price swings

The HRG4+ currency will make its first tariff appearance in 2016/17. Steve Brown reports on this and other proposals in Monitor and NHS England's tariff engagement document

The key decisions for the 2016/17 tariff will be around how prices will be revised to reflect cost increases and efficiency requirement. Monitor and NHS England's two-stage tariff engagement – which got under way in the middle of August – means the service will have to wait for these crucial figures until after the spending review later in the year.

However, the first part of the engagement – setting out currency changes and price relativities – also signals some important changes that will start to help organisations understand exactly how challenging next year could be.

The *August 2016/17 national tariff proposals: currency design and relative prices*, a month later than last year's engagement document, sidesteps the key issues of cost and efficiency. But the proposals will themselves lead to some major changes in relative prices paid for different healthcare resource groups (the main currency for admitted patient care, outpatient procedures and accident and emergency attendances).

First, Monitor and NHS England have confirmed they will introduce the revised HRG currency HRG4+ some three years after it was first introduced for the 2012/13 reference costs. The two bodies acknowledged this as their 'most significant proposal'.

Greater granularity

The new design offers much greater granularity, best demonstrated with numbers. There are just 1,300 tariff prices in the current tariff design and more than 2,000 in the proposed HRG4+-based tariff. This is likely to mean some big swings between prices paid within HRG sub-chapters.

But prices also change each year simply as a consequence of changes in the underlying cost data (whether reflecting changes in costing approach or real changes in clinical practice). Normally this would be a one-year change, with the new tariff based on the next available year's reference costs.

But the tariff prices for 2016/17 will in fact be based on 2013/14 reference costs. This is a good thing because prices will be based on more recent cost data. But it could also imply greater price swings as it will incorporate two years of cost changes (for providers currently on the enhanced tariff option, which were based on the 2011/12 reference costs) and three years for some

Quick guide to HRG4+

HRG4+ was developed by the National Casemix Office (NCO), part of the Health and Social Care Information Centre, and builds on the pre-existing currency HRG4. The first reference costs submission to use the revised design was for the 2012/13 financial year.

In theory, this would have meant the data was available to be used as the basis for the 2015/16 tariff. However, Monitor and NHS England did not propose using it as part of the 2015/16 proposals, claiming that having only one year of cost data available using the new currency meant the move was 'too uncertain'.

HRG4+ is more granular than its predecessor. Monitor and NHS England say there are about 2,000 currencies in HRG4+ compared with the 1,300 in HRG4. In fact, these numbers just refer to the HRGs with national prices. The NCO points out that its engagement grouper for the 2016/17 tariff in fact includes 2,361 HRGs.

The key change responsible for the increase in HRG volume is a more sensitive approach to the impact of

providers (on the default tariff rollover). There are two core challenges for organisations in understanding the impact of the tariff proposals. First, organisations need to understand where any changes are coming from – the new currency design or changes in the underlying cost data. And then, crucially, they need to be able to cope with any changes in income implied by the new tariff – although Monitor and NHS England are proposing to smooth the overall financial impact.

The key change with HRG4+ (see box below) is that it takes much more account of complexity and comorbidities with a new CC scoring approach. Monitor and NHS England say this will mean providers receive more appropriate reimbursement for the care they give. And, because HRG4+ recognises multiple procedures within a single spell of care, it will also more fairly reimburse care that appropriately minimises multiple interventions.

Currency design changes could increase or decrease average prices for different services. This could have a significant impact on some providers' overall income

Impact assessment

An impact assessment shows how the currency design changes could increase or decrease average prices for different services. This could have a significant impact on some providers' overall income, even when their total expenditure is held constant. Similarly, there would be an impact on commissioner spending.

The impact assessment looks at the potential impact on prices compared with both ETO prices and DTR prices. Comparing just with the ETO prices, the biggest possible increase would be in orthopaedic trauma procedures (HRG4+ subchapter HA, +14% – worth £150m), with significant decreases in orthopaedic non-trauma (HB, -10%, £210m) and orthopaedic reconstruction (HR, -31%, £150m). Maternity prices would also increase (+ 11%, £260m).

Monitor and NHS England say the orthopaedic price changes are similar to those seen in last year's draft prices, which in the end were not implemented. They say they are 'working to understand' if the changes are appropriate, looking particularly at the treatment of prostheses in reference costs.

At the provider level, the impact assessment suggests that for 90% of providers, the draft prices would change operating revenue by less than +/- 2.5%. Orthopaedic specialists would see the biggest falls in revenue – with three specialist providers losing more than 7%. All clinical commissioning groups would see spending change by just +/-1.3% of their allocations. Independent sector providers would see a reduction in income of around 7% – again largely a result of the orthopaedic prices.

