

## PAYMENT MODEL PRIMER

# Capitated Payments

A capitation payment is a fixed dollar amount paid per member over a set period of time (per-member-per-month is the most common approach) to cover a defined set of services for a defined population.<sup>1,2</sup> There are 2 broad types of capitation: integrated capitation, which is a payment across various systems or services,<sup>3</sup> and population capitation, which targets a specific group of individuals.<sup>4</sup>

### HOW IS IT SUPPOSED TO WORK?

Capitation payments are adjusted for risk, based on population acuity to ensure adequate payment. To ensure the entity receiving the capitated payment does not withhold care, plans and providers receiving capitated payments often report on quality and utilization measures, which can be linked to performance bonuses or publicly reported to increase transparency. Capitated payments are generally made prior to care delivery and are based on the spectrum of services and utilization of services.

### WHAT IS THE GOAL?

The goal of capitated payments is to reduce, or slow the rate of growth of health care expenditures and to improve quality of care by encouraging greater management and coordination of care.<sup>1,5</sup> Capitation payments can be appealing to

both public payers and commercial payers, as they shift the locus of care oversight to another entity, whether that be a managed care organization (MCO), physician group, or health system.<sup>5</sup> This allows the payer to focus on tasks that are more limited in scope, such as enrollment, claims processing, risk analysis, reinsurance, and customer service.<sup>5</sup>

### HOW AND WHERE HAS IT BEEN USED?

Key components of payment structure

#### Commercial

For private-sector or commercial payers, health maintenance organizations (HMOs) typically enter into capitation contracts with primary care physician groups, health systems, or individual hospitals.<sup>6</sup> The provider then oversees and manages utilization of health care services, so that money

spent on patient care does not surpass capitation payments.<sup>6</sup> In 2019, Kaiser Family Foundation estimated that 19% of individuals with employer-sponsored insurance are enrolled in HMOs.<sup>7</sup>

## Medicaid

State Medicaid officials pay MCOs a capitated payment to cover a set of Medicaid patients that live in a particular part of the state. It is common for state Medicaid programs to have 3 or more MCOs.<sup>1</sup> MCOs then use the capitated payment to reimburse providers for the covered Medicaid services an enrollee may require.<sup>1</sup> MCOs are at financial risk if spending on services and administration exceeds payments.<sup>1</sup> However, if they do not exceed the capitated payment, they may retain a portion of payments as profit. If the capitated payments are too low, access to services may be curtailed as insurance plans may not be able to adequately reimburse clinicians or hospitals.<sup>1</sup> In 2017, spending on Medicaid MCOs totaled over \$263 billion, representing 46% of all Medicaid spending and care for around 80% of Medicaid beneficiaries.<sup>8,9</sup> As of September 2019, there were 283 Medicaid MCOs operating across 40 states.<sup>10,11</sup>

## Medicare

Medicare uses capitation payments to pay commercial insurance companies that offer Medicare Advantage (MA) plans.<sup>12</sup> These plans are paid a capitated, per-enrollee amount by the Centers for Medicare & Medicaid Services (CMS) based on their county-level bids to provide benefits to enrollees. The payments are risk adjusted based on demographic characteristics (e.g., age and gender) and diagnoses.<sup>12</sup> MA enrollment hit 26 million enrollees, or 42% of all Medicare enrollees in 2021.<sup>13</sup>

## Multipayer opportunities or past applications

One example of multipayer use of capitated payments is New York's Capital District Physician's Health Plan, an independent health insurance

company that has had both Medicare and commercial plans, and has a primary care pay model since 2008.<sup>14</sup> As part of this initiative, primary care clinicians (PCP) receive a risk-adjusted capitated payment that pays them 50% more than that what they would receive in fee-for-service payments.<sup>14</sup> Participating PCPs are also eligible to receive a 20 % bonus based on hitting certain quality metrics.<sup>14</sup>

