

Using Cost Accounting Data to Develop Capitation Rates

By: Mark E. Toso, CPA, President
Anne Farmer, Vice President
TriNet Healthcare Consultants, Inc.

A capitation payment arrangement can be an effective means to control health care costs, because it allows both the insurer and the employer to predict costs for health care services more accurately. This article describes a six-step methodology for developing a capitation payment rate and establishing such arrangements. The six steps are: (1) determine the delivery system cost base, (2) develop use rates, (3) calculate capitation rates, (4) adjust rate for impact of incremental volume, (5) negotiate the contract, and (6) monitor performance.

INTRODUCTION

Two major objectives of health care reform are controlling the growth of health care expenditures and managing the utilization of health care resources. The development of managed care models has prompted providers, insurers, and employers to begin to restructure the health care delivery model from its current fragmented state into an integrated entity able to provide a full continuum of care. The development of integrated health care systems, involving the merging of hospitals, the development of physician-hospital organizations, and the merging of insurers with providers, will enable managed care networks and other payers to evolve toward reimbursement methodologies that are different than the traditional fee-for-service reimbursement models in use today.

Under the Clinton health care reform proposal, the directive calling for the formation of Affiliated Health Plans (providers) and Health Alliances (purchasers) is consistent with the development of a capitation payment method. Using such a method, there is a uniform per capita payment or fee.

When a capitation payment method is used, the financial risk of caring for the patient is transferred to the medical delivery system. This type of payment method will not work unless the hospital and physicians are integrated, either organizationally or contractually, and a sufficient population can be identified where the utilization of medical services by that population can be predicted with a reasonable degree of certainty. As integrated health care delivery systems evolve, both these criteria must be met.

Using the capitation payment method, the health care provider assumes that for a given insured population, the provider will cover all health care services for a fixed payment per member per month (PMPM). This capitation payment could cover the full continuum of services, including acute hospital stays, non-acute

hospital stays, outpatient visits, home health visits, primary care physician visits, specialty physician visits and tertiary physician visits (see Figure 1).

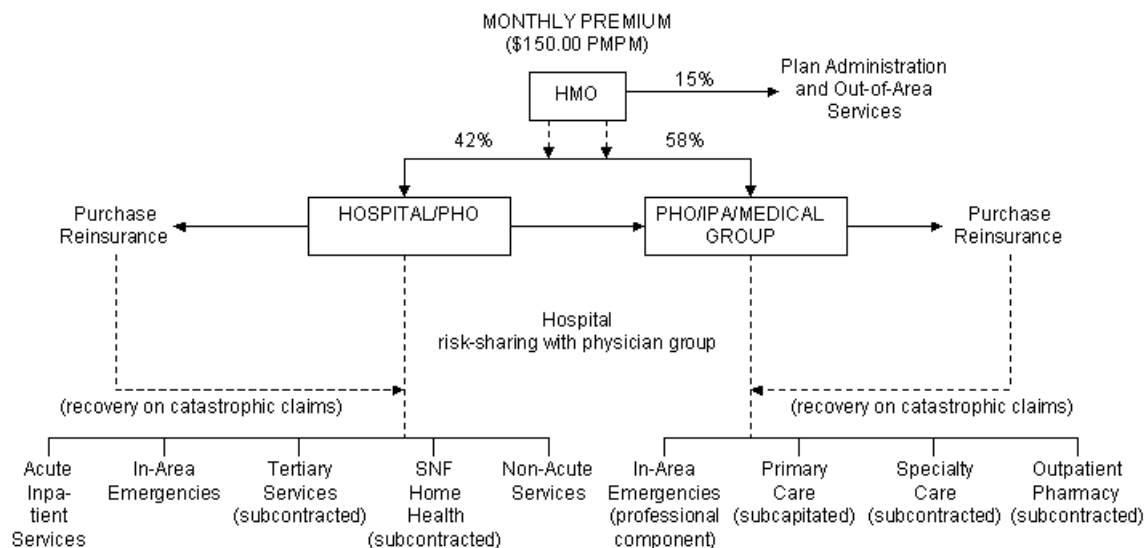


Figure 1. Typical hospital-physician capitation rate development.

