Maternity Pathway Bundled Payment

Country Background Note: United Kingdom (England)

John Henderson, Department of Health
May 2016

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This country background note was completed based on a template circulated to countries and experts involved in the OECD Project on Payment Systems. This completed template was used to inform the OECD Project on Payment Systems and was last updated in May 2016. It does not include policy changes that occurred since then. Author is responsible for any error.

This country background note informs the publication *Better Ways to Pay for Health Care* available at: http://www.oecd.org/health/better-ways-to-pay-for-health-care-9789264258211-en.htm.

OECD Template for Case Studies of Innovative payment Systems: Maternity Pathway Systems.

A: Short description of the new payment scheme.

Under the new system, a commissioner will pay a single lead provider for all the pregnancy related care a woman may need. There are three payments in total,

- one for antenatal care,
- one for the birth, and
- one for postnatal care.
  (See also Annex).

Lead providers retain full responsibility for how they deliver care even where a woman chooses to use a different provider for an element of their care and commissioners will judge providers solely on the outcome of that care. The aim is to encourage efficient, outcome focused care. Where a second provider gives some elements of care, they are paid by the lead provider who has received the pathway payment.

B: Context and problem the reform aims to address.

1. **What problems did the reform aim to address?**
   The Maternity pathway payment approach was introduced to address two main issues arising from the previous episodic payment system. Firstly, there were problems with the way different organisations described and recorded antenatal and postnatal non delivery activity which persisted despite changes implemented every year to attempt to resolve the problems. Secondly, under the old system, organisations were paid for each inpatient spell, scan or hospital visit, so the more clinical interventions, the more a hospital received. This may have been counter to some patients' interests who benefit most from proactive care, closer to home.

   The new approach aimed to resolve these issues and to encourage a more proactive and woman-focused approach to the delivery of maternity care – in conjunction with patient choice and local contracts that focus on quality – focusing on patients' best interests.

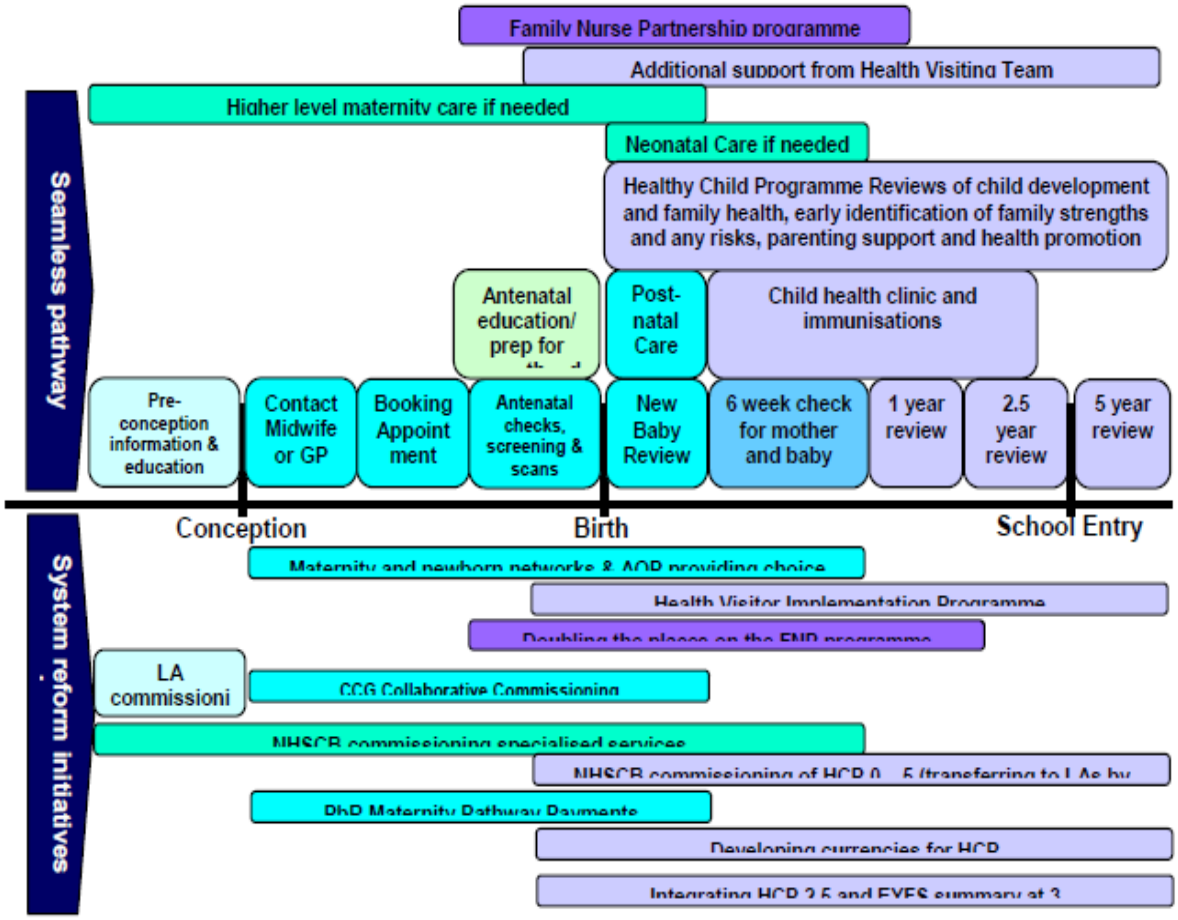
2. **How was this problem identified and assessed? (Quantitative data, opinions, etc.)**
   Issues with coding and inconsistency of recording had been raised by providers and commissioners for a number of years. The Hospital Finance Managers Association commissioned a report which demonstrated considerable variation in the levels of activity, and some women having more than the recommended levels of interventions.

