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Beyond Capitation: How New Payment Experiments Seek to Find the 'Sweet Spot' in Amount of Risk Providers and Payers Bear

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ANALYSIS & COMMENTARY

Beyond Capitation: How New Payment Experiments Seek To Find The 'Sweet Spot' In Amount Of Risk Providers And Payers Bear

ABSTRACT A key issue in the decades-long struggle over US health care spending is how to distribute liability for expenses across all market participants, from insurers to providers. The rise and abandonment in the 1990s of capitation payments—lump-sum, per person payments to health care providers to provide all care for a specified individual or group—offers a stark example of how difficult it is for providers to assume meaningful financial responsibility for patient care. This article chronicles the expansion and decline of the capitation model in the 1990s. We offer lessons learned and assess the extent to which these lessons have been applied in the development of contemporary forms of provider cost sharing, particularly accountable care organizations, which in effect constitute a search for the "sweet spot," or appropriate place on a spectrum, between providers and payers with respect to the degree of risk they absorb.

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The story of capitation payment models is central to understanding the struggle over controlling US health care spending. We relate that story here, beginning with the capitation experience in the 1990s, when its popularity peaked and then declined.

We recount the lessons learned and explain how they have been or could be applied to modern payment models, with a particular focus on the accountable care organization. We conclude that the vision of the accountable care organization model reflects some of the lessons learned from capitation during the 1990s. Nevertheless, limitations remain that leave in question whether these organizations will succeed where capitation failed as a successful cost-control model.

Originating in California and spreading across the country, capitation emerged in the mid-to-late 1990s as an instrument used by managed care organizations to control skyrocketing health care spending. Under capitation, the managed care organization paid providers a fixed annual or monthly lump sum per patient. If a provider organization could deliver health care services to a specified patient or group of patients that cost less than the lump sum, it made a profit; otherwise, it lost money.[1] The idea was that capitation would offer incentives to provide "the right care, at the right time, in the right place, with the right use of resources."[2]

Relative to other managed care cost-control tools (for example, preauthorization requirements and utilization review), capitation did have advantages for payers, such as greater certainty when setting budgets, and for providers, such as more control over the provision of care. But it also had limitations, such as greater financial risk for providers who could not offer care for less than the lump sum, and incentives to stint on care.[3]

The story of capitation exists within a decades-long struggle among US health care stakeholders to control spending. That struggle continues today, motivating experimentation with different payment models. Among these experiments, a key distinction is the degree to which they attempt to control or influence the volume and intensity of services provided, as opposed to merely controlling prices. "It's the Prices, Stupid," is the title of a now-famous article by Gerard Anderson and colleagues establishing that US health care spending is above that of other nations in large part because of higher prices.[4]

It is also true, however, that prices—at least those of public programs—have been somewhat stable, growing at a modest rate over the past several decades. Price control has been established in Medicare, for example, because of reforms that replaced purely cost-based reimbursement with prospective payments and bundling. Those reforms have contributed to a gradual slowing in Medicare spending growth.[5] Yet health care spending growth is still above that of the wider economy, as measured by the gross domestic product. Although health care prices are a significant growth factor in the commercial insurance market, the main culprit for public and private payers alike is likely to be health care service volume.

Policy makers have again turned their attention toward new methods to control volume, including exhibiting renewed interest in shifting cost risk to providers, as capitation did in the 1990s. Yet the capitated arrangements of that era proved unsustainable. Is history doomed to repeat itself? Not necessarily, as we explain.

Managed Care In The 1990s

As costs of job-based traditional indemnity health insurance contracts, also known as traditional fee-for-service or conventional insurance, increased in the late 1980s and early 1990s, employers sought less costly alternatives. Managed care groups, such as health maintenance organizations, preferred provider organizations, and point-of-service plans, emerged to offer employers cheaper options in exchange for restricting employees' access to providers within the managed care network.

