

# Developing an episodic payment approach for mental health

This short guide explains what an episodic payment approach is, and the steps involved where this approach is being used for mental health services provided in secondary care. This is one of two payment approaches that providers and commissioners should consider developing; the other is a capitated payment approach.

## What is an episodic payment approach?

An episodic payment approach is the payment of an agreed price for all the healthcare provided to a patient during an agreed time period – the episode. The price paid depends on the mental health condition a person is being treated for and any co-morbidities they may have.

## Clusters

The units of healthcare used for payment are known as currencies. The mental healthcare clusters were mandated as the currencies for much of adult and older people's mental healthcare in 2012.<sup>1</sup> There are 21 mental healthcare clusters (listed in the table below) and these can be grouped into three broad diagnostic categories: psychotic, non-psychotic and organic.

The most appropriate cluster is assigned to a person following their assessment using the mental healthcare clustering tool.<sup>2</sup> This tool captures the needs of a person with mental ill health and indicates their likely cluster assignment. All providers are contractually obliged to assign the most appropriate cluster to each patient, and submit this categorisation each month as part of the broader Mental Health Dataset Submission requirements.

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<sup>1</sup> Under local payment rules commissioners and providers can agree an alternative payment approach, provided this is consistent with the principles governing locally determined prices.

<sup>2</sup> Available from:

[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/379574/S118\\_Annex\\_7C\\_NTCN1516.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379574/S118_Annex_7C_NTCN1516.pdf)

## Payment based on episode or year of care

Each cluster has a defined outer review time for the reassessment of the person with mental ill health, as shown in the table below. The long-term nature of interactions that people with mental ill health typically have with mental healthcare services means reimbursement on a year-of-care basis is appropriate for many of the clusters. Where care is likely to be provided on a short-term basis, payment for the outer review period (episode of care) is preferable.

Cluster	Cluster label	Max review period	Suggested payment approach
0	Variance group cluster allocation not initially possible	6 months	Episode
1	Common mental health problems (low severity)	12 weeks	Episode
2	Common mental health problems	15 weeks	Episode
3	Non-psychotic (moderate severity)	6 months	Episode
4	Non-psychotic (severe)	6 months	Year of care
5	Non-psychotic (very severe)	6 months	Year of care
6	Non-psychotic disorders of overvalued Ideas	6 months	Year of care
7	Enduring non-psychotic disorders (high disability)	Annual	Year of care
8	Non-psychotic chaotic and challenging disorders	Annual	Year of care
10	First episode in psychosis	Annual	Year of care
11	Ongoing recurrent psychosis (low symptoms)	Annual	Year of care
12	Ongoing or recurrent psychosis (high disability)	Annual	Year of care
13	Ongoing or recurrent psychosis (high symptoms and disability)	Annual	Year of care
14	Psychotic crisis	4 weeks	Cluster episode (at first presentation)
15	Severe psychotic depression	4 weeks	Cluster episode (at first presentation)
16	Dual diagnosis (substance abuse and mental illness)	6 months	Year of care
17	Psychosis and affective disorder difficult to engage	6 months	Year of care
18	Cognitive impairment (low need)	Annual	Year of care (annual review)
19	Cognitive impairment or dementia (moderate need)	6 months	Year of care (annual review)
20	Cognitive impairment or dementia (high need)	6 months	Year of care
21	Cognitive impairment or dementia (high physical need or engagement)	6 months	Year of care

The initial cluster assessment happens when those with mental ill health are first referred to secondary mental healthcare. A provider is paid separately for this assessment, recognising that some people will be assessed as not requiring specialist mental health treatment, or will be referred to other services. These costs are already collected separately in the reference cost collection.

The outer review period applies where it has not been possible to assign someone with mental ill health to a cluster (ie those in Cluster 0).

The care clusters apply regardless of the setting in which a person with mental ill health is cared for. This means that the agreed price is paid for an episode of care regardless of whether this care is provided in an inpatient setting, in the community or in the home. This approach should provide the right incentives for care to be provided as close to a person's home as possible, and in the least restrictive setting possible.

Clusters 14 and 15 deserve special mention as they represent people experiencing a psychotic crisis. We know from reference cost data that the cost of treating those in psychotic crisis is high. However, we do not want the new payment system to introduce a perverse financial incentive by rewarding providers when patients are in crisis, instead of rewarding them for helping people to manage their condition and avoid crisis.

We currently consider a separate payment should be made for up to four weeks of care for anyone in crisis who is accessing mental health services for the first time. Otherwise payment for crisis should form part of the prices agreed for other psychotic clusters.

Providers have told us that an increasing number of people experiencing a psychotic crisis as a result of using legal highs are coming into contact with mental health services, sometimes repeatedly. These people do not otherwise have mental health problems but can be very expensive to treat during their crisis. Further, at the end of an inpatient stay they are likely to be referred to drug and alcohol treatment and recovery services or other services not strictly related to mental healthcare. No ICD-10 code captures the use of legal highs, but we consider a separate four-week payment for treating this group to be appropriate.

