Getting Ready for Value-Based Care

# Understanding Your Options Before You Ask, "Am I Ready?"

As the healthcare industry accelerates its shift toward Value-Based Care (VBC), providers are increasingly asking, "Am I ready?" However, readiness isn't just about willingness – it's about understanding the landscape you're stepping into.

With CMS aiming to transition 100% of Medicare Fee-For-Service beneficiaries into Value-Based Programs by 2030, it becomes essential to understand the options, financial and operational considerations, and attribution mechanics that define success in VBC models. The decisions you make now will shape your performance - and your potential to earn shared savings - in the years ahead.

## Step 1: Understanding Your Value-Based Care Options

Not all VBC models are created equal, and participation requires aligning with the right structure for your organization's capabilities and patient population.

Two of the most common pathways in Medicare's value-based care landscape are the Medicare Shared Savings Program (MSSP) and ACO REACH (ACO Realizing Equity, Access, and Community Health). While both models shift providers toward accountability for cost, quality, and patient experience, they differ significantly in structure, risk levels, and incentives.

**Here's a breakdown of the key differences:**

| Feature | MSSP | ACO REACH |
|---|---|---|
| **Risk & Rewards** | Offers a simpler, no risk or moderate-risk program based on fee-for-service (FFS) payments, with shared savings opportunities for ACOs and providers who reduce healthcare spending. | Offers advanced levels of risk, including capitation and other alternative payment mechanisms. ACO REACH also has a focus on community health equity |
| **Alternative Payment Models** | Primarily uses a traditional FFS payment model, exemption from most MIPS reporting and MIPS payment adjustment for credentialed practitioners, 0.75% increase in Medicare FFS conversion factor vs standard 0.25% increase and potential MACRA bonus (pending Congressional approval in 4th quarter of 2025). | Offers alternative payment arrangements like capitation while focusing on health equity and enhanced patient benefits. |

ACOs have the option to choose between the following attribution methods:

- **Retrospective** - Patients are assigned based on care provided for primary care services during the contract year and final attribution occurs at the end of the performance year.
- **Prospective** – Assigning beneficiaries to the ACO at the beginning of the performance year based on their historical Medicare claims data from the previous two years.

### Step 2: Operational Readiness – Can Your Infrastructure Support VBC?

Beyond patient attribution, providers must assess whether their clinical and operational workflows are ready for VBC success. Critical areas include:

1. **Data & Reporting Capabilities**
   - Does your organization have access to claims data so that the ACO can determine your eligible beneficiary panel and offer predictive analytics to track patient outcomes and spending?
2. **Billing, EHR & Compliance**
   - Does your EHR system have the ability to provide quality data that an ACO can use to manage and improve patient care?
   - Do you have a dedicated billing lead to ensure accurate coding and claim submission for maximum reimbursement? You can use your biller or the dedicated ACO biller.
3. **Provider Engagement & Care Coordination**
   - Are your clinical teams open to best practices for reducing avoidable hospitalizations and improving care transitions?
   - Are you prepared for ACO engagement to share strategies, achieve desired outcomes, and cost efficiency?
4. **Quality**
   - Are you open to receiving quality performance reports to measure success in key metrics like hospitalizations, chronic disease management, and medication adherence?

### Step 3: Evaluating the Financial Risk & Reward

One of the most overlooked aspects of VBC is the financial structure of participation. Key considerations include:

- **Benchmark Alignment** – If an ACO's benchmark is significantly different from your historical cost structure, it may not be a good fit for you.
- **Risk vs. Reward Balance** – Some VBC models require downside risk, meaning providers could owe money if they exceed benchmarks. Others, like MSSP Level A (Enhanced Track), offer only upside rewards meaning the ACO is taking on all the risk.
- ACO Savings Distribution – Has the ACO historically generated and distributed savings to its participants? A lack of proven success should prompt further due diligence.

### Step 4: Achieving Attribution – Knowing Who You're Accountable For

Beneficiaries are assigned to the highest biller for primary care services to gain plurality. One annual physician visit needs to be conducted for each beneficiary to ensure attribution.

### Final Thoughts: Readiness is About Strategy, Not Just Willingness

Before jumping into a value-based care arrangement, providers must take a data-driven, strategic approach to assess their attribution, operational readiness, and financial alignment. Success requires more than just a willingness to participate—it demands the right infrastructure, partnerships, and execution plan.

By evaluating these factors before asking, "Am I ready?" organizations can position themselves for sustainable success in value-based care.

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