HFMA response
October 2018

The HFMA's response to the 2019/20 payment reform proposals

Engagement by NHS Improvement and NHS England

NHS Improvement and NHS England recently set out the main proposed changes to the payment system in 2019/20 and the Healthcare Financial Management Association (HFMA) has provided feedback on behalf of its members.

The responses were formed based on discussions at various HFMA committee meetings and also feedback to our earlier briefing *2019/20 payment reform proposals: a summary*.

Submitted via an online survey, our responses to the payment reform proposal survey and also the separate market forces factor survey are included below.

The statutory consultation is currently scheduled to begin on 17 January 2019.

2019/20 payment reform proposals

Overview

The survey accompanies the document 2019/20 payment reform proposals. The document summarises some of the principal changes to the payment system NHS Improvement and NHS England are proposing to make for 2019/20.

PLEASE NOTE: This document is intended to aid stakeholders in responding to our online survey. Please do not use this document to feedback to us.

Introduction

This survey has been divided into a number of sections. You do not have to answer all the questions.

Duration of the tariff

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

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.

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.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

In the current climate, we recognise the need for and are in support of the proposal for a one-year tariff. However, the certainty and stability afforded by a two-year tariff, or longer, would be strongly supported once the long-term plan for the NHS has been developed. We would not be in support of a one-year tariff on an on-going basis.

Blended payment for emergency care

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.

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.

To what extent do you support a move to blended payment for emergency care?

• Strongly support • Tend to support • Neither support or oppose ✓	• Tend to oppose • Strongly oppose • Don't know

Please explain the reasons for your answer

Our members have mixed views on the blended payment approach, some organisations suggest the approach will:

- streamline the payment mechanism by removing MRET and 30-day readmission rules.
- offer a mechanism to reimburse the true level of variable costs (recognising that it is a national average).
- acknowledge that while preferably avoided, there is a cost to treating patients who are readmitted through an emergency setting.

However, others have expressed concerns that:

- the 20% variable cost element doesn't appear to include the cost of additional medical and nursing staff required to provide clinically safe, high quality emergency healthcare when activity is greater than planned.
- the level of negotiations involved in agreeing an appropriate planned level of activity, and the setting of a break glass threshold, will cause delays in the planning process and potentially lead to an increased number of disputes between commissioners and providers.

What do you feel would be the advantages and disadvantages of the options set out?

Option A

The advantage of Option A is that it ensures the funding is available for an emergency department for a planned level of activity. Allowing providers stability in their workforce and operational planning, which can then be scaled up or down as demand dictates.

Also, if 100% of fixed costs are covered, providers are more likely to be encouraged to be innovative in managing their emergency patient flow.

One disadvantage however, is that the 20% variable costs is a national average based on all levels of activity. In reality the variable cost of each unit of activity over and above expected levels is likely to be higher than the variable cost of all activity (per unit). But this is true of both options.

Option B

A disadvantage for Option B is that it suggests the variable costs of activity under a planned level are the same as the variable costs above a planned level, due to the premium costs associated with temporary staffing this is rarely the case.

On balance, which of the two options do you prefer?

Option A ✓	Option B

To what extent do you agree that the blended payment approach should…

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
...include a 'break glass' threshold	✓					
...have a threshold below which the blended model wouldn't apply		✓				
...have a 'collar' around the planned activity level where the variable rate would not apply		✓				
...cover ambulatory emergency care				✓		
...exclude specialised commissioning		✓				

Are there any other design elements you think will be important?

The tendency to agree with the collar is only apply if Option A is in place. If Option B was in place, then the response would be "tend to disagree".

The tendency to disagree with a blended payment approach to cover ambulatory emergency care is due to the lack of a consistently applied definition or approach to delivery of ambulatory care.

How do you think providers and commissioners could best be supported to agree a planned level of activity?

For example, this could be nationally set assumptions, a national default or using three-year average growth.

Nationally set three-year average growth based on individual provider rather than a national average, with abnormal growth factors in baseline or planned activity to be agreed locally.

Are there any barriers that you think might make implementing a blended payment approach difficult?

The relationship between fixed and variable costs will no doubt put pressure on organisations whose emergency departments have lower fixed rate element than the national average. It would be interesting to know how wide the range of fixed/variable ratios is.

Do you have any other comments on this proposal?

