Capitation begins to transform the face of American medicine

Milan Korcok

In Brief • En bref

Canadian physicians only need look to the south to see that capitation can control not only their fees but also the amount of resources they use, the amount of care their patients can expect and the way doctors and patients relate to one another. In the US, capitation is rewarding doctors for doing less and penalizing them if they do too much. "Instead of a being cash source," says Dr. John Verhoff, a family practitioner in Columbus, Ohio, "a patient visit is a cash drain." Milan Korcok looks at the ways capitation is changing medicine in the US.

Pour voir comment la capitation risque de contrôler non seulement leurs honoraires, mais aussi la quantité de ressources qu'ils utilisent, la somme de soins que leurs patients recevront et même leurs rapports avec les patients, les médecins du Canada n'ont qu'à jeter un coup d'œil chez nos voisins du sud. Aux États-Unis, la capitation récompense les médecins s'ils en font moins et les punit s'ils en font trop. «Au lieu d'être une source de revenu, dit le Dr John Verhoff, médecin de famille de Colombus (Ohio), la visite du patient devient une ponction». Milan Korcok examine comment la capitation est en voie de transformer la médecine aux États-Unis.

Canadian doctors have heard a lot about capitation lately, and may be wondering if this is just another fad dreamed up by accountants and bureaucrats to rein in physicians' fees.

That may be part of it, but Canadians only need look south to the United States to see that capitation can control not only their fees but also the way resources are used, how much or how little patients can expect, and how doctors and patients relate to one another. In the US, capitation is standing incentives on their heads: it is rewarding doctors for doing less and penalizing them if they do "too much."

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Under capitation, doctors accept a flat monthly fee per person to take care of all the health care needs of members in a given group, such as a health maintenance organization (HMO). If those members are healthy and don't require much care or expensive services, all's well. The monthly fees keep rolling in to the office even if the members don't, and doctors profit.

But if the HMO members are not very healthy and require frequent care, expensive services or big-ticket technology, the financial risk grows and physicians face the agonizing choice of either losing money or denying medical services.

The many varieties of capitation arrangements sprouting in the US offer bountiful case studies for Canada's doctors to consider. For example, some HMOs pass all the risk off to primary care doctors — gatekeepers — and let them manage and pay for referrals to specialists and for other services. This is not an arrangement for the faint of heart. Some HMOs have one capitation contract for gatekeepers and another for specialists, which helps to split the risk.

Some HMOs pay gatekeepers by fee for service and capitate specialists, while others reverse the arrangement. Some capitate gatekeepers, pay specialists by fee for service and give hospitals an all-inclusive per diem rate. Still others allow their enrolled members to seek medical services outside the HMO network, but they must pay extra. There are also staff models in which physicians are salaried but have bonus plans to "encourage" cost containment.

Whatever the mix, capitation works to shift much or all of the financial risk for providing health services to the doctors in the system. On the one hand, physicians who overuse services, fail to meet financial targets or "cost" more than they take in will lose money. On the other, physicians who have good preventive programs, use resources wisely, craft their contracts carefully and have a lot of luck can make money. In both cases, there are likely to be some clear pressures on the patient–physician relationship.

Here is an example of the way a typical capitation system operates in the US. "God's Own" HMO is paid a given enrolment fee — a ballpark figure would be $150 a month per member. Of that $150, $35 may go to doctors, $60 to hospitals, $8 to drugs and miscellaneous services and the remainder to administration, marketing and HMO profits. Actual percentages will vary according to the demographics of the population being served.

The $35 monthly fee may not sound like a lot, but that's per enrolled member, not per patient seen. And if this is a relatively healthy group, most of the members will rarely turn into patients. In addition, most HMOs require "patients" to pay another $5 or $10 per visit, money that goes straight to the doctor.

Dr. John Verhoff, a member of a Columbus, Ohio, family practice, has been working with capitation contracts since the 1980s, long before they became fashionable (see sidebar). He told *CMAJ* that there is no question the shift in risk requires "some adjustment" in a doctor's thinking.

"You certainly are far less likely to see patients who don't need to be seen or provide services that aren't needed," he said. "But you still need to see the patient, you need to order tests and make referrals appropriately."

