

New models for delivering care

Payment models for integrated care

A capitated payment approach

Introduction

This series of briefings is designed to help members understand the different models of care that are emerging in the NHS in England, their associated contractual and payment models and the practical implications for doctors.

Providers of acute, community and primary care tend to operate separately at present. But increasing emphasis on new, integrated models of care across the sectors, and greater networking within sectors, has the potential to change the provider landscape over time. Be informed.



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Background

The main payment system in England, the national tariff, is widely recognised as posing a barrier to integration.¹ Some areas are already moving towards other payment systems, such as block contracts or outcomes-based contracts, to facilitate integration. NHS Improvement and NHS England are also working with some areas to develop a new payment approach, which may be adopted by emerging MCPs (multispecialty community providers), PACS (primary and acute care systems). This briefing focuses on the approach they are developing, which is based on capitation. See our other briefings for further information on [existing payment models](#) (eg the national tariff), and [MCPs and PACS](#).

A capitated payment approach

Capitation is a payment system where lump-sum payments are made to care providers based on the number of patients in a population, to provide some or all of their care needs. It is not linked to how much care is provided. Capitation is currently used to determine core general practice funding.

A capitated, whole population budget forms the basis of the new payment approach, along with an improvement payment scheme and a gain/loss share arrangement. Together, these elements are intended to enable longer-term planning and a more flexible use of resources to best meet the needs of the whole population, with targeted financial incentives.

Whole population budget

The WPB (whole population budget) is the funding available to the MCP/PACS. It will cover the total registered population for all services within the scope of the MCP/PACS, for the duration of the contract (expected to be 10-15 years).

The initial value of the WPB will be estimated from current commissioner spend on the services and population within the scope of the MCP/PACS. Depending on the scope, this could include spend on GP funding streams, community care services, social care and local authority spend on public health. Local adjustments may be made for forecast increases in provider costs and efficiency requirements.

This initial value will then be used to forecast the value of the WPB in future years. The forecast will be updated at least annually to reflect local demographic changes, and may be adjusted periodically to reflect more significant changes, such as changes to the population or service scope.

Improvement payment scheme

The improvement payment scheme – a type of performance related pay – is designed to incentivise improvement in quality, outcomes and transformation. The scheme is a top slice of the contracted WPB value, with the national element likely to be around 2.5-4% of the contract. Payment will be given to the MCP/PACS on delivery against agreed targets in line with national priorities. Commissioners may also increase the percentage value of the scheme by adding in local indicators.

Initially, it is likely that metrics similar to those used in current arrangements (ie quality and outcomes framework) will be used. However, MCP's/PACS's performance against outcome metrics will be published in a new dashboard, and over time payment may increasingly be linked with performance against such outcome metrics.

Gain/loss share agreement

There will be a gain/loss share arrangement to align financial incentives between the MCP/PACS and the wider health economy. The arrangement will be designed and agreed by the MCP/PACS, the commissioner(s) and other local providers. It should incentivise effective management of patients in the community and disincentivise shifting of activity outside the MCP/PACS to save costs.

Payments will be made to MCP/PACS if they generate savings for commissioners against agreed targets. For an MCP, this will often be the result of causing lower-than-expected activity in an acute care setting. In time, it is expected that MCPs/PACS will also be able to lose funding (ie if demand on other providers is not reduced, or if it increases, the MCP/PACS will lose some funding to cover this).

If GPs have entered into a MCP/PACS contract, their interaction with gain/loss share arrangements will depend on the level of integration they agree to. In a partially-integrated model a proportion of the overall gain/loss share payment will be distributed to GPs, with any payments made to salaried GPs determined at a practice level. In a fully-integrated model all payments will be made to the MCP/PACS as a single entity, with payments made to individual GPs determined by the MCP/PACS.

Implementation

NHS Improvement and NHS England have been working with MCPs, PACS and other sites to develop this approach. A number of sites have begun to test elements of the model, although it is unlikely that any will go fully live until April 2018. Some practicalities are still being worked through, such as how to disaggregate existing block contracts (commonly used in community care and mental health services). Initial [guidance](#) on the payment approach has been published, and will be followed by a more comprehensive 'handbook'.² In time, it is likely to become part of the national tariff process; however, for now it remains a voluntary approach and may be subject to further refinement.

What's the BMA's policy?

The BMA has been and remains clear that the current payment system in England (the national tariff) is not fit for purpose and does not support integrated working around the needs of patients. Following a literature review in 2015 (before the detail of the new capitated payment approach had been developed), we concluded that: 'payment reforms that focus on capitation look, at present, to be the most realistic way of achieving closer working between different parts of the health service'.³

It is essential that any capitated budget is sufficient to fund services and accommodate local variations (eg in population health). However, the assumption behind many new care models, that shifting care out of hospital will save money, is not supported by evidence.⁴ Any movement of care into the community must be adequately funded. The financial challenges facing the NHS are well-documented and the risk of taking on responsibility and accountability for a whole population budget must not be underestimated. This is particularly pertinent for GP partners and practices operating as providers as part of an MCP.

We believe spending for core general practice should be ring-fenced, to ensure these essential services are protected for all patients, regardless of postcode. We also have concerns that a single capitated budget could result in unintended consequences, such as a pressure to reduce referral rates, particularly where there is a need to run an overall profit to provide adequate income or meet internal fiscal targets. This not only risks patient care, but risks doctors' professional duty and relationship with patients. Targets for outcomes or activity levels in any gain/loss share arrangement must be carefully considered, as service demand (particularly for A&E) can be very difficult to predict or control. Improving patient care must be the priority and complexity within the system, should be minimised where possible.

References

- 1 Monitor (2013) *How can the NHS payment system do more for patients?* Monitor.
- 2 NHS England (2016) *Multispecialty community provider (MCP) financial strategy*. NHS England.
- 3 BMA (2015) *Models for paying providers – capitation*. London: British Medical Association.
- 4 Nuffield Trust (2017) *Shifting the balance of care – great expectations*. London: Nuffield Trust.