

Statement of Sean Cavanaugh  
Chief Administrative and Performance Officer  
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Full Committee Hearing: "Lower Health Care Costs Act"

Before The  
U.S. Senate Committee on Health, Education, Labor and Pensions (HELP)  
June 18, 2019

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Chairman Alexander, Ranking Member Murray and members of the Committee, thank you for inviting me to discuss the Lower Health Care Costs Act.

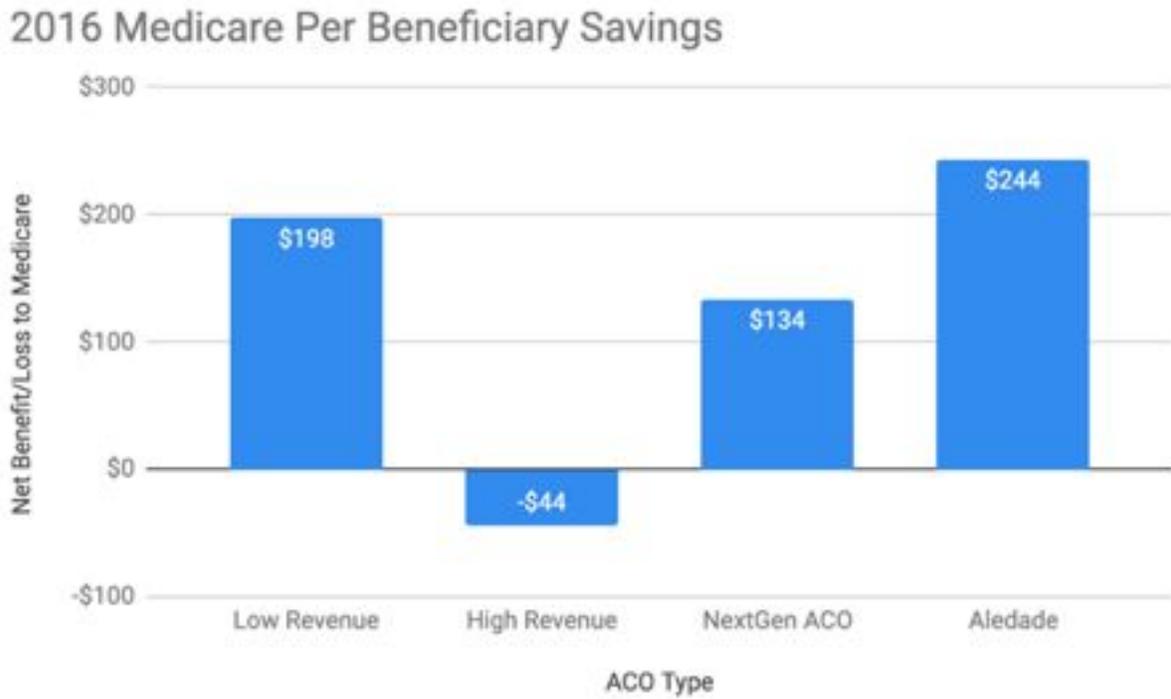
My name is Sean Cavanaugh, Chief Administrative and Performance Officer for Aledade, a health care company that partners with independent primary care physicians to help them transition to and thrive under value-based payment models. Previously, I served at the Centers for Medicare and Medicaid Services (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 physicians thrive in value-based programs. We bring together independent primary care practices who are committed to value-based care, join the Medicare Shared Savings Program, and negotiate similar accountable care organization (ACO) arrangements with commercial payers. We provide population health workflow tools and integrated data analytics, and we transform how our practices deliver care.

Aledade has grown rapidly and continues to do so. This year, Aledade is partnering with over 430 independent physician practices, Rural Health Centers and Federally Qualified Health Centers. Organized into 27 ACOs across 24 states, these physicians are accountable for nearly 650,000 people; this includes 350,000 beneficiaries through the Medicare Shared Savings Program, and almost 300,000 people (Figure 1) through ACO arrangements with Medicare Advantage plans, commercial insurers and other payers. More than half of our primary care providers are in practices with fewer than ten clinicians.

