

Capitation payment of ACO REACH plans will sabotage “Realizing Equity, Access, and Community Health.”

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ACO REACH (Realizing Equity, Access, and Community Health) is the latest effort by Centers for Medicare and Medicaid Services (CMS) to “move away from fee-for-service” and toward “value-based payment,” shifting insurance risk onto doctors and hospitals with an eventual goal of pre-payment with capitation.¹ Capitation means paying on a per-capita (per-person, per enrollee, per assignee) basis, so it requires defined members. It is attractive to payers such as CMS because it pre-pays for care of a defined population, enabling a set budget without the inconvenience of variability in cost of claims year-to-year with fee-for-service. Pre-payment via capitation was also intended to be a form of budgeting for cost control, despite its recent history in Medicare Advantage of substantially increasing costs compared with traditional fee-for-service Medicare.²

All capitated entities accept insurance risk, covering the unpredictable year-to-year variation in healthcare cost. This includes all health insurance plans, Health Maintenance Organizations (HMOs), Accountable Care Organizations (ACOs), Direct Contracting Entities (DCEs), and ACO REACH plans. Some of these, including DCEs and ACO REACH plans in particular, in turn shift insurance risk onto direct providers of care: doctors and hospitals, and especially primary care doctors. Along with risk, capitation also means the opportunity to profit from paying for or delivering less care.

A major problem with capitation is that the smaller the capitated entity, the more vulnerable it is to financial devastation by unexpected high-cost cases, and with smaller size the advantages of risk pooling are diminished. Risk can be buffered with insurance reserves and reinsurance, or shared with a larger entity via risk corridors, especially for smaller capitated entities such as primary care practices.

Another major problem is large variation in cost of care within a population. Unadjusted capitation based on average cost would grossly overpay for the healthy and even more grossly under-pay for the sick. Capitation therefore requires risk adjustment and quality incentives to mitigate its inherent incentives to worsen disparities in care. Risk adjustment and quality incentives in turn require detailed data on diagnoses and treatment, adding administrative costs and burdens that exceed those required by fee-for-service (FFS).

This push toward capitation is justified by the common assertion that FFS incentivizes excessive “volume” (over-use) of care and that this can be corrected by shifting insurance risk onto providers of care. However, the four key assumptions – that there is widespread overuse of care due to FFS, that capitation carries improved incentives compared to FFS, that risk adjustment can be done accurately, and that the overhead cost of capitation is worth it to achieve more cost-sensitive care – are all contradicted by the evidence. There is very little evidence for the claim that “volume” of services with FFS payment, as opposed to their price, explains the high

cost of health care in the US.^{3,4,5} It appears demonization of FFS in health policy is mainly a rationale promoted by the insurance industry to justify a central role for themselves in health care, because unlike FFS, capitation requires their capacity to handle the data demands of risk management. But the overhead required for capitation far exceeds savings from the incentive to reduce care, so patients get less care, Medicare pays more, and intermediary insurers take home large profits.

Problems with risk adjustment:

Beneficiaries are enrolled or assigned to capitated plans as individuals and risk adjustment is applied to individuals, but risk adjustment is based on demographic and diagnostic *categories*.⁶ The most accurate way to predict future risk would be to base it on prior year healthcare spending for each individual, but use of prior year spending as a risk adjuster would completely defeat the goal of using capitation as a cost control strategy, since the more that was spent on care in one year the higher the capitation payment would be the following year. Any other method of attempting to capture all the variables needed to approximate future risk at the individual level without using prior year cost would be impossibly complex and expensive.

Difficulties with individual-level risk adjustment have necessitated use of a category-based risk adjuster. Reasonable accuracy at predicting cost for an individual requires that categories be closely related to healthcare cost and have little variability in cost within each category. Demographic categories were tried first, but they include far too much variability and could predict only 1% of the variability in cost. Diagnostic categories (Hierarchical Condition Categories, or HCC) were added by CMS in 2004 to improve accuracy of risk adjustment for Medicare Advantage, but there is still large variability in cost of care within almost all diagnostic categories. Risk adjustment based on diagnostic categories correlates poorly with individual risk and remains demonstrably vulnerable to substantial gaming through diagnostic upcoding and risk selection.

