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Value-based contracts: Evaluating Medicare Advantage

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Introduction

In today's health care environment, any component of reimbursement that supplements or replaces traditional fee-for-service reimbursement may be considered to be "value-based." The term encompasses models such as bundled payments, reimbursement for care coordination or meeting performance targets, shared savings programs and financial risk arrangements such as partial or full capitation. This resource describes issues that physicians may encounter when contracting with Medicare Advantage (MA) plans, including common contractual terms that are industry-standard or required by Centers for Medicare & Medicaid Services (CMS) and other terms that directly address value-based reimbursement and are more likely to be negotiable.

Enrollment in MA has grown rapidly, to the point where a majority of Medicare beneficiaries are enrolled in a MA plan, rising to a projected 60% of eligible beneficiaries by the end of the decade.[1] In 2017, CMS introduced the Value-Based Insurance Design model (VBID), which permits MA plans to structure enrollee cost sharing and other benefit design elements to encourage enrollees to use high-value clinical services. For example, VBID rules permit MA plans to reduce or eliminate enrollee cost sharing for services from physicians identified as "high value" based on the quality of care delivered and not solely based on cost.[2] According to the Healthcare Payment Learning and Action Network, risk-based value-based care models accounted for 38.9% of all MA payments in 2022 (the most recent year for which data was available at the time of publication). This was a higher percentage than the traditional Medicare program and Medicaid, and it's over twice the percentage of commercial payments made through value-based models.[3]

Physicians would be well served to prepare for this shift toward value-based reimbursement. Taking a more active role in managed care contracting is a necessity in a value-based world where financial risk is being placed on the provider. For value-based contracts, one of the most significant differentiators is a demonstrated ability to deliver quality care. Physician practices that can point to their contributions to high CMS Star ratings or otherwise demonstrate that they provide efficient clinical care while maintaining high-quality outcomes are highly desirable from a MA plan's perspective. Factors such as physician group size, location and specialty can also play a significant role in contract negotiations.

Value-based care in Medicare Advantage plans

Participants in MA plans have unique opportunities and considerations for value-based care. Because MA plans are at risk for the full cost of Medicare-covered health expenses, they have incentives to "push down" or delegate this risk to providers. Plans often use value-based models to achieve this goal.

1. Neuman, T., Freed, M., and Biniek, J., Henry J. Kaiser Family Foundation, 10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters, Available: https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/.
2. Medicare Advantage Value-Based Insurance Design Model (VBID) Fact Sheet (updated Feb. 2, 2018). Available: https://innovation.cms.gov/Files/fact-sheet/vbid-factsheet.pdf.
3. Health Care Payment Learning and Action Network, 2023 APM Measurement (2023). Available: https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/.

MA-driven value-based models may take various forms. These may range from full or partial capitation (including "global" capitation, in which a practice may be responsible for managing professional, facility and sometimes drug spending), withholds or holdbacks, in which a portion of reimbursement is conditioned on meeting certain quality or cost goals, and shared savings relationships similar to those used in accountable care organization (ACO) models.

The diversity of models makes it difficult to generalize best practices for MA value-based models. However, physicians should keep certain principles in mind. First, although MA plans must comply with federal rules, they have substantial flexibility to negotiate financial arrangements with practices. This document includes a summary of provisions *required* by Medicare vs. those *regulated* by Medicare while allowing room for negotiation.

Second, as with any contract, practices should understand the financial arrangement. For example, the contract should clearly specify the expenses used to identify "savings" or "losses." In general, physicians have more control over clinical expenses but may not have meaningful influence over spending on supplemental benefits offered by the MA plan. A primary care practice should consider whether it can realistically impact the cost or quality of care offered by an MA plan's preferred hospital system (especially if the MA plan operates a narrow network where the only in-network hospital is geographically distant from the practice). Similarly, a specialty practice may not have meaningful ability to influence total health care spend. Technical provisions like attribution, risk adjustment and methodology adjustments can have significant implications for the practice's success or failure under the contract. Practices should also understand whether they can terminate the agreement in certain cases (for example, if a partner hospital goes out of network), and whether the termination of the value-based agreement requires termination of the entire MA contract.

