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# Community Midwifery Payment Model

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# Report and Recommendations of the Community Midwifery Funding Co-design Project

**November 2017**

**Executive Summary**

This report sets out the process taken and the findings of the Community Midwifery Funding Co-design Project carried out by the Ministry of Health and New Zealand College of Midwives co-design team with regard to a future payment model for community midwifery services.

The co-design team, with facilitation from Think Place, established that to design a funding model that upheld the community midwifery service principles required separate consideration of funding mechanisms and payment structures. This report presents the process and findings of the work to co-design a future payment structure, including high level consideration of implementation.

Our key findings are:

* The current capped fee for service payment model is not fair for midwives or women and drives perverse incentives that reduce the accessibility and quality of care that midwives are able to provide to women, babies and families
* There are many different payment models used across the New Zealand public health sector and across community midwifery services internationally. All have strengths and limitations.
* A payment model that approximates the actual costs of service provision is the most equitable to midwives and to women across a range of situations, but is also the most complex to conceptualise and model
* Payment models are primarily a mechanism for purchasing services but all payment models have the ability to drive desired behaviour and create perverse incentives and thus require support structures around them and regular audit and review
* Regardless of the payment model, remuneration must be set at fair and reasonable levels for work done.

Our recommendations are:

* Midwives are paid operating costs evenly throughout the year to provide income security as caseloads, and currently income, fluctuates significantly month to month
* Midwives are explicitly compensated to recognise the unique on call requirements of community midwifery care
* Financial incentives are introduced that support recruitment, retention and workforce distribution as these are the most urgent issues facing the sustainability of this service
* Aspects of the current capped fee for service model are retained, but are reviewed so that they drive best practice and compensate the realities of the work midwives do
* Midwives are funded to provide additional time and travel to women as they need it, based on professional judgement, rather than funding additional services using a obstetric/medical/social risk factor approach or a primary/secondary classification
* A blended payment model is developed that incorporates the above recommendations by blending aspects of fixed, capitated, capped and un-capped fees-for service and incentive payment models into a payment structure that approximates the real costs of services and meets the highly variable needs of women and midwives.
* A new payment model is implemented as soon as possible, via a staged approach.

**Introduction**

Over the past nine months a Community Primary Midwifery Funding Model Co-design process has been undertaken between the Ministry of Health, the New Zealand College of Midwives (NZCOM), practicing midwife Lead Maternity Carers (LMCs) and consumer representatives.

As a result of completion of this process, the overall co-design recommendations are to establish a national organisation that holds a national contract to support the workforce and fund contracted midwives via a blended payment model that approximates the real costs of services and meets the highly variable needs of women and workforce.

This paper provides a high level overview of the blended payment model rationale, structure and initial implementation planning to give effect to this aspect of the co-design recommendation.

**What is a payment model?**

A payment model is the mechanism by which a practitioner is compensated for the work they do. It is the fee or the remuneration structure as distinct from the employer, contracting body or funding mechanism. A payment model is agnostic as to the funding model and could be operationalised as a national service or a devolved service through one or more providers. The current payment model is capped fee for service via the Primary Maternity Services Notice 2007 and accompanying fee schedule pursuant to Section 88 of the Public Health and Disability Act 2000.

**Why change the payment model for community midwifery?**

The current payment model is not fit for purpose:

* Fees have not kept pace with fair and reasonable remuneration
* Income for midwives is unpredictable and services are provided without payment for up to 5 months
* Payment model does not recognise families’ additional need for midwifery time, and current structure can result in highest need/input clients attracting the least fees
* Some services and activities do not attract fees such as care for a woman experiencing miscarriage
* Payment model incentivises high caseloads by paying per case
* Payment model incentivises care of low need women by paying the same for all levels of need regardless of time spent
* Payment model disincentives appropriate use of a backup community midwife by requiring LMCs to pay their back up midwives out of their caseload fees
* Payment model is legislation based which is inflexible and hard to change.
* Rural and remote rural services are unsustainable
* Payment model disincentivises service provision in women’s homes and communities

This impacts the workforce:

* There are significant financial barriers to entry to practice
* There is poor retention – currently 17% annual exit rate nationally and up to 37% regionally
* In response to midwife shortages and low fees per case, some midwives are taking on very high caseloads resulting in long hours, unsafe working conditions & burn out

This impacts women:

* There is mal-distribution of the workforce across regions and population groups:
  + No LMCs available for women due over Christmas & New Year in some regions
  + Very hard to get a LMC if you don’t book by 6-8 weeks of pregnancy
  + No LMCs available at all in some communities
* There are significant barriers to access for care for women and families, particularly those with high need
* Some women are limited in their place of birth options as a result of limited choice of LMC
* Some women get fewer than recommended antenatal and postnatal visits
* Some women have to travel to get postnatal care

**What is a blended payment model?**

It is a fee structure that combines capped and uncapped fee for service payments, regular fixed payments and incentive payments to midwives for the full scope of community midwifery services. It combines the useful aspects of a fee for service payment model, the useful aspects of salaries, the useful aspects of capitation and the useful aspects of a pay per performance/incentive model. It is designed to approximate the actual costs of work done, to drive desired workforce distribution and behaviour and minimise perverse incentives associated with each of the component payment models.

