Beyond the value-based care label: A framework for risk and payer contracting

Fee-for-service remains embedded in most arrangements, even as shared savings, episodes and population-based payments expand. Groups need a disciplined way to decide which risk to accept, what data to demand and how to align operations.

By Chris Harrop

A decade ago, payer-contracting discussions often assumed a fairly direct transition: Fee-for-service (FFS) would recede, global payment would advance, and medical groups would reorganize around population health. The transition has been real but neither swift nor clean.

The latest national measurement (done in 2024) found that 44.9% of the healthcare payments captured in the study flowed through shared-savings, shared-risk, episode or population-based arrangements. Only 28.7% flowed through arrangements that included downside risk. Most payment innovations still combine methods — for example, FFS plus a care-management payment and shared savings — rather than replacing claims-based payment outright.[1]

That mixed-model reality pushed aside the question of "when will value-based care replace FFS?" and left executives to assess whether their organization can manage a portfolio of overlapping payment rules without taking on financial exposure it cannot measure, influence or finance.

The answer depends less on the contract's label than on its design.

THE MARKET'S UNEVEN SHIFTS

Alternative payment adoption differs substantially by line of business. Medicare Advantage has moved furthest into higher-accountability and downside-risk arrangements; commercial contracts remain more dependent on fee-for-service architecture.

Payers expect more movement: 70% of respondents to that national survey expected alternative payment activity to increase over the following 24 months, and 55% expected the greatest growth in shared-risk or procedure-based episode arrangements. At the same time,

TABLE 1. SHARE OF 2024 PAYMENTS IN HIGHER-ACCOUNTABILITY PAYMENT MODELS

Line of business	HCPLAN Categories 3–4: shared savings, shared risk, episodes or population-based payment	Categories 3B–4: includes downside risk	Practical implication
All lines	44.9%	28.7%	Hybrid revenue remains the norm.
Commercial	38.9%	19.4%	Rate adequacy and claims operations still matter greatly.
Medicare Advantage	60.0%	45.2%	Groups need stronger cost, attribution and risk-adjustment controls.
Medicaid	42.7%	20.6%	State and managed-care designs vary; operational terms need close review.
Original Medicare	44.4%	36.4%	ACO and episode strategies are increasingly consequential.

Source: AHIP's 2025 national Alternative Payment Model Measurement Effort, published in 2026 and reporting calendar-year 2024 payments. The study included 58 health plans, two fee-for-service Medicaid states and Original Medicare, representing 271 million covered people, or 87.5% of the insured market measured. Because participation was voluntary and coverage varied by line of business, the results should be treated as directional market data rather than a complete census.[1]

respondents identified provider willingness to accept risk, provider readiness and the ability to operationalize models as leading barriers.[1]

MGMA's own polling reflects that caution. In early 2025, only 40% of medical practice leaders reported a positive outlook for value-based care in their organizations, while another 40% were neutral.[2]

The hesitation is rational. In many markets, practices negotiate with payers that have substantial local leverage. The American Medical Association's 2025 competition analysis classified 97% of metropolitan commercial insurance markets as highly concentrated using current federal thresholds. A practice cannot manufacture negotiating power it does not have, but it can become much more selective and precise about the obligations it accepts.[3]

"VALUE-BASED" IS NOT A CONTRACT TERM

Two arrangements can both be called "shared savings" and have dramatically different economics.

One may attribute patients prospectively, provide monthly claims files, cap losses, exclude catastrophic cases, and use a benchmark that reflects current local cost trends. Another may identify the population after the year ends, provide data months late, include spending the group cannot influence, and rebase the benchmark in a way that makes repeat success progressively harder.

Before evaluating the potential bonus, leaders need to identify the machinery beneath it:

- How are patients attributed, and when does the group know who they are?
- Which services and sites of care are included in total cost?
- How are the benchmark, trend factor and future rebasing calculated?
- How are clinical and social risk differences adjusted?
- Which quality measures act as gates, and can clinicians influence them?
- What minimum savings or loss rate applies?
- Are there risk corridors, stop-loss protection or caps on aggregate loss?
- When will the group receive claims, encounter, pharmacy and authorization data?
- What happens when a payer changes a policy, measure specification or fee schedule midyear?
- Who owns the data, and who has audit rights at reconciliation?