Third, practices should understand the regulatory implications of various value-based opportunities. For example, in some states (e.g., California), a practice may be required to obtain special regulatory approval to manage both professional and facility spending. In others (e.g., Massachusetts and New York), intermediate entities under the MA program, like ACOs or independent physician associations (IPAs), may be subject to obtain additional state regulation. In some cases, these state approval processes may require new legal entities or time-consuming approval processes that should be considered in any contracting timeline.

Non-negotiable provisions

These provisions appear in nearly every MA value-based managed care contract. Plans will typically not entertain requests to modify this language.

Mandatory MA terms

Some terms are required by CMS regulations and include, for example, provisions addressing 10 year record retention, CMS's right to audit, provider compliance with the MA plan's CMS obligations, termination for unsatisfactory performance, ongoing monitoring of provider performance and provider certification that data provided to the MA plan is truthful, complete and accurate.[4] The MA Regulatory Addendum will typically also require the physician to include these same terms in any of the physicians' agreements with subcontractors. CMS has published a template "MA Contract Amendment" that meets these minimum regulatory requirements.

4. 42 C.F.R. § 422.504(i).

While these provisions are mandated by CMS regulation, care should still be taken to review them. MA plans have been known to expand the scope of these provisions beyond regulatory requirements, interpret them in highly plan-friendly ways or to add non-mandatory provisions, which they suggest are required by regulation.

Key question: Mandatory terms

How can I locate and identify all of the mandatory MA terms that are required by CMS? In MA managed care contracts these provisions are often, but not always, grouped together in a "Medicare Advantage Regulatory Addendum." To evaluate whether a contract's Medicare Advantage Regulatory Addendum potentially includes terms that are not required by regulation, compare it to CMS's template MA Contract Amendment.

Provisions regarding physician incentive plans

A physician incentive plan (PIP) is "any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee."[5] Depending on their structure, value-based arrangements can qualify as a PIP. MA plans are required by law to ensure any PIP in its network, even one operated entirely by subcontractors such as ACOs, clinically integrated networks (CINs) or physician practices who have accepted risk, meets regulatory requirements. Contracts typically require, at a minimum, disclosure of any PIP arrangements to the MA plan.

Typical language: Physician incentive plans

Any incentive plans between Plan and Provider shall be in compliance with applicable laws, rules and regulations. Upon request, Provider agrees to disclose to Plan the terms and conditions of any "physician incentive plan" as defined by applicable law or regulation. Each party represents that no specific payment will be made directly or indirectly to a physician or physician group as an incentive or inducement to limit medically necessary Covered Services furnished to a Member. This requirement shall be contained in any subcontract of this Agreement between Provider and any other physician.

Fraud, waste and abuse compliance obligations

MA plans are required to implement an effective compliance program which prevents, detects and corrects fraud, waste and abuse (FWA) and noncompliance with CMS requirements.[6] As part of this mandate, a MA plan must establish and implement effective training and education on an annual basis to ensure network providers are familiar with the plan's compliance program and the provider's responsibilities under it.

Typical language: FWA compliance obligations

In accordance with, but not limited to 42 C.F.R. § 422.503(b)(4) (vi)(C)&(D), Provider agrees and certifies that it, as well as its employees, subcontractors and agents who provide services under this Agreement shall participate in applicable compliance training, education and/or communications as reasonably requested by Plan or its designee annually or as otherwise required by applicable law.

5. 42 C.F.R. § 422.208(a).
6. 42 C.F.R. § 422.503(b)(4)(vi).

Offshoring disclosures and attestations

CMS requires MA plans to collect certain information from providers about their use of vendors located outside of the United States (i.e., "offshoring") and to attest that the plan has taken appropriate steps to address the risk to a patient's protected health information associated with the use of such vendors. To meet the CMS requirement, MA plans look to providers to disclose offshore arrangements and to attest that the provider has in place appropriate safeguards. MA plan-specific attestation forms typically request information about the identity of the offshore contractor, a description of the safeguards in place to ensure the security of patient protected health information and an attestation that the provider will conduct an annual audit of the offshore contractor.

