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NHS Dental Contract Reform And Clawback Risk – How Far Away And How Real ?

- Contract reform has revenue implications for dental practices offering NHS dental services, as reimbursement would switch to a mix of capitated and activity-based payments
- Systemic and local barriers challenge the introduction of contract reform at pace in the short-term, although Covid-19 has created a window of opportunity for change
- Investors should closely consider the impact of a changing payment model on target assets to fully understand the opportunity and risks
- Income from NHS dental services has been protected despite reduction in activity due to Covid-19. Feedback suggests NHS is highly unlikely to engage in punitive clawbacks

NHS dental services have attracted significant investor attention in the recent months as a number of assets, both standalone practices and multi-site groups, have come to market. These have offered entry and expansion opportunities to investors and operators.

Increased market activity may reflect a number of factors. Assets planned for sale earlier in the year but delayed due to the initial Covid-19 outbreak are now seeking buyers as the arrival of vaccines prompts more certainity of a way-out of the current operating environment.

The pandemic is likely to have pushed older practice owners who might have been beginning to consider retiring or reducing their hours towards a complete exit from the sector. These primarily single-site practices may continue to become opportunities throughout 2021 as long-practicing dentists decide that they would prefer not to face either the risk of Covid-19 or the pressure of managing the pent-up demand that will come when full activity resumes.

In addition, on-going market rumours of the Chancellor raising capital gains tax in the next financial year have prompted some practice owners to sell and cash out this year. Larger groups have also come on the market for strategic and financial reasons.

Marwood Group has closely followed the UK dental sector for several years – and our expertise in public policy and reimbursement has meant we have been well placed to follow the ongoing conversation over NHS dental contract reform and Covid-19 NHS income protections.

Given the level of sector interest – including increasing numbers of investors looking at the public pay healthcare space as an opportunity given its relative protection during the pandemic – Marwood Group is sharing insights gained from talking to dental sector stakeholders at a local and national level.

In this thought leadership we examine areas of interest for investors – including the implications of a new payment model for NHS dental services and the potential timing of a transition. We also consider the potential for punitive clawbacks as concerns about practices receiving full payment despite performing at significantly reduced activity levels mount.

For more information on how Marwood Group could support your interest in the dental sector, please contact Jyoti Mehan (jmehan@marwoodgroup.com)

Contract reform has revenue implications for dental practices offering NHS dental services, as reimbursement would switch to a mix of capitated and activity-based payments

There is widespread consensus that the current reimbursement system for NHS dental services is unfit for purpose and the need for a change is generally accepted by stakeholders across the sector. The NHS in England has struggled to create a dental payment model that manages to align patient experience, payor oversight, and dental practice satisfaction.

The introduction of a capitated system in the early 1990s for adult patient registration and children up to 16 was the first major change since the 1950s. Meanwhile, individual treatments covered over 400 line items creating confusion for patients, and encouraging a 'drill and fill' treadmill that incentivised more complex, costly work.

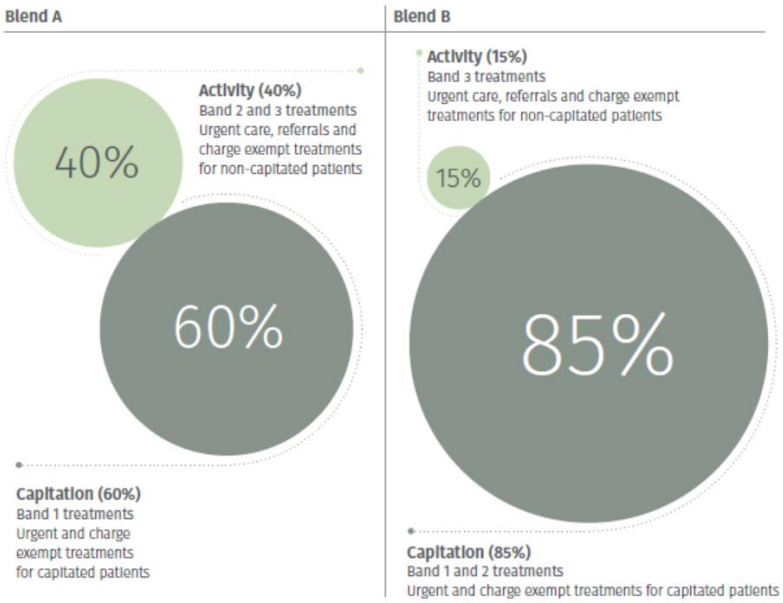
> *"Last time we had capitation in the 90s – we were criticised for supervised neglect. [We were] paid for not doing the work." (Clinical advisor to NHS England)*

