

Office Visit: The '90s are Back

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Trends from the 1990s are coming back in force this fall; most notably, neon clothing and the practice of paying physicians through capitation. Of the numerous health care suggestions coming out of Washington this month, capitation is one that deserves more consideration.

The concept of capitation is not new, but until recently, it had fallen out of favor in much of the country. Used by Kaiser Permanente for more than 50 years, capitation is the practice of paying physician groups an agreed-upon amount of money every month to take care of a given population's medical needs. The funds are determined and distributed on a per-patient basis rather than through a fee-for-service model.

If a physician group cannot provide a service needed by a patient, it pays another health care provider to deliver the service (again, through capitation funds provided for that purpose).

In simplified terms, giving your child a set allowance each week and asking him or her to cover expenses through smart money management is a form of capitation. Giving your child a fluctuating allowance based on specific chores completed around the house is equivalent to the fee-for-service model.

Capitation proponents believe the model eliminates health care's biggest cost waster – unneeded procedures. They advocate that under the fee-for-service model, physicians have an incentive to perform more procedures, necessary for the patient or not, because they are paid based on the number of medical services they provide. Supporters also argue that groups using capitation have been leaders in the health care industry's quality improvement movement, as they not only must show that they are providing all recommended health services to patients, but they are providing higher quality care as well.

Critics argue that rather than eliminating unnecessary services, capitation pushes physicians to withhold needed care because the payment structure is the same whether the physician performs the service or not. They also say flat-rate plans do not meet the costs of delivering care.

So who has it right?

The answer may be Massachusetts. The state recently has adopted a hybrid plan that combines the old model of capitation with new parameters. Under the Massachusetts plan, base pay rates for capitation allotments are determined by cost of care, and incentive pay – up to 10 percent above and beyond base pay – is calculated on quality scores. This is attractive to providers because physicians do not want to be distinguished for their cost and efficiency alone, but for the quality of care they are able to provide their patients. The hybrid model allows for both.

Because capitation rates are determined by local costs and average utilization of services, they can vary from region to region, but most agreements contain a similar list of primary care services that

must be provided to each patient. These are preventive, diagnostic and treatment services; injections, immunizations and medications administered in the office; outpatient laboratory tests done either in the office or at a designated laboratory; health education and counseling services performed in the office; and routine vision and hearing screenings. In other words, we are looking at preventive and healthy lifestyle maintenance.

In some areas of the country, where patients generally lead healthier lifestyles, capitation could be a great cost savings to a practice. In other locations, much of the routine work done by a physician might be reactive and therefore not covered by capitation. With all its pros and cons, why not develop health plan options that let each physician group decide if capitation is a good fit for the practice? Remember the cost of delivering care for physicians is also increasing each year.

In the end, choices for physicians ultimately mean more choices for patients, and isn't that what we are all after?

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