One area where there may be offshoring issues is in a physician's arrangements with downstream vendors. For example, it is not uncommon for physician groups to contract with vendors that provide data analytic services or auditing services to track performance or to confirm appropriate reimbursement from a MA plan. If these vendors are located outside of the United States or otherwise make Medicare beneficiary protected health information available to employees or contractors located outside of the United States, offshoring requirements could be implicated.

Typical language: Offshoring disclosures and attestations

In no event shall Provider employ or contract with a person or entity pursuant to which Medicare beneficiary protected health information will be sent or accessed offshore without first disclosing such arrangement to Plan. Plan may prohibit Provider from utilizing such offshore person or entity. Provider shall comply with additional requirements related to offshore operations as described in the Provider Manual. For purposes of this Section, "offshore" refers to locations outside the fifty United States and the United States territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands).

Importantly, neither the Health Insurance Portability and Accountability Act (HIPAA), nor any other federal law prohibits a physician from contracting with a vendor and making *any* patient protected health information available to individuals outside of the United States. Therefore, if a physician practice, or one of its vendors, engages in offshoring, these provisions should be reviewed to ensure that it does not prohibit offshoring entirely.

Potentially negotiable provisions

While every provision of a MA managed care contract is important, it may be best to devote time and resources on those provisions that are negotiable and present the greatest risks to the physician. Terms impacting reimbursement are typically at the top of that list. The primary goal in negotiating reimbursement-related provisions should be to ensure that the methodology used is clearly explained and mathematically corresponds to higher reimbursement if the physician achieves the stated performance levels. A secondary goal is to limit the plan's ability to deny or unreasonably delay payment. As a preliminary matter, physicians should ensure that the measures on which value-based payments are based are relevant to the physician's practice and that the performance for which the physician is held accountable under those measures is within the physician's control.

It is also important to know the overall goals of the particular payment methodology that a plan uses. Most value-based methodologies implement a variety of strategies based on improving or maintaining the quality of care as determined by certain performance measures, reducing the use of services that are not medically necessary and incorporating efficiencies that are likely to lead to reduced costs to the plan, such as device standardization. As part of the negotiation process with the MA plan, you should consider ways in which the value-based methodology corresponds to your practice and consider omitting language from the contract or reconsidering participation if fulfillment of the terms will not work for your practice.

The following provisions, which directly or indirectly impact reimbursement, should be reviewed closely and revised accordingly to ensure they are clear, objective and relevant to the physician's practice.

Data sharing

Access to accurate, actionable performance data is essential to success in all value-based arrangements. Such data can be used to improve clinical practices and to confirm that the MA plan's calculations of value-based payments are accurate. Physicians should negotiate for timely access to usable data and analyses or require the plan to submit data reports to physicians to perform these and other analyses. If available, physicians should also negotiate for access to plan resources for data management. Conversely, plans will often require physicians to submit certain data to enable the plan to calculate value-based reimbursement to the physician and for other plan purposes. It is not uncommon for plans to require submission of all applicable data (including claims and encounter data) within 90 days from the end of a performance period.

Preferred language: Data sharing

Plan shall maintain a twenty-four (24) hour accessible, secure online portal and/or dashboard to allow Provider to view and download patient data and metrics with respect to quality or value-based achievement, any reports or tables, and itemized billing, patient encounter, and other data used to evaluate Provider's performance under this Agreement. Plan shall make every reasonable effort to update such data on a daily basis, and at a minimum, shall update such data on a weekly basis. Plan shall provide Provider a comprehensive report, which shall include data in a readable, understandable format for Provider (e.g., Plan shall not only provide raw claims data, but shall provide metrics and analyses to enable Provider to understand the import of such data to the model under the agreement), no less frequently than on an annual basis and also upon Provider's written request. Provider shall timely submit patient data, the content and process for submission of which to be mutually agreed upon by the Parties in writing, and failure to timely submit such data may delay the determination by Plan of Provider's performance for the period of time for which such data is applicable. Both Provider and Plan shall make every reasonable effort to notify the other party of any deficit or technical interruption of data availability or reporting.

