The 2014/15 national tariff payment system

A Healthcare Finance quick guide to the tariff, including national prices and rules for 2014/15

Monitor and NHS England published their first national tariff on 17 December 2013, having assumed responsibility for price setting in April. The *2014/15 national tariff payment system* replaces the payment by results guidance issued in previous years and clearly sets out to provide national prices, where they exist, and rules for all healthcare activity outside of primary care services.

The final document builds on a formal consultation undertaken in October. The consultation provides an opportunity for clinical commissioning groups and relevant providers to challenge the method for determining national prices. The level of objections (0.5% of CCGs and 16% of relevant providers) were below the thresholds (51%) that would have required Monitor and NHS England to re-consult or make a reference to the Competition Commission.

The two bodies say the final document is 'materially similar' to the consultation document although some queries raised as part of the consultation have been clarified in the text or will be addressed in a series of *Frequently asked* questions on Monitor's website. This *Healthcare Finance* quick guide builds on an earlier quick guide covering the consultation document. It has been revised to take account of the final tariff document and in particular to reflect updated assumptions behind the cost uplift calculation (section 5).

The approach for 2014/15 reflects two key aims:

- To encourage local experimentation in payment approaches to support service redesign
- To reduce volatility in currencies, national prices and national rules.

Introduction (section 1)

This section provides an overview of the national tariff. It explains that the document's title reflects the requirement for the tariff to 'encompass a comprehensive payment system, including not only a set of specified currencies and associated prices, but a suite of rules and variations that apply both nationally and locally'. Together with its supporting documentation, the publication will replace the existing

payment by results documentation.

The section also describes the structure of the tariff document, summarising each section and associated annexes, and supporting documentation.

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1A Glossary

Context and strategy (section 2)

NHS England and Monitor argue that a well-designed payment system can do much more than regulate the flow of funds from commissioners to healthcare providers. If it is supported by accurate information on cost and quality of care, it can act as a tool to effect change. They underline that different payment approaches may be appropriate for different types of care. For example different incentives may be needed for elective care and long term conditions. And the payment system is only one lever, working alongside other levers such as transparency about performance and clinical guidelines.

With a projected £30bn funding gap by 2021/22, services need to be redesigned to offer improved outcomes at lower cost to ensure the NHS remains sustainable. Alongside the development by NHS England of a strategy looking over five- and 10-year horizons, there have been reviews of seven-day services and urgent and emergency care and there is a focus on the care needs of vulnerable and older people. Integrated care has also been identified as critical to improving service quality in a context of constrained resources.

The payments system needs to underpin these changes. In particular, the existing activity-based payment system has been identified as one of the barriers to greater integration. A number of alternative payment approaches have been investigated including paying for whole pathways of care – from referral to reablement – or purchasing a person's care for a year or other suitable time period. The two bodies say they are 'considering design options for payment approaches that promote integrated care for all patients'. However in the meantime, 'local health economies can experiment with their own payment approaches, using the rules for local variations (section 7)'.

Monitor and NHS England published a discussion document in May on how the payment system could develop. Feedback has suggested that activity-based payment remains suitable for some services, but not for all. In particular stakeholders said alternatives may be needed for emergency services, long-term conditions and care of the frail and elderly. However in general there is support for a national system of rules and prices.

The sector has backed the concept of linking payment more closely to outcomes, but pointed out that these can be hard to define and measure. So linking payment to input and output measures is likely to continue in some form, particularly where there is evidence connecting the inputs or outputs to better outcomes. There was also support for making the payment system support longer-term planning and aligning the incentives that apply to primary, secondary, community, social and mental health services. And the sector also called for the payment system to promote cooperation. NHS England and Monitor have promised to take this feedback into account in developing the future payment system.

In line with the key priorities for 2014/15 of reduced volatility and enhanced local experimentation, the

key measures in the 2014/15 tariff are described as:

- Establishing a regulatory platform to help commissioners' and providers' planning
- Progressing the development of payment approaches for mental health (but not introduce major changes at this point)
- Introducing the first national price linked to reported patient outcomes
- Strengthening incentives for co-ordinated whole system responses to managing demand for emergency care
- Introducing freedoms to allow commissioners and providers to vary local payment approaches to suit local circumstances

Scope (section 3)

Under the 2012 *Health and social care act,* all payments for the provision of NHS health care services can be included in the national tariff. However, the national tariff also has to be consistent with current legislative requirements relating to payment – including those covering primary care services. These separate payment systems are not covered in the *2014/15 national tariff payment system*. NHS England and Monitor say they will work together to ensure there is a coherent payment system in these areas in future and 'agree the scope of the national tariff for future years'.

