New care models

Finance and Payment Approach for ACOs

Accountable Care Organisation (ACO) Contract package - supporting document

Our values:
clinical engagement, patient involvement, local ownership, national support

August 2017

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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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Introduction

1 The objective of Accountable Care Organisations (ACOs), including Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) is to dissolve the divides that exist between services provided by different parts of the health and care system, providing an integrated, holistic and person-centred model of care to a whole population. To facilitate this, in contracted-for ACOs, budgets will be combined wherever possible to allow for more flexible allocation of resource, directed towards the areas in which the funds will have the greatest impact on population health and care.

2 The payment approach comprises three elements;

- 'Integrated budget', a single payment made to the ACO entity
- 'Improvement Payment Scheme' (IPS) to incentivise improvements in care quality, outcomes and transformation
- 'Gain/loss share agreement' to align financial incentives across services provided for the care model population, including those in acute settings. Note that where the care model has the majority of acute services within scope it may not be necessary to adopt gain/loss mechanisms to align incentives with the acute sector. However, in this situation the gain/loss sharing approach could be used to support gradual transition of acute sector demand risk where this is being transferred from the commissioner to the provider (i.e. where local areas are moving from paying the acute on a PbR to a block contract basis).

How the three elements of the payment system work together

3 The combined use of an integrated budget with an element of outcomes-based approach is designed to ensure the stability to plan for the longer-term, flexible use of budget between service settings, and the incentive to invest in prevention and treating patients in the lowest-cost setting appropriate. For new care models, especially those with limited coverage of acute services, the addition of the gain/loss share arrangement results in the provider standing to benefit from a positive financial impact elsewhere in the local health economy. Aligning incentives with providers outside of the ACO scope in this way will also help to prevent cost shifting.

This first section of this paper provides further detail on how current funding streams will enter the integrated budget estimate and how estimated integrated budget values will be converted into contract values. It also outlines the format and national framework for gain/loss share arrangements and the design of the 'Improvement Payment Scheme'. The document describes at a high level how social care and public health funding would be included in the integrated budget. We are considering further how local authority funding flows might optimally work for people registered with the ACO but resident elsewhere, or vice versa, and will provide further detail on this in a future version of the Integrated Budget Handbook. Commissioners and providers should note that the National Tariff Payment System (NTPS) would continue to apply to payment for many of the NHS healthcare services included within an ACO arrangement. For this reason, local implementation of an integrated budget for ACO services within scope of the NTPS must comply with the local pricing rules set out in the NTPS. These rules allow, for example, one or more commissioners and one or more providers to agree "local variations" to vary the prices and specifications of the relevant services.

4 The second section of the paper covers CCG business rules and capitalisation requirements for ACO entities.

Integrated budget

Calculating the size of the integrated budget (fully-integrated ACOs)

5 The funding available to the ACO will be delivered as an integrated budget, derived from current commissioner expenditure on services it provides for its population. These are commonly described in the sector as whole population budgets (integrated budgets) 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, rather that this is a budget for the whole of 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 integrated budget approach promotes that the whole population is incorporated into the budget, but allows for flexibility of service scope to account for different care models being developed to meet local needs.

6 As now, some payments to the ACO will be dependent on performance through the IPS. The IPS scheme, which will replace current national performance pay schemes for providers moving into the ACO, is a top slice of the contracted integrated budget value, which is paid out upon ACO delivery against targets for agreed care quality, outcomes and transformation metrics.

7 The integrated budget value is initially estimated from current commissioner spend on the services and population within the scope of the ACO Contract. The choice of current commissioner spend as a starting point for calculation of the contract value reflects a recognition that constraints on activity and cost data, and the ability to link patient-level data across care settings, limit the capacity to implement a patient-level capitated payment mechanism at the current point in time.

8 Fully-integrated ACO providers will have three core funding components contributing to the overall size of the integrated budget - primary care, local authority funded social care and public health services, and all other service scope. Once all relevant funding streams have been integrated within the integrated budget, the ACO provider will have the flexibility to determine the best use of these resources

Calculation of core funding components

9 Primary care

- Primary Care funding moving into the integrated budget will include as many of the existing funding streams as it is possible to move into the integrated budget.
- However, there are a number of GP funding streams it is not possible to move into the integrated budget at this point in time (more detail in following section)
- Any non-recurrent funding (e.g. GP Forward View funding) will not enter the integrated budget

- The calculation of Primary Care funding entering the integrated budget will be based on current commissioner spend on the GP funding streams planned to enter the integrated budget.

