

Capitation payment worsens disparities

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“A remarkable consensus has developed that the fee-for-service approach for paying medical providers must be replaced. This payment approach is said to increase the volume of services....” That is how one health policy economist described the view widely held among US policy-makers that the root cause of health care inflation is the fee-for-service method of paying doctors.¹

There is very little evidence for the claim that “volume of services,” as opposed to their price, explains the high cost of health care in the US, and virtually no evidence for the claim that what little documented overuse exists is caused by fee-for-service (FFS) payment.² Moreover, there are several reasons to oppose the widespread use of “capitation” payment, the method preferred by those who subscribe to the belief that overuse of medical services is rampant and FFS payment is the cause. In this article I discuss perhaps the most important reason: Capitation worsens disparities between races, income groups, and the sick and the healthy.

“Capitation” means paying on a per-capita (per-person, per enrollee, per assignee) basis. Premiums paid by a subscriber or employer are other forms of per-person payment. All per-head payments carry built-in incentives to worsen disparities between races, income groups, and the sick and the healthy. This is true regardless of the label used, and regardless of the recipient of the payment. The recipient can be an individual doctor or clinic, a group of hospitals and clinics, or an insurance company.

Inaccurate risk adjustment of capitation payments worsens disparities

The reason capitation and all other per-person payments worsen disparities is three-fold:

* Unlike fee-for-service, which pays for services *after* they are rendered, capitation payments are paid *before* services are rendered, which requires accurate prediction of what enrollees within a given risk pool (say, all Medicare beneficiaries who signed up with Humana for 2021) should cost over a future time period, typically a year;

* health care spending is heavily skewed (the sickest among us are far more expensive than the healthiest); and

* our ability to “risk adjust” capitation payments (to pay more for the sick and less for the healthy) is extremely crude, which means recipients of capitation payments with risk adjustment are still almost always underpaid for sicker enrollees (who are more likely to have low incomes and to be from minority populations) and overpaid for healthier and more socially advantaged enrollees. This creates a strong financial incentive to avoid covering or caring for sicker and socially disadvantaged individuals and to selectively enroll healthier and more advantaged individuals.

Medicare Advantage plans market and offer perks to healthy seniors and impose narrow networks, formulary restrictions, and prior authorization policies that make care of sicker, more complex patients frustrating, enabling them to effectively “cherry pick” and “lemon drop” to secure a healthier and less costly risk pool than the average³. Accountable Care Organizations and Direct Contracting Entities do not have subscribers and are not chosen by members, but their members are “aligned” according to which doctors they see most often. However, they can accomplish the same kind of risk pool gaming by managing their physician network to exclude doctors treating sicker and more disadvantaged patients and populations. In both cases, the incentive is to worsen disparities for the population as a whole.

Why can't risk adjustment correct for the incentive to worsen disparities?

The Centers for Medicare and Medicaid Services (CMS)-uses the Hierarchical Condition Categories (HCC) adjuster to adjust capitation payments to Medicare Advantage plans and “direct contracting entities” (DCEs) participating in the new “Global and Professional Direct Contracting” demonstration or its new iteration, “REACH” (Realizing Equity, Access and Community Health), as well as shared savings payments to “accountable care organizations” (ACOs). The HCC was selected by CMS among a half-dozen other proposed models two decades ago, and is probably the most studied risk-adjuster in the world.

Factors affecting future cost are extremely complex and difficult to capture, so the HCC bases risk adjustment on categories, either demographic or diagnostic. However, individuals sign up with or are assigned to plans as individuals, not categories, and there is large variability in cost and complexity of care within almost all categories. The HCC is therefore grossly inaccurate at predicting future costs for individuals. According to a 2014 Medicare Payment Advisory Commission (MedPAC) report to Congress, the HCC overpays for the healthiest quintile of Medicare beneficiaries by 62 percent and underpays for the sickest one percent by 21 percent⁴ (see "standard model" column, bottom half of Table 2-1 p. 30 https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun14_entirereport.pdf)

The statistical accuracy of the HCC has never been able to predict more than 12-13 percent of the variation in spending for individual beneficiaries: (p. 30, MedPAC report, see link above).

Attempts to improve the accuracy of the HCC by adding more diagnostic categories and more specific sub-categories still fail to account for most of the variability within even these narrower categories, and result in little improvement in predictive accuracy.

There have been suggestions to add data on social determinants of health to improve the accuracy of risk adjustment, but attempts to do so have likewise failed to improve predictive accuracy⁵. ([Chapter 4: Issues for risk adjustment in Medicare Advantage \(MedPAC Report June 2012\)](#)).