In the meantime the national tariff system will 'interact' with existing arrangements.

- Public health services: National tariff does not apply.
- Primary care services: National tariff does not apply to core primary care services, although local pricing may apply for some services provided in primary care setting
- Personal health budgets: Patient assessment to determine budget and payment for advocacy not covered by tariff. However payment to providers of NHS services from a notional personal health budget held by a commissioner on behalf of a patient, or a third party budget, will be based on national or local prices.
- Devolved administrations: The national tariff will apply in 'some but not all circumstances' of cross border service provision.
- Integrated health and social care: Joint financing arrangements, such as pooled budgets, remain in place. Healthcare services commissioned under these arrangements are in scope of tariff system.
- Contractual incentives and sanctions: Rewards such as CQUIN payments should be applied after provider's income has been determined in accordance with tariff.

Currencies with national prices (section 4)

This section summarises the concepts of classification, grouping and currency, explains the approach for determining which services have mandated national currencies and sets out minor changes to currencies for 2014/15.

Most currencies will stay the same as in 2013/14, with prices also staying the same (other than changes to reflect cost pressures and efficiency gains). These unchanged currencies and prices cover the follow service areas:

Admitted patient care - separate prices remain in place for non-elective care and for elective care/day cases combined. For a small number of healthcare resource groups (HRGs) there is a single price across outpatient procedures and day cases or a single price across all settings.

Chemotherapy and radiotherapy – chemotherapy payment remains split into three parts. These include: a national price for a core HRG covering the primary diagnosis or procedure; a local currency and price for unbundled HRGs for chemotherapy drug procurement; and national prices for unbundled HRGs for chemotherapy delivery. Radiotherapy HRGs include a set for radiotherapy planning and radiotherapy treatment (delivery per fraction). There are national prices for external beam radiotherapy preparation and delivery and local currencies/prices for brachytherapy and liquid radionuclide administration.

Post discharge rehabilitation – national prices for four post discharge rehabilitation currencies (cardiac, pulmonary, hip and knee replacement) will continue to be mandatory for integrated acute and community providers. For other providers, national prices are non-mandatory.

Outpatient care – national prices for outpatient attendance remain based on treatment function codes with prices only applicable to pre-booked, consultant-led attendances. Prices for other attendances are agreed locally. Distinct outpatient attendances on the same day should be counted separately and each attract a separate national price – unless a pathway price is in place. There are mandatory prices for some outpatient procedures. Diagnostic imaging in outpatients remains covered by separate prices.

Direct access – there are a number of mandatory prices for activity accessed directly from primary care, for example diagnostic imaging, airflow studies and flexible sigmoidoscopies. There is also a non-mandatory price for direct access plain film X-rays.

Urgent and emergency care – mandated prices for A&E and minor injury units will continue to be based on 11 HRGs. Type 1 and type 2 A&E departments continue to be eligible for the full range of prices, with type 3 departments eligible only for the most simple VB11Z currency (*no investigation with no significant treatment*).Type 4 NHS walk-in centres do not attract national prices. Short stay emergency prices remain in place to ensure appropriate reimbursement of stays of less than two days, where the average length of stay of the HRG is longer.

Best practice tariffs – Amendments are made to two of the 17 existing best practice tariffs (BPTs), one of which (cataracts) remains non-mandatory. The best practice characteristics have been changed in the major trauma care BPT, while the paediatric diabetes BPT has been updated to include inpatient care. A new BPT for primary hip and knee replacements is described as the 'first step to linking payment to outcomes'. Payment will be linked to data collected through patient reported outcome measures and the National Joint Registry.

Pathway tariffs – two pathway tariffs in place in 2013/14 will remain unchanged. These include payments for the maternity pathway and the cystic fibrosis pathway.

There are some changes to currencies and associated prices. HRGs are introduced in four areas. For example six HRGs covering laparoscopic kidney and ureter operations are deleted and replaced by eight new groups. There are also design changes in a handful of other currencies. A mandatory currency was

introduced for looked after children health assessments in 2013/14, following concerns about assessments in out-of-area placements. This was supported by non-mandatory prices. These prices will become mandatory in 2014/15.

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4A Additional information on currencies with national prices

4B Maternity data requirements and definitions

Determining national prices (section 5)

Monitor and NHS England set out the key plans for 2014/15 in a pre-summer 'engagement document'. They then gave details in October's consultation document of the proposed adjustments for inflation and efficiency to the current 'rollover' prices. The final tariff document has now firmed up these adjustments and provides details of the underpinning assumptions.

