

Governing Body: MARION COUNTY COMMUNITY AND PROVIDER SERVICES (CAPS)	Function: INTEGRATED DELIVERY SYSTEM (IDS) HANDBOOK	
Subject: Financial Model	Prepared By: CAPS	Original Date: 10/01/2007 Revised Date: 3/01/2011 Effective Date: 1/01/2011

PURPOSE AND SIGNIFICANCE:

Community and Provider Services (CAPS) is responsible for managing the outpatient capitation that is received from the Mid-Valley Behavioral Care Network (MVBCN). Capitation received is for various age groups and populations that need to be taken into consideration when evaluating how the outpatient capitation is spent. CAPS is committed to closely spending the capitation on the age groups and populations it is received for. In doing so, CAPS has created a financial management model that requires IDS Providers to monitor who they serve, how many are served and how much service is needed. CAPS has created an incentive pool for IDS Providers to incentivize agencies. IDS Providers will need to closely monitor their agency’s performance to contractual agreements to be eligible for any incentives. Changes to the model are intended to create open access. It is anticipated that a formal Level of Care (LOC) system will be developed. The LOC will provide a payment structure that is intended to direct resources & services for the most severely affected individuals.

PROCESS AND/OR PROCEDURE:

This will serve as a guide in managing the financial model developed by CAPS. Please note, service years begin January 1st and end December 31st.

Financial Model

Each agency will have to provide services to Members within a 95%-110% range of their contracted Cost Per Member Per Month (CPMPM) for adults (18 and over) and children (under 18).

In order to maintain the required distribution of funds for adults and children, the agency will have CPMPM specific and separate for adults and children. CAPS will provide monthly statistical reports that will assist IDS Providers in managing their CPMPM, however self-monitoring is expected. Technical assistance in managing to the CPMPM may be obtained from the CAPS Management Analyst or Team Supervisor. CAPS will internally monitor the balance of distribution of members (based on funds distribution) to ensure that the ratio of adults to children being provided services by member agencies match the distribution of funds. If an agency exceeds the required ratio, CAPS will notify the agency and the affected member group will be closed to new members until the required ratio is reached.

Agency budgets do not include Oregon Health Plan open card members, member’s capitated to other counties, assessment only authorizations, and secondary authorizations from another IDS

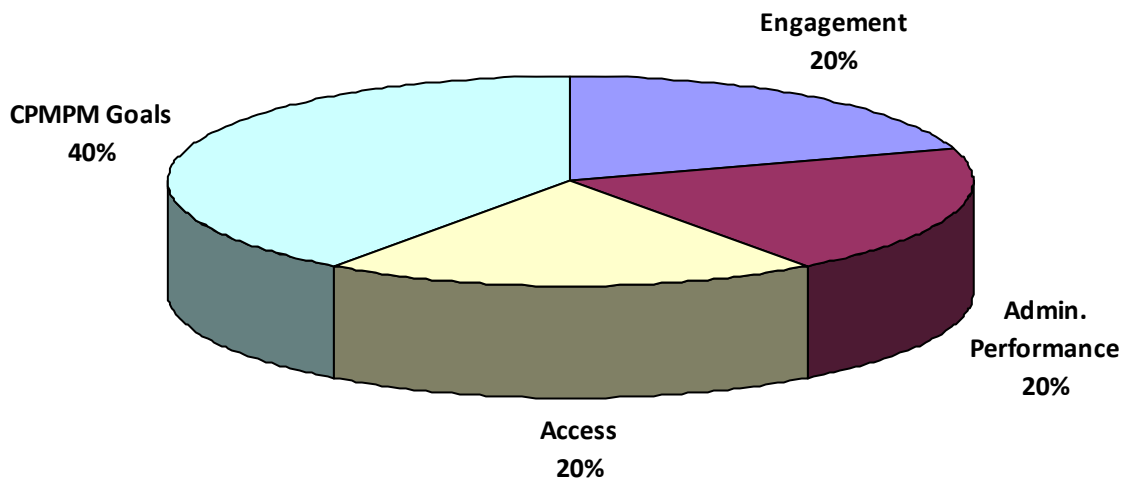
Provider, Mission Transition, Respite Services, and Psychiatric Security Review Board/Extended Care Management/Supported Housing members.