The introduction of the 2006 contract was an aim to simplify the payment system. However, the new contract has generally failed to satisfy dentists and did not significantly push forward the aims of a more preventative approach to oral health.

Since the 2009 Steele Review, NHS England has been experimenting with blended payment models that would incentivise dentists to engage in preventive care through a capitated payment for a defined population, whilst retaining an element of activity based payments for higher acuity needs.

This activity-based element would also reassure payors that dentists were undertaking necessary work and not creating a situation where lack of activity leads to a large, uncosted backlog of demand to be met in future years.

NHS England has been trialling two blends – called Blend A and Blend B, with varying proportions of capitation and activity based payments. Fig. 1 depicts the key features of the two models.



Band 1	Examination, diagnosis and advice
Band 2	All Band 1 treatment, plus fillings, root canal treatment and removing teeth (extractions).
Band 3	Covers all Band 1 and 2 treatment, plus more complex procedures, such as crowns, dentures and bridges

Fig. 1: Blended payment models being trialled by NHS England

Source: NHS England, Marwood Group

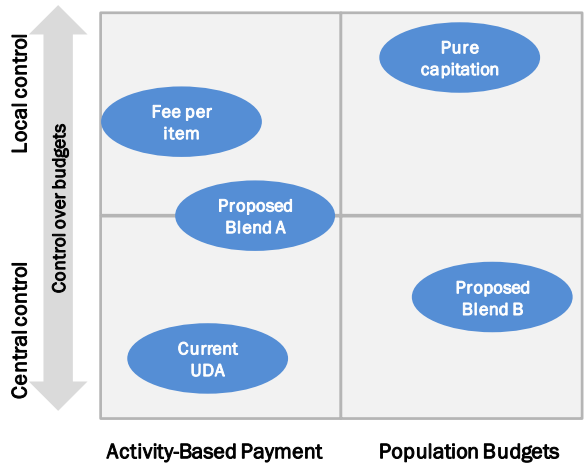
Dentistry is different to other elements of the NHS because there is already an established private-pay sector, and many dentists have either fully opted-out of the public-pay model or have the flexibility to offer a part-NHS, part-private pay practice. This means that the level of control exerted by public payors is lessened and so the proposed payment model must offer up adequate incentives to all the varying stakeholder interests invested in its creation, rather than being a centrally imposed condition.

> *"If it was Fee-Per-Item we would be criticised for unnecessary work. There needs to be a balance. If a capitation system was well supervised it would work and avoid the challenge of supervised neglect." (Clinical advisor to NHS England)*

Since different payment models offer up benefits relative to their structure, investors must consider the implications of these models for assets they are diligencing.

Fig. 2 presents a useful framework for understanding dental reimbursement dynamics. Payment can be delivered either on a strict population budget basis – a payment per registered patient – or by the activity undertaken – fee-per-item. However, options may take a mixed approach – where the balance sits between them.

A key factor is the level of control that payors have. The current Unit of Dental Activity (UDA) system has a high level of centralised control, whereas other models place more power directly into the hands of dentists. The framework can help understand what kind of activity can generate the maximum benefit for an asset being considered under each of the payment systems.



- Capitation approaches are based on allocating a set budget for a given population and managing demand within the allocated budget – no incentive to dentists to deliver care
- Fee per item approaches incentivise dentists to overperform for financial benefit
- Fee per item approaches distribute budgetary control locally as local NHS bodies ratify activity and payments and monitor for gaming and fraud
- In different models NHS uses different levers to control expenditure e.g. in the UDA model central control is exerted through mechanisms to penalize under/overperformance

Fig. 2: Different modes of payment for dental services

Source: Marwood Group Analysis

When considering an investment in the dental sector – whether it is a single practice or a corporate provider with dozens of locations – it is vital to work through the implications of change in the payment model. Marwood can help investors understand the impact of adoption of these payment models on their target portfolio of practices.