An acceptable payment must be fair both from the insurer's point of view and from that of the delivery system or provider. The flow chart in Figure 1 demonstrates that the insurer will be limited by what the consumer can afford to pay for health insurance. Managers of the health care delivery system must know the per capita cost of providing care to the insured population and compare that cost to what the insurer is being paid per capita per month.

As Health Alliances, or managed care plans, move toward a capitation payment method, the transfer of financial risk to the medical delivery system will require the managers of such delivery systems to control costs and manage utilization. To prepare for the changeover to this type of payment system, health care providers will need to be able to:

- predict the utilization of health care services by a specific population, and
- predict the cost of providing those services with a significant degree of accuracy.

Under a capitation payment plan, the delivery system also takes on the risks normally assumed by the insurance company. Therefore, the risks need to be carefully assessed and considered when negotiating the contract.

This article provides an overview of the development of capitation rates, using cost accounting information as well as data from a market study. The conclusion covers several critical issues that should be considered during the contract negotiation phase.

DEVELOPMENT OF A CAPITATION PAYMENT RATE

A strategy, or approach, for developing a capitation rate with an insurer for an identified population is outlined in Exhibit 1. The methodology shown represents the steps of a general approach to develop a capitation rate and, as normally occurs within the health care system, the actual process will no doubt be considerably more complex.

1. *Determine Delivery System Cost Base for Targeted Population* – The first step in determining the capitation rate is to predict the costs of providing care to the insurer's population, based on assumptions about the population and on the cost structure of the delivery system. Information from a cost accounting system is necessary for this step. Accurate cost data should be figured by service and should be broken out into the components of fixed and variable costs. Exhibit 2 shows sample cost information for a hypothetical hospital by service line. Using this method, inpatient service lines are defined by grouping diagnosis-related groups (DRGs) into 16 categories. Although decision support systems allow products or service lines to be defined using any of a number of variables, a classification of services on the basis of DRGs is preferable because details about DRGs are generally available in comparative data bases (described in step 2).

Before producing such reports, an assumption must be made about the patient population to be covered. If the current volume from the insurer is not significant, then a larger patient base, but one with utilization patterns similar to those of the insurer's population, should be used to determine costs.

In this example, the patient subset includes all hospital cases covered by nongovernment payers (i.e., Medicare and Medicaid patients have been excluded). Inpatient volume has been adjusted for case-mix intensity (CMI) using the current DRG weights supplied by the Health Care Financing Administration. The reason the inpatient volume has been adjusted for CMI is to calculate an average cost per case. The CMI provides the appropriate weighting for each case, which allows for the calculation of an average cost per case.

Although the example in Exhibit 2 does not include the physician cost components, such components need to be included in the development of the capitation rate. Without the inclusion of physicians' fees in the capitation contract, the delivery system would not control the primary decision-maker with regard to utilization of services.

Exhibit 1. Strategy for Developing Capitation Rate

Step 1 – Determine Delivery System Cost Base

- Define service lines
- Determine patient population for cost analysis
- Apportion cost by delivery (I/P, O/P, home health)
- Determine fixed and variable costs by service
- Adjust volume for case mix intensity

Step 2 – Develop Use Rates for the Insured Population

- Determine patient population (e.g., all non-government payers)
- Determine service area/localities of population covered
- Calculate use rate by service (optional: by diagnosis related group, age, payer)

Step 3 – Calculate Capitation Rates

- Determine number of enrollees for insurer
- Apply use rates from step 2
- Determine costs for expected volume
- Calculate costs per member per month

Step 4 – Adjust Capitation Rate for Impact of Incremental Volume

- Compare expected volume to current volume from insurer
- Determine fixed costs (covered by existing volume)
- Determine variable costs (volume x variable cost/unit)
- Recalculate costs per member per month

