THIS TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING THURSDAY, APRIL 26 AT 10:00 AM

Statement of Sean Cavanaugh
Chief Administrative and Performance Officer
Aledade
On
Innovation in Health Care
Before The
U.S. House Ways and Means Committee
Subcommittee on Health
April 26, 2018

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Subcommittee on Health
"Innovation in Health Care"
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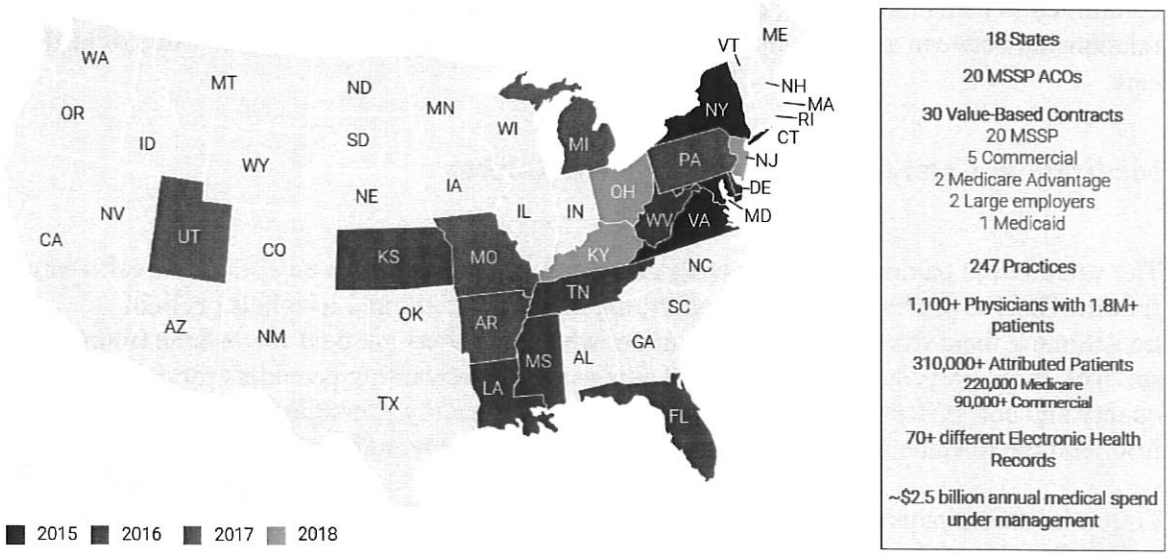
Chairman Roskam, Ranking Member Levin and Members of the Subcommittee, thank you for inviting me to discuss the innovative practices and technology that Aledade is using in partnership with independent physicians across the country to change the landscape of health care.

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. Prior to joining Aledade last year, I served at the Centers for Medicare and Medicaid Services (CMS) for six years including a period as the Deputy Director of the Center for Medicare and Medicaid Innovation (CMMI) and three years as Deputy CMS Administrator and 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 transition to and thrive in value - based programs. We identify and 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, provide data-informed population health workflow tools, and transform how our practices deliver care.

