



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Global Capitation to an Organization

Robert A. Berenson
URBAN INSTITUTE

Divvy K. Upadhyay
URBAN INSTITUTE

Suzanne F. Delbanco
CATALYST FOR
PAYMENT REFORM

Roslyn Murray
CATALYST FOR
PAYMENT REFORM

April 2016





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Contents

Global Capitation to an Organization	1
Key Objectives	2
Strengths	3
Weaknesses	3
Design Choices to Mitigate Weaknesses	5
Compatibility with Other Payment Methods and Benefits Designs	6
The Focus of Performance Measurement	6
Potential Impact on Provider Prices and Price Increases	7
Note	9
Acknowledgments	10
Statement of Independence	11

Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

Global Capitation to an Organization

Global capitation is a payment model specifically for integrated health care delivery. In this model, capitation payment for services delivered by different providers or at different levels of care is combined into a single prospective payment to an integrated care organization or a large physician group. The provider is then responsible for delivering all needed care for a defined population and for distributing payments to its constituent providers out of the capitation pool. The core concept is that total payment does not vary based on the actual services provided to individuals in the population served.

The services included in global capitation typically include at least physician, hospital, and postacute care facility-based services, and may include additional services, such as prescription drugs. For health plan enrollees, capitated payments are expressed as per member per month payments¹ and are usually adjusted at least for age and sex. Payers also have pushed to risk-adjust payments by enrollees' health status, usually calculated based on the diagnoses clinicians and hospitals specify on encounter forms. A similar approach that effectively provides global capitation is for insurers to pay a specified “percentage of premium”—an actuarially based amount that represents the percentage of the

market-specific insurance premium (which also is made per member per month) that supports the clinical services for which the capitated provider organization is responsible.

By accepting a defined fixed payment to provide contracted services, providers assume the financial risk for their patients, usually including both insurance risk and technical risk. The former is financial risk caused by the likelihood of a random event occurring that is not under the control of providers. The latter relates directly to how care is produced, and therefore is under the providers' control. Because of insurance risk, organizations accepting global capitation typically buy reinsurance to help protect against losses from unanticipated high-cost cases.

For global capitation contracting to work well, it should apply over a sufficient number of members to spread insurance risk, thereby reducing volatility and the impact of bad financial experience resulting from random occurrences. Capitation rates are usually determined based on actuarial analysis, taking into account prior spending by the population to be served, the benefits covered in the capitation payment, and assumptions about medical management and other cost controls available to the integrated group.

Although the global capitation model had been in limited existence for many years, it spread substantially in the 1990s with sharp growth in the number of HMOs. The failure of physician practice management companies (which were hired to manage risk) and some integrated delivery systems (that were taking risk), as well as the negative reactions from providers and patients about perceived restrictions on choice and access to care, dampened this trend. Over the past decade, there has been a shift from global capitation toward capitation for professional services only. Also, self-funded employers are generally precluded from shifting risk to provider organizations, as this would bring scrutiny from state insurance regulators.

Key Objectives

Because payment does not vary based on the actual services provided, global capitation encourages provider organizations to deploy the mix of activities and staffing they deem best able to serve the populations assigned to their care. If payers similarly provide global capitation payments, the recipient organization in effect must manage within a defined, known budget, with inherent incentives to increase efficiency and manage costs. In essence, global capitation transfers responsibility for managing medical care costs and quality from the third-party payer directly to the provider receiving the payment.

Strengths

- Global capitation is the most robust method for health care services across the spectrum to internalize incentives for improving efficiency and effectiveness. It is the prototypical population-based payment method and offers the recipient organization the greatest opportunity to change its business model and culture.
- The model promotes integration of services across what are often “siloed” independent clinicians and facilities.
- Global capitation is a form of prepayment that provides ongoing cash flow, which permits recipients to deploy capital for delivery system enhancements and to establish reserves that comply with regulatory requirements on risk bearing.
- The model offers providers broad flexibility to determine the best mix of services and to identify the particular professionals best able to meet the target population’s needs.
- Global capitation puts clinicians, rather than payers, directly in charge of patient care decisions, but offers incentives for more prudent expenditures.
- A global capitation payment is a relatively simple transaction, involving less administrative infrastructure for both payers and providers than fee-for-service does. Yet, the method becomes complex when payers require risk adjustment of payments and monitoring of quality.
- Approaches such as two-sided shared savings attempt to incent provider organizations to reduce total cost of care. In contrast, global capitation, which makes up-front base payments to the provider organization, permits the greatest flexibility in deployment of resources and payment of health professionals, other providers, and suppliers.

