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COMMENTARY

How to harness value-based care codes

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Many of you reading this column joined Medicare accountable care organizations (ACOs) sometime between 2011 and 2016. As the power of prevention, wellness, and the medical home model are starting to be realized and appreciated, those benefits may be swamped by two new Centers for Medicare and Medicaid Services value-based revenue streams that did not exist when many of you first joined your ACO.

The Medicare Access and CHIP Reauthorization Act (MACRA) was passed in 2015 and is just now being implemented. Value-based, fee-for-service payments started out rather modestly a few years ago as chronic care management codes, but they have exploded to include more than 20 codes, counting the new ones coming online in 2018. Let's call them collectively value-based care codes, or VCCs.

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Even better, the proactive and coordinated care called for to succeed under MACRA and the VCCs will also drive higher quality scores and shared savings distributions for ACOs that incorporate them. There is opportunity to leverage all three of these revenue streams collectively using your ACO's chassis.

Many practices are trying to understand and perform the basic requirements to avoid penalties under MACRA's Merit-based Incentive Payment System (MIPS) program. Some primary care practices, however, see the upside potential and bonuses stacking up to 30% or more.

Did you know that even if you are in, let's say, a basic Medicare Shared Savings Program ACO – the MSSP Track 1, with no exposure to risk – you get special treatment on reporting under MACRA as a MIPS Advanced Practice Model (APM)?

But more importantly, MACRA is a team game. Getting into an MSSP Track 1 is justified just to get practice for the care coordination you'll need. Few physicians know that they are judged under MACRA MIPS for the total costs of their patients, not just their own costs. A primary care physician receives only up to 8% of the $10 million your patients consume on average. The best way to counter that is through an ACO.

Further, we are aware of ACOs that have chosen risk-taking Medicare models such as NextGen <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/> , even though they predict small losses. Those losses are because of the automatic 5% fee-for-service payment bump to its physicians for risk taking if they are in a MACRA Advanced Alternative Payment Model (AAPM).

There's a wide range of primary care physicians who are seizing opportunities offered by VCCs.

A family physician friend of mine who practices in a rural area generated more than 50% of his revenue from value-based care coding last year. And he has personally generated more than $350,000 in additional annual revenue, not counting the revenue from additional medically necessary procedures revealed by this more proactive wellness assessment activity and early diagnoses.

On the other hand, because busy physicians have a hard time wading through all these regulations and implementing the required staff and technology changes, it is reported that only about 8% of physicians are employing even the chronic care management codes. And when they do, they only achieve an 18% eligible patient penetration. My friend has broken the code, so to speak; he has protocolized and templated the process, has happy patients, has an ongoing 93% penetration rate, and actually has more free time.

While you are busy saving lives, I have had the luxury of looking from a high level at these tectonic, value-based payment shifts. To me, it's a no-brainer for a primary care physician to leverage their ACO to maximize all three revenue streams. Look at MACRA MIPS, MIPS-APM, and AAPM measures anew, and see how well they play into integrated care.

As quarterback of health care through the patient-centered medical home, you are in great position to drive substantial bonuses. Similarly, when one looks at VCCs, the ACO can: help you navigate through the paperwork, perform much of the required reporting, and select the highest value-adding initiatives to monitor and drive higher quality and shared savings for the ACO.

As readers know, we firmly believe that, to have sustained incentivization, every ACO needs to have a merit-based, shared savings distribution formula. Accordingly, your compensation should rise under MACRA, VCCs, and the ACO.

This shift to value care is hard. But your colleagues who have made these changes are enjoying practice as never before. Their professional and financial rewards have climbed. But, most important, their patients love it.

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