



Overview of integrated budgets for ICPs

Draft Integrated Care Provider (ICP) Contract - consultation package

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Version number: 1

First published: August 2018

NHS England Publications Gateway Reference: 07883

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1. Introduction

This overview has been jointly produced by NHS England and NHS Improvement. It is designed to be used alongside the [Integrated Budgets Handbook](#), which includes information gained through working with vanguards and provides guidance on a number of technically challenging aspects of designing and calculating an integrated budget, building on previous publications on capitation.^{1,2,3}

2. Summary of approach

The vision for health and social care in England presented in the [NHS Five Year Forward View](#) highlighted three 'gaps' that need to be addressed:

- funding and efficiency
- health and wellbeing
- care and quality

The NHS Five Year Forward View promoted new care models, including multispecialty community providers (MCPs) and integrated primary and acute care systems (PACs), to close these gaps. One way in which commissioners are looking to put in place these new care models is through the award of an Integrated Care Provider (ICP) Contract⁴, which could include within its scope a requirement to provide the majority of services for a given population. NHS England has produced a draft ICP Contract to be used for this purpose (subject to the outcome of consultation), and a payment approach has been developed for this contract in order to put in place financial incentives to facilitate greater co-ordination and integration of care.

This document describes the overall payment approach for whole population models of integrated provision, centred on integrated budgets derived from current commissioner expenditure. These are commonly described in the sector as whole population budgets (WPBs) and we therefore use this term for consistency. This does not imply that the budget provides for all of the services delivered to an individual, but rather that this is a budget for the whole of the population served by the relevant provider, across the services in scope of its contract. This approach has been developed to encourage the promotion of whole population management, prevention, self-care and a focus on outcomes rather than inputs.

The WPB approach is characterised by the following features. It:

- covers the relevant service scope for the ICP's population
- removes the direct relationship between activity and payment where this currently exists
- improves alignment of payment for all providers within the care model
- better incentivises prevention and wellbeing
- focuses on management of outcomes, activity and costs across the system.

1 An introduction to capitation can be found on the Government website: <https://www.gov.uk/guidance/capitation>, (Information accessed 16 July 2018)

2 Local examples of capitation can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445731/LPE_Capitation.pdf, (Information accessed 16 July 2018)

3 International examples of capitation can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445741/Capitation_payment_-_international_examples.pdf, (Information accessed 16 July 2018)

4 'Integrated Care Providers' (ICPs) were previously referred to as 'Accountable Care Organisations' (ACOs).

There are three elements to the overall payment approach for ICPs:

- 1. Establishing the required WPB for delivering services:**
 - calculating the baseline contractual value of services in scope of the ICP
 - estimating WPB values for the full contract term to support multiyear contracting
 - converting estimated WPB values to contractual values.
- 2. Ensuring the ICP will have access to an incentive scheme that will operate as a top-slice from the WPB.**
- 3. Developing gain/loss sharing to:**
 - build and align financial incentives across local areas
 - manage the transfer of utilisation risk from commissioner to provider that is associated with implementing a WPB.

In the short to medium term⁵, given current system capability and data availability, we consider this approach to be the most effective and practical way of facilitating ICP implementation.

We have developed this document to support local development of a WPB using what we have learned from working with vanguards. The Handbook includes case studies to illustrate the main stages in developing a WPB for an ICP, from design considerations through to WPB calculation, and tools and templates to help you on this path.

Contract value and possible variations to value and scope during the contract term

It is important that the procurement documents for the relevant contract set out the indicative annual contract values and the way in which payment may be made (including any possible extensions/variations).

Commissioners may, for example, wish to have dialogue with the bidders in relation to payment mechanisms as part of the procurement process. Commissioners must do so taking account of their obligations to be transparent and to treat bidders equally and in a non-discriminatory manner.

To minimise any potential procurement risk that contract value or payment changes during the term of the contract could trigger, then in their procurement documents, commissioners should state that the contract value or payment mechanism may be subject to change, and provide a list of non-exhaustive options as to the types of changes that may occur during the term of the contract.

