HFMA Payment by results flexibilities survey – September 2011

The HFMA's Payment by Results Special Interest Group provides a focal point for the association's work around the English system of financial flows. During the summer of 2011, the group surveyed NHS finance directors to understand how flexibilities, set out in the PBR guidance for 2011/12, were being used and where other local arrangements had been put in place.

The sample

The survey attracted only a small response but is considered to provide a snapshot of practice across the service. In total just 25 responses were received, 11 each from NHS trusts and NHS foundation trusts, with a further four from commissioning primary care trusts.

Outpatient procedures

In 2011/12, the Department of Health expanded the number of mandatory outpatient procedure HRG tariffs. The survey asked if local health economies had moved beyond this mandatory list. Just under half the sample had agreed local prices for procedures not on the national list.

Have you agreed local prices for outpatient procedures that are not covered by the mandatory list in 2011/12?		
Answer Options	**Response Percent**	**Response Count**
Yes	44%	11
No	56%	14

Examples given included wet AMD Lucentis procedure in ophthalmology and HRGs CZ08T and CZ08Y (minor ear procedures without comorbidities or complications) involving microsuction, where a lower tariff had been agreed 'to reflect the low complexity of the work involved'. One trust had agreed local prices for AB06Z (acupuncture) for similar reasons. The same organisation had a local price for FZ24Z (wireless capsule endoscopy). Dermatology and interventional radiology were also cited as examples. One FT said it had been operating local prices for outpatient procedures for a number of years prior to implementation of national procedure tariffs. Price varied depending on specialty and procedure type.

Maternity

Non-delivery events in maternity continue to be problematic with a range of different approaches to recording this ante natal activity. Where the published tariff for the relevant HRGs is 'clearly over-reimbursing actual local costs', the PBR guidance calls on commissioners to 'consider the use of a payment flexibility'. Nearly half the sample had local arrangements in place.

Are you using any payment mechanisms or risk sharing arrangements to manage costs of maternity non-delivery events (NZ04 - NZ09)?		
Answer Options	**Response Percent**	**Response Count**
Yes	46%	11
No	54%	13

Many respondents were paying for an outpatient attendance above a set threshold, set at a percentage of births. Specific comments/approaches included:

'All NZ04-NZ09 are charged at outpatient tariff for admissions between 6pm and 8am where length of stay is less than two hours. Also admissions within 8am-6pm, where length of stay is less than four hours, are charged at outpatient tariff. Further, funding is limited to a ratio based on the number of actual deliveries.'

'We've only paid NZ codes above for 30% of births. Above this level, events are paid at new outpatient attendance only.'

'These are capped as a percentage of live births.'

'We expect a certain ratio of outpatients / ward attenders to inpatients in this area (roughly 80:20 split). We have a 10% tolerance on this ratio, which would trigger a financial adjustment. This is a one-year arrangement.'

Pathway tariffs

The Department has indicated it will launch its first formal pathway, covering maternity services, from 2012. It is also interested in the potential for year of care tariffs, particularly for chronic diseases and has encouraged local developments in this area in the current year. Only a handful of respondents had made moves towards local pathways.

Have you agreed any pathway tariffs through bundling or other arrangements?		
Answer Options	**Response Percent**	**Response Count**
Yes	16%	4
No	84%	21

One trust had introduced a tariff for audiology using old indicative PBR recommended tariffs. Elsewhere a 'treat and return' adjustment tariff was being used for cardiology patients transferred from a local district hospital and returned on the same day. Another organisation said specific local tariffs were being used for stroke, while a tariff for ambulatory care was being worked on with commissioners. One trust highlighted an unbundled tariff for patients stepping down from acute care into community beds.

Outpatient diagnostics

The PBR guidance also allows for flexibility where specialist providers are carrying out more complex and costly diagnostic imaging than the average covered within outpatient attendance tariffs. This can particularly be the case for specialist orthopaedic providers.