These provisions often matter more than the headline percentage of shared savings.

The Medicare experience shows both the promise and the design sensitivity of accountable payment. In performance year 2024, Medicare Shared Savings Program (MSSP) ACOs earned $4.1 billion in shared savings while saving Medicare $2.5 billion. By 2026, 82.8% of MSSP ACOs were participating in tracks that meet federal criteria for Advanced Alternative Payment Models (APMs). CMS also updated the ACO REACH financial methodology in 2025, projecting that the changes would decrease net spending in 2026 without disrupting patient care. Accountable care does not succeed or fail in the abstract; the payment formula, benchmark and incentives determine the result.[4]

Expected value = Fee-for-service contribution margin
+ Fixed prospective payments
+ Expected incentives or shared savings
– Expected losses
– Incremental operating costs
– Cost of capital and risk

MATCH RISK TO CONTROL, DATA AND CAPITAL

The central discipline in payer contracting is to avoid accepting accountability that exceeds your practical authority.

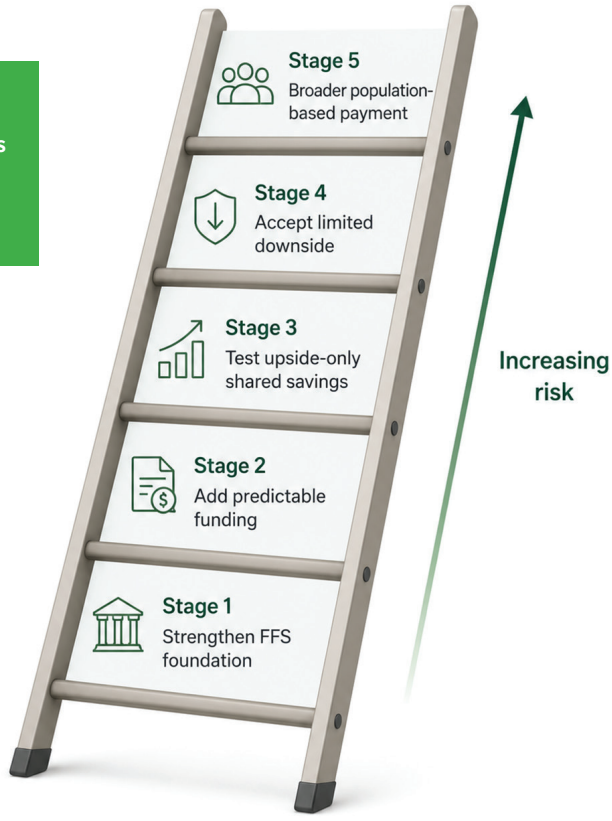
A primary care group may influence preventive care, chronic disease management, avoidable emergency department use, referral patterns and care transitions. It may have far less control over drug prices, out-of-network utilization, hospital contracting, patient benefit design or a specialist's treatment choices. A specialty group may be able to manage an episode tightly but have little ability to affect a patient's total annual cost of care.

Before taking risk, map each major spending category into three buckets:

1. **Directly controllable**: Services, workflows or referrals the group can change.
2. **Influenceable**: Costs the group can affect through care coordination, network relationships or patient engagement.
3. **Externally driven**: Costs the group cannot reasonably change within the contract period.

A contract should not treat all three as though they are equally manageable. Externally driven exposure calls for exclusions, risk adjustment, corridors, stop-loss protection or a narrower definition of accountability.

Capital also matters. A technically profitable contract can threaten cash flow if the group must hire care managers, purchase analytics, fund patient outreach, and wait until well after the performance year for reconciliation. Downside risk adds the possibility of a repayment and may require additional reserves or other financial protection. The organization should model not just expected revenue, but the timing and volatility of cash.



A LADDER, NOT A LEAP

Risk should increase only as capabilities become reliable. A medical group can use a staged approach.

Stage 1. Strengthen the FFS foundation

Validate fee schedules, coding, modifier rules, payment policies, timely filing, prior authorization, denials, prompt payment and escalation clauses. FFS is still the operating base of many higher-accountability arrangements, so weak revenue-cycle performance will undermine value-based results as well.