The Payment by Results (PbR) team in the Department of Health began work on the new system in 2010. Variations in funding levels were further highlighted in the 2012 NAO report.

3. **Who initiated the reform? What was the catalyst to make the payment reform possible? (e.g. political support?)**
   The Payment by Results team in the Department of Health developed the approach to allocating women to different pathway levels on the basis of their characteristics. Midwives across the country tested the system for two months, looking at characteristics and factors affecting nearly 7,000 pregnant women.
   In addition several NHS providers undertook detailed costing work to ensure that the groupings created on the basis of service user characteristics really did bring together women that would consumer similar levels of resources.

4. **Was payment reform the only way envisaged to address the problem?**
   Many other policies and system reform initiatives aim to complement the PbR payment system.

Figure 1. Maternity of services in England



http://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf

5. **Was the reform part of a larger set of policy reforms?**
   (See Figure 1.) As well as resolving the previous issues, the new system aims to encourage a more proactive and woman focused approach to the delivery of maternity care.

C: <u>Understanding payment reform</u>.

1. **Which type(s) if provider does the new payment scheme target?**
   Public hospitals and midwifery teams, and birth centres.

2. **Does the payment scheme target a specific patient group?**
   Pregnant women- before, during and after birth.

3. **Does the new payment scheme replace part or all of an existing payment method or is it an additional payment?**
   The new payment system brings together types of care that were previously funded in different ways. Inpatient care was funded via episodic tariffs. Community antenatal and postnatal care were, and some other elements were funded through block contracts.

4. **How was the level of remuneration set? I.e. methods to determine the level of the remuneration and process to implement it (negotiation, unilateral decision).**
   The objective of the new system was not to increase total funding for maternity services, rather to allocate it more effectively. The total level of funding was therefore set on the basis of the total reported costs of current maternity care for the three stages, antenatal, delivery and postnatal care. Using these total costs, individual prices per woman were calculated such that it was possible to pay more for women who may have a clinical need for greater care.

5. **Were outcome measures or indicators used?**
   No. The payment is made based on intention to treat.

6. **If the payment scheme target institutions or groups of providers, how is the remuneration shared between providers?**
   For payment purposes, the pathway is split into three stages. Women choose their lead provider for each stage of the pathway. Commissioners pay once for each of these stages per woman. This could mean three separate payments to the same lead provider or three payments to different lead providers. Where a woman chooses or is referred to another provider for an element of their care, the second provider invoices the first provider as they have received the payment. Published business rules provide transparent instructions on what to do if a woman moves home and therefore commissioner during their pregnancy.

7. **Where relevant: do all purchasers use this payment scheme or is it limited to specific payers?**
   All purchasers that go through the NHS.

8. **Is there a payment ceiling? What are the conditions?**
   Yes, three set payments per woman + supplementary payments for specific complications.

9. **Was evaluation embedded as part of the policy reform?**
   No

10. **Was the policy scaled up if it was initially a pilot?**
    N/A

11. **Do certain aspects get revised/ updated? If so how frequently does it happen?**
    After the initial implementation, the list of special cases for additional funding was updated. However, there is no set timescale for revisions. Updates/revisions will be made if and when needed.

D: Implementation of the payment reform.

1. **Who initiated/proposed the reform?**
   The PbR team in the Department of Health

2. **Which stakeholders were involved in the implementation strategy?**
   Government. NHS England, Monitor

3. **Was the participation voluntary?**
   no

4. **What was the timeline of the payment reform? (Abrupt change, or slowly fazed in?)**
   Was mandated in April 2013 following a shadow year.

E: Assessing payment reform.

