Monitor
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NHS England

# Developing a capitated payment approach for mental health

This short guide explains what a capitated payment approach is, and the steps that need to be taken to adopt this approach 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 an episodic payment approach.

The Five Year Forward View (5YFV) has set out objectives to transform the way healthcare is organised and delivered. Locally developed capitated payment for mental health could support these objectives.

To support the development of local payment approaches for mental healthcare, this short guide sets out:

- what a capitated payment is
- the models of integrated care that can be supported by capitation
- the strengths and limitations of capitation
- the key enablers to developing this payment approach
- the seven design steps for implementation.

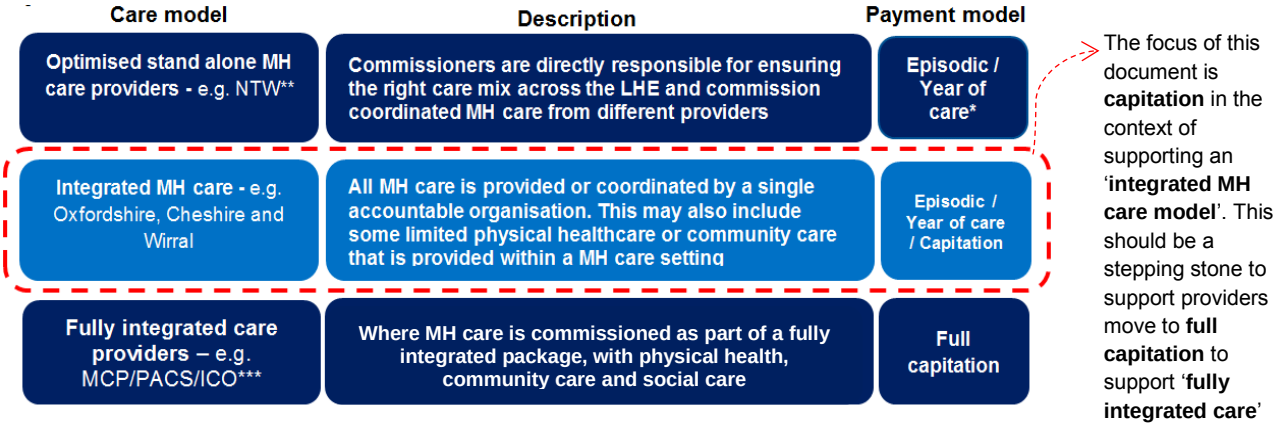
Our focus in this guide is how capitated payment can be developed for mental healthcare covered by the mental healthcare clusters (secondary mental healthcare for adults and older people), with some elements of physical, social and community care included. However, the same seven design steps can be used to cover mental healthcare that goes beyond the care clusters (eg children's and young people's or secure and forensic mental healthcare). This more limited scope for capitation focused largely on mental healthcare could be a stepping stone to developing fully integrated care models, such as multispecialty community providers (MCPs) or primary and acute care systems (PACS).

## What is a capitated payment approach?

A capitated payment approach is the payment of a provider or group of providers to cover a range of care for a population across a number of different care settings. Payments are made on a per person basis and are risk adjusted to reflect the different needs of people with mental ill health.

Any capitated payment for mental health must include a component linked to achieving agreed quality and outcome measures. This ensures that providers remain directly accountable for providing timely care that is in the best interest of people with mental ill health.

We know that local health economies (LHEs) are looking at new care models that can support their population's needs more effectively. Capitation can support different models of care, as outlined in the 5YFV, including a 'fully integrated care model' and 'integrated mental health care models'. Payment should then be locally developed to support this. The diagram below shows potential combinations of care models[1] and payment approaches.[2]




* Northumberland, Tyne and Wear NHS Foundation Trust

** For further information, see our companion guide Development of an episodic payment approach fo health

*** ICO, integrated care organisation

## What are the strengths and limitations of a capitated payment approach?

The table below outlines some of the main strengths and limitations of using a capitated payment approach.