All payment proposals must comply with National Tariff Payment System rules and principles, including that they are in the best interests of patients, as explained further in Section 3.4.

⁵ The time between implementing a WPB and transition to a full capitated payment system will depend on the business case for change, and on the availability of accurate patient-level costing information and may vary between organisations.

3. Integrated budgets to support implementation of whole population care

3.1. Need for a new payment approach

A new payment approach will be needed to support ICPs in delivering whole population integrated care. Sector feedback indicates that the current landscape of primarily activity-based payment systems do not always support delivery of more integrated and better co-ordinated care centred on the patient.

Activity-based payment models incentivise the delivery of an increased volume of activity rather than prevention or delivery of better outcomes. Block contracts tend to provide a consolidated fixed payment irrespective of activity and outcomes, with no incentive to deliver services or activity beyond those specified in the contract. Further, block contracts often do not provide the transparency necessary for continuous improvement.

3.2. Capitation with outcomes

A capitated outcomes-based payment model is one approach to the payment of integrated health and care services delivered by an ICP. NHS England and NHS Improvement have documented the international evidence⁶ supporting capitation, and working with local sites, have illustrated how it may apply in England⁷ and how it could be combined with gain/loss sharing to align and manage system-wide incentives.⁸

Capitated approaches should have the following core characteristics:

- **Predictability:**
 - to increase system stability to plan and implement changes. The value of the budget is identified upfront and set in the context of a multiyear contract.
- **Accountability and flexibility:**
 - to increase provider accountability for the holistic care needs of individuals by providing an incentive to co-ordinate care across settings and providers
 - to increase opportunities to change service delivery across care pathways centred on individuals
 - potentially to reduce complexity of commissioner and provider relationships.
- **Risk and reward:**
 - to incentivise investment in preventive care and treatment in the appropriate lowest cost setting
 - to reward providers for doing the right thing but without specifying exactly what is done or how care is delivered.

6 International examples of capitation can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445741/Capitation_payment_-_international_examples.pdf (Information accessed 16 July 2018)

7 Local examples of capitation can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445731/LPE_Capitation.pdf (Information accessed 16 July 2018)

8 Local guidance on gain/loss sharing arrangements can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445617/GLLPE.pdf (Information accessed 16 July 2018)

A capitated approach works by enabling risk to be more appropriately allocated to the organisation best placed to influence, manage and bear specific types of risk. The most sophisticated capitation models include risk adjustments to reflect the differing needs of individuals within the population, use person-level information and consider utilisation of the full range of services covered by the payment.

Capitation aims to allocate risk as follows:

- **Risks borne by commissioners:**
 - Population-size risk: The risk that the population within scope of the new care model is materially larger or smaller than initially assumed
 - Epidemiological and demographic risk: The risk that the composition and health needs of the population materially differ from those initially assumed; for example, it has a higher proportion of elderly service users or a greater prevalence of long-term conditions.
- **Risks borne by providers:**
 - Utilisation risk: The risk that services are utilised more or less frequently than predicted given the population size and profile
 - Volatility risk: The risk that random variation in usage patterns may result in different levels of service use
 - Efficiency risk: The risk that the intended efficiency gains are not realised, or that the unit cost of services is not as expected
 - Quality risk: The risk that a system-wide change adversely affects the quality of care provided, and in turn individual health outcomes.

3.3. Why integrated budgets (WPBs) with outcomes-based payment?

WPBs are a simplified version of capitated payments, providing periodic payments for a range of services, initially based on current commissioner spend, according to the size and needs of the population. In the near term, WPBs are the pragmatic payment solution for the following reasons:

- An ICP would provide care for a whole population. Matching this coverage in payment terms offers greater opportunities to integrate care and incentivise prevention.
- Data and capability constraints, particularly outside of acute care, limit the ability to implement a formula-based or person-level capitated payment mechanism at this time. The whole population approach can more readily use data currently available in the NHS as a starting point for calculation of payment.
- It is easier to operate than a population segment-based approach, as individuals and the care they receive do not need to be allocated to mutually exclusive segments, and movement of individuals between segments does not need to be regularly tracked.

