From the Field

From Capitation To Fee-For-Service In Cincinnati: A Physician Group Responds To A Changing Marketplace

Financial incentives, not physician payment method, can be key to promoting high-value, efficient health care.

by Nora Super

ABSTRACT: The experience of Group Health Associates, a multispecialty practice physician group in Cincinnati, Ohio, offers an important case study of how payment incentives and market realities can change the way physicians practice medicine. After nearly thirty years as a capitation-based medical group, these physicians recently switched completely to fee-for-service reimbursement—not willingly, but in response to an evolving marketplace. Their new business strategy seeks to create a case for being paid for performance and treating the chronically ill. [Health Affairs 25, no. 1 (2006): 219–225]

Physician payment policy has been caught in a struggle between two opposing camps for essentially the past seventy years.1 On one side are those who believe in the office-based, fee-for-service (FFS) delivery system, in which the majority of physicians still practice today. On the other are those who believe in large, prepaid, multispecialty group practices and the promise of integrated delivery systems (IDSs).

In FFS medicine, the incentives are clear: A physician or other practitioner charges separately for each patient encounter or service rendered; spending and incomes rise if more units of service are provided or more costly services are substituted for less costly ones. Under prepaid capitation, an individual or institutional provider is paid a fixed amount for each person eligible to be served, regardless of the actual number or nature of services provided to each person in a time period. This approach is intended to encourage providers to control health care use. Under full-risk capitation, the health plan is at risk for use of primary care, specialty care, hospital, and ancillary services. As the marketplace evolved, more physicians began to accept capitation as a form of payment but at varying levels of risk. For example, some physician groups are at risk for primary and specialty services, whereas others are for primary care services only.2

The Cincinnati Market

Noted by survey researchers at the University of Cincinnati as an accurate reflection of national attitudes and trends, Cincinnati, Ohio, offers a compelling market in which to study the influence of incentives on the health care delivery system.1 Cincinnati is characterized by strong players in all sectors of the market: large employers such as Procter and Gamble and General Electric, competitive hospital systems and national health plans, and physician groups with the power to push back in
contract negotiations. Like many markets across the country, Cincinnati is dominated by single-specialty groups, with one exception: Cincinnati Group Health Associates (GHA). This large multi-specialty physician practice group recently switched to FFS reimbursement after nearly thirty years with capitation. The GHA doctors did not do so willingly; rather, this change was an effort to stay in business in response to an evolving marketplace.

**GHA’s Tough Transition**

GHA was founded in 1974 by three physicians (an internist, a pediatrician, and a family practice physician) around a traditional group-practice model. At first they accepted only capitation, and their primary insurance partner was the local Blues plan, Cincinnati Community Mutual. As the model caught on and as local large employers jumped on the health maintenance organization (HMO) bandwagon, GHA’s practice flourished. By all accounts, it was quite successful at capitation. At its peak in 1996, GHA employed more than 100 physicians, had 100,000 capitated lives, and had net revenues of $100 million.

Cincinnati Community Mutual, meanwhile, was undergoing its own transformation. In 1995 it merged with the Associated Group, an Indianapolis-based company that ran Blues plans in Indiana and Kentucky. The merged company was renamed Anthem.9 Anthem is now the largest U.S. health insurer. Its 2004 merger with WellPoint created a company that now serves approximately twenty-eight million members.7 As Anthem gained more and more market share, its emphasis shifted toward large-panel preferred provider organization (PPO) products and away from small capitated products.

According to GHA, Anthem’s product pricing and benefit structures did not support continued growth of capitated products in the Cincinnati market. Anthem reports that benefits were richer in its HMO products, but consumers wanted greater choice of physicians in response to the managed care backlash of the 1990s.

As PPOs became more popular, GHA’s signature product was no longer a marketable commodity. The number of capitated lives continued to decline dramatically year by year (Exhibit 1). By 2002 the number had declined by nearly 25,000, whereas FFS lives had increased by roughly the same number. In 2003 many health plans converted to FFS, and GHA saw its numbers change even more dramatically, with more than two-thirds of its patients now enrolled in FFS-type plans.8

GHA’s net patient service revenue in 2003 was about $58 million, a decrease from $66 million in 2002 for more patient visits (Exhibit 2). GHA management found that it was hard to operate with conflicting incentive structures. In January 2004 the group decided to make a complete switch to FFS. As the practice has shifted to full FFS, it has been able to increase its reimbursement rates, according to the firm’s chief financial officer (CFO), but

**EXHIBIT 1**

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<th>Capitated Lives Versus Fee-For-Service Lives, Cincinnati Group Health Associates (GHA), 1998-2002</th>
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**SOURCE:** Cincinnati Group Health Associates.