Cost uplifts – operating cost inflation was considered in three areas – pay (65% of total costs), drugs (7%) and other operating costs.

Pay: although pay negotiations for 2014/15 continue, the Department of Health has provided an estimate for pay inflation of 1.5%, covering both pay settlements and pay drift. This translates to a **1%** impact on national tariff prices.

Drugs: although drug costs are a small component of total provider costs, they tend to grow faster than other costs. The Department's best estimate for the increase in provider's drug costs is 7.2%, translating to a **0.5%** cost uplift.

Other operating costs: a further **0.4%** has been allowed for other operating costs, based on a 2.1% forecast of the GDP deflator announced in the Chancellor's autumn statement. (The GDP deflator used in the October consultation document was 1.9%)

CNST: on average, for all services, CNST cost uplifts equate to a price adjustment of **0.3%.** However the vast majority of this uplift is applied differentially to appropriate HRG sub-chapters.

Capital costs: providers' capital costs typically include depreciation charges and private finance initiative payments. In aggregate the Department has projected PFI and depreciation to grow by 3.8% in 2014/15, translating to a **0.2%** impact on tariff prices.

Service development: an uplift is included to cover the costs to providers of major initiatives in NHS England's mandate. There was no allowance included for this in October's draft tariff as NHS England's mandate had not yet been published. One of two development areas being allowed for relates to the expansion of the friends and family test. This is estimated to add £46m to provider costs, translating to a **0.1%** cost uplift. The other nationally driven costs are related to requirements linked to recommendations of the Francis and Keogh reports. These are specific to acute health services but are expected to add £150m, translating to **0.3%** cost up lift (for acute services only).

In total this equates to cost uplifts of **2.5%** (for acute services and not including CNST uplifts applied to HRG sub-chapters).

Efficiency – The other side of price adjustment is efficiency. Tariff prices will incorporate an efficiency requirement of **4%**. The two organisations have been 'guided' by recent financial returns from foundation trusts. These suggest that most providers have recently delivered efficiency gains of 3.5% or above and more than two-thirds anticipate gains of 4% or more in 2014/15.

The document acknowledges this is a 'stretching requirement' but says it has been 'cross-checked with an impact assessment analysis'. This analysis suggests that even if providers only achieved 3% efficiency gains, they would remain financially viable, although some may move from small surplus to small deficit.

Overall price adjustment –'On average, and not taking account of the CNST costs that we allocate to specific groups of HRGs, the draft prices for 2014/15 are around **1.5%** lower than their corresponding 2013/14 prices,' the tariff document says.

So the nominal price adjustments that should be used as the basis for local negotiation are

- -1.5% for acute services
- -1.8% for non-acute services

The larger nominal reduction for non-acute services reflects the fact they should not incur the costs relating to the acute-specific recommendations related to the Francis and Keogh reports.

For services subject to national prices, final adjustments are made at the HRG sub-chapter level to reflect CNST cost increases. This has the impact of increasing prices on tariff services by an average of 0.3 percentage points. This means, on average, tariff prices will be **1.2%** lower than in 2013/14.

Given that prices have not been based on updated reference costs (which would have incorporated some currency changes), the document explains how it has set prices for new and altered currencies. For example, it explains how it has used the existing prices and total spend on the six HRGs for laparoscopic operations being withdrawn in 2014/15 to determine prices for the eight new HRGs that will replace them.

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5A National prices

National variations to national prices (section 6)

This section says it is sometimes necessary to make national adjustments to national prices to take account of elements of costs or to share risk more appropriately. These are known as national variations and, once these have been applied, the price becomes the nationally-determined price. National variations aim to better reflect differences in costs because of location and patient complexity, incentivise risk sharing for the prevention of hospital stays, and share financial risk following or during a move to a new payment regime.

There are some points to note in the application of national variations – they only apply to services with national prices; they do not need to be applied to bundled services with a mix of national and local prices (here, local variation rules apply); applications or agreements for local modifications must reflect national

variations; and local price-setting rules should be used for new services with no national price.

The document says there are four types of national variation that can be applied to national prices:

Market forces factor – this has been retained unchanged for 2014/15, except where organisations are merging or undergoing another form of restructuring, such as dissolution during 2013/14. The new organisations should have a recalculated MFF for 2014/15.

Top-up payments – the proposed level and coverage of specialised service top-ups remain the same as 2013/14. These are children (high 64%, low 44%); neurosciences (28%); orthopaedic (24%); and spinal surgery (32%). With the exception of orthopaedics, top-ups are only available to specified providers.