The WPB approach requires more effort to maintain from year to year than person-level capitation, for example an additional year-to-year adjustment mechanism is required.⁹ Nevertheless, when implemented correctly, a WPB can achieve the core characteristics of capitation set out above.

⁹ Under person-level capitated payment, such adjustment is automatic, based on the movements of people onto/off registered lists.

The inclusion of an outcomes-based payment mechanism in WPBs will help mitigate the risk of perverse incentives typically associated with a capitated approach, namely restriction of the number of health and care services provided, particularly services associated with higher costs. Although contracts and regulation will enforce minimum quality, strengthening provider accountability through an outcomes-based payment should enable improvements to health outcomes and service quality.

3.4. An integrated budget (WPB) in the context of the National Tariff Rules and GMS/PMS regulations

National Tariff Payment System rules

The National Tariff Payment System (NTPS) rules and principles give commissioners and providers broad scope to determine local payment approaches that support the development of more integrated approaches to delivering care.

In developing a WPB to support implementation of an ICP, commissioners and providers must be satisfied that their proposed local payment approach complies with the principles and rules detailed in the NTPS local pricing section.¹⁰ In particular, the commissioner and provider must be satisfied that the proposed payment approach for the NHS services within the WPB is in the best interests of patients. To the extent that a WPB covers services which have national prices and/or national currencies under the NTPS, a WPB payment approach may be adopted by the commissioner and provider agreeing “local variations” (i.e. by agreeing to vary the prices and/or specifications of the relevant services) in accordance with the NTPS rules. This would involve the commissioner and provider agreeing to vary the currencies and (if applicable) prices for those services, and combining them with other services which do not have national prices and/or currencies (e.g. community services and primary medical services), to deliver a single package for which a single annual price is paid.

The provisions of the NTPS cover all NHS-funded healthcare services, except those primary care services where the remuneration of providers is determined by or in accordance with regulations, directions or related instruments under the National Health Service Act 2006 (the 2006 Act),¹¹ and those services which are funded by personal health budget ‘direct payments’. Where payment for primary care services is not determined by the 2006 Act framework, the NTPS rules on local price setting apply. For example, local price setting rules apply to minor surgical procedures performed by GPs and commissioned by clinical commissioning groups (CCGs). Local authority-funded social care or public health services, including those commissioned under joint commissioning arrangements (a local authority and its NHS partners), are outside the scope of the NTPS.

10 The National Tariff Payment System documents can be found on the NHS Improvement website: <https://improvement.nhs.uk/resources/national-tariff-1719/> (Information accessed 16 July 2018)

11 These include core general practice services covered by the GMS or PMS contracts, community pharmacy, dental practice and community optometry.

GP participation options

Primary medical services and general practice are central to the development of an ICP. We envisage two main approaches for voluntary GP participation where a new contract is commissioned:

- Full integration, where the ICP brings together all primary care services operating under a single WPB. More information about primary care funding streams that can move into the WPB is provided in Section 2.5 of the Handbook. The conditions of payment under the ICP Contract would be set out in the contract and supporting documents.
- Partial integration, where the ICP Contract excludes primary medical services covered by GMS/PMS contracts. It would be supported by contractual arrangements between the ICP and the GPs to achieve operational integration.

3.5. Essential requirements

Payment design should not be developed in isolation of care model development as it is an enabling mechanism to support the service transformation. In addition, local areas will need to consider the following:

Data availability and quality

The availability of high quality and up-to-date data on activity, quality and costs is essential for developing, implementing and continual evaluation of a WPB and gain/loss sharing mechanisms, as well as the care models themselves. There is a collective responsibility to ensure that, where appropriate, all parties collect and have access to the information required for such assessments.

