Blended Capitation Model –
Fact Sheet for Primary Care Physicians

Eligibility for the Blended Capitation model

Office-based comprehensive primary care clinics that have high administrative capacity and are able to adapt to the anticipated practice changes are eligible to apply for the Blended Capitation ARP model.

In addition, prospective clinics must operate out of a single location, have a minimum of three physicians, and all of the physicians within the clinic must be interested in joining the model.

The physicians may provide services in this clinic full-time or part-time, but is not able to provide the same program services (or "in-basket services") to the same program patients (or "rostered patients") outside of this clinic.

No requirement to maintain a certain number of affiliated patients

Clinics that join this model are not subject to any roster size requirements. Clinics have the discretion to sign up, or affiliate, as many patients as they see want. The model compensates clinics based on their rostered patients.

Rostered patients who are not able to access services at the clinic and must seek care elsewhere cause the clinic to be financially penalized for the amount of the in-basket services provided.

This means that physicians should consider patient access when creating their service delivery model.

The physician-patient affiliation process

Both the physician and patient sign a form agreeing to a physician-patient relationship and its associated expectations and benefits. Completed forms are collected by clinics who submit the corresponding patient information electronically through the Central Patient Attachment Registry (CPAR) online system.

Physicians can bill up to 2 interactions with each patient before formally committing to the relationship. However, once the initial 2 interactions are exhausted, the physician will not receive compensation for any subsequent services provided unless they affiliate the patient.

Basket of services and capitation rates

A basket of services reflects the typical activities of a non-specialized general practitioner in an office-based setting.

The capitation rate is calculated based on a patient's average use of the basket of services based on their age, sex and risk status.

How physicians are paid

Once a patient is formally affiliated with a participating clinic, a patient-based capitation payment is made bi-weekly. These payments compensate physicians for any in-basket health services provided and are calculated based on 85% of the patient's total capitation rate.

Physicians are eligible to receive the remaining 15% of the patient's total capitation rate through fee-for-service submissions.

Physicians do not receive more than 100% of the patient's capitation rate for providing in-basket health services.

All out-of-basket services are paid at 100% of the fee-for-service rate.

All other payments, such as the Business Cost Program and Rural Remote Northern Program, will not change.

Compensation for out-of-basket services

For rostered patients, a clinic is paid 100% fee-for-service for any out-of-basket health services provided. For non-affiliated patients, clinics can bill up to 2 interactions (inclusive of in-basket and out-of-basket services) with each patient.

However, once the initial two interactions are exhausted, the physician will not receive compensation for any subsequent services provided unless they affiliate the patient.

Submit fee-for-service claims for in-basket health services

Physicians must continue to bill for all services provided, even when the physician has received the full capitation rate for a rostered patient.

Capitation rates are calculated based on the average use of the basket of services, therefore a significant decrease in reporting could compromise the level of compensation physicians receive.

Additionally, a patient's risk status is determined based on diagnostic codes associated with fee-for-service claims.

If reporting decreases, risk status will be underestimated, patients will appear to be healthier than they are, and payment will be under-represented.

Compensation compared to fee-for-service

In general, compensation levels depend on a number of factors. For example, if a clinic creates efficiencies by utilizing other providers or prioritizing disease prevention, they may be able to affiliate more patients and receive a higher level of compensation.

However, if a clinic increases its panel size to the extent that patient access is compromised, compensation may decrease due to financial penalties.

Financial modeling is completed for clinics that are eligible and selected for inclusion in the model. This modeling gives clinics an idea of their future compensation levels.

Additionally, clinics can leave the model at any time if the compensation arrangement no longer works for them.

Patients who receive care at another clinic

If an affiliated patient receives an in-basket service at another clinic, the home clinic receives a financial deduction (or negation) for the value of the service provided. The home clinic is negated at 100% of the service cost, but is not negated more than 85% of the capitation rate for that patient.

The home clinic is not negated if an affiliated patient receives an out-of-basket service at another clinic. If an affiliated patient subsequently signs up with a different clinic or leaves the province or country, the initial affiliation is automatically terminated.

Information technology requirements

Physicians are given access to CPAR in order to maintain their roster, and access to the APP Online system to access their financial reports. They are also required to use an electronic medical record.

Clinics receive support for using both CPAR and APP Online prior to implementation of the Blended Capitation model.

APR model or fee-for-service

All physicians within a clinic need to move onto the Blended Capitation model. This allows for continuity of care and sufficient access within the clinic.

Switch to a Blended Capitation model

If you are interested in the Blended Capitation model, contact us. Participation is voluntary and clinics can leave the model at any time if the compensation arrangement no longer works for them.

In 2017, the Sylvan Family Health Center was selected as the demonstration project for the Blended Capitation model.