Capital District Physicians' Health Plan (CDPHP) used this capitated payment model as part of the multipayer Comprehensive Primary Care Initiative Plus (CPC+) in New York Capital District-Hudson Valley region, involving 149 primary care practice sites.<sup>15</sup> In addition to Medicare Fee for Service, 4 private health plans participated in CPC+ including CDPHP, Empire Blue Cross, Highmark Blue Cross Blue Shield of Northeastern New York, and MVP Health Care.<sup>15</sup>

## Provider types and provider characteristics

Capitated payments can include services provided by a wide variety of providers with differing provider characteristics; capitated arrangements can focus on care delivered by a particular provider or provider type.<sup>16</sup> They may also include payments for both a provider type and related services by another provider (e.g. a primary care provider and radiology or physical therapy).<sup>16</sup> Global capitation payments cover services for an entire population (see [Global Payment](#) brief).

The provider types included will vary depending on the scope of services included in the capitated payment (e.g., some capitated payment arrangements may include 16 dental services, long-term care, or behavioral health services in addition to typical acute and preventive care services).

## WHAT HAVE BEEN THE RESULTS?

### Financial

Audits have found that capitated MCO contracts have led to savings. For instance, Texas saved

## State considerations

When entering into capitated arrangements directly with providers, states may want to consider<sup>17,18</sup>:

- Whether providers are independent or part of integrated systems, as the incentives to scrutinize and manage service levels are different for these groups.
- The extent and scope of provider services to be included in the capitated payment.
- Whether provider networks are sufficient to meet access and network adequacy requirements.
- Limiting the availability of the payment model to practices that can demonstrate core competencies such as panel management, or prior value-based purchasing experience including managing financial risk, and that are financially stable.

between \$5.3 and \$13.9 billion through the use of Medicaid managed care between 2009 and 2017.<sup>19</sup> Between 2016 and 2017, Ohio saved between \$3.5 and \$4.4 billion through its Medicaid managed care program compared to what it would have paid through a fee-for-service system.<sup>19</sup> In addition, Pennsylvania Medicaid managed care is estimated to have yielded overall Medicaid savings of \$5 billion to \$5.9 billion (\$2.9 billion to \$3.3 billion in State funds) when compared to fee-for-service over 11 years (2000–2010).<sup>19</sup> The same has not occurred in Medicare. The federal government spent \$321 more per person for beneficiaries enrolled in MA plans than for those in traditional Medicare in 2019, which equaled \$7 billion in additional spending.<sup>13</sup> A 2014 study of the primary care initiative in New York showed

that the model incurred savings of \$20.7 million between 2012 and 2014.<sup>14</sup>

### Low- and high-value services

A 2020 study by researchers at the University of Washington found that capitation payments had no impact on the rate of low-value advanced imaging being offered to Medicare enrollees.<sup>20</sup> However, other organizations such as the Urban Institute have found that the financial risk imposed by capitation can reduce the rate of unnecessary services being rendered.<sup>21</sup>

### Health outcomes

Capitated payments seek greater accountability for care and patient outcomes, partly by limiting the provision of unnecessary care or costly procedures, and focusing on care that prevents longer term costs or poor outcomes. However, capitation arrangements have also been viewed as restricting care for complex populations such as individuals with disabilities.<sup>22</sup> For instance, as more beneficiaries with disabilities have transitioned from fee-for-service to MCOs, some states have received beneficiary complaints that their services are being unfairly reduced.<sup>22</sup> A frequent complaint is that MCOs have inappropriately reduced approved hours for personal care attendants and private duty nurses.<sup>22</sup> Researchers at the National Council on Disability, an independent federal agency that advises the White House, Congress, and federal agencies on disability policy, have attributed this trend to MCOs' focus on controlling costs and generating profits for shareholders.<sup>22</sup>