Systemic and local barriers challenge the introduction of contract reform at pace in the short-term, although Covid-19 has created a window of opportunity for change

There are systemic and local factors that create a difficult environment for a nation-wide reform to be implemented. However, these factors are not new – and are issues that policy-makers have been grappling with since discussions over a new payment model got underway. The big change event has been Covid-19. The sudden requirement to introduce sweeping payment reforms – to ensure that NHS dental income was protected from a complete drop-off in activity – can be seen to be giving

momentum to those that see the pandemic as an opportunity to drive transformational reforms. This is seen as a potential driver for change.

From speaking to key local dental leaders, Marwood believes that there is still considerable division as to the likelihood of reforms, and the pace of change. Some anticipate the possibility of a big national adoption as early as April 2021 and others, perhaps more pragmatically, anticipating a gradual region by region roll out to complete in 2023.

> *"Contract change has really focused the mind of NHS England. In April 2021, UDA [could] go out the window. BDA is lobbying hard to get it out – they see it as an opportunity. National roll-out needs to make it go as a big bang." (Chair of Local Dental Network, Midlands)*

> *"The reform is Eric Rooney's baby. Leadership change could slow things down. I think it will be gradual, not a big bang though, perhaps expanding by regions till 2023. It won't be a sudden nightmare like last time." (Chair of Local Dental Network, North England)*

Whilst it is difficult to see an implementation pathway that is possible for an April 2021 roll-out – or certainly not one that wouldn't encourage many dental practices to consider their commitment to NHS dentistry – the fact that it appears to be on the table demonstrates the seriousness with which reform is being considered. It certainly puts in place the possibility that roll-out could be conceivable by April 2022.

However, significant barriers remain and whilst the NHS – and potentially the current Government – may be ambivalent to the role of the dental sector within NHS-delivered non-urgent treatments – it is likely to require some political will to push through the payment reforms at a rapid pace.

Key barriers to a rapid introduction and expansion of a new payment model centre around the patient charge element, lack of agreement on the best payment model for the future between commissioners and providers and a significant lack of knowledge and awareness amongst dentists on the ground about how proposed changes might impact their practice and patient health.

A lack of clarity of how a payment model will impact on patient charge revenue generation

Currently, all patients (unless exempt due to age or socio-economic status) accessing care at a NHS practice are expected to pay a part of their treatment cost, called the patient charge. The NHS then recovers the patient charge from practices through a contractual reconciliation. The amount depends on the complexity of treatment delivered. The mechanism for reconciling this element of financing with the new proposed models has not yet been agreed between stakeholders.

The NHS has responded to budgetary pressures by progressively increasing the patient charge as a proportion of the total cost of treatment over the years. It now consists of nearly 30% of the total spending on NHS dentistry. Given the likely budgetary pressures across the healthcare system as a result of Covid, it is unlikely that health payors are keen to find themselves required to meet the shortfall that may arise from a reduction in patient treatment (and therefore patient charge) as a result of a new payment model.

Implementation of any new model will require a resolution to the question of how to address the patient charge element for capitated patients.

A consensus on the optimal payment model for all stakeholders still needs to be reached

The dentists' trade association, the British Dental Association (BDA), is lobbying hard for dental practices to be given a choice of which blended model, of the two being trialled, they accept for their practice. However, whilst a powerful voice in the ecosystem, there is significant push back from public payors – and, it is believed, the Treasury remain concerned over the lack of mechanisms to hold dentists to account for the public revenue they would be receiving.

The BDA's position are broadly in favour of the more highly capitated Blend B, which guarantees a larger proportion of the practice's income through capitation. However, NHS commissioners may push for Blend A, given some dentists have historically done the minimum needed for full payment when capitated payment models were in place. This view may have been reinforced during the Covid-19 crisis when some practices have been seen to be restricting face to face patient access and doing the absolute minimum required to be demonstrated by commissioners while claiming full contractual payment.