Incentive Pool

To motivate agencies, an incentive pool for the IDS has been developed. The total amount available within the pool varies each year and is based upon the total IDS budget. The value of the incentive pool will be 5% of the IDS budget. Each agencies share of the incentive pool is based upon their allocation of the IDS budget for adults and children. All payouts of the incentive pool will occur by the end of March for the previous calendar year. Agencies will receive periodic information on the status of the incentives.

The incentive pool is only available if the IDS agency maintains within a **95-105%** range of their contracted Cost Per Member Per Month (CPMPM) for adults (18 and over) and children (under 18). targets for the year. If an agency exceeds their CPMPM by 10%, the incentive pool is forfeited.

The incentive pool is broken down into 4 distinct sections, each requiring specific performance goals to be met.



IDS Incentive Criteria

CPMPM Goals – 40% of Incentive Pool

The CPMPM portion of the incentive pool is divided into **two distinct groups**, adults and children; each group is allotted **50% of the pool**.

To be eligible for the incentive for the CPMPM portion of the incentive pool, agencies must manage their CPMPM within a **95-105%** range of their contracted CPMPM for adults (18 and over) and children (under 18).

- Adults
 - The agency is within **95-100%** of their annual contracted CPMPM over the 12 month service year for adults; or

- The agency is within **100-105%** of their contracted CPMPM over the 12 month service year for adults; or
- Children
 - The agency is within **95-100%** of their annual contracted CPMPM over the 12 month service year for children; or
 - The agency is within **100-105%** of their contracted CPMPM over the 12 month service year for children; or

If the above criteria are met and the agency is eligible to receive incentive funds, the payment will be calculated as follows:

Score	Incentive Payment
Adults (50% of pool):	
If agency CPMPM averages 95 to 100% of their contracted CPMPM	100%
If agency CPMPM averages 100 to <105% of their contracted CPMPM	75%
If agency CPMPM is >110% of their contracted CPMPM	Agency will be closed to new members
Children (50% of pool):	
If agency CPMPM averages 95 to 100% of their contracted CPMPM	100%
If agency CPMPM averages 100 to <105% of their contracted CPMPM	75%
If agency CPMPM >110% of their contracted CPMPM	Agency will be closed to new members

If the agency's average is below annual targets for CPMPM for 2 or more months during any 6 month review period, CAPS reserves the right to adjust the agency's CPMPM.

If the agency average is above **110%** during any reporting period, CAPS reserves the right to require the agency to close to new members. CAPS will allow agency to reopen to new patients when the agency's CPMPM comes within the range of the incentive pool. CAPS will provide additional claims data review of those agencies whose CPMPM is approaching **110%** to confirm the CPMPM is correct and provide assistance to ensure agency does not exceed the **110%** threshold.

Engagement Strategies – 20% of Incentive Pool

The Engagement Incentive is new for contract year 2011, and will replace the Out of Clinic Incentive. A broader approach to encourage individuals in seeking and maintaining contact with provider agencies is valued. To that end, provider agencies can now earn incentives for improvements in engagement with enrolled individuals. Even though the Out of Clinic incentive has been discontinued, the higher reimbursement rate for Out of Clinic services will remain.

Incentives will be awarded for an overall reduction in agency No Shows. A No Show is defined as an appointment not keep within 24 hour of the scheduled appointment time. Appointments

canceled in advance of 24 hours are considered a cancelations and not a No Shows. Some strategies for improvement in no shows may continue to include outreach, as well as central management of clinician schedules, reminder calls for appointments and/or agency policy addressing time between intake and next appointment. Improvement in the No Show rate will be calculated on the agency performance of No Show data for the previous contract year. The Engagement Incentive target has been set at 20%.

The Engagement metric will be reported monthly and the percent Engagement Incentive will be calculated as follows:

Score	Incentive Payment
A Reduction of No Shows >10% to <15%	80%
A Reduction of No Shows ≥15%	100%

Administrative Performance – 20% of Incentive Pool

The administrative performance incentive pool is divided into 4 distinct equal groups. The administrative performance metric will be reported monthly and, at the end of 2009, the amount available for each agency will be based on the following:

(The error rates are the total number of procedures with the corresponding error code divided by the total number of procedures.)