### **What are the strengths and limitations of an episodic payment approach?**

As with any payment approach there are a number of strengths and weaknesses associated with moving to a new method. Below is an outline of the strengths and limitations of this payment approach.

Risk-sharing agreements and caps and collars can be used to manage any financial swings (see below).

Strengths	Limitations
<ul style="list-style-type: none"> <li>• Greater accountability for and transparency of delivering excellent patient care</li> <li>• Ensures that money follows the patient so that providers are fully resourced for the care they deliver</li> <li>• Allows the costs of individual patients to be assessed against the outcomes that are being achieved for them, so can assess the value of innovative treatments</li> </ul>	<ul style="list-style-type: none"> <li>• Shifts financial risks to commissioners</li> <li>• Requires more active monitoring than a block contract</li> </ul>

## What are the necessary components to develop this payment approach?

This payment approach makes use of well-established data flows to the Health and Social Care Information Centre (HSCIC). It also builds on what is already being implemented or shadowed in many areas: payment based on mental healthcare cluster currencies. Providers are familiar with submitting reference costs based on the clusters as they have been doing this since 2012, and for the past two years have been required to submit agreed local prices for the care clusters to Monitor.

We consider it is essential that outcomes measures become an intrinsic part of the payment mechanism for mental health services. The mental health dataset already contains a number of items that can be used to look at outcomes by cluster. Quality and outcomes measures will need to be agreed and monitored as part of the contract, along with agreement on data reporting and quality assurance of the data. This should include both nationally and locally determined measures.

## How is this payment approach developed locally?

If payment is to be based on an episode of care, both commissioners and providers must have confidence in the internal processes for capturing the data that flow to the HSCIC and the quality of those data. Good quality local data will be needed for the delivery of effective evidence-based services that reflect the needs of local populations. Risk-sharing agreements and caps and collars can help to manage the impacts of a change in the payment approach, particularly in the short term. Such arrangements can also allow providers and commissioners to share financial risks and benefits that may come from different ways of delivering care.

A good starting point is to look at current contact values and the active caseload. However, both commissioners and providers need to be mindful of the need to provide care that is effective. Care models must reflect evidence-based approaches to care and National Institute for Health and Care Excellence (NICE) guidance. They must also meet the new access and waits standards to be introduced over the

coming year. Meeting these standards may involve additional costs and these need to be factored in when developing local prices.

Appropriate attention needs to be given to prevention and early intervention to ensure improved outcomes for those with mental ill health, and the most efficient and effective use of resources. This may require analysis and some bottom-up costing to understand the needs of the population, what the most effective and efficient service design is, and how payment should be developed.

The active caseload is the number of people with mental ill health by cluster who are receiving treatment or being assessed. To assess this, data must be cleansed so that only those currently being assessed or receiving treatment are included. The number of people with mental ill health on the current active caseload can be determined by taking a snapshot of caseload analysed by cluster and initial assessment at a particular point in time, or by taking an average over a period. Either way, it is important that active caseload accurately reflects activity and that the process used to determine it is agreed between commissioners and providers. The monthly reports provided by the HSCIC include information on caseload.

Where caseload changes are anticipated in the coming years (whether from planned changes to service delivery or demographic changes), they should be agreed by commissioners and providers. They should also be monitored on a quarterly basis, broken down by initial assessment, cluster allocation and treatment.

The resources required to provide care to people with mental ill health in each cluster, as well as to conduct their initial assessments, will differ. These differences can be captured by calculating the relative resource intensity (RRI) for each cluster. Although packages of care will be personalised for each person in any single cluster, on average they will use similar levels of resources. The RRI weighting can be used to calculate prices, based on the existing contract value, which reflect the different resource requirements of delivering care to patients assigned to a particular cluster. Organisations that have a patient-level information and costing system (PLICS) can use this system to calculate the RRI. For organisations without such a system, per diem reference costs can be used as a proxy for RRI in the interim. Detailed guidance on calculating the RRI will be published early in 2016.<sup>3</sup>

## **Risk sharing**

We recognise that moving to any new payment approach has associated risks. These need to be managed to prevent destabilisation of either the providers or commissioners. There are two approaches that could be used:

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<sup>3</sup> This will be published as part of *Guidance on mental health currencies and payment* that will accompany the statutory consultation for the national tariff (s118 notification).