10 Local authority funded Social Care and Public Health

- Local authorities contributing funding into the integrated budget will retain statutory responsibility for provision of services for their resident population. As such, we recommend that Local Authority funding for the ACO is calculated on the basis of its current spend on the resident population of the locality of the care model.
- A future version of the Integrated Budget Handbooks will describe the considerations for determining the population and service scope for ACO funding for people registered with the ACO but resident elsewhere, or vice versa. However, it is worth noting that we envisage this will be a local decision.
- In some areas the numbers of people living within the ACO geography but registered with GPs elsewhere will be approximately equal to the number of people to which the opposite applies. In these cases our recommendation is to adopt a pragmatic 'knock-for-knock' position.
- In other areas there will be a significant mismatch between the two groups, Where this is the case it will be necessary for the CCG and Local Authority to reach a joint agreement around how funding flows will support people whose funding for local authority services sits outside the ACO but wish to receive those services within it, and vice versa.
- Commissioners may agree a different approach for social care than for public health funding if, for example, public health spending were harder to disaggregate on a case-by-case basis than social care spending.

11 Remainder of ACO service scope

- Calculated on the basis of current commissioner spend on the population **registered** with GPs and those in the locality of the care model not registered with GPs, and included with the remainder of the integrated budget as far as legally possible
- This will include CCG spend currently directed to social care via the Better Care Fund

12 As set out in 'ACOs and the NHS commissioning system' paper current legislation governing the pooling of budgets across health bodies and between health and social care is complex. Commissioners must satisfy themselves that any proposals to pool budgets in order to form an integrated budget are lawful, and that funds are not being used for an unlawful purpose. Annex 2 to 'ACOs and the NHS commissioning system' is intended to assist with this exercise.

GP funding in the integrated budget

13 There are three circumstances in which it may not be possible to move primary care funding streams into the integrated budget at the start of the contract period:

- Payments are activity-based and require incentivisation for public health reasons (e.g. vaccinations)
- Funding is pooled centrally and individual practices apply to access this (e.g. GPFV funding)
- Current legislative framework doesn't allow funding to be pooled within the ACO (e.g. dispensing doctors payments)

14 We are proposing that the majority of these payments flow through the fully-integrated ACO but are accessed according to the same criteria as under the current system. For example, vaccinations and immunisation payments would be made according to activity performed.

15 The only exception to this is dispensing doctors' payments, for which the current legislative framework does not permit the ACO to access funding.

16 Integrated budget values for the duration of the ACO Contract will be estimated according to the following principles:

Where the ACO is significantly aligned with the populations and services covered by commissioner(s) the starting point for forecasting the future value of the integrated budget will be the combined growth in commissioner allocations.

Where there is not significant alignment between the coverage of commissioner and the population/service scope uplifts to the integrated budget will be based on forecast increases in provider cost pressures, offset by local efficiency requirements and anticipated efficiencies as a result of the new care model. This forecast integrated budget will be triangulated against forecast growth in commissioner allocations and provider costs to verify commissioner affordability, and, if necessary, commissioning plans will be revised. There is a need to ensure that:

- Plans are affordable and deliverable for both the ACO and overall system.
- At the level of the CCG, growth in Primary Care spending at a minimum reflects increases in CCG primary care allocations (i.e. where ACO Primary Care funding has grown more slowly this has been offset by growth elsewhere in the CCG's Primary Care provision)
- Where commissioners believe there is reason for Primary Care funding entering the ACO to grow at a slower rate than set out in allocations they should be able to evidence the rationale behind choosing to invest more heavily in Primary Care outside the ACO (for example because health needs have grown faster for this population)

17 Where commissioner allocations are significantly above or below expected levels such that there is a need to renegotiate the ACO Contract value, this may need to be accompanied by a corresponding renegotiation of contract obligations to ensure continued affordability and sustainability of services. When revisiting the contract commissioners should look to consider both the ACO and other healthcare providers and be mindful of the information provided in the paper on 'Procurement and assurance approach' and guidance set out in paragraphs 18 – 20 below. The Integrated Budget Handbook provides further guidance on this.

Converting the integrated budget estimates into contractual values

18 We anticipate that the practical operation of ACO Contracts of up to 10 years will include periodic updates and agreement of the integrated budget for future years of the contract as follows:

- Through a pre-agreed mechanistic update, at least annual, to reflect any movement into and out of the ACO population and any change to the overall population health profile.
- Periodic updates of the integrated budget contract value over the course of the Contract to reflect changing circumstances. This will include availability of new CCG or LA allocations, and changes to either population or service scope. Further information about how to manage changes in the Contract that could lead to integrated budget movement are set out in the 'Procurement and assurance approach' paper.