Weaknesses

- The method places both insurance and technical risk on providers, which can result in financial losses outside providers’ control and lead to indiscriminate service reductions and stinting on care.

- Many organizations lack the capital and infrastructure, including administrative data systems, to manage substantial financial risk. Global capitation may not be a payment reform with broad applicability, especially given the cautionary experience of its wider use in the 1990s.
- Similarly, organizations may lack the managerial skills and commitment to manage patient care in ways consistent with global capitation.
- Risk-bearing provider organizations have greater potential to become insolvent or to compromise quality. This potential calls for strong regulatory oversight, which some jurisdictions may be reluctant to take on. Further, oversight of globally capitated entities can be challenging because data and reporting are lacking when there is no fee-for-service billing.
- In market-based health systems without regulated prices, consolidated and integrated groups capable of accepting global capitation can develop market power and use it in their price negotiations with payers, thereby raising prices and health care spending even if they are able to reduce service use.
- Common risk-adjustment approaches using recorded diagnoses are subject to “code creep”—when more extensive coding of diagnoses and procedures increases patients’ apparent costliness. Adjusting for and detecting code creep also makes the approach more administratively complex than the simple per person per month payment suggests.
- Established approaches to global capitation, in an HMO context, generally require individuals to “enroll” with the capitated organization, therefore limiting their freedom to select clinicians of choice at the point of service.
- Many clinical activities—for example, evidence-based recommendations for prevention services—don’t “pay off” for many years. The typical one-year enrollment does not reward globally capitated providers for investing in preventive activities when would be realized in the future, when the patient may no longer be enrolled with that organization.
- Consumers may be concerned that the incentives in global capitation (as well as in other forms of capitation) will compromise the doctor-patient relationship, at the core of which is the physician’s duty to act in the patient’s best interests, regardless of impact on the bottom line.

Design Choices to Mitigate Weaknesses

Various approaches to addressing insurance risk are possible, including reinsurance for high-cost individuals and for excessive aggregate spending—typically, these are available at a cost to the organization. Global capitation can be accompanied by risk corridors, in which a payer and an at-risk provider organization agree to share in both upside and downside risk. This reduces financial exposure (even for technical risk) and can be especially beneficial for organizations new to the approach or with limited reserves, while still providing financial incentives to prudently preserve resources.

Global capitation works best with implementation of sophisticated risk adjustment for patients' health status. Risk adjustment attempts to mitigate providers' incentives to avoid sick or complex patients and promotes integrated management models to care for such patients. However, the data needed for most risk adjustment models must be collected from encounter data with diagnoses, thereby reducing administrative simplicity, one theoretical advantage inherent in paying a fixed, prospectively set amount. Risk adjustment based on diagnostic coding in claims or encounter forms is subject to code creep that raises risk scores and, thus, payments. That has been the experience in Medicare Advantage and could be even a greater issue when provider organizations have a direct interest in “finding” all diagnoses to improve risk scores—and payment amounts.

How capitation rates are updated determines their impact on spending over time. Setting and updating capitation payments based on providers' incurred costs can reduce incentives for cost control. So, in distinct contrast to typical calculations in shared savings payments for ACOs, global capitation payments are often based on actuarial analysis of likely costs for the average patient across all providers, then risk-adjusted for the population served by the organization.

An appeal of percentage-of-premium payment is that it grounds payment to the average marketplace premiums (or the equivalent for public payers). However, percentage-of-premium payments may also reflect strategic considerations the payer uses in determining its premium rates (e.g., to gain market share by having aggressively priced premiums). When that occurs, the percentage-of-premium may be lower than the capitation rate that would otherwise have been determined through actuarial analysis.

