Payment system reform proposals for 2019/20

A joint publication by NHS England and NHS Improvement

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1 Introduction

1. The current National Tariff Payment System (NTPS) allows significant flexibility to support new ways of delivering care. NTPS rules on locally determined prices (see Section 6 of the 2017/19 NTPS) allow providers and commissioners to set appropriate local prices and payment approaches, provided they:

   - are in the best interests of patients
   - promote transparency
   - result from providers and commissioners engaging with each other constructively.

2. We want to develop payment approaches, such as the blended payments described in Section 2.2 below, that:

   - support a more effective approach to resource and capacity planning that focuses commissioners and providers on making the most effective and efficient use of resources to improve quality of care and health outcomes
   - provide shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions by providing the right care in the right place at the right time – and shared financial responsibility for levels of hospital activity
   - fairly reflect the costs incurred by efficient hospitals in providing care and provide incentives for continuous improvements in efficiency
   - minimise transactional burdens and provide space to transform services.

3. This document summarises some of the principal proposed changes to the payment system in 2019/20. You can give feedback on the proposals by responding to our online survey[1] that allows you to provide feedback on the proposals and also contains additional information. All final proposals will be subject to statutory consultation in due course.

[1] https://engage.improvement.nhs.uk/pricing-and-costing/2019-20-payment-reform-proposals

2 Our proposals

4. This document sets out some of our main reform proposals for the next NTPS.

2.1 Duration of the tariff

5. We are proposing to set the next national tariff for one year.

6. The vast majority of feedback we have received regarding the impact of the two-year tariff has been very positive. However, in setting the two-year tariff for 2017/19, we developed a method for assessing the appropriate length of the tariff.[2]

7. Based on our criteria, we believe that the flexibility of a one-year tariff will be necessary to be able to respond effectively to developments taking place within the NHS, including the forthcoming release of the long-term plan for the NHS. Fixing a tariff for a longer period would limit our ability to make changes to support necessary strategic developments.

2.2 A blended payment approach for emergency care

8. We propose introducing a 'blended' payment approach for emergency care. This would comprise a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity.

9. The payment model would cover A&E attendances, non-elective admissions (excluding maternity and transfers) and, potentially, ambulatory emergency care. It would serve as the new 'default' reimbursement model, but would not stand in the way of local systems continuing to move faster towards population-orientated payment models.

10. This proposed approach is designed to provide greater stability. It would enable providers and commissioners to focus on how to use resources most efficiently and effectively to improve quality of care and health outcomes, while sharing both responsibility for the resource consequences of increases in acute activity and the benefits of system-wide action to reduce growth in activity.

[2] https://improvement.nhs.uk/documents/222/Annex_E_Final_two_year_tariff_paper_with_cover.pdf

11. Under a blended payment approach:

    - prices would still be calculated at an HRG level and would be used as a basis for contract negotiation and for continued episodic payment where required, for example cross-border activity
    - the marginal rate emergency tariff (MRET) and the 30-day readmission rule would be abolished as national rules, on a financially neutral basis between providers and commissioners
    - contracts would include a ‘break glass’ clause which applies when activity is significantly higher or lower than assumed and requires the emergency care payment elements of the contract to be reviewed and potentially renegotiated
    - the blended payment would be the default payment arrangement for all contracts above a defined value threshold, with the default for contracts below this threshold being episodic payments
    - depending on the design of the blended payment approach (see below), some best practice tariffs (BPTs) might need to be revised or removed.

12. Good quality activity and cost data would continue to be essential for making optimal decisions on service design, improving efficiency and improving patient outcomes. Providers would still be required to collect and submit data regularly.

13. We welcome views on three specific design issues in particular.

14. The first concerns the relationship between the fixed and variable elements of the blended payment model. For 2019/20, we propose that the variable element be set at 20% of the HRG price, which broadly reflects current data on variable costs; over time, we would seek to adjust the levels to more accurately reflect costing data. There is then a choice as to whether:

    A: The fixed element of payment (based on locally agreed forecast levels of emergency activity) should correspond to 100% of costs (based on HRG prices), with additional payments (at 20% of the HRG price) for activity above this forecast level and deductions (at 20% of the HRG price) for activity below the forecast level. Local areas would be able to agree to make these additional payments on an alternative basis if that would better suit their local system.

B: The fixed element of payment should be a capacity payment corresponding to fixed and semi-fixed costs (for 2019/20, as a proxy, we would use 80% of expected revenue), with the variable element (20% of the HRG price) paid for all units of activity, not just activity in excess of plan.