Resolution of this misalignment of incentives will also take time, making an April 2021 national roll out unlikely. Theoretically, NHS could impose a top-down contract reform upon practices but this is highly unlikely as this could cause serious service disruption and the Government will be wary of not being on the receiving end of a backlash similar to the Junior Doctors Contract disputes.

NHS will need to undertake extensive efforts to educate dentists before any change is implemented

A 2019 Marwood survey of dentists from across the country revealed that understanding of these models and their potential impact on practice and patient health was not well understood by professionals on the ground. Over 40% responded they were not sure of the impact of the proposed payment model change on their patients and practice.

Amongst the dentists that said they understood the impact of reform, about half thought the changes will be good for the practice and patients and half thought they will be bad. In order to effectively implement any meaningful reform, NHS will have to engage and educate the frontline dentist work force nationally which will also require time, making a short term implementation unlikely.

Investors should consider model revenue projections at target practices across various reform scenarios to get a fuller understanding of the potential impact on income.

Marwood Group can provide support and assistance in planning detailed scenario analysis across multi-site practices that may be operating significantly different patient-mix and UDA variance.

The Unit of Dental Activity (UDA) system and its issues

Currently, each NHS practice is paid to deliver a set quantum of Units of Dental Activity (UDAs). Dental treatments are grouped into three bands that define how many UDAs are allocated to each treatment, depending upon its urgency and complexity as shown in Table 1.

The UDA system has been criticised for imposing challenging targets on practices and being unequitable for practices. The rate of payment for a UDA varies widely between practices and regions, which means that dental practices get paid different amounts for the same treatment.

Treatment Band	UDAs	Treatments
Band 1	1	Exam, diagnosis (incl. X-rays), preventive care, scale/polish
Band 2	3	Fillings, root canals, extractions
Band 3	12	Crowns, dentures, bridges
Band 4	1.2	Emergency treatment

Table 1: NHS dental treatment bands and associated UDAs

Fig. 3 demonstrates the variation in average UDA rates across various regions of England – with nearly a 33% price differential between highest and lowest areas. Some variance can be attributed to higher operational costs in the south and west, but that does not account for all variations – and even withn regions, dental practices will have varying UDA levels.

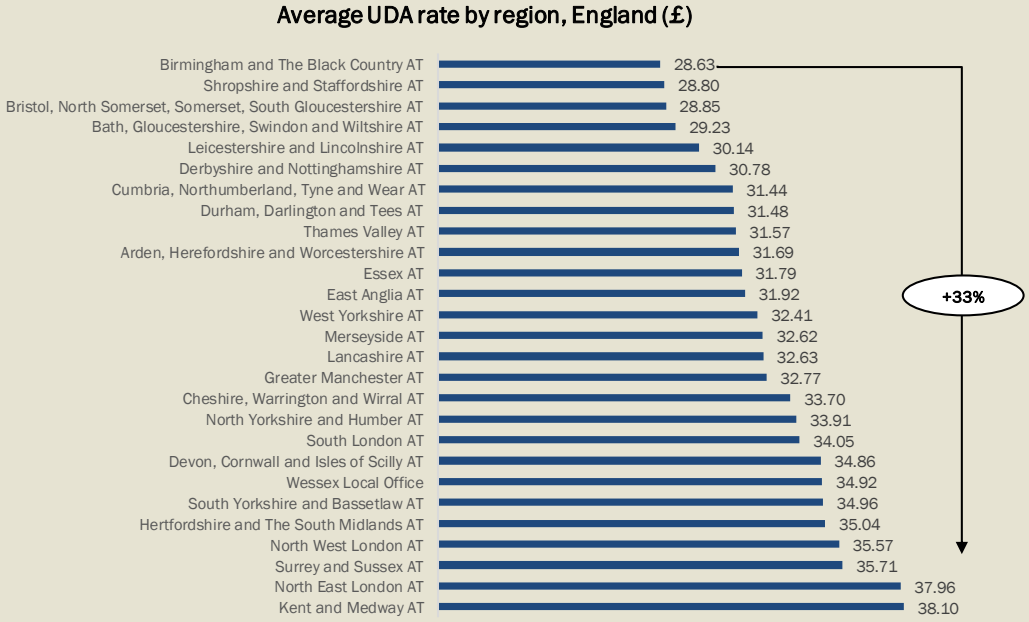


Fig.3: Average UDA rate (£) by region in England, 2019. AT stands for Area Team, the local NHS team

Source: NHS BSA data, Marwood analysis

Whilst the UDA system is expected to be replaced in the longer run, it is likely to remain the predominant model in use in the near-to-medium term horizon while the NHS addresses the barriers to introduction of a new payment system.