Preventing avoidable stays – the 30% marginal emergency rate and the arrangements for reimbursement for emergency readmissions within 30 days incentivise the care of patients in the most appropriate setting and the prevention of avoidable emergency admissions. While the latter has been retained unchanged, the threshold at which the marginal rate emergency rule is activated could be adjusted. This could happen where there had been a significant change in emergency admissions.

Revisions to healthcare resource groups and the introduction of best practice tariffs had made it difficult to set baseline values and NHS England and Monitor say they expect providers and commissioners to be pragmatic. Changes in emergency admission volumes had varied, with some providers seeing significant changes outside their control – due to local service reconfiguration, shifts in population and changes in providers' market shares, for example. The baseline values should be adjusted in these cases if the changes are material:

- Changes in demand between providers, for example where demand rises because of a reduction in a nearby provider's A&E opening hours or demographic changes, such as the opening of a new retirement home
- Changes in provision of a provider's emergency services, for example where commissioners designate a trauma centre or hyper acute stroke unit.

However, changes would not need to be made in some cases, for example if activity changed due to a reduction in the consultant presence in the A&E department.

Where there are shifts in demand between providers, the baselines of the providers should be adjusted symmetrically as far as possible.

The 70% retained tariff should be spent on managing demand for emergency care. There should be evidence-based plans showing how the expenditure would relieve pressure on emergency care. The plans should be coordinated with other demand management programmes, developed through constructive engagement and communicated to stakeholders.

Supporting the transition to new payment approaches – a number of national variations will mitigate the potential for a destabilising change in income or expenditure following the introduction of a new approach to payment. These apply to:

- The maternity pathway currency – local risk-sharing arrangements should continue in 2014/15
- Diagnostic imaging in outpatients – commissioners and providers will continue to be able to manage financial risk following the introduction of separate prices for diagnostic imaging in outpatients by sharing

the expected gain or loss as a result of the change and by applying a marginal rate of 50% of the national price to activity above a baseline

- Chemotherapy delivery and external beam radiotherapy – following the transition in 2013/14, national prices must be used in 2014/15 unless doing so would have an unmanageable impact on provider or commissioner. The tariff document says this would be the case in only a small number of local health economies – these would not use the full national prices in 2014/15, but would be expected to move further towards the national prices
- The new best practice tariff for hip and knee replacements – in some circumstances providers may not be able to demonstrate that they meet best practice criteria, but it would still be appropriate to pay the full best practice tariff. These are: where the improvements in patient outcomes have been made, but are not yet reflected in national data; where providers have a credible plan to address their outlier position in patient-reported outcome measures (PROMs) but the impact is not yet known; and where a particularly complex casemix that is not yet reflected in PROMs. The full BPT should be paid where the provider can demonstrate any of these circumstances apply.

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6A Market forces factor payment values

6B Specialised services and eligible providers list

Locally determined prices (section 7)

Local prices can be a result of variation or modification to national prices or where services do not have a national price, including some acute, mental health and ambulance services. Some of these have national currencies.

Commissioners and providers can agree variations to national prices if they are not appropriate for local circumstances – for example, if they wish to introduce an integrated pathway of care – but they must follow the rules set by Monitor and NHS England. Variations could mean increasing or decreasing prices and changing currencies.

Local modifications – whether by agreement between provider and commissioner or by application from a provider where a local agreement cannot be reached – can be made where it would be uneconomic for a provider to offer the service at national tariff. Modifications can only increase the price paid. The method for agreeing such modifications is set by NHS England and Monitor.

When agreeing a local payment approach (local prices or variations and modifications to national prices), there are a number of general principles commissioners and providers must follow:

- The approach is in patients' best interests – they should not reduce quality (maintain or improve outcomes, patient experience and safety); improve cost effectiveness; support innovation; and allocate risks associated with unit costs, patient volumes and quality to protect the patients' best interests
- It must promote transparency – commissioners and providers should consider accountability and the sharing of best practice

- The parties must engage constructively with each other – they should consider agreeing a negotiations framework, policies for sharing information, involving the relevant clinicians and other stakeholders and setting short- and long-term objectives.

In addition, when setting a local price where there is no national price, commissioners and providers should take account of the national tariff efficiency and cost uplift factors for 2014/15. Where there is a national currency it must be used as the basis for local price setting, unless an alternative payment approach is agreed. Where there is no national currency, the price must be determined in accordance with the terms and service specifications in locally agreed commissioning contracts.