Considerations for procurement: Variations to contract value and scope during the contract term

19 To ensure transparency during procurement it is important that the procurement documents for the relevant contract set out the estimated contract value and the way in which payment may be made (including any possible extensions/variations).

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

21 To minimise any potential procurement risk that could be triggered by changes to contract value or payments during the term of the Contract, commissioners should build in the fact 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. Please refer to the 'Procurement and assurance approach' paper for information on the variations that are permitted by current procurement legislation.

Primary Care

22 GPs moving into partially-integrated models will retain their current GMS/PMS contracts and the related core funding and QOF. The CCG may decide to include local enhanced services within the scope of the Contract although these may continue to be provided by GPs, for example via a subcontract back to individual practices.

Improvement Payment Scheme (IPS)

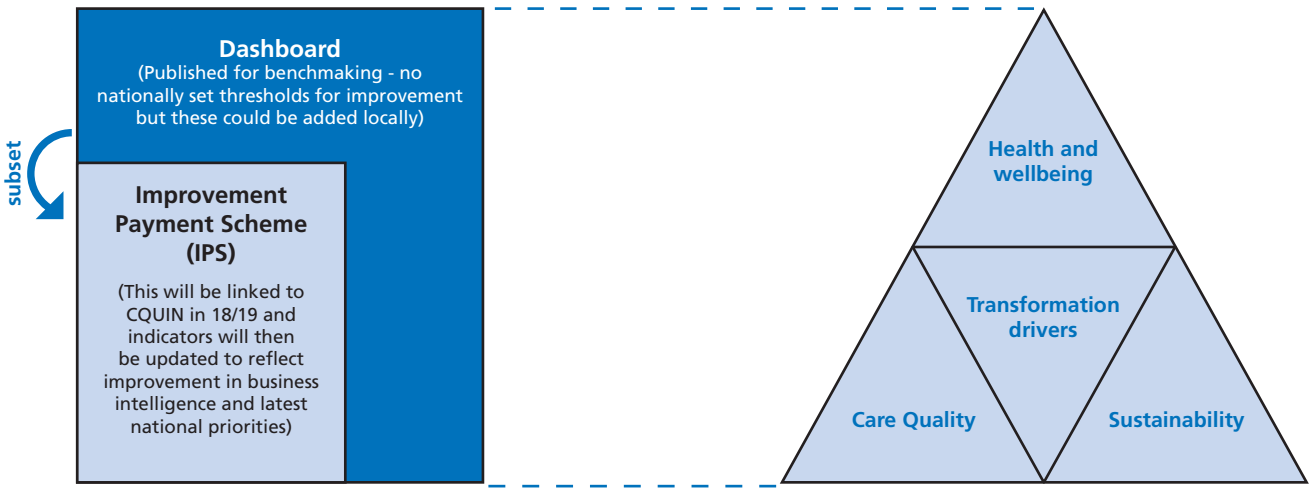
23 The national element of the scheme will be designed to:

- Align with the vision of the care model and the Five Year Forward View (FYFV) Triple Aim objectives;
- Incentivise ACOs to achieve a defined set of national initiatives and priorities
- Drive improvements in population, clinical and patient reported outcomes.

24 The quantum for the national element of the scheme will be designed to replicate the balance of financial risk and incentives that exist in the current national performance pay schemes (eg. CQUIN and QOF). The intention, at a national level, is not to increase significantly the levels of unearned provider income. Assuming comparable indicator earnability, the implication of this is that national IPS will be worth around 2.5% for a partially integrated ACO.

25 Commissioners will have opportunity to supplement the indicators in the scheme with their own locally designed indicators and, in doing so, increase the quantum assigned to the scheme. The additional financial risk borne by sites choosing to include local metrics and assign additional contract value to them will be assessed through the Integrated Support & Assurance Process (ISAP) run by NHS England and NHS Improvement. Commissioners will be expected as part of their ISAP submission to establish a clear narrative setting out how financial risk to the ACO is managed e.g. through robust indicator design, cost effectiveness considerations and thresholds set at levels that will be realistic for the ACO to deliver in the given time period. IPS indicators the ISAP panel believe inflate financial risk beyond the level providers are able to bear could result in proposals being red-rated at the relevant ISAP checkpoint, with the details of the scheme recommended for review. Please refer to further guidance on the ISAP at https://www.england.nhs.uk/resources/resources-for-ccgs/#isap.

