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Capitation's Second Coming Debated

Christopher Cheney, for HealthLeaders Media , October 26, 2015

In the "Great Capitation Debate of 2015," a semi-fictional duo goes head-to-head with opposing perspectives on the dawning of the value-oriented era of healthcare.

With **public payers accelerating adoption** of value-based payment models and **commercial payers launching their own** value-based initiatives, the delivery of medical services is shifting away from fee-for-service payment, the economic model that has dominated the healthcare industry for generations.

The shift away from fee-for-service payment has reignited interest in capitation, one of the economic building blocks of the health maintenance organization era in the 1980s and 1990s.

James "Larry" Holly, MD

To debate the issue and peer into the future of the healthcare industry, I've assembled a semi-fictional duo with opposing perspectives on the dawning of the value-oriented healthcare era. The format gives each debater about 500 words to answer a handful of questions about the role capitation could play in the evolving economics of the healthcare industry.

Arguing *for capitation*, and maintaining that its time has come with a vengeance for a second time is James "Larry" Holly, MD, CEO of Beaumont, TX-based Southeast Texas Medical Associates (**SETMA**).

Arguing *against capitation* on the belief that it is no more than a partial substitute for unfettered fee-for-service medicine is Reginald Thump, wealthy Manhattan businessman and candidate for president of the United States.

HLM: Is healthcare capitation here to stay this time around?

Thump: First of all, let me say I don't have a plan for the future of the healthcare industry, but I have a vision for a plan, which is great for the American economy and great for the American people.

Traditional capitation is a hugely problematic payment system—hugely problematic. Under this model, a healthcare provider receives a fixed payment for every patient, regardless of health, and the provider is expected to provide all of the care that patient needs.

If providers get very sick patients, they can go bankrupt. This creates unfortunate incentives to cherry pick patients and to deny patients needed care.

Not even health insurance companies are willing to accept true capitation payments for Medicare patients. All payments to **Medicare Advantage plans** are risk-adjusted. Yet many Medicare Advantage plans try to pay providers on a traditional capitation basis, which means the health insurance company profits by giving more risk to the providers than the health insurance plan takes from Medicare.

The new health insurance exchanges have risk-adjusted transfer payments to protect health plans from adverse selection, but capitation contracts do not have similar protections for providers. Health plans have large reserves to protect themselves from random variation in costs, but providers have no similar reserves to manage risk under capitation.

Reginald Thump

Image: TLB Designs

On the other hand, health systems and multi-specialty providers can take risk-adjusted global payments from Medicare or a commercial health plan. Under risk-adjusted global payment, the provider receives more money for sicker patients to reflect the fact they need more care.

No individual physician can accept capitation or even a risk-adjusted global payment. Capitation or risk-adjusted global payments have to be accepted by a large group of physicians, an

independent physician association (IPA), or a health system. And that means there still has to be a way to pay the individual physicians and hospitals for the services they deliver. Many physician IPAs accept capitation payments from health plans, but they still pay individual physicians using fee-for-service, which means fee-for-service is here to stay.

Holly: Capitation will last "this time around," but only if it is joined with a value-based payment system with quality-outcomes bonuses and analytics-based demonstration of continuous performance improvement.

SETMA, founded in August 1995, began working in a capitated, global-risk care model in March 1996 through an IPA. By 2000, a fifth (20%) of our payment came from capitation, which grew to a present-day 40%.

When we began in 1995, we measured performance by volume, including charges, collections, patient visits, and X-ray and laboratory tests. By October 1997, we were failing financially. We had not changed the cost curve and our IPA was losing money every month.

SETMA decided to "capitate" laboratory services for IPA members, a decision that cost SETMA $50,000 in profit a month. It was hard, but it was critical to the success of our IPA and to changing to a value-based model of care. With this capitation approach, the IPA was solvent and growing in 90 days.

HLM: Are there adequate information technology capabilities in the healthcare industry to amass, analyze, and distribute the data necessary to support capitation?

Thump: Data systems are much better now than in the past, but data systems are only as good as the data that the dummies running healthcare have been collecting.

In many cases, key characteristics of patients that affect how much it will cost to care for them are not collected, which is huge! HUGE. For example, the stage of cancer is a key factor determining the cost of cancer treatment, but stage of cancer is not coded even under ICD-10. So a data system that depends on ICD-10 codes will not be able to accurately determine whether the cost of cancer care is too high or to predict whether a capitation payment will be adequate to cover the costs of treatment.

The importance of an IT system depends on whether it is the primary method being used to control costs, or whether all of the individual physicians are working to control costs within their practices. If the individual physicians are working to control costs, then the data system is only needed to help with care coordination.

Holly: Healthcare IT is mature enough to provide support for capitation, analytics, and pay-for-performance contracting.

The foundation of successful capitation is analytics. One of the deficiencies with the previous experience with capitation was that primary care providers often simply referred patients to specialists without seeing them.

In May 1999, SETMA defined 10 principles of practice growth and medical record development. In 2000, we expanded our statistical analytics to populations of patients.

Combining capitation with population management and performance improvement creates a perfect platform for payment by quality rather than quantity, or payment for value rather than volume. This approach eliminates the historical abuse of capitation.

HLM: Can a sustainable customer-experience model be crafted to support capitation?

Thump: Absolutely. You just do it!

If the global payment structure is used to pay individual providers in ways that support better patient care, the patient experience can be better. Under a properly structured payment model, patients will not be denied care by a distant bureaucracy's dummies trying to control costs.

But you have to cut a good payment deal. Whether payment is through fees or capitation, if payment is high enough, a good **customer experience** can be offered. If payment is too low, patients will have a bad customer experience.

Holly: Patient-centric healthcare is the ideal model for "sustainable customer-experience" in a capitation environment.

Transformation is self-sustaining, generative, and creative. In this context, SETMA believes that efforts to transform healthcare may fail unless four strategies are employed:

1. The methodology of healthcare must be electronic patient management.
2. The content and standards of healthcare delivery must be evidenced-based medicine.
3. The organization of healthcare delivery must be based on patient-centered medical homes.
4. Capitation is the best payment methodology for healthcare delivery paired with additional reimbursement for quality performance and cost savings.

HLM: Is capitation unsustainable in some local markets, or is it a universal payment model for the healthcare industry?

Thump: Capitation or global payment is designed to support the entire range of services that a group of patient needs. In rural communities, not all of the services are delivered locally, which makes it difficult for any local provider to accept responsibility for the cost and quality of all services.

Capitation is not a universal payment solution for healthcare. In some markets, it will be a two-time loser.

Holly: Finally some common ground with Thump! The limitations of capitation are based on volume of patients, not volume of services. There is nothing unique about one market or another, except in the case of rural areas, where the numbers of patients are so small that they may make payment by performance and cost savings difficult to compute.

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