Developing payment and currencies using good quality data

CHKS Conference

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Developing payment and currencies using good quality data

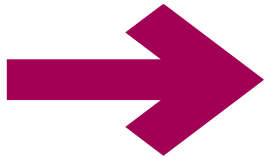
- Direction of travel for payment and plans for 2017/18
- Implications of using HRG4+ for payment
- Will coding always underpin payment?
- How poor data hampers development of payment
- Development of new datasets and use for payment

Future direction of travel for the payment system – supporting the five year forward view

- Need to develop new payment approaches to support the new care models set out in the 5YFV
- Multi-speciality community providers (MCPs) and Primary and acute care systems (PACS) are population-based care models covering a number of services
- To support these we are developing a population-based payment model, a Whole Population Budget, based on a single payment covering all the services and patients within the scope of the new care model
- Payment will also be overlaid with a gain/loss share to balance risk between provider and commissioner and link a proportion of payment to outcomes
- We are working with a small number of Vanguards to develop these new approaches so that sites are ready to go live from April 2017

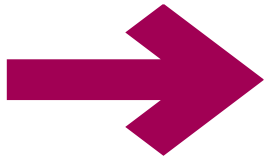
National tariff plans for 2017/18 and 2018/19

- The tariff will be set for a two-year period
- HRG4+ currency design will be used as the basis of the tariff and reference costs from 2014/15
- Cost uplift will be 2.1% in both years offset by a 2% efficiency requirement plus CNST increases added direct to prices (worth 0.7% on average)
- Some “smoothing” of prices which have seen the biggest changes will be made to mitigate the impact of the new tariff
- New specialist top-ups will be introduced based on the Prescribed Specialised Services (PSS) identification rules
- New Best Practice Tariffs and new Innovation & Technology Tariffs to support the adoption of innovative treatments across the NHS



Implications of introducing HRG4+ for payment

- Better capture of complications and co-morbidities
- Better identification of specialised activity
- More HRGs in total
- More important to ensure that coding is accurate to ensure the appropriate level of payment
- Revision to top-ups as the HRG design now captures some specialised activity better



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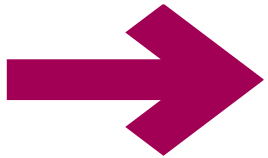
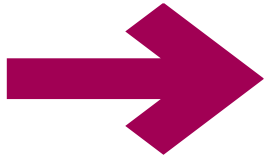


