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Reimbursement of urgent and emergency care: discussion document on options for reform

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1: Summary

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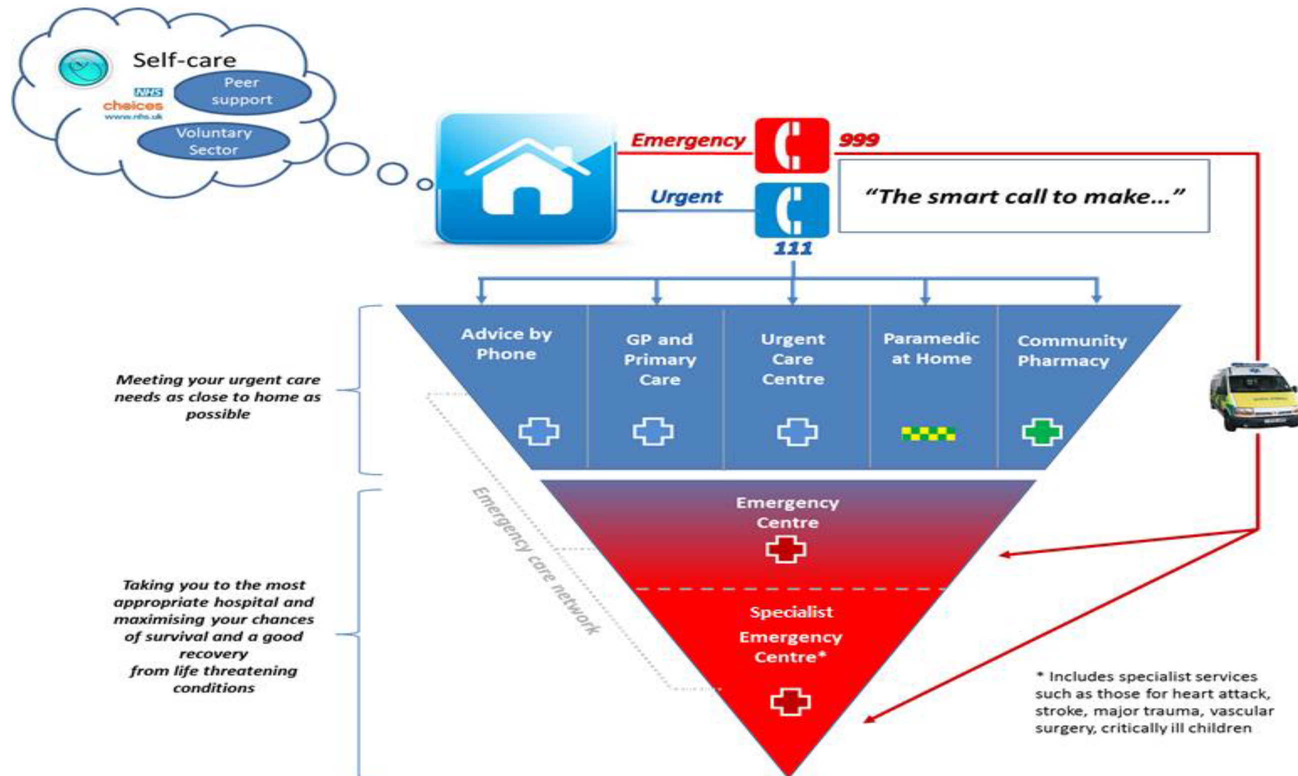
- NHS England's review of urgent and emergency care (the 'UEC Review') described a vision for a new way to deliver UEC as a co-coordinated system covering all patient 'touch points' along the urgent and emergency patient pathways.

A new vision for the urgent and emergency care system



1: Summary

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- The UEC Review recommends:
  - delivering care closer to the home
  - a move towards planned care to prevent urgent needs from arising
  - better access for patients to specialist advice and specialist care when needed
- NHS England and Monitor recognise that this vision could be more achievable through a new approach to reimbursing urgent and emergency care services which would combine
  - a **substantial proportion of fixed core funding** to reflect the 'always on' nature of the services and to focus on planning capacity across the system to specified minimum access and quality standards
  - a **proportion of volume-based funding** to manage unpredictable fluctuations in demand
  - **using provider-specific and system-wide quality metrics** as eligibility criteria for different rates of fixed and volume-based funding, and as the basis for bonuses and penalties to support service change and quality improvement
- The options discussed are supported from previous research and analysis including the 2013 review of the marginal rate for emergency admissions. The options presented identify a longer term solution for payment of UEC, where the marginal rate rule in its current form may not be required. All final proposals will be determined through the formal tariff engagement processes.