15. Option A could support a fuller focus on how to make the most efficient and effective use of an agreed amount of resources. It might also allow a greater reduction in transactional activity, for example relying on monthly reconciliation of activity rather than episodic payments or basing the variable element on units above HRG level, such as the number of non-elective admissions and A&E attendances. Option B could be more easily compatible with pricing incentives (such as new currencies and prices) and the use of BPTs (where considered helpful). It could also ease contractual negotiations by providing a nationally set default for both payment elements.

16. The second issue is whether to include arrangements whereby additional activity within a defined tolerance does not attract additional payment (or deduction). We could either include arrangements of this kind in the national (default) tariff system or leave it to local health systems to agree any such arrangements. There could also be a 'break glass' point, as set out in paragraph 11 above.

17. The third issue is whether the level of activity should be defined and agreed locally when contracts are agreed or whether there should be a national default for each contracting round, with providers and commissioners able to agree to move away from this where appropriate.

18. The worked example overleaf illustrates how the options set out in paragraph 14 might work in practice. If the agreed activity levels are the same, both options produce arithmetically equal results and it is the flow of payment that is likely to differ between the two options, not the amount paid.

19. We are keen to hear your views on the proposed blended payment approach. Your feedback will help us refine the proposals we include in the statutory consultation on the next tariff.

Option A

The expected level of activity of 10,000 units.

The HRG price is £100 and the provider and commissioner agree a variable payment of 20% of the price for any activity over or under the planned level.

The provider is given a fixed payment of £1 million (£100 × 10,000 units). The provider receives an additional £20 (£100 × 20%) for each unit of activity above the expected level. The provider loses £20 for each unit of activity below the expected level.

- If activity is 1% higher than planned, i.e. 10,100 units, the provider receives £1 million + (£20 × 100) = £1.002 million.
- If activity is at the planned level the provider receives £1 million.
- If activity is 1% lower than planned, i.e. 9,900 units, the provider receives £1 million less (£20 × 100) = £998,000.

If a threshold is agreed, whereby no variable rate is applied if activity is activity is +/-1% from the planned level, the provider would receive £1 million in all of the situations above.

Option B

The expected level of activity is 10,000 units.

The HRG price is £100: 80% of this is fixed and semi-fixed costs; 20% is variable costs.

The provider is given a fixed payment of £800,000 (80% × £100 × 10,000 units). The provider also receives £20 (20% × £100) for every unit of activity.

- If activity is 10,100, the provider receives £800,000 + (10,100 × £20) = £1.002 million
- If activity is 10,000 units the provider receives £800,000 + (10,000 × £20) = £1 million
- If activity is 9,900 units, the provider receives £800,000 + (9,900 × £20) = £998,000.

2.3 Outpatient attendances

20. The 2017/19 NTPS included a set of national prices for first and follow-up attendances for 56 treatment specialties. The difference between first and follow-up prices varies by specialty, with up to 30% of the cost of follow-up attendances front-loaded into first attendance prices. The national prices are for consultant-led, face-to-face attendances.

21. We believe that the way outpatient activity is funded could be improved. Our aim is to design a payment mechanism for outpatients which maintains quality of care and:

    - incentivises increased use of non-face-to-face (eg telemedicine) and non-consultant-led activity where clinically appropriate
    - reduces incentives for unnecessary consultant-led face-to-face activity
    - helps support lower unit cost of outpatient services
    - helps providers meet the referral to treatment (RTT) standard by freeing up consultant time to deliver more first attendances.

22. To work towards these aims, we propose to create non-mandatory prices for non-face-to-face follow-ups for specialties with national prices. We would also create non-mandatory prices for non-consultant-led first and follow-up attendances. We would continue to front-load first attendance prices but propose changing the level of front-loading for services that require regular ongoing follow-up appointments as part of good practice: ophthalmology (decrease from 30% to 20%), dermatology (decrease from 30% to 20%) and nephrology (decrease from 10% to 0%).

23. We are also planning to pilot using a single price for all outpatient attendances for a specialty, regardless who the appointment is led by (consultant or not) and whether it is delivered face-to-face or not. This model should incentivise a move towards non-face-to-face and non-consultant-led activity where it is appropriate for patients. We will consider developing this approach further in future years.

2.4 Market forces factor

24. The market forces factor (MFF) estimates the unavoidable cost differences between healthcare providers, based on their geographical location. Each NHS provider is assigned an individual MFF value. MFF values are used to adjust national prices and commissioner allocations.

25. The MFF is an important part of the NTPS. However, it has not been updated for almost 10 years. The current MFF is based on primary care trust (PCT) boundaries, which no longer exist. In addition, the underlying data used to calculate the MFF has changed since it was last reviewed – in particular, wage differences between London and the rest of England.