Step 5 – Negotiate Contract

- Patient incentives
- Termination clauses
- Inflation indices
- Implications of not negotiating
- Initial settlement process
- Risk sharing
- Volume adjustment
- Case mix adjustment
- Operational issues

Step 6 – Monitor Contract Performance

- Monitor utilization/use rates
- Manage costs

Exhibit 2. Delivery System Costs

Service	Fixed Costs	Variable Costs	Total Costs	Cases or Visits	CMI	CMI--Adj. Volume	Costs/Unit		
							Fixed	Variable	Total
Cardiac Surgery	136,000	124,000	260,000	24	3.0833	74	1,837.84	1,675.68	3,513.52
Cardiology	1,342,200	894,800	2,237,000	763	0.8493	648	2,071.30	1,380.86	3,452.16
Detox	490,000	397,000	887,000	261	0.9579	250	1,960.00	1,588.00	3,548.00
Gastroenterology	440,000	366,000	806,000	298	0.8289	247	1,781.38	1,481.78	3,263.16
Gynecology	550,000	491,000	1,041,000	317	1.0032	318	1,729.56	1,544.03	3,273.59
Neurology	220,000	177,000	397,000	153	0.9281	142	1,549.30	1,246.48	2,795.78
Neurosurgery	158,000	137,000	295,000	47	1.6596	78	2,025.64	1,756.41	3,782.05
Nursery	232,000	194,000	426,000	1,683	0.5205	876	264.84	221.46	486.30
OBS--Delivery	2,178,000	1,452,000	3,630,000	1,909	0.4547	868	2,509.22	1,672.81	4,182.03
OBS--Nondelivery	254,400	169,600	424,000	265	0.3849	102	2,494.12	1,662.75	4,156.87
Oncology	268,000	233,000	501,000	91	1.2527	114	2,350.88	2,043.86	4,394.74
Other Medical	1,234,800	823,200	2,058,000	735	0.8925	656	1,882.32	1,254.88	3,137.20
Pediatrics	1,204,800	803,200	2,008,000	788	0.8249	650	1,853.54	1,235.69	3,089.23
Psychiatric	351,000	234,000	585,000	148	0.8581	127	2,763.78	1,842.52	4,606.30
Special Care Nursery	357,000	307,000	664,000	339	1.5251	517	690.52	593.81	1,284.33
Other Surgery	2,732,400	1,821,600	4,554,000	1,026	1.5107	1,550	1,762.84	1,175.23	2,938.07
Subtotal Inpatient	12,148,600	8,624,400	20,773,000	8,847	0.8158	7,217	1,683.33	1,195.01	2,878.34
Outpatient	4,820,000	3,940,000	8,760,000	17,000		17,000	283.53	231.76	515.29
Home Health Care	306,000	438,000	744,000	10,000		10,000	30.60	43.80	74.40
Subtotal Outpatient	5,126,000	4,378,000	9,504,000	27,000		27,000	189.85	162.15	352.00
Total Hospital	17,274,600	13,002,400	30,277,000						

Source: Hospital Cost Accounting System. Data includes all nongovernment payers.

Other supporting documentation might include reports on costs by DRG, by department, by physician and/or specialty, by age break out, and by other detailed information that is normally found within the hospital's cost accounting system. This information can be used in developing more detailed rates as well as in monitoring contract performance. In particular, age and sex break outs can be used to develop detailed rates, which will enhance the predictability of costs.

Without the inclusion of physicians' fees in the capitation contract, the delivery system would not control the primary decision-maker with regard to utilization of services.

2. *Develop Use Rates by Major Service for the Insured Population* – Because the delivery system will be responsible for managing the utilization of health care resources for the covered population, it is important to understand the health care utilization patterns of that population. A market study should be used to calculate use rates for the population to be covered. In many states, inpatient case-mix data, at the patient level, is publicly available and can be used for this purpose. In fact, to facilitate access to this data, such comparative data bases may be loaded into the provider’s decision support system. It is important that such a comparative data base include, minimally, the following elements; DRG, age, zip code, and payer category (e.g., Medicare, Medicaid, commercial, self-pay).

