HFMA briefing
July 2017

Maternity payment approach

Survey report July 2017

Introduction

This survey was initiated by NHS England's pricing team with the support of the HFMA's National Payment Systems Special Interest Group (NPS SIG) to identify key issues to be addressed in relation to the maternity pathway payment ready for the 2019/20 national tariff.

The Better Births report[1] makes a number of recommendations with regards to payment, in particular the need to ensure that the payment system does not act as a barrier to delivering future models of care. These models are being developed and tested now. The pricing teams in NHS England and NHS Improvement are working with all pilot sites to identify payment related issues that may require changes to the current approach to reimbursement.

As part of this exercise, NHS England is keen to look at the existing pathway payment approach and how it operates in practice, to determine whether there are further improvements that can continue to be made in the short-term.

Overview

Only 12 NHS provider organisations and 1 clinical commissioning group (CCG) completed the survey that covered:

[1] *Improving outcomes for maternity services – A five year forward view for maternity care*, National Maternity Review, 2016

- the day-to day issues encountered when operating the current approach – for example, provider to provider charges
- the development of local solutions
- operational issues created by the current payment approach.

Whilst a sample of this size is too small to draw many conclusions, the report will still be useful to NHS England, in particular respondents' additional comments.

The survey revealed the following key points:

- all respondents experience day-to-day issues with provider to provider payments/ recharges
- 38% of respondents operate a local work around. For one respondent, this is the implementation of a block contract
- 83% of respondents stated that the current arrangements exacerbate operational issues
- clinical time is spent on administrative queries particularly in relation to data challenges to provdiers.

Results

Day-to-day issues

On a day-to-day basis, finance teams regularly encounter difficulties with the following issues (respondents were asked to select all issues that applied):

Issue	%
Problems with supporting information and data flows from NHS Digital	38
Provider to provider payments	100
Disputes with commissioners	77
Clarity about what is included and excluded in each element of the pathway	38
Other	15

The other issues encountered include:

- patients that come to triage and have not registered with a provider or have not declared who the lead provider is
- the facility to move patients, once booked, between pathways.

Specific issues identified included:

- agreeing a reasonable, but practical, level of detail to support provider to provider recharges
- disputes with non-NHS providers of community antenatal care – for example, a provider failing to recognise nationally published tariffs and seeking prior approval before accepting any liability for charges
- provider to provider charges are not capped and can be more than the pathway payment received by the lead provider
- disputes generating unresolved and aged debt. This situation is exacerbated when private providers deliver part of the patient pathway.

Comments included:

'We are just constantly in dispute with providers and have very aged debts on both sides.'

'As a host CCG, we are asked to help resolve/ mediate provider to provider issues. The main issue and cause of dispute is that the pathway payment tariff (for provider to provider recharges) is not viable when charged at the full tariff premium.'

'When dealing with non-NHS 'private' providers of antenatal care, applying 'provider-provider' arrangements are difficult. The Trust has encountered significant problems in recovering outstanding debt, with the 'private' provider disputing/ challenging the application of tariff, querying why patients are treated, and the care provided (as well as) requesting permission is sought prior to treating patients.'

Local work arounds

The survey asked respondents if local work arounds had been used to solve issues with the current payment approach – this has included moving to a block contract approach for one respondent. Results were as follows:

Issue	%
Yes	38
No	62

Comments included:

'NHS Improvement tried to develop a 'work around' which suggested the host CCG act as 'broker' with both the 'private' provider and the Trust invoicing the CCG directly. However, after much debate the CCG did not support the agreement. So, the Trust is continuing to provide care to the patients booked with the 'private' provider, and is struggling to recover the outstanding debt.'

Greater Manchester NHS bodies have developed the following approach:

'…we agreed that the birth provider would claim the tariff which made it more practical to agree a standard level of reimbursement where the community provider was different (as the service model, and therefore associated value/ cost could be considered more stable/ predictable). Where we need to evolve this is in standard 'on account' arrangements with reconciliation later (within reasonable tolerances), to avoid unnecessary bureaucracy where the transactions are reasonably material).

Similarly, we have been able to agree some standard principles/ conditions within which CCG queries can/ should be placed with us that could be shared.'

'Agreed a block for the activity as the patient flow from the midwife-led unit to our consultant-led unit was large enough to do so.'

Ante-natal pathway allocation

67% of respondents agree that 12-14 weeks is too early to decide the antenatal pathway. This conclusion is based on:

- not all of the clinical information is available at this stage
- late miscarriage can still happen
- patients develop complications later on in the pregnancy.

83% of respondents stated that the current arrangements exacerbate the operational issues identified earlier.

Comments included:

'Uncertainty within the service has taken a lot of effort to overcome - midwives unsure of how to log patients onto the system depending on who they are delivering with, who they had their scans with, etc. Lot of crossover with our trust.'

'We believe these inter-provider issues can hinder good relationships and practice among all providers however we have countered this by developing strong clinical pathways between our providers.'

'Midwives are spending time researching notes etc when other providers invoice for ladies we have not booked and they are getting stressed when other providers are charging us for activity that we would not charge other providers for (i.e. miscarriages, multiple outpatients on the same day - for what they call a booking appointment where lots is done in one attendance) ... checking provider to provider invoices is a massive administrative burden.'

'Midwives required to enter data on the provider to provider, numbers of weeks at transfer, require data quality and involvement in data challenges.'

'Once the block was agreed there is no incentive for the other provider to enhance out of hours cover.'

NHS England then asked for views on an alternative: would it be better to make a payment based on the standard pathway for every woman as soon as she has her booking appointment, with any further payment related to risk factors made at a later point in the pregnancy?

Results were as follows:

Issue	%
Yes	38
No	15
Maybe	47

Although cautious, this was generally welcomed. Comments included:

'Splitting the antenatal pathway payment into two - one for the community element and one for the hospital element will eradicate provider to provider invoices and make a large impact on midwives, admin staff and finance staff in trusts located near other maternity providers where ladies exercise choice.'

'It depends on the approach, and on the rationale for this. If it is to provide a 'base' level of income common to all with a risk adjustment paid as a premium later that would not necessarily equate to real-time deployment of resources. If it means income could go down (as well as up) for each patient, then it may result in less predictable income flows and also further reconciliation issues with each individual CCG. How would inter-provider transfers part way through then be handled?

If it results in the same or broadly similar level of overall income for providers as the current system it has not necessarily added any value to outweigh the additional transactional consequences and costs.'

'This could be difficult to implement and add additional burden to the billing process.'

The birth episode

At the moment, there are two levels of payment for the birth episode. NHS England is looking at how this might change to more closely reflect the costs incurred by providers. Comments included the following:

- it would be helpful to reflect the variation in costs associated with different social economic backgrounds
- introducing more levels will ensure that tariff more accurately reflects the levels of resource required in the actual delivery - for example, the additional costs of a theatre delivery
- the introduction of HRG4+ and patient level costing would support a more granular approach.

Other issues

Finally, the survey asked respondents to identify any further issues of which NHS England should be aware. These include:

- duplication of charges to commissioners
- it is difficult to achieve local agreements between providers
- charging of non-mandatory tariff for inter provider activity. One respondent suggested reviewing the non-mandatory tariffs against similar or the same procedures - for example ultrasound procedures: NZ21C has a cost of £286 versus RA43Z with a cost of £54; why does a maternity ultrasound cost 5+ times more than a standard direct access and outpatient diagnostic imaging services tariff?