Local Payment Variations document

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Description	As part of the work of developing the 2014/15 National Tariff, we are reviewing the arrangements for local commissioners and providers to vary a National Tariff price or currency. These arrangements used to be called “flexibilities” and were described in Section 13 of the *Payment by Results Guidance*. However, in line with the terminology introduced in the Health and Social Care Act 2012[1], we are now calling them local payment variations.	
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1. Introduction

From 2014/15, NHS England and Monitor will have joint responsibility for the payment system for NHS-funded care, as set out in the Health and Social Care Act 2012. Within our partnership, we have different responsibilities. As the body charged with overseeing the commissioning of health care services, NHS England will specify the units of purchase (currencies) for the services commissioners buy on behalf of patients. Meanwhile, Monitor is responsible for designing the rules governing payment and the pricing methodologies which will govern the flow of funding from commissioners to providers of NHS care. We will publish the results of our joint work in the 2014/15 National Tariff and are working together to produce a long-term strategy for the payment system.

As part of the work of developing the 2014/15 National Tariff, we are reviewing the arrangements for local commissioners and providers to vary a National Tariff price or currency. These arrangements used to be called "flexibilities" and were described in Section 13 of the *Payment by Results Guidance*. However, in line with the terminology introduced in the Health and Social Care Act 2012[1], we are now calling them local payment variations.

Section 4 of *The National Tariff 2014/15: An Engagement Document* sets out our initial proposals for rules for local variation of national currencies and/or prices (local payment variations) as well as rules governing payment for services where there is no national currency or price (local price-setting). For example, we propose that new services that aim to deliver more integrated care, perhaps bringing together health and social care, may best be considered as services without a national price (local price-setting). However, where commissioners want, for example, to share volume risk with a provider for services covered by national prices (such as emergency care), this would be considered a local payment variation. Similarly, where a nationally specified service is provided in a different setting, perhaps a community clinic, or delivered using a new, less invasive medical technology, a local payment variation could be negotiated and agreed between a provider and a commissioner.

Your response to this discussion paper will therefore inform both the final local payment variation rules for the 2014/15 National Tariff and, potentially, the shaping of rules for local price-setting of services without national currencies and/or prices.

2. Rationale for local payment variations

We are very interested in facilitating new approaches to reimbursement, especially those that support innovations in integrated care, payment based on outcomes rather than volume, and better value for patients. Some excellent and innovative work in these areas is already taking place across the country, especially on delivering more integrated care. In the 2014/15 National Tariff we would like to provide an opportunity for commissioners and providers to use local payment variations to continue to advance this work.

We also know providers and commissioners sometimes find it difficult to comply with current payment rules. For example, anecdotal evidence suggests that many commissioners lump together a provider's likely total income from all sources and guarantee it under a block contract or cap and collar arrangement[2]. This is often seen as the only way to deliver required QIPP[3] savings.

[1] See sections 116(2) and 118(4) of the Act.

2 For example, a cap and collar agreement might set out minimum and maximum revenue bounds

However, this practice can undermine the effectiveness of the incentives within the payment system, for example, it may undermine patient choice and discourage the design of new sustainable service models.

In the 2014/15 National Tariff we would like to clarify for commissioners and providers the rules governing when local payment variations can be used, and provide information and support to help them to implement these rules. The revised rules would give commissioners and providers the ability to use innovative payment approaches where these are in patients' best interests. By adhering to the local payment variation rules, providers and commissioners will be in compliance with the National Tariff.

We need your help in getting these new rules right. This discussion paper asks for your views on specific questions concerning: appropriate objectives for local payment variations; what can be done to overcome issues identified to date with implementing local payment variations; and reporting and oversight of local payment variations in practice. If there are important areas you believe we have missed, please do tell us.

Your feedback will inform our review of existing flexibilities and arrangements for local payment variations to be included in the 2014/15 National Tariff Document. The proposed tariff, including the rules for local payment variations, will be published for statutory consultation in the autumn.

3. Overview of existing flexibilities

Section 13 of the national *Payment by Results Guidance for 2013/14* on flexibilities sets out three criteria for allowing local variations. These allow for variation from national currencies and tariff prices (upwards or downwards) if the variation:

- supports the provision of better care for patients, for example: moving day cases to community settings; enabling dialysis away from the usual setting; or paying for the use of innovative technologies; or
- supports material service redesign or more efficient pricing, for example: reductions to tariff to enable immediate investment to achieve future savings; bundling for pathways; or unbundling; or
- enables appropriate reimbursement where casemix differs significantly from the norm, for example: paying less than tariff where a provider has referral criteria that restrict the complexity of cases they can treat.

Currently, commissioners and providers receive little guidance on how to design alternative payment approaches in these circumstances and there are few tools available to support implementation. There is also no requirement for local payment variations to be evaluated and no direct central oversight of variations.