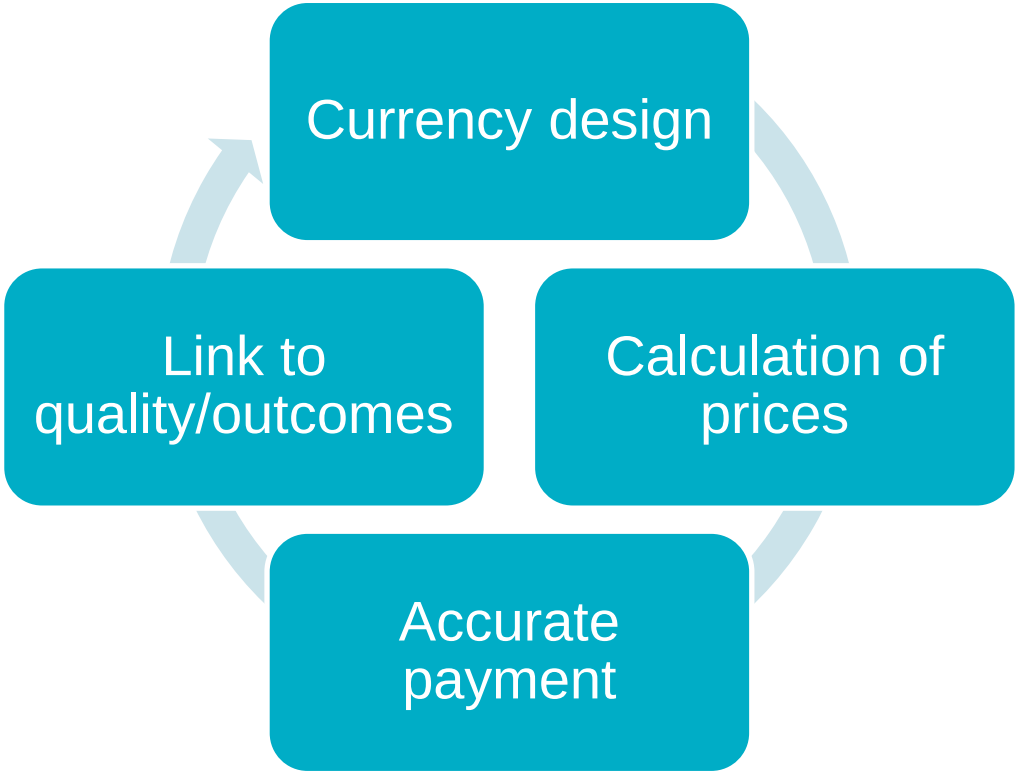
The adoption of HRG4+

HRG 4	
FZ67A	Major Small Intestine Procedures 19 years and over with CC
FZ67B	Major Small Intestine Procedures 19 years and over without CC

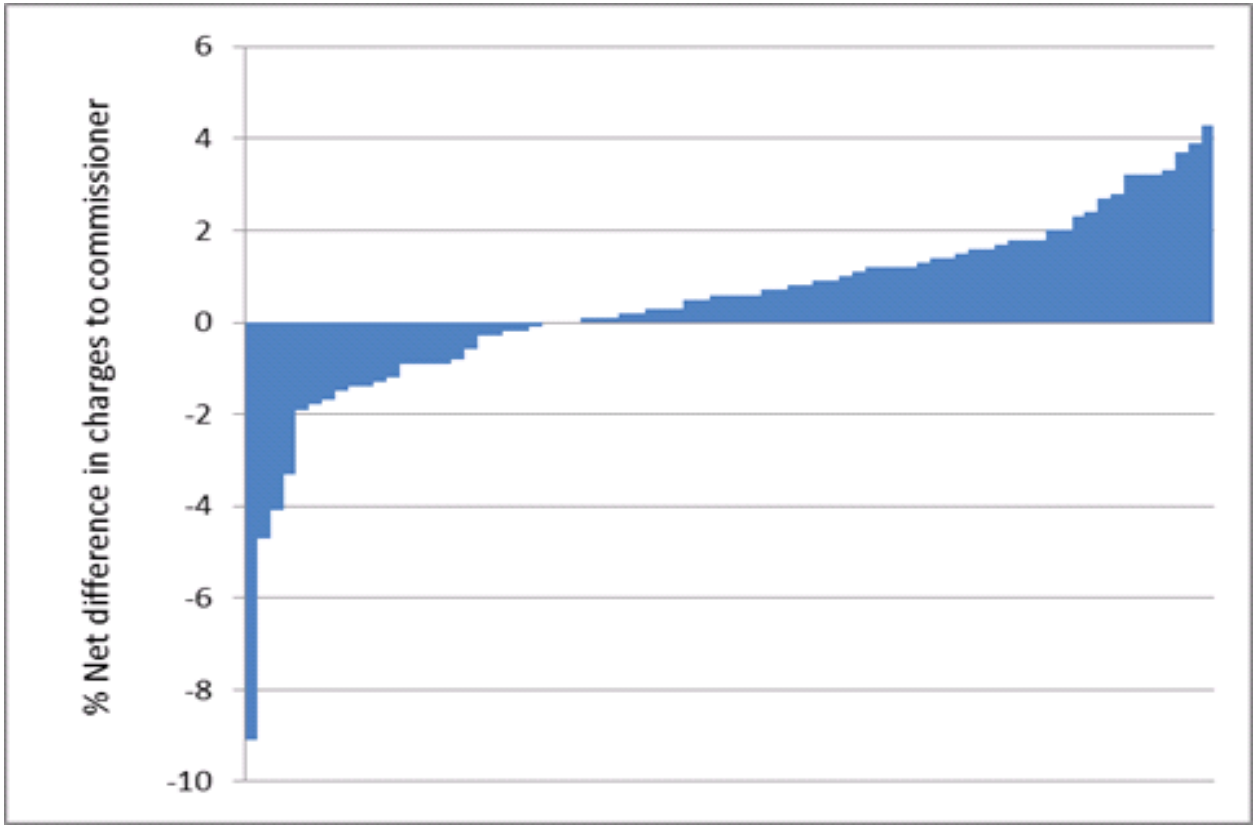
HRG 4+	
FZ67C	Major Small Intestine Procedures, 19 years and over, with CC Score 7+
FZ67D	Major Small Intestine Procedures, 19 years and over, with CC Score 4-6
FZ67E	Major Small Intestine Procedures, 19 years and over, with CC Score 2-3
FZ67F	Major Small Intestine Procedures, 19 years and over, with CC Score 0-1