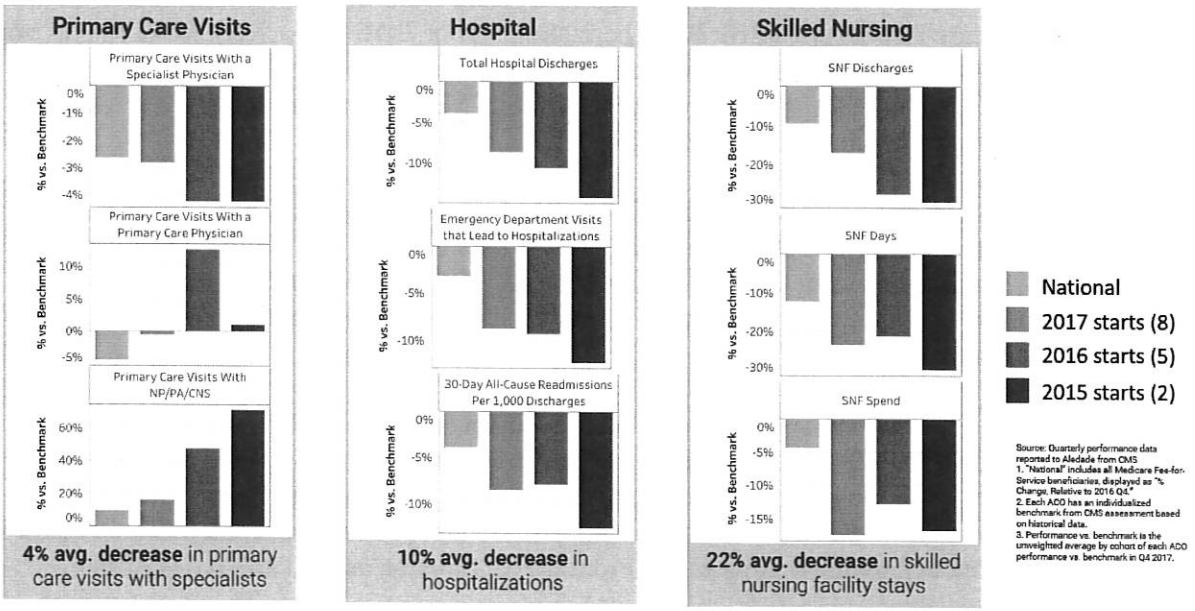
Aledade has grown rapidly and continues to do so. Aledade partners with 247 independent physician practices, Federally Qualified Health Centers and Rural Health Centers in value-based health care. Organized into 20 ACOs across 18 states, these physicians are accountable for 220,000 Medicare beneficiaries through the Medicare Shared Savings Program and an additional 90,000 people (Figure 1) through ACO arrangements with commercial insurers. More than half of our primary care providers are in practices with fewer than ten clinicians.

Figure 1. Summary of Aledade's Footprint.



Aledade is producing meaningful results. 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 determine 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 to improve the value of health care.

Medicare as Catalyst for Delivery System Reform

The value-based payment and service delivery movement has been a key pillar of health care reform. This movement has been transforming how physicians and hospitals get paid, transitioning them from fee-for-service under which providers get paid for volume (more services, more procedures, more hospital admissions) to rewarding providers for delivering high quality and cost efficient care and for keeping patients healthy. Changing the financial incentives from volume to value is essential to address the unsustainably high growth of health care costs.

This value-based payment movement has accelerated over the past 8 years thanks to the Affordable Care Act (ACA). The ACA created and funded CMS' Innovation Center to design and test new payment and service delivery models to reduce program expenditures while improving the quality of care for beneficiaries. Under these models, CMS rewards value, tests these ideas in the real world, rigorously and independently evaluates them to learn what works and what does not, and scales the ones that do work. The Innovation Center's portfolio spans ACOs, patient-centered medical homes, episodes of care, and even state and community-led innovation efforts.

Congress reinforced the importance of the work of the Innovation Center when it passed the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA, as you know, incentivizes practitioners in Medicare to participate in Advanced Alternative Payment Models (AAPMs). The Innovation Center is the arm of CMS that has the authority to test and expand alternative payment models in Medicare.

CMS has been a catalyst to move from fee-for-service to rewarding value. In 2011, almost none of Medicare's payments were significantly tied to value; as of 2016, over 30% of Medicare payments are made under value-based payment models.[1] Additionally, private insurance companies and state Medicaid programs are increasingly joining the movement and becoming leaders in their own right.

The cornerstone of CMS' value-based payment movement has been ACOs. In 2017, it is estimated that there are 923 ACOs in the country covering more than 32 million people, nearly 1 in every 10 Americans, including 10.5 million Americans in the Medicare Shared Savings Program alone.[2] We have strong evidence that ACOs do indeed reduce cost and improve quality. CMS' independent evaluation reports of the Pioneer ACO model, as well as studies of the

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03- 03-2.html
[2] https://www.healthaffairs.org/do/10.1377/hblog20170628.060719/full/

Medicare Shared Savings Program, published by Harvard researchers, have shown CMS' ACO programs have saved Medicare's Trust Funds hundreds of millions of dollars.[3]

In particular, the body of evidence shows independent physician-led ACOs achieved greater savings than those led by hospital systems. This makes intuitive sense - independent physicians are not conflicted with needing to preserve unnecessary inpatient admissions or high cost procedures to fund a hospital's budget. Independent physicians play a critical role to improving quality, reducing costs, and fostering competition to ever-consolidating health systems. However, independent physicians often lack the financial and technical resources available to hospital systems to join the value-based payment movement. Aledade addresses just that - we help independent physicians transition to and thrive under value-based programs.

