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What US Medicine Needs To Do To Finally Embrace Capitation

Vishal S. Arora, Sachin H. Jain

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For decades, health care executives and policy makers have voiced the need for the health care industry to reward value over volume. While there have been promising alternative payment pilots, a vast majority of the US health care system remains financed through fee-for-service payments, meaning that more office visits, hospitalizations, or procedures will generate more revenue and margin. The coronavirus pandemic has

challenged this decades-long business model. As elective procedures and office visits declined, health systems across the country lost billions of dollars. Hospitals, integrated health systems, and even independent practices are now facing a financial crisis when patients and families need them most.

Policy experts are increasingly advocating for capitated forms of reimbursement for health systems such as global capitation or budgeting. These are risk-adjusted lump sum payments based on the number of patients a provider organization is serving. In global capitation models, these payments would cover total cost of care. The immediate benefits of capitation during the pandemic are obvious: liquidity-constrained health systems receive cash inflow independent of procedures and office visits performed. There are also long-term benefits to capitation, such as rewarding judicious use of health care resources. However, often unstated are the key challenges and risks that health care organizations must navigate if they plan to execute capitation for their health systems in the long run. We address some of these challenges here.

Consolidated Health Systems Must Find A Balance Between Funding Hospitals And Alternative Sites Of Care

Over the past decade, US hospitals have pursued an aggressive acquisition of physician practices, and the line continues to blur between the two. In 2012, there were 35,700 hospital-owned physician practices, and in 2018, there were 80,000 hospital-owned physician practices, constituting 128 percent growth. The coronavirus pandemic may actually accelerate these acquisitions due to reduced revenues for independent physician practices.

Consolidation changes the calculus of global capitation. If independent physician groups had control over global capitation payments, there is a clear financial incentive for clinicians to scrutinize hospitalizations and emergency department visits and provide greater service levels to patients. For example, CareMore is a physician-payer group (author S.H. Jain formerly led this group) that accepts full responsibility for total cost of care, which has demonstrated 42 percent fewer hospital admissions than the national average. For consolidated health systems that include hospitals and employed physician groups, health care executives face significant pressure on finding appropriate resource allocation to cover fixed and variable costs of inpatient care while also funding alternative sites of care. Striking this balance with a fixed budget is not obvious, and health care executives may need to divest from more expensive hospital-based labor and capital over the long run.

Specialists Need To Be Paid In A Way That Incentivizes Partnership With Primary Care

Despite calls for increases in the primary care workforce, the number of specialists has outstripped that of primary care physicians. In 2005, primary care physicians comprised 44 percent of the physician workforce, and in 2015, they comprised 37 percent of the physician workforce. Under a fee-for-service model, specialists and primary care physicians may often work in siloes for a patient, with primary care seen as an avenue to direct patients to specialty care. From 1999 to 2009, the probability a patient would be referred to a specialist increased from 5.8 percent to 9.9 percent. This corresponded to an absolute change from 22 million to 51 million visits, a 132 percent increase. These referral rates were lower for providers in managed care contracts.

The decision to involve specialists in patient care is never solely a financial one, but capitation is a powerful financial tool to ensure specialists are a last resort rather than a first stop for care. Ultimately, specialists have to be paid in a way that makes them partially responsible for total cost of care. This can be done by providing capitation payments to specialists based on percentage of premiums from health plans. Provider groups could also use their global budget to implement fee-for-service with financial incentives for primary care engagement, which is still weak among specialists today.

What's evident from the pandemic is that procedural specialists garner more financial importance from health system leaders in a fee-for-service model. Capitated models could weaken this standing in favor of adept generalists who can coordinate care and adopt lower-cost solutions to involve specialists, such as electronic consults.

Patients Must See Value And Coordination Benefits From Narrow Provider Networks

In the 1990s when managed care expanded across the country, capitation was a common form of reimbursement for providers. To contain expenditures, payers focused on making provider networks narrower so that it included lower-cost providers. While this kept premiums in check, it also led to backlash. Patients felt that insurers were interfering with their ability to be referred to a specialist or to have a test or procedure performed.

Backlash from locking patients into a provider network is still possible if provider organizations implement capitation. However, if narrower choice of physicians led to a better experience for patients with higher degrees of coordination and information

liquidity—and lower costs—patients might be willing to embrace narrower networks of care. This seems to be at play with the Kaiser Permanente health plans, in which patients are limited to physicians from the Permanente Medical Groups but also experience higher service levels and integration of their medical information across sites of care.

Health Systems Will Need To Learn How To Manage Financial Risk For Patients While Maintaining Quality

When health systems operate under fee-for-service, there is actually very little to no financial risk if there is a poor patient outcome. In fact, although most complications are unintentional, they can actually be profitable for a health system by increasing health care use and reimbursement. Under capitation, unpredictable expenditures or poor outcomes even for a small cohort of patients could lead to financial losses for health systems. As a result, providers may be reluctant to adopt this new financial model of delivering care, especially if poor outcomes or disease treatments are considered unavoidable. This could be mitigated through stop loss insurance as well as carve out payments for high-cost specialty drugs and devices that are deemed medically necessary. Such changes would mitigate the advantages of the capitated model.

Alternatively, health systems could also take advantage of the capitated payments by making patients seem sicker through upcoding of diagnoses. These diagnoses are used to form risk-adjusted payments. Upcoding could be mitigated through a capped percentage increase in capitated payments from the previous year. At the same time, there is an incentive to perform less care under a capitated payment, even for care some would consider is clinically indicated. This incentive could be mitigated by monitoring a select number of patient risk-adjusted outcomes and levying penalties for worse outcomes.

Harmonization Of Payer Contracts Is Necessary For Capitation To Succeed

Unlike other countries, a hallmark of the US health care system has been a fragmented payer system. Providers are simultaneously receiving payments from Medicare, Medicaid, and commercial payers. With capitation and fee-for-service providing different incentives, it will be difficult to navigate various contracts from payers. One way this could be mitigated is if providers enter multipayer contracts that harmonize capitation, rather than negotiating separately with each payer. This will allow providers to take care of patients under one payment system.

Ultimately, no payment system will reward all stakeholders equally. In the case of global capitation, specialists and hospitals will face greater scrutiny on their value proposition for patients in the long run. Whether or not health care executives decide to execute capitation is dependent on their view of the pandemic. If this pandemic is viewed as a temporary crisis that simply needs to be controlled, a health care executive may rather pursue government aid and a return to their status quo business model. If this pandemic is viewed as an opportunity to fundamentally change our health care system, these challenges would be worth addressing to finally build a reimbursement strategy that bolsters primary care, encourages care coordination, and disincentivizes waste.

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7500 Old Georgetown Road, Suite 600

Bethesda, Maryland 20814

T 301 656 7401

F 301 654 2845

customerservice@healthaffairs.org