The engagement document could set out more clearly the advantages a blended payment approach is designed to produce. What changes in commissioner or provider behaviours are expected as a result from the blended payment approach? It does not feel too dissimilar to a tariff and marginal rate. The lack of clarity regarding the reasoning for the implementation of a blended payment approach may mean the opportunities the mechanism is designed to promote could be missed.

Outpatient attendances

We are proposing 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.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

The approach allows providers to plan resources around fewer variables e.g. cost and outcomes, rather than income, cost and outcomes.

Market forces factor

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) (rather than PCT area) for the non-medical and dental staff index
- 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.

See *Market force factor review and update* for more details of the proposed changes. There is also a more detailed survey available to collect feedback on the MFF proposals.

To what extent do you support this proposal?

• Strongly support • Tend to support ✓ • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

Our members support the use of travel to work areas and the use of the latest data available.

The ability to include land and buildings as a single component, as discussed during the

NHS Improvement webinar on 19 October, would be preferable.
Having a refreshed MFF as part of the routine of planning and payment mechanisms would also be helpful to avoid any future disparity.

Centralised procurement (SCCL)

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.

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.

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 will receive central funding from the NHS England budget to pay for its overheads. This would reduce the cost to NHS providers of procuring supplies from SCCL.

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 Payment System.

If we were not to do this, NHS England would not be able to provide central funding and SCCL would need to recover its overhead costs through increased mark-ups on product prices.

Would you prefer the overhead costs of SCCL to be funded by an adjustment to the tariff cost uplift factor or through a mark-up on product prices?

Tariff cost uplift factor	Mark-up on SCCL product prices ✓
Please explain the reason for your answer	
The tariff cost uplift factor method will artificially decrease expenditure levels in national and local costing data, resulting in the appearance of efficiency. The method of mark-up on SCCL product prices will allow trusts to make a direct comparison from one year to the next. The tariff cost uplift method will not allow this as easily. Direct comparisons will also be able to be made when benchmarking against alternative providers.	

Do you have any other comments on this proposal?

No matter which overhead funding solution is implemented, it would be helpful to have a published review of the effectiveness of the SCCL.

Maternity

We are making all maternity prices non-mandatory to address the issue that the maternity pathway payment includes some public health services, known as Section 7A public health services. These services fall outside the scope of national prices in the national tariff.

We are also proposing some other changes to the pathway (see questions below).

Making all maternity prices non-mandatory

To what extent do you support the move to non-mandatory prices?

• Strongly support • Tend to support ✓ • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments?

While our members would prefer a mandatory price to be set for the maternity services, thus reducing the level of potential disputes over the reimbursement levels, it is recognised that a non-mandatory tariff is the most pragmatic solution for the current situation regarding price setting for this service.

Specialist fetal medicine

We propose to remove 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.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

HFMA's provider members have commented on the additional administrative burden resulting from the current arrangements and welcome the simplified approach proposed.

Delivery payment levels

We are considering moving from two payment levels to a six- or 36-level payment approach. 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.

To what extent do you support the proposal to introduce more granular payment levels?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

If a more granular approach was introduced, would you prefer six or 36 levels?

6 levels ✓	36 levels	No change (2 levels)

To what extent do you agree that the potential negative impact on providers offering home births should be mitigated?

• Strongly agree ✓ • Tend to agree • Neither agree nor disagree	• Tend to disagree • Strongly disagree • Don't know

Do you have any comments on the proposal to move to more granular payment levels?

HFMA's members are in support of a more granular payment level for maternity delivery, enabling a reimbursement which is more reflective of the care provided.

Abnormally invasive placenta (AIP)

We propose 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.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

Given the complex nature of this treatment we are in support of care being delivered from a number of specialist centres and therefore support the tariff being removed from the scope of national prices.

Postnatal complexities

We propose to update the complexity factors for the postnatal phase and change the casemix assumptions used to calculate postnatal phase prices.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

We support the updating of complexity factors for the postnatal phase as it will better reflect the clinical care patients require.

Mental health

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

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

To what extent do you support this proposal?

• Strongly support	• Tend to oppose

• Tend to support • Neither support or oppose ✓	• Strongly oppose • Don't know

Do you have any comments on this proposal?

Our members are keen for the payment systems to be simplified, in order to enable flexibility to move money where investment is needed to support pathways.

