Editor's Note

HEALTH CARE POLICY AND LAW

Full Risk Yet Little Reward?—When Clinicians Take On Risk-Based Contracts in Medicare Advantage

Ishani Ganguli, MD, MPH

Value-based payment models are one of those rare ideas in health care policy that enjoy bipartisan support. The concept is appealing: clinicians are held responsible for total spending and quality targets for patients, enabling them to make care decisions that prioritize health outcomes over service volume. Studies on accountable care organizations (ACOs), the earliest versions of such models that started in traditional Medicare through the Affordable Care Act, have shown some evidence of savings with time, with success dependent on factors like whether the ACOs are physician (vs hospital) led or their proportion of primary care physicians.[1,2]

Related article

Enter Medicare Advantage (MA), the increasingly popular alternative to traditional Medicare in which the federal government outsources plan administration (including provider networks and utilization review, which are unique to MA) to private insurers. Increasingly, these insurers pass on the full financial risk of MA plans to clinicians. Yet we know surprisingly little about what does and does not work in these value-based MA arrangements.

In this issue of *JAMA Internal Medicine*, Schwartz et al[3] used 2015 to 2021 data and a difference-in-differences approach to compare overall and low-value care use by patients in Humana's MA plans who were in provider organizations that either voluntarily transitioned to risk-based MA provider contracts (upside only, meaning financial bonuses but no penalties, or 2-sided risk, meaning both) vs stayed with the same contracts. The upshot? Across 35 outcomes, there were few differences in care use, most of which disappeared after accounting for trends that preceded the contract changes.

Why were there no consistent effects? To answer this, it helps to take the perspective of the clinicians entering these arrangements. Provider organizations signing on to these contracts might attempt to succeed in them by hiring value-minded physicians, setting up technology (eg, electronic health record clinical decision support, telemedicine), and creating programs and workflows (eg, hypertension management registries, specialist electronic consultations) meant to improve population health and curb spending.[4,5] These efforts require time, money, and having a large enough share of patients in value-based models for them to make financial sense. Clinicians in the organization (who would likely prefer to be payer agnostic) must know which of their patients are eligible for which programs based on their insurance plans. While these contracts dictate how and how much payers pay health systems and other provider organizations for enrolled MA members, it also matters how the organizations choose to distribute that money to employed clinicians. For instance, considering that primary care physicians are central to the success of value-based payment, do the organizations provide bonuses and/or pay them a certain amount per empaneled patient to afford them the flexibility and time to provide nonbillable yet valuable services, like care coordination and asynchronous secure messaging, or do they stick to traditional visit productivity-based models that are often counterproductive to value-based payment goals?

For low-value services specifically (like cancer screenings for adults older than certain ages), while such care is bad for spending and quality, many provider groups may not see low-value care reduction as a financial priority,[6] and it is hard for health systems to intervene when much of this low-value care is delivered outside of their walls.[7] Any potential benefits from these contracts would have to be large enough to be noticeable beyond the effects that the utilization management approaches of some MA plans have already had on reducing low-value care.[8,9] For other outcomes the researchers examined, like outpatient visits and testing, the "right" amount of utilization change is unclear. Finally, while Schwartz et al[3] compared 1-sided vs 2-sided risk, there is substantial heterogeneity within these plan types, which requires unpacking. There may also be heterogeneity in how different provider groups or different clinicians respond to these contracts. For example, we have found that under MA, women who are primary care physicians tended to perform better on quality metrics and on reduction of emergency department visits and hospitalizations than their counterparts who are men, with a commensurate reversal of the gender wage gap.[10]

In summary, Schwartz et al[3] provide valuable evidence that full risk sharing with provider organizations in MA is not yet showing signs of consistent benefit. The idea of passing on risk may still be a good one, but only more time (and, importantly, a closer look at the messy details) will tell.

Author Affiliations: Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts; Associate Editor, *JAMA Internal Medicine*.

Corresponding Author: Ishani Ganguli, MD, MPH, Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital, 1620 Tremont St, 3rd Floor, Boston, MA 02120 (iganguli@bwh.harvard.edu).

Published Online: November 10, 2025. doi:10.1001/jamainternmed.2025.5924

Conflict of Interest Disclosures: None reported.

1. McWilliams JM, Hatfield LA, Landon BE, Hamed P, Chernew ME. Medicare spending after 3 years of the Medicare shared savings program. *N Engl J Med*.

2018;379(12):1139-1149. doi:10.1056/NEJMsa1803388

2. Bond AM, Civelek Y, Schpero WL, et al. Long-term spending of accountable care organizations in the Medicare shared savings program. *JAMA*. 2025;333(21):1897-1905. doi:10.1001/jama.2025.3870

3. Schwartz AL, Kim S, Chhatre S, et al. Changes in health care utilization and low-value service use after risk-based contract adoption in Medicare Advantage. *JAMA Intern Med*. Published online November 10, 2025. doi:10.1001/jamainternmed.2025.5917

4. Ganguli I, Ferris TG. Accountable care at the frontlines of a health system: bridging aspiration and reality. *JAMA*. 2018;319(7):655-656. doi:10.1001/jama.2017.18995

5. Ganguli I, Morden NE, Yang CWW, Crawford M, Colla CH. Low-value care at the actionable level of individual health systems. *JAMA Intern Med*. 2021;181(11):1490-1500. doi:10.1001/jamainternmed.2021.5531

6. Haverkamp MH, Peiris D, Mainor AJ, et al. ACOs with risk-bearing experience are likely taking steps to reduce low-value medical services. *Am J Manag Care*. 2018;24(7):e216-e221.

7. Ganguli I, Crawford ML, Usadi B, et al. Who's accountable? low-value care received by Medicare beneficiaries outside of their attributed health systems. *Health Aff (Millwood)*. 2023;42(8):1128-1139. doi:10.1377/hlthaff.2022.01319

8. Beckman AL, Frakt AB, Duggan C, et al. Evaluation of potentially avoidable acute care utilization among patients insured by Medicare Advantage vs traditional Medicare. *JAMA Health Forum*. 2023;4(2):e225530. doi:10.1001/jamahealthforum.2022.5530

9. Duggan C, Beckman AL, Ganguli I, et al. Evaluation of low-value services across major Medicare Advantage insurers and traditional Medicare. *JAMA Netw Open*. 2024;7(11):e2442633. doi:10.1001/jamanetworkopen.2024.42633

10. Ganguli I, Daley NE, Polt L, DiGennaro V, Kornitzer B. Gender differences in primary care physician earnings and outcomes under Medicare Advantage value-based payment. *JAMA Health Forum*. 2025;6(5):e252001. doi:10.1001/jamahealthforum.2025.2001