MA plans will occasionally object to providing such data on grounds that such disclosure is prohibited by federal privacy laws. This objection is typically without merit. But to the extent it does apply to a particular value-based arrangement, the physician may need to execute a Business Associate Agreement with the plan that specifies the physician's obligations with respect to such data.

Key question: Data sharing

What considerations should physicians make with respect to data sharing provisions in MA contracts? Where a contract with a MA plan calls for data sharing between the parties, physicians and physician groups should carefully consider operational questions, including the content of data shared, frequency and the format in which the data is provided. For example, if a physician requires data to be in a particular format to make it usable, that and other technical requirements should be specified in the contract. Similarly, if the plan requires the physicians to submit data, physicians should understand expectations around format, frequency, timeliness and volume. These are often negotiable terms, so physicians should carefully review these requirements and negotiate the most advantageous terms. The American Medical Association has an extensive Data Sharing Playbook.

Termination for adverse changes

The majority of MA managed care contracts permit the plan to unilaterally amend the contract. In addition, the plan almost always retains the right to amend its policies unilaterally. Either of these types of amendments can have a significant effect on physician reimbursement and the administrative effort needed to comply with plan requirements. Ideally, to protect against such outcome, any amendments to the terms of the contract or to plan policies applicable to physicians should require notice and, preferably, the physician's written consent, although most plans will deny that type of language. Physicians are much more likely to gain some measure of protection by securing the right to terminate the contract in the event the plan makes amendments that adversely affect physicians.

Preferred language: Termination for adverse changes

Notwithstanding any other provision of this Agreement, in the event Plan proposes an amendment to this Agreement or to any policy or procedure which would result in an adverse change for Provider, Plan shall notify Provider of such amendment at least thirty (30) days in advance of the amendment, in writing, and in accordance with the Notice provisions of this Agreement. If any such amendment does or would result in an adverse change, Provider may terminate this Agreement upon thirty (30) days' written notice to Plan. For purposes of this section "adverse change" means any change that results in: (a) a decrease in actual or expected reimbursement realized by Provider on a per treatment or aggregate basis under this Agreement or (b) an increase in administrative costs of performing services on a per treatment or aggregate basis under this Agreement.

Changes to the value-based payment methodology

MA plans and physicians are continually learning from their value-based experience and seeking to improve the program for beneficiaries. Physicians should be alert for attempts by the MA plan to adjust the value-based payment methodology or performance metrics during a performance period. Physicians rely on the data available and the methodologies and metrics established at the beginning of a performance period. Moving the goalposts in the middle of a performance period is unfair.

As noted above, physicians are unlikely to get MA plans to agree that every amendment to the contract or to plan policies should require physician consent. However, physicians should draw the line at any proposed changes to the value-based payment methodology. Ideally, physicians

should require physician consent for any such proposed change. It is more feasible, however, to limit the MA plan's ability to unilaterally change the value-based methodology during the performance period.

Preferred language: Value-based payment methodology changes

If Plan desires to change the Value-Based Payment methodology (including any benchmarks, targets, metrics or other criteria that may impact aggregate Provider reimbursement) Plan shall notify Provider at least ninety (90) days in advance of such change, which shall take effect at the beginning of the next Performance Period. Notwithstanding any other provision of this Agreement, in no event may Plan revise or update the Value-Based Payment methodology during any performance period without Provider's prior written consent.

Key question: Payment methodology structure

Is it more common for payment methodologies to be set in stone for the entire contract period or adjusted on a year-to-year basis? It depends on the payer, but allowing for some changes may work to the physician's advantage. For example, if a physician group determines that certain quality measures no longer apply to the provision of care by its physicians, allowing for year-to-year revisions to the payment methodology may allow the physician group to switch out the measures on which performance will be evaluated. To allow for this contingency, the physician group will want to ensure that the agreement states that measures cannot be added, deleted or significantly altered without the agreement of both parties.

