Panel Discussion: *Enhancing the Ability of PB-TCOC Models to Be Competitive*

Panelists:

Subject Matter Experts

- **J. Michael McWilliams MD, PhD** – Warren Alpert Foundation Professor of Health Care Policy and Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- **Stephen M. Shortell, PhD, MPH** – Blue Cross of California Distinguished Professor of Health Policy and Management Emeritus, Dean Emeritus, and Professor of the Graduate School at the School of Public Health and Haas School of Business, University of California-Berkeley
- **Jose Peña, MD, FACP** – Chairman of the Board and Chief Medical Director, Rio Grande Valley (RGV) ACO Health Providers, LLC
- **Tim Layton, PhD** – Associate Professor of Public Policy and Economics, Frank Batten School of Leadership and Public Policy, University of Virginia

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Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School

“Competitiveness” of Total Cost of Care Models

J. Michael McWilliams, MD, PhD

Professor of Health Care Policy and Medicine

Harvard Medical School and Brigham & Women’s Hospital

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Disclaimer: The views I present are my own and do not necessarily reflect those of any organization with which I am affiliated, including the Center for Medicare and Medicaid Innovation (CMMI)

Key Points

- Goal is success (not “competitiveness” per se)
- Important to define what is meant by “competitiveness”
- “Competitiveness” w/ FFS traditional Medicare (TM) → ACO contract design
  - Provider decision: for TCOC models to succeed, must make efficiency financially attractive
- “Competitiveness” w/ MA → payment policy for MA vs. TM
  - Beneficiary decision: no amount of ACO contract redesign can “compete” w/ MA subsidies
  - Broader policy question about “level playing field” and need for TM to discipline MA market
    - Prospects for stronger competition within MA?
    - Effectiveness of direct regulation if competition limited or unproductive?
    - If level playing field, at what level of payment, benefit generosity?
  - Role of ACOs in TM-MA interaction:
    - Can lower cost of leaning on TM to discipline MA
    - If ACOs can share savings with patients, pressure MA plans to offer more

Key Points cont'd

- "Competitiveness" as better – why make pop-based provider payment (ACOs) more "competitive"? What is potential added value?
- Helps navigate tradeoff between cost containment and access/quality:
  - Letting providers gain from efficiency helps preserve access as spending is reduced (harder when only dial is fee reductions)
  - Alternative way to finance services that are multidimensional, hard to price, and thus prone to underuse or overuse under FFS
  - Minimizing incentives that get in the way → more flexibility for providers to do what they think is best for patients (neither FFS or capitation optimal)
  - Enlisting informed providers may make for more nuanced, patient/doctor-friendly UM
- Multipayer alignment: Is most important step fixing ACO contracts in TM?

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Impact of Vertical Integration: Implications for ACOs

Stephen M. Shortell, PhD, MBA, MPH
Distinguished Professor of Health Policy and Management Emeritus, and Dean Emeritus, School of Public Health, UC Berkeley

- *Member - Better Healthcare Policy Group*
- *Member - California Office of Healthcare Affordability (OHCA) Advisory Committee*
- *Member - California Integrated Healthcare Association (IHA) Board*
- *Member - Catalysis (Quality Improvement Educational Organization) Board*