However, use of diagnoses in an attempt to improve the accuracy of the HCC risk adjuster has opened the door to widespread gaming by upcoding, or adding more diagnoses or more severe sub-diagnoses compared to what would be necessary for purely patient care purposes. There is extensive evidence of upcoding by capitated Medicare Advantage⁶, Medicaid Managed Care

plans⁷, and Accountable Care Organizations^{8,9}, and sometimes this crosses the line into fraud⁶. Many of the newer Direct Contracting Entities/REACH plans are owned by publicly traded insurance companies and private equity firms that are telling their shareholders they intend to assure profitability by employing the same strategies as Medicare Advantage plans¹⁰.

Conclusions

Congress has been told repeatedly (by MedPAC and other analysts) that risk adjustment is grossly inaccurate, and the result is overpayment for the healthy and underpayment for the sick, which in turn worsens disparities. Congress has also been told that risk adjustment cannot be improved by adding more diagnoses to the HCC, and it cannot be improved by adding data on race and income. Yet Congress, MedPAC, and CMS, cheered on by proponents of Medicare Advantage, ACOs, DCEs, and other “value-based payments” that require per-head payments, refuse to draw the conclusion that any program that relies on capitation worsens disparities, and this unacceptable result requires terminating Medicare Advantage, the ACO programs, and other programs that require capitation payments.

¹Roger Feldman, “The economics of provider payment reform: Are Accountable Care Organizations the answer?,” *Journal of Health Politics, Policy, and Law*, 2015; 40(4): 745–760.

² It was not until the 21st Century that health policy analysts began to question the conventional wisdom that overuse of medical care is rampant. The most compelling evidence against that claim is presented in two literature reviews, one in Appendix A of *Crossing the Quality Chasm*, published in 2001 by the Institute of Medicine (IOM), and another in a 2012 article by Deborah Korenstein et al. The two reviews reached remarkably similar conclusions. They concluded that very little research on overuse existed, and what little there was tended to focus on antibiotics and cardiovascular procedures. Korenstein et al. concluded: “The robust evidence about overuse in the United States is limited to a few services.... [T]he majority of studies [that found overuse] focused on four interventions: antibiotics for URI and three cardiovascular procedures [carotid endarterectomy, coronary angiography, and bypass surgery].” (Deborah Korenstein et al., “Overuse of health care services in the United States: an understudied problem,” *Archives of Internal Medicine* 2012).

The editor of *Archives of Internal Medicine* was so struck by how little evidence Korenstein et al. found that he felt compelled to comment. “What is most striking about this report,” he wrote, “is how hard the authors searched for data on overuse of health care and how little they found. They viewed 21 years of the medical literature and evaluated 114,831 publications, yet found only 172 articles that addressed overuse of health care.” (Michael H. Katz, “Overuse of health care: Where are the data?” 2012;172:178) Note: Katz should have said 31 years, not 21 years.

³ Neuman P, Jacobson GA. Medicare Advantage Checkup. *N Engl J Med* 2018; 379:2163-2172 DOI: 10.1056/NEJMp1804089

⁴ June 2014 [Report to the Congress: Medicare and the Health Care Delivery System](#). MedPAC June 13, 2014.

⁵ [Chapter 4: Issues for risk adjustment in Medicare Advantage](#) (June 2012 report). MedPAC June 1, 2012.

⁶ Schulte F. Researcher: [Medicare Advantage Plans Costing Billions More Than They Should](#). Kaiser Health News. Nov. 11, 2021.

⁷ Geruso M, Layton TJ, Wallace J. [Are All Managed Care Plans Created Equal? Evidence from Random Plan Assignment in Medicaid](#). NBER Working Paper Series. Working Paper 27762. August 2020.

⁸ Markovitz AA, Hollingsworth JM, Ayanian JZ et. al. Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit. *Ann Intern Med* 2019;171:27-36. [doi:10.7326/M18-2539](#)

⁹ Markovitz AA, Hollingsworth JM, Ayanian JZ et al. Risk Adjustment in Medicare ACO Program Deters Coding Increases But May Lead ACOs to Drop High-Risk Beneficiaries. *Health Affairs* 38 (2) 2019:253-261. [doi:10.1377/hlthaff.2018.05407](#)

¹⁰ Oak Street Health, Inc. [\(OSH\) Q2 2021 Earnings Call Transcript](#) | The Motley Fool. August 10, 2021.