### Model sustainability

The concept of capitation dates back to the early 1900s.<sup>23</sup> It became more prolific in the 1970s, following the passage of the HMO Act in 1973, which encouraged the development of such plans, and specifications as to how they should operate.<sup>23</sup> By the late 1970s, Medicare began to allow beneficiaries to obtain services through HMOs, and in 1982 Arizona became the first state to have Medicaid enrollees receive services via

capitated managed care plans.<sup>23</sup> By the 1990s, capitated HMOs began to face criticism for slowing access to care as they required authorization from a PCP to access care from specialists or other providers.<sup>23</sup> In addition, they appeared to have a higher denial rate of new and experimental treatments compared to non-capitated plans.<sup>23</sup>

This led to a perception that the plans operating under capitation were motivated to find ways to reduce utilization of care in an effort to ensure they would receive a profit from the populations enrolled in their plans.<sup>23</sup> These concerns led to legislation in the 1990s that aimed to strengthen appeal and grievance rights, and requirements for HMOs to contract with any provider willing to agree to the HMO's contractual terms and conditions.<sup>23</sup> Ultimately, enrollment in capitated HMOs decreased in the 1990s and 2000s for commercial

enrollees, while increasing for Medicare and Medicaid enrollees.<sup>23</sup>

Within Medicaid, capitated MCOs have faced criticism that they undermine access to care for specialists including dentists, pediatricians, psychiatrists and other behavioral health providers, and other clinicians (e.g., dermatologists, ear-nose-throat doctors, orthopedists and other surgeons, neurologists, cancer and diabetes specialists).<sup>1</sup> Others have noted managed care has improved access to care compared to fee-for-service as the result of network adequacy standards in place for MCOs.<sup>1</sup> Medicaid payment rates to MCOs have also been cited as a concern.<sup>1</sup> In Illinois, the safety-net provider community boycotted the state's MCO when capitated payment rates were too low, which trickled down to inadequate payments for physicians and hospitals.<sup>1</sup>

## What works and what doesn't?

### Strengths and impacts

- Capitation encourages coordinated care across multiple provider types.<sup>12</sup>
- Under capitation, there is an increased focus on care management which can reduce unnecessary utilization of medical services, such as trips to emergency departments and avoidable readmissions.<sup>12</sup>
- Capitation creates a separation (or check and balance) in duties between those receiving the capitation and those that issue it, with those paying the capitation rate no longer having to provide day to day care management of patients.<sup>12</sup>
- Payers and providers alike have a more predictable payment model.
- Providers are incentivized to innovate and champion care that is effective and efficient.

### Concerns and downsides

- If payments are not adequately risk adjusted, capitation can lead to underpayment for both the entity receiving the payment and the clinicians and hospitals who they then pay.<sup>12</sup> The result can be narrower networks and more limited access to care.<sup>12</sup>
- Patient choice can be more restricted, compared to noncapitated coverage.<sup>26</sup>
- HMOs and MCOs may feel incentivized to deny care in an effort to ensure a profit margin under capitation.<sup>26</sup>

## Health equity and social determinants of health

Under federal Medicaid managed care rules, Medicaid MCOs can use their capitation payments to pay for “In-lieu-of” services, which can include nonmedical care that MCOs find necessary to improve the health of a patient.<sup>24</sup> For example, a state could authorize in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to traditional office visits.<sup>24</sup> Similarly, MA plans have been able to use their capitation rates to offer food, transportation, and gym memberships.<sup>25</sup>

## WHAT ARE THE OPERATIONAL CONSIDERATIONS?

### Addressing downsides of capitation

To address some of the downsides associated with capitation, payers like Medicaid programs and other state payers could incorporate quality measures into their plan contracts to incentivize certain patient outcomes, such as timeliness of an appointment to see a specialist, or addressing social determinants of health. Louisiana for instance, withholds a portion of capitation funds and pays them to the plans that perform best on quality performance targets.<sup>27</sup> State payers could also require standardized medical necessity guidelines. For instance, Arizona Medicaid reviews clinical guidelines and regularly conducts a MCO medical director meeting every 2 months to review clinical practice guidelines.<sup>28</sup>

Similarly, state payers could standardize administrative processes and forms across plans.<sup>29</sup> For instance, California Medicaid developed a state-issued template to standardize how plans classify and report grievances and grievance resolution.<sup>29</sup> Ohio Medicaid requires exclusive use of state developed standardized prior authorization (PA) and concurrent review forms.<sup>29</sup>

## IT infrastructure and analytics

In a capitated payment system, HMOs, MA plans, and MCOs utilize IT to track encounter data, which details the specific services provided to an enrollee by a provider.<sup>30</sup> Encounter data can be used to identify enrollees who may need additional care coordination, for instance, when medical records show events like emergency room visits and hospitalizations.<sup>30</sup> When states delegate care management and service payment to managed care entities, states must also develop the infrastructure to receive and adjudicate encounter data.

