“Payment by Results” in England: Is it time to re-think activity-based payment?

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http://www.kingsfund.org.uk/publications/payment-results-0
History of “payment by results” (PbR): activity-based payment in England

Innovation increased sharply after 2009/10 with P4P, bundling, expansion beyond acute care, best practice pricing and non-linear pricing

2004/5  550 tariffs for FTs
2005/6  550 elective tariffs cover all acute providers
2006/7  PBR (elective, emergency, A&E & outpatient) covers all acute trusts
2007/8  Transition funding ends
2008/9  PBR extended to ISTCs under NHS choice programme
2009/10 CQUIN increased to 0.5% of provider income
HRG4 implemented 1400HRGs
2010/11 CQUIN increased to 1.5% of provider income
Best Practice tariffs (BPT)
30% marginal tariff for emergency admissions
2011/12 No-payment for emergency readmission with 30 days expansion of BPT
CQUIN increased to 2.5%
2012/13 Innovation increased sharply after 2009/10 with P4P, bundling, expansion beyond acute care, best practice pricing and non-linear pricing

Acknowledgements:
Anita Charlesworth
Nuffield Trust
Small share of Payment by Results (PBR) in Hospital & Community Services Revenue

Acknowledgements: Anita Charlesworth Nuffield Trust
Initial impact of payment by results

- Length of stay fell more rapidly where PbR was implemented
- Day case rates increased more rapidly where PbR was implemented
- Some increase in acute hospital activity associated with PbR
- Little measurable impact on quality of care
- Coding errors reduced from 15% to 7.5%

<table>
<thead>
<tr>
<th>Treatment group</th>
<th>Control group</th>
<th>Year</th>
<th>Length of stay - days</th>
<th>Day case - rate</th>
<th>Growth of hospital admissions - rate</th>
<th>In-hospital mortality - rate</th>
<th>30 day mortality - rate</th>
<th>Hip fracture emergency readmission - rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Trust</td>
<td>NHS Trust</td>
<td>2004/05</td>
<td>0.02</td>
<td>0.04</td>
<td>-0.25</td>
<td>0.01</td>
<td>0.01</td>
<td>-0.68</td>
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<tr>
<td>Foundation Trust</td>
<td>Scotland</td>
<td>2004/05</td>
<td>-0.08</td>
<td>0.04</td>
<td>1.33</td>
<td>-0.058</td>
<td>0.03</td>
<td>0.73</td>
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<td>2005/06</td>
<td>-0.03</td>
<td>0.08</td>
<td>2.57</td>
<td>0</td>
<td>-0.05</td>
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</table>
Concerns about activity-based payment in the NHS in England

- Transactions costs – est. £40-60 million per year
- Gaming - no evidence of systematic up-coding
  - Distortion of within-hospital referrals
- Windfall gains & losses - provider financial instability
- Costing & prices not robust enough to create price signals for specific procedures or services lines
- Perceived barrier to system efficiency & integration
  - 4-5% per year growth in emergency admissions but doubtful that ABP is driving this: 30% price for emergency volume growth since 2009
- Half or more purchasers break ABP rules to mitigate risks
  - Increased use of block or global budget contracts, with risk sharing
  - Non-tariff revenue growing faster than ABP tariff revenue – negotiated offsets to national price tariff reductions, community & mental health care
Main messages in King’s Fund paper

1. Payment systems can’t do everything

2. One size does not fit all
   - Different payment methods are needed for different services and different patient groups

3. Payment systems need to be flexible
   - Service innovation, local provider/clinician engagement & context

4. Trade-offs between objectives are inevitable

5. Data needs to be strengthened & new metrics developed
   - Gap in data & metrics for non-acute care in England
Is activity-based-payment (ABP) suited to future health system challenges?

- ABP is not designed to –
  - shift resources to prevention or reduce demand for acute care
  - shift care from hospital to primary or community care setting
  - incentivize integration or coordination of care across providers
  - Incentivize better service delivery models for patients with long-term conditions and co-morbidities
  - drive major service re-configuration

- ABP places a high burden on purchasers to drive these objectives, in the face of limited purchaser capacity and conflicting provider financial interests

- National regulated ABP price tariff creates windfall surpluses & deficits

- Limit to ability to drive provider efficiency through tariff reductions

- Disconnect between ABP contracting and “clinical commissioning” and local service redesign
Innovations in payment methods in the NHS in England

- Pay-for-performance
- Bundled (package) payments
  - Pathway (extended episode) payments
  - Year-of-care payments
  - Capitation of provider networks with P4P & risk/gain sharing
- Integrated budgets & bonus schemes for integrated provider networks
Pay-for-performance for hospitals

- Advancing Quality initiative – adapted a US quality programme
  - Quality improvement programme supported by financial incentives
  - AMI, CABG, heart failure, pneumonia, hip & knee replacement
  - Risk-adj. absolute mortality fell 1.3 % points (890 deaths, 18 months, 24 hospitals); largest for pneum. Not signif. for AMI or HF.