In contrast to traditional indemnity contracts, which paid most providers on a fee-for-service basis, managed care paid providers contracted within their networks discounted fees subject to utilization review—largely in the form of preauthorization for services and networks of preferred providers. The fees also provided some financial incentives, or bonuses, for providers to keep costs down.[6] This form of selective contracting and reimbursement discounts signaled a temporary shift in the balance of power from providers to managed care organizations.[7]

Initially, managed care groups found it relatively easy to keep cost growth low. They negotiated lower prices from providers who were worried about losing patient volume if they were not included in managed care networks. As a result, health care spending grew more slowly in the first half of the 1990s than it had in the prior decade.[8]

After a few years, however, the ability of managed care groups to continue paying providers at discounted rates waned. By 1997 fewer than half of all managed care organizations were profitable, largely because of a return to more rapid growth in medical expenditures.[9] As managed care groups attempted to leverage their control over providers through more onerous utilization restrictions and additional demands of price reductions, conflict arose, sparking a provider backlash in the late 1990s. Providers consolidated to gain market leverage and negotiate more favorable contract terms with managed care organizations.[10] Over time, the managed care utilization reviews and restrictions became unpopular with the general public as well.[11]

Nevertheless, capitation increased in popularity and became more widely adopted during this time period. The attraction was in part because of managed care plans' efforts to limit their financial exposure through capitation and in part because of many providers' desire to regain more professional autonomy by escaping the demands of other managed care cost-control tools (for example, preauthorization and utilization review). By 1999 approximately one-third of physicians had capitation contracts. Among those who did, revenues from these contracts accounted for 21 percent of their total revenues.[12]

Capitation Temporarily Shifts Risk To Providers

PHYSICIAN PRACTICE MANAGEMENT COMPANIES

Growth in physicians' acceptance of the capitation model coincided with the rapid expansion of physician practice management companies—corporate entities designed to operate physician practices efficiently. As for-profit, investor-owned companies, these firms purchased physician practices and linked them together in large networks to gain economies of scale and scope as well as to enhance bargaining power against managed care organizations.[13] The three largest companies—Phycor, MedPartners, and FPA Medical Management—went public in the mid-1990s and saw their stock prices and revenue skyrocket in their early years.[14]

At this point, the fate of capitation became partially connected to the fate of these physician practice management companies. Both raised the following question: How much financial risk could providers handle?[15]

Similar to managed care, physician practice management companies initially performed well financially. They infused many physician practices with badly needed investment capital and revenue at a time when physicians' average net income was dropping.[16] Yet as was true of managed care organizations, their earnings were short-lived, as stock prices increased initially because of the belief that market growth would later translate into more efficient care—and not because of improved management.

By 1998 Phycor and FPA Medical Management declared bankruptcy, while MedPartners sold off its physician groups to become a pharmacy benefit manager only. Wall Street's valuation of the fifteen largest physician practice management companies fell by more than 60 percent between December 1997 and September 1998, and the entire industry lost nearly half of its stock market value over the same period.[13,14]

At the same time, many provider groups suffered massive financial losses from their capitation contracts in part because of a downward pressure from payers on payment rates that occurred while medical spending growth reaccelerated.[17]

ACQUISITIONS AND MERGERS Seeking a competitive edge, physician practices grew through acquisitions and mergers. The larger the provider group, the more leverage it would have to secure better terms in contract negotiations with managed care organizations. Thus, as providers regained the upper hand in their annual negotiations with insurers in the late 1990s, they canceled their capitation contracts. A less positive consequence of larger provider organizations, though, was that many became saddled with conflicting physician and administrative cultures, resulting in diseconomies of scale and unmanageable entities.[13]

Lessons Learned From The 1990s

We can draw several lessons from the experience with capitation in the 1990s that may inform current cost-control efforts. First, in shifting the liability for health costs from insurers to providers, capitation forced providers to learn to manage financial risk. Relatively smaller health care organizations were unable to spread such risk over sufficient numbers of patients, which threatened their viability and the quality of care they provided.[18] Providers, therefore, were encouraged to consolidate to spread risk over a greater number of patients. Yet even by consolidating, not all providers succeeded in controlling the risk or managing their larger organizations.

