

Capitation is not value: Rewarding continuity, not containment

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For payers, the central question is not how to cap costs in sleep care, but how to sustain measurable reductions in downstream utilization over time.

Across many health systems, “value-based care” has become the dominant language of reform. In practice, however, value is increasingly implemented through capitated or quasi-capitated payment models that prioritize cost predictability over sustained health outcomes.

Health economics reviews note that affordability and budget impact are increasingly driving real-world decision-making, even though they are conceptually distinct from value itself. While frameworks often acknowledge factors such as adherence, durability of benefit and long-term outcomes, these elements are inconsistently measured. As a result, many models default to short-term utilization and spending proxies.¹⁻³

This slippage is evident in payer guidance. Capitation and per-member-per-month contracts are frequently presented as prototypical “value-based” payment models. In effect, a cost-containment mechanism is treated as interchangeable with outcomes-aligned incentives.

The problem with capitation as “value”

Capitation pays providers with a fixed amount per patient for a defined period, regardless of how much care the patient ultimately needs. These budgets are set against expected average utilization, leaving

providers financially exposed when patients require more intensive or prolonged care.⁴

Critiques of value-based payment frameworks point out that, under many capitated arrangements, value is functionally defined as spending below a benchmark rather than as improved outcomes per dollar. When capitation is treated as a shortcut to value, cost control risks being mistaken for value creation itself, rather than as only one component of it.

Analyses of value-based healthcare frameworks emphasize that no value is created if outcomes that matter to patients do not improve, no matter how much money is saved.⁵

Organization for Economic Co-operation and Development (OECD) analyses further show that capitation is used predominantly in primary care and is effective at controlling costs, but it carries a recognized risk of care under-provision.⁴ This concern is particularly relevant for patients with more complex or long-term needs, where outcomes depend on sustained engagement rather than episodic care.

In chronic conditions, this misalignment has measurable consequences. Disengagement rates increase after initial therapy phases. Additionally, downstream costs, particularly cardiovascular and metabolic events, remain insufficiently mitigated when continuity is not incentivized.

The mismatch between sleep care and capitated models

Sleep medicine, and obstructive sleep apnea care in particular, are inherently longitudinal. Effective treatment often requires repeated testing, therapy adjustments, mask changes, comorbidity management, behavioral support and re-engagement over time.

In this sense, sleep disorders function as a stress-test for value-based care models. If a payment model cannot support care in sleep medicine, it is likely to struggle in other longitudinal, adherence-dependent conditions as well. Sleep care combines chronic disease management, variable patient trajectories, and outcomes that depend on intermittent re-engagement over years rather than predictable, continuous utilization. And these are precisely the dynamics that expose the limits of capitated payment models which are built around fixed budgets and short evaluation windows.

Capitation assumes that utilization can be forecast and contained within an expected average. Under it, each additional touchpoint in sleep care can be framed as “leakage”, rather than as a requirement for achieving durable improvements in symptoms or cardiometabolic risk. Consequently, it will consistently under-recognize the value created when patients return for troubleshooting, modality changes or renewed support, even though these encounters are where long-term benefit is either preserved or lost.

Short-term adherence metrics reinforce this dynamic. In the United States, for instance, continued positive airway pressure (PAP) device coverage is often tied to a 90-day adherence threshold.⁶ This structure encourages front-loaded activity, after which ongoing clinical involvement or re-engagement is deprioritized or minimally reimbursed, despite the long-term nature of benefit.

France provides a relevant counterexample. National reimbursement policy links continued PAP coverage to ongoing usage and clinical follow-up beyond initial setup, with standardized monitoring over time rather than a single early adherence checkpoint.⁷

In parallel, Germany’s statutory system reimburses ongoing physician oversight and device-based monitoring, recognizing sleep apnea as a chronic condition requiring longitudinal management rather than a one-time intervention.⁷

These models do not fully operationalize outcome-based reimbursement, but they do demonstrate a policy direction: sustained engagement anchors reimbursement logic.

What value is meant to reward

Value in healthcare is conceptualized as the relationship between health gains and the resources required to achieve them.⁸ Work on value assessment underscores that value includes clinical benefit, adherence-improving factors and patient experience, not just immediate net costs.²

In an outcome-focused model, payment aligns with improvements in metrics that matter to patients and systems, such as symptom control, functioning and reduced downstream events. For chronic conditions, this requires attention to continuity and renewal, not just efficiency within a single episode of care.

A distinct alternative: Continuity-linked reimbursement

Continuity-linked reimbursement represents a separate class of value-based care, not a variant of capitation. Under this approach, payment is explicitly tied to sustained patient engagement and validated outcomes annually, rather than short initiation windows.

Research on chronic care management and alternative payment models for chronic conditions indicates that dedicated, recurring payments for ongoing assessment, care coordination and condition management enable proactive, between-visit care and are associated with better outcomes and reduced hospital and emergency department use, compared with traditional visit-based payment that does not fund this.^{9,10}

Sleep care is well suited to this approach. Objective device data, validated symptom measures and established links between treated sleep apnea and downstream cardiovascular, metabolic and mental health outcomes make longitudinal measurement feasible.

When follow-up visits, therapy transitions and digital outcome tracking are treated as value-generating services, providers are supported in keeping patients engaged rather than being nudged to discharge once a short-term threshold is met. Long-term adherence to PAP therapy has been associated with reductions in cardiovascular events and improvements in healthcare utilization patterns, including fewer hospitalizations and emergency department visits.^{11,12,13}

Policy adjustments to realign value

To realign sleep care with true value, reimbursement policy should make three targeted changes.

First, regulatory and health technology assessment (HTA) bodies should explicitly classify continuity-linked reimbursement as a distinct value-based care category. It should require outcome measurement beyond cost benchmarks in coverage evaluations.

Next, one-time adherence thresholds should be replaced with staged, outcome-based evaluations (e.g. at 6, 12 and 24 months). These assessments can incorporate measurable indicators such as device usage trends, symptom improvement, and comorbidity markers. This will allow payers to verify sustained benefit while aligning reimbursement with the longitudinal nature of sleep therapy.

Third, billing codes should be introduced for follow-up, re-engagement visits, therapy switching or progression (e.g. mandibular advancement device (MAD) to PAP, or PAP-only to combination therapy), and remote monitoring review with defined minimum frequencies over an annual cycle. These activities are central to maintaining benefit and should be recognized as outcome-generating rather than ancillary.

Protecting value across chronic disease care

If capitated contracts continue to be treated as synonymous with value-based care, health systems may achieve predictable budgets and tidy dashboards, but they risk overlooking one of the most effective levers for safeguarding existing investments. Sleep health sits at the intersection of cardiovascular, metabolic and mental health. Stabilizing sleep care, therefore, protects the value created in many of the chronic conditions already prioritized by health system.

Without the requisite changes, reimbursement frameworks will continue to reward cost containment over disease control and undermine both clinical outcomes and mid- to long-term system efficiencies.

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