Exhibit 3 shows the calculations for the use rates by service line for the population to be covered by the capitation contract. Again, a patient subset that would reflect similar utilization patterns to that of the insurer must be selected. Because patient data that is publicly available is generally not detailed by individual insurer, a larger group of patient data must be selected as the basis for such calculations. In this example, all cases covered by nongovernment payers in the service area were included.

Exhibit 3. Use Rates

(1) Service	(2) Svc area cases/visit	(3) CMI	(4) Svc area volume (C2 x C3)	(5) Popula- tion	(6) Use rate per 1000 (C4 / C5 x100)
Cardiac surgery	357	3.4734	1,240	85,000	14.59
Cardiology	1,575	0.8559	1,348	85,000	15.86
Detox	604	0.9272	560	85,000	6.59
Gastroenterology	945	0.7937	750	85,000	8.82
Gynecology	670	0.9537	639	85,000	7.52
Neurology	432	0.8981	388	85,000	4.56
Neurosurgery	139	2.4173	336	85,000	3.95
Nursery	3,233	0.4132	1,336	85,000	15.72
OBS--Delivery	3,652	0.4614	1,685	85,000	19.82
OBS--Nondelivery	595	0.3748	223	85,000	2.62
Oncology	403	1.0819	436	85,000	5.13
Other medical	2,171	0.9139	1,984	85,000	23.34
Pediatrics	2,186	0.9058	1,980	85,000	23.29
Psychiatric	540	0.8389	453	85,000	5.33
Special care nursery	638	1.5345	979	85,000	11.52
Other surgery	3,477	1.5200	5,285	85,000	62.18
Total inpatient	21,617	0.9077	19,622	85,000	230.84
Outpatient	28,000		28,000	85,000	329.41
Home health care	20,000		20,000	85,000	235.29
Subtotal outpatient	48,000		48,000	85,000	564.71

The service area must be defined to include the localities of the population to be insured. Exhibit 3 includes the patients from selected zip codes (which represent the localities served by the insurer's population). Although the hospital does not currently provide care to 100 percent of the insurer's population, the calculations are based on the assumption that once the capitation contract is negotiated and signed, the hospital would be responsible for all of the insurer's covered lives in its service area.

3. *Calculate Capitation Rate* -- The information from the cost accounting system and the market study is then combined to determine the expected costs of covering the insured population. Exhibit 4 shows the calculations of the capitation rate. The rate is predicated on the assumption that the cost per unit for the services provided by the delivery system would not change if the entire insurer's population was provided services by the hospital through its Affiliated Health Plan.

Based on the assumptions made in steps 1 and 2, the baseline capitation rate to cover costs is determined to be \$74.13 PMPM. The calculations that established this rate do not offer a way to adjust the figure for changes in the incremental volume and/or changes in the fixed or variable costs.

In addition to covering the cost of delivering health care services, the capitation rate should also include, if possible, an amount to cover capital replacement, working capital, and profit margin. Exhibit 4 includes a profit margin of 2.5%, a \$1.50 PMPM for capital replacement, and \$1.00 PMPM for working capital in the capitation rate. This brings the capitation rate to \$77.71 PMPM.

4. *Adjust Capitation Rate by the Incremental Volume* – The insurer assumes that the contracted delivery system will be responsible for providing health care to the entire population served by the insurer. If the insurer directs all of its subscribers within its service area to use the services provided by the delivery system and the use rates do not increase or decrease, then the capitation rate could be adjusted for the fixed and variable cost structure of the provider. As shown in Exhibit 5, if there is existing capacity, and if the fixed-variable cost relationships in the cost accounting system are valid, then the baseline cost to provide services to the insurer's subscribers is reduced from \$4,449,133 (Exhibit 4) to \$3,271,716, the difference being due to fixed costs savings. If the incremental volume is directed to the delivery system, then the adjusted capitation rate based upon cost is reduced to \$54.52 PMPM. This reduction from \$77.71 to \$54.52 PMPM assumes that the delivery system will be able to maintain its utilization and cost structures at the current levels and that the delivery system provides all of the required services to the insurer's subscribers.