Key Takeaway Points

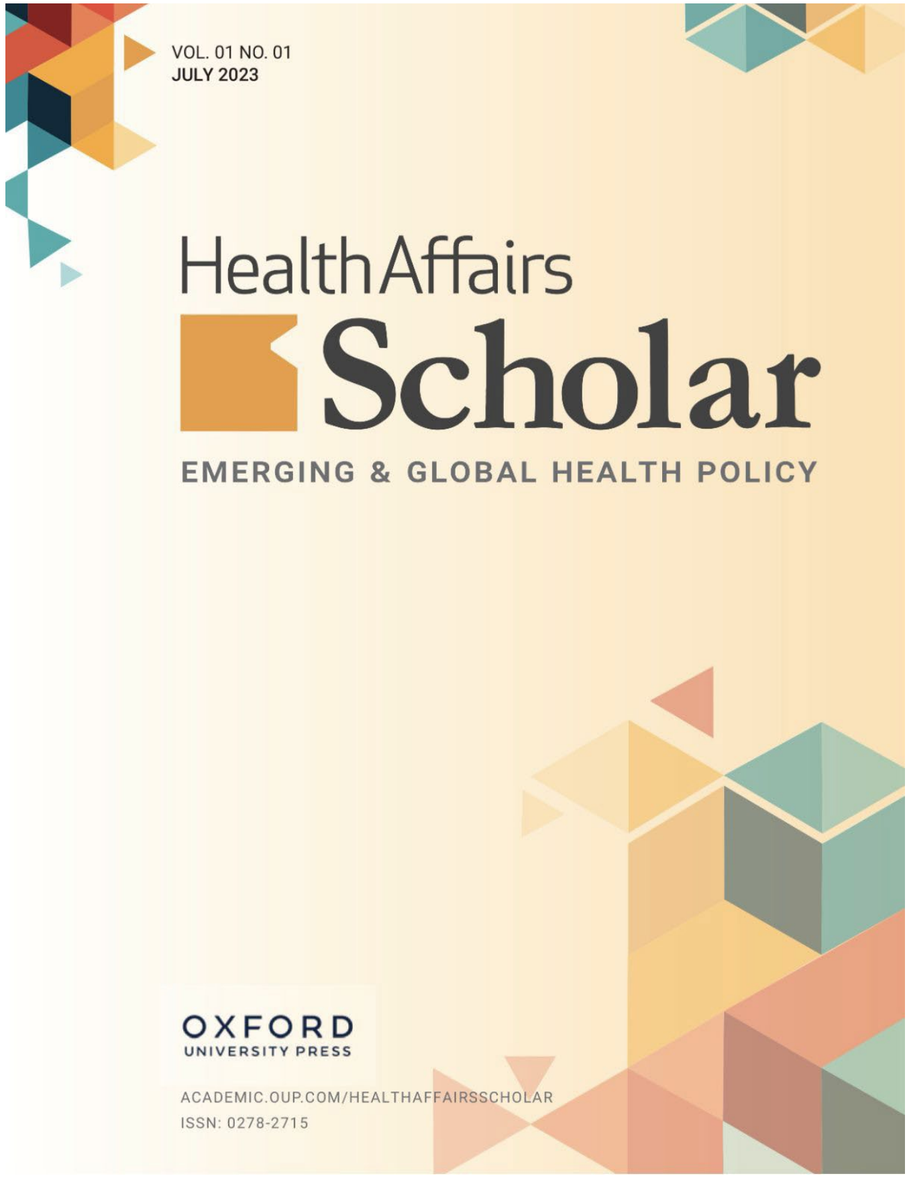
- **Vertical** Integration Is Associated With Increasing Negotiating Leverage With Insurers And Increased Prices
- **If Participating** In Accountable Care Organization, The Above May Be Attenuated To Some Extent Due To Incentives To Share In Savings From Reducing The Total Cost Of Care While Maintaining Or Improving Quality Of Care
- **Research** Suggests That Hospital-Affiliated ACOs Tend To Have Higher Overall Spending Than Independent Physician-Affiliated ACO Groups Due To Higher Inpatient Use And Speciality Services
- **No Consistent** Differences In Regard To Quality Of Care Services

CHALLENGE:

How To Design Payment Models To Take Advantage Of The Resources And Infrastructure That Hospital/Health Systems Can Provide To Medical Groups That Also Reduce The Incentive To Increase Spending. For Example, All Payer Risk-Adjusted Prospective Payment, Global Budgets And Related

Appendix

Shortell SM, Toussaint JS, Halvorson GC, Kingsdale JM, Scheffler RM, Schwartz AY, Wadsworth PA, Wilensky G. The Better Care Plan: a blueprint for improving America's healthcare system. Health Aff Sch. 2023 Jun 20;1(1):qxad007. doi: 10.1093/haschl/qxad007. PMID: 38756832; PMCID: PMC10986211.



Berkeley Public Health

Panel Discussion: *Enhancing the Ability of PB-TCOC Models to Be Competitive*

Jose Peña, MD, FACP

Chairman of the Board and Chief Medical Director, Rio Grande Valley (RGV) ACO Health Providers, LLC

Factors Affecting the Competitiveness Of PB-TCOC Models with Other Options in the Medicare Program

Jose F. Peña, MD, FACP

Chairman of the Board & Chief Medical Director,
RGV ACO Health Providers, LLC

Chief Medical Officer,
Kaizen Clinical Partners

Board Member,
Valley Integrated Physicians

Board Certified Internal Medicine,
Quality Assurance & Utilization Review

About Us

- Our business model: Patient-centered care approach; Financial performance focus; Exemplary commitment; Outcomes oriented
- Established 2012 – Rio Grande Valley
- 2015 – Added Clinics in San Antonio
- 2019/2023 – Added Clinics in New Jersey
- 15,000+ Members (REACH & Commercial)
- 130+ Providers
- 35+ Clinics
- 9 Consecutive Years – **Ranked as a Top Performing ACO in the Nation**

PB-TCOC Challenges

Growth of Medicare Advantage (MA) Plans

- MA Plans are expanding rapidly in most markets.
- Significant advantages over ACO MSSP and ACO REACH (i.e., vision, dental, no deductible).