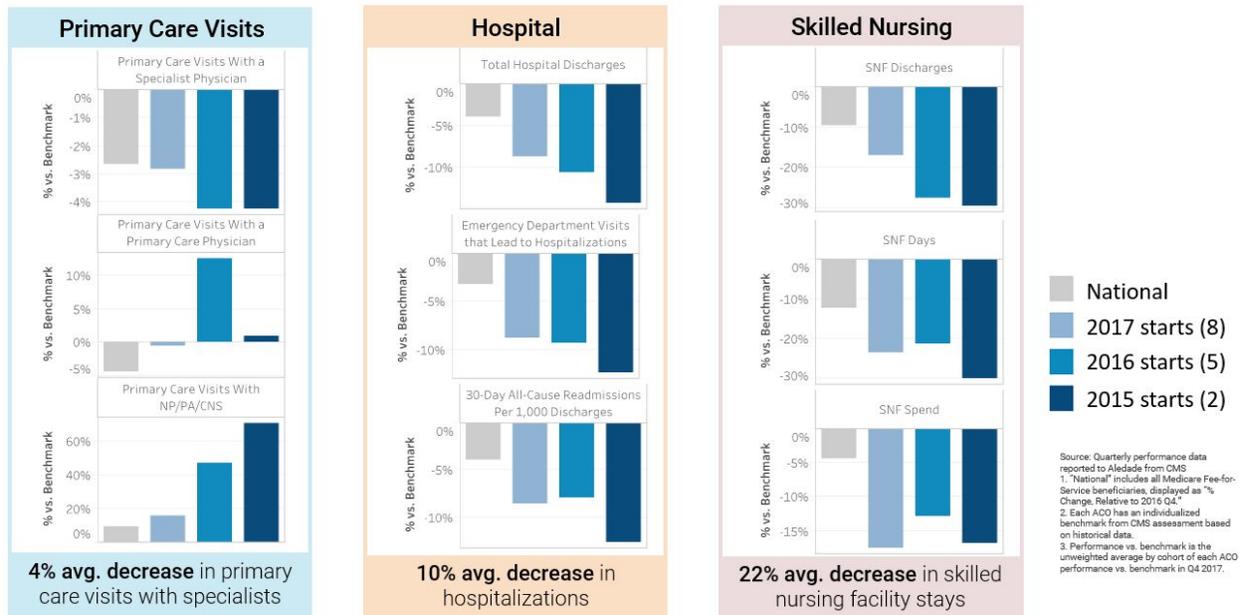


Figure 2. 2016 MSSP ACO Performance



These savings were generated through real improvements in the care received by Medicare beneficiaries. 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 2).

Figure 2. Summary of Aledade's Results.



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 the Lower Health Care Costs Act. I have 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 over \$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. Evidence continues to show that when hospitals merge prices increase and quality stagnates.<sup>1</sup> And this makes sense: concentration increases the local bargaining power of large health systems, which allows them to demand higher prices for services in the commercial market. And without alternative providers to generate competition, there is little incentive to provide higher quality care.<sup>2</sup> 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.

I applaud this Committee for confronting some of the current contracting abuses and market failures -- and for trying 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, and patients and their representatives, such as employers, ought to know it. A similar abuse arises when health systems demand 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.

There is one objection to these provisions that I'd like to address, both as a former regulator and in working closely with rural health care providers today. Some have

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<sup>1</sup> Vogt, W.B., & Town, R. (2006). How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? Robert Wood Johnson Foundation. Research Synthesis Report No. 9.

[http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2006/rwjf12056/subassets/rwjf12056\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1);

Ginsburg, P.B. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power.;

Gaynor, M., & Town, R. (2012). The Impact of Hospital Consolidation – Update. Robert Wood Johnson

Foundation. Policy Brief No. 9. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261); White et al. Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients. Cooper et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured; New York State Health Foundation, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement.

