



RESEARCH REPORT

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

Primary Care Capitation

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





ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

Contents

Primary Care Capitation	1
Key Objectives	2
Strengths	2
Weaknesses	3
Design Choices to Mitigate Weaknesses	4
Compatibility with Other Payment Methods and Benefit Designs	5
The Focus of Performance Measurement	5
Potential Impact on Provider Prices and Price Increases	6
Note	7
Acknowledgments	8
Statement of Independence	9

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](#).

Primary Care Capitation

Capitation is a prospective unit of payment per patient, per month or year, in which a payer makes a fixed payment for a defined set of services, regardless of the quantity of services actually provided. This payment approach can be used for an individual health professional, for a group of health professionals for their collective professional services (“professional capitation”), or for provider organizations to assume risk for most health services (“global capitation”). Primary care capitation was a commonly used payment method in the 1980s and 1990s and still persists (although less commonly) today, associated with the rise and decline of health maintenance organizations (HMOs) as a common form of managed care. Primary care capitation required insured individuals to select one primary care physician (known variously as a “gatekeeper” or “primary care case manager”) both to provide of routine care and to approve referrals for other nonemergency health services.

Actuarial concerns complicated the early capitation models that estimated rates based on an actuarial analysis of fee-for-service claims; arguably, serving as a gatekeeper requires providers to expend additional effort that was not recognized under fee schedules and was therefore not included in their payments. Also, primary care capitation methods typically adjusted payments for a patient’s age

and gender but not for health status, leading to a mismatch between patients' needs and capitation payments.

Many states, concerned about the incentive to deny needed services under primary care capitation, consider the method to constitute risk bearing. These states thus restrict primary care capitation for use within an HMO structure, but not in other products, including the more common and growing preferred provider organization (PPO) insurance model.

Key Objectives

The theoretical virtue of primary care capitation is that it permits primary care physicians themselves to decide what mix of activities best serves each patient, rather than rely on third-party payers to approve payment codes and payment levels to influence how clinicians spend their time. Primary care capitation places decision-making in the hands of health professionals who may be in a better position than distant insurers to act in patients' best interests. In addition, in direct contrast to fee schedules, primary care capitation in effect establishes spending limits for the patients a physician is responsible for, thereby creating financial incentives in favor of activities that reduce spending.

Strengths

- Primary care capitation places “performance risk” on clinicians, providing them financial incentives to limit provision of unneeded services.
- This payment approach internalizes to the primary care physician decisions over the allocation of activity and costs, permitting more flexibility in individualizing care to meet patients' needs.
- Payers can support newer forms of communication and care delivery that substitute for the traditional office visit, such as e-mail and telehealth, much more easily and prudently through capitation than under fee schedules.
- The approach gives payers predictable and capped costs, while providing the recipient clinician a predictable cash flow.
- Primary care capitation is administratively straightforward (although design approaches to address its weaknesses can add substantial complexity). At its simplest, providers receive

payment every month for a roster of patients, obviating the need for billing and paying for each service provided (as under fee-for-service).

Weaknesses

- Primary care capitation has traditionally been adopted in HMOs, which can restrict patients' choice via the primary care physician route.
- HMOs are subject to state regulatory oversight and thus have limited potential to apply primary care capitation. Self-funded employers and PPO products are not subject to such oversight and are therefore not permitted to use this approach.
- Primary care capitation may lead to stinting on care—particularly care that can be avoided without compromising the patient's well-being in the short term (e.g., disease screening and prevention services).
- In the absence of risk adjustment for health status, primary care physicians can “cream-skim”—that is, shun sicker, costlier patients that would take up more time and resources in favor of healthier ones for whom payment would be the same.
- The approach creates an incentive for primary care physicians to refer their patients to other physicians for services outside the scope of the capitated payment. For example, primary care clinicians under a capitated payment may choose to refer patients to specialists, who may be paid fee-for-service, rather than caring for them directly, fragmenting care and raising total costs to the payer.
- In a pure primary care capitation model, payers can't use a fee schedule or P4P to promote activities or services they want to encourage.
- A single monthly capitation payment has little transparency to reveal clinicians' activities, making performance measurement, performance assessment, and risk adjustment for health status virtually impossible.
- Payment per capita provides clinicians a financial incentive to take on too many patients, exacerbating concerns about stinting and overreferral.

