

Postmortem of the Rochester Capitation Experiment

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In late 1987 community mental health centers in the Rochester, New York, area began enrolling persons with a history of extensive state hospital care into a comprehensive capitation program. This program involved a prospective quarterly payment to a lead provider agency to coordinate care for each enrolled person at one of two levels. At the first level, the agency assumed total responsibility for comprehensive care for each enrollee, including all aspects of living. At the second level, the agency assumed responsibility for all ambulatory mental health care, which included psychiatric medications but not medical coverage or residential care. Participation in the capitation program was voluntary for both providers and patients.

The demonstration project that sponsored the capitation program ended in January 1993, and the program was terminated after a total of more than 700 persons had been enrolled. In this paper we articulate what we learned in the course of conducting the program, discuss the rea-

sons for its termination, and assess the potential value of capitation models in promoting care for persons grappling with long-term serious mental illness.

Several writers have described the opportunities and risks associated with capitation programs for serious mental illness (1-5). A synopsis of some of the issues raised is presented here in the context of the Rochester experience with capitation.

Capitation opportunities

By assigning providers a clear responsibility for care, attaching money to individual patients rather than to units of service, and reducing restrictions about types of care provided, capitation offers a unique opportunity to improve care for persons with serious mental illness.

Assignment of clear responsibility for care promotes continuity of care outside institutional settings, continuity that has generally been lacking for persons with serious mental illness. It also promotes more aggressive outreach to avoid dropout from treatment or exacerbation of illness requiring more expensive levels of care.

When adequate funds are attached to patients with serious mental illness, services that were often unavailable in the past can be developed. Removal of restrictions in coverage enables the care plan to address all aspects of an individual's life that may complicate adjustment or recovery from illness.

Rochester providers who participated in the capitation program greatly appreciated the opportunity to address the needs of enrolled individuals without distraction, rather than having to design care from the

menu of reimbursable services available. In fact, systems of care developed under the capitation program did not depart significantly from relatively traditional clinical models, relying most heavily on case management, continuing treatment, clinical care, and social supports.

Providers often mentioned the benefit of having flexible dollars available that could be committed for multiple purposes, such as rent deposits; purchase of food, medications, clothing, or household goods; and telephone installation or monthly utility payments.

More aggressive outreach appeared to be the norm under the capitation program, as most providers instituted same-day follow-up in the event of unexpected absences or difficulties. Systemwide efforts to improve rehabilitation offerings were initiated later during the capitation program.

Availability of care targeted to the needs of persons with serious and persistent mental illness changed greatly during the five-year demonstration project. Each of the community mental health centers developed satellite sites dedicated to providing patients served by the capitation program with a full range of services, including clinical services, case management, and day programs (continuing treatment or psychosocial clubs).

To a degree, these program changes paralleled changes in service systems that were occurring throughout the nation, and thus they cannot be attributed solely to the capitation program. However, without the expectation that such a program would shift responsibility for care for significant numbers of state hospital patients to community centers, and without the availability of dollars to initiate programs, services would certainly not have been developed as quickly, nor would they have been as comprehensive.

Armed with the knowledge that the demonstration involved an infusion of state dollars into the development of the long-term-care system in the community, the New York State Office of Mental Health vigorously reduced the adult inpatient

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census at the Rochester Psychiatric Center and closed the center's outpatient facilities during this period.

In essence, the demonstration project effected the transfer of care for persons with serious and persistent mental illness from the state hospital to community mental health centers. Most other localities have suffered greatly because dollars have not been available to create an infrastructure of appropriate services for seriously ill patients discharged from state hospitals. The return to regular methods of mental health care financing following discontinuation of the capitation program has heightened the awareness of providers and community planners about the lack of flexibility or positive incentives attached to these funding approaches.

In sum, the capitation program offered important opportunities to improve care by assigning clear responsibility to providers and by allowing them flexibility in selecting and providing services.

Capitation risks

With one important exception, the problems associated with capitation involve financing methodology rather than patient care. The risk associated with patient care in any type of capitation program is that it may provide incentives to underserve enrollees in order to obtain short-term profits. Minimizing the risk of underservice requires an aggressive and vigilant quality assurance program linked to measurable outcome expectations. In fact, providers who choose to underserve enrollees run even greater risks of promoting fragile patients to higher, more expensive levels of care or of incurring liability for visible community tragedies that reveal inadequate care.