<sup>2</sup> Gaynor, M., Ho, K., & Town, R.J. (2015). The Industrial Organization of Health-Care Markets. *Journal of Economic Literature*. 53(2), 235- 284. <http://dx.doi.org/10.1257/jel.53.2.235>; Vogt, W. B., & Town, R. How has hospital consolidation affected the price and quality of hospital care?; Gaynor, M., & Town, R. (2012). The impact of hospital consolidation—Update.

claimed that banning these market distorting practices could limit the power of health systems to negotiate higher rates that support some rural hospitals. In response, I would first question how prevalent this dependence is. Second, where these rural hospitals do struggle, the solution to inadequate funding is not to promote anti-competitive behavior and opaque cross-subsidies. If rural hospitals need greater support, direct subsidies would be a more efficient and transparent mechanism.

I also note that there are new models being tested that focus on rural health care, including important ones in Pennsylvania and Maryland, under the auspices of the CMS Innovation Center. Both of these models seek to ensure access to care in rural communities while still promoting high value care. Neither model relies on anti-competitive behavior.

In addition, there are other ideas to promote rural health while advancing value-based care competition. One such idea would fix what is known as the Rural Glitch, which is a quirk in Medicare ACO policy that systematically disadvantages rural providers who participate in ACOs. Such policy remedies come at a much lower cost because they directly address the rural issues. We urge Congress to press ahead with such proposals and consider incorporating them in your legislation.

There are additional elements of this legislation that would address other market failures and deserve support.

*Surprise billing.* Surprise billing involves taking advantage of vulnerable patients who are not in a position to make an informed alternative choice. A functioning market would never permit surprise billing because it would drive away business from those who engage in the practice. The fact that we have this problem is proof of a market failure that requires corrective action by Congress. We applaud this Committee's willingness to take on this issue and to consider multiple solutions.

*All-payer claims database.* For many years, studies of the American health care system relied on Medicare claims data, which was the only available national database. But we know that Medicare beneficiaries are very different from the privately insured population and that the two markets often behave very differently. Many of the anti-competitive practices that this legislation seeks to correct were exposed by studies using multi-payer claims databases, such as the one administered by the Health Care Cost Institute. We need to support and nurture these types of databases to understand market dynamics.

*Restrictions on PBM spread-pricing.* Markets do not work when important information is kept from customers, including health plans and employers. PBMs should be competing on the basis of providing high-value formularies to health plans and should generate revenue on that basis, not by arbitraging asymmetries in information between drug manufacturers and health plans and employers. Again, if the market for PBM services were highly competitive, PBMs would not be able to withhold information from their customers. In light of this market failure, it's appropriate for Congress to take action. .

*Claims submission time limit.* We are supportive of time-dependent requirements on billing. This is directionally the right step, it promotes transparency, and it is patient-centric. One cautionary note: we worry that this could impose a burden on small physician practices. Many of our solo practitioners who work around the clock seeing patients may struggle to submit a bill within 30 days. So I urge you to consider exemptions or longer time frames for small practices in legislation like this.

## Additional Recommendations to Improve Competition

This legislation takes steps to address the most egregious contracting practices that result from consolidation, but there is much more to be done to make our provider markets more competitive. Some of the ideas highlighted here 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.<sup>3</sup>

- *Site-neutral payments.* Facility fees paid to hospital outpatient departments for services that can be provided in physician offices helps hospitals acquire independent practices and reduce competition in their markets. 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.”. In recent rulemaking, the CMS has attempted to apply site-neutral payments to a limited number of so-called “excepted” sites, and for a limited number of services. That rule change is being challenged in court, and we encourage a legislative remedy that achieves full site neutrality.
- *Improve access to capital for independent practices.* Independent physician practices, especially PCPs, appear to 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 Association 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, it 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

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<sup>3</sup>[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/](https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/)

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.

- *Require patient-centric data sharing.* Medical and economic literature demonstrate 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 we bear the cost of the interfacing and there is no technological barrier. CMS recently published rules requiring hospitals to share admission, discharge and transfer data. We applaud this move as it will greatly increase patient safety. That the rules are needed at all is proof that maintaining a competitive environment requires vigilance.

I am very supportive of this legislation and 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.