It is from this perspective that I offer my assessment on the guiding principles for continued payment and delivery system innovation and policy recommendations to strengthen the financial incentive to support innovation, increases access to necessary information, and increasing the actionability on information.

Guiding Principles for Payment and Delivery System Innovation

As federal policy seeks to encourage payment and delivery system innovation, I offer these guiding principles.

- *Patient-Centered Care* – A strong primary care physician-patient relationship is the strongest tool available to create more value in health care. This proposition is strongly supported in the health services research literature and in the results of the MSSP.[4][5]
- *Choice and Competition in the Market* – Congress has taken initial steps to reduce regulatory incentives encouraging the merger of hospitals and physician practices, but more needs to be done. Congress should further eliminate payments for physician practices to merge with hospital systems such as facility fees creating higher payment for the same services and the 340B program making drug pricing uncompetitive in private practice. Congress and CMS should take steps to prevent other anti-competitive behaviors such as data blocking.
- *Provider Choice and Incentives* – Value-based programs that provide a business case for improving care will attract voluntary enrollment by physician practices. These models should, over time, put physician practices at financial risk, but that risk must be proportional to the finances of independent physician practice and not so large as to favor consolidation of practices. Models should provide predictability in benchmarks and move over time to a financial and evaluation structure that includes a comparison to their local market.
- *Benefit Design and Price Transparency* – Price transparency to health care providers and to consumers creates competition by informing the choices of both beneficiaries and referring physicians. Benefit design should incentivize the building of the primary care physician-patient relationship and other cost-saving choices.

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[3] http://www.nejm.org/doi/full/10.1056/NEJMsa1600142; http://annals.org/aim/article-abstract/2566329/savings-from-acos-building-early-success; https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601418

[4] http://www.nejm.org/doi/full/10.1056/NEJMp1709197?query=TOC

[5] http://www.nejm.org/doi/full/10.1056/NEJMsa1600142#t=article

Recommendations to Create a Reliable Financial Model to Support Innovation

Limit one-sided risk.

Today the vast majority of Medicare ACOs (460 of 561, or 82%) are still in one-sided risk models. The Track 1 MSSP model undeniably serves as a critical on-ramp for providers to gain experience with total cost of care models, particularly for the physician-only group of ACOs that have demonstrated the greatest ability to generate savings for Medicare. However, upside-only models do not force organizations to make a commitment to a new business model centered on value and outcomes, rather than volume and market power.

CMS Administrator Verma recently expressed her intention to take a close look at the current ACO model "to make sure that they are not driving out smaller practices." A major driver of provider consolidation has been differential payments for "facility fees" when private practices are purchased and rebadged as hospital outpatient departments (which the 2018 President's Budget has proposed to eliminate). The Medicare Payment Advisory Commission (MedPAC) has proposed site neutral payment policies to address this issue. But short of practice acquisition, hospitals can use one-sided ACO models as a safe haven for a softer form of consolidation: increasing "in-network utilization" for purposes other than lowering costs. Allowing providers to stay in one-sided risk also decreases savings for Medicare in the long run.

To address these concerns, CMS should continue to limit one-sided MSSP ACOs to two, three-year performance periods – six years total. CMS should not extend one-sided risk for the third MSSP contract.

This could result in some ACOs dropping out of the program; among the most recent cohort ending their initial three-year contract, only 8 out of 65 (12%) voluntarily moved to risk. However, we believe that if two-sided risk is made less risky, and more predictable, then most successful ACOs will be willing to move up the risk continuum. The success of the value-based movement should be measured not only by the number of ACOs, but also by their ability to generate results.

Make downside risk less risky.

The Medicare ACO Track 1+ model, which was unveiled by the CMS Innovation Center in late 2016, took a big step towards creating a two-sided model that is feasible for organizations of differing finances by introducing the concept of revenue-based downside risk. This model qualifies as an AAPM under the "more than nominal risk" test of MACRA, as it provides for penalties of up to 8% of practice revenue for poor performance. For organizations with profit margins of 2–3%, that is certainly sufficient to assuage concerns that ACO waivers could lead to higher costs.

Track 1+ had a strong debut in 2018, with 55 ACOs entering this Innovation Center model. In contrast, only a few ACOs entered the MSSP's current two-sided models – two in Track 2 and

eight in Track 3. To generate better evidence on the level of risk that yields the best results for the ACO program, CMS should extend revenue-based risk to the MSSP program, and offer additional incentives for organizations that take on more risk.