In Rochester, the quality assurance program attached to the capitation program was relatively weak. It involved quarterly reporting of patient incidents, ratings of patient functioning, and indexes of hazard to patient or community (for example, arrests or victimizations). A provider quality assurance group reviewed information and cases to attempt to address systemic problems or disturbing patterns. Providers were acutely aware that this capitation ex-

periment was being followed by others in the state and in the nation and thus may have been more cautious than would be expected under other circumstances.

The risk of underservice is most pronounced when capitation rates are reduced to the point that they fail to cover the provider's costs. In the first two years of the program, the capitation rates were based on projected costs. These rates were more than sufficient to cover the cost of care and resulted in a surplus to be used by the community for development of new services. Even after adjustment to more closely approximate costs, rates did not challenge providers to seek out less costly methods of meeting enrollee needs.

Other risks attached to capitation relate to problems in developing and maintaining seamless funding streams that can cover the comprehensive needs of persons with long-term mental illness. Financing for care of a population with disabling mental illness currently derives from several sources: federal entitlements for living expenses (Supplemental Security Income or Social Security Disability Insurance), Medicaid, Medicare, and state and county allocations for mental health services.

Federal funding streams (SSI, SSDI, and Medicare) are very difficult to manipulate into a single consolidated stream. Inasmuch as SSI and SSDI already go to the recipient in a capitated amount, they are available to address the person's needs. The negotiated capitation rate was discounted for recipients of SSI payments, which continued as before.

Medicare is a major health care payer for persons with disabling mental illness. It encourages providers to use reimbursable service modalities regardless of whether those modalities best address the patient's needs. In any event, the interplay between Medicaid and Medicare, along with other government and voluntary financing, presents serious obstacles to the development of a capitation funding stream. Our estimates suggest that the consolidation of all of these payment streams still leaves a significant gap in coverage of comprehensive costs. These

uncovered costs are probably assumed in part by families and other social systems but also may reflect a pattern of subsistence living by many persons with disabling mental illness.

Because it was difficult to bring all funding streams into the capitation program, the Rochester capitation contracts encouraged providers to continue to collect all revenues available to them and to submit them to the local management corporation for redistribution. The corporation returned all state portions of reimbursements to the State Office of Mental Health to avoid double payment, inasmuch as the state was the sole source of funding for the capitation program. County portions of reimbursements were returned to the county for those persons who had been institutionalized and might otherwise not be in the community. All other revenues were distributed to the providers and the local management corporation.

The process of resolving the amount of revenues due each entity was labor intensive at all levels, but it had the one positive feature of promoting a better understanding of the revenues available to support the population with severe mental illness. Incentives attached to reimbursement encouraged providers to offer more services that were reimbursable in order to receive a share of reimbursements. Upon removal of reimbursement incentives through capitation, a clear pattern was observed in which higher levels of non-reimbursable services were provided to persons enrolled in the capitation program compared with other patients.

Capitation rates are a concern of most persons who contact us about our experiences with capitation. How should rates be structured to allow high-quality care, yet not prevent stretching limited dollars to cover the full population in need of long-term care? The natural tendency of government is to ratchet capitation rates down to the lowest tolerable level to avoid accumulation of dollars within a provider agency or group. Unfortunately, if knowledge of the lowest tolerable level is deter-

mined by the point at which providers begin losing money, the capitation system itself is likely to collapse.

In the 1980s we witnessed such a collapse in a Medicaid capitation program for general health care, an event that left area providers very nervous about the stability of capitation funding. In the case of our long-term comprehensive mental health capitation program, providers were most concerned about assuming responsibility for a fragile group of previously institutionalized patients; they wondered what would happen if the system collapsed and funds were no longer available. Parallel situations have occurred in many areas as state hospital beds have been reduced and no additional funds have been made available to develop needed community services. The principal difference between such situations and the Rochester capitation program is that in Rochester the community provider clearly had claimed responsibility for care.

Our experience with capitation rates indicates that they may vary according to availability and composition of services, previous service utilization and expectations, and other factors related to costs of services in specific areas, such as living costs of staff members and enrollees in the program. We gained much knowledge about what it costs to care for a severely mentally ill population using a relatively traditional approach to care. We were not forced to learn how to promote optimum outcomes using highly creative cost-efficient approaches, but we have learned a good deal about the nature and composition of the costs needed to support this group in community settings.

