# Evaluating Medicare Advantage Value-Based Contracts

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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.

Since 2010, enrollment in MA has grown by 71%, to the point where now 1 of every 3 Medicare beneficiaries is enrolled in a MA plan.[1] In 2017, the Centers for Medicare & Medicaid Services ("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]

Physicians would be well served to prepare for this shift towards value-based reimbursement. Taking a more active role in 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 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.

1 Jacobsen, Gretchen, et. al, Henry J. Kaiser Family Foundation, *Medicare Advantage 2017 Spotlight: Enrollment Market Update* (June 6, 2017).

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.

## 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.

### 1. 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.[3] 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.

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 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.

### 2. 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."[4] Depending on their structure, value-based arrangements can

3 42 C.F.R. § 422.504(i).

4 42 C.F.R. § 422.208(a).

qualify as a PIP. MA plans are required by law to ensure any PIP in its network, even one operated entirely by its subcontractors, meets regulatory requirements. Contracts typically require, at a minimum, disclosure of any PIP arrangements to the MA plan.

**Typical Contract Language**

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 medical necessary Covered Services furnished to a Member. This requirement shall be contained in any subcontract of this Agreement between Provider and any other physician.

### 3. 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 non-compliance with CMS requirements.[5] 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 Contract Language**

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.

### 4. 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 ("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 Contract Language**

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 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.

5 42 C.F.R. § 422.503(b)(4)(vi).

## 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 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.

1. **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 Contract Language**

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 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.

### 2. 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 would require 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 Contract Language**

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.

### 3. 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 likely, however, to limit the MA plan's ability to unilaterally change the value-based methodology during the performance period.

**Preferred Contract Language**

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 payor, 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.

4. **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 Contract Language**

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 with in ninety (90) days of the effective date of termination of the Agreement.

5. **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").[6] CMS does not require that such cuts are passed on to providers. In fact, CMS has advised MA plans that how Sequestration affects provider reimbursement is governed by the terms of the contract between the MA plan and the provider.[7] 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 group 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 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.

# 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.

6 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.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/PaymentReductions.pdf.

7 *Id.*

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