Population and service scope

The scope of health and care services included in an ICP Contract needs to be identified early on. The service scope should be sufficiently wide to prevent cost-shifting between care settings and precisely defined so there is no ambiguity about which care activities are in scope. Similarly, the population should be of a sufficient size to support integration of care, minimise risks from random cost variation and incentivise prevention.

Shadow test and refine

Where possible, before implementing a WPB, a local area should shadow test the likely financial impacts and necessary payment operations. This involves scenario testing to understand and refine any incentives and to evaluate the appropriateness of the baseline, forecast and gain/loss sharing mechanism.

Provider-to-provider payments

A clear set of rules should be agreed locally to determine payment to any subcontractors and/or distribution of the WPB between the different parties involved in the ICP care model, including any gains/losses under a risk sharing arrangement. Any provider-to-provider payments should continue to support the objectives of the care model.

3.6. Commissioner considerations

Agreeing the WPB

Commissioners must have regard to their statutory duties and other obligations.^{12,13,14} As such, they need to assure themselves that the WPB for an ICP is consistent with appropriate distribution of funding between the ICP and all other services they are accountable for commissioning.

In particular, as set out in Section 3.4, implementation of a WPB must comply with NTPS rules and principles, including that the proposed payment approach is in patients' best interests. Commissioners, in conjunction with key stakeholders, need to consider system sustainability, ensuring that the multiyear WPB is both affordable and covers efficient costs. They need to review the planned WPB in the context of pressures across the wider local health and care system, forecasting demand and spend on services within and outside the scope of an ICP in parallel, and ensuring consistency with local sustainability and transformation partnerships (STPs).

This review needs to consider the national model for oversight and regulation of new care models (in development) and any requirement to mitigate risks, including those set out by the [Integrated Support and Assurance Process \(ISAP\)](#). NHS Improvement has published the [Single Oversight Framework](#) to support NHS providers in attaining and maintaining the standards required to meet their regulatory obligations, including during the transition to new care models.

Where the estimated WPB (and therefore the ICP Contract) is considered unaffordable or unsustainable in the context of the overall local STP and commissioning plans, commissioners need to consider what adjustments they must make to maintain system sustainability. These are likely to include changes to the ICP care model or its scope, as well as potential changes to other local commissioning plans. In all cases commissioners will need assurances that delivery of the contract obligations for the population and services in scope of the ICP are achievable within the WPB value, and as such local areas need a shared understanding of how any savings will be realised.

Patient choice

Patient choice is a key feature of NHS care. When people covered by the WPB choose to receive services from providers outside the ICP, these providers will need to be reimbursed from the WPB and appropriate arrangements will need to be set up for this. ICP funding will also need to be adjusted for individuals choosing to register with (or leave) the ICP as their primary care provider during the contract period.

12 Guidance for NHS commissioners on Equality and Health Inequalities legal duties can be found on the NHS England website: <https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/> (Information accessed 16 July 2018)

13 The NHS Act 2006 can be found on the Government website: <http://www.legislation.gov.uk/ukpga/2006/41/contents> (Information accessed 16 July 2018)

14 The Health and Social Care Act 2012 can be found on the Government website: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> (Information accessed 16 July 2018)

Integrated personal commissioning

The integrated personal commissioning (IPC) programme supports integration and personalisation of services by joining up health, social care and other services at the level of the individual.¹⁵ Part of this programme includes expanding the use of personal health budgets (PHBs) to give a small number of people with the highest care needs, such as those with long-term health conditions or disabilities, more choice and control over how money is spent on meeting these needs.

As PHBs are calculated at an individual level, how these funds will be administered in relation to a WPB needs to be considered and what is agreed needs to be recorded as part of the ICP Contract. Funding will flow accordingly.

Procurement and financial assurance processes

Commissioners need to take into account the current procurement rules and regulations, and need to carefully plan any procurement and subsequent contract delivery. This should include ensuring that they are aware of the potential for subsequent changes to a contract post award, as this could trigger a further procurement decision.