**What are the benefits of a blended payment model?**

Change to the payment model is primarily a mechanism to compensate for service provision but offers opportunities and benefits beyond compensation for work done including:

* Sustaining the midwifery workforce by paying fair and reasonable remuneration
* Increasing workforce recruitment and retention through cost recovery and incentives
* Moving the workforce onto integrated IT platforms and improving the Ministry’s maternity data collection
* Eliminating existing perverse incentives for very high & selective caseloading
* Enabling a midwifery model that is more responsive to client need, particularly the needs of high needs and hard to service women
* Improves access by funding first trimester care & miscarriage care and by incentivising the workforce to cover current hard-to-staff situations
* Improve safety and quality by eliminating the disincentive to call a back-up midwife, also reducing demand on DHB core midwifery staff
* Supporting normal birth by enabling midwives to provide care in the manner in which the model of care intended, supporting and funding continuity of care and community based including home and primary facility birth

**What are the components of the proposed model and their proposed fee levels?**

The proposed blended payment model has four components: 1) through fixed and capitated monthly payments, it creates a more even distribution of income over time for individual midwives. 2) through changes to the structure of modular fee for service payments it better reflects the work done, and reduces existing perverse incentives. 3) through additional time and travel payments, midwives can be compensated for the extra time and travel provided to clients with additional need. 4) through incentive payments it supports recruitment, retention and redistribution to meet current and future workforce demands.

**Part 1: fixed payments**

The model has the following fixed payments:

* Operating costs of up to $41,000 per annum paid monthly to all midwives on a weighted sliding scale of FTE capped at 1FTE[[1]](#footnote-1).
* On call costs of up to $30,000 per annum paid monthly to all midwives on a weighted sliding scale of FTE capped at 1FTE.

**Part 2: modular fee for service payments**

The model has the following modular fee for service payments

* Registration fee – claimable once per midwife per pregnancy to cover the costs of the extended ‘booking’ visit. Paid upon receipt of registration information.
* First trimester fee - claimable if a midwife has provided care to a registered woman prior to 14 weeks. Paid upon receipt of first trimester service information.
* Second trimester fee - claimable if a midwife has provided care to a registered woman between 14 weeks and 27 weeks + 6 days. Paid upon receipt of second trimester service information if no other second trimester claims are made (otherwise partial to be paid).
* Second trimester partial fee - claimable if two midwives have provided care (change of registration) between 14 weeks and 27 weeks + 6 days. Paid upon receipt of two second trimester service information submissions.
* Third trimester fee - claimable if a midwife has provided care to a registered woman between 28 weeks and onset of labour-related care. Paid upon receipt of third trimester service information if no other third trimester claims are made (otherwise partial to be paid).
* Third trimester partial fee - claimable if two midwives have provided care (change of registration) between 28 weeks and onset of labour. Paid upon receipt of two third trimester service information submissions.
* Labour and birth fee - claimable if a midwife has provided face to face care to a registered woman any time between onset of labour-related care to two hours following birth of the placenta. Paid upon receipt of labour and birth service information. Intrapartum care over 8 hours can be claimed as additional time.
* Postnatal fee - claimable if a midwife has provided care to a registered women (and baby) from two hours post birth to six weeks following birth (or EDD for premature birth). Paid upon receipt of postnatal service information if no other postnatal claims are made (otherwise partial to be paid).
* Postnatal partial fee - claimable if two midwives have provided care (change of registration) postnatally. Paid upon receipt of two postnatal service information submissions.
* Second midwife attendance fee - single service module claimable by a midwife who is not the woman’s registered midwife for second midwife labour and birth support under specified circumstances.
* Primary or home birth support fee – claimable if a midwife has provided support to a registered woman planning a home or primary maternity unit birth, to cover the costs of an additional late pregnancy home visit birth planning meeting, plus home and primary birth consumables.
* Options visit fee - single service module claimable to cover the costs of meeting a client face to face who does not then register with that midwife. Can be claimed once per woman per midwife. Midwife who registers that woman is not eligible for this payment.
* Miscarriage fee - single service module claimable for miscarriage or termination of pregnancy support for a woman who is not registered with any midwife. Expectation is that if a woman is registered, that woman’s midwife will provide this care as part of first or second trimester services.

**Part 3: additional time and travel payments**

The model funds an average of 48 hours contact, non-contact and travel time per straightforward client through the fees set out in part 2. Some women (estimated 25%) have additional needs that would benefit from additional midwife time, or would benefit from care being provided in that woman’s home or community (necessitating additional travel). The model has the following additional payments claimable where additional time or travel is provided.