Recognising that some providers and commissioners may need time to respond to these changes, the two tariff organisations are evaluating possible smoothing adjustments. Three options are being considered, including smoothing at the level of:

- HRGs
- HRG chapters or subchapters
- Providers.

The engagement document offers example approaches. 'Under a price smoothing approach, a maximum change in relative prices of between 5%, 10%, 15% or 20% could be introduced,' it says. 'Under an income or expenditure approach, a maximum change in operating income or expenditure of 1%, 2%, 3%, 4% or 5% could be introduced.'

The document points out that smoothing mechanisms already exist in the NHS – moving CCGs towards their target allocation over a number of years, introducing market forces factor changes over time and phasing in education and training tariffs. It adds, however, that adjustments would be temporary and would only be repeated if the year-on-year threshold was met again.

There are other changes in the scope of national prices – with proposals for seven new HRGs and additional outpatient prices, along with the possible replacement of six nationally priced nuclear medicine HRGs with 68 locally priced ones. But the other major further changes are around the maternity pathway tariff and best practice tariffs.

The maternity pathway tariff was introduced in April 2013. It replaced a tariff that paid for individual contacts between mothers-to-be and clinicians with a pathway approach, with a single payment for the antenatal phase, another for the delivery itself and one for the postnatal

complications and comorbidities on the costs of care. The existing HRG4 currency – versions of which are used in both the draft tariff rollover and enhanced tariff option prices – basically splits many HRGs by with or without CC (complications and comorbidities).

Under HRG4+, however, CC scores are introduced. What might have been a two-way with-or-without split in HRG4 might become a four-way split (see example below for root HRG FZ67). The CC score is built up using a scoring system related to secondary diagnoses. HRG4+ also takes account of multiple procedures, formalising the use of procedure grouping logic in some areas and using single or multiple intervention splits as a proxy for disease severity in others. Again the overall aim is to ensure care that consumes more resources is distinguishable from more routine care.

HRG4+ has been released for reference cost purposes in three phases. Approximately 25% of HRG subchapters were redesigned for reference costs 2012/13, a further 25% for reference costs 2013/14 and 25% again for 2014/15. The remaining 25% of subchapters did not require a redesign.

The tariff for 2016/17 will use the phase 2 design of HRG4+. It is presumed that phase 3 – with the key change being the addition of CC scores to orthopaedic procedures – could be used as the basis for the 2017/18 tariff, although no mention is made of these advance plans in the tariff engagement document.

FZ67 – major small intestine procedures, 19 years and over

HRG4		HRG4+	
		FZ67C	CC score 7+
FZ67A	with CC	FZ67D	CC score 4-6
FZ67B	without CC	FZ67E	CC score 2-3
		FZ67F	CC score 0-1