Given the pressure to make ends meet, not all doctors do. A recent Congressional report on access problems among HMOs showed that cost-based denials happen far too often because of the temptation to make more money by denying care. For example, in one 24-hour period a Medicare beneficiary with signs and symptoms pointing to pneumonia and a heart attack was twice denied admission to a hospital, and both times a capitated primary care physician concurred with the decision. After the second attempted admission, the patient died on the way to his primary care doctor. (In the US, Medicare refers to a government-sponsored program that provides health care to the elderly.)

In another case, a Medicare patient experienced recurrent urinary tract infections, tested positive for protein and blood in the urine and had test results that suggested prostate cancer. Several months passed before this patient was referred by his HMO gatekeeper to a urologist for tests. The patient ended up in a hospital emergency room, where he was treated for undiagnosed bladder cancer that had perforated the large intestine.

The Congressional investigation, released in August 1995, found that serious quality problems were found in most of the "risk-contract" HMOs that serve Florida residents who re-

"INSTEAD OF BEING A CASH SOURCE, A PATIENT VISIT IS A CASH DRAIN"

Getting involved with capitation requires "some adjustment" of a physician's thinking, says Dr. John Verhoff, a family physician in Columbus, Ohio.

"Instead of being a cash source," he warns, "a patient visit is a cash drain. And [under capitation] you certainly are far less likely to see patients who don't need to be seen or provide services that aren't needed."

But quality and appropriate referrals have to be maintained, and controlling the quantity and conditions of a capitation contract is vital to physicians who want that business, says Verhoff, a partner in the seven-member Beechcroft Family Practice Group.

At present, approximately 10% of Beechcroft's practice is with capitated patients who are covered by two health maintenance organization (HMO) contracts. Other forms of managed care cover an additional 48% of the patient roster, and the remainder have other insurance.

"I wouldn't be too upset with the capitation portion going up to 20%, if appropriately capitated, but I'd start to get shivers if it went over that," Verhoff told *CMAJ*. "[The HMOs] would have too much leverage. If they didn't like the way you're doing business, they could take away those patients."

It's also critical to know the patient group being covered and to negotiate a "realistic" capitation rate, says Verhoff. Physicians have to be aware of levels for fee-for-service payments and then set capitation levels accordingly, he says. Beechcroft appears to do this well because its capitation rates generally yield as much as fee-for-service payments, "or a little better."

When the Beechcroft group first got involved in capitation contracts in the 1980s, the partners assumed all the risk for specialist referrals as well as their own primary care. To protect against really catastrophic possibilities, such as million-dollar neonatal emergencies or "whole families caught in train wrecks," they took out reinsurance programs that cover unanticipated high costs over certain levels.

(In fact, provider-excess-loss (PEL) reinsurance, one of the hottest-selling insurance products among HMOs today, is also being aggressively marketed to hospitals and doctors directly. John Alden Life Insurance Co. in Miami says it has tripled its PEL business in the last year.)

Today, Beechcroft assumes only the primary care risk, with specialists and other providers taking care of their own.

Verhoff, who is also vice-president of the American Academy of Family Practice, says that capitation, like managed care, will continue to increase, and all physicians need to learn about it.

ceive Medicare. (These are fully capitated HMOs that assume responsibility for all medical services.) Professional reviews found problems of "incorrect diagnoses, inappropriate assessment of test results, inappropriate treatment plans, underutilization, access concerns, delays in treatment and treatment that was not competent or timely."

Like the managed care environment in which they thrive, capitation contracts are numerous, varied and tilted in favour of the "managers" — the people who write them. Some contracts "withhold" a significant portion of a doctor's capitation fees, usually 10% to 25%, until managers can assess whether they have met their "targets." Management experts warn doctors not to count on the routine return of their "withholds" at year's end.

Some contain "no cause" nonrenewable clauses that allow HMOs to fire physicians without explanation. Some specifically prevent them from ever explaining their HMO's policies to their patients or criticizing them in public.

Why, then, would physicians ever consider taking on such risk and perhaps jeopardizing relationships with their patients? The reason is simple: that's where the patients are going, thanks to pressure from employers, insurers and governments that fund health care and fuel marketplace incentives.

According to the American Medical Association Center for Health Policy Research, 25% of American doctors have at least some patients covered by capitated contracts. More than one-third of all physician revenues are derived from managed care, and 15% of that is attributable to capitation.

