sector.

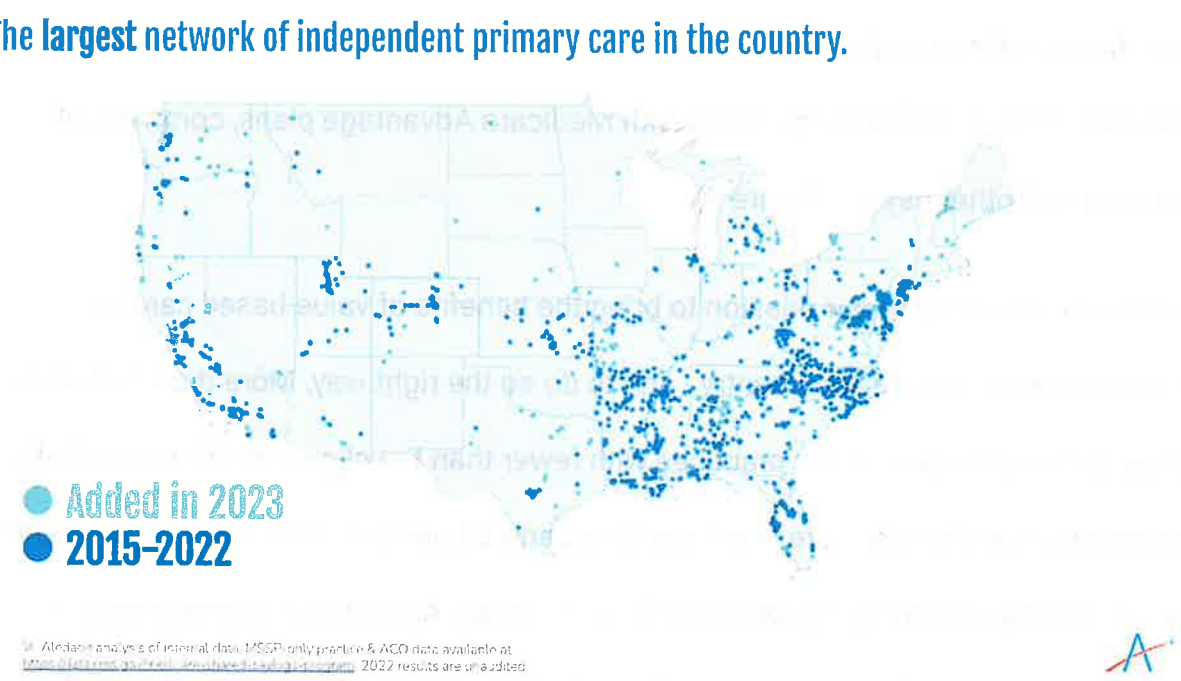
Aledade was founded in 2014 to help independent primary care practices thrive in value-based programs. We bring together independent primary care practices that are committed to value-based care, join the Medicare Shared Savings Program, and negotiate similar accountable care organization (ACO) arrangements with Medicare Advantage, Medicaid, and commercial health plans. We provide population health workflow tools and integrated data analytics, and we transform how practices that join our nationwide network deliver care.

Today, Aledade is the largest network of independent primary care in the country. This year, Aledade is partnering with more than 1,500 independent physician practices, including 200 Rural Health Centers and Federally Qualified Health Centers. Organized

into 45 MSSP ACOs across 45 states and Washington, DC, these practices are accountable for more than 2.2 million patients; this includes 1 million Medicare beneficiaries through the Medicare Shared Savings Program, and more than 1.2 million patients through ACO arrangements with Medicare Advantage plans, commercial insurers and other payers (Figure 1).

We have committed to our mission to bring the benefits of value-based care to communities all across the country - and to do so the right way. More than half of our primary care providers are in practices with fewer than ten clinicians; 60 percent of our practices are in Primary Care Shortage Areas and 50 percent in Medically Underserved Areas. And by becoming a public benefit corporation, Aledade has committed to a corporate structure that requires weighing the interests of our primary care practice partners, their patients, our employees, and those who bear the burden of rising health care costs, alongside those of our shareholders, when we make decisions.