Thank you to all HFMA Corporate Partners for their continued support

hfma

ASTERAL

Grant Thornton

LIAISON

PHILIPS

Bellis-Jones Hill

Newton
The science of performance

CIVICA

Healthcost

NHS
NHS Supply Chain

Penna

CRS VAT Consulting

hp

CACI

Roche

HCL Clarity
Managed Services

NHS
Shared Business Services

ridouts
solicitors

software europe

CIMA
Chartered Institute of Management Accountants

fleet solutions NHS

celesio

Advanced

MAQUET
GETINGE GROUP

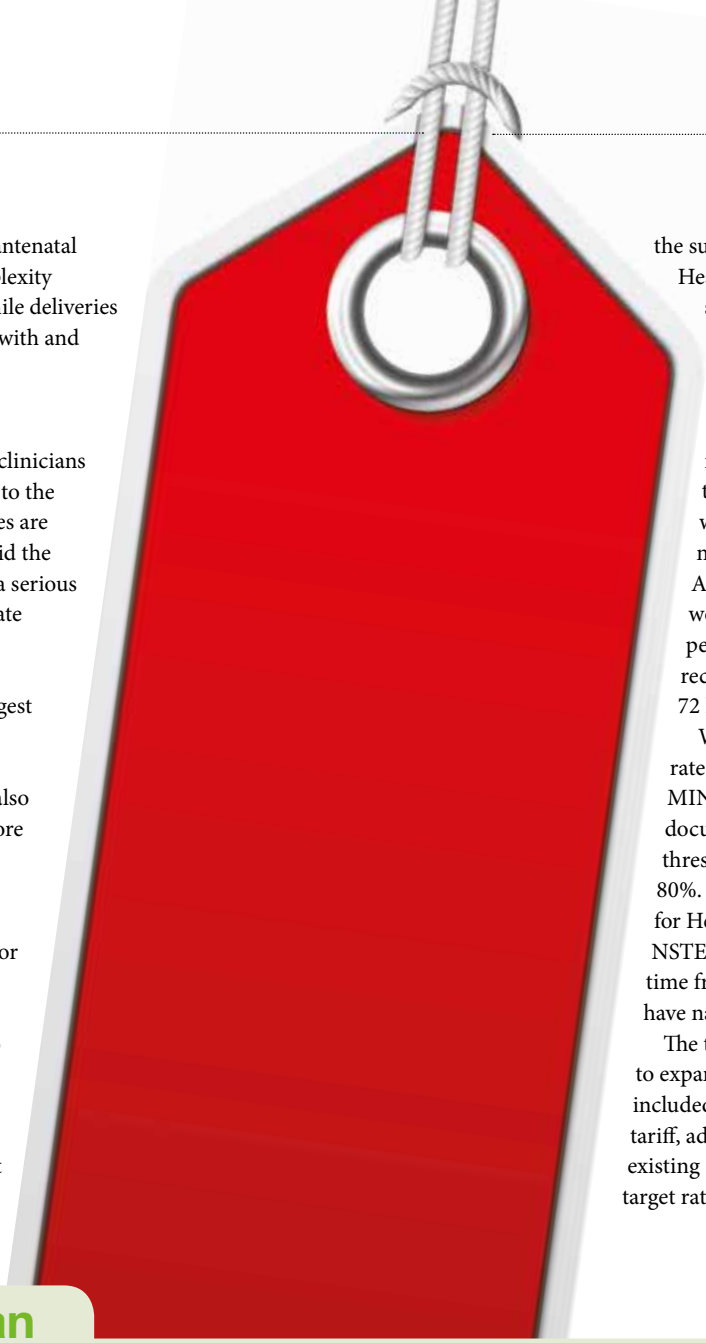
de Poel
health+care

OLYMPUS
Your Vision, Our Future

For more information about the benefits of our Corporate Partners, please contact Paul Momber

E paul.momber@hfma.org.uk T 0117 938 8972

HFMA does not endorse products and services supplied by these organisations.



phase. The level of payment in both the antenatal and postnatal phases was linked to complexity (standard, intermediate or intensive), while deliveries were split into just two prices, deliveries with and without complications.

Clinical aids

Following feedback from the sector that clinicians were finding it difficult to assign women to the right complexity pathway, the tariff bodies are proposing adding six clinical factors to aid the process. For example, if the woman had a serious neurological condition, this would indicate the intensive pathway, as would a body mass index of more than 49. A serious gastroenterological condition would suggest the intermediate pathway.

Changes to how the money would be split across these different pathways are also proposed, increasing the payment for more complex pathways.

HRG4+ also increases the number of HRGs available for deliveries, but these would be mapped down to the two with or without complication categories.

Best practice tariffs also face changes. Under the proposals, there would be two new BPTs – for emergency admissions for heart failure and non-ST elevated myocardial infarction. The heart failure BPT, which would in fact have an impact on five HRG prices, would incentivise the submission of data to the National Heart Failure Audit and encourage specialist input in more cases.

Providers not meeting both criteria would receive a price 10% below the increased BPT level.

The second BPT would look to improve the time from admission to coronary angiography for people with non-ST segment elevation myocardial infarction (NSTEMI). A 10% increased best practice tariff would be triggered when a specified percentage of patients with NSTEMI receive coronary angiography within 72 hours of admission.

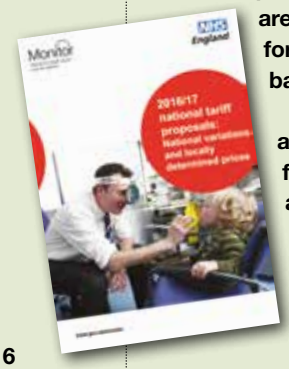
With the current achievement rate of 55% (measured through the MINAP database), the engagement document seeks views on setting the threshold for 2016/17 at 60%, 70% or 80%. According to the National Institute for Health and Care Excellence's NSTEMI costing statement, a reduced time from admission to angiography will have national cost impact of under £1m.