Exhibit 4. Capitation calculation

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Service	Use Rate per 1000 (Exhibit 2)	Total Enrollees (estimate)	Cost/Unit (Exhibit 1)	Annual units (C2 x C3)	Total annual cost (C5 x C4)	Cost per enrollee/ month (C6 / 12 / C3)
Cardiac surgery	14.59	5,000	3,513.52	73	256,487	4.27
Cardiology	15.86	5,000	3,452.16	79	272,721	4.55
Detox	6.59	5,000	3,548.00	33	117,084	1.95
Gastroenterology	8.82	5,000	3,263.16	44	143,579	2.39
Gynecology	7.52	5,000	3,273.59	38	124,396	2.07
Neurology	4.56	5,000	2,795.78	23	64,303	1.07
Neurosurgery	3.95	5,000	3,782.05	20	75,641	1.26
Nursery	15.72	5,000	486.30	79	38,418	0.64
OBS--Delivery	19.82	5,000	4,182.03	99	414,021	6.90
OBS--Nondelivery	2.62	5,000	4,156.87	13	54,039	0.90
Oncology	5.13	5,000	4,394.74	26	114,263	1.90
Other medical	23.34	5,000	3,137.20	117	367,052	6.12
Pediatrics	23.29	5,000	3,089.23	116	358,351	5.97
Psychiatric	5.33	5,000	4,606.30	27	124,370	2.07
Special care nursery	11.52	5,000	1,284.33	58	74,491	1.24
Other surgery	62.18	5,000	2,938.07	311	913,740	15.23
Total inpatient	230.84	5,000	2,878.34	1,156	3,512,956	58.53
Outpatient	329.41	5,000	515.29	1,647	848,683	14.14
Home health care	235.29	5,000	74.40	1,176	87,494	1.46
Subtotal outpatient	564.71		352.00	2,823	936,177	15.60
Total hospital					4,449,133	74.13
Primary care physicians						0.00
Specialists						0.00
Subtotal physicians						0.00
Capitation rate at cost						74.13
Capital replacement						1.50
Working capital						1.00
Profit margin						1.08
Other						0.00
Capitation rate loaded						77.71

Exhibit 5. Incremental Volume

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Service	Annual units (Exhibit 3)	Current volume	Incremental volume (C2 - C3)	Fixed cost (c3 x FC / unit)	Variable costs (c2 x VC / unit)	Total costs (C5 + C6)	Volume adjusted capitation rate (C7 / 12 / 5,000)
Cardiac surgery	73	43	30	79,027	122,325	201,352	3.36
Cardiology	79	42	37	86,995	109,088	196,083	3.27
Detox	33	15	18	29,400	52,404	81,804	1.36
Gastroenterology	44	24	20	42,753	65,198	107,951	1.80
Gynecology	38	20	18	34,591	58,673	93,264	1.55
Neurology	23	13	10	20,141	28,669	48,810	0.81
Neurosurgery	20	12	8	24,308	35,128	59,436	0.99
Nursery	79	46	33	12,183	17,495	29,678	0.49
OBS--Delivery	99	52	47	130,479	165,608	296,088	4.93
OBS--Nondelivery	13	10	3	24,941	21,616	46,557	0.78
Oncology	26	15	11	35,263	53,140	88,404	1.47
Other medical	117	60	57	112,939	146,821	259,760	4.33
Pediatrics	116	62	54	114,919	143,340	258,260	4.30
Psychiatric	27	16	11	44,220	49,748	93,969	1.57
Special care nursery	58	34	24	23,478	34,441	57,919	0.97
Other surgery	311	150	161	264,426	365,497	629,923	10.50
Total inpatient	1,156	614	542	1,080,064	1,469,191	2,549,255	42.48
Outpatient	1,647	950	697	269,354	381,709	651,062	10.85
Home health care	1,176	650	526	19,890	51,509	71,399	1.19
Subtotal outpatient	2,823	1,600	1,223	289,244	433,218	722,461	12.04
Total hospital				1,369,307	1,902,409	3,271,716	54.52
Primary care physicians				0	0	0	0.00
Specialists				0	0	0	0.00
Subtotal physicians				0	0	0	0.00
Capitation rate at cost							54.52
Capital replacement							1.50
Working capital							1.00
Profit margin							1.08
Other							0.00
Capitation rate loaded							58.10