Make the benchmark more predictable and strengthen the link to Medicare Advantage.

The original ACO financial benchmarking methodology was an attempt to move money from regions with high per-capita Medicare spending to regions with lower spending, while still rewarding efficiency. It has proven unsuccessful at both. It is time to create a better measure of whether an ACO actually generates savings to the Medicare program compared to the alternatives.

One of the major hesitations that ACOs have about entering into two-sided risk is the complexity and unpredictability of the program's current benchmarking methodology. Sophisticated statistical analysis by Harvard Medical School Department of Health Care Policy researchers has shown that the current benchmarks do not accurately share savings based on a given ACO's activities because they do not account for local variations in cost trends. As a consequence, some ACOs generate "savings" against a benchmark that was not attributable to their actions, while other ACOs are told that they did not generate any savings, even as they have worked hard to improve patient outcomes and reduce hospital and emergency department utilization. Both scenarios sap provider confidence to take on two-sided risk, and reduce the program's ability to reduce costs.

CMS introduced a regional benchmarking approach last year to account for regional trends, but the complex benchmark calculations conducted between the close of the performance year and the "final reconciliation" are not possible for ACOs to replicate. The regional benchmarking methods also inadvertently introduced a new problem that systematically disadvantages rural ACOs by including their population in the regional comparison group. This policy decision also exacerbated the confounding effects of the approach towards risk adjustment in the ACO program, wherein risk scores for continuously enrolled patients can be reduced, but not increased.

As a result, ACOs are faced with a no-win situation, penalized whether their risk scores decrease or increase. The Next Generation ACO program – an Innovation Center demonstration – has also had shortcomings with respect to the benchmarking methodology, and many of its most promising features are rarely used.

As one recent study of independent ACOs observed, the lag between performance and evaluation, the "black box" of risk adjustment, and benchmarks that are perceived as constantly moving targets, all contribute to a reluctance to move ahead with two-sided risk. Pushing ACOs to take more risk, while creating a more predictable and equitable benchmark can lead to greater savings to the taxpayer without encouraging further provider consolidation.

A radically simpler solution would be for CMS to move all ACO benchmarking towards a methodology based on Medicare Advantage (MA) benchmarks. This approach could also be used to develop an improved version of the Next Generation ACO program that provides an on-ramp for smaller practices. To preserve the existing historical-to-regional transition of MSSP, the

ACO's benchmark could initially be set at their historical percentage of the MA rates in their area (120% or 80%, etc.) during one-sided risk, and then begin the transition towards the actual MA benchmarks as soon as the ACO takes on two-sided risk.

The processes for establishing these benchmarks are well understood, and the benchmarks themselves are much more predictable. The rates are set prospectively, and do not require extensive analysis of cost trends months after the conclusion of the performance years. Improving the timeliness and predictability of benchmarks would greatly benefit ACOs at no loss to CMS; in fact, it would greatly reduce the cost and complexity of maintaining the ACO program for Medicare, since the MA program has already invested in the policy and analytic tools for solving many of the technical problems that ACO benchmarking faces.

Tying ACO benchmarking to MA benchmarks would also have the advantage of giving risk-taking providers greater competence – and confidence – in taking risk for MA patients, and partnering with plans to create more MA options for seniors.

Reward (and simplify) quality.

Currently, ACO quality scores appear to be uncorrelated with savings against benchmark. It is reassuring that the savings are not coming at the expense of patient care, and there is no evidence ACOs are stinting on needed health care. However, there is an opportunity to incentivize improved patient experience and quality outcomes in addition to savings, similar to the MA program. A simplifying approach aligned with the Patients Over Paperwork initiative would be for CMS to use identical clinical and utilization measures for the ACO programs and the MA STAR rating program, evolving both towards more meaningful outcomes and patient-reported measures over time. Such an approach would reward quality through increases in the benchmark, reduce administrative burden for CMS and providers, allow consumers to make informed choices between ACOs and MA, and provide an opportunity for making improvements in both.

Engage consumers.

ACOs face limitations in using benefit design to align financial incentives with beneficiaries as in MA. For example, currently ACOs are unable to waive copays for high value primary care services. Similarly, ACOs are unable to include Medicare beneficiaries in any financial benefit from cost savings. Just as financial incentives are powerful mechanisms to change providers' behaviors, they can be effective to drive positive consumer behavior change.