Fees earned during the term of the contract

Meeting performance targets established by a MA plan under value-based managed care arrangements requires significant time and effort by the physician. Reimbursement for such effort, however, sometimes lags for months after the performance period has ended and while the MA plan aggregates the applicable data and calculates the physician's performance. A lot can happen during this lag time, including contract termination. At a minimum, a physician should strike language requiring the physician to be a participating provider on the date of payment in order to be eligible for any value-based payments. In addition, depending on the nature of the value-based payment, it may be appropriate to request payment for value-based efforts completed prior to contract termination.

Preferred language: Payment entitlement after termination

In the event this Agreement terminates for any reason during a Performance Period, Provider shall be entitled to that pro-rated portion of the Value-Based Payment that is reasonably calculable and payment shall be made to Provider within ninety (90) days of the effective date of termination of the Agreement.

Sequestration and other reductions in CMS payments

Every MA plan has a contract with CMS outlining how the plan will be paid by CMS. CMS still retains the authority, however, to adjust payment unilaterally in certain circumstances. For example, in 2013 in response to a federal law directing across-the-board spending cuts by

federal agencies, CMS unilaterally reduced its payments to MA plans by 2% (sequestration).[7] CMS does not require that such cuts are passed on to providers. In fact, CMS has advised MA plans that the effect of sequestration on provider reimbursement is governed by the terms of the contract between the MA plan and the provider.[8] Nevertheless, it is common for MA Plans to attempt to pass the risk of a CMS-imposed reduction in payment at the plan level on to the provider via contract. This is typically accomplished by requiring that reimbursement amounts are automatically reduced by the same percentage that CMS payments to the MA plan are reduced.

Key question: Payment reductions

What should a physician practice do in the event that an agreement with a MA plan calls for reductions to physician reimbursement that correspond to decreases from CMS? Physicians should resist any attempt by plans to pass this risk of reduced payment by CMS on to physicians by deleting such language entirely. MA plans are not required to pass these types of reimbursement rate cuts on to physicians.

Risk adjustment and diagnosis coding

CMS "risk adjustment" policies mean that MA plans can earn higher payment for caring for relatively "sicker" beneficiaries. As a result, many MA plans incentivize providers to document all applicable patient diagnoses.

Proper documentation of all applicable diagnoses can be important for managing population health, but physicians should understand that the Medicare program has stringent rules for documenting diagnosis codes. Among other things, all diagnoses must be documented based on a face-to-face visit with a qualified professional. In recent years, the Department of Justice has alleged that the risk adjustment programs operated by several large payers violate federal fraud laws because they allegedly involved "upcoding", one-sided documentation of diagnoses (i.e., adding supported diagnoses without removing unsupported diagnoses), or improper documentation of diagnoses in violation of Medicare rules.

Physicians should understand that they are ultimately responsible for exercising their medical judgment to document genuine diagnoses. In the event of a fraud complaint or compliance audit, regulators may choose to review a physician practice's activities alongside those of the MA plan. To the extent an MA participation agreement calls for (or financially incentivizes) risk adjustment documentation, practices should ensure these requirements are consistent with actual practice procedures and do not conflict with applicable law or payment rules (including Medicare rules) around diagnosis documentation.

Clean claims and prompt payment

Physician practices sometimes experience delays in receiving payment from MA plans. CMS regulations establish specific prompt payment rules for a small category of MA plans and for services provided by out-of-network providers (See 42 C.F.R. § 422.520). For in-network providers, MA plans are required to have a prompt payment provision in their provider agreements and must pay providers consistent with this contract language.

7. CMS Letter to Medicare Advantage Organizations, Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs, May 1, 2013. Available: https://www.hhs.gov/guidance/document/additional-information-regarding-mandatory-payment-reductions-medicare-advantage-part-d-0.
8. Id.