Assumption of risk management by providers puts them in a different business than one solely of provision of care. Good care for a particular patient may demand greater use of resources than a provider can bear financially. This may motivate providers under capitation to refer patients to practices outside their organization (thereby shifting the risk to another organization), while retaining the capitated payment. Although this may be financially advantageous for providers, it fragments care and may have adverse consequences for patients' health and satisfaction.[19]

The consolidation that capitation encourages increases provider market power. As their negotiating leverage relative to that of insurers increases, providers can demand and obtain better contracting terms, including higher payments and even a departure from capitation itself.

Coupled with the financial risks of being too small, the negotiating power of consolidation suggests there is a "sweet spot" for capitation somewhere in between for both providers and insurers. A small provider bears too much financial risk under capitation; a large provider shifts too much negotiation risk to insurers. It is unclear whether policy makers or scholars know how to manage health systems into that sweet spot or even know what size it is.

The 1990s experience suggests several shortcomings of early capitation models. Below we discuss whether newer payment models may successfully avoid them.

Today's Incentives For Efficiency

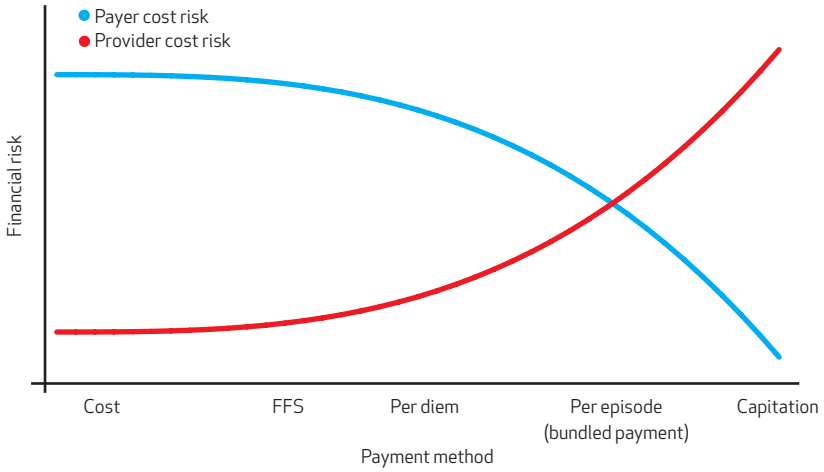
There is renewed interest today in shifting the risk of health care costs from payers to providers once more, particularly under health reform. With the latest efforts, policy makers and stakeholders seem to have learned some of the lessons from the 1990s experience with capitation. As we discuss, new provider payment models share some similarities with the capitated arrangements of that era, but they also feature important differences. It thus is not clear whether or not they will suffer the same fate.

Payment systems vary in the degree to which providers and payers bear the risk and responsibility for financing health care costs (Exhibit 1). For instance, in a fee-for-service model, payers bear more financial risk than providers. Under capitation, providers bear more risk than payers.

Today, the majority of physicians are paid on a fee-for-service basis, while most hospital pay-

EXHIBIT 1

Financial Risk Of Care For Provider And Payer, By Payment Method



SOURCE Authors' adaptation of a similar figure in Averill RF, Goldfield NI, Vertrees JC, McCullough EC, Fuller RL, Eisenhandler J. Achieving cost control, care coordination, and quality improvement through incremental payment system reform. J Ambul Care Manage. 2010;33(1):2–23. **NOTES** The figure is focused on ways of paying providers for the care of a single patient. Omitted, for example, are paying physicians by salary (as in the Department of Veterans Affairs) and providing an institution with a budget that encompasses many or all patients. FFS is fee-for-service.

ments are tied to diagnosis-related groups (DRGs), a form of bundled payment for inpatient services based on diagnoses. Unlike cost-based reimbursement, which establishes no prospective control over prices or volume, fee-for-service and DRG-based payment offer certainty of prices, which are set or negotiated prospectively. However, the level of utilization is typically not under payers' control. Consequently, for all practical purposes, most of the financial risk in the US health care system still rests on the payer side. Whatever level of services providers deliver, payers must reimburse.