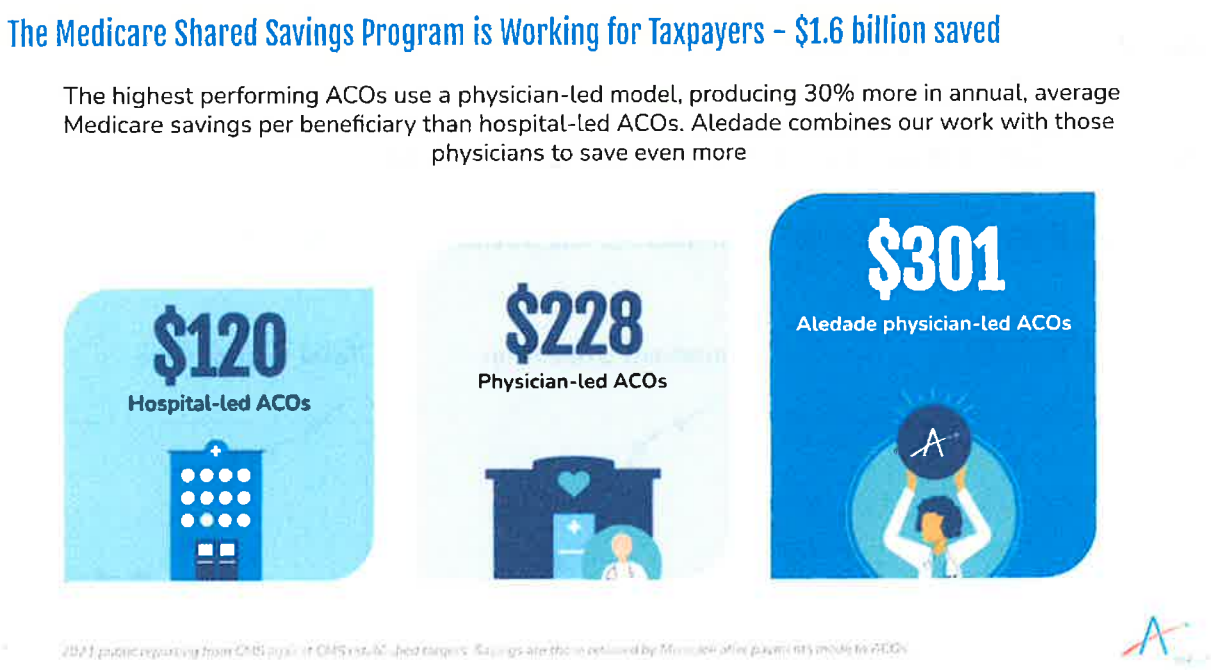
Figure 1 Map of Aledade's Network of Primary Care Partners



Most importantly, Aledade is producing meaningful results. In 2022, our ACOs are projected to save Medicare more than $535 million. In 2021, four of the top ten performing ACOs in MSSP were Aledade ACOs (measured by per-beneficiary savings), and the top-performing MSSP ACO in the entire country was an Aledade ACO. The fourth-ranked ACO in the nation was also an Aledade ACO, the Mississippi MSSP Community Health Center ACO, which faces some of the most challenging health care headwinds in the entire country. This ACO, composed entirely of community health centers, outperformed many of our nation's top hospitals and health systems in terms of savings for taxpayers through better patient care.

We are not alone in succeeding in the Medicare Shared Savings Program. Our analysis of CMS data shows that physician-sponsored ACOs are generating outstanding results (Figure 2).

