New Payment Model

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URGENT AND EMERGENCY CARE EVENT – LONDON

17 November 2015
Payment reform necessary to support the UEC Review

Self-care
- Peer support
- Voluntary Sector

"The smart call to make..."

Meeting your urgent care needs as close to home as possible

Taking you to the most appropriate hospital and maximising your chances of survival and a good recovery from life threatening conditions

* Includes specialist services such as those for heart attack, stroke, major trauma, vascular surgery, critically ill children

Advice by Phone | GP and Primary Care | Urgent Care Centre | Paramedic at Home | Community Pharmacy

Emergency Centre

Specialist Emergency Centre*
Payment needs to change to support the service reforms

Current commissioning and payment models

Activity, cost and quality data is not robust enough
Focused on institutions
Differing incentives
No reflection of “always on” capacity

Proposed solution

Better data on activity, costs and quality
A payment approach that better reflects the service characteristics
We are working with our partners on a wider programme of work on payment.
We have proposed a direction of travel for UEC payment based on work so far

- A coordinated and consistent payment approach across all parts of the UEC network (not just in the acute setting)

- Making use of three elements:

> **Core payment**
> Fixed in-year costs – 'always-on' capacity

> **Volume based payment**
> Variable costs – activity

> **Outcomes and performance**
> Service transformation, patient experience and outcomes

- Other payment approaches desirable & feasible e.g. capitation? Potentially where service integration reaches beyond UEC…
The basic design of the three part system

Payment System:

A – Fixed payment. This is received regardless of the volume of cases dealt with.

B – Volume based payment. If volume lower than expected ($V_{\text{LOW}}$) commissioner makes savings. If volume higher than expected ($V_{\text{HIGH}}$) commissioner over runs (against estimated baseline).

C – Outcomes/performance payment. Payment linked to performance using agreed metrics and target levels against those metrics.
Steps in designing the three-part approach

- Plan and designate UEC network services
- Determine services to be covered by new payment approach
- Determine timeframe for payment

- Estimate baseline total revenue requirement – for each provider and for the network
- Determine fixed core element
- Determine payment to be linked to outcomes and performance
- Determine volume based element

➤ There are many possible options at each design step – balance of pros & cons need to be assessed to determine the preferred option

➤ We have taken a pragmatic approach to developing the three components
The pragmatic approach to development (1)

**Services covered by the new payment approach**

The more of the network covered the better, but need to reflect:

- Sufficient coverage of patient access and direction points
- Settings of definitive care
- Existing current data flows and other payment infrastructure in place

**Timeframe for payment**

Important that payment including a partially fixed element reflects:

- Expectations of how care models and service provision is planned to change
- How activity might shift across settings when UECR service changes implemented
- How quickly the changes might occur

**Total revenue requirement**

Need robust activity and revenue forecasts - part of usual strategic and operational planning processes (providers, commissioners, UCNs)

- Project forward from current level of activity for each service, taking into account demographic changes and impact of service reforms;
- Apply national, local or estimated unit cost prices to the forecast activity; and
- Assess the cost of planned changes in the mix of inputs for each service in the network
The pragmatic approach to development (2)

**Fixed core payment**

Determine as % of total revenue requirement, based on:
- Understanding of underlying cost structures of each service
- Consideration of volume risk placement between commissioners and providers

Reflect envisaged activity shifts over a multi-year timeframe

<table>
<thead>
<tr>
<th>Criteria</th>
<th>% Fixed and when to select this option</th>
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<tbody>
<tr>
<td></td>
<td>80%</td>
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<tr>
<td>Importance placed on availability and coverage aspect of the service</td>
<td>Defining characteristics of the service</td>
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<tr>
<td>Proportion of costs that are known to be fixed</td>
<td>Large majority</td>
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<tr>
<td>Confidence in forecasts</td>
<td>High</td>
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<tr>
<td>Need for certainty for investment in new services</td>
<td>High</td>
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<tr>
<td>Ability and willingness of the parties to take on risk in return for potential savings</td>
<td>Providers willing</td>
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</table>
The pragmatic approach to development (3)

Role of outcomes and performance

Amount available to link to outcomes & performance, funded through:
- Small top-slice of the total revenue requirement for each provider; or
- Commissioner expectations of savings generated by service reforms

Metrics that payment is linked to:
- Reflect system-level outcomes and performance – including progress with reform
- Consistent with organisation-level metrics
- Make use of existing agreed local and national metrics and indicators

Volume based payment

Currencies used for payment:
- National and local currencies where defined (APC, A&E, Ambulance)
- Simple contact counts for activity categories that are reported at local level

Prices to monetise activity:
- Nationally mandated and locally agreed where available
- Local unit cost estimates benchmarked for efficiency
- Applied as marginal prices on all volume, adjusted for the %ages of fixed core and outcome/performance payments
There is a lot of work to do...

**Design**
- Specification of the network scope
- Determining the core payment
- Balance between the three elements
- Network-wide gain/loss sharing arrangements

**Progress**
- Constructing Local Payment Example
- Ongoing research around fixed component
- Constructing Impact Assessment
- EY tool to model potential gain/loss sharing
There is a lot of work to do…

**Work with partners**

- Improve understanding of costs and impacts
- Work with sector to develop and test approaches
- Produce tools for test and demonstration sites

**Progress**

- Supporting RCEM and HSCIC to produce new data set
- Working with potential test sites to shadow test model
- EY “Project in a Box” workshops to model gain/loss sharing
The plan going forward

- Encouraging change through local arrangements (whether 3-part payment or justified alternative payment approach), from 2016/17

- Continue work on the building blocks by developing robust patient costing and supporting the work by HSCIC and NHS England on clinically relevant counting units

- The next steps on payment approach (*timescales are currently indicative*):
  
  - **2015/16**: Work with sites (incl. vanguards) on detailed payment design(s)
  - **2016/17**: Vanguards shadow test
  - **2017/18**: Vanguards implement; rest of sector encouraged to shadow test / implement
  - **2018/19**: Potential new national default? (or sooner / later)
Questions for you.

• Does this look feasible? If so, how long will it take to achieve?

• What are likely to be the major challenges and how will we overcome them?

• What national guidance or support would be most helpful? Where do you want to retain local flexibility?

• What are the relative weights you would put on the three different elements?
Further information

UEC Local Payment Example:
https://www.gov.uk/government/publications/local-payment-example-3-part-payment-for-urgent-and-emergency-care

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