

Capitation: What Was Old Is New Again

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Although there were a few prepaid health plans dating back to about 1929, Health Maintenance Organizations (HMOs) did not gain a foothold until 1973 with the passage of the Health Maintenance Organization Act. Growth of HMOs was slow during the 1980s and expanded during the 1990s. Capitation, which refers to a flat-fee monthly payment per patient (per head) made to a physician (typically a primary care physician) to care for all of the patient's medical needs, is a creation of HMOs.

In the 1990s, capitation was touted as the wave of the future. Capitation was reportedly going to solve the problem of runaway medical costs while maintaining good-quality medical care. At the very least, capitation was going to provide greater cost certainty for both employers and payers.¹

By 1999, one-third of practicing physicians had a capitated contract, accounting for about 21% of their total practice revenue.¹

The harsh and detrimental rationing of care by HMOs that ensued was brought to the forefront in the award-winning 1997 movie, *As Good as It Gets*. When Academy Award-winning actress Helen Hunt launched into an obscenity-laced rant describing how an HMO had denied coverage for needed care of her chronically ill child, audiences in movie theaters throughout the nation erupted in loud applause and cheers. Finally, someone had publicly exposed the truth about how HMOs ration care for profit. It led to Congress considering ways to curb the HMOs' egregious abuses, and led health-plan lobbyists to engage in damage control.

Capitation: a Complete Failure

Failure of the capitation payment model was predictable. Risk was shifted from HMOs to physicians. The physician was essentially placed in the position of functioning like an insurance company.

The economics of capitation are simple. If a physician is able to provide care to a patient for less than the monthly lump-sum payment, then the physician makes a profit. If, however, it costs more to care for the patient than the monthly payment, the physician suffers financial loss. As one article reported: "[Capitation] had limitations, such as greater financial risk for providers who could not offer care for less than the lump sum, and incentives to stint on care."¹

Financial viability in a capitated payment model depends on the physician's having a sufficiently large number of patients, and especially a large number of healthy patients who need little or no continuing care. This financial reality led to a biased selection of patients. One article reported: "The study showed that the capitation practices reported fewer sick patients, and more patients enrolled in the practices compared to enhanced FFS [fee-for-service] models."²

Continuity of care often suffered under the capitated payment model as patients requiring expensive care were often dismissed and referred to another practice. As reported in an article published in *Health Affairs*: "Good care for a particular patient may demand greater use of resources than a provider can bear financially. This may motivate providers under capitation to refer patients to practices outside their organization (thereby shifting the risk to another organization), while retaining the capitated payment."¹ Chronically ill patients became a financial liability that no physicians wanted in their capitated practice.

Rationing and skimping on care were common in capitated systems. Chronically ill patients suffered the consequences without even knowing what test or treatment they should have received but never did. A review article reported the findings of a survey and medical records analysis focused on care provided to diabetic patients in capitated systems: "The authors reported that, under capitation incentives, there existed a smaller chance of the physician ordering a proteinuria assessment [a relatively inexpensive lab test which checks for kidney dysfunction]."²

The belief held by some, that capitation could provide high-quality care and not be affected by the perverse incentives that were created to skimp on care, was thoroughly discredited. A Cochrane review reported the shocking finding that: "...there is evidence that payment systems do influence PCP [primary care physician] behaviour."³ It is blatantly obvious that capitation was designed specifically to influence physician behavior so as to control costs. However, the indisputable fact is that "capitation failed as a successful cost-control model," and physicians abandoned capitation in droves in the late 1990s, having suffered massive financial losses.¹ The so-called safeguards for quality that HMOs implemented in the capitation model also failed miserably.

The financial vulnerability of small practices or of practices that accepted too many sick patients, and the lack of infrastructure to track cost, utilization, and quality have been cited as reasons why capitation failed in the 1980s and 1990s. An article posted on the Athenahealth website states: "[In the mid-1990s], provider organizations couldn't track cost, quality or utilization in a timely enough manner, and ended up with huge financial losses."⁴ Government-coerced adoption of electronic health records by physicians now provides the tools necessary to track cost and utilization metrics. Tracking quality care remains highly problematic, as there is no agreed-upon definition of quality care. Payers have often reduced assessment of quality care to compliance with one-size-fits-all guidelines, which are too often plagued by conflicts of interest, and are often outdated by the time they are published. It is noted that Athenahealth sells medical network applications including electronic health records, medical billing, patient engagement, population health, care coordination, and Epocrates® software

(which delivers “safety, diagnostic, and treatment information, right in the moment of care”⁵).