Have you agreed higher prices for outpatient attendances that involve complex diagnostic imaging?		
Answer Options identified such an arrang	**Response Percent**	**Response Count**
Yes	4.0%	1
No	96.0%	24

Only one organisation – a specialist orthopaedic provider - identified the use of such a flexibility, making an additional charge for outpatient imaging in an outpatient setting. However one trust where no additional payments were in place indicated that the outpatient procedure tariff was used where appropriate. Another trust said it had tried to negotiate tariffs for complex diagnostic imaging with commissioners without success. It said this was due to a lack of definition of complex imaging provided by the PBR guidance.

It added: ***'We have worked with our clinicians to define our view of complex imaging and this was provided as feedback through the 2011/12 road testing returns.'***

New drugs and technology

The PBR guidance allows for innovation payments to be made for new devices, drugs, treatments and technologies – or for a new application of existing technologies. For instance a commissioner could agree to make an additional payment for care that has long term efficiency benefits – perhaps reducing the likelihood of the need to repeat a procedure.

Have you agreed any innovation payments for new drugs, treatments and technologies or a new application of existing technology?		
Answer Options	**Response Percent**	**Response Count**
Yes	8.3%	2
No	91.7%	22

Again very few health economies identified the use of innovation payments, with just two organisations adopting the approach. One organisation said payments were in place to cover the application of exogen to stimulate union of fracture sites and for halo radiofrequency ablation in endoscopic treatment of dysplasia or early neoplasia in Barrett's oespophagus. Another trust said it charged for a range of high cost drug-related saving schemes, sharing the gain with commissioners. One trust said it was considering the use of innovation payments for sentinel node/one-step nucleic acid amplification (OSNA) patients in breast cancer

Service redesign

The PBR guidance allows for flexibilities to support service redesign, for example enabling some gain sharing or the adoption of joint incentives. One area given as an example in the guidance is to support the concentration of a service at a tertiary level such as specialised coronary interventions.

More organisations had adopted flexibilities in this area, with just over a quarter of the sample having some local adjustments in place.

Have you agreed any changes to tariff prices to support service re-design, for example a lower price to reflect activity that is less complex than the normal casemix range?		
Answer Options	**Response Percent**	**Response Count**
Yes	28%	7
No	72%	18

Medical assessment units were one area where special tariffs had been adopted although two providers also said they were charging some day cases as outpatient procedures.

Other comments/service areas included:

'A children's emergency medical assessment unit local tariff for attendances with no admission but a 4-6 hour work up.'

'We have agreed a local price for medical assessment unit triage service (MAU T). This service is aimed at reducing non elective admissions.'

'A lower tariff for attenders at the A&E departments, who are triaged into the urgent care centres.'

'Rheumatology injections and other procedures that could be provided in a primary care setting eg anti coag clinics.'

SHA rules

The PBR guidance makes it clear that strategic health authorities will retain the flexibility to 'manage risks and pressures associated with PBR, while converging towards an overall national strategy'. One in four responders said that there were overarching rules in place.

Has your SHA used its flexibility to set any overarching rules or risk sharing mechanisms to manage risk and pressure associated with PbR?		
Answer Options	**Response Percent**	**Response Count**
Yes	28%	7
No	72%	18

Some of these rules related to the reinvestment of readmissions penalties and outpatient first-to-follow up ratio caps.

One foundation trust commented: '***The SHA has facilitated sensible risk sharing local agreements around readmission reductions.'***

Cardiac services

There is no specialised services top-up for cardiac services. However the PBR guidance allows for a flexibility to enable commissioners to support specific services where the tariff may not provide sufficient reimbursement. In particular the guidance identified primary angioplasty, grown-up congenital heart disease services and management of arrhythmias.

Only three organisations in the sample had put flexibilities in place to support these services.