26 In addition to the paid for element of the quality-incentive scheme, we will set out a range of outcome metrics against which ACO performance will be published. Both the paid for (IPS) scheme indicators and wider outcome indicators will be published as part of a dashboard, as set out below:



27 The IPS scheme will reflect the existing CQUIN scheme during 18/19. The indicators will evolve over time, reflecting the increasing sophistication of ACO business intelligence systems and the commitment to streamline oversight between commissioners and providers. For more detail see the incentives framework for ACOs.

Gain/loss share arrangements

28 Where new care models have limited coverage of acute services, the gain/loss share arrangement is designed to align incentives between the ACO and services outside its current scope. In particular, the mechanism should be designed to:

- Incentivise more effective management of patients in the community to avoid unnecessary acute intervention
- Disincentivise cost-shifting of activity outside of the ACO (for example, where acute services are not included within scope referring a greater number of patients for treatment in the acute provider)

29 Gain/loss share arrangements of this type will be designed as agreements between the commissioner, ACO, and where appropriate providers outside of the scope of the ACO (primarily the acute). These may either be set up as a series of bilateral contracts between the CCG and individual providers, which will need to be signed in parallel, or as a multilateral arrangement between all parties.

30 Gain/loss mechanisms should be set up such that payment is made to the ACO on delivery of identifiable commissioner savings against an agreed counterfactual for services not included within the model. These savings will most often be as a result of lower-than-expected activity in the acute (for example A&E admissions falling significantly below the agreed counterfactual), although could conceivably be set up to incentivise reduction in use of other services outside the scope of the model. In some cases, the provider outside the ACO that sees a fall in activity may not be able to reduce its costs in line with its fall in revenue. Where this is the case the gain/loss share can be used to help manage the impact on the non-ACO provider. The share of gains to the non-ACO provider can reduce in later years of the Contract as the provider is able to reduce its fixed costs.

31 The type of gain/loss mechanism described above will help ensure that the ACO is both rewarded for successful reduction of activity in services falling outside its scope, and disincentivised from cost-shifting of activity outside the ACO.

32 For these types of gain/loss mechanisms the level of ACO risk exposure needs to be proportionate to its ability to influence the targeted risk, and its ability to absorb this. In addition, it may take some time for the ACO to effect large-scale changes against some of the gain/loss metrics incentivised (e.g. reduction in non-elective admissions). For this reason we anticipate a gradual transition towards ACOs taking on full downside risk from gain/loss share arrangements relating to services outside the scope of the ACO. However, in later years of the Contract it is expected that the ACOs will stand to either gain or lose funding depending upon performance against the agreed system activity levels.

33 Where new care models have close to full coverage of acute services, the risk of acute demand being higher than planned will be internalised. As such, reductions in acute service use will be automatically incentivised through a need to bring costs within the financial envelope set by the integrated budget.

34 In these cases the gain/loss sharing approach can be used to smooth the transition of the acute utilisation risk from the commissioner (where it sits under payment by results) to the provider. Gain/loss sharing arrangements designed for this purpose would operate for a time-limited period until the provider is sufficiently mature to absorb the full utilisation risk associated with acute services.

35 It is worth noting that this mechanism could also be used in instances where a provider takes on a large volume of additional demand risk from services other than the acute (e.g. to smooth the additional risk of moving to large multiyear contracts).