Capitation: Ethical Conflicts

In the 1990s, I overheard a physician telling another physician that he was elated that capitation was being offered by HMOs because now he “could get paid for doing nothing.” There were likely other physicians who felt the same way, but who were less forthcoming in voicing their work ethic and medical ethics.

Capitation requires that a physician adopt a population-based approach to medical care and engage in denial about the harm being done to individual patients as a result. Capitation encourages post-care rationalization by physicians: Maybe the patient really did not need that lab test or treatment, and if he did, failing to provide it falls within the population-based standard of care. Efficiency of the capitated practice is thus enhanced by not ordering the diagnostic test or treatment. And, there is no need to see the patient back in the office to see how he is doing on his antihypertensive medication or diabetic medication. An annual visit will probably suffice. Physicians who participate in capitation essentially must adopt a one-size-fits-all treatment protocol. Deviation from the payer-approved treatment guideline to accommodate the needs of an individual patient is subject to financial punishment.

An evaluation of capitation, performed in 2001 to 2003, confirmed that “patients had fewer office visits to physicians working under capitated payment compared to physicians performing under FFS [fee-for-service].”² Another community tracking study found that “in 2000–2001, greater managed care involvement was associated with greater financial incentives to reduce services.”²

Moral dilemmas disappear when the focus is on doing what is best for the population as a whole. In an op-ed published in the *New York Times*, the authors point out the danger of “moral licensing” in a payment system that is based on population medicine:

When a patient asks “Is this treatment right for me?” the doctor faces a potential moral dilemma. How should he answer if the response is to his personal detriment? Some health policy experts suggest that there is no moral dilemma. They argue that it is obsolete for the doctor to approach each patient strictly as an individual; medical decisions should be made on the basis of what is best for the population as a whole. We fear this approach can dangerously lead to “moral licensing”—the physician is able to rationalize forcing or withholding treatment, regardless of clinical judgment or patient preference, as acceptable for the good of the population.⁶

In a capitated payment model, individual patients are essentially irrelevant. A patient provides only a single data point in the metrics selected by the payer. Capitation must serve the cost-control needs of the employers or taxpayers, who are the actual “customers.” One article put it this way: “It’s only by capturing more of the premium dollar that investments in population health will generate real return.... Payers’ most important customers—employers—just want to control their health insurance costs.”⁴

Another article, authored by two Intermountain Healthcare

executives, stated: “The solution to this quandary is to change the way businesses, government, and other purchasers pay for health care to population-based payment.”⁷ They even suggest a new acronym, PBP [population-based payment], to describe what they consider to be a “better capitation model.”⁷

Capitation Returns

In the context of the sea of red ink engulfing the Medicare program⁸ and the oppressive burden of Medicaid costs in the states, the stage is set for a comeback of capitation with the hope that somehow, this time, it will work.

Politicians and their bureaucratic minions, unfortunately, are often fond of bringing back failed, costly, and detrimental concepts under a new name. But, calling a skunk a pretty little black kitty with a white stripe down its back does not make it smell any better.

On Sep 24, 2001, the Department of Health and Human Services (HHS), for example, changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). Based on years of interference in the patient-doctor relationship, obstruction, and meddling in medical care, it became clear that HCFA was not simply limiting its function to the financing of medical care for seniors, disabled, and Medicaid beneficiaries. Following the name change, CMS has continued and enhanced its longstanding tradition of micromanaging and meddling in the delivery of medical care.

Recently, HHS introduced a new flat-fee payment method as a means to curb costs in the Medicare program. Flat monthly per-head payments will be offered to primary care physicians. Like capitation before it, CMS administrator Seema Verma prophesies that this flat-fee payment method will result in better outcomes for patients as opposed to the fee-for-service model, which she says creates “perverse incentives to offer more care.”⁹

In government-run programs like Medicare and Medicaid, and third-party-payment systems (e.g. HMOs), perverse incentives are part of the system, as someone other than the patient and physician determine what is “medically necessary.” In CMS’s most recent flat-fee payment model, there is a demonstrated willingness to exchange the perverse incentive to provide more care for the perverse incentive to provide less care or, in some cases, no care at all.

