Paying Physicians By Capitation: Is The Past Now Prologue?

Health Affairs, 2010, 29(9), 1611-1666.

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January 25, 2011.
Introduction

- Capitation of payments
  - mechanism for restraining health care costs.
  - shifting financial risk to providers
  - created incentives to provide more efficient health care

- A decline in HMO enrollment
  - from a peak of 80.5 million in 1999 to 64.5 million in 2008.
  - the shift to PPOs, which pay providers on a fee–for–service basis, led to the decline in capitation as a payment mechanism.
Introduction

- Continued increases in health care costs today
  - renewed interest in physician payment reform
  - renewed interest in capitation because of its strong cost containment incentives.
To explore the prospects for these types of reforms

- analyze trends in physician capitation over the period 1996–2007 for all types of physician care

- to understand the circumstances in which capitation was sustained as a payment mechanism and those in which it failed to maintain a strong foothold.
Data from the Medical Expenditure Panel Survey (MEPS) conducted by AHRQ

- Supplemental surveys of physicians’ offices conducted annually from 1996 through 2007.
- Each year, a large sample of physicians identified by MEPS household respondents is contacted to collect additional information on spending and payment.
- For each reported physician visit, the billing office or billing service for the physician is asked, “Was the practice reimbursed for this visit/these visits on a fee-for-service basis or capitated basis?”
Adjustments

Sampling
- Not all physicians identified by MEPS respondents are sampled each year
- Households do not always sign permission forms allowing MEPS surveyors to contact their physicians
- Some physicians refuse to participate

Use propensity-score methods to adjust
- Probability-based sampling with the size of the sample varying year to year, from a low of 22,794 to a high of 61,900, during 1996–2007.
only asked whether individual visits were covered under these contracts.

May have underestimated physician capitation to the extent that capitated physicians substitute e-mail messages, telephone calls, and other kinds of contacts for traditional visits.
Study Results

- Decline Of Capitation
- Declining Enrollment In HMO

**EXHIBIT 1**

Percentage Of Office-Based Physician Visits Covered Under Capitation Arrangements, 1996–2007

![Graph showing percentage of office-based physician visits covered under capitation arrangements from 1996 to 2007.]

**Source:** Medical Expenditure Panel Surveys, 1996–2007. **Notes:** U.S. civilian noninstitutionalized population, 1996–2007. HMO is health maintenance organization.
Capitation remained highest in counties with the highest HMO penetration rates

**EXHIBIT 2**

Percentage Of Office-Based Physician Visits Covered Under Capitation Arrangements, By County HMO Penetration Rate, 1998 And 2006

**Sources** Medical Expenditure Panel Surveys, 1996-2007, and HealthLeaders/InterStudy Managed Market Surveyor. **Notes** U.S. civilian noninstitutionalized population, 1998 and 2006. HMO is health maintenance organization.
Study Results

Geographic Variation

EXHIBIT 3

Percentage Of Office-Based Physician Visits Covered Under Capitation Arrangements, By Region, 1996 And 2007

- Northeast
- Midwest
- South
- West

Low levels of physician capitation consistent with the easier study that measured income from capitated arrangements relative to total practice revenue.

Earlier surveys of HMOs found that they predominantly used capitated contracts with primary care physicians, rather than specialists.
Discussion

Reasons For Declining Capitation

- **Consumer backlash**

- **Provider backlash**
  - less likely to assume the risk of capitated contracts
  - Are there well-organized large, vertically integrated physician groups?
    - to assume the risk associated with capitation contracts.

- **Administrative complexity**
  - calculating and negotiating capitation rates are complexity
  - might not have delivered on its promise of cost containment
  - Some HMOs have stopped using primary care physicians as gatekeepers
Implications For Payment Reform

- Original problems of capitation still remain
  - Health care costs rise continually
  - Financial pressures on employers, governments, and consumers
- Growing concerns about the quality of care and obtaining value for health care dollars
- This has led to proposals contain features of capitation, along with quality assessment
Implications For Payment Reform

- **Pay-for-performance**
  - Combine a base payment with incentive payments linked to defined outcomes or quality targets for specified population

- **Episode-based arrangements**
  - Global payments are made for all care over a specified period of time or for an episode of illness
  - Encourage coordination across providers and the use of the most efficient combination of resources

- **Proposals for accountable care organizations**
  - Include some form of capitated payment to integrated provider networks, in return for their providing comprehensive care for large populations of patients.
Implications For Payment Reform

- Common to current payment reform proposals is the reliance on some form of capitation or risk sharing with physicians.
- Strong mechanisms for integration or coordination will be needed.
- Integrated physician groups are able and willing to assume the financial risks and administrative burden of contracts involving capitation.
Thanks for your attention!