2: The case for reform

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- The UEC Review sets out a vision for changing UEC services and practices to form a co-coordinated system covering all patient touch points and has two main objectives:
  - **for urgent but non-life threatening needs** to provide **highly responsive, effective and personalised services outside of hospital delivering care in, or as close to home as possible**
  - **for more serious or life threatening emergency needs** to ensure treatment in **centres with the very best expertise and facilities, to maximise chances of survival and a good recovery**
- Evidence shows how better self management, care planning and co-ordination could prevent the need for urgent responses and lead to care being delivered in more effective and potentially lower cost settings whilst improving care for patients.
- The UEC Review identifies two main elements of change needed to deliver the vision:
  - helping people to get the right advice in the right place, the first time
  - connecting UEC services so that the overall system becomes more than the sum of its parts

2: The case for reform

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- Evidence suggests that changes to current funding arrangements for UEC services would help to achieve the envisaged service reform. Currently individual providers bear little or no accountability for the cost and quality performance of the UEC system as a whole, and may face financial incentives in conflict with working with others to improve the system's operational performance if this would impact their own revenue
- Reimbursing services between different providers and care settings in a way that makes co-ordination worthwhile for all parties would help to achieve the service changes envisaged in the UEC Review
- To encourage system wide co-ordination a number of options for developing the payment approach are being considered to include ways to:
  - better match the economics of organising and delivering UEC services to reflect their 'always on' nature
  - ensure risks are allocated between different providers and between providers and commissioners to achieve benefits for patients
  - develop reliability in measuring activity, costs and quality of care across the system as a whole so that any financial savings (losses) can be shared between all contributing parties
  - work if new commissioning and contracting arrangements are put in place to redistribute funding in line with providers' operational contribution to the system

3: A potential new payment approach for UEC

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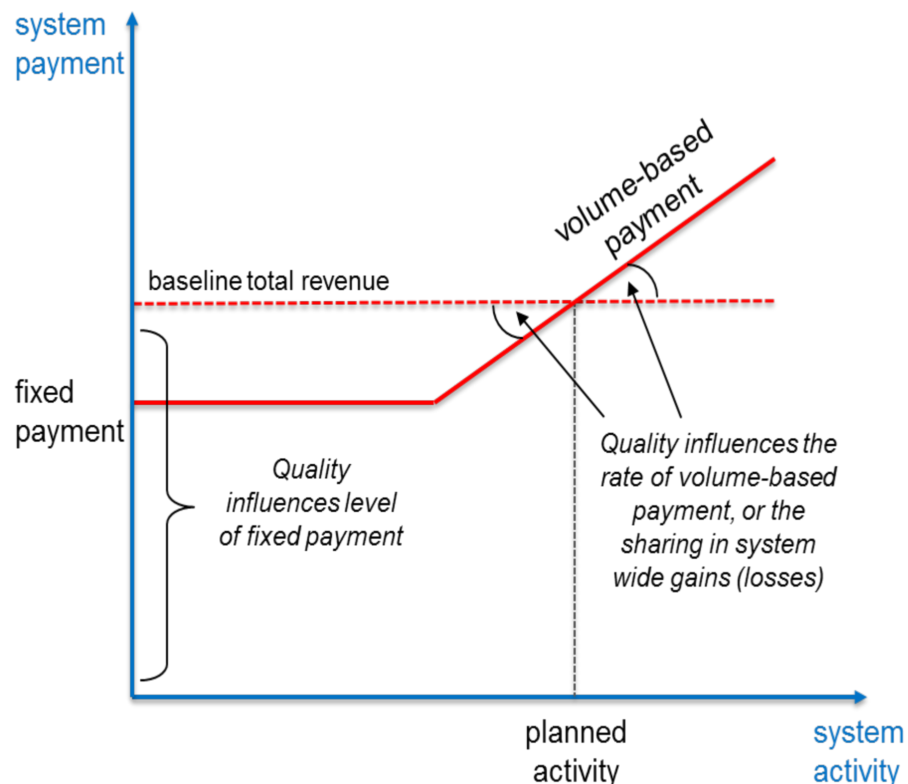
A new payment approach would seek to be consistent across all components of care delivery and enable individual providers to share in the benefits (or costs) of their actions to the system as a whole The approach could combine:

- A **substantial proportion of fixed core funding** to reflect the ‘always on” nature of services and focus on planning capacity to specified minimum access and quality standards
- A **proportion of volume-based funding** for individual providers to meet unpredictable fluctuations in demand and share in the financial impact of their actions on the system as a whole
- Using **provider-specific and system-wide quality metrics** as eligibility criteria for different rates of fixed and volume-based funding, and as the basis for bonuses and penalties, to support service change and quality improvement.

