



Guess what? It's time to rethink capitation

By Jessica Sweeney-Platt | May 3, 2017

As healthcare marches toward value-based care, many hopes have been pinned on Accountable Care Organizations, which take on risk-based contracts through programs like Medicare Shared Savings. But so far, it's unclear whether ACOs have actually delivered on their goal: Reducing costs while improving quality and access for patients.

Some early studies of Medicare Shared Savings participants show improved quality but higher costs; others show improvements that are modest at best. And that tepid success underscores an uncomfortable truth: Value-based models might well be the future of healthcare, but shared savings alone is insufficient to the task.

For ACOs to reach their full potential, they will have to embrace capitation.

I realize that, by saying this, I might soon find my photo on a dartboard in healthcare offices. And of course, I understand the skepticism. A lot of people remember the first time healthcare providers took on capitated risk, back in the mid-1990s. While there were some success stories, there were far more failures: Provider organizations couldn't track cost, quality or utilization in a timely enough manner, and ended up

with huge financial losses. For the better part of the next 20 years, capitation became a dirty word.

But this isn't the 1990s. The landscape of healthcare has changed. The tools available to healthcare systems have evolved. And the motivation capitation would provide is crucial. It's only by capturing more of the premium dollar that investments in population health will generate real return.

The limits of shared savings

Shared savings – the most common model for ACO reimbursement – suffers from three main problems.

First, it doesn't eliminate the fee-for-service structure. In most shared savings contracts, providers continue to bill their services in the same way they always have, and at the end of a performance period, if they have saved enough money and maintained or improved on quality metrics, they are eligible for a bonus. That means the reward for changing behavior is far away, while the rewards for staying the same are immediate.

Second, shared savings contracts have no staying power; over time, savings opportunities get smaller and smaller.

And third, lack of downside risk means rewards are also commensurately small. Nearly 90 percent of ACOs have little or no downside risk. This is largely because Medicare wanted to encourage otherwise wary organizations to dip their toes in the water, but in the absence of a penalty for poor performance, many ACOs have not made difficult decisions to dramatically change staffing models or approaches to patient care.

One ACO I know of, in a market with very little regulatory or competitive pressure to control costs, shares physicians' monthly quality data, but provides no mechanism – or incentive – for improvement on those metrics. As long as healthcare organizations have the volume they need, they aren't really interested in changing.

The table is set

So what's different now? Two high-level trends make it possible to imagine provider success under capitation in 2017.

Better data

In 2001, 18 percent of healthcare organizations had an electronic record for patient care. Today, 96 percent of hospitals and 90 percent of doctors use EHRs. The digitization of health information, and an information marketplace that increasingly puts a premium on interoperable data architectures, is the primary enabling factor for better management of capitated risk.

The availability of health data allows provider organizations to do two things they couldn't do in the 1990s. First, they can identify cost and utilization patterns much more quickly and accurately. In the '90s, they were essentially flying blind – paper charts and fragmented billing information made it almost impossible to know how you were doing against targets until it was too late.

Second, it's possible now to connect data across silos to see the entirety of the patient experience, and minimize duplicative efforts. High-performing organizations we have worked with at athenahealth

are “radically transparent” with this data. They use it to ensure that everyone knows how the organization is doing on the clinical and financial metrics that matter most, and they point to this transparency as a key aspect of their ability to manage risk.

Convergence of marketplace interests

One of the primary reasons for the fizzling out of the “capitation revolution” in the '90s was that it was led almost entirely by commercial HMOs. The failure of the Clinton-era healthcare reform legislation meant that Medicare was essentially sitting on the sidelines. So when the economy started to take off in the late '90s, and cost pressures on employers abated somewhat, there were no stakeholders left to push payment change along.

Today however, Medicare is leading the charge, driven by several decades of above-inflation cost increases and the aging of the baby boomers. And many commercial payers are following suit.

Mindsets and memories

Still, it's going to be hard to shift the healthcare industry to capitated risk. Here are some of the major barriers:

Physician resistance

At the top of most CEOs' lists of priorities is physician burnout, widely recognized as a threat not only to health systems' value-based care strategies, but to patient care and overall physician well-being. At a minimum, many doctors feel overwhelmed by systemic change, and unable (or unwilling) to invest in major changes to their practices or practice patterns.

For generations, medical education has taught physicians that they are personally responsible for all aspects of patient care, and that if they have to rely on anyone else for help (a colleague, a nurse), it is a failure of that training.

While this set of assumptions has resulted in physicians with deeply ingrained senses of mission and responsibility, it also has led to a cultural reluctance to adopt standardized approaches to patient care.

It has also served as a cultural barrier to team-based care, which is a foundational capability for any organization looking to redesign care and spread physician expertise out over a larger panel of patients.

Long memories

In addition, many of these organizations remember getting burned by managed care, and don't believe that even today's vastly more robust health data can accurately capture the idiosyncracies of their patient panels. Ensuring physician confidence in performance data is a slow process that depends upon close, trust-based working relationships with both health systems and payers.

Payer-provider misalignment

When executives at provider organizations are asked to name the biggest obstacles to taking on more risk, their top answers usually include "a lack of willing payer partners." Ironically, when payers are asked a similar question, their answer is often "lack of capable provider partners." He-said-she-said dynamic aside, it's clear that there are mismatches here. But perhaps the bigger obstacle is the lack of market pressure on payers.

Payers' most important customers – employers – just want to control their health insurance costs. Currently, they are managing this through high deductible health plans and dabbling in wellness programs designed to lower risk in their employee pool. With a few notable exceptions, they aren't pushing their insurance companies to partner with providers in different ways.

The future is now

There is one factor, however, that could tip the entire marketplace: the rise of Medicare Advantage and managed Medicaid. Both of these huge (and growing) lines of business will require provider organizations to work with payers to manage risk. With the federal government providing a lump sum to payers and leaving it to them to manage the risk, these are essentially capitated models.

Now, payers will need to decide if they will maintain fee-for-service relationships with providers, or work with providers to share the incentives and the risk. The latter option may pave the way for an overhaul on the commercial side as well.

Capitation may never be the only payment structure in healthcare; fee-for-service will likely hang on in certain specialties and certain areas. But if the economics of value-based care are ever going to work, population health managers are going to have to take on capitated risk, and align every stakeholder's incentives around driving quality, curbing costs, and improving the experience for both patients and providers.

Shared savings is an ideal entry-level strategy – an on-ramp for those organizations still building their skills and defining their priorities. But as ACOs mature, capitation offers greater rewards, more scope for innovation, and more chances for success. Why settle for a piece of the pie when you could have the whole thing?

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