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[1] Further information on the new care models, as outlined in the 5YFV, including integrated care organisations, integrated and acute care systems, and multispecialty community providers is available at: www.england.nhs.uk/ourwork/futurenhs/new-care-models/

[2] Further information on the different payment approaches, including capitation, is available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

| Strengths | Limitations |
|---|---|
| • Strong incentives to invest in early intervention and prevention to avoid potential complications resulting in higher costs<br>• Allows more flexible and efficient allocation of resources for improved efficiency gains<br>• Greater accountability for delivering high quality patient care | • Providers may 'cherry pick' patients and restrict access to care if mechanisms are not in place to ensure quality and access<br>• Risk of cost shifting if service and population scope is not clearly defined<br>• Requires good data on activity, costs and outcomes linked at patient level across relevant providers<br>• Risk of driving down quality of care for financial gains if appropriate mechanisms are not in place |

Providers and commissioners should work together to develop and implement local mitigations to the potential risks identified above. Clear governance structures, payment linked to locally developed quality and outcome metrics,[3] and the financial gain/loss sharing mechanism[4] can help mitigate some of these risks. Also, under a capitated payment arrangement it would be important to ensure patient choice is supported. Where patients' right to choice applies to a mental health service, commissioners must commission the service from any provider that meets their criteria for providing that service.

The arrangement does not need to be limited to one provider for each type of service; it could, for example, include multiple community providers and/or acute providers. However, including some but not other providers in the arrangement must not restrict patient choice: a patient must not be denied the choice (where applicable) to be referred to a provider that is not part of the arrangement.[5] Further, capitation should not prevent patients from having a personal budget, where applicable. People with mental ill health with a personal budget would still enjoy the same choice of services and providers delivering them: the personal budget would be deducted from the total capitation payment and paid instead to the providers chosen by the patients.

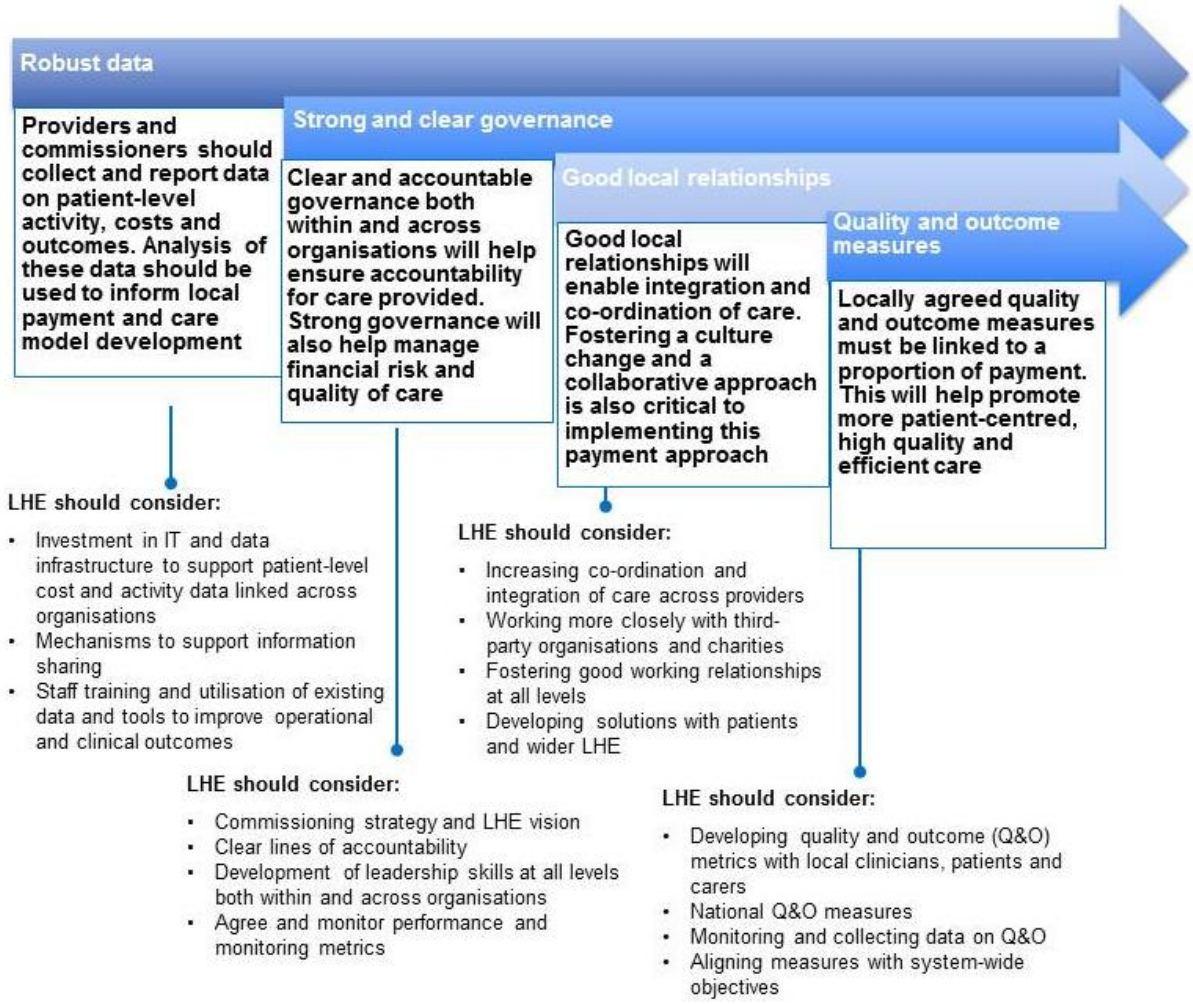
[3] The local payment example on outcomes-based payment for mental health is available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#outcomes-based-payment-for-mental-healthcare