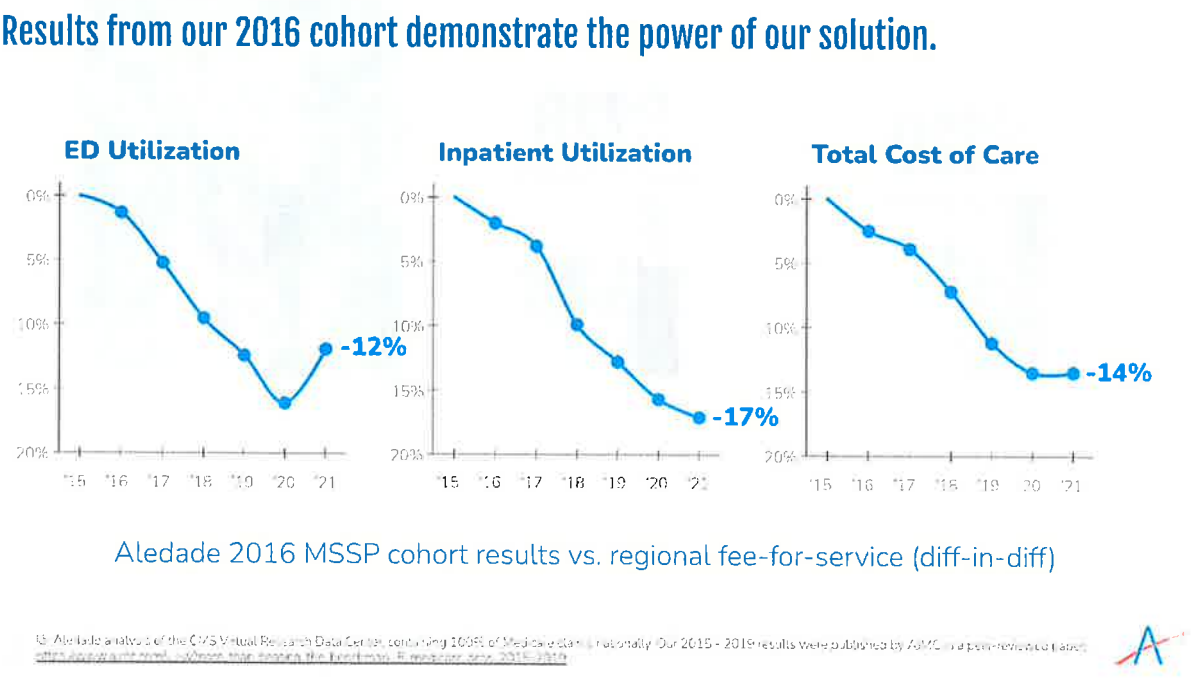
Figure 2 Medicare Shared Savings Programs Net Savings by ACO Type



These savings were generated through real improvements in the care primary care practices delivered to Medicare beneficiaries. In 2021, the most recent data released by Medicare, practices in Aledade ACOs helped their patients avoid more than 24,000 unnecessary hospitalizations and more than 120,000 unnecessary visits to the emergency room.

This happened because patients in Aledade's network had better blood pressure screening, A1C control, and cancer screening rates. In MSSP specifically, Aledade had three ACOs in the top ten percent of all ACOs for blood pressure control and statin therapy. An Aledade ACO was also the top performer for diabetes control. We have empowered our practices to deliver more primary care and reduce unnecessary hospitalizations and post-acute care stays, and our results improve the longer our practices work with us (Figure 3).

Figure 3 Aledade's Results from our Longest Running ACOs



We are committed to outcome-based approaches to improve the value of health care. We are committed to using technology, data, practice transformation expertise and, most important, the relationship between a person and their primary care physician (PCP).

We are pleased to see the Committee's attention to lowering health care costs and believe that increasing provider competition is central to doing so. My testimony focuses on the encouraging pro-competitive provisions included in several of the bills under consideration today. I also offer several additional ideas for the Committee to consider as it continues to assess next steps.

Competition

As a nation, we need to make a fundamental decision about how to drive more efficiency and higher quality in our health care system. In simple terms, this choice is between a competitive approach and a regulatory approach. I have extensive experience as a regulator: I set all-payer prices for Maryland hospitals and established provider and health plan payment rates at CMS, which guide more than $600 billion in spending a year. But, we should rely on regulation only when market competition isn't feasible, or when it has failed. To give markets a chance to work, we have to establish an environment that fosters competition. Unfortunately, our current health care system has a number of market failures, including payer and provider consolidation, and our laws permit practices that undermine competition.