Summary of potential payment approach



3: A potential new payment approach for UEC

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To support the delivery of the UEC Review recommendations, the potential payment approach would seek to support system-wide accountability

- The payment approach can enable the UEC review vision by providing a consistent approach to the different components of care delivery that recognises the interdependency of the system and by establishing system-wide sharing in benefits (or costs)
- Opportunities for improving quality of care and efficiency through better co-ordination may be facilitated by establishing UEC wide accountability for:
  - overall volume of activity and costs in the system
  - ensuring care is delivered in the right setting, first time
  - improving quality of care and outcomes for patients
- All providers could benefit from the savings they generate for the system as a whole, as well as for themselves. Any losses from slow implementation of service redesign would be shared between all parties responsible for delivering change.
- There remains uncertainty over which of the component services would be covered by the new payment approach. Coverage would be dependent on the capability of commissioning and contracting arrangements in place as well as the quality of available data. It is likely that while the payment arrangements could cover most of the component services, care provided through community pharmacies and GP surgeries may come later.

3: A potential new payment approach for UEC

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The payment approach could include a substantial proportion of fixed funding to reflect the planned level of capacity

This would aim to:

- reflect the economic model of how UEC services are organised and delivered – the ‘always on’ nature
- concentrate attention on planning capacity to specified minimum access and quality standards

Research on the cost structures of providing UEC shows:

- the majority of costs are either fixed or semi-fixed over a 12 month period with respect to changes in volume of activity, with the proportion of variable costs between 0% and 21% of total costs across the different system components
- a substantial proportion of semi-fixed costs come from making a planned level of capacity available irrespective of the number of patients actually seen [can account for 90% + of total costs for ambulance services within a year]
- while implementing the UEC Review vision could lead to a significant change in input mix, activity volumes or cost levels it may leave the relationship between costs and volume largely unchanged in the short term, meaning current cost structures could provide a good indication of likely cost structures following service reform.
- Including a fixed core funding element is feasible since benchmarking and trend analysis can forecast overall levels of demand for services. Additionally, through analysing patient data it is possible to establish which population groups use UEC services and which patients could benefit from reducing or substituting their consumption.

3: A potential new payment approach for UEC

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The payment approach could maintain a proportion of volume-based payment

A key risk with payment approaches that include a substantial proportion of fixed funding is that demand for services fluctuates around the predicted volume, for the local UEC system as a whole or for the individual components of the system. If payment was fully fixed:

- under-predicting demand (and required capacity) places all financial risk on providers
- over-predicting demand (and required capacity) leads to providers gaining unearned surpluses at the expense of commissioner budgets
- potentially places on acute providers a disproportionate financial impact from delays in service reform and demand management effectiveness. Providers may have insufficient means of control to manage demand, care substitution and access to the UEC system, particularly if some key elements of the system e.g. urgent primary care provision remain outside the co-coordinated payment approach

A partially volume-based approach can help providers and commissioners manage uncertainty by allocating some of the funding to where care actually takes place and provides a potential tool to incentivise substitution and to allocate risks and financial responsibility between providers and commissioners that supports delivery of the UEC vision. Maintaining a proportion of volume based payment could provide the metrics needed to attribute the benefits (or costs) envisaged under the review in terms of the effects of service changes and system-wide sharing of benefits (or costs) from individual provider actions.

3: A potential new payment approach for UEC

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Linking quality to the payment mechanism could be beneficial, particularly if payment includes a substantial fixed funding element

- A risk of using a substantial proportion of fixed funding is that providers may restrict access or reduce quality of care to achieve acceptable margins. Making payment contingent on quality can enhance accountability and incentives for quality, improving patient outcomes and supporting delivery of right care at the right time in the right place
- Various ways quality could be linked to payment:
  - making fixed funding dependent on meeting minimum standards
  - as qualification criteria for differential volume-based rates of payment
  - participation in different levels of gain/loss share arrangements
  - bonus/ penalty system based on system-wide or provider-specific outcome and quality metrics

4: Emerging thinking on options for the detailed design

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Combining the payment elements to determine the overall revenue profile for the UEC system

The overall revenue profile produced by the payment approach and how this compares to the cost profile ultimately provides signals from the payment system to providers that will influence service design and practices. Combining the fixed, volume based and quality elements of payment in a gain/loss sharing arrangement around a baseline total revenue requirement may be a practical way of reimbursing services to allow providers to realise the benefit (or cost) of their actions.