The Affordable Care Act includes a number of initiatives designed to move Medicare away from fee-for-service or DRG-based payment models. One of them is the National Pilot Program on Payment Bundling, which will combine payments for services delivered across an episode of care, such as heart bypass or hip replacement, instead of paying for services separately.[20] As shown in Exhibit 1, episode-based bundled payments are one step shy of capitation. They shift the risk of costs under each episode toward providers that bundle all hospital, physician, and other clinical services into a single rate[21] but put the payer at risk for the number of episodes.

The Affordable Care Act also supports the creation of accountable care organizations. An accountable care organization is a network of providers responsible for the care of a defined group of patients and, in part, the cost and quality of that care. Modeled somewhat on private-sector examples of fully or partly integrated health delivery systems such as Kaiser Permanente and Geisinger Health System, accountable care organizations have the goal of providing financial incentives for coordinated, judicious use of appropriate, high-quality care.[22] Examples are discussed below.

MEDICARE'S SHARED SAVINGS PROGRAM Under Medicare's Shared Savings Program, contracted providers are paid standard Medicare rates and receive bonus payments if quality targets are met and if total spending for patients affiliated with the accountable care organization falls below a certain benchmark. This benchmark consists of a projected spending amount based on the provider's past Medicare costs. The lower the spending relative to the benchmark, the larger the organization's bonus payment, although some of the savings are retained by, or "shared" with, Medicare.

Qualification for and levels of bonuses depend on performance relative to thirty-three quality measures pertaining to patient experience and safety; preventive health services; and at-risk populations, including those with diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease. Tying bonuses to quality metrics is intended to strike a balance between appropriate efficiency and inappropriate stinting or rationing.[23]

There are two possible types of accountable care organization contracts under the Medicare Shared Savings Program. One has only an upside: Accountable care organizations can obtain bonuses if their spending is below their benchmark. Another has an upside and a downside: Accountable care organizations entering into such two-sided shared savings and risk contracts can obtain slightly larger bonuses as well as pay a penalty if their spending is above the benchmark.[24]

As of August 2012 the Centers for Medicare and Medicaid Services had entered into Shared Savings Program contracts with 116 organizations serving 2.4 million beneficiaries in forty states.[25,26] Among them are nine independent practice associations that are affiliated with Collaborative Health Systems, a subsidiary of Universal American Corporation, which offers insurance products, including Medicare Advantage plans.[25] This fact illustrates that it is not just hospitals that can become accountable care organizations, but any organizations that contract with independent physicians.

MEDICARE'S PIONEER ACCOUNTABLE CARE ORGANIZATIONS In December 2011 the Department of Health and Human Services (HHS) also announced the selection of thirty-two health care

provider organizations to participate as Pioneer Accountable Care Organizations.[27] These organizations already had experience managing financial risk and had systems in place for delivering quality-monitored care.

Pioneer Accountable Care Organizations are eligible to receive bonuses or incur penalties if their payments are below or above, respectively, an established benchmark based on their spending histories. In addition, in the third year of the program, these organizations can enter into partial capitation arrangements with Medicare, under which a portion of their payments will take the form of a capitated, fixed payment, while the rest remain as fee-for-service payments (Hoangmai Pham, Center for Medicare and Medicaid Innovation, personal communication, June 18, 2012).[28]

PRIVATE-SECTOR INITIATIVES Contracts similar to accountable care organizations also exist in the private sector. At least eight private insurers have contracted with providers under a two-sided shared savings and risk model, including Aetna; Anthem/WellPoint; and Blue Cross Blue Shield plans in Illinois, Massachusetts, New Jersey, and North Carolina. And at least twenty-seven private-sector insurers have entered into shared savings contracts with providers, making them eligible for bonus payments but not placing them at risk for penalties. Other plans have contracted with providers on a partial capitation basis, featuring a combination of a preset budget with fee-for-service payments.