**NOTE:** Numbers for 2003 are not directly comparable with those of earlier years because GHA received partial capitation during several months of the year as health plans converted to fee-for-service.
revenues per visit have not yet risen to the level achieved under capitation.9

Changing Practice Patterns

GHA’s culture had been built around its multispecialty practice and had emphasized achieving shared objectives. The extra “cushion” achievable from capitation payments had enabled the practice to invest in its information infrastructure to create an electronic medical record (EMR) and have staff members devoted to quality measurement and care coordination. It also had allowed the practice to subsidize some specialties that received lower reimbursements with the higher reimbursements received from other, more profitable specialties.

One of the biggest challenges of changing to an FFS environment was that many of GHA’s doctors had never worked outside of a salaried practice. Located close to the University of Cincinnati medical school, GHA has long recruited physicians directly from residency. They came to GHA because it emphasized a culture of conservative medical management. FFS, it seems, has turned that culture upside down.

■ Elimination of departments. As a result of its switch to FFS, GHA had to eliminate departments that were not adequately reimbursed under FFS, such as mental health, eye care, and dietary counseling. Practices and clinicians who were not able to at least break even were closed or let go.

■ Improved profitability. The practice improved the profitability of its reimbursable ancillary services (such as radiology, physical therapy, and pharmacy) and added other profitable services (such as cardiac imaging and vascular ultrasound).10

■ Changed financial incentives. Michael Barber, GHA’s chief executive officer (CEO), says that there’s no question that physicians must be more productive under GHA’s FFS model.11 Although it has generally been the same physicians who worked under the capitated system as the FFS system, GHA leaders had to redesign their salary structure to reward the most productive physicians. GHA has moved to a “collections-based” salary system, also more brutally known as the “eat-what-you-kill” system. In other words, physicians who see more patients, who order more tests, and whose patients use more GHA-owned ancillary services (such as pharmacy and physical therapy) make more money.

Under GHA’s capitated system, Barber explains, physicians were used to coming in at 9 a.m. and leaving at 5 p.m. There was no incentive to take a patient who needed to be seen at the end of the day. Under the FFS system, doctors have a financial incentive to stay late to see those extra patients and run those extra tests. On the other hand, FFS seems to create incentives to see more patients for less time, whereas under the old capitated system, physicians presumably could have spent more time with patients without financial penalty.

Douglas Conrad and colleagues have argued that to understand the financial incentives influencing a physician’s behavior, it is more important to focus on compensation by the medical group to the individual physician than on plan payment method.12 Before the
complete switch to FFS, the GHA medical group was paid primarily by Anthem by what Conrad characterizes as “professional capitation.” This means that the group was at risk for primary care and specialty services, but not for hospital and ancillary services. GHA physicians were paid 80 percent on a salary basis and 20 percent based on a physician’s productivity (generally measured as FFS-equivalent services provided to patients). After the switch to FFS, the health plan payment method to the group was FFS without risk. Physicians’ compensation is based solely on each physician’s productivity.

Thus, GHA’s overall increase in productivity might be tied more to its change in physician compensation than to the switch from capitation to FFS. Indeed, recent empirical findings from Conrad and colleagues confirm that physicians in medical groups that base a higher percentage of the typical physician’s compensation on one’s own production do spur increased effort. Capitation’s proponents agree that productivity measures can be built into a prepaid system as well.

Some GHA physicians have been more willing to embrace this new professional culture than others have been. GHA uses peer data to compare its physicians with one another. Barber explains that some doctors use their own pharmacy downstairs, which is available at no extra cost to the patient, two or three times more often than other doctors do, even though GHA leaders have encouraged their physicians to offer it to their patients. Some physicians see it as “unseemly” to suggest the in-house services; others view it as a patient courtesy, not to mention an income booster.13

More frequent visits. Under the new productivity-based FFS system, GHA physicians and other health professionals are expected to see more patients more frequently. Physical therapy offers a case in point. Under capitation, GHA patients saw their physical therapists four or five times in a typical episode of care. GHA’s approach to care was to train patients to do most of their physical therapy on their own, at home. The Cincinnati community norm in physical therapy is about nine to twelve visits, so GHA’s business strategists figured that GHA could now earn more in this line of business by increasing the number of office visits and deemphasizing patient training.