However, they are concerned that the creation of new payment systems, and their required understanding and negotiations, may distract from the partnership working conversations. The redesigning of payment systems should be a product of collaborative working and reflective of new service provisions. Changing the payment approach before these conversations have been concluded could be counter-productive.

As with emergency care, the engagement document could be clearer about the advantages a blended payment approach is designed to produce. What changes in commissioner or provider behaviours are expected as a result from the blended payment approach?

Other areas of work

This page contains questions on:

- currency design and specification
- evidence-based interventions
- best practice tariffs
- high cost drugs and devices
- price and revenue volatility adjustments
- specialist top-ups
- non-mandatory prices.

You do not have to answer all questions and please scroll down to find the areas that you are interested in.

Currency design and specification

We propose to continue using the HRG4+ currency design to set national prices, moving to the version used for 2016/17 reference costs. We would also create national, rather than non-mandatory currencies for both wheelchair and spinal cord injury services from 2019/20.

To what extent do you support these proposals?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

Given the current transitioning financial landscape, we are in support of continuing to use HRG4+, updated to the version used for 2016/17 reference costs.

Evidence-based interventions

The recent consultation on evidence-based interventions included the following proposal:

Introduce zero payment for Category 1 interventions without IFRs [individual funding requests]

For the four Category 1 interventions we propose to no longer routinely commission, we will consider how the National Tariff and the NHS Standard Contract could be changed to support this clinically led

change. For the Tariff, we will consider removing Category 1 from the scope of the National Tariff price or establishing a national variation, so that providers are not paid for activity unless in exceptional circumstances, where prior approval of an IFR has been given by the commissioner. We want to implement this change as quickly as possible, and are proposing it applies from April 2019. We would welcome views on this. If an IFR is made, providers would be paid under the existing tariff.

To what extent do you support the implementation of this proposal in the national tariff payment system from April 2019?

• Strongly support ✓	• Tend to oppose
• Tend to support	• Strongly oppose
• Neither support or oppose	• Don't know

Do you have any comments on this proposal?

We are in support of removing the default payment for any interventions which offer no clinical benefit except in exceptional circumstances. We are also in support of routinely reviewing which interventions should attract a national tariff price.

Best practice tariffs

We propose to introduce two new BPTs:

- One for emergency laparotomy to increase the proportion of patients whose surgery is directly supervised by both a consultant surgeon and a consultant anaesthetist, and who are transferred directly to a critical care unit from theatre.
- One for spinal surgery to cover all admissions for HRGs HC50-64. Payment of the BPT would depend on submission of data to the British Spinal Registry (BSR). We are considering setting the organisation-level attainment rate at 80% and having a 10% differential between the BPT price and the standard price.

We are also considering updates to existing BPTs, following feedback from users or as a result of new data becoming available, to ensure the BPTs are able to achieve their intended purpose.

To what extent do you support these proposals?

• Strongly support ✓	• Tend to oppose
• Tend to support	• Strongly oppose
• Neither support or oppose	• Don't know

Do you have any comments on these proposals?

We are in support of routinely updating existing BPTs to ensure they achieve their intended purpose. A BPT should, by nature, only exist for a short period of time until it can be considered a routine tariff rather than best practice. If this has not occurred, the incentive has not achieved its purpose and should be re-considered.

High cost drugs, devices and listed procedures

There are 406 drugs on the high cost list published as part of the 2017/19 NTPS. For 2019/20, we propose to remove 47 drugs; add 109 drugs and amend one drug on the list.

We propose to add three devices to the high cost devices list and clarify that three devices nominated for inclusion on the list are covered by existing categories. We would also expand the guiding principles used to determine the high cost list to support procurement arrangements introduced by NHS England Specialised Commissioning.

We also propose to make changes for molecular diagnostic tests, so that: five of the current six tests are removed from the list of excluded procedures; Oncotype DX and PD-L1 are retained on the list; EndoPredict and Prosigna are added to the list.

For details of all proposed changes to the drugs and devices list, see the Draft price relativities workbook.

To what extent do you support these proposals?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on these proposals?

We are in support of routinely updating the list to ensure it is line with clinical practice and NHS England Specialised Commissioning procurement arrangements.