States using capitated programs must comply with a range of oversight and monitoring requirements that include ensuring adequate access, quality, efficiency of payment, and oversight of program integrity. Many of these functions will require significant analytic capabilities. Additionally, states are required to develop actuarially sound capitation rates, which requires extensive data validation and analytics.<sup>18</sup>

## Stakeholder perspective

### Commercial insurance companies

Capitation can impose a level of uncertainty for insurance companies. For instance, Wellcare, a company that offers commercial MA and MCO plans, said it is common for MCOs to be contractually obligated to pay state mandated fee schedules, but that as those fees are adjusted, capitation rates are not raised concurrently.<sup>31</sup> America’s Health Insurance Plans (AHIP) point out that capitation rates are often the subject of state budget cutting.<sup>32</sup> Some states historically have modified capitation rates during a contract year in response to state budgetary pressures by reducing MCO rates and without altering the expectations of the scope of services that should be rendered to an enrollee.<sup>32</sup>

### State Medicaid directors

Medicaid directors prefer that capitation rate decisions remain at the state level, and have rejected increased federal oversight on this matter.<sup>33</sup> State Medicaid officials point out they need the flexibility to establish unique payment arrangements (such as the use of withholds from capitation rates) in response to variables such as enrollment, legislative action, or budget constraints which are out of their control.<sup>33</sup> They have also found this flexibility to be a key tool to drive quality improvement and performance in Medicaid managed care plans.<sup>33</sup>

### Private physician practices

In primary care practices, capitation from commercial payers have been key to funding care manager positions.<sup>34</sup> These dedicated care managers concentrate on patient management between office visits, which alleviates physician workloads.<sup>34</sup> Providers also like the predictability of knowing a set amount in revenue is coming in each month, and that that amount has been adjusted based on patient characteristics, such as age, sex, and health status.<sup>34</sup> Capitation payments have also been key in allowing for the care of patients who are uncomfortable receiving care in traditional medical settings due to prior care experiences.<sup>34</sup> Practices have been able to use capitated payments for innovative and flexible delivery of care, such as to deploy mobile units to community centers and other nontraditional care settings.<sup>34</sup>

### Authorities (state and federal)

There are three managed care authorities states can leverage to implement capitated payments in Medicaid. These include State Plan authority under Section 1932(a) of the Social Security Act, waiver authority under Section 1915(a) and (b), and demonstration waiver authority under Section 1115 of the Social Security Act. Which authority is needed depends on whether the program is state-wide, has freedom of choice, uses a broker, offers nonmedical or “in-lieu-of” services, and which populations are to be enrolled in the program.<sup>19</sup>

Commercial HMOs are regulated at both the state and federal levels.<sup>23</sup> States issue certificates of authority, which allows a plan to operate an HMO.<sup>23</sup> Both state and federal regulators also issue their own respective mandates around scope of services.<sup>23</sup> The National Association of Insurance Commissioners adopted the HMO Model Act in 1972, which was intended to provide a model regulatory structure for states to use in authorizing the establishment of HMOs and in monitoring their operation.<sup>23</sup> To be federally qualified, HMOs had to satisfy a series of requirements such as meeting minimum benefit package standards, demonstrate network adequacy, establish quality assurance systems, and ensure financial solvency.<sup>23</sup>

## Other briefs in this series

- [Bundled Payments](#)
- [Cost Growth Targets](#)
- [Global Payments](#)
- [Outcome Incentives and Disincentives](#)

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