It is well known that hospital consolidation is a growing impediment to a high-value health care system. The Kaiser Family Foundation published a summary[1] of the academic literature on the effects of provider consolidation and they concluded:

[1] https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

- Hospital mergers have been steadily rising since 2005
- Horizontal consolidation among hospitals and among physician practices leads to higher prices
- Vertical consolidation also leads to higher prices
- There is no clear evidence that consolidation leads to higher quality care

Provider concentration increases the local bargaining power of large health systems, which allows them to demand higher prices for services from health plans. And without alternative providers to generate competition, there is little incentive to provide higher quality care. Further, we see the most aggressive actors exert their market dominance with anti-competitive contracting practices that entrench their position in the market. Hospitals have argued that consolidation will lead to greater efficiencies and more coordinated care, but the evidence shows the opposite is true.

Unfortunately, COVID may have accelerated these trends. Some providers, such as smaller practices and safety net hospitals, entered the pandemic with vulnerable financial positions and were less likely to access emergency relief funding.[2] I worry that the several decade trend of consolidation has accelerated over the past three years.

Reversing these trends and establishing the framework for a high performance health system will require more than legislation, but this Committee has an opportunity to take meaningful action to promote competition and transparency in this country.

[2] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2771582

First and foremost, everything we have learned in the recent history of Medicare is that true transformation starts with a robust investment in primary care. This committee should continue to support greater investments in primary care, including community health centers and independent practices. These organizations are the foundation of true health care transformation. I thank the Committee for holding a hearing recently on workforce needs, and recognizing the need to bring more primary care physicians and mental health providers to rural areas.

Second, the Committee should eliminate existing Medicare policies that inhibit competition in health care. Several bills before the committee would move Medicare toward site neutral payments, which is an important first step. Facility fees paid to hospital outpatient departments for services that can be provided in physician offices are part of the financial engine that hospitals rely on to acquire independent practices and reduce competition in their markets. Independent practices and community health centers struggle to recruit new physicians because they cannot compete with hospitals that are receiving higher payments. Congress passed legislation in 2015 to put an end to extra Medicare payments to new hospital sites but "grandfathering" allowed sites acquired before 2017 to continue billing and receiving facility fees. Additionally, CMS imposed site-neutral payments for a limited number of services. However, the vast majority of services in provider-based clinics continue to receive higher payments for services from Medicare and from the many payers that utilize similar payment mechanisms, such as Medicare Advantage and commercial insurance plans. In

addition to exacerbating consolidation and increasing costs to the health care system, these facility fees raise out of pocket costs to Medicare beneficiaries. We should not support this whenever these services can be provided safely and at high quality in a physician office or ambulatory surgery center.

Additional Recommendations to Improve Competition

As the Committee continues its work to improve transparency and competition in health care, there are other ideas it should consider as well. The following ideas are drawn from the work of Dr. Farzad Mostashari (CEO of Aledade), Dr. Martin Gaynor and Dr. Paul Ginsburg, writing with the support of the Brookings Institution.[3]

- **Anti competitive contracting.** Congress needs to address some of the current contracting abuses and market failures to chart a path towards true competition. Gag clauses, anti-tiering, anti-steering, as well as all-or-nothing clauses, are prime examples of excess market power enabling anti-competitive behavior. By banning gag clauses, Congress can prohibit dominant providers from concealing the price and quality of the care delivered by health systems; this is information about the people's health care that patients and their representatives, such as employers, need to know. A similar abuse arises when health systems demand

[3] Gaynor, M; Mostashari, F; Ginsburg P (2017) Making Health Care Markets Work: Competition Policy for Health Care. Brookings Institution. https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/

that insurance companies do not "tier," or rank, their providers based on the cost and quality of the care that patients receive. Anti-steering clauses prohibit health plans from encouraging patients to receive care with higher value providers. And finally, "all or nothing" clauses are coercive to health plans; they state that "if you're going to contract with any providers of our system, you must contract with all of them." This allows a monopoly in one area to diminish competition in a completely different market.