Reasons for termination

We have often been asked why a seemingly successful capitation program was terminated. There is no single simple answer, but several observations shed some light. The most compelling reason is that the New York State Office of Mental Health did not view a comprehensive capitation program as being affordable by or broadly applicable to all regions of the state. Instead, the state continued to expand its intensive case manage-

ment programs, targeted to a high-risk group, and capitation enrollees considered at highest risk were transferred to that program at the end of the demonstration project.

Several features of the demonstration program served to aggravate the governmental bodies involved. Primary among them was the fact that the local management corporation providing oversight of the demonstration was a not-for-profit membership corporation that included payers, providers, and (later) consumers. This format promoted difficulties between the competing interests and also raised issues of provider control. At the end of the demonstration, the corporation was converted to a community corporation that administers contracts, facilitates coordination and planning of care, and monitors and evaluates programs under a service contract with the county.

Inasmuch as the capitation rates were higher than needed in the first two years, the capitation program allowed profits to accumulate at the provider agencies, a situation viewed as intolerable by state personnel. Community plans to deploy these funds proceeded slowly.

A basic problem was the considerable time and effort required to develop and maintain contracts to support a unique pathway of funding and services oversight. In addition, it was difficult to maintain financing parity among state regions and programs with varying fiscal structures.

Another complication was the lack of clarity about the county's role in the planning and oversight of mental health services. Given complete freedom to determine its own fate, the community would have chosen to continue with a comprehensive capitation program, albeit in altered form. As one provider aptly put it following the end of the demonstration project, "We have won a great defeat."

In 1992 the state legislature passed legislation requiring that Medicaid patients be enrolled in managed care programs. Evolving legislation will likely permit development of special care programs targeted to persons designated by the

Office of Mental Health or other agencies as exempt populations. Area planners see in this legislation an opportunity to once again apply comprehensive capitation or alternative financing of services for persons with disabling mental illnesses. The Office of Mental Health does not choose to promote a specialty managed care package, but the community continues to explore ways to implement mental health managed care.

In planning for such a program, we would consider extensive changes in the earlier capitation system. Some changes are clearly needed. For example, it was a mistake to let provider agencies bear the full financial risk of the capitation. A single catastrophic case, especially one that included medical care, could break a community mental health center. On the other hand, the potential for accumulation of profits within a provider agency creates difficulties and may exacerbate incentives for underservice.

Operating under a broader, more central administration, future capitation models might allocate total dollars among the various service sectors in an effort to foster consistent outcome expectations for enrollees and to pool the risk among all participating providers. It follows that the absorption of most risk at the community level would eliminate the need for a stop-loss mechanism, which in the original program permitted patients who returned to long-term care to be dropped from the capitation program. General health care coverage would be provided by the health maintenance organizations that are currently available to Medicaid patients in Rochester, but coordination between health and mental health services would be the responsibility of the mental health provider.

Conclusions

Rochester mental health providers and planners are convinced that capitation is an effective financing mechanism that allows care to be tailored to the needs of the individual and that can drive development of needed services. Some of the problems encountered involved the

stability of the financing mechanism, new assumption of costs not previously borne by mental health dollars, the appropriateness of stop-loss mechanisms, methods of incorporating Medicaid and Medicare funds, and definition of capitation rate groups as well as parameters for movement in and out of groups.

Many of the contractual and administrative obstacles would be ameliorated if mechanisms were available at higher levels of government to allow for capitation financing and incorporation of other financing and reimbursement sources. The clinical benefits of capitation in Rochester were most demonstrable in the development of systems of care targeted to persons with serious and persistent mental illness and the transfer of care to the community for most of these persons. Whether capitation programs provide incentives for underserving enrollees was not really adequately tested in this demonstration project, as the capitation rates were generally adequate to support the needed care.

The question has been asked whether we would implement another capitation program if given the opportunity. The answer is a resounding "You bet!"

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liest social work aftercare practice. This practice and the ideas that shaped it occurred decades before de-institutionalization and case management became policy passwords, and policies and programs are still evolving to adequately recognize and appropriately channel the effort and resources required.

In looking back at the early professional collaboration between social work and psychiatry, we confront the vision that infused it. We recognize the need for continued shared struggle to conceive and to implement an integrated and collaborative vision of treatment, care, and rehabilitation for persons with serious mental illness: a vision that fundamentally recognizes the moral necessity for treatment that is caring, the therapeutic potential of care that is proper, and the value of comprehensive rehabilitation that is medical, psychological, and social.

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treatment slots leave tens of thousands of people who desperately need treatment without access to treatment services. Increased funding to expand methadone maintenance programs and improvement of the quality of medical and psychiatric services in those programs are urgently needed.

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