Greater flexibility should be given for ACOs to engage consumers as long as it does not come at the cost of greater administrative burden, such as requiring each patient to fill out additional paperwork. Such flexibility may be provided through legislation or through increased guidance and clarity on the use of waivers to anti-kickback and associated rules that have largely been unused by ACOs.

Recommendations to Improve Access to Information

Include admission, discharge and transfer data feeds as a condition of participation in Medicare for hospitals.

There is much more information available than simply claims data. One of the most available pieces of information is known as admission, discharge and transfer data (ADT) feeds. These are notifications when a person is admitted to a facility, discharged from it and transferred within it. For facilities with certified electronic health record -- which includes over 95% of hospitals -- there are not technical barriers to sharing this information. We have successfully built a link between our ACO and a hospital in 30 minutes once the business and policy issues were settled. We still see hospitals that will not share this information with primary care physicians. In some cases, this is for business reasons where they see the information as a competitive edge. In other cases, they are unwilling to make even the minimal investments on the technology side to make this change.

We have reached an inflection point with ADT data. It is time for sharing facility notifications with physicians for common patients to no longer be considered an aspirational goal, but a quality and safety requirement. We believe that it should become part of the Medicare conditions of participation.

Direct CMS to make all available data available to ACOs through API style interfaces to improve the ability to take action on the data and its security.

One of the keys to successful population health is to use data to inform accountable physicians about the health care the patient is receiving from others. From admissions to the hospital to whether a referral was completed to whether a prescription was filled, the sharing of data can greatly reduce the burden on the patient and health care provider alike to remember to share information with each other. MSSP has been an exemplary standard in providing claims data, transaction data that details a patient's each encounter with the health care system - which provider they saw or which hospital they were admitted to, for what diagnosis, and what services were furnished or procedures performed.

However, other sources of CMS data remain unavailable to ACOs. For example, when a physician practice queries Medicare for eligibility they receive back a host of information beyond simply whether the person enrolled in Medicare. They receive the last date of several preventative services and the due date of preventative services. Not only could CMS make this query available to ACOs, but they could enhance the information provided. For example, they could include which physician a Medicare beneficiary is attributed to an ACO model if any.

CMS currently sends a monthly batch of 11 different files with claims data to the ACO. Because of the claims lag from provider to CMS, the latest month of data is not very reliable. As a result, we receive reliable claims data for events that happened by the end of April around mid month of May. This six week delay is a barrier to action.

CMS is currently experimenting with an API interface that would allow a beneficiary to give an ACO permission to access claims data every day. Rather than waiting until next month's file, an ACO's data would improve every day. CMS should move the entire claims information distribution to an interface basis. Not only is it faster, but it is more secure as there would no longer be static files just sitting on a website, a secure website to be sure, but still a static one where millions of Medicare claims sit for 30 days.

Standardize claims feed for commercial payers.

Commercial plans are even more challenging as there is not a uniform structure for providing claims data. Commercial data differs in both content and structure from Medicare and other commercial plans. An effort to standardize the claims feed – just as the claims forms themselves have been standardized - would reduce barriers to access of information.

Support electronic health record (EHR) interoperability through APIs.
Clinical data housed in EHRs is also very informative. This clinical data includes patient's medical history, patient's state of health (e.g., existing conditions, test results), and physicians' care plans going forward. However, it is also the hardest to access across providers. With the proliferation of ACOs where the providers themselves are responsible for total cost of care, a provider-led business case for sharing clinical data has emerged.

At Aledade, we interface with 70 different versions of EHRs. The key to such proliferation is determination as the ACO will not be successful without the information. We also do not let the perfect be the enemy of the good. An interface that cannot support sharing notes but can share lab results is better than no interface at all.

CMS and the Office of the National Coordinator (ONC) are currently moving towards FHIR based APIs. These hold a lot of promise, especially if we abide by the principle of not letting the perfect be the enemy of the good. We should not prevent an EHR API from sharing lab data just because it cannot share notes. Our experience is that once any data is flowing, it will get better, faster and more comprehensive over time. The key is to get some data flowing.

Thank you for the opportunity to share Aledade's experiences with you. I look forward to continuing to engage with Members of the Subcommittee as you consider these important questions, and I am happy to answer any questions you may have.