4. Overview of integrated budget (WPB) development

The main stages in developing a WPB are:

- calculating the WPB baseline
- estimating WPB values for future years
- converting estimated WPB values to contract values for each year in a contract
- agreeing an incentive scheme for the ICP
- introducing gain/loss sharing arrangements.

An overview of each of these stages is given below.

4.1. Calculating the integrated budget (WPB) baseline

The WPB baseline is the total amount available for payment to the ICP to fund services for the target population in the first year of the contract. The bulk of this amount will form the Whole Population Annual Payment, part will be for payment on an activity basis (e.g. vaccinations and immunisations where these are within the ICP service scope), and part will be for payment under the [Incentives framework for ICPs](#) described in Section 4.4.

It is likely that the WPB baseline will be calculated, at least initially, using data on commissioner spend because of limitations in the understanding and transparency of provider costs, particularly at individual level and in community settings.

The baseline spend is currently spread across a number of separate contracts for different care settings. The Handbook details how to disentangle and then amalgamate the necessary data to calculate the WPB baseline. The starting point is a clear definition of both the scope of services and the population covered by the ICP.

15 The Integrated Personal Commissioning Emerging Framework can be found on the NHS England website: <https://www.england.nhs.uk/healthbudgets/wp-content/uploads/sites/26/2016/05/ipc-emerging-framework.pdf> (Information accessed 16 July 2018)

4.2. Estimating integrated budget (WPB) values for future years

To facilitate system transformation and realise associated health and cost benefits, it is likely that initial ICP contracts would have a duration of up to 10 years. Organisations need to forecast the WPB (i.e. total amount available for payment to the ICP) for each year of the contract and to do this using transparent mechanisms and assumptions about future economic factors. These forecasts, to be included in the contract, will facilitate investment by setting provisional indications at the procurement stage of what the WPB might be in each year of the contract. They will take account of expected:

- future cost and activity pressures, for example anticipated changes in population size, demographics as well as inflation in health and care provision costs (as reflected in national planning assumptions)
- provider efficiencies, for example annual efficiency targets on unit costs in acute settings
- funding requirements associated with implementing the ICP care model plus any efficiencies over and above those expected of the NHS more broadly as the new care model scales up.

Commissioner allocations act as an overall constraint on the level of funds available for health and care services in the local area. This together with wider commissioning and service plans for the local health economy and local STPs must be recognised in estimating the WPB value for future years.

4.3. Converting estimated integrated budget (WPB) values into contract values

The baseline and forecast values are the basis for agreeing the ICP contract WPB values. But this needs to recognise that it will not be possible to, for example, accurately forecast population movements for the full contract period. Commissioners and providers will need to agree a mechanism to adjust the contract WPB values periodically so that they continue to reflect the needs of the population in scope of the ICP and to allow the use of up-to-date or improved data. Commissioners must take into account current procurement rules and regulations as explained in Section 3.6.

4.4. Incentives scheme for ICPs

The incentive scheme for ICPs constitutes a portion of the contracted integrated budget value and is paid upon delivery against targets for agreed metrics, in line with prevailing national schemes such as Commissioning for Quality and Innovation (CQUIN). In addition to the paid-for element of the quality-incentive scheme, it will be possible for the CCG to include supplementary short and long term metrics against which ICPs' performance will be published. See the [Incentives framework for ICPs](#) for more information.

4.5. Gain/loss sharing

The introduction of a gain/loss sharing mechanism in addition to a WPB will further support the transformation of health and care services. Gain/loss sharing can help to:

- better align financial incentives across services not covered by the WPB
- manage the transition and impact of utilisation risk to providers over time.

Further information on gain/loss sharing is provided in Chapter 6 of the Handbook.

5. For more information

For further information, it will be useful to review the existing [Integrated Budgets Handbook](#), alongside the main consultation document and package.

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