

Tufts Managed Care Institute—January 2002 Capitation: Status and Trends

The status of capitation has received considerable attention over the past year. Under capitation, health plans pay physician organizations a fixed amount to cover specific services for a defined patient population. The physician entity assumes some financial risk for providing these services, with the opportunity to retain unspent funds but also the risk of spending more on services than the capitation budget can cover. A few years ago, managed care featuring capitation contracts was considered to be the future of health care in America. However, enrollment in HMOs has leveled off, and capitation arrangements are less common than expected.

Capitation has been hailed as the essential tool in managing population health. It flips the incentives in fee-for-service, in which physicians earn more by providing more services, to a system that rewards efficiency, cost-effectiveness, and capable management of patients at risk or in need of care. One description of capitation's potential to improve health care was written by Donald Berwick, MD, one of the nation's leading experts in health care quality. There are many examples of independent practice associations (IPAs) and other physician organizations that have both prospered under capitation and improved the care for their patients.

Despite these positives, capitation has lost ground where it was popular and failed to catch on elsewhere. The following are some of the sources documenting these trends.

- Health plan perspective (InterStudy Competitive Edge): Fewer HMOs used capitation to pay primary care physicians (PCPs) and specialists in July 2000 than in July 1999. Still, in July 2000, more than 60% of HMOs capitated some PCPs, and more than 40% capitated some specialists. A small percentage of HMOs (11%) reimbursed all their PCPs exclusively through capitation. Major national health plans including Aetna, UnitedHealthcare, Cigna Health, and PacifiCare Health Systems have converted some existing capitation contracts to fee-for-service reimbursement.
 - Physician group perspective (Evergreen Re): The percentage of surveyed groups with at least one capitation contract decreased from over 70% in 1999 to 55% in 2000. Still, groups involved with capitation averaged more than four such contracts and 25% of these groups expected to add more contracts in the next year.
 - Physician perspective (Medical Economics): In spring 2001, just over half of all responding primary care physicians were participating in capitation to varying degrees; there were sharp drops from the previous year in all primary care specialties except for obstetrics/gynecology.
- Several factors have kept capitation from becoming the prevalent form of reimbursement.
- Capitation is difficult. Keys to success for capitated physician entities include size (both physicians and patients), knowing how to manage care for populations, solid information systems, good management, and access to capital. Most groups do not have the qualities.

- Capitation was blamed for physician group failures, even if it was only one of many problems experienced by these groups.
 - Appropriate capitation rates are hard to set, and groups were sometimes underfunded.
 - Contracts may have included high risk and high cost services such as prescription drugs, surgeries, and inpatient care; this made it more difficult for capitated groups to be successful.
 - Health plans offered members more open access to physicians, making it harder for the capitated entity to manage its enrollees' medical costs.
 - Some health plans prefer to pay claims and manage care themselves, rather than passing on more of the premium revenues and patient care responsibilities to the provider network.
 - The public perception has been that capitation represents incentives to reduce or limit care.
- As the delivery system continues to consolidate, larger entities can accept capitation from health plans and then develop their own strategies for reimbursing physicians within their organization or network.
 - Employers will not tolerate double-digit increases in premiums. Some employers will look for a return to traditional managed care and capitation arrangements as a way to control costs.
 - Health plans can experiment with different models and service packages in order to structure arrangements that limit physician risk but still create incentives for managing care.

To conclude, the challenges of providing high quality and cost-effective care to patients and populations still confront us. Capitation has tried to serve as a strategy and a method for improving health care. It has not achieved the potential that its proponents envisioned, but it will continue to play a part in the evolution of the nation's health care system.

References

- Despite the constraints on its growth, capitation is far from extinct. Here are some important points to keep in mind:
- Capitation can and does work in many places. There are lots of precedents of health plans and physician entities forging mutually satisfactory relationships and providing excellent care to enrollees through capitation contracts.
 - Some physician groups do less well with fee-for-service than with capitation, and they will resist losing their contracts.
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