Capitation: It's older than you think

by Robert Sigmond

OF ALL THE ELEMENTS OF the Community Care Network℠ vision, capitation is the least understood. Worse yet, it is the most *misunderstood.* For many physicians the term is synonomous with socialized medicine and loss of professional prerogatives. For many individuals, it is primarily associated with limitation on choice of their favorite physician or hospital. For health care executives, it often connotes sharing of risks they are unable to control.


Sigmond

In an effective community care network, capitation is none of these. Rather, it is an approach to paying for health services that enlists the discipline of the marketplace to manage a seamless continuum of care with limited resources.

But what does the word *capitation* mean? The dictionary defines capitation as "by the head" or "payment of a uniform amount for each person." In the health care field, it means prospective payment for a package of comprehensive service benefits, at a rate not directly affected by how much service an individual receives or how much work is required to provide services.

In the American Hospital Association's vision of community care networks, the source of the capitation payment is not specified, but it is specified that the capitation is paid to the network, not directly to the provider. The network takes responsibility for converting the overall capitation payment from the consumer or the consumer's third-party agent into a variety of payment arrangements as the money is allocated to the various elements within the network. For example, the network might pay different providers by fee for service, salary, program budget or capitation.

Historical perspective. Contrary to what many people may believe, capitation is not new. During the Great Depression of the 1930s, hospitals were in desperate financial straits but managed to survive by playing a leading role in inventing capitation payment for services.

The initial plans, as in Dallas, involved hospitals selling their services to individuals and families for a monthly capitation fee of 50 cents to $1. Under this arrangement the subscribers paid the hospital directly, without any "intermediary." Payment arrangements within the hospital organization, however, remained unchanged.

Literally hundreds of hospitals throughout the nation began to market their services to businesses, other organizations and individuals on a capitation basis, guaranteeing service in exchange for a modest monthly payment. Curiously, this "exclusive provider plan," as we would label such arrangements today, preceded the development of the "free choice" Blue Cross plans.

Eventually, with strong leadership from the American Hospital Association, which sponsored the Blue Cross Commission and owned the Blue Cross symbol, hospitals throughout the nation joined in local networks, through which all the hospitals in an area agreed to the same capitation charges to the subscribers by the Blue Cross network, no matter which hospital was used. All of the plans then converted their capitation receipts into fee-for-service payments to the individual hospitals.

The system worked very well when it was young and growing, because the hospitals had a strong interest in keeping the capitation (the premium) rate as low as possible so that more and more individuals who could not afford hospital fee-for-service charges would be able to join. Families that could not possibly pay a hospital bill of a couple hundred dollars could afford the 50 cents or a dollar per month that upgraded them from charity or bad-debt status.

Furthermore, since the Blue Cross plans started with no reserves at all, the hospitals all guaranteed service, whether or not the plan had the cash to pay. The hospitals underwrote the plan in the early days, as the participating physicians did with the early Blue Shield plans. The plans depended on the hospitals and physicians—not only for providing services but for absorbing any cash shortages.

In those early days, hospitals frequently accepted temporary reductions in payment for services that had already been rendered, and consequently were deeply involved with the governance of the plans. They had a much more direct understanding of the intricacies of capitation payment than is required today.

Seattle model. One of the most interesting developments of the early days of capitation development in this country occurred in the Seattle area. A not-for-profit hospital and a group of physicians joined with consumers to form a health care cooperative organized much like a food store or housing cooperative.

Co-op assessments entitled members to comprehensive care, with no out-of-pocket payment. This early approach to a capitated community care network is still organized as a co-op today, but is more commonly seen as the largest HMO in the Seattle area—one of the few in the nation that owns its own hospitals.

Federal government follows suit. Capitation became the predominant form of hospital reimbursement when the government adopted this approach with tax payments as sourc-

Robert Sigmond is a scholar in residence, Temple University, Philadelphia. This article is adapted from Inventing the Future: Creating Change in New Jersey, *published by the New Jersey Hospital Association, Princeton, 1993.*

es of funding for Medicare and Medicaid. Insurance premiums and taxes both represent capitation—that is, money collected from individuals without reference to their actual use of the services.