26. We propose updating the method used for calculating the MFF and the data it is based on. The proposed key changes are:

    - using travel to work areas (TTWAs)[3] (rather than PCT area) for the non-medical and dental staff index; we have smoothed out large differences in values between trusts close to the border of neighbouring TTWAs (cliff edges)
    - including business rates
    - an effective reduction in the weight of the land index from an improvement in how the components are combined into a single MFF value
    - using the latest available data to calculate the MFF index.

27. The updated MFF values would mean a significant change in income and allocations for several providers and commissioners if implemented without a transition path. We therefore propose implementing the changes over a number of years. We have produced a document that sets out details of the proposed changes to the MFF, as well as providing details of the proposed provider MFF values.[4] We are considering a four-year transition path and would welcome your views on this.

28. We would expect that changes to MFF will not affect local prices that are already based on local costs. However, local prices which are based on the provider MFF could be adjusted for new MFFs.

[3] Travel to work areas are geographical boundaries of local labour markets, produced by the Office for National Statistics.
[4] See *Market forces factor review and proposed updates*. Available from: https://improvement.nhs.uk/resources/201920-payment-reform-proposals

2.5 Centralised procurement

29. NHS Supply Chain is being reorganised and managed by a new organisation, Supply Chain Coordination Limited (SCCL). SCCL aims to increase NHS purchasing power and give providers access to lower procurement prices.

30. SCCL estimates that its overheads will be around £250m in 2019/20. We are asking for feedback on potential approaches to funding these overhead costs.

31. Currently, NHS Supply Chain is funded through a mark-up on the prices it offers. The Department of Health and Social Care intends that SCCL overheads will be funded using money allocated to the national tariff. This central funding would reduce the direct cost to NHS providers of procuring supplies from SCCL.

32. If we were to recover SCCL's overhead costs through lowering the tariff, we could reflect this by reducing the overall tariff uplift factor, lowering national prices. The estimated overhead costs of SCCL are around 0.35% of the total amount covered by the national tariff.

33. If we were not to do this, SCCL would need to recover its overhead costs through mark-ups on product prices.

2.6 Maternity pathway

34. The maternity pathway payment involves national prices for the integrated package of care offered to all pregnant women and their newborn babies. The pathway consists of three integrated packages of care covering the antenatal, birth and postnatal phases. The clinical pathways are well described and adhered to and linked to the safe management of the mother and her child.

35. We have become aware that the integrated package may include some public health services, known as Section 7A public health services, which fall outside the scope of national prices in the national tariff.

36. To address this issue, we propose making all maternity prices non-mandatory. We considered removing the conflicting services from Section 7A arrangements, or removing these services from the maternity pathway currency design. However, we felt that changing the specification of Section 7A arrangements would risk the delivery of the public health screening

programmes contained in the maternity pathway. We also felt that the data available on the Section 7A services is not sufficiently detailed to allow for currency redesign.

37. We believe that, in the short-term, making the prices non-mandatory is likely to be the most appropriate way to address the issue and maintain the integrity of the package of care provided to women and their babies. Providers and commissioners would be strongly encouraged to use the non-mandatory prices.

38. It is important to note that we are considering this change to address the current mix of services issue only. The non-mandatory prices would continue to be calculated using the costs associated with the delivery of the maternity pathways.

39. We also propose increasing the number of payment levels for delivery from two (with or without complications) to six or 36. The 36-level payment approach would mean providers are reimbursed on the basis of each of the 36 birth HRGs; the six-level approach groups the HRGs together, reflecting clinical complexity.

40. In addition, we propose the following changes to the maternity pathway:

    - Updating the complexity factors for the postnatal phase to better reflect the clinical care women require.
    - Removing abnormally invasive placenta from the scope of national prices. Care would be delivered from a number of specialist centres and be directly reimbursed by NHS England Specialised Commissioning.
    - Removing specialist fetal medicine from the scope of national prices. NHS England would directly reimburse designated providers, operating a networked hub-and-spoke approach, for the care provided.

2.7 Other payment reform proposals

Price calculation method

41. Since publication of the 2017/19 NTPS, we have rebuilt the model used to generate national prices. This has not changed the price calculation methodology, but updating the model processing infrastructure has made it faster, more reliable and transparent.

42. We propose modelling national prices for 2019/20 using the same method as for the 2017/19 NTPS, with updated inputs and adjustments. We propose additions to, and removals from, the high cost drugs and devices lists. We are also considering adjusting the tariff to support the findings of the recent consultation on evidence-based interventions.[5]

43. We propose introducing BPTs for spinal surgery and emergency laparotomy. We also propose changing some BPTs following feedback from the sector or as a result of new data becoming available to ensure that the BPTs achieve their intended purpose.