Have you agreed any top-ups to tariff for specific cardiac services (primary angioplasty, grown up congenital heart disease services and management of arrhythmias)?		
Answer Options	**Response Percent**	**Response Count**
Yes	13%	3
No	87%	21

One provider said it had agreed a top up above the HRG and device cost for transcatheter aortic valve implantation (TAVI). However it added that ***'the price commisisoners agreed to does not fully recover our costs'.***

In another organisation a £150 top on the HRG price had been agreed to support the creation of a 24/7 service. One trust said that arrangements only covered PBR excluded services/devices.

Readmissions

New rules were introduced in 2011/12 covering readmissions wth the aim of reducing avoidable readmissions. The rules mean that commissioners do not pay for emergency readmissions (with some defined exceptions) within 30 days of discharge from an elective inpatient episode. For readmissions following emergency admissions, local rules apply based on agreed threshold rates.

More than half the sample said they had initiated some risk sharing arrangements around readmissions, although it wasn't always completely clear if these arrangements covered readmissions following elective or non-elective initial admissions.

Have you implemented any risk sharing arrangements in relation to readmissions?		
Answer Options	**Response Percent**	**Response Count**
Yes	52%	13
No	48%	12

Some trusts had incorporated fixed sums to cover this issue in contracts – amounting to the removal of £500,000 from one trust's contract to cover electives readmitted as

emergencies. Others said that there had been agreement for all penalties to be reinvested. One organisation with such an arrangement in place said it was also '***working with PCT colleagues to agree how readmissions will be avoided through the establishment of reablement and post discharge support services'***.

Another trust said it was taking the risk on delivering non-elective to non-elective readmissions, while it had to demonstrate that each elective to non-elective readmission is not related to the initial spell. A further trust similarly identified a local agreement to look on case by case basis at unrelated re admissions.

In a different approach, one provider said that a fixed cap had been agreed on the amount of readmissions that the PCT would not pay for.

Specific comments included:

'[We have] agreed a contract reduction based on a fixed block adjustment. This will be monitored against actual performance.'

'This is a huge area of dispute and the PBR guidance on this is appalling and an administrative nightmare.'

'***The income has been blocked back to us and we are working in partnership to understand the reasons for admissions. to this aim we have undertaken a joint audit of 500 sets of notes and are now in the process of looking at redesigning services jointly in order to target some of the underlying reasons for readmissions.'***

'The trust is still seeking a realistic agreement which reflects being paid for unrelated admissions.'

'Block transfer value agreed as tariff rules not well developed or thought through. Too many legitimate readmissions would be charged at zero tariff if implemented as per guidance.'

'Fortuitous PCT gains have been blocked back as transitional support in 2011/12.'

Other flexibilities/adjustments

The survey asked respondents to identify any other areas where the local health economy had moved away from PBR guidance or adjusted tariff prices. Just under two thirds of the small sample had implemented some further adjustment or local arrangement.

Have you agreed any other variations to tariff prices, whether through a change in unit price or a marginal rate above an agreed threshold?		
Answer Options	**Response Percent**	**Response Count**
Yes	60%	15
No	40%	10

These arrangements included a simple 'block contract for non-elective', the use of tolerances, caps, collars and marginal rates on elective activity and reduced tariffs for emergency activity with a zero length of stay and for some satellite clinics. One provider said that caesarean sections had been capped at 22% of all births, with normal delivery rates applying above the cap

Some specific comments/approaches included:

'***We did have marginal rates in place in 2010/11 - 50% on electives for any under or over performance however this was non-recurrent. Within 2011/12 we have agreement around transformational funds to contribute to service change to reduce activity within future years. This works alongside QIPP schemes.'***

'We have a risk sharing contract where additional cost is only paid above tolerance.'

'A risk share on outpatient new-follow up ratios effectively brings in a 50% marginal price. For outpatients done in polyclinics, PCTs have demanded and secured a reduced tariff.'

'30% marginal tariff not applied to neurosurgery and trauma non elective cases.'