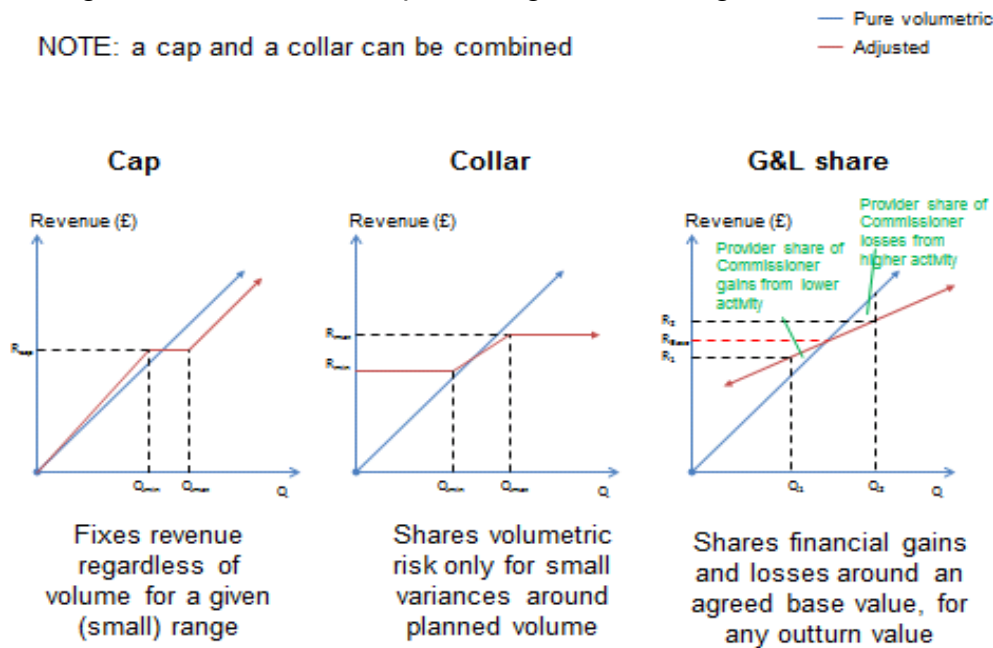
1. The simplest approach is to set a range for activity changes that have no associated resource implication for commissioners or providers – known as a **collar**. Activity changes within this range are absorbed in year, but can be reflected by agreement in future years' contracts. The threshold at which activity triggers payment is locally agreed by providers and commissioners. It is suggested that a level of at least  $\pm 5\%$  is set in the first year to reflect the developmental nature of this approach and the continuing underlying issues of data quality.

Ideally, such arrangements should be employed at cluster level, but local arrangements may determine that these are aggregated at a total contract level. Any activity changes beyond this threshold will attract funding at 100% of the cluster price.

2. The second approach is to agree a level of variation within which the activity attracts funding adjustments, but outside of which is capped – known as a **cap**. It is suggested that a low cap level is set (eg  $\pm 2\%$ ). There will be some volatility as cluster-based contracts are embedded and as a result some variation in activity is driven by data quality rather than demand. This variation needs to be addressed by providers and commissioners, and recorded in either Schedule 3A (Local prices) or in Schedule 2G (Other local agreements, policies and procedures) in the contract. For more information, please refer to the *NHS standard contract 2016/17 technical guidance s44.3*.<sup>4</sup>

An agreement should also be reached on how any financial gains or losses will be managed and shared. Examples are given in the figure below.

NOTE: a cap and a collar can be combined



<sup>4</sup> Available from: [www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/04/NHS-Standard-Contract-2015-16-Technical-Guidance.pdf](http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/04/NHS-Standard-Contract-2015-16-Technical-Guidance.pdf)

We strongly recommend that organisations have a memorandum of understanding in place to manage the financial risk for both parties and that this covers:

- management of data quality, and arrangements for cleansing caseload activity through the year. This will ensure that changes in caseload arising from data quality improvement rather than changes in demand have no financial implications
- arrangements for reflecting service improvement/transformation in the contract
- arrangements for re-basing the contract through the year where this is appropriate.

### **Cluster pathway payment and choice of provider**

People with mental ill health have a right to choose a provider for their first outpatient appointment with any clinically appropriate healthcare professional.<sup>5</sup> Payment for mental health services which is made on the basis of an episode of care should facilitate choice. We will publish support materials to help commissioners effectively support choice for mental healthcare.

### **Defining quality and outcomes incentives**

In any capitated payment approach providers and commissioners must identify and link payment to quality and outcomes metrics, which will influence the final payment made to the provider(s). This can ensure providers do not sacrifice quality and patient outcomes to generate financial savings. Providers and commissioners must identify the quality and outcomes measures to link to payment. These should include the national measures for mental healthcare that are being developed, but locally-determined measures will also be needed. Local measures should be co-developed with all important local stakeholders, ie service users, clinicians, providers and commissioners, and reflect evidence-based approaches to care and NICE guidance. Monitor and NHS England will provide further guidance on using and developing quality and outcomes measures, and how these can be linked to payment.

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<sup>5</sup> As for physical health services, choice does not extend to people needing urgent and emergency care.