44. We have sought significant clinical input into our draft prices, including speaking to NHS Digital's Casemix Expert Working Groups (EWGs) to identify any issues with price relativities from a clinical perspective.

45. The draft national prices published in the accompanying workbook are the 2019/20 national prices scaled to 2018/19 levels.[6]

46. We recognise that some of our proposed changes may have a significant impact on services or providers. We are still developing the policies that will determine proposals for the final price levels. These policies include potentially setting different cost uplift factors for different services (for example, different factors for acute, community, ambulance and mental health services) in response to adjustments that may be required for pay and centralised procurement in 2019/20.

[5] www.england.nhs.uk/evidence-based-interventions/

[6] This means we equalise the funds that would be paid for the same group of patients under both years' prices before overall adjustments (for example, for inflation or efficiency). This allows providers and commissioners to understand how the proposals affect them when benchmarked against 2018/19 levels. In the statutory consultation we will apply the 2019/20 uplift and deflationary factors to produce prices. We will also provide our proposals for the overall price levels in the tariff (the cost base).

47. We will aim to avoid destabilising services and manage volatility of provider revenue and commissioner expenditure by:

    - ensuring prices for healthcare do not fluctuate significantly year-on-year without a valid explanation
    - providing a degree of stability to providers by minimising the impact of large changes in revenue year-on-year caused by policy or price changes. This includes continuing to adjust prices to mitigate the impact of the move to HRG4+ – we propose that the affected services are reimbursed 50% of the loss, rather than the 75% in the 2017/19 NTPS.

Mental health

48. In the 2017/19 NTPS we introduced local pricing rule 7.

49. We propose changing the rule to mandate a blended payment approach for mental health services for working-age adults and older people. This would consist of a fixed element based on forecast activity, a variable element and an element linked to locally agreed quality and outcomes measures. There would also be an optional risk share to promote collective management of financial risk.

50. We also propose publishing non-mandatory guide prices for improving access to psychological therapies (IAPT) assessment and treatment.

Other area of work

51. We propose to continue using the HRG4+ currency design to set national prices but moving to the version used for 2016/17 reference costs.

52. We are developing prices for advice and guidance, IVF and smoking cessation in hospital services.

53. We propose that both wheelchair and spinal cord injury services have national rather than non-mandatory currencies from 2019/20. We also propose setting new non-mandatory prices for wheelchair services.

54. We have also developed draft currencies for community services that could be used as the basis for a blended payment approach for community services in their local areas.

3 Supporting analysis

55. We have undertaken two projects, summarised below, which aim to ensure that our analysis of the impact of national tariff proposals is as accurate as possible, and that we are sharing information with stakeholders transparently.

56. First, as in previous years, we ran an enhanced impact assessment (EIA) project. Ten participants, including commissioners and NHS and independent providers, assessed the impact on their organisation of draft national prices. The project allows us to examine the difference between stakeholders' impact analysis and our own, helping us understand where our methodology could be improved.

57. Second, for every provider and commissioner that delivers nationally priced services, we are producing an individual impact analysis. This consists of a PDF report, giving a high-level assessment of the likely impact of our proposals, and an Excel spreadsheet giving more detail of the same data.

58. It is important to note that the impact analysis is based on 2016/17 activity data and assumes all national prices are used. However, we hope organisations will find the reports a useful indication of the impact we are expecting. We will aim to provide updated individual impact analysis reports for providers and commissioners that deliver nationally priced services alongside the statutory consultation.

59. Reports will only be shared with the organisation whose information they contain. We have sent details on how to access the reports to each organisation's authorised responder (the person who gives the organisation's response to the national tariff statutory consultation). To find out more about the reports, and if you are unsure who the authorised responder is for your organisation, please contact pricing@improvement.nhs.uk.

4 How to provide feedback

60. We have set up an online survey[7] to gather your feedback on these proposals.

61. The survey also contains further detail on the proposals set out in this document.

62. The deadline for feedback is 29 October 2018.

63. This document is supported by the following materials, available to download from the NHS Improvement website:[8]

    - *Draft price relativities workbook*
    - *Market forces factor review and proposed updates*. There is a separate online survey for more detailed feedback on the MFF proposals.[9]

[7] https://engage.improvement.nhs.uk/pricing-and-costing/2019-20-payment-reform-proposals
[8] https://improvement.nhs.uk/resources/201920-payment-reform-proposals
[9] https://engage.improvement.nhs.uk/pricing-and-costing/mff-proposals

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