Together, these practices are anti-competitive and hurt patients. They stand in direct opposition to the movement to value-based care, asserting that cost and quality don't matter if dominance in the market is great enough.

- **Optimize MSSP for Rural Providers.** Some have claimed that banning these market distorting practices could limit the power of health systems to negotiate higher rates that support some rural hospitals. (Similar claims have been made about site neutral payments.) But in both cases, the solution to inadequate funding is not to promote anti-competitive behavior and opaque cross-subsidies. Where rural hospitals and physicians need greater support, direct subsidies would be a more efficient and transparent mechanism.

In addition, there are other ideas to promote rural health while advancing value-based care competition. As Congress considers updating the 2015

Medicare Access and CHIP Reauthorization Act (MACRA), members can refine the Medicare Shared Savings Program to use cost setting principles, or benchmarking, that creates an enduring opportunity for rural health to succeed in value based care. We urge Congress to direct CMS to set benchmarks that do not decrease as accountable care organizations reduce costs. By doing so, Congress establishes a long term future for rural health based on better care and better health for rural Amercians.

- **Improve access to capital for independent practices.** Independent physician practices, especially primary care physicians, perform better in value-based models, but their financial status is often weak. Congress could expand loan repayment programs to providers who serve in rural areas, even if they work at private practices. Congress could also focus on Small Business Administration loans targeted at rural private practices.

- **Reform Certificate of Need (CON) rules.** When a state strictly limits the number of hospitals that can receive a CON for a particular service, the state is often granting monopoly power for that service in those markets with no corresponding mechanism to control costs or improve quality. Congress could establish federal grants for states that commit to pro-competitive policies, such as repealing or reforming CON laws.

- **Reinvigorate antitrust enforcement.** The FTC, which can oversee mergers of

nonprofit hospitals, does not have the ability to review other potentially anti-competitive behavior by hospitals. While this legislation would outlaw many of the contracting abuses that FTC would potentially monitor, we believe that the agency should be better equipped moving forward.

- **Regulating Anti Competitive Data-Sharing Practices.** No one should be able to limit competition by limiting access to patient data. The Office of the National Coordinator of Health IT (ONC) has defined information blocking as required by the 21st Century Cures Act. Since April 2021, ONC has received more than 300 reports of information blocking, yet the Office of the Inspector General (OIG) still has to finalize its rule regarding penalties for networks found to be information blocking.[4] CMS must also propose a framework for "appropriate disincentives" for providers. Access to data leads to better patient care and a more competitive marketplace for health care services. For example, medical and economic literature demonstrates that patients have fewer readmissions and other adverse outcomes when they see their PCP after discharge from the hospital. Aledade practices avoid one hospital readmission for every eight transitional care visits they provide. But independent physicians can provide this care only when they receive timely notification of the patient discharge. Aledade has encountered resistance from some hospitals in providing these data -- even when our company bears the cost of the interfacing and there is no technological barrier. CMS has rules requiring hospitals to share this information for patient safety.

[4]https://www.healthcaredive.com/news/onc-micky-tripathi-information-blocking-enforcement-complaints/637500/#:~:text=The%20OIG%20has%20the%20statutory,the%20size%20of%20any%20penalties.

ONC has rules requiring hospitals not to block information. Yet, health systems and other actors can still prioritize their information-sharing practices in anti-competitive and unsafe ways. OIG should finalize its penalty regulations as soon as possible to ensure that information follows the patient and is not confined to a closed health network, and CMS should take the next step to formalize provider disincentives.

Thank you again for this opportunity to testify on these important bills and I commend the committee for its bipartisan work. Thank you for the opportunity to share Aledade's experiences with you, and I look forward to continuing to engage with Members of the Committee as you consider this legislation.