If all of the expected volume from the insurer is incremental (i.e., there is currently no contract with the insurer), then the PMPM costs could be reduced to the variable costs only, which would enhance the delivery system's position in negotiating a contract. Affiliated Health Plan managers contemplating short-term pricing strategies to attract volume must also consider the implications for long-term pricing strategies which must include fixed costs. Eventually, the PMPM rate each subscriber must pay will have a portion of the delivery system's fixed costs built into the capitation rate.

5. *Negotiating the Contract* – The risks associated with a capitation payment method need to be identified and addressed within the capitation contract. The following items should be considered when negotiating such a contract:

- Forecasters recognize that there is a greater potential for error in predicting health care costs for a small insured population than there is in predicting costs for a large insured population. Therefore, the capitation contract should have provisions that prevent a catastrophic loss.
- Provisions in the capitation contract should be written to mitigate the risks being undertaken by the delivery system. To the greatest extent possible, the contract should transfer back to the payer those risks that are not controllable by the provider. Such risks include stop loss coverage, volume corridors, out-of-plan services, catastrophic loss, significant case-mix changes, outliers, etc.
- During the initial year or period covered by the contract, or until the Affiliated Health Plan (provider) has a high degree of confidence in the accuracy of its cost and utilization projections, the contract must have built-in settlement process.

As with any contract, the implications of *not* negotiating should also be examined. If the provider currently has a contract with the insurer, what would be the costs of losing the contract?

6. *Monitor Contract Performance* – Once a contract has been negotiated and signed, it must be monitored carefully to assess financial gain or loss. The success of a capitation contract is directly related to how well the managers of the health care delivery system have projected the costs and how well they manage the utilization of the population covered. With the advent of prospective

The success of a capitation contract is directly related to how well the managers of the health care delivery system have projected the costs and how well they manage the utilization of the population covered.

Exhibit 6. Estimated payments based upon capitated payments and increasing use rates.

(1) Service	(2) Capitation rate (Exhibit 4)	(3) Projected volume (Exhibit 3)	(4) Capitation budget (Exhibit 4)	(5) Actual volume (DSS)	(6) Fixed costs (Exhibit 4)	(7) Variable costs (C5 x VC / unit)	(8) Total costs (C6 + C7)	(9) Gain (loss) (C4 - C8)
Cardiac surgery	3.36	73	201,352	97	79,027	162,541	241,568	(40,216)
Cardiology	3.27	79	196,083	95	86,995	131,182	218,176	(22,094)
Detox	1.36	33	81,804	36	29,400	57,168	86,568	(4,764)
Gastroenterology	1.80	44	107,951	42	42,753	62,235	104,988	2,964
Gynecology	1.55	38	93,264	41	34,591	63,305	97,896	(4,632)
Neurology	0.81	23	48,810	25	20,141	31,162	51,303	(2,493)
Neurosurgery	0.99	20	59,436	18	24,308	31,615	55,923	3,513
Nursery	0.49	79	29,678	86	12,183	19,046	31,228	(1,550)
OBS--Delivery	4.93	99	296,088	102	130,479	170,627	301,106	(5,018)
OBS--Nondelivery	0.78	13	46,557	14	24,941	23,279	48,220	(1,663)
Oncology	1.47	26	88,404	28	35,263	57,228	92,491	(4,088)
Other medical	4.33	117	259,760	120	112,939	150,586	263,525	(3,765)
Pediatrics	4.30	116	258,260	140	114,919	172,997	287,916	(29,657)
Psychiatric	1.57	27	93,969	29	44,220	53,433	97,654	(3,685)
Special care nursery	0.97	58	57,919	60	23,478	35,629	59,106	(1,188)
Other surgery	10.50	311	629,923	367	264,426	431,309	695,735	(65,813)
Total inpatient	42.48	1,156	2,549,255	1,300	1,080,064	1,653,340	2,733,404	(184,149)
Outpatient	10.85	1,647	651,062	1,750	269,354	405,580	674,934	(23,871)
Home health care	1.19	1,176	71,399	1,200	19,890	52,560	72,450	(1,051)
Subtotal outpatient	12.04	2,823	722,461	2,950	289,244	458,140	747,384	(24,922)
Total hospital	54.52		3,271,716		1,369,307	2,111,480	3,480,788	(209,071)
Primary care physicians	0.00							
Specialists	0.00							
Subtotal physicians	0.00							
Capitation rate at cost	54.52		3,271,716				3,480,788	(209,071)
Capital replacement	1.50		90,000				90,000	0
Working capital	1.00		60,000				60,000	0
Profit margin	1.08		64,800				64,800	0
Other	0.00						0	0
Capitation rate loaded	58.10		3,486,516				3,695,588	(209,071)