However, CMS rules do not specify the terms of the prompt payment provision for in-network providers. Instead, CMS rules state that the provision must be "developed and agreed to by both the MA organization and the relevant provider" (See 42 C.F.R. § 422.520(b)(1)). In other words, this is a provision that can and should be negotiated by physician practices.

Practices sometimes erroneously believe they are protected by prompt payment under state law. In fact, several courts have ruled that MA program rules "preempt" or supersede state law in most areas. This means prompt payment timelines required under state law may not apply to the MA agreement. This issue is compounded by contract language that sometimes includes a generic statement that simply says the MA plan will "follow all laws applicable to prompt payment." Practices should carefully review the terms of their MA provider agreement and ensure the contractual terms expressly align with their expected payment timeline.

Finally, MA insurers usually do not start the prompt payment "clock" until they receive a clean claim—or a claim that meets all payer requirements for processing. The MA participation agreement (or related policies, manuals, etc.) should define what is meant by a clean claim. Providers should confirm that the definition of this term aligns with their expectations.

Utilization management

MA plans are required to cover all Medicare fee-for-service covered benefits. However, MA plans may impose utilization management procedures, including prior authorization processes, to ensure medical necessity, subject to federal rules.

In 2023 and 2024, CMS made several important changes. First, it mandated that MA plans' standards for medical necessity must not impose additional or different coverage criteria that differ from fully established Medicare fee-for-service program criteria. MA plans may still establish their own criteria in limited circumstances where traditional Medicare guidance is "not fully established" because it is flexible, unclear or absent, but even in these cases, MA plans must follow certain standards for communicating their coverage criteria.

CMS also clarified that payment reviews for medical necessity must be based on the medical judgement of a qualified provider. MA plans cannot rely on automated denials using algorithmic or artificial intelligence tools. Finally, prior authorization processes may only be used to confirm the presence of appropriate criteria to ensure the service is medically necessary, such as the presence of clinically relevant diagnoses. CMS also limited the use of prior authorization in certain situations, including for continuity of care (see 42 C.F.R § 42 C.F.R. 422.112(b)(8), which prohibits payment denial or disruption of care for prior authorization purposes for a period of 90 days following a beneficiary's transfer to a new MA plan) and emergency situations (see 42 C.F.R. § 422.113). Separately, CMS also finalized other rules designed to limit disruptions to patient care related to prior authorization, including a rule on prior authorization and interoperability that generally goes into effect in 2026 and 2027.

Importantly, these are legal requirements applicable to all MA plans. Physician practices should be wary of attempts to characterize MA plans' compliance with these rules as a negotiating concession. Physician practices should also carefully review any modified plan language related to medical necessity, utilization review and prior authorization to ensure it is consistent with their understanding of these new requirements. These provisions represent significant improvements in the clinical validity of MA prior authorization programs and protect continuity of patient care. Physicians play an important role in holding MA plans accountable for complying with these new requirements.

Supplemental benefits

MA plans are able to offer various supplemental benefits that go beyond those offered by the Medicare fee-for-service program.

These supplemental benefits represent costs to the plan. However, many providers do not consider them to be medical expenses. In the context of value-based models or sub-capitation, in which providers are responsible for controlling costs, the treatment of these supplemental benefit expenses can be an important consideration. In particular, practices should ensure any description of savings-based methodologies (such as shared savings, withholds, holdbacks or similar incentives) aligns with the practice's expectations.

Conclusion

MA managed care contracting has never been an easy process for physicians, who often face an uphill battle to negotiate fair terms with payers. In the past, this disadvantage led physicians to accept a MA plan's standard contract as long as the fee-for-service rates were acceptable.

This resource highlights how the shift towards value-based care in MA plans complicates the contracting process by introducing new, complex and rapidly changing reimbursement methodologies. Despite this, physicians would be well served to actively review and negotiate MA value-based arrangements to ensure the terms that are fair and clear and protect the physician's right to payment.