[4] The local payment example on multilateral gain/loss sharing is available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#multilateral-gain-loss-sharing

[5] For instance, if a patient chooses another provider (not part of the gain/loss sharing arrangement) for an elective procedure, that provider would be paid for this procedure and this amount would be included in the outturn when calculating gains/losses.

## What are the enablers to developing a capitated payment approach for mental health?

A number of local enablers are fundamental to the development and implementation of any capitated payment approach for mental health, as shown below.

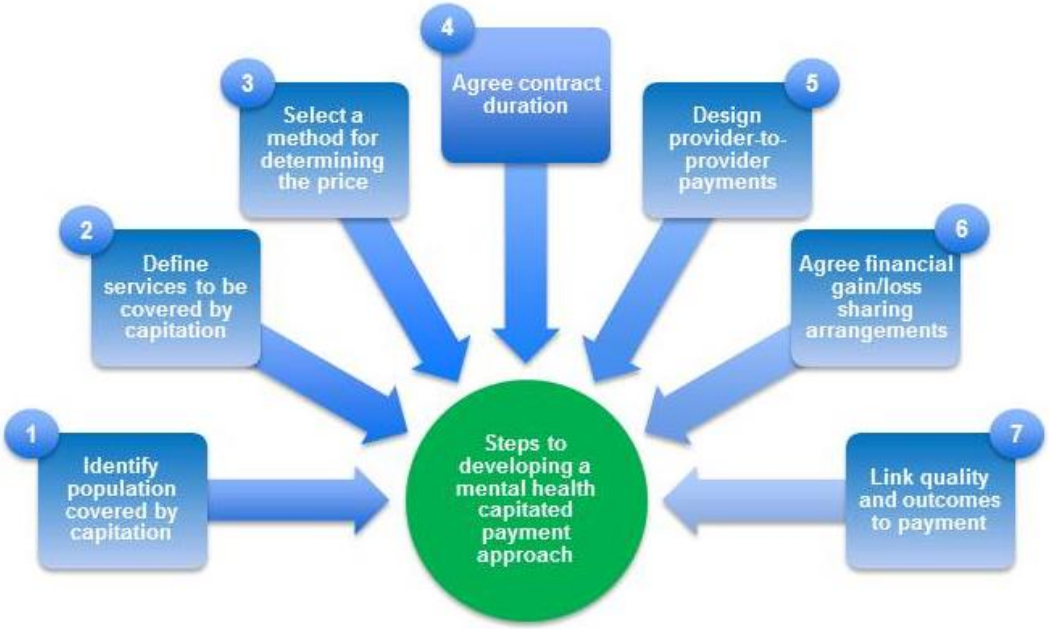



## What are the components needed to develop a capitated payment approach for mental health?

The scope of care covered by capitated payment, and contractual arrangements underpinning capitated payment, may vary depending on local factors. Factors to take into account may include the degree of co-ordination between mental healthcare and other services, and/or on the robustness of data.