Why is good quality coding important in payment?



Impact of poor coding on accuracy of payment



But will coding always underpin payment?

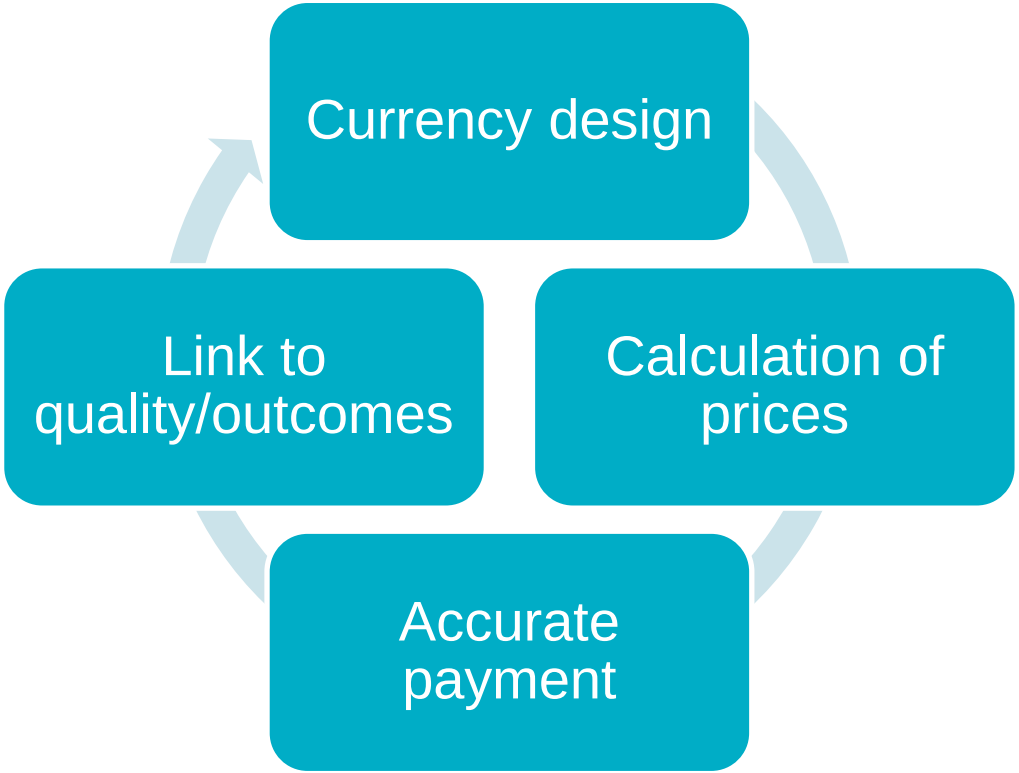
- If we move to more bundled payment approaches, e.g. pathway or population/capitation-based payments then coding may not underpin the direct payment to providers, however…

- Coding will still be important for:
  - provider-to-provider payments
  - how to calculate the single payment
  - calculating the impact of any gain/loss sharing
  - cost data for benchmarking