Compatibility with Other Payment Methods and Benefits Designs

Globally capitated providers adopt their own provider payment methods rather than rely on the third-party payer to do so. Global capitation is flexible in permitting a range of options, assuming the globally capitated group can administer or contract out for the approach, which may involve sophisticated claims processing. The payment method may vary based on specific participants in the risk-bearing entity and the particular delivery culture. For example, a globally capitated, integrated health system based around a hospital might use DRGs to make hospital payments compatible with the dominant Medicare system, while providing incentives to reduce length of stay. Yet, a globally capitated medical group might shop aggressively for hospital care and use per diems, because the group, through its own physicians, could assure that length of stay is not extended unnecessarily.

Globally capitated provider organizations can pick a range of payment options to compensate health professionals, including salary, productivity analysis of fee-schedule-based relative value units produced, various forms of sub-capitation, including primary care, specialty, and contact capitation.

Because most states regulate risk-bearing provider entities out of concern providers could become insolvent or stint on care, global capitation requires an HMO product design, rather than a PPO. PPOs' market shares have been growing with a concomitant decrease in HMO share, because PPO products are consistent with employer self-funding and because PPOs assure patients more choice in providers.

Global capitation relies fundamentally on supply-side rather than demand-side attention to costs and cost control. Under global capitation, fee-for-service transactions between payer and provider do not exist, so some forms of patient cost-sharing do not work well. Co-payments for office visits and some other services are commonly used, but high deductibles, coinsurance, and value-based benefit designs would seem incompatible, because the patient's share of the cost would be tied to encounter codes, which may not be relevant under global capitation. At the same time, high deductibles and other forms of cost-sharing do discourage spending so have theoretical appeal to some.

The Focus of Performance Measurement

Payers can require quality-related performance measures to expose organizations that would stint on care, as well as to counter the disincentive to invest in prevention activities that might prevent illness. Providing the public with measures of primary and secondary prevention services, such as those

available through HEDIS, may help allay consumers' concerns about health professionals compromising care for financial reasons.

However, provider organizations are responsible for the entire continuum of care, not simply prevention and routine services (for which there are a raft of available performance measures). Globally capitated providers want to keep most services within their own delivery system, even when a referral might produce a better clinical outcome, because of cost differentials and because continuity and coordination of care is easier within a narrower group of health professionals. Yet, currently, few measures of referral appropriateness for services for which differences in clinical expertise may be relevant to the resultant care outcomes. Where measures fall short, payers will have to consider other approaches to holding provider organizations accountable for quality.

Potential Impact on Provider Prices and Price Increases

Global capitation rates are typically calculated based on actuarial analysis of average individuals—the normative or community average—not the historic costs of care capitated providers have experienced. In short, paying the community average, adjusted for individual consumer risk, provides a basis for addressing pricing (in that the capitation amount would exclude the effect of prices on overall spending).

However, an insurer's ability to globally capitate a provider based on the community average varies with each party's negotiating leverage. Provider organizations with pricing power can achieve higher capitated payment levels that deviate up from the community average. When the payer must concede higher capitated rates to some provider organizations, it might have to reduce payments to other providers to meet actuarial targets for competitive premiums, thereby further increasing pricing variations across providers.

A globally capitated health care system or physician group offers different opportunities for addressing pricing differences in hospitals and, to a lesser extent, the physician specialty market. Health care systems typically grant preference to hospitals within their own systems, whatever their prices. In contrast, a physician group without commitment to a particular hospital or hospital system can aggressively shop on price, assuming quality is comparable. By actually moving or threatening to move patients from one hospital to another, a capitated physician group can achieve price concessions from hospitals seeking to preserve or increase their market share of bed days and outpatient services. Of

course, again, physician groups can only negotiate lower prices in reasonably competitive markets, such that the threat of moving patients is a credible one.

Note

1. Where consumers are not enrolled as members in a health plan, capitated payments might be referred to as per person per month.

Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.

A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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2100 M Street NW
Washington, DC 20037

www.urban.org