Two options are being considered for combining an element of fixed core and volume-based funding:

Type A: Approaches that add a volume-based rate(s) on top of a fixed lump sum, both of which are set in advance. The volume-based rate can be set at equal to, at less than or at more that the estimated incremental cost of a unit of activity, and can be set to vary at different levels of activity, depending on the desired behavioural signal.

Type B: Approaches that focus on gain/loss share arrangements around a prospectively estimated baseline revenue requirement. The amount of guaranteed core funding and the volume-based rate are implicit in the gain/loss share design and the rates of gain/loss shares with respect to actual activity can be set with reference to estimated incremental costs.

4: Emerging thinking on options for the detailed design

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Differences of the Approaches:

- **Signals provided by the payment system to providers and commissioners:**
  - Type A starting point is a target volume at each provider to be used to send signals to providers in relation to own activity and costs
  - Type B starting point is a target cost (or revenue) of the UEC system providing signals in relation to the impact of individual provider actions on the system as a whole with no reference to individual provider cost profiles and the volume-based rate
- **Ability to promote co-ordination:** Type B approaches potentially more able to to make different providers realise the benefit (or cost) of their actions on UEC as a whole whereas under Type A this could be complicated and less effective requiring multiple and blended volume-based rates to be determined conditional on UEC system performance.
- **Information requirements:** Type A require knowing top-down how much demand to shift between settings to enable the core and volume-based rates and thresholds to be set accordingly. Type B more suited to allowing optimal configurations to emerge through co-ordination between providers, but may require more reliable metrics on costs, volume and quality.

4: Emerging thinking on options for the detailed design

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Currencies for calculating/ pricing the fixed core funding element

Three types of currency for determining the core funding element under either Type A or Type B approach considered so far are:

- **geographic coverage (capitation):** payment is made per person per year and determined on the basis of the needs of the patient population
- **expected activity:** payment is determined by expected volume of activity
- **planned capacity:** payment is made on the basis of specified inputs needed to deliver required capacity and the efficient cost of those inputs

Each currency can be used to determine the core or baseline total funding requirement.

	Advantages	Disadvantages
Geographic coverage	• Encourages care in most appropriate setting for system wide co-ordination • Flexibility for innovation in service delivery • Fits with long term payment approaches for people with (i) multiple long-term conditions & (ii) mental health needs	• Requires accurate estimation of demand for services based on population risk profiles • Requires definition of catchment population Not take into account current level of inputs used leading to significant change from current levels of funding
Expected activity	• Reduces risk of under provision of services • Easy to implement in short term • Feasible starting point for services which already have nationally or locally established activity measures	• May discourage or constrain innovation to deliver value care beyond agreed service levels • Exposes providers and commissioners to volatility if currencies need updating due to clinical or technological innovation
Planned capacity	• More precise and targeted thereby reducing risk of too little capacity • Quality requirements can be attached to the capacity measures used • Reassurance that as capacity is reallocated across the system, funding follows the efficient costs of the specified inputs in different care settings	• Requires use of standards informed by professional bodies to estimate optimal capacity of each provider; define capacity based & clinically relevant payment currencies avoiding unintended consequences; & have confidence that planned inputs will deliver best care all of which may be challenging to achieve in practice • Risk of locking in specific inputs, technologies, delivery models etc thereby discouraging service innovation

4: Emerging thinking on options for the detailed design

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Which elements of the payment approach should be centrally determined and which locally determined?

- Determination will be within the context of NHS England's work on potential contracting and commissioning changes to support the delivery of the UEC Review vision
- Number of potential approaches from nationally mandated prices through to fully locally determined payment. Even if the proportions and rates of the payment elements are locally determined, data requirements, payment rules, currencies, payment methods and precise formulas used to calculate the payment could still be nationally determined.
- National determination of payment elements may promote efficiency while more localised approaches could provide flexibility to account for variations in cost that providers/commissioners have little control over.
- Best approach will depend on extent to which NHS England:
  - envisages central/regional planning of all or some of the UEC components (such as specialist emergency centres)
  - encourages CCGs to create larger planning or contracting units
  - allows UEC component mix to be tailored locally
- Also need to establish the extent to which payment elements ought to vary by specific UEC component. Research on cost structures shows that the proportion of fixed and semi-fixed costs associated with providing a minimum level of capacity varies between the different components of the UEC system as do the cost structures of different providers of the same service. These findings suggest there could be benefits to determining the proportions and rates of fixed core and volume-based funding separately for the different UEC services, possibly by location and potentially by provider.