- Conversely, primary care capitation assumes statistical averaging of patients with different health care needs, so a minimum number of patients is needed for it to work correctly. Payers may need to maintain a fee-for-service program in parallel with capitation, adding administrative complexity.
- Direct payments to primary care providers represent a small percentage of health care spending—5 to 6 percent. Unless the design includes a strong incentive system for rewarding or penalizing total health care spending attributable to the physicians' patients, this approach might not be worth the implementation effort.

Design Choices to Mitigate Weaknesses

Payers can design primary care capitation to mitigate stinting by measuring performance of preventive services. Yet that requires physicians to submit information typically contained in fee schedule claims, counteracting the simplicity capitation offers. Encounter data would allow payers to perform risk adjustment of capitation payment levels, as well as to assess quality and access to care.

Primary care capitation gives physicians strong incentives to refer patients to providers outside the purview of their capitation payments. To address this, payers could impose financial penalties for excessive referrals and downstream health care spending. Such an approach would help justify the administrative effort to introduce a capitation method only for a subset of physicians. In the past, primary physicians under capitation were accountable for health spending for patients in what were called risk pools. Capitation “withholds (e.g., 20 percent of the monthly capitation amount) could be returned if the risk pool showed a surplus, a form of the shared savings approach now being used for accountable care organizations (ACOs).

Payers may impose ceilings on the number of individuals physicians can have on their rosters, to counteract the incentive to overexpand the physician's patients. Cream-skimming can be addressed through risk adjustment, but that would require physicians to submit encounter forms with claims-like detail; moreover, experience suggests encounter data that is not part of a payment claim may be less reliable.

Payers can encourage performance of particular services by making them targets of a complementary P4P program, or “carving out” services from the capitation package (e.g., immunizations, for fee schedule payment). Most generally, primary care capitation might be placed with

some amount of fee schedule payments in a mixed payment model to balance the incentives of the two approaches.

Compatibility with Other Payment Methods and Benefit Designs

Capitation is typically used only by HMOs because only HMOs can use a primary care physician system in which a patient selects a single physician or group for services and for access to specialty care.

As discussed under fee-for-service, a hybrid of primary care capitation and fee schedule payment, as well as incremental payments such as shared savings and P4P, are all compatible—and in some contexts, probably desirable. This hybrid approach softens the polar financial incentives of capitation and fee-for-service but adds complexity to the payment approach.

Flat co-payments for office visits can be accommodated under primary care capitation, but high-deductible plans and prepayment through capitation would seem incompatible, at least from the standpoint of the primary care physician trying to manage total costs of care. However, high patient cost-sharing reduces patients' demand for services, which would actually result in less demand on physicians' time and practice resources. But the payers' actuaries would realize this reduced spending and would likely seek to lower capitation levels. Value-based insurance design (V-BID), which reduces or eliminates cost-sharing for certain high-value primary care services, would counter the incentive for physicians to stint on these particular services.

Prior authorization by primary care clinicians is a natural complement to this payment approach and, indeed, is the clinicians' responsibility when they have the formal role of gatekeeper to elective services provided by other providers. Capitated primary care physicians might welcome precertification by health plans for specialty-generated care if they have risk pools or other two-sided risk incentives.

The Focus of Performance Measurement

HEDIS-type performance measures are strong in the areas of screening and primary and secondary prevention services, and they can be useful to identify stinting on these services.¹ Because concerns

about appropriate referrals are central to assessing performance, measures related to referral rates would be desirable, as would rates of emergency room and hospital admission and readmission.

Potential Impact on Provider Prices and Price Increases

Capitation rates are typically calculated based on actuarial analysis of past experience, so that the rates represent a community average rather than historic costs for individual practitioners or practices. In this way, capitation payments do not reflect provider-specific pricing differentials. However, physician practices with negotiating leverage can, nevertheless, achieve higher capitated amounts that deviate from the community average, effectively passing through higher prices and desires for higher-than-average price increases in their capitated rates.

Note

1. The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used health care performance measures in the United States and is managed under the auspices of the National Committee for Quality Assurance.
www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx#sthash.B74KCSM4.dpuf.

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.

STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



2100 M Street NW
Washington, DC 20037

www.urban.org