

# Health Affairs **Blog**

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## The Payment Reform Landscape: Capitation With Quality

Posted By [Suzanne Delbanco](#) On June 6, 2014 @ 10:36 am In [Costs and Spending, Insurance and Coverage, Organization and Delivery, Payment Policy, Quality](#)

When I began this [blog series](#) <sup>[1]</sup> in February, I explained how Catalyst for Payment Reform (CPR) views [different payment reform models](#) <sup>[2]</sup> along a continuum of financial risk. Thus far, we have used this series to explore the evidence behind “upside only” models that give providers the chance for a financial upside, but no added financial risk, or downside. We’ve looked at the evidence behind pay-for-performance and per-member per-month payments to support patient-centered medical homes. This month, we move across the risk spectrum to examine a model that offers both upside and downside financial risk for providers—capitation.

### What is Capitation? Is It Widespread?

Capitation is nothing new when it comes to paying for health care. It had its heyday in the HMO era of the 1990 s, but something was seriously lacking in the capitation arrangements of the past that led to a strong backlash from consumers. Consumers feared their health plans were more interested in saving money than providing them with the quality care they needed; in a [Kaiser Family Foundation Survey](#) <sup>[3]</sup> at the time, most reported they or someone they knew had a problem with their plan. Some of these fears proved to be warranted. Fortunately, since the 90s, payers and providers have worked to put quality safeguards in place.

When tracking value-oriented payment, CPR only examines capitation arrangements with a quality measurement and incentive component — what we call “capitation with quality.” CPR defines capitation with quality as “a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance and patient risk.”

Our [2013 National Scorecard on Payment Reform](#) <sup>[4]</sup> revealed that 11 percent of commercial

payments across the nation are tied to value. Within that 11 percent, just 1.6 percent of payments flow through arrangements with providers for full capitation with quality.

If you live in a state like Minnesota or California, that figure will sound low. Several regions and states across the nation have much higher levels of providers accepting capitation arrangements. Indeed, our 2013 [California Scorecard on Payment Reform](#) <sup>[5]</sup>, revealed that, within California, 32.5 percent of all commercial sector health care payments flow through capitation with quality arrangements. Though our Scorecard results are in the aggregate and do not reveal the performance of any one health plan, anyone familiar with the California private sector landscape can easily identify the influence of Kaiser Permanente.

### **Does Capitation Work?**

Take a look at the largest nonprofit, integrated health care delivery system in the United States, Kaiser Permanente, and you'll be inclined to answer "yes." Kaiser Foundation Health Plan pays its affiliated medical groups on a capitated basis, and several studies have documented the success Kaiser's capitated model has had in improving health outcomes. For example, [various Kaiser regions have had documented success](#) <sup>[6]</sup> reducing smoking rates among patients, improving patient safety, reducing readmissions, and reducing heart attacks. Traditionally, Kaiser had enjoyed the reputation of being a lower-cost coverage option as well. [Several academic studies](#) <sup>[7]</sup> show capitation can lead to fewer unwarranted hospitalizations, test and procedures as well, as the financial incentive the "do more" is removed.

Other experts have studied the model and noted capitation is associated with savings. A [2008 article in The New England Journal of Medicine](#) <sup>[8]</sup> reported, "Experiments with capitation in commercially insured populations demonstrate reductions in cost."

Yet, if capitation is associated with lowering costs, one should be able to look at California and expect to see overall lower health care spending, given the high rate of capitation in the Golden State. This isn't necessarily true. A [2012 California HealthCare Foundation \(CHCF\) publication](#) <sup>[9]</sup> revealed California's health care spending per capita ranks as the ninth lowest in the nation — that is good news. But employer premiums are higher than the national average (possibly also the result of cost-shifting, since California's Medicaid reimbursement rates are relatively low). [Some news stories](#) <sup>[10]</sup> have hinted that provider market power in California is largely to blame; [others](#) <sup>[11]</sup> have suggested that care could be less expensive — but isn't — because large systems like Kaiser "shadow-price" the rest of the market, or [keep premiums higher to avoid an influx of patients](#) <sup>[12]</sup>.

Other CHCF research on the California marketplace has suggested that there is still insufficient transparency — we really don't know enough about quality outcomes or prices to be able to

say capitation is a success. [According to the CHCF publication](#) , “Documenting capitation’s potential to improve efficiency and value will require more transparent and accountable monitoring than now exists.” Anecdotally, many of the large employers and purchasers we work with have voiced the same frustration in trying to access quality data, specifically at the provider level, from large integrated delivery systems including Kaiser.

### **How and When Is Capitation Most Likely to Enhance Value?**

We have learned some lessons from the managed care era of the 80s and 90s. First, capitation needs to include safeguards for quality. The California experience teaches us providers may be able to accept and successfully operate under capitation when they are in well-organized, well-managed groups with sufficient infrastructure. And we have learned that transparency is fundamental — payers need to understand prices and quality outcomes, especially to guarantee they are truly seeing capitation with quality.

**ACOs: capitation redux?** The current lively dialogue over ACOs and their growing popularity has led many to ask the question: Are ACOs just old wine in new bottles? Given that ACOs offer providers upside and downside financial risk to manage the total cost of care for patients, are they really that different than their “capitation with quality” cousins?

Princeton University economist Uwe Reinhardt, PhD, said in a [2009 article](#) <sup>[14]</sup> that “ACOs are a good idea as ideas go.” However, “it is not at all a new idea. It’s the Kaiser model, the Ellwood-Enthoven model.”

In fact, some ACO payment arrangements may provide incentives less potent than capitation with quality, by offering financial upside-only in the form of shared savings, rather than the potential downside risk that capitation also provides. We’ll explore the topic of shared savings as a payment reform model, and the evidence behind it, in next month’s post.

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