Financial Predictability

- MA Plans provide more financial stability than ACO MSSP and ACO REACH programs.

Physician Resource Challenges

- Physicians often lack the financial resources and administrative expertise to remain competitive in PB-TCOC models.

Data Access & Utilization

- MA Plans have real-time access available for utilization patterns.
- ACO REACH model lacks data access compared to the ACO MSSP model.

Recommendations & Takeaways

Increase Stability & Predictability

- CMS should enhance financial and policy stability in PB-TCOC models (i.e., ACO REACH, ACO MSSP).

Reduce Regulatory Burdens

- Streamline waivers and improve ACOs ability to recruit beneficiaries.

Maintain Telehealth Payments

- Facilitate access to care and reduce acute costs through continued telehealth reimbursement.

Lower Financial Guarantee Requirements

- Reduce the percentage of TCOC required for financial guarantees to free up operational funds.

Improve Data Sharing

- CMS should provide timely and actionable beneficiary utilization data to ACOs, inclusive of risk stratification.

Recommendations & Takeaways, Continued

Increase Up Front Funding

- Enable infrastructure development through access to advanced payments.

Expand Community-Based Organization (CBO) Services

- Provide resources to address SDOH to improve patient's outcomes and reduce costs. Allow ACOs to engage with CBOs more freely.

Adjust V28 HCC Model & Introduce Social Risk Score

- Reduce burden of the V28 HCC model and incorporate social risk factors

Reduce CMS Discount From ACO REACH Benchmark

- Minimize the impact of CMS discounting, which significantly reduced the shared savings potential.

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Associate Professor of Public Policy and Economics,
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University of Virginia

Separating Dual Goals of Total Cost of Care Models

Timothy Layton
University of Virginia and
National Bureau of Economic Research

Comments for:

Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Two Goals

- Discussions about APMs/TCOC models often confuse two goals:
  1. Lowering spending
  2. Improving the allocation of a fixed amount of $$, i.e. “more bang for the buck”
- It is important to recognize that we don’t actually need TCOC models to do (1).
  - We can just cut payments across the board!
- The real purpose of TCOC models is (2)
  - It’s really hard to set every payment for every service in FFS correctly, especially when services are complements or substitutes, when some services have high fixed costs and low marginal costs and vice versa, etc.
  - TCOC models provide an opportunity to step back and let organizations experiment with different allocations until they find the ones that deliver the most value to consumers, with consumers signaling value via demand.
- The problem is that when we try to do both (1) and (2) via a single instrument (TCOC payment policy), we end up doing a poor job of both.

Why “Shared Savings” Are Misguided

- Key to this problem is the drive to claw back “shared savings” via payment rules
- **Insight:** ANY shared savings, will decrease incentive for organization to participate
  - Weird, mis-guided (dare I say “actuarial”) idea that payments should equal costs
  - Leads to payment policies that ***disadvantage*** *TCOC models* in order to “capture” savings
  - Basically, we make goal (2) less likely by focusing payment policy on goal (1)

- Breaking two goals apart leads to a different type of payment policy: **All models (FFS, ACOs, MA, etc.) need to be paid the same amount for the same person**, i.e. “level playing field”
  - We can choose that amount to be whatever we want it to be, based on what we think is the right level of spending
  - Maybe some models survive under certain payment levels and others die. That’s ok!
  - But all models should get the same amount, and then we “let the market decide”
  - Want ACOs to take savings and use it on things people want. Don’t need to force this. Competition among ACOs and competition with FFS and MA should do that If ACO can take same $$ and get loads of people to want it, then it is delivering more value for the same $$
  - May need to improve active choice/competition policy to achieve this, but this is the way
  - Remember, purpose of ACOs is getting the allocation right, not the level.

How to do it

- The big question is how to actually provide a level playing field.
  - How to pay FFS, ACOs, and MA the same amount for the same person.
- Hard – Classic causal inference problem. We don't know counterfactual Traditional Medicare spending for people in ACOs and MA.
- We try to solve with risk adjustment systems, but those have had major issues in the past (see MA).
- That said, these issues are solvable if there's a will to solve them.
  - Survey-based risk adjustment
  - Randomization of defaults (FFS, ACO, MA) for a subset of those who don't make active choices
  - Or just simple (imperfect, but likely good enough) fixes to the current risk adjustment system
- Finally, this really only works well if demand follows value, so we will need to improve choice architecture, push for more active choice, competition policy, etc.