4. Scope of this review

Local Payment Variations, the subject of this review, refer to the local variations to national prices and currencies which commissioners and providers could adopt under rules to be included in the National Tariff. Such variations could be used to develop new payment approaches in order to deliver different models of care with the aim of achieving better value for patients.

[3] Quality, Innovation, Productivity and Prevention

When proposing new service delivery models and payment approaches, commissioners and providers must also adhere to a series of other requirements which may impose limits on what can and cannot be done. Many of these additional constraints on flexibility are binding as they are imposed under legislation (see Annex 1), including:

- National Health Service Act 2006;
- NHS Constitution;
- CQC Requirements;
- Competition Law;
- Regulations under section 75 of the Health and Social Care Act 2012; and
- Monitor's Provider Licence.

This paper does not intend to review these binding constraints.

Discussion of local payment variations also inevitably raises the related subjects of contracting and competition. While these are closely related subjects, this review aims to focus exclusively on the rules, guidance, tools and support that commissioners and providers need to be able to use local payment variations to benefit patients.

Specifically, this review will:

- solicit and consider feedback from the sector regarding the rules and support for local payment variations;
- aim to devise criteria for local payment variations that encourage innovation without undermining the discipline and incentives of the payment system;
- consider the different types of variation in services that might suggest a different payment approach is appropriate;
- seek to identify what local payment variations might suit new or improved services;
- make recommendations for additional guidance, tools or support that may assist the sector in designing local services and implementing resulting payment variations (eg, measurement of outcomes);
- identify arrangements for gathering feedback to assist future policy development and for oversight, including any circumstances in which commissioners and providers may need approval from Monitor and NHS England; and
- manage inter-dependencies or links with the Integrated Care Pioneers programme and experimentation around contracting and procurement.

This review does not consider issues related to local modifications. These involve a distinct regime for modifying prices, introduced by the Health and Social Care Act 2012. From 2014/15, local modifications will allow National Tariff prices to be increased (subject to Monitor's approval) in situations where the costs of delivering health services are structurally higher than average, making delivering services at tariff prices uneconomic for a provider.

5. Choosing appropriate objectives for local payment variations

Monitor and NHS England believe the design of the NHS payment system should focus on promoting value for patients. By value for patients we mean continual improvement in the quality of care, using scarce resources as sustainably as possible. To achieve this overall aim, we believe

we need to allow for different payment approaches where people's care needs differ and to provide room for local flexibility bounded by a clear structure of rules.[4]

This review of existing payment flexibilities presents an opportunity to develop revised local payment variation rules designed to achieve the following specific objectives:

- support local, "bottom-up" development of new service models that deliver better value for patients;
- highlight payment approaches that are in line with the broader aims of the health service;
- deter payment approaches that conflict with the broader aims of the health service;
- enhance the overall transparency of payment practices; and
- build a body of evidence about alternative payment approaches to improve national prices and the overall NHS payment system.

Q1: Are these appropriate objectives for local payment variations? Please include the reason for your response.

6. Issues identified to date with implementing local payment variations

Stakeholders have raised the following issues and barriers related to implementing local payment variations[5], pointing to the need for their review.

- Awareness of existing flexibilities: there are low levels of awareness of the variation provisions within the payment system.

- Understanding of the main opportunities where payment variations can be used to promote value for patients: there is a widespread lack of clarity about the circumstances where payment variations should be actively considered (eg, which patient groups would benefit and what payment approaches might be suitable).

- Permission and criteria for allowing payment variations:
    - commissioners and providers often perceive they require 'permission' to test new approaches when they do not; and
    - the three criteria for allowing a local payment variation, outlined in Section 2, are confusing. They do not provide enough guidance on what types of variations are and are not permitted.

- Provider and commissioner willingness to agree new approaches: the existing PbR flexibilities and the new local payment variation provisions require providers and commissioners to agree to vary payments. However, misaligned incentives can deter the agreement of new approaches.

[4] "How can the NHS payment system do more for patients?" http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-34
[5] "Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS" http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

- Ability to implement new approaches: there is a lack of capability and capacity to implement variations (this issue was highlighted in Monitor's Fair Playing Field Review[6]). In particular, there is uncertainty regarding:

    - allocating costs and sharing financial risks across providers (primary and secondary care / health and social care) to support integration or outcomes-based payment:
        - the variety of distinct payment mechanisms and contracts agreed with different commissioners across the spectrum of providers can make it difficult to reach agreement on innovative delivery and payment models; and
        - proposed new models may be in the best interest of patients yet may not benefit some providers.

    - what is / is not allowed under existing choice and competition regulation:
        - patient choice requirements are sometimes seen to trump integrated care;
        - competitive tendering requirements for new services may inhibit provider-commissioner co-design of new models of care and there is a lack of understanding of how competition could be used to promote innovative service models;
        - information sharing between providers is seen as anti-competitive; and
        - there is a perceived tension between payment models based on minimum volumes or pathways and allowing patients free choice of providers at all stages of care.