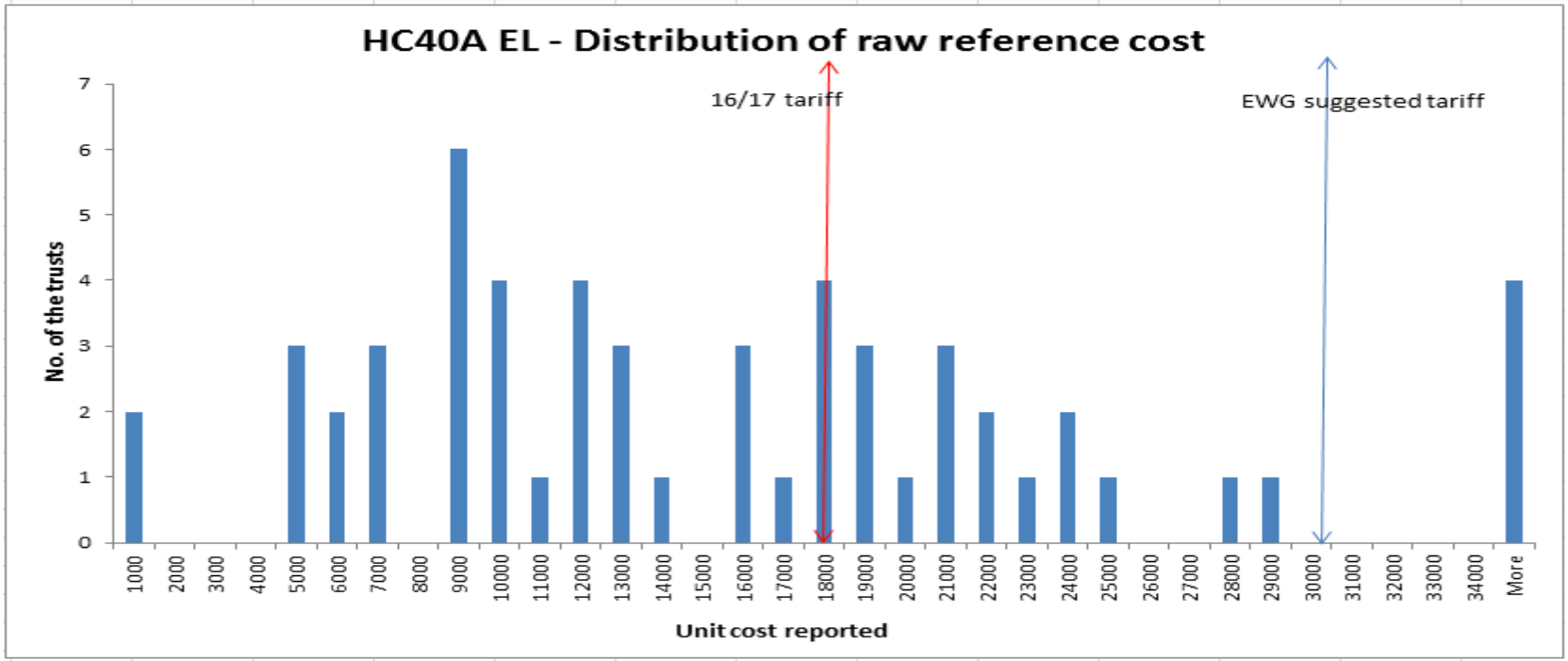
- Improving the coding in non-acute services will be important to support new care models

- Unlikely that we will have full coverage (either geographical or services) of a population-based payment soon so some payment based on clinical coding will still be necessary for the next few years

How poor data hampers development of payment



Example of a typical problem in reference cost quality



Development of new datasets and use for payment

- Mental health:
  - Adult – move away from block contracts to episodic or capitation
  - IAPT – mandated from April 2018
  - CAMHS – testing proposed groupings
  - Secure & forensic – supporting MH new care models
- Community – development of dataset and standard currencies for counting, costing & payment
- Emergency care – new dataset and use of SNOMED data to replace current ED HRGs

Summary

- Introduction of HRG4+ means coding of complications & co-morbidities is more important to ensure correct level of payment
- Implementation of new care models may mean a move to more bundled payments but coding still important to support the underpinning elements of these payments
- Importance of good quality data in non-acute settings will become more important for new care models spanning different settings
- Unlikely that bundled payments will have full coverage soon so coding will still be required to underpin payment for the next few years, particularly in elective & specialised services
- New datasets and currencies are being developed in non-acute settings to be used as the basis for payment – either directly or as part of a wider bundled payment