That discipline matters when operating costs are rising. The majority of groups have reported higher year-to-date operating costs in recent years. A practice cannot indefinitely subsidize new care-management and analytical capabilities from a deteriorating base-payment margin.[5]

Stage 2. Add predictable funding and limited performance incentives

Care-management fees, infrastructure payments and prospective primary care payments can fund team-based care before the organization assumes material loss exposure.

CMS' ACO Primary Care Flex model illustrates this direction. It combines Medicare Shared Savings Program participation with a flexible prospective monthly primary care payment intended to support access, care coordination and new delivery approaches. The model began in 2025 and runs through 2029.[6]

Stage 3. Test upside-only shared savings
Use the period to validate attribution, payer data, utilization opportunities, quality workflows and internal reporting. Treat any bonus as contingent revenue, not as funding for permanent overhead.

Stage 4. Accept limited downside in a defined population or episode
Require a credible benchmark, explicit loss limits, timely data and enough covered lives or episodes to reduce random variation. Consider stop-loss protection and exclusions for costs the group cannot influence.

Stage 5. Consider broader population-based payment only with mature infrastructure
The organization needs actuarial and financial modeling, reserves, clinician alignment, care-management capacity, network management, data integration and governance that can act quickly when performance deteriorates.

Independent and smaller practices do not need to own an integrated delivery system to participate. They may join an ACO, clinically integrated network, independent practice association or another contracting entity. But the intermediary becomes another contract to examine. Practices should understand participation fees, data rights, governance, attribution, shared-savings distribution, reserve requirements, exit terms and whether the entity can change performance rules without participant approval.

TREAT DATA AND ADMINISTRATIVE PROVISIONS IN ECONOMIC TERMS

A reimbursement increase can disappear under the cost of denials, prior authorization, portal work, delayed data and manual reconciliation, all of which are part of the effective rate, not incidental to it.

Most practices report their staff using at least seven payer portals each week.[7] In an AMA survey of 1,000 physicians, respondents reported an average of 39 prior authorization requests per physician each week and 13 physician-and-staff hours spent on those requests. Even when a practice is not bearing total-cost risk, administrative friction changes staffing needs, access and contribution margin.[8]

Federal rules are beginning to change the baseline. Starting in 2026, impacted payers generally must provide specific reasons for denied prior authorization decisions for covered medical items and services, meet defined decision timeframes and publicly report certain authorization metrics. The rule does not cover drug authorizations. Beginning in 2027, impacted payers generally must implement standards-based interfaces for provider access, payer-to-payer exchange and prior authorization.[9]

Medical groups can use this changing environment to negotiate clearer contract provisions now:

- Exact turnaround times for urgent and standard authorization requests
- A specific denial reason and required documentation for resubmission
- Continuity protections when a patient changes coverage or an authorization is active
- Gold-card or exemption criteria for consistently approved services
- Limits on retroactive medical-policy and coding changes
- A defined cadence and format for attribution, claims, encounter, pharmacy and quality files
- Reconciliation detail sufficient to reproduce the payer's calculation
- Audit, dispute and escalation rights
- Financial remedies for persistent noncompliance when legally permissible

Data must also arrive early enough to change care. A claims file received after the performance year is only useful for accounting, not management. For population-based contracts, leaders should seek regular attribution rosters, near-current utilization feeds, inpatient and emergency notifications, pharmacy

TABLE 2. 8 TESTS BEFORE SIGNING OR RENEWING A RISK-BASED CONTRACT

Test	Questions for the medical group	Minimum protection to seek
1. Population	Can we identify attributed patients before intervention is needed?	Prospective or frequently refreshed attribution; transparent turnover rules
2. Scope	Are we accountable only for services we can control or influence?	Defined inclusions, exclusions and outlier treatment
3. Benchmark	Can we reproduce the target and understand rebasing?	Written methodology, trend factors and access to source data
4. Risk adjustment	Does the method reflect clinical complexity without encouraging inappropriate coding?	Model specifications, audit rules and a correction process
5. Quality	Are measures limited, stable and actionable?	Clear specifications, performance period and cure process
6. Data	Will information arrive in time to manage care and validate payment?	File cadence, format, completeness standards and audit rights
7. Financial exposure	Can the group absorb the downside and investment cost?	Risk corridor, loss cap, stop-loss and predictable payment timing
8. Governance	Can rules change unilaterally, and how are disputes resolved?	Change-control, notice, appeal, escalation and termination rights

information, risk-gap files and clear quality-measure specifications.