- Short contract durations:
    - short contracts are a barrier to significant service change and innovative payment models that require a longer time horizon to achieve patient benefits and allow providers to recover investments associated with delivering new forms of care; and
    - short contracts require regular renegotiation resulting in higher transaction costs.

Q2: Are there other issues or barriers related to the implementation of innovative local payment approaches that need to be considered?

Q3: What role can Monitor and NHS England play in helping local areas overcome these issues and encourage more widespread innovation in payment approaches?

7. Evidence gathering and oversight

The objective of gathering evidence is to share best practices and inform future payment design, as well as to provide oversight of what is happening at the local level. Monitor and NHS England must give consideration to how they will gather information about local payment variations in order to build a body of evidence about innovative payment approaches.

We must also consider the level of oversight required for local payment variations. Too little central oversight may introduce unacceptable risk or blunt incentives, enabling payment systems that are not in the best interests of patients. However, too much central oversight and the related administrative burden may constrain or discourage commissioners and providers from agreeing and reporting local payment variations and may increase transaction costs.

[6] "A fair playing field for the benefit of NHS patients" http://www.monitor-nhsft.gov.uk/sites/default/files/publications/The%20Fair%20Playing%20Field%20Review%20FINAL.pdf

The spectrum of reporting and oversight options ranges from the more to less intrusive. The parties agreeing local payment variations could be required to:

- gain formal approval before implementing a local payment variation;
- self-certify the compliance of their local payment approach against set criteria (eg, a check list);
- submit their local payment approach to Monitor without having to gain approval, ie, simply inform Monitor of what they propose to do; or
- publish their payment approach locally, without having to submit it to Monitor or gain approval.

Q4: How can Monitor and NHS England balance the need to gather information in order to build an evidence base and provide oversight without overburdening local areas?

8. Conclusion and next steps

This review is at an early stage and we need to gain as much insight as possible from all stakeholders to inform our decisions as we proceed. We are particularly interested in any evidence of where current payment flexibility rules are either enabling or impeding local innovation and improvement.

We will incorporate feedback from the sector as we draft the new local payment variations rules for inclusion in the 2014/15 National Tariff. The proposed 2014/15 National Tariff will be published for statutory consultation in autumn 2013.

To provide feedback on this paper, please fill out our online questionnaire available at www.monitor.gov.uk/pricing. The deadline for comment is **5pm Tuesday 9 July 2013**.

We have also scheduled three online webinars and would welcome your participation. These will take place on:

- 26 June 2013, 5:00 PM;
- 27 June 2013, Noon; and
- 4 July 2013, 8:00 AM

If you would like to express an interest in attending, please go to www.monitor.gov.uk/pricing.

Annex: Binding constraints on new service delivery and payment approaches

National Health Service Act 2006

- Sets out the duties and powers of all organisations operating within the health economy.
- Includes duties to promote choice; innovation; the NHS Constitution; and to ensure standards of quality and safety.

NHS Constitution

- Outlines the guiding principles and values that must be abided by across the NHS.
- Includes 25 legally binding patient rights, as well as additional patient pledges pertaining to: access to health services; quality of care and environment; nationally approved treatments, drugs and programmes; respect, consent and confidentiality; informed choice; patient involvement in health care and the NHS; and complaints and redress.
- NHS providers and commissioners have a statutory duty to have regard to the Constitution (Health Act 2009).

CQC Requirements

- To be registered, a provider must meet essential standards of quality and safety in all of its regulated activities at each location. These essential standards come from 28 regulations that providers are legally required to comply with.
- Sixteeen of these relate directly to the quality and safety of care; the other 12 regulations relate more to the routine day-to-day management of a service.

Competition Law

- The impact of any new payment approach on competition and plurality of providers must be considered within the context of UK and European Union competition law.

Regulations under section 75 of the Health and Social Care Act 2012

- See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (S.I. 2013/500) and related guidance.
- These statutory requirements relate to the procuring of health services and include requirements relating to:
    - Adhering to good procurement practice;
    - Protecting and promoting the right of patients to make choices with respect to treatment or other health care services; and
    - Not engaging in anti-competitive behaviour unless it is in the interests of people who use the services to do so.

Monitor's Provider Licence

- Foundation trusts have been required to have a licence since April 2013, and independent providers of NHS services (with > £10m turnover) will require a Monitor licence from April 2014. The licence includes a number of conditions relevant to pricing and payment:

- General conditions, including those such as payment of fees and a requirement for providers to be registered with the CQC.
- Pricing conditions cover the recording and provision of information, compliance with the National Tariff, and constructive engagement with commissioners around local modifications to the National Tariff.
- Choice and competition conditions.
- Integrated care condition requires that licensees shall not do anything that would reasonably be regarded as detrimental to enabling integrated care. and
- Continuity of services conditions ensure that services continue to operate when providers are in financial distress.

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