When developing local capitated payment arrangements, the seven steps described below need to be followed. Where more than one mental health organisation is responsible for delivering a capitated contract, a lead provider who holds the capitated budget must be agreed. This lead provider then works with each of the other (delivery) partners to deliver care.

Commissioners will need to use an appropriate process to decide which provider is best placed to be the lead provider. Commissioners can contact Monitor for support in ensuring this process delivers good outcomes for patients and is consistent with the Procurement, Patient Choice and Competition Regulations.




## Step 1: Identify the population to be covered by capitation

Providers and commissioners must identify the adult and older people's cohort to be included in the capitated payment for mental healthcare. They may consider including other population cohorts (eg children) as well as provision of other health and social care under a capitated payment.

GP registration lists should be used to identify the population for capitation. However, not everyone is registered with a GP and other data are needed to identify the population to be covered by the capitated payment. and to understand unmet need and the potential demand for mental health services. The points to consider listed in the table below illustrate why a combination of GP registration lists and referral lists is best for the identification of the population to be covered by capitation.

| GP registration lists | People referred to secondary mental health services |
|---|---|
| • Strongly incentivise the capitated budget holder to undertake early intervention and prevention (ie to avoid referrals to more expensive secondary mental health services)<br>• This better captures unmet patient demand than looking only at secondary mental health provider activity<br>• Lists are relatively large, and therefore capture a large proportion of the LHE<br>• Providers need to ensure that they can manage the demand for services covered by capitation from those whose needs may not have been previously met | • Provides a more focused identification of the local population that may need mental healthcare<br>• Reduces risk of transferring insurance risk to provider<br>• Need to consider how service users access services, as some self-refer without a GP referral. Service entry points need to be clearly defined so that there is no restriction of access to care<br>• Does not strongly incentivise early intervention and prevention<br>• Likely to cover a smaller population and less likely to capture wider MH care needs in the LHE |

To determine the potential demand for mental health services in the target population, it is also important to understand the levels of unmet need in this population. This should include assessment of other data may include Office for National Statistics data, emergency services data and referrals to secondary mental health services.

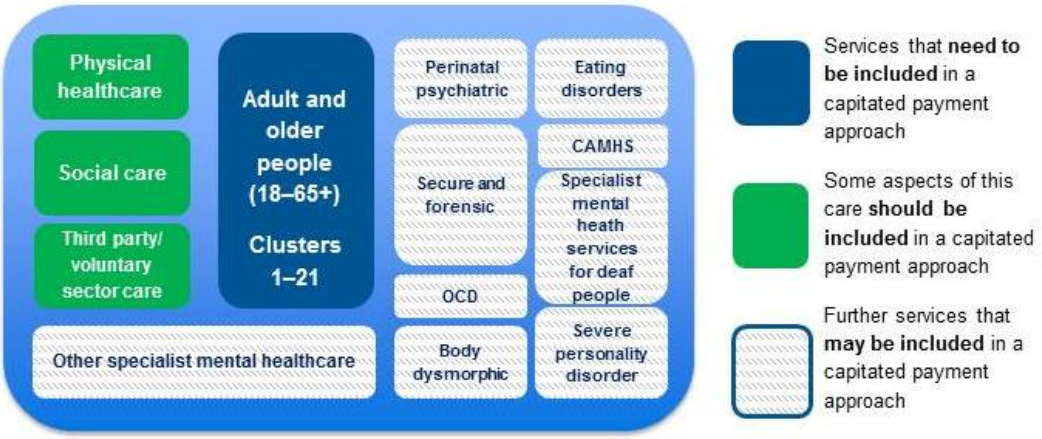
### Step 2: Define services to be covered by capitation

Providers and commissioners must work together to specify the scope of services, in collaboration with people with mental ill health, carers, clinicians and also other interested organisations (eg local authorities). The scope of services should be based on clinical guidance and evidenced-based care, and support agreed quality and outcome measures.