Physicians posit that there is a quality argument on both sides. If patients come into the office for physical therapy, therapists can supervise patients to ensure that they are doing their exercises correctly. On the other hand, it certainly costs patients and health insurers more if patients come to the office, although there is no guarantee that patients are doing the exercises correctly at home. Now that GHA has changed its practice patterns, physical therapists are expected to see ten to twelve patients per day. GHA points out, however, that this is still below the community average, which is closer to twenty.

GHA offers physical therapy in three of its eight offices and plans to expand to a fourth office in the coming year. According to GHA executives, it is an important line of business, and patients, in particular, appreciate the convenience of accessing this service in their doctors’ offices.

The Dark Side Of Medicine, Or Playing By The Rules?

Under the old capitated structure, physicians actively discouraged patients from having unnecessary tests, which made the practice more profitable. Now, board members say, they don’t encourage them, but they don’t discourage them, either. And they do recognize that there can be revenue from ordering a test. The new GHA mindset supports the idea that if patients want a test, let them have it. “Hell, we don’t want to get sued!” says one board member, implicitly using malpractice fears to justify less conservative physician practice. Such fears apparently were not operational when GHA operated under capitated payment contracts.

“This transition has created a conflict for many of the physicians at GHA, which is not only financial, but cultural as well,” according to Thomas Fischer, an allergist and GHA board member. He pointed out that GHA does
not gain financially from each test ordered, because many patients go to other facilities to have the tests done, and that, of course, much valuable clinical information can be gained from the tests. According to GHA, 85 percent of high-tech tests (such as scans) are done outside of GHA. Moreover, GHA has not seen a sizable change in the use of laboratory or other imaging services since its switch to FFS.

**Different paths.** Paul Beckman, an Anthem vice president who had been a GHA administrator for twenty years, says that GHA did not have to choose this path, implying that if GHA had demonstrated that its methods of practicing medicine had higher value, it could have negotiated better reimbursement. When told of this statement, GHA executives were incredulous. “Capitation did not go away because GHA made it go away,” remarks Christopher Hayner, a member of the GHA board. “If anything, we moved away from capitation later than we should have,” says Brad Hall, GHA’s CFO. “There was no product out there that financially rewards the type of system we had in place for the first thirty years.”

Prior to moving to FFS, GHA had an exclusive joint venture (called Paragon) with Anthem from 1996 to 2003, whereby nearly all of their patients were insured by Blue Cross and Blue Shield. CFO Hall now believes that such dependency on a single plan was unhealthy and says that GHA has worked to diversify the number of plans with which they contract. They now accept insurance from all three big insurers in the Cincinnati market (United, Humana, and Anthem), plus some other smaller ones in town.

**Writing the rules.** Other GHA physicians who are not happy about GHA’s transition say, off the record, that GHA has gone to the “dark side of medicine.” In response to this statement, Hayner remarks, “It’s not the dark side, it’s playing by the rules as they are established. But we don’t make the rules and the rules don’t make sense. ...But we’re doing what we need to do to survive.” Unfortunately, GHA has not explicitly measured whether the quality of care has changed since it switched to FFS.

**We Don’t Want The Soccer Moms Anymore**

For the first time in a long time, providers are looking to care for sick people. As Hayner puts it, under FFS, “You don’t want the soccer moms in minivans [who tend to use fewer services] showing up once a year; you want the diabetics who are really sick, because that’s what pays the bills.”

Capitation, on the other hand, encourages providers to avoid risk. According to GHA’s CEO, this emphasis on caring for the chronically ill is part of GHA’s vision for the future. GHA tried to take its experience with managed care and apply it to a new chronic care model. It wants to be known as the place to go to manage chronic diseases.