As well as complying with the bullet points above, a local variation must comply with the following rules – it must be documented in the commissioning contract; the commissioner must use Monitor's summary template when preparing the written statement on the variation, which must be published; and the written statement must be sent to Monitor. The tariff document says that local variations to national prices should not be used to introduce price competition that could risk the safety or quality of patient care.

When looking at a local modification, providers must demonstrate that a service or services is/are uneconomic at the national tariff. It can do so by showing the average cost of providing each service is higher than the nationally determined price; that it is reasonably efficient compared to other similar providers; and that it has tried to engage with commissioners to consider alternative delivery models, but it is not feasible to deliver the care at nationally determined prices. It should also demonstrate that its costs are higher as a result of structural issues that are:

- Specific
- Identifiable
- Non-controllable
- Not reasonably reflected elsewhere.

Local modification agreements should demonstrate the uneconomic nature of providing the service at nationally agreed prices, specify the services affected, the start date and projected activity; and show that the modification reflects a reasonably efficient cost.

Where providers and commissioners cannot agree a local modification, the provider can make an application to Monitor to introduce the modification locally. In its application a provider must:

- Demonstrate it has engaged constructively with commissioners
- Specify the service affected and the expected volume of activity
- Show the services are commissioner requested services
- Have a deficit equal to or greater than 4% in the previous financial year
- Demonstrate that a service or services is/are uneconomic at the national tariff
- Propose a modification.

Monitor will publish key information on all local modifications and applications that are approved.

The document also outlines eleven rules covering the setting of local prices. Some of these are general rules covering services where there is no national price and services where there is a national currency

but no national price. Others are service specific.

Mental health services – the 21 care clusters must be used as currencies to agree local prices for the services covered by the clusters, unless the commissioner and provider have agreed an alternative payment method. Providers must complete the mental health minimum data set in all cases, including the cluster allocation, whether or not they have used the cluster system as the basis for payment (see guidance in supporting documents below).

Ambulance and patient transport services – providers and commissioners must use the four national currencies as the basis for payment unless an alternative approach has been agreed. Quality and outcome indicators must be agreed locally and included in commissioning contracts, while agreed local prices must be submitted to Monitor. When agreeing prices for services not covered by the national currencies, such as air ambulance, patient transport services and neonatal transfers, commissioners and providers should stick to the general rules outlined above.

Services delivered in a primary care setting – where the price for a service is determined by agreement between NHS England or a clinical commissioning group and a primary care provider, the general rules must be applied. These services include those previously known as locally enhanced services, for looking after patients in a residential home for example, which are now commissioned by CCGs through the *NHS standard contract*.

Community services the general rules should be followed when agreeing prices for these services, which include community nursing, physiotherapy, podiatry and children's wheelchair services. Most are funded through locally-agreed block payments. However, where services are bundled and some are covered by the national tariff, the rules for local variation must be followed. It encourages the development of evidence-based innovation in payment approaches to support pathways that include rehabilitation and reablement.

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7A Specified services for acute services for local pricing

7B High cost drugs, devices and listed procedures

7C Mental health clustering tool booklet

Payment rules (section 8)

This section sets out the rules for billing and payment and for activity reporting. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS standard contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions, such as those in the NHS standard contract (eg breach of the 18-week referral to treatment standard). For NHS activity, where there is no national price, providers must adhere to any reporting requirements agreed in the NHS standard contract. For services with national prices, providers must submit data monthly to the secondary uses service (SUS) system and comply with the four submission dates for each month (inclusion date; first reconciliation date; post reconciliation inclusion date; and final reconciliation date).

Supporting documents

Consultation on the *2014/15 national tariff payment system* gives details of how the consultation process for the *2014/15 National Tariff Payment System* worked and responses to the key issues raised.

Towards an NHS payment system that does more for patients explains to patients how the payment system can affect the quality of care and how the national tariff for 2014/15 is a step towards making the NHS payment system do more for patients.

Impact assessment of proposals for the 2014/15 national tariff payment system looks at the effect of the tariff (as proposed in October) on patients, providers and commissioners.

A guide to the market forces factor explains the calculation and application of the MFF in 2014/15.

Monitor and NHS England's review of the marginal rate rule describes the findings and conclusions of the review of the 30% marginal rate for emergency admissions.

The national tariff information workbook is an Excel file that provides operational information on implementing the 2014/15 national tariff.

Guidance on locally determined prices details the method for local modifications and offers guidance on the templates for local prices, variations and modifications and a constructive engagement document.

Guidance on mental health currencies and payment describes how providers can use the mental health currencies, including as a basis for setting local prices.

Enforcement of the national tariff explains how Monitor and other regulators can use their powers to ensure the tariff is followed.