The practice also needs one internal source of truth. Conflicting payer portals and dashboards should be normalized into a limited set of operational priorities.

Market-rate data deserve similar attention. Federal Transparency in Coverage (TiC) files give practices access to public negotiated-rate information, but polling as recent as December 2025 found that only 18% of medical groups were using those data in payer negotiations. The files are difficult to normalize, but they can help a group test payer claims, define rate targets and identify codes where reimbursement is furthest from the local market.[10]

ALIGN CLINICIANS WITHOUT REPRODUCING CONTRACT COMPLEXITY

The payer contract, medical group budget, and clinician compensation plan cannot point in opposite directions. But alignment does not require passing every payer metric directly into an individual compensation formula.

Clinicians should be accountable for a small number of measures they can understand and influence. Measures can include access, evidence-based care, documentation accuracy, patient follow-up, referral management, care-team participation and selected outcomes. Total-cost performance may be more appropriate at the group, site or service-line level, where random variation and shared operational responsibility can be pooled.

Leaders should explain four things before the performance year begins:

1. Which patients and services are in scope?
2. Which behaviors are expected to change?
3. How will performance be measured and reported?
4. How will success or loss affect resources and compensation?

A large year-end incentive tied to an opaque total-cost calculation is unlikely to guide daily decisions. A visible monthly scorecard, clear workflows and timely coaching are more useful. The compensation formula should also protect clinical judgment and avoid creating incentives to withhold necessary care.

A "no" on one test does not automatically end a negotiation. It identifies the price, protection, or operational change needed to make the arrangement workable. Several unresolved "no" answers are a warning that the contract is transferring uncertainty rather than purchasing better care.

MANAGE THE PORTFOLIO, NOT JUST EACH CONTRACT

Even a well-designed contract can fail when it collides with the rest of the payer portfolio. One payer may reward keeping care in network, another may require a different preferred network and a third may measure a conflicting set of quality priorities. A medical group cannot redesign the same workflow differently for every payer.

Leaders should create a cross-payer contract matrix that shows:

- Payment architecture
- Attributed lives
- Base reimbursement and fixed payments

- Revenue at risk
- Maximum downside exposure
- Quality measures
- Reporting and reconciliation calendar
- Data-delivery requirements
- Operational owner
- Renewal and termination dates

The group can then identify the common clinical and operational denominator: the few capabilities that improve performance across contracts. Examples include access, accurate documentation, medication management, care transitions, referral closure and chronic disease outreach.

The group also needs a risk limit. The board or governing body should know the maximum aggregate downside exposure, the portion secured by reserves or stop-loss coverage, and the concentration of risk by payer and line of business. A series of individually tolerable contracts can create an intolerable combined exposure.

GOING HYBRID WITH DISCIPLINE

The evidence points toward a layered payment system: claims-based reimbursement combined with prospective primary care funding, care-management payments, quality gates, shared savings, selected episodes and increasing downside risk. The market is moving through hybrids rather than a single replacement model.[1]

There is opportunity for groups that can translate contract language into an operating model, but it also creates danger for groups that treat "value-based" revenue as a bonus disconnected from staffing, data, clinician compensation and capital planning.

The hallmarks that you have a strong contract include:

- The group knows who its attributed patients are.
- The financial target can be reproduced and independently checked.
- Data arrive in time to change care, not just to reconcile it.
- The clinical work being asked of the team is realistic.
- The upside covers the capabilities the contract requires.
- The downside stays proportionate to what the group actually controls.

Medical groups should take on risk deliberately rather than as a gesture. Where risk, authority, information and resources line up, alternative payment can support better care and a more durable practice. Where they do not, the contract simply moves the payer's uncertainty onto the provider. ■

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NOTES

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