* Additional time: claimable in 2 hour increments once a midwife has provided care over ‘straightforward’ case expectations, up to twice the time allowance for that module. Paid upon receipt of additional time information.
* Additional travel: claimable at a per km rate once a midwife has travelled 550km for that client. Paid upon receipt of additional travel information.

**Part 4: incentive payments**

As a blended model, the model has the opportunity to introduce incentive payments. These are currently focussed on workforce stability as this is the most urgent issue facing midwifery at the present time. These could be added to or changed in future as additional priorities arise. Proposed incentive payments are:

* Recruitment incentive – a grant payment available once to a midwife newly entering community midwifery practice (new grad or new to community practice) to offset a start-up caseload and cover some establishment costs.
* Retention incentive – a per annum payment available to midwives who have been in continuous community midwifery practice for 5 years or more.
* Hard to staff region – a per registration payment where domicile of woman at registration is on the agreed ‘hard to staff’ list.
* Hard to staff time of year – a per registration payment where the expected date of delivery for a woman at registration is in December or January.

**How does the blended payment model support fair and reasonable remuneration?**

The central goal of the blended payment model is fair pay for work done. The model achieves this through an overall increase in fee levels and a fairer allocation. The model is geared to meet this fair remuneration for a varying caseload make up across one full time equivalent (FTE).

Under the blended payment model, as additional time is spent and claimed, a midwife is compensated for that time, enabling the midwife to maintain 1FTE work hours and 1FTE income, at a lower caseload with more time per client.

**How does this look in practice?**

1FTE of straightforward clients is 45 clients at 48 hours each = 2160 hours per annum, @$3750 per client equals $168,750 in fees (excluding incentives & single service modules).

1FTE of the national average casemix (75% straightforward/20% some additional time/5% all additional time) is 40 clients at 54 hours each = 2160 hours per annum, @$4219 per client equals $168,750 in fees (excluding incentives & single service modules).

1FTE of clients requiring all additional time is 22.5 clients at 96 hours each = 2160 hours per annum @$7500 per client equals $168,750 in fees (excluding incentives & single service modules).

**How would we make this happen?**

As per the overall recommendation, the co-design team see the future state for the blended payment model is administration through a national contract with a national community midwifery organisation. This will require the establishment of a new organisation and then establishment of individual contracts with all midwife LMCs as well as development of a new payments system, reporting processes and all associated administration infrastructure and personnel.

While this is the recommended end state, there is need to address immediate pressures faced by this workforce due to the current payment model, therefore we recommend a staged implementation approach that is not contingent on devolution to a national community midwifery organisation in the first instance, and as such would enable LMC midwives to provide services and be paid under the blended payment model contract and fee structure from October 2018.

The high level implementation approach involves four stages:

**Stage 1:** refinement and testing of the blended payment model with midwives. Procurement of payments infrastructure to administer the model. Development of a new national community midwifery services contract, service specification and reporting requirements (Jan – Sept 2018)

**Stage 2:** moving LMC midwives from the current contract (Section 88) to the new national contract outside of legislation and from the current fee structure to the blended payment model fee structure. Go live with the new payments infrastructure (from October 2018)

**Stage 3:** devolution of responsibility for contract management and payments infrastructure from current provider to a national community midwifery organisation, with the Ministry of Health continuing to pay on actual costs (from July 2020)

**Stage 4:** full devolution of responsibility to a national community midwifery organisation, including a bulk funded contract (from July 2021)

**The Payment Infrastructure Market**

Payments infrastructure (contracting, clinical data capture, claiming functions and making of payments) are currently provided for community midwives by the Ministry of Health (contacting, claims and payments), the MMPO (clinical record, claims and payments) and a number of IT vendors (clinical record and claims). The Blended Payment Model requires a contract for services, clinical data capture, claiming functions and making of payments, so to implement rapidly in order to address immediate pressures the co-design team sees MMPO as the logical interim payment infrastructure provider until such time as a national organisation can provide this function.

The MMPO already has clinical data capture, claiming and payment infrastructure via contracts for 70% of community midwives. Purchasing this function through MMPO is expected to be faster, and cheaper than procurement of an internal Ministry of Health solution or an external vendor who is new to any or all of these components.

An additional benefit is the alignment of IT vendor between the National Maternity Record and the MMPO clinical and payment services as both of these are purchased via Clevermed and both operate off the Maternity Spine/Connected Health platforms.

Other IT vendors could continue to provide clinical data capture and claiming as they currently do, providing choice of vendor for midwives, however this claiming would be received by MMPO rather than by the Ministry directly. This means the Ministry of Health would only have one payee for services and would receive consistent data and information across all midwives and women, compared to the complexity of over 1300 midwife claimants, at least four IT vendors with varying data quality assurance, direct access online an paper based claiming.

Once a national organisation is established and operational, the payments infrastructure would be purchased by the national organisation.

1. See Pricing Paper for definition of 1FTE [↑](#footnote-ref-1)