1. **What was the impact of the reform evaluated? What did the evaluation analyse? What time of evaluation was carried out? What information/data were used? Who carried out the evaluation (e.g. commissioned, government, academic)**

In a consultation notice for 2015/16 National tariff payment system[1] -the maternity pathway was used as an example of a rushed policy as engagement did not happen early enough. When

[1] *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379076/NTPS_ConsultationNotice_26Nov.pdf*

asked- Do you agree with the proposal to add six factors to the maternity pathway currency to improve allocations? There were 110 responses, 79% in support.
- Both commissioners and providers sought clearer definitions and better guidance.
- Providers comments focused on the level of the tariff that they say underfunds the cost of service and on cross provider charging (admin burden).
Problems with the new scheme include mechanics of provider to provider charges. Complexity of information doesn't allow the flow of confidential data, which makes it difficult for finance departments to find out who the lead provider is for invoicing purposes. For most healthcare treatments under the national tariff payment system, providers invoice a commissioner directly for the activity they undertake. However, for the maternity pathway a provider may need to identify the lead provider in order to invoice a particular patient. There was a delay in the operation of the maternity dataset. The data will contain most of the data items needed to determine the pathway a woman is on. Providers will not however, be able to directly determine the lead provider for any woman from this dataset in the first instance. Therefore, until the dataset becomes available, providers and commissioners were advised to develop local arrangements to help identify the lead provider and resolve the billing and invoicing issues.
Problems of double booking- some women, particularly in urban areas, go to more than one provider for an assessment visit. This may be because they do not find the first provider they attend convenient or for other reasons of personal preference. If this is not clearly communicated, both the first and other providers may think that they are the lead provider and invoice the commissioner for the same woman. Commissioners receive aggregated data, and are unable to identify which patients they are being invoiced for, leaving them at risk of paying twice for the same care.
Providers responded positively to the payment reform. Requested clearer conditions for special circumstances, therefore Monitor released further definitions in order to clarify.

a. **Unintended consequences: Did providers adopt behaviours to optimise payment received besides expected behaviour changes? (e.g. neglecting other activities, selecting patients, upcoding?) Did the new payment scheme generate positive spill over effects? Were there other unintended consequences? (e.g. patient behaviours, changes in providers market, etc.?)**

   Unintended consequences - Payment for birth is the same for caesarean and natural birth (e.g. paid for need not delivery method) which could affect the incentives for caesareans.

Annex

2015-16 tariff - maternity pathway

1 Delivery phase

Code	Name	Outpatient procedure tariff (£)	Combined day case / ordinary elective / non-elective spell tariff (£)	Long stay trimpoint (days)	Per day long stay payment (for days exceeding trimpoint) (£)
n/a	With complications and co-morbidities	-	2,373	7	358
n/a	Without complications and co-morbidities	-	1,613	5	358

2 Non-delivery phases

2a Antenatal phase

Code	Name	Tariff (£)
n/a	Standard	1,043
n/a	Intermediate	1,669
n/a	Intensive	2,777

2b Postnatal phase

Code	Name	Tariff (£)
n/a	Standard	246
n/a	Intermediate	311
n/a	Intensive	836

Antenatal assignment of women to care group

	INTERMEDIATE	INTENSIVE
Current factors	Complex Social Factors Obesity - BMI >= 35 Physical disabilities Underweight - BMI < 18 Substance / alcohol misuse	Twins or more
Medical Factors	Mental health Hepatitis B or C Genetic/Inherited disorder Epilepsy requiring anti-convulsants Hypertension Previous uterine surgery (exc. C-section)	Cardiovascular disease HIV Malignant disease Diabetes/other endocrine Rhesus isoimmunisation/ other significant blood group antibodies Renal disease Severe (brittle) asthma Autoimmune disease Venous thromboembolic disease Sickle cell disease / thalassaemia Thrombophilia / clotting disorder
Previous Obstetric History	Pre-eclampsia, eclampsia, HELLP Puerperal psychosis Term baby <2½kg or > 4½kg Intrauterine growth restriction Placenta accreta Fetal loss (2nd/3rd trimester) Neonatal death/stillbirth 3 or more consecutive miscarriages Early pre-term birth (<34 wks) Fetal congenital anomaly	Previous fetal congenital anomaly that required specialist fetal medicine

- **Any Intensive factors? → INTENSIVE (7.1%)**
  If not, any Intermediate factors? → INTERMEDIATE (27.3%)
  Else, no factors → STANDARD (65.5%)

Postnatal assignment of women to care group

	INTERMEDIATE	INTENSIVE
Current factors	Complex Social Factors ■ ■ Substance / alcohol misuse Obesity - BMI >= 35 ■ Woman in Prison ■	
Medical Factors	Mental health ■ ■ Cardiovascular disease Diabetes/other endocrine ■ Genetic/Inherited disorder ■ Rhesus isoimmunisation/ other significant blood group antibodies ■	Renal disease ■ HIV ■
During this pregnancy	Pre-eclampsia, eclampsia, HELLP ■ ■ Hypertension Twins or more ■ ■ Neonatal death/stillbirth Diabetes ■ DVT / Pulmonary embolism ■	

- **Any Intensive factors? → INTENSIVE (0.8%)**
  If not, any Intermediate factors? → INTERMEDIATE (35.0%)
  Else, no factors → STANDARD (64.2%)