The scope of services included in a capitated payment will depend on the LHE characteristics and needs of the population to be covered. LHEs should include mental healthcare for adult and older people in the capitated payment, but also some aspects of physical, social and community care. This widening of the scope of services is particularly important given the strong clinical interrelationship between mental and physical ill health for recovery and wellness. Therefore, co-ordinated care benefits both people with mental ill health, and system efficiency by ensuring care is co-ordinated effectively. Similarly, it may be appropriate for the capitated payment to cover other mental healthcare (eg children's mental healthcare and/or specialised mental healthcare for adults).

The scope of services should apply to the whole population covered by capitation, but additional care/interventions can be specified for a subset of the population; for example, people with dementia or serious mental illness.

Possible in-scope services are outlined below.




Providers and commissioners may include mechanisms that help the capitated budget holder to better manage financial risk. For example, specific (expensive but infrequent) care for people with mental ill health can be excluded from the payment arrangement (eg care for those in high secure units).

### Step 3: Select a method for determining the price per person per year

Current commissioner spend is used as the starting point for the calculation, but the following three factors all need to be taken into account when determining the capitated payment:

1. Existing baseline spend on mental healthcare and adjustments for the (actual) baseline cost of provision incurred by providers.

2. Adjustments to the overall payment based on forecast need and associated costs:

    - financial impact of putting in place, potentially new, effective and efficient clinical models that meet the needs of the population, including the delivery of NICE-concordant care

    - year-on-year adjustments to reflect expected changes, eg population/casemix changes, cost inflation, efficiency savings

    - possible adjustment to reflect the cost of providing care to those who have been assessed and are on a waiting list, as well as those whose need is as yet unidentified. This requires analysis of a number of information sources, such as mental health risk stratification tools (eg from Public Health England), and engagement with other local services (eg emergency services, education and local government).

3. Where a multi-year arrangement is agreed, in future years, adjustments can be based on actual outturn given that the forecasts are unlikely to be accurate over the entire period.

## Step 4: Agree contract duration

Providers and commissioners must agree upfront the duration of the capitated contract. This should be long enough to realise the potential benefits to people with mental ill health and the wider LHE.

Providers and commissioners should ensure that any agreed contract is consistent with the local payment rules.

## Step 5: Design provider-to-provider payment mechanisms

Where a provider subcontracts the delivery of care to other providers, it is important to agree a clear and robust provider-to-provider payment mechanism. In the case of a capitated payment focused on mental healthcare provision, payment would be made to a lead/accountable provider, which may then make subcontract arrangements with other providers of mental healthcare and related services. The subcontracted payment arrangements would vary depending on the incentives that need to be created by the lead provider, as well as the nature and duration of the contract. An example of how a lead provider could work with other subcontracted providers is given below.


## Step 6: Agree financial gain/loss sharing arrangements

Any gain/loss sharing mechanism[6] must align with the system-wide objectives and allocate financial risk appropriately. Providers and commissioners should agree in advance how, and to what extent, any financial gain or loss is shared between them. It may also be desirable to link all providers under one gain/loss sharing

[6] The local payment example on multilateral gain/loss sharing is available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#multilateral-gain-loss-sharing

arrangement with a commissioner(s), particularly where co-ordinated care is being delivered. The proportion of financial gain that is shared with any provider(s) should be sufficient to incentivise their delivery of high quality care and innovation. The proportion of financial loss that is shared should be agreed in advance, and must not negatively impact the quality of care. It may also be possible to phase in gain/loss sharing arrangements to allow providers to transition to the new payment approach. For example, in the first phase financial gains only could be shared and these used to invest in infrastructure and training. The second phase could entail providers sharing both financial gains and losses.

### Step 7: Link quality and outcomes to payment

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 National Institute for Health and Care Excellence (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.

## Further resources

This short guide is one in a series of publications to help support the sector develop payment approaches for mental health.[7]



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[7] Further resources, including local payment examples on outcomes-based payment and multi-lateral gain/loss sharing for mental health are available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models