- CQUIN – nationwide, mandatory for local contract negotiations
  - 2 national quality indicators; 1546 local indicators – 34% outcome
  - 70% of indicators had no baselines
  - of 9 indicators evaluated, only hip fracture associated with better outcomes (comparing Trusts with and without each indicator)

- Best practice tariffs – quality adjustment to selected case tariffs
  - Increased day-case rate for cholecystectomy 6.3%; increased wait time
  - No additional impact in stroke – quality, outcomes already improving
  - Hip fracture: 0.7% mortality reduction, 2.1% increase in rapid return home
## Design of hospital P4P schemes

<table>
<thead>
<tr>
<th>Aspect</th>
<th>AQ</th>
<th>CQUIN</th>
<th>BPT</th>
<th>NPP</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
<td>2011</td>
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<td>Participants</td>
<td>Hospitals</td>
<td>Hospitals</td>
<td>Hospitals</td>
<td>Hospitals</td>
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<tr>
<td>Reward</td>
<td>Budget</td>
<td>Revenue</td>
<td>Revenue</td>
<td>Revenue</td>
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<tr>
<td>Size</td>
<td>4% of tariff</td>
<td>1.5% of total</td>
<td>5-34% tariff</td>
<td>100% tariff</td>
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<tr>
<td>Bonus</td>
<td>Bonuses</td>
<td>Penalties</td>
<td>Mixed</td>
<td>Penalties</td>
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<td>Pay schedule</td>
<td>Lump sum</td>
<td>Target</td>
<td>Per-patient</td>
<td>Per-patient</td>
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<tr>
<td>Measurement</td>
<td>Tournament</td>
<td>Absolute</td>
<td>Absolute</td>
<td>Absolute</td>
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<tr>
<td>Monitoring</td>
<td>Self-report</td>
<td>Local agree</td>
<td>Admin. data</td>
<td>Admin. data</td>
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<tr>
<td>Frequency</td>
<td>Quarterly</td>
<td>Annual</td>
<td>Continuous</td>
<td>Continuous</td>
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<tr>
<td>Support</td>
<td>Extensive</td>
<td>Weak - public</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Bundled (package) payment innovations

- Extended Episode or Pathway payments
  - Maternity care tariff
  - Discharge tariffs for post-discharge rehabilitation for joint replacement
  - New mental health patient classification system and tariff

- Year-of-care payments & capitation combined with P4P
  - Cystic fibrosis year-of-care tariff
  - New mental health patient classification system and tariff
  - Year-of-care pilot for frail elderly with multiple comorbidities
  - Buckinghamshire musculo-skeletal services contract

- Global budget (tender with competitive negotiation) plus P4P
  - Drug & alcohol recovery - 8 pilots – P4P 5%-50%
The NWL Integrated Care Pilot

What are we trying to achieve in NWL?

1) Improve patient outcomes and experience through collaboration and coordination care across providers (4 hospitals, 3 community providers, 93 GP practices, 5 social care organisations) with shared clinical practices and information

2) Over 5 years decrease hospital usage including emergency admissions by 30% and nursing home admissions by 10% for diabetics and frail elderly through better more proactive care

3) Reduce the cost of care for those groups by 24% over 5 years
Aligning financial incentives – Funds flow from the Commissioner directly for guaranteed payments funded recurrently without taking from providers up front.

Funding flows (2011/12)

Commissioner

Infrastructure / IT

MDG Resource

Integrated Management Board allocates funding

Providers paid for activity using existing contracts – PbR for acute and block for MH / Community

70% marginal rate for emergency activity over 08/09 baseline held by SHA

Readmissions top slide held by PCTs

Does the IC pilot deliver improvements?

No

Yes

Commissioner Balance

QIPP saving

x/2

x/2

Acknowledgements: Daniel Elkele, NHS London
Trade-offs in payment system design

- Budgetary control
- Quality
- Clinical engagement
- Provider efficiency
- More complex
- Less complex
- Focused objectives
- Low transactions costs
- System Efficiency