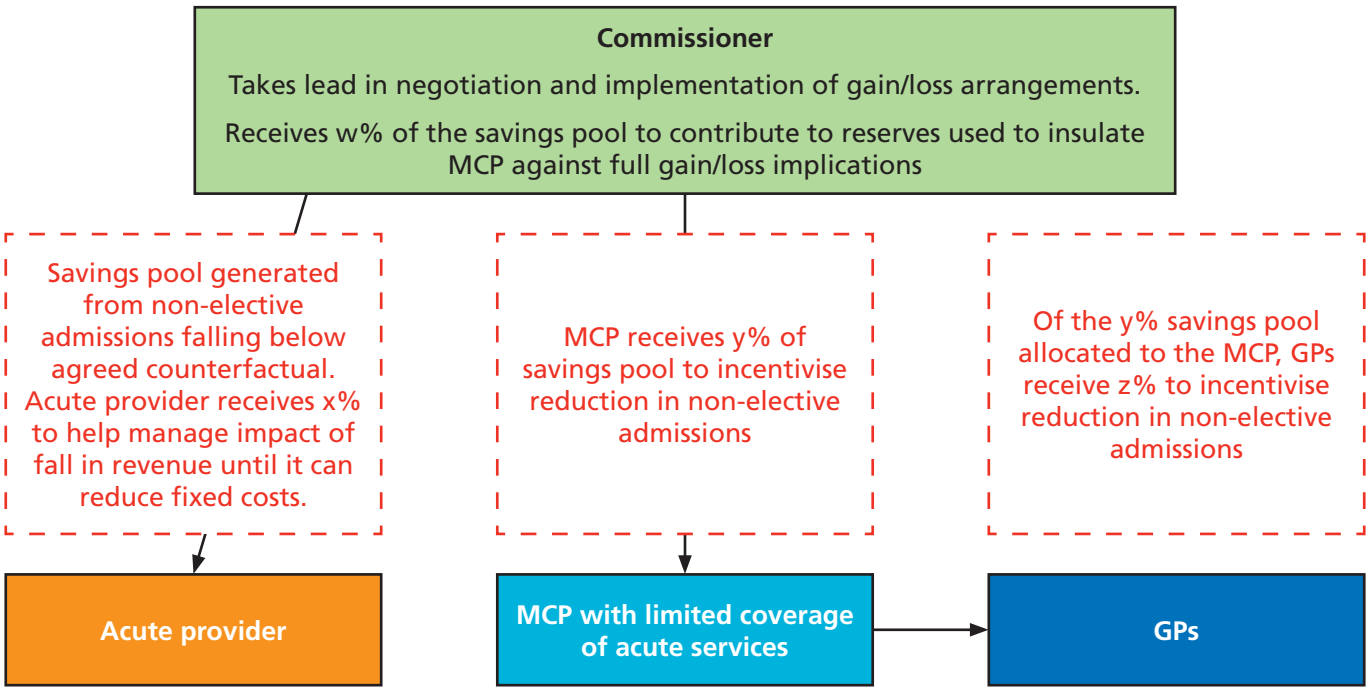
GP interaction with gain/loss share arrangements

36 Partially-integrated model

- Under the partially-integrated model a proportion of the overall gain/loss share payment accruing to the ACO could be distributed to practices via the Integration Agreement signed between practices and the ACO
- Any payments made to employed GPs as a result of the gain / loss share mechanism will be determined at a practice level.

37 Example of gain/loss share in partially-integrated model with limited coverage of acute services

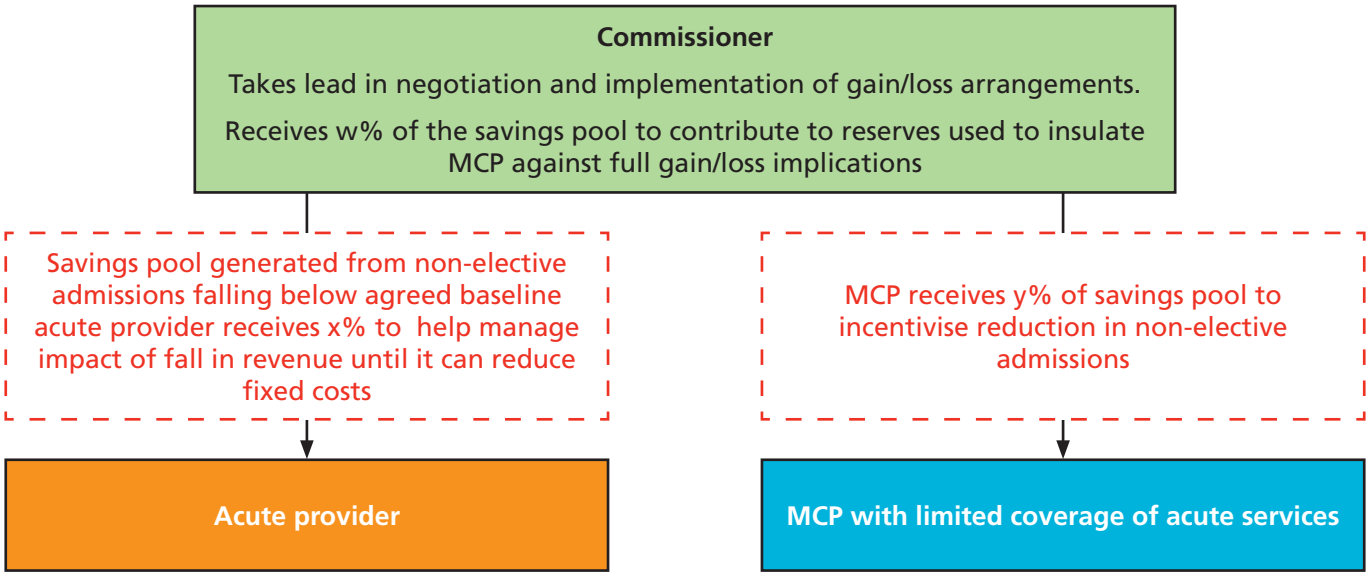
- The below example is a gain/loss distribution model set up to incentivise an ACO (in this case an MCP) to reduce non-elective admissions.
  - Note: most local areas will take on a number of gain/loss metrics (and in the end-state these could cover the entirety of acute services the ACO has the ability to influence). For simplicity the model below isolates a single metric.
- The proportions of the savings pool distributed to each provider are illustrative and will be for local negotiation.
- A proportion of any system gains may be distributed to an acute provider to cover some of their fixed costs if they are unable to reduce these in line with their fall in activity. This payment will reduce in later years of the Contract as the acute is able to reduce its fixed costs.