The tariff setters have continued to expand the number of procedures included in the day case best practice tariff, adding a further 22 procedures to the existing 16. They have also increased the target rates in two of the existing day case

Marginal rate plan

Monitor and NHS England propose that the marginal rate emergency tariff for 2016/17 will be set at 70%.

In a document on national variations and locally determined prices, the national bodies said the rate would be increased from the 2014/15 level of 30% to 70% for admissions above threshold. This approach already applies to providers opting for the enhanced tariff option (ETO) in the current financial year.



The document explains that the national bodies must start with the national tariff currently in force – the 2014/15 tariff – after the planned 2015/16 tariff was not implemented. The 2015/16 proposals included a plan to raise the marginal rate for activity above threshold to 50%. However, following the successful objection to the tariff proposals, providers could choose either the ETO or default tariff rollover (DTR).

Those opting for the ETO are being paid a marginal rate of 70% of tariff, but providers that chose the DTR are being reimbursed this year for activity above an agreed baseline at the 30% rate.

The marginal rate rule sets a monetary baseline value for a provider's emergency admissions, though this can be adjusted to account for significant changes in the pattern of emergency admissions.

Any increases in the value of emergency admissions is paid as a percentage of the full tariff. Commissioners must set aside the remaining funding – currently either 70% or 30% of the relevant tariffs – for demand management and improved discharge schemes.

The document also proposes to remove three national variations for:

- **The maternity pathway payment**
- **Unbundled diagnostic imaging in outpatients**
- **Chemotherapy delivery and external beam radiotherapy.**

These were transitional arrangements, introduced in 2013/14, to help the service adapt to new payment approaches.

Guidance is also proposed on setting locally determined prices, together with a 30 June deadline each year for commissioners to submit local variations included in a commissioning contract for the year. There would be a deadline of 30 September each year for providers to submit their local modification applications to Monitor.

BPTs and made changes to the BPTs for stroke, outpatient procedures, endoscopy and hip and knee replacements.

The interventional radiology BPT has been removed as the aims are achieved by the new HRG4+ currency design.

BPT prices

The methodology for setting BPT prices is also being simplified to ensure that BPTs are neutral at the HRG level, avoiding the need to adjust the overall tariff deflator to offset any additional efficiency challenge imposed by BPTs.

The approach will broadly model BPTs by setting a fixed differential based on an assumed compliance rate. Monitor and NHS England say that making each BPT cost-neutral at an HRG level will be more transparent for the sector, reduce the possibility of the sector being asked to deliver an addition efficiency requirement and be simpler to calculate.

Providers spoken to by *Healthcare Finance* in mid-August, just after the tariff document was published alongside the Health and Social Care Information Centre's engagement grouper, estimated that it would take several days to run the raw data.

But the changes are complex. For example, the removal of some devices from the high-cost drugs and devices list, and their average cost being included in HRG prices, will take some unpicking for relevant providers. Finance practitioners said it would be early September before they could start to understand the real likely impact of the changes.

Even then, this would only be a partial position as the crucial cost uplift and efficiency requirement decisions are still to be announced.

With responses to the proposals wanted by 14 September, the NHS has significant challenges ahead of it simply to understand the implications and then feed back its views.

Tariff objection shift

The Department of Health has proposed changes to the tariff objection mechanism introduced as part of the *Health and Social Care Act 2012*. The mechanism enables commissioners and providers to object to the proposed method for calculating national prices. Monitor cannot adopt a new tariff if 51% of commissioners/providers object (by number) or if the providers that object represent more than 51% of the share of supply of prescribed healthcare services.

After providers exceeded the share of supply threshold last year, the Department proposes changes for the 2016/17 tariff process. These include:

- **Removing the share of supply threshold**
- **Raising the 'by number' objection thresholds to between 66% and 75%.**

The Department believes the changes will 'balance [the objection process] in favour of the whole sector rather than a relatively small number of objectors and require levels of objection to be significant enough to warrant a pause to and revisiting of the introduction of the proposed tariff'.

Consultation lasts until 11 September.

HFMA AWARDS 2015

Recognising achievement and innovation in healthcare finance

The HFMA Award categories for 2015 are:

- Accounts Team of the Year Award
- Costing Award Sponsored by CIMA Chartered Institute of Management Accountants
- Innovation Award
- Governance Award
- Working with Finance – Clinician of the Year Award
- Deputy Finance Director of the Year Award
- Finance Director of the Year
- Havelock Training Award

Nominate now to recognise excellence and celebrate success in your organisation

Deadline for applications: Friday 2 October 2015

For more information please visit **hfma.org.uk/awards**
or contact **awards@hfma.org.uk**