Then Versus Now: Challenges Ahead For Accountable Care Organizations

DIFFERENCES Accountable care organizations and managed care organizations employing capitation share one goal: to increase efficiency of health care delivery by shifting risk to providers. However, the accountable care organization model diverges from managed care and capitated payments in several respects.

First, managed care organizations are insurers, not providers. Although some accountable care organizations may assume insurance risk, or be liable for losses if their costs exceed payment, they are first and foremost provider organizations. Second, unlike in managed care organizations, to receive coverage for care, Medicare patients are not required to see providers within an accountable care organization, and they are not penalized if they seek care elsewhere. For payment and quality monitoring purposes, Medicare patients are assigned to accountable care organizations based on where they typically receive primary care. However, they may seek care from any health care provider.[29] Some private-sector accountable care organization–like contracts do provide incentives to patients to receive in-network care, but they do not bar patients from seeking care elsewhere.

Third, none of the accountable care organization arrangements feature full capitation. Instead, they are a mix of fee-for-service payments with shared savings; shared savings and shared risk; or partial capitation, which is a combination of a preset budget with fee-for-service payments. As such, they are an intermediate step toward cost control, one that includes greater incentives for providers to control the use of services but places them at less risk than full capitation does.

Finally, accountable care organizations are paid, in part, based on achieving quality targets. This was rarely, if ever, a part of the 1990s capitation contracts.

HAVE THE LESSONS OF THE 1990S BEEN APPLIED? Some of the lessons of the 1990s experience with capitation seem to have informed the new accountable care organization payment models. First, the movement away from full capitation is an important one. Accountable care organizations do not put providers at the same high degree of risk for health care spending that capitated arrangements do. If accountable care organizations fail to meet utilization benchmarks, the financial penalties are more modest than under full capitation, and in some cases there are none. In addition, Medicare rules dictate that accountable care organizations must serve at least 5,000 beneficiaries, thereby spreading risk over a relatively large patient base.[28,30]

Nevertheless, accountable care organizations that are better able to assume risk for health spending may be better positioned in the long term.[31] Fee-for-service Medicare payments to hospitals and physicians are scheduled to decline considerably in the coming years.[32] Consequently, the bonus payments available via accountable care organization payment models may become a relatively more important source of provider revenue.

Organizations that can manage costs as well as care across a continuum of settings are more likely to succeed as accountable care organizations. Some observers argue that the required operational infrastructure is more likely to be found among health plans, as opposed to provider groups.[33] This prospect suggests that organizations with an insurance operation, such as Geisinger Health System or Kaiser Permanente, may be better able to serve and survive as accountable care organizations. An unanswered question is how the ideal accountable care organization can be successfully replicated.

Another lesson from the 1990s pertains to how decisions will be made to assign the cost of care for patients when it is delivered outside the contracted organization. Under all of the Medicare accountable care organization models, the cost of care is attributed to the accountable care organization to which a patient is assigned, regardless of who treats the patient. Under capitation, that cost was borne by whoever provided the care. Assigning costs to the accountable care organization even when the organization does not provide the care reduces the perverse incentive under managed care to refer patients to other organizations for high-cost services.

However, patients may voluntarily choose to receive high-cost services elsewhere for a variety of reasons. Should accountable care organization be fully liable for the cost of care in these instances? Accountable care organizations in competition with each other could attempt a strategic game of providing high margin services to each other's assigned patients, collecting payment while having the cost assigned to their rivals, as some analysts have suggested.[34]

CHALLENGES AHEAD An inevitable question in today's health reform environment is whether, given the challenges associated with capitation-based models in the past, the accountable care organization model can succeed. Perhaps the best evidence we have to date are the results of the 2005–10 Medicare Physician Group Practice demonstration.

Under the demonstration project, ten participating medical groups, covering 220,000 beneficiaries, were eligible for shared savings contingent on performance on ten to thirty-two quality measures. The results were mixed. Quality improved, but Medicare saved only about $121 per beneficiary over the span of the demonstration. However, the modest savings may reflect insufficient incentives for efficiency, rather than a failure of the shared savings concept in general.