Marwood can help investors understand the opportunity and risk picture over the investment timeline factoring in payment model change timing and impact on asset portfolios.

Income from NHS dental services has been protected despite reduction in activity due to Covid-19. Feedback suggests NHS is highly unlikely to engage in punitive clawbacks

The onset of the Covid-19 crisis saw dental activity cease, followed by an uncertain restart with new Standard Operating Procedures (SOPs) required for infection control. Whilst private practice incomes dried up completely, NHS and mixed practices were relatively protected as the NHS continued to pay out contracted monthly instalments to practices subject to demonstration of 20% of expected activity.

The activity could be any patient contact, whether done in-person or through telephone or other remote consultation methods. The general perception amongst stakeholders is that the NHS has, so far, been quite generous towards practices.

There has been increasing awareness that some dental practices have been comfortable only operating to the bare minimum to trigger full payment, even when there has been operational capacity to undertake a high throughput. Dental practices have reported receiving patients from other local dentists due to continued restricted access to face to face appointments.

> *"Only some practices are doing the maximum they could, most are taking the opportunity and doing the minimum of 20%." (Former Chair of Local Dental Network, North England)*

As concern from commissioners increases and patient complaints about access to dental services mount, fears have been triggered that payors may seek to engage in punitive action against practices that have restricted access artificially whilst claiming full payment.

However, it is felt that in reality there will be limited ability to engage in clawbacks. The general feeling is that although dental practices may not be acting within the spirit of the guidance, they are operating within the agreed terms. This may make any attempt to take action against practices highly challenging and potentially not worth the resources to pursue it.

> *"Personally, I would support claw backs. But not sure how this would happen – it was not made a clear legal process, and this could then make it very challenging. I feel there is little risk of repercussion for dentists." (Clinical advisor to NHS England)*

Feedback suggests that the requirements to receive full payment may be increased in the coming months. Increased scrutiny over practice performance is certainly likely from commissioners. Significant increase in activity will require installation of ventilation systems which, some stakeholders feel, may not be capital funded by NHS England. Practices may be expected to fund this investment as NHS has been paying them full contract value for delivering much lower activity levels at significantly lower operating costs for several months.

> *"I think the 20% could be increased to 30%-40%. If we need to go further, it is going to require us to put ventilation systems in place. I do not see NHS England capital funding this." (Chair of Local Dental Network, Midlands)*

Investors and operators can reassure themselves that, in the view of key leaders in the profession, there is little risk that they might face a sudden clawback bill in the coming months.

Practices can actually benefit from converting some of the accumulated demand as a result of low activity in year to private pay, especially if there is a risk of their patients seeking private pay treatment elsewhere if they are unable to provide it.

Dentistry remains an attractive segment for investors and operators

In conclusion, we believe that despite the proposed changes to the sector and its recent Covid-19 induced hardship, the dental sector is likely to remain profitable and attractive to investors and operators.

Understanding the impact of the proposed payment models on portfolio practices can help existing investors and operators redirect practice activity to more profitable avenues. Investors looking to enter the market will benefit from understanding the implications of a mid-investment horizon transition on practice portfolios they acquire.

It also appears that the risk of financial punitive action from commissioners, while present, is low. This should provide investor reassurance, even if it doesn't entirely mitigate the requirement to diligence each dental practice location on its own merits.

So, as the demand in dentistry remains strong, and the risk to practice income as perceived by stakeholders is small despite proposals for contract reform, we believe that NHS dentistry will continue to generate financial value for investors and operators alike.

Contact Us

For more information on any of the content in this publication or to learn more about Marwood Group Advisory's capabilities, we encourage you to please contact us.

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