38 Fully-integrated model

- Under the fully-integrated model all gain/loss payments will be made to the ACO (in this case an MCP) as a single entity. Any payments which under the partially-integrated model would have been paid to GP partners are included within this overall sum.
- Any payments made to GPs (either employed or acting as partners or shareholders) will be determined by the MCP Board.

39 Example of gain/loss share in fully-integrated model with limited coverage of acute services



National framework

40 NHS England and NHS Improvement are working with sites to complete a national framework for gain/loss share arrangements. This will set out detailed examples and case studies of how these arrangements could be set up, and how these arrangements might vary dependent on the scope of the local care model.

41 For areas wishing to determine alternative local arrangements there will be flexibility to move away from the national framework set out. However, to align incentives sufficiently to deliver real behaviour change and a reduction in acute activity there will be a requirement for all new care models, without full coverage of acute services within the integrated budget, to operate gain/loss share agreements covering key parts of acute hospital use by their population.

CCG business rules

Existing deficits

42 Sites intending to transfer services into a different organisational form will need to consider treatment of current provider deficits. In particular, we will need to consider the risks of either concentrating deficits within existing providers, or transferring deficits into organisations that are not robust enough to take them on.

STP control totals

43 ACOs will need a provider control total that is understood and consistent with the overall STP position.

Contingency

44 CCGs' 0.5% contingency held against in-year risks and pressures will remain with the CCG rather than transferring to the ACO. Access to this funding will remain at the discretion of the commissioner. The only exception to this will be in cases where the ACO holds the entire system utilisation risk (including that for the acute provider).

Admin budgets

45 An assessment will need to be made of how much current CCG and CSU spend relates to activities which will in future be carried out by the ACO. This should inform a decision about how much of the CCG admin budget transfers to the ACO.

VAT

46 The additional VAT liabilities, demonstrated in the case of Uniting Care Partnership (UCP), continue to apply to NHS bodies in certain contracting arrangements such as corporate joint ventures. We have raised with HMRC the issues around the loss of VAT recovery on NHS contracted out services as highlighted in the review of the UCP contract (described in the NAO's report on the matter: https://www.nao.org.uk/report/investigation-into-the-collapse-of-the-unitingcare-partnership-contract-in-cambridgeshire-and-peterborough/).

47 Those discussions have now concluded and it is clear that the position described in the UCP case stands. This will be of interest to local health economies, particularly providers, so they can consider carefully the VAT implications of any organisational form they choose to develop for the purpose of holding an accountable care contract for an MCP or PACS model: https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/. We will ensure that due consideration has been given to the issue through the Integrated Support and Assurance Process (ISAP) for complex contracts, which was established in response to the UCP case.

Capitalisation requirements

48 Whether providers hold sufficient levels of capital to take on new ACO Contracts will be tested through the ISAP. We do not anticipate setting out the level of capital we would expect providers to hold in specific circumstances because it will be dependent upon a series of factors including the scope of services included in the Contract and gain/loss share as well as the provider form. All bidding providers will be required, in the course of a procurement, to provide analysis of their ability to manage reasonable downside risks and how they can demonstrate their ability to withstand this. This should form part of commissioner's bid evaluation.

49 Assessing the downside risk, and resulting capitalisation requirements, will involve a degree of judgement. This will take account of how the ACO risk profile compares to that in current organisations.

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

www.england.nhs.uk/newbusinessmodels **#futureNHS**