Moreover, the five-year time span of the demonstration may have been too brief for groups to adjust patterns of care substantially from prior norms.[35] Nevertheless, the experience of the Physician Group Practice demonstration raises questions as to whether the accountable care organization model will generate sufficient savings, either.

Health policy experts have raised additional concerns about the viability of the accountable care organization model. For one, concerns have been raised that accountable care organizations provide incentives for coordination and provider integration that can encourage the amassing of market power among providers, as occurred among physicians in response to managed care organizations in the 1990s. As hospitals consolidate into systems or merge with physician practices to better provide a continuum of coordinated care, they also gain greater negotiating power over payers.

Although Medicare is largely immune to provider market power, private insurers are not. One potential consequence of Medicare's push toward accountable care organizations is that hospitals and other provider groups in some markets will increase their bargaining leverage over insurers, extracting higher prices in contract negotiations and leading to higher private insurance premiums.[36]

Conclusion

The allure of shifting financial risk from payers to providers under capitation is understandable: the nation faces rising health care spending driven largely by growing volume and intensity of care, including potentially wasteful and inappropriate use. But such a shift may encourage stinting, promote growth of provider market power, or threaten the viability of providers that are not capable of managing the risk. The experience of the 1990s demonstrates that these are not just theoretical concerns.

However, newer models of provider payment reform offer an intermediate point between full insurer and full payer financial risk. None of the new payment models being introduced or coming online in the next several years would fully capitate payments to providers. Yet they still provide incentives for providers to deliver less-costly and higher-quality care.

Together with other health reforms and initiatives, such as increased comparative effectiveness research and Medicare savings pursued by the Independent Payment Advisory Board, accountable care organizations offer an opportunity to increase quality and reduce spending while potentially avoiding some of the larger dangers that doomed capitation.[37] Nevertheless, they are not without their own limitations and challenges, as we have noted.

Examples of successful, efficient provider organizations already exist today—including Virginia Mason and Group Health of Puget Sound in Seattle, Carilion Health System in Virginia, and Scott and White Healthcare in central Texas. However, these organizations have not all fully integrated the delivery and payment functions of an accountable care organization.[28,30] Replicating efficient models that do integrate delivery and payment is a challenge, in that an efficient delivery system usually entails a reduction in spending, which translates into the loss of income for providers.[38]

We believe that the new payment models being

pursued under health reform have sufficiently evolved from the failed capitated arrangements of the 1990s to make them a worthy experiment. However, some observers are skeptical that newer models can save a sizable amount of money, arguing that only full capitation or similar models will do so.[39,40] Yet as we explained, policy makers and stakeholders are justifiably wary of repeating the failed capitation experiment. It is not yet evident how to resolve this Catch-22. Full capitation did not succeed, but models that fall short of it might not, either.

The United States remains in the same situation it has been in for decades: unsure of how to bend the cost curve while maintaining or improving the quality of care. With accountable care organizations, the search for the sweet spot between provider and payer risk continues. ■

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NOTES

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In this month's *Health Affairs*, Austin Frakt and Rick Mayes chronicle the history of capitation—lump sum, per person payments to health care providers to provide all care for a specified individual or group—and analyze the extent to which lessons from this history have been applied in new payment and delivery experiments, such as accountable care organizations.

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In 2009 Frakt launched the *Incidental Economist*, an online resource for researchers, journalists, decision makers, and managers; its mission is to translate and disseminate research relevant to health policy. Frakt is also a member of the New England Comparative Effectiveness Public Advisory Council, which assists New England practitioners and policy makers in applying the latest medical evidence to clinical and coverage decisions. He has a doctorate in statistical signal and image processing from the Massachusetts Institute of Technology.

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Mayes has authored several research studies on payment issues and attention deficit hyperactivity disorder, as well as books on universal insurance coverage and Medicare prospective payment. He holds a master's degree and a doctorate in political science from the University of Virginia.