The Medicare Advantage (MA) program is growing rapidly, now enrolling more than 44% of all Medicare beneficiaries, with that number expected to surpass 50% in the next several years. This growth has occurred during the same period as expansions of value-based alternative payment models in traditional Medicare (TM), such as Accountable Care Organizations (ACOs), most commonly under the Medicare Shared Savings Program (MSSP). With the growth of these different models of payment and care delivery, it is imperative to better understand how these programs compare with one another. The study by Parikh and colleagues begins to address these questions.

In this observational study, the authors use detailed clinical and spending data from a single health care system in the southern United States to compare spending patterns between MA enrollees and MSSP-assigned beneficiaries. They identified 4 primary disease cohorts (hypertension, diabetes, congestive heart failure, and chronic kidney disease) and used propensity score matching to compare between the 2 programs. Importantly, the propensity scores the authors used included detailed clinical information that would not typically be available in claims and also adjusted for other potential differences using zip code and primary care physician fixed effects. Using these adjustments and a generalized estimating equation approach, they found that across all 4 disease categories, MSSP enrollees were associated with substantially higher spending ($2159 for diabetes, $4074 for CHF, $2560 for CKD, and $2335 for hypertension). While it is important to note that these findings only represent the experience of a single health care system and may not be generalizable to all settings nationally and that there is opportunity for unmeasured selection to affect these findings, the results are striking in light of the robust clinical controls included. This study adds to a small but growing body of literature that the care management practices of MA plans might be stronger than that of ACOs.

What might lead to these stark differences even after accounting for a robust set of clinical controls? First, as the authors note, there still may be important differences in socioeconomic factors between the MA and MSSP enrollees even after controlling for zip-code fixed effects. If MSSP enrollees have disproportionately more complex care needs, these findings could be consistent with those differences. MA plans in general also may have many more levers to pull that could control costs than would be available in the MSSP. MA plans can limit their enrollees to a limited set of potentially lower cost clinicians and facilities and also have the flexibility to enforce greater control over the care received through the use of prior authorization requirements. An ACO typically does not have as much control over what care their patients receive and where they receive that care, putting similar models at a disadvantage when trying to control spending relative to MA plans.

Another key feature of this study is that the comparison MA plan is not a stand-alone plan, but one that is affiliated with the studied health system. There is a growing trend toward vertical integration between plans and health care systems in the MA program with health systems either creating their own plans or partnering with insurers to offer exclusive insurance products. Prior work has found that these vertically aligned plans differ in terms of their overall quality and the outcomes that they deliver for enrollees. The MA plan that the authors evaluate is one such aligned plan, which may further explain the differences in spending. Under vertical alignment, health systems receive a fully capitated payment to care for their MA enrollees, which may provide an even stronger
incentive to reduce spending for their MA enrollees. If a health system performs well in reducing spending, they may stand to profit more than they could under the shared savings in MSSP alone.

Given the findings of this study, if other health systems are able to better control costs or successfully select for lower cost patients under an MA model than under an ACO model, then integrating with MA plans may be a more attractive option. There is currently a lack of evidence as to the effects of vertical alignment of MA plans and health care systems on patient outcomes, so the welfare implications of such a shift are currently unknown. The authors propose that to counteract the imbalanced financial incentives between MA plans and ACOs, ACOs can be provided more generous financial targets and social needs can be adjusted for. The new ACO REACH model will also give health care systems the opportunity to receive fully capitated global payments, which may help to better align the incentives to that of MA plans. However, as long as MA plans still have a wider variety of cost controlling levers, imbalances will be likely to continue. With MA penetration on the precipice of becoming the dominant payer in Medicare, further elucidating the different incentives of MA plans, ACOs, and health systems in general will be imperative.