Score	Incentive Payment
If Authorization Errors ≤5%	25%
If Billing Errors ≤1%	25%
If Duplicate Claims ≤5%	25%
If Turnaround Time ≤15 days	25%

The following table describes the above measures in detail:

Error	Description
Authorization Error	<ul style="list-style-type: none"> ▪ Payment denied/reduced for exceeding auth ▪ Authorization missing or invalid
Billing Error	<ul style="list-style-type: none"> ▪ Maximum benefit reached ▪ Claim/Service not covered by benefit ▪ Diagnosis inconsistent with procedure ▪ Diagnosis inconsistent with member’s age ▪ Procedure code inconsistent with/or missing modifier ▪ Provider wasn’t certified/eligible to be paid for service ▪ Payment adjusted due to submission/billing error
Duplicate	<ul style="list-style-type: none"> ▪ Duplicate claim/service
Turnaround Time	Average number of days from the service date to the received date of the claim

Agency Access – 20% of Incentive Pool

An evaluation of the overall IDS system has been conducted to establish baseline data related to consumers of mental health services experience of engaging in services. CAPS piloted a

CIM data tracking related to access. Given the changes in how access is being reported, CAPS anticipates a change in the overall access performance. Performance is expected to be lower than previously reported give the redesign of the access monitoring system. The length of time from first call /contact to first treatment is considered to have an impact on a members' engagement into service. IDS Agencies are required to enter all request for service in CIM, regardless of the IDS agencies availability to serve the member. This will be one data measure used to calculate improvement in access for members. IDS Agencies will be reimbursed for mental health calls logged into CIM. The use of the baseline CIM access data, by agency, will be used to set agency targets for reaching minimum expectations for the Access Incentive.

Agency access is defined and limited by the following factors:

- Following the initial request for a covered service, the OHP Member is offered an intake appointment within 2 calendar weeks from date of call;
- Individuals can choose to wait for initiation of service. This usually occurs due to specific factors such as members constraints on time of day of the appointment, language or therapist preference.
- Provider Agency has the option to decline the request for services if it is outside of scope of services offered by the agency.

For individuals choosing to wait for initiation of services, those calls will not affect the agency incentive. If a Provider Agency declines the request for services due the request falling outside the scope of that agencies services, those calls will not affect the agency incentive. The CIM record should reflect the service being requested that the agency does not offer.

The Agency Access Incentive will be divided as follows:

- 25% of the available incentive will be set aside for agencies scheduling 70 % of intake appointments within 14 days of the first contact;
- 75% of the available Incentive will be set aside for agencies scheduling 90% of intake appointments scheduled within 14 days of the first contact;
- A portion of the overall incentive will be set aside to reimburse agencies on a per call basis for recording of mental health access calls in the CIM system.

Agencies are encouraged to respond to callers in a variety of ways including, but not limited to:

- Same day appointments
- Accepting individual seeking services at first call
- Triage need of caller and determining the need to provide an emergent appointment is warranted.

Tracking of Agency Access will be monitored through the CIM system on a monthly basis and reported through IDS advisory meetings. Review of Agency Access will be accomplished at 6-month intervals to determine if there is *required adjustment necessary*.

At the end of the service year, the amount available for each agency will be based on the following:

Score	Agency Incentive Payment
Agency intakes schedule with 14 day >70% of the time	25%
Agency intakes schedule with 14 day >90% of the time	75%
Agency logged calls in CIM	Per access logged call in CIM

During Seasonal peaks or periods when access is significantly outside of the 14 standard, a request may be issued to IDS providers to increase capacity. Each agency will be asked to develop a “**Ready to Act**” plan to respond to a system level request for increased access. CAPS will maintain their role in facilitating access to care when providers are unable to get individuals into services.

Incentive Pool Disagreements

If an IDS Provider disagrees with their eligibility for incentive pool funds, a formal review can be requested. The IDS Provider must request in writing, with justification, why they are eligible for all or a portion of the incentive. CAPS and the Community Mental Health Director will review the request for consideration and provide a written response within 30 days. There are no appeals once a decision has been issued.

Adjustments to Budgets

CAPS reserves the right to adjust targets over the course of the year based on member preference, agency capacity or other factors. If an IDS Provider is at the point that they knowingly will be either under or over serving a contracted population outside the 90-105% CPMPM corridor, the IDS Provider may formally request an adjustment to their CPMPM. Adjustments to budgets will be made twice per year, June and December. To request an adjustment, the IDS Provider must submit a formal request identifying the adjustment requested along with any supporting data. Adjustments to CPMPMs will be negotiated within the context of the entire IDS system performance. Adjustment requests should be sent to the CAPS Team Supervisor. CAPS will review the request with the Community Mental Health Director and provide a written response to the IDS Provider. All decisions issued are final; there is no appeals process.