payment systems in the 1980's hospital administrators learned to manage length-of-stay and utilization of ancillary services. However, under such a system, managing admissions has not been a factor because payment methods generally had volume incentives. Using the capitation payment method, the provider is given incentives to reduce admissions.

Exhibit 6 shows how an increase in the use rates or a variation in the services provided can have an impact on the financial condition of a health care delivery system. In this example, an increase in surgery and pediatrics volume resulted in a loss of \$209,000, or 6 percent of the costs. Management of costs will have a similar effect on the financial performance of the contract; an increase in costs above the rates assumed in the contract will result in a financial loss, whereas a decrease in costs below the assumed rates will produce a financial gain.

CONCLUSION

A capitation payment arrangement can be an effective means of controlling health care costs, because it allows both the insurer and the employer to predict costs for health care services more accurately. Using a capitation method, the onus shifts to the provider for the accurate prediction of costs. If the health care delivery system currently does not have a cost accounting system or the ability to develop cost information on each payer and service line, then it will become necessary to find a mechanism to develop such information prior to entering into a capitation contract.

The following critical issues must also be recognized by delivery system managers planning to enter into a capitation contract:

- The development of an accurate projection of utilization by the insured population by service is critical to the financial performance of the delivery system. Factors impacting utilization must be considered and monitored, including physician and patient incentive and changes in patient demographics.
- Capitation contracts create incentives to reduce utilization of health care resources and to employ the most cost-effective delivery site and service. The managers of such delivery systems must have the ability to monitor contract performance and to effect changes to the contract when necessary.
- Because physicians control the utilization of resources, they must be integrally linked with the delivery system or, at a minimum, they must operate under similar incentives for utilization and cost management.
- The list of services the delivery system is expected to provide must be clearly defined. If there are services the system cannot provide, it must either establish contracts with other facilities for those services or carve those services out of the capitation rate.

- The acceptance of a capitation contract by a delivery system effectively makes the system an insurance company. The delivery system should consider maintaining necessary financial reserves to cover the risks assumed by insurance companies.
- Managers of a health care delivery system must have the capability to monitor the contract (i.e., information systems and physician-supported utilization review functions).
- It is important to determine what the involvement of the health care delivery system should be with respect to marketing its services to the insurer (payer). There is an inherent conflict of interest if the success of the insurer directly improves the financial performance of the provider.
- The managers of the health care delivery system should have knowledge of, and control over, as many of the pieces of the continuum of care as possible prior to entering into a capitation contract. Or they should make sure fixed-payment arrangements with providers are built into the capitation payment contract.