Surprisingly, GHA physicians say that they now have more incentive to do follow-up with patients who have missed preventive care in disease management than they did under capitation. Despite research showing the contrary, GHA physicians believe that the incentives for prevention under capitation were weak over the long term, especially because they were at risk for only primary and specialty care services. According to GHA, patients are reluctant to come in for an uncomfortable test, such as a colonoscopy, and salaried physicians have no real financial incentive to encourage patients, especially those who have not visited the doctor’s office for a while. Under FFS, physicians earn money simply by administering the test. GHA’s new business strategy uses its EMR to find patients who need preventive tests, especially in slow months, creating what it believes is a “win-win” situation for both patients and physicians. Whether or not the practice can actually earn a profit under this model remains to be seen.
Changing The Incentives: Is Paying For Performance The Answer?

GHA’s case study reminds us of the power of financial incentive. For all the promise of the prepaid group practice and the fervor of its true believers, market trends show that the American public is not ready to embrace this form of health care delivery. Yet classic FFS reimbursement seems so outdated in the face of what we have learned about evidence-based medicine, the need for good chronic care management, and the efficiency of electronic communication. Moreover, the GHA case demonstrates that FFS can drive up demand for unnecessary care by rewarding face-to-face visits when e-mail or self-care might be preferable for patients and physicians alike.

The latest craze in Washington and in the business community has been a move to pay for health care services based on performance. “Pay-for-performance” seeks to reward physicians and other health care providers for delivering health care that meets specified standards or achieves defined levels of quality.16

In June 2003 Cincinnati launched its Bridges to Excellence pilot project to test the idea that the quality of care could be improved through rewards and incentives that encourage providers to deliver optimal care and encourage patients to seek evidence-based care and manage their own conditions. Cincinnati’s program focuses on diabetes care.17 One key objective of the program is to identify physicians who are seeing participating employers’ diabetic patients, educate them, and encourage them to apply for recognition. A second is to recognize and reward certified physicians for delivering care meeting industry guidelines.

GHA has been a recognized and participating physician group nearly since the program’s inception. To date, more than $200,000 in rewards have been paid to physicians in Cincinnati.18 According to Joyce Huber at GE Transportation, “PCP [primary care provider] costs are up, and inpatient costs and emergency room costs are down, which is exactly what we wanted to happen!”19 Congressional leaders, the Centers for Medicare and Medicaid Services (CMS), and the Medicare Payment Advisory Commission (MedPAC) have taken notice of these private-sector efforts and have begun to call for Medicare to adopt some pay-for-performance methods of its own.

The evolution of GHA demonstrates that payment incentives can change the way physicians practice medicine. Fearing economic hardship, GHA physicians changed their practice patterns, which suggests that sticks are more powerful than carrots. On 1 July 2005 GHA merged with TriHealth Inc., a hospital-based system, with plans to develop an IDS. GHA also hopes to provide seamless care, with a common EMR platform, that helps realize its vision of a high-quality chronic disease program.

As both private and public purchasers look for ways to align the incentives to improve the quality of care as well as to reduce inappropriate care, GHA’s experience reminds us that neither capitation nor FFS is all good or all bad. FFS might give us higher cost growth, from both the combined market power of allied providers and the incentive for greater use. Capitation, on the other hand, might have led to less care than was optimal under certain circumstances. Financial incentives to promote high value and efficient resource use under either FFS or capitation might be one way to get the best of both worlds.

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NOTES
3. Alfred J. Tuchfarber, director emeritus, Institute for Health Policy and Health Services Research, University of Cincinnati, presentation at the National Health Policy Forum site visit, Cincinnati, Ohio, 24 May 2004.
8. Numbers for 2003 are not directly comparable to earlier years because GHA received partial capitation during several months of the year as health plans converted to FFS.
10. Michael Barber, CEO, GHA, personal communication, 15 August 2005.
11. Unless otherwise specified, this and all other statements attributed to GHA personnel are from interviews with the author, 27 August 2004.
12. Conrad et al., “Primary Care Physician Compensation Method.”
14. The Ethics in Patients Referrals Act (known as Stark I) was enacted in 1989 and expanded in 1993 (Stark II). The statute prohibits certain types of financial relationships between physicians and facilities to which they refer patients. However, the law does allow physicians to provide most designated health services in their own offices (known as the in-office ancillary exception).
17. Beth Hallgren, health care manager, GE Transportation, presentation at the National Health Policy Forum site visit. Bridges to Excellence also has programs in Boston, Louisville, and Albany/Schenectady, which focus on other diseases or processes of care. For more information, see http://www.bridgestoexcellence.org.