5: Next steps and longer term outlook

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Next Steps:

- Develop proposals on which components of the UEC system should be covered by the co-coordinated and jointly accountable payment approach
- Develop further the options on how to combine the three different payment elements, including design and operation of gain/loss share arrangements
- Develop options for currencies for calculating/ pricing the fixed core funding element
- Develop further how quality metrics could be linked to payment
- Assess data requirements for testing and evaluating the proposals
- Analyse the interaction of the payment approach for UEC with payment approaches for other areas of care

Future work:

- Produce example(s) of the new payment approach for testing and evaluation in 2015/16
- Publish the example(s) together with guidance to encourage commissioners and providers to test in 2015/16 as local variations
- Identify local health economies to test the designs further during 2015/16

6: Conclusion and Opinion

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- The Urgent and Emergency Care proposals have been restated in the "Five year forward view" and there is a strong sense that the model described here is a template for the future, a model that seeks to bind health communities together
- There will be considerable anxiety amongst emergency care clinicians that any system resembling a block contract is being muted
- Closer inspection will, however, provide some solace that there is a clear attempt to recognise the core costs of providing 24 hour, 7 day a week emergency services while recognising the need to protect a service from unfettered demand without consequence
- The proposal is not dissimilar from the concept of the Primary Care Contract with an element of income based on list sizes, an element based upon quality and outcome frameworks and an element for additional or variable or enhanced service. It is important that lessons are learned from that exercise particularly the structure of quality payments
- The delivery of system wide incentives to bind health economies together will be extraordinarily complex and it is difficult to see how this will be delivered without structural change to national contracts and the development of incentives that flow all the way through to individuals
- The task of structuring incentives and levers across diverse providers such as General Practice, Community services, Acute services, Ambulance services, community pharmacists, out of hours providers, telephone advice providers and third sector and voluntary agencies is considerable
- There is, nevertheless, an opportunity to develop systems that deliver integrated urgent and emergency care services that will undoubtedly benefit patients and an opportunity for genuine system leaders and innovators to step forward

Annex 1 – Reimbursement of urgent and emergency care – summary of findings on cost structures of different UEC services

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Research from Monitor and NHS England examined how costs vary with volumes of activity in the different components of the UEC system.

Methodology: costs were assigned to the clinical and non-clinical inputs necessary to provide different components of the system through case studies of two local health economies one urban and one rural. The study covered the majority of component services in the UEC systems including:

- NHS 111
- GP out of hours
- Walk in centre
- 999 and ambulance see-and-treat
- 999 and ambulance treat-and-convey
- minor injuries unit
- type 1 A&E and emergency admissions shorter than 48 hours
- type 1 A&E and emergency admissions longer than 48 hours
- type 1 A&E trauma
- type 1 A&E and emergency admissions longer than 48 hours, with rehabilitation

The research aimed to establish detailed bottom up costings for the actual clinical models caring for the actual patient flow in the case study local health economies. It generated a full list of inputs required for each component service, categorising them as fixed, semi-fixed or variable depending on how they respond to changes in activity levels. The research identified the sixe of the changes in activity that would lead to changes in the various semi-fixed inputs and also the minimum level of semi fixed and variable inputs that would be needed to provide a viable capacity to respond to demand. The clinical models, input data and assumptions generated were validated against audited accounts and reference cost data and tested directly with the participating providers.

Annex 1 – Reimbursement of urgent and emergency care – summary of findings on cost structures of different UEC services

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Key findings

- The large majority of costs are either fixed or semi-fixed over a 12 month period with respect to changes in volume of activity, with the proportion of variable costs ranging between 0% and 21 % of total costs across the different service components in the system
- A substantial proportion of semi-fixed costs are associated with making a planned level of capacity available irrespective of the number of patients actually seen in year. Together with fixed costs these unavoidable semi-fixed costs related to expected capacity can be over 90% of total costs for ambulance services within a year, over 55% for short stay emergency admissions, and nearly 50% for a minor injuries unit at the bottom of the range in the sample.
- The cost structure varies significantly between different components. For example, the 111 service may have almost no variable costs compared to 21% at the minor injuries unit. There are also differences in the cost structures of the comparable components of the rural and urban case study local health economies.
- While implementing the UEC Review vision could significantly change the input mix, levels of activity and levels of input costs, it may leave the relationship between costs and volume largely unchanged. This could mean that current cost structures are a good guide to the cost structures once the service reform is complete.