One man’s cost control, of course, is often another man’s pain. In this case, some patients will incur the pain of being denied care for profit, and primary care physicians participating in the program will incur “a downside risk of 10%.”⁹ CMS hopes to attract at least 25% of the nation’s primary care physicians by dangling the possibility of a 50% increase in income for those physicians who are able to keep their patients relatively healthy. The program begins Jan 1, 2020.

Under the new flat-fee payment model, physicians will be rewarded for not ordering tests and consultations for their patients, and for adopting the approach advanced by former President Barack Obama. When a woman asked President Obama at a healthcare forum about her 105-year-old mother, who was told at age 100 that she was “too old” for a pacemaker, President Obama answered: “Maybe you’re better off not having the surgery, but taking the painkiller.”¹⁰ The elderly woman, however, was not in any pain and did not require any painkiller. Moreover, insertion of a pacemaker does not constitute major

surgery. Fortunately, the daughter ignored the recommendation to deny her mother a pacemaker, and she was able to obtain a pacemaker from another cardiologist. Her mother did well. This is precisely why we should not allow government officials and bureaucrats to practice medicine.

The Affordable Care Act (ACA or “ObamaCare”) also brought forth Accountable Care Organizations (ACOs), which moved medical financing in the direction of population-based payment and capitation.

As in years past, when promoters of HMOs maligned fee-for-service as “unmanaged care,” promoters of capitation portray capitation as “value-based” as opposed to “volume-based” fee-for-service.

Physicians, who are weary of the incessant and ubiquitous micromanagement and obstruction of care by HMOs (including Medicare managed care), are vulnerable to making the same mistake that many made in seeking an end to the sustainable growth rate (SGR) formula. Physicians were so eager to eliminate the highly flawed SGR, which Congress had implemented in an attempt to control costs in the Medicare program, that there was a naïve willingness to accept anything to make that happen. The old adage, “be careful what you ask for because you might get it,” was totally disregarded. The result was something worse—the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

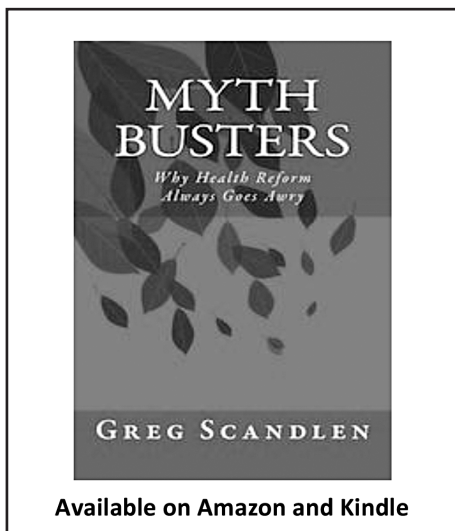
Conclusions

Population-based care/capitation is a derivative of socialism. It is a system that places the good of the population as a whole above the good of the individual. Population-based care/capitation also violates the time-honored professional standards set forth in the Oath of Hippocrates. Physicians should provide treatment according to their training and judgment in order to benefit the sick, as opposed to rationing or denying care to benefit the population. Physicians should also avoid any act of impropriety or corruption, such as adopting a capitated payment system that requires rationing and denial of care to individual patients for personal profit and the alleged good of society. Moreover, irrespective of ethical constraints, calling an old, failed system of capitation a new name, “flat-fee” payment, does not overcome the fact that “socialism fails every time.”¹¹

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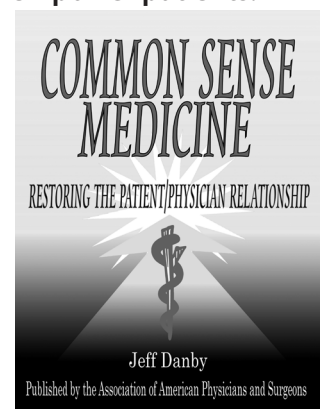
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