To quote from a 2012 MedPAC report to Congress, “. . .we examined FFS beneficiaries who were grouped into the HCC for congestive heart failure (CHF) in 2008 and had no other HCCs. In 2008, the beneficiary at the 95th percentile of costliness had more than \$37,000 in Medicare spending, while the beneficiary at the 5th percentile had \$115 in Medicare spending.”⁶ And a 2014 report to Congress on problems with risk adjustment found the HCC accurately predicted the *average* cost of care for each of 9 common diagnostic categories, yet overpaid for the least costly quintile of beneficiaries by 62% and underpaid for the costliest 5% by 18-29%.⁷

Multiple attempts to improve the accuracy of the HCC by adding more detailed diagnostic categories or social determinant categories have failed to improve on these results.^{6,7} This means even after risk adjustment, there remains a strong financial incentive to avoid covering or caring for sicker and socially disadvantaged individuals and to selectively enroll healthier and more advantaged individuals, regardless of diagnosis. The inability of risk adjustment to correct this means any entity paid with risk-adjusted capitation still has a strong incentive to worsen disparities in care.

Risk adjustment of capitation is a “damned if you do, damned if you don’t” proposition. Without it, the incentive to worsen disparities is severe; with risk adjustment based on prior year health spending the incentive to maximize “volume” of care is worse than with FFS; and risk adjustment based on diagnostic categories cannot predict individual risk well enough to correct the incentive to worsen disparities.

Gaming of risk pools by Medicare Advantage Plans

Gaming of risk pools means capturing a population of members or beneficiaries (risk pool) with lower-than-average health risk while getting paid for an average risk pool, so as to profit from the difference. MA plans use marketing tactics² (including variations in coverage and contracting with employers to directly enroll newly Medicare eligible retirees) that attract healthier beneficiaries, and they employ multiple tactics to deny care to the sick, including narrow networks, formulary restrictions, and prior authorization. Sicker enrollees, such as in the last year of life, who have been frustrated by denial or delay of services tend to disenroll and return to the traditional Medicare program.⁸ The effect of both marketing tactics (“cherry-picking”) and disenrollment of sicker beneficiaries (“lemon-dropping”) is to create for Medicare Advantage plans a healthier and less costly than average risk pool.^{9,10}

Up-coding

CMS added diagnostic categories to the HCC risk adjustment formula in 2004. This improved its predictive accuracy from 1% to only 12%,⁷ but linked diagnosis to payment and introduced a major new opportunity for gaming: up-coding. Up-coding means choosing more specific or severe (and more highly paid) diagnosis codes than would be required for purely patient care purposes, and fraudulently adding irrelevant or non-existent diagnoses. Up-coding has been extensively exploited by Medicare Advantage plans since soon after diagnoses were added to the HCC, apparently often to the point of fraud^{11,12}. According to one expert estimate, the cost to Medicare of aggressive diagnostic coding by Medicare Advantage plans and the failure of CMS to correct for it will reach several hundred billion dollars in coming years.¹³

ACOs, DCEs, and ACO REACH plans

Accountable Care Organizations (ACOs), Direct Contracting Entities (DCEs), and ACO REACH plans (Realizing Equity, Access, and Community Health) were introduced within Traditional Medicare since 2012 and are paid by Medicare with capitation. Earlier versions of ACOs used shared savings and pay-for-performance bonuses, but Medicare still paid for direct care with fee-for-service. DCEs and ACO REACH plans may also pay providers for direct care with full or partial capitation. With DCEs and REACH, expanded use of capitation invites ownership and investment by private equity investors and for-profit insurance companies, who will expect return on their investment. Increasing ownership of physician practices by for-profit corporations has also accelerated involvement of profiteers in DCE and ACO REACH plans.

Unlike Medicare Advantage plans, with ACOs, DCEs, and ACO REACH plans individuals do not choose to be members in the plan but are attributed or “aligned” according to which primary care doctor they saw most often over a 2-year “lookback” period, or by the individual filling out

a form to designate a particular practitioner as their primary care provider. “Alignment” enables Centers for Medicare and Medicaid Services to pay the plan with capitation (per-member), as with Medicare Advantage, but “aligned” members are still free to see any Medicare participating doctor, as with traditional Medicare. ACOs, DCEs, and REACH plans are within Traditional Medicare and are expected to follow Medicare policies on covered benefits and medical necessity.

Some of the capitation payment flowing to these plans goes to administration and profit. With ACO REACH, one hundred percent of the first 25% in savings stay with the contractor (not to CMS), who may share those savings with providers. The patient care part of their budgets goes to *participating* primary care practices as payment in full, and to *preferred* non-primary care specialists and institutional providers with varying degrees of partial payment. Medicare reduces FFS fees in proportion to the degree of payment via the ACO, putting pressure on doctors to earn the reduction back from their share of the ACO’s capitated budget. Payment to providers via the ACO includes shared savings and bonuses and penalties tied to utilization, quality metrics, and cost of care.¹⁴ Thus, doctors have “skin in the game” – if they reduce care, they stand to profit personally.