John Alden Life Insurance Co., a large American health insurance firm, conducted a survey in which two-thirds of physician groups expected to receive patients through capitation agreements within the next 5 years. More than 40% of the managers surveyed said their groups already receive some patients through capitation, accounting for close to 16% of their revenues; they anticipate that will rise to 66% within 5 years.

For most doctors, capitation is not an "either-or" situation. In areas where managed care and capitation contracts are flourishing, physicians need to have a presence in all camps, and it is not unusual for them to have capitation contracts that account for up to 20% of their patients, as well as preferred provider arrangements or other managed care coverage for another 40%, and indemnity insurance coverage for the remainder.

Shawn Schwartz, assistant director of Interstudy Publications, a Minnesota-based research organization that has been following the development of HMOs for many years, says capitation not only has a lot of growth potential but also is adaptable to many styles of practice.

As an example of "mega-style" capitation, he cites a recent 3-year, $7 million deal between a group of Florida oncologists and one of the state's largest HMOs for comprehensive provision of oncology services for a group of approximately 100 000 enrolled members.

For approximately $2 per member per month, the oncology group will provide all necessary services (clinical, laboratory, professional, administrative, etc.) to any member who needs them. This is mostly a middle-class and young to middle-age group that's not too high on the risk scale, and a perfect target for skin-cancer-prevention programming.

"This contract is a foreshadowing of opportunities for single-specialty groups to take advantage of their competency, information system, ability to track quality of care and implement preventive care," says Schwartz. If they are confident of their ability to do these things and also very sure of the demographic characteristics of the group to be served, "why not go out and try this kind of contracting?"

They do need to be sure of their capability, he warns. "They know that if their pathologist misses something early on, it's going to cost them a lot of money later."

In the US today, such capitation contracting is within reach of most physician practices and is practical for most population groups. However, the stakes get higher with the elderly Medicare population because funding from the federal government's Health Care Financing Administration (HCFA) is much more abundant. "Risk contract" Medicare HMOs, which assume full risk for all enrolled members — comprehensive care with no additional copayments or supplemental costs — also fully capitate their participating physicians. To date these "risk contract" HMOs serve only about 9% of the 37 million Americans covered by Medicare, but private investors have made fortunes on them. They figure highly in the federal government's proposed restructuring of Medicare, and they are opening rapidly in all parts of the US.

The law sets HMO fees for this care at 95% of Medicare's estimated average cost of treating patients in the fee-for-service sector. For a typical noninstitutionalized 70- to 74-year-old man in Bronx County, New York, HCFA will pay a monthly rate of $653.44; the national average is about $600 per month. The trick then becomes spending less than that on patient services — that's how investors make their fortunes.

Writing in the *New England Journal of Medicine* in July, editor-in-chief Dr. Jerome Kassirer warned that market-driven care is likely to alienate physicians and undermine patients' trust of physicians' motives. Yet the "incentive to remain employed" is powerful indeed, and that sets up some conflicting emotions.

"When the care in a community becomes heavily capitated," said Kassirer, "many physicians are forced to join managed care plans or be left without patients.

"On the one hand doctors are expected to provide a wide range of services, recommend the best treatments, and improve patients' quality of life. On the other, to keep expenses to a minimum, they must limit the use of services, increase efficiency, shorten the time spent with each patient, and use specialists sparingly. [They are being] forced to choose between the best interests of their patients and their own economic survival."

This can be a tough, thankless choice. Recently, a group of anesthetists at three hospitals in Long Island, NY, sued Aetna Life and Casualty Company for allegedly pressuring them to sign contracts that limited their ability to provide quality care. They ultimately signed the contracts, but said they did it only after Aetna threatened to end its association with the hospitals they worked in.

Aetna called the allegations "ridiculous," saying it made no sense to limit care; a patient who is denied care would only end up in the hospital emergency room at much greater cost. The dispute continues.

This was one of the first legal actions taken by doctors against an HMO on the grounds that quality of care was being threatened, but legal experts say there will be many more as managed care tools such as capitation contracts push and pull doctors to change the way they practise, view their patients and deal with conflicts among themselves.

Given Canada's current flirtation with capitation and managed care, some of these conflicts may eventually move north of the border. ■