Unfortunately, as the system grew and developed, the hospitals became more and more isolated from direct involvement in the capitation premium—and from the reasons for keeping it as low as possible—primarily because they were paid on a fee-for-service basis, with no obvious stake in the capitation payment at all. Even the hospital guarantee of the plan's financial stability was eliminated from Blue Cross contracts. The unthinkable resulted in West Virginia in the late 1980s when the hospitals allowed Blue Cross to file for bankruptcy.

Current developments. With the growth of HMOs in recent years, the pattern of "one-way" capitation has been replicated in almost all instances: Money collected on a capitation basis has been converted to fee-for-service payments to the hospitals. Hospitals thus had little experience with the positive incentives implicit in the capitation approach.

One of the major goals of a community care network is to re-establish the commitment to, and involvement in, a community capitation rate by the leadership of the hospitals and other providers. This means shifting to "two-way" capitation: capitation from the consumers and capitation to the delivery system.

Hospital involvement. The hospital can become directly involved in the potential benefits of capitation payment by assuming responsibility with physicians and others for organizing, providing or arranging for the comprehensive health services for some of the enrolled population. This will work best if the geographic area served on a capitation basis coincides with the hospital's community or its service area.

Other hospitals may not wish to become involved in managing the comprehensive care and the capitation payments of people enrolled in the network, but rather concentrate on providing specific services to patients who are enrolled in the community care network. Such hospitals may prefer to function exclusively as referral centers, developing centers of excellence paid for on a fee-for-service basis by other organizations that have assumed responsibility for managing a capitated population.

Most hospitals will probably opt to play a dual role in a capitated community care network: (1) taking responsibility for managing the capitation funds and the care of enrolled people in their own service area; and (2) simultaneously providing specific services on a fee-for-service basis to those enrolled with other elements of the network with which the hospital would be associated.

To manage capitation funds effectively will probably require a hospital and some of the physicians on its medical staff to develop an organizational framework for assuming the risk together and working together on managed care issues.

Hospitals invented capitation in order to survive in the 1930s.

Also, if the hospital decides to play a dual role, then it will necessarily have to be prepared to manage both capitation receipts as well as some combination of fee-for-service receipts and payments:

- Capitation receipts from the population it is serving on a capitated basis
- Fee-for-service payments to other hospitals and providers for referral service to patients from the capitated population
- Fee-for-service receipts for service to patients who are capitated to other organizational elements and referred for care

Demonstration projects. Working with capitated populations requires a paradigm shift in thinking on the part of clinicians, finance officers, executives and trustees. Since income for the capitated population is fixed prospectively, there is significant danger of financial disaster if the program is not understood, does not reflect sufficient commitment and economic risk sharing, and lacks sound, experienced management.

Many hospitals have gained the necessary experience with one or more of the following populations:

- Hospital employees and their employees' dependents
- The Medicaid population, or a segment of it
- The Medicare population
- Selected employers

Involving physicians. A close relationship with physicians committed to working with the hospital on capitation is essential to success. Without that, the hospital will be seen as just another third-party managed care entity trying to tell physicians how to practice. It is essential that the physicians involved have a sense of ownership of the project—a common commitment to manage their own affairs without outside interference. Hospitals successful in developing joint capitation products with physicians have learned that they should:

- Encourage interested and committed physicians to form a separate entity from the medical staff organization to contract with the hospital on capitation products. Do not enter into a contractual arrangement with the medical staff organization. Medical staff organizations historically have never been involved in financial arrangements between the hospital and various contracting physicians (e.g., radiologists) and should not be in this case.
- Encourage the physician entity to develop objective criteria and processes for deciding who will participate. Avoid including any who are not committed. Physicians should be those who have demonstrated the capacity to manage care effectively both in the hospital and beyond.
- Be prepared to respond immediately and effectively to any allegations from those physicians who are not part of the project that they are becoming "second-class citizens" with respect to their valid hospital property rights. This applies especially to admitting priorities, operating room scheduling, and house staff services.
- Be sure that primary care physicians make up the leadership of the physician entity. Even the most sensitive surgeons and other specialists are not able to respond effectively to the marketplace for capitation products.

A capitation system offers the greatest potential for more effectively linking financing and management of comprehensive services for a community and region—thereby providing higher quality and more accessible health services for less money. ■