Since DCE and ACO REACH plans don’t process Medicare FFS claims, they can’t use prior authorizations or denial of payment to restrict care. They also cannot prevent self-referral to any qualified Medicare provider. And since they don’t enroll subscribers, they can’t use marketing as a cherry-picking tactic.

How REACH ACOs game risk pools, upcode, and skimp on care

However, REACH ACOs do control physician payment and incentives. They can accomplish the same kind of risk pool gaming as with Medicare Advantage by using annual “wellness” visits to capture more healthy people in their “aligned” beneficiary pool, and they can use financial incentives to encourage their doctors and institutional providers to restrict care and avoid referrals. The incentives inherent in capitated payment encourage doctors to avoid high-risk/high-cost patients and populations.

The addition of investor money enables DCE and REACH plans to offer higher pay to primary care doctors up front to induce them to join, while glossing over the strategies they intend to use to extract return on investment down the road. ACO REACH plans can withhold bonuses from doctors whose patients self-refer to non-participating ACO specialists or emergency rooms too often, or they can drop such doctors from the plan to improve the ACO’s risk pool.¹⁵ They can use financial incentives to push doctors and hospitals to up-code diagnoses as much as possible. These perverse incentives are magnified by for-profit investors expecting return on investment. In other words, they can use financial carrots and sticks to induce doctors to serve corporate financial goals, even when they conflict with the best interests of their patients.

Doctors evicted from ACO plans because they don’t adequately cater to corporate goals are forced back to fee-for-service Traditional Medicare, where they are subject to the onerous data reporting and staffing requirements imposed by the MACRA law and MIPS¹⁶, with escalating fee reductions for failure to comply. This is a strong incentive for primary care practices to submit to the corporate pressures of ACOs and ACO REACH plans.

There is already evidence that ACOs have engaged in risk pool gaming (cherry picking and lemon dropping).^{17,18} And skilled nursing facilities participating in ACO plans have been shown to arbitrarily deny or refuse care more often compared to before they joined the ACO¹⁹.

Although the acronym REACH stands for “Realizing Equity, Access, and Community Health,” payment via capitation undermines the goals suggested by the acronym. CMS apparently believes these problems can be corrected with risk adjustment (which we know is gamed in practice), restrictions on up-coding, and incentives added on to encourage serving underserved populations and to discourage cherry picking and lemon dropping of patients. CMS believes these counter-measures or “guardrails” will assure “equity.”

Medicare Advantage plans have achieved profitability largely by gaming their risk pools, up-coding, and blunt restrictions on care, and minimally if at all by improving care.^{20,21} ACO REACH plans will use somewhat different gaming strategies than MA plans, but they are highly motivated to achieve the same goals, encouraged by the impressive profits realized by MA plans and the ability to keep all of the first 25% in savings, and much beyond that. Indeed, the Financial FAQs for contractors indicate that annual diagnostic upcoding of 3% is permitted.²²

Conclusion

Payment with capitation requires much higher administrative cost for both payer and provider compared to FFS in Traditional Medicare. Typical administrative costs for Medicare Advantage and Medicaid Managed Care Organizations, including profits, have been in the 15-20% range, compared to 2% for Traditional Medicare.^{23,24} Thus, it does not appear possible for ACO REACH plans to achieve profitability and also save money for taxpayers purely by improving care without gaming, and the numbers don't add up for the scheme to work the way CMS imagines it should. As far as we can see, either 1) ACOs will find workarounds to game the CMS “guardrails” and continue to cheat to achieve profitability (as Medicare Advantage plans have done), or 2) The “guardrails” will work well enough so that ACOs will be unable to cheat enough to be profitable and they will drop out of the program. Neither of these outcomes will reduce health inequities or improve access or community health.

All capitated entities, whether they are commercial insurance plans, Medicaid managed care plans, Medicare Advantage plans, ACOs or ACO REACH plans, or doctors and hospitals, will have incentives to restrict care, cherry pick and lemon drop to improve their risk pools, and upcode to game risk adjustment. Involvement of for-profit investors greatly amplifies these perverse incentives. Patients will be deprived of care, shareholders and executives will profit, and taxpayers will subsidize the entire sad charade. This is true even with risk adjustment (which is always inaccurate in practice) and “guardrails,” because they cannot neutralize the incentives inherent to capitation to worsen economic and health disparities for the community as a whole.

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