Global Capitation — It’s Baaaack...

April 01, 2009 | Medical Billing & Collections [1], Finance [2]
By Ken Terry [3]

This time, it's back with a quality twist.

As the national healthcare reform debate heats up, an innovative approach to physician reimbursement in Massachusetts may provide a model for the future of the national system. Combining global capitation with graduated quality incentives, that state’s Blue Cross and Blue Shield company aims to eliminate misuse of care while reining in costs.

At the same time, the so-called “alternative quality contract” gives practices the opportunity to manage their own patients’ care, and to benefit financially from the savings they achieve. Capitation is nothing new: It was popular among health plans in the late 1990s and earlier in this decade but was widely disliked by physicians, many of whom saw it as a cynical attempt by payers to shift their financial risk to providers. But the new Massachusetts Blues’ model is different, its supporters say.

“The alternative quality contract is very attractive to us,” says cardiologist H. Eugene Lindsey, president and CEO of Atrius Health, a contracting organization of five medical groups, because it combines “the best that capitation has to offer with the best that the focus on quality can achieve. ... [I]t’s trying to move physicians toward limiting services that are unnecessary and that, in some cases, may harm our patients — those things that we just do because it creates this income flow for us.”

Under the alternative quality contract, Blue Cross/Blue Shield, which has about 45 percent of the private insurance market in Massachusetts, pays contracting groups to provide all care, including inpatient services, for its members. The payments are risk-adjusted for age, gender, and health status. Any savings the physicians achieve remain with their group, unless they share the risk with a hospital; in the latter case, part of the savings flow back to the hospital. Physicians and hospitals can also receive bonuses of as much as 10 percent by doing well on nationally recognized process and outcomes measures. Unlike many pay-for-performance programs, this one rewards improvement. The rewards are given for passing any of five “gates” that signify levels of achievement.

The quality-of-care bonuses are the key difference between the Blue Cross/Blue Shield’s version of capitation and the models that were tried around the country several years ago. Their inclusion is why Lindsey isn’t worried that the contract will lead to underuse of services that could jeopardize patient health.

“When physicians are dually incentivized to manage resources for a population and to produce the best outcomes,” he says, it helps ensure that no corners are cut. “I can honestly say to my patients that if I don’t recommend this to you, it’s because I really don’t think it will make you better.”

Massachusetts, of course, is in the midst of another experiment that seeks to achieve near-universal coverage by requiring all state residents to obtain health insurance. While the state has largely achieved that goal, the long-term success of the effort is in doubt because insurance costs are still rising 8 percent to 12 percent a year. That’s one reason why the Massachusetts Blues embarked on its quest for a new method of reimbursing healthcare providers, says internist John Fallon, senior vice president and chief physician executive of the health plan. Fee-for-service was driving up costs without improving quality of care, he recalls. While the Blues plan had a pay-for-performance program, “we were only improving things around the edges,” he says.

Aside from the improvement incentive, the Massachusetts Blues’ program — the first major global capitation effort on the East Coast in a decade — is innovative in that it adjusts payments based on patients’ current health status, not just age and gender, and because the company has pledged to raise capitation rates at the rate of inflation. This means that it won't penalize groups that achieve savings by cutting their rates in future years. On the other hand, if successful, it would limit cost growth to the level of the Consumer Price Index.
That’s OK with Lindsey. “As I plan the economic future of this organization, I’m not going to plan for revenue increases above the CPI any longer. The increase in the medical cost ratio should head toward the CPI, and that’s fundamental in our discussions with Blue Cross.”

Lindsey would like to see the top quality incentive head up toward 25 percent, which is about what U.K. primary-care physicians get. But he doesn’t believe that Atrius should have to trade reduced capitation rates for the higher quality reward. “There are other ways,” he says. “If we have 30 percent waste in the system, and we can take out the waste, we could split the savings with payers.”

The Blues’ global capitation contract is designed for larger groups that have already demonstrated their ability to manage and improve care — such as Atrius, which has about 800 physicians and $1.4 billion in annual revenue. But Fallon suggests that a group with as few as 50 doctors might have a sufficient population to take this amount of risk safely. The company is also targeting IPAs, which are usually composed of many small groups.

The Massachusetts Blues’ plan is attracting a lot of interest from group practices and other kinds of contracting organizations. The majority of them realize that they’re not ready for it yet, but they want to know what they can do to prepare for it, Fallon says.

There are signs that national health reform may be moving in the direction of the alternative quality contract concept. For starters, both private payers and CMS are doing pilot tests of the “patient-centered medical home,” which includes capitation payments for care coordination. There are a number of proposals, including some from the Medicare Payment Advisory Commission, to have CMS pay for value rather than just for services. And a recent Congressional Budget Office report calculated that if a quarter of primary-care physicians’ Medicare reimbursement were in the form of capitation, the doctors would earn more and the government would save $5 billion over 10 years.

If some combination of capitation and quality incentives replaced fee for service, along the lines of the alternative quality contract, physicians would thrive only if they joined larger organizations. But as Fallon points out, that doesn’t rule out small practices, if their physicians can learn how to work within a larger structure.

Ken Terry is a New Jersey-based freelance writer and the author of the book “Rx for Health Care Reform.” He can be reached via physicianspractice@cmpmedica.com.

This article originally appeared in the April 2009 issue of Physicians Practice.

**Disclosures:**

**Source URL:**

**Links:**