Price and revenue volatility adjustments

We propose to continue adjusting prices to mitigate the impact of the move to HRG4, so that affected services are reimbursed 50% of the loss, rather than the 75% in the 2017/19 NTPS. We are also proposing to introduce any changes in MFF values over a number of years.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

We continue to support the mitigation of the move to HRG4 to help prevent the potential destablising of providers and individual services.

Specialist top-ups

We propose working with NHS England Specialised Commissioning to update the Prescribed Specialised Services (PSS) Identification Rule (IR) and Provider Eligibility Lists (PELs). We would implement the second 25% step in the four-stage transition for orthopaedics, paediatrics and spinal cord injury services, who lost funding after PSS began to be used for specialist top-ups.

Draft specialist top-up flags and rates are available in the Draft price relativities workbook.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

We are in support of updating the specialist top-up rules.

Non-mandatory prices

We propose to clarify the intention behind new non-mandatory prices and whether they are intended as testing prices or benchmark prices. Testing prices are based on reference cost data and calculated using the same method as national prices. Benchmarks prices are intended as a guide to aid local price-setting.

We propose to introduce testing prices for wheelchair services and renal transplantation. We propose to introduce benchmark prices for services including advice and guidance, IAPT and specialist rehabilitation.

For more details, see the Draft price relativities workbook.

To what extent do you support this proposal?

• Strongly support ✓ • Tend to support • Neither support or oppose	• Tend to oppose • Strongly oppose • Don't know

Do you have any comments on this proposal?

We are in support of clarifying the reasons for introducing non-mandatory tariffs (e.g. test or benchmark), as this will assist contract discussions and inform local service provision.

Market forces factor: proposed updates

Overview

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

We are proposing a new set of MFF values from 2019/20. These would be based on the most up-to-date data available and some changes to the methodology.

The proposed changes to data and method are set out in the document *Market forces factor review and proposed updates*. Please read the document before answering this survey.

The deadline for feedback is 5 pm on Monday 29 October 2018.

PLEASE NOTE: This document is intended to aid stakeholders in responding to our online survey. Please do not use this document to feedback to us.

Updating the MFF

After reading 'Market forces factor review and proposed updates', to what extent do you agree that the MFF should be updated for both method and data?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer					
We agree that the MFF should always be calculated on the most up to date information available.					

To what extent do you agree or disagree with the general approach used to identify suitable cost drivers to be included in the MFF?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer					
We agree with the general approach used to identify suitable cost drivers. However, there must be some stability and consistency in which drivers are used and the drivers should not change too often.					

The proposed MFF includes the following components. Do you feel these should or should not be included?

	Should include	**Not sure**	**Shouldn't include**
Medical and dental (M&D) staff	✓		
Non-M&D staff	✓		
Land	✓		
Buildings	✓		
Business rates	✓		
Please explain the reasons for your answer and, if you feel there are any other cost components that should also be included, please provide details			
The ability to include land and buildings as a single component, as discussed during the NHS Improvement webinar on 19 October would be preferable.			

Changes to the MFF method

To what extent do you agree that non-medical and dental staff costs should continue to be calculated using private sector pay via the General Labour Market (GLM) method?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer					
As organisations are competing with private sector organisations for non-medical and dental staff, we agree that the costs should continue to be calculated via the GLM method.					

To what extent do you agree that non-M&D staff costs should be based on travel to work areas?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer. If you disagree, please specify a preferred alternative geography (if possible)					
We agree that the travel to work areas are more reflective of the market place in which organisations are recruiting their valued staff and therefore should be used as part of the MFF calculations.					

To what extent do you agree that there should be adjustments for 'cliff edges' between providers?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer.					
We agree that while the travel to work areas are appropriate and will reduce cliff edges, some will still exist, and suitable adjustments to take these into account are a reasonable solution.					

Phasing in changes

To what extent do you agree with the proposal to introduce the new MFF values over a four-year period?

Strongly agree ✓	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Please explain the reasons for your answer.					
Fluctuations in income bring additional risk to providers, many of which already are severely financially challenged. As a result, we agree that a phased approach to the MFF adjustments is correct. Anything longer than a four-year period could potentially result in the MFF figures becoming outdated once again.					

Any other comments

Do you have any other comments on the proposed changes to the MFF?

Given the changes are proposed to be implemented over four years, it would be helpful to ensure that going forward the MFF is updated on a more regular basis to avoid becoming this far out of date again e.g. data refreshed and methodology reviewed either each year or each tariff cycle.