Health Care Transformation Task Force

Enhancing Provider Experiences in Medicare Advantage Value-Based Models

In May 2025, the Center for Medicare & Medicaid Innovation (CMMI) announced a new strategy to Make America Healthy Again. The strategy discusses potential Medicare Advantage (MA) models that incorporate inferred risk scores, regional benchmarks, or changes to quality measures. The focus on MA makes sense, as MA plans have become a key driver of value-based care (VBC) in the U.S. health care system. MA plans have greater VBC adoption than any other line of business, particularly for population-based models. MA plans also have strong financial incentives to identify and prevent fraud, waste, and abuse. However, provider experiences in these models highlight opportunities for policymakers to enhance care delivery and health outcomes. This issue brief assesses MA investment in value-based arrangements, discusses provider experience in these models, and identifies opportunities for CMMI to promote best practices in this market.

MA Investments in Value

Medicare Advantage plans are actively deploying a range of value-based arrangements. Recent findings include:

- In a retrospective analysis covering 6.6 million person-years (2016–2019) across MA plans, patients served by fully accountable ("at-risk") **MA arrangements by the same physician groups had superior outcomes in 16 of 20 quality and efficiency measures compared with traditional Medicare patients.** These improvements included 20% fewer hospitalizations, 39% fewer 30-day readmissions, 19% fewer avoidable emergency department visits, and 23% lower use of high-risk medications.
- Serving over **350,000 Medicare beneficiaries** across 230 centers in 27 states, Oak Street's integrated care model emphasizes physical, behavioral, and social services to improve outcomes in underserved areas. The model achieved a 44% reduction in hospital admission rates compared to Medicare benchmarks.
- Aetna's value-based care (VBC) provider network includes over 1,200 groups and supports 2.4 million MA members, accounting for 59% of Aetna's MA spending. Providers in VBC arrangements outperform those under traditional fee-for-service on closing **MA care gaps,** delivering **proactive preventive care**, and providing **more holistic**, **coordinated patient management**. The providers in two-sided risk arrangements had the strongest quality performance, closely followed by those in upside-only arrangements.

Value-based arrangements are generally voluntary between MA plans and providers.

Provider Experiences in MA Value-Based Arrangements

HCTTF members participating in MA value-based arrangements note that contracts vary widely across plans and geographies. **Unlike the more standardized arrangements in programs such as ACO REACH and the Medicare Shared Savings Program (MSSP), providers must negotiate each element of an MA arrangement – which is a key pain point for many providers.** Several industry stakeholders developed a playbook of voluntary best practices for VBC arrangements related to patient attribution, benchmarking, risk adjustment, quality, financial risk, payment timing and accuracy, and incentives for participating practices.

Providers face two primary types of risk in these models:

1. **Insurance Risk:** Risk derived from changes in pricing and benefit design, which is largely outside provider control. Insurance risk is automatically excluded from CMS models like REACH and MSSP.
2. **Performance Risk:** Risk based on quality of care and outcomes, which is typically linked to provider performance on STAR measures under MA arrangements.

HCTTF members note that it is critical to negotiate with MA plans for contracts that are based on performance risk, which should limit or exclude insurance risk. This often constitutes a capitated payment for the elements of care delivery and quality that providers have greater ability to influence.

HCTTF Recommendations

HCTTF has developed recommendations for MA opportunities that align with CMMI's strategic pillars of promoting prevention, empowering patients, and driving choice and competition. We believe that supporting providers in MA arrangements will align incentives across lines of business, creating strong market incentives to engage patients, invest in preventive care, and drive competition based on provider quality.

CMMI has demonstrated an interest in mandatory models. HCTTF assesses our support for mandatory models on a case-by-case basis, in contrast to many stakeholders that advocate exclusively for voluntary models. However, because CMMI has operated a limited number of MA models, we recommend beginning with voluntary models that compare new and existing methodologies. Specifically, HCTTF recommends:

1. **Conduct "shadow tests" of new payment methodologies, including changes to risk adjustment, benchmarking, and quality measurement.** CMMI should concurrently test both existing and new methodologies (e.g., shadow test) for 3 years while holding providers harmless, to understand the impact of the changes on cost, quality, and patient outcomes. CMMI should publish the outcomes of these tests to promote transparency.
2. **Avoid mandating untested methodologies.** If CMMI applies new risk adjustments to mandatory models, this could inadvertently prompt payers to withdraw from certain geographic areas, reducing access to care. Similarly, provider groups may also exit partnerships in unprofitable markets, which would further create access issues for patients.
3. **Seek opportunities to incentivize the best practices in the playbook.** For example, CMS could incorporate best practices from the playbook into future models. CMS could also consider building modular contract templates that include best practices but still allow for some customization.

As MA continues to expand, it is essential to continue promoting MA value-based arrangements, while also improving provider experiences and patient outcomes under these programs. Policymakers, payers, providers, and patients have the opportunity to work together to streamline arrangements, refine risk adjustment, and promote sustainable value-based care delivery.