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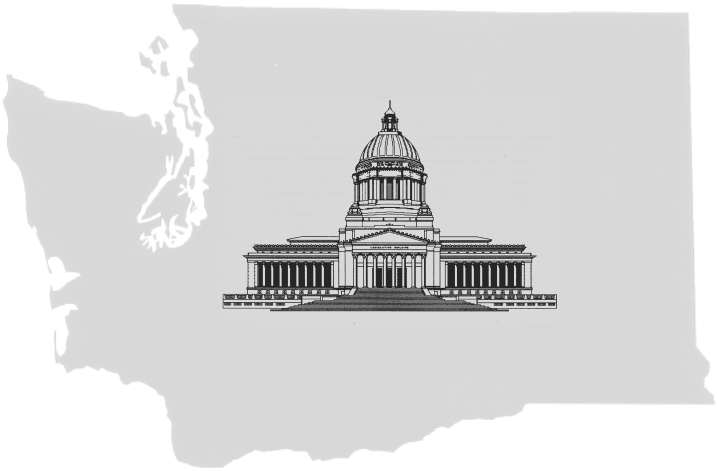

Mental Health System Performance Audit

Report 00-8

December 13, 2000

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Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other policy and fiscal studies. Studies focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.

MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

REPORT 00-8

REPORT DIGEST

DECEMBER 13, 2000

STATE OF WASHINGTON

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MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

The public mental health system in Washington spends almost $1 billion per biennium and serves approximately 106,000 people per year. The system is administered by the Mental Health Division (MHD), of the Department of Social and Health Services (DSHS), which also operates the two state mental hospitals. The MHD contracts with 14 county-operated Regional Support Networks (RSNs) for the provision of community-based mental health services and allocates federal and state funding to the RSNs. The RSNs administer mental health services at the local level and contract with private and public providers of community mental health services.

This study was required by the Legislature via a proviso in JLARC's 1999-01 Biennial Budget. The Legislature required JLARC to conduct a broad review of the performance of the public mental health system to include:

- An analysis of the roles and responsibilities of the MHD, RSNs, and community mental health providers.
- An analysis of funding of the RSNs through contracts let by the MHD.
- An analysis of service levels, outcomes, and costs for RSNs.
- An analysis of contracts between RSNs and community mental health providers.
- Recommendations for modifying the basis on which RSNs and community mental health providers are funded.

MAJOR FINDINGS

1. There are problems with coordination of services between the MHD and other DSHS divisions including the Developmental Disabilities Division (DDD), Division of Alcohol and Substance Abuse (DASA), the Aging and Adult Services Administration (AASA), and between the state mental hospitals and the RSNs.

2. The MHD has made efforts to streamline burdensome activities to promote system accountability. However, these accountability activities are focused on processes of service, rather than on outcomes of service. There is almost no information collected on a statewide basis on client or system outcomes.

3. The fiscal, client, and service data collected by the MHD to promote system accountability are not consistently reported by providers and RSNs.

4. Because of the inconsistencies in the reporting of fiscal, client, and service data, comparisons of the *efficiency* of services provided by RSNs and providers are suspect. Because of the lack of statewide outcome data, comparisons of the *effectiveness* of services provided by RSNs and providers are impossible.

5. The MHD's method of providing capitated funding to RSNs under a managed care approach creates incentives for RSNs to provide services in a cost-efficient manner. However, there are wide disparities in the amount of resources allocated to the RSNs. These resources include funding for community mental health services as well as the allocation of state hospital beds among the RSNs. The disparity in resources is not associated with differences in the prevalence of mental illness, the severity of the clients served, or geographic cost differences among RSNs.

6. The disparity in funding to RSNs leads to disparities in the amount of service provided to clients. Higher-funded RSNs have higher expenditures per client served than lower-funded RSNs.

7. There are wide differences in how RSNs operate. Some RSNs pass on almost all of their funding to community mental health providers and exert relatively little oversight over their providers. Other RSNs spend considerably more money at the RSN level and provide more oversight over their providers. However, without information on client or system outcomes, whether one approach is more effective than another is impossible to determine.

CONCLUSIONS AND RECOMMENDATIONS

Due to the decentralized administration of community mental health services, the MHD's role is limited to statewide planning and policy direction, system oversight, allocation of resources to RSNs, and operation of the state hospitals. We believe the MHD has been taking appropriate steps to improve the system, for example, by instituting a capitated method for allocating resources and by streamlining its activities to promote system accountability. However, we believe further improvements are needed to better coordinate services for clients, to ensure resources are allocated equitably among the RSNs, and to promote accountability by measuring the outcomes of service, rather than the processes of service. The report includes 14 recommendations intended to achieve the following:

- Improve the coordination of services between the MHD and other DSHS divisions, and improve the coordination of state hospital discharge planning between the state hospitals and the RSNs.
- Improve the consistency of fiscal, client, and service data collected by the MHD.
- Further streamline and eliminate process-oriented accountability activities to be replaced with a system for measuring client and system outcomes.
- Change the resource allocation methodology to simplify the methodology, provide further incentives for the provision of services in a cost-effective manner, and improve the consistency of services to clients around the state.
- Promote the identification of best practices among providers and RSNs in order to facilitate the cost-effectiveness of the public mental health system.

COMMITTEE ADDENDUM

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Services and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.

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SECTION 1 – BACKGROUND

In 1989, the Legislature passed the Community Mental Health Act, which emphasized the provision of mental health services in the community and decentralized the administration of the system by creating county-operated Regional Support Networks (RSNs). The Act also established priorities for who should receive public mental health services. Previously, the administration of the system had been centralized under the Mental Health Division (MHD) of the Department of Social and Health Services (DSHS). Washington's public mental health system spends almost $500 million and serves approximately 106,000 people each year.

The MHD provides system planning and oversight, operates the two state mental hospitals (Western and Eastern State Hospitals), and the Child Study and Treatment Center, and provides funding for the Special Commitment Center. The MHD contracts with 14 county-operated RSNs for the provision of community-based outpatient and inpatient services. The RSNs plan and administer community-based services, and contract with approximately 150 public and private providers of community mental health services. The MHD allocates federal and state funding to the RSNs using a managed care funding approach. This means that the RSNs are allocated a fixed amount of money, within which they are required to provide a full-range of mental health services to all Medicaid-eligible persons, crisis services to anybody regardless of Medicaid eligibility, and broader services to non-Medicaid eligible persons if funding is available. While the MHD contracts with RSNs require a broader range of services for the Medicaid-eligible population than for non-Medicaid-eligible persons, the statutory priorities for who should be eligible for services do not mention Medicaid eligibility as a criterion.

This performance audit of Washington's public mental health system was required by a legislative mandate enacted as a proviso in the Joint Legislative Audit and Review Committee's (JLARC) 1999-01 Biennial Budget. The budget proviso required the audit to address several issues including:

- The roles and responsibilities of the MHD, RSNs, and community mental health providers.
- The allocation of funding to the RSNs including recommendations for modifying how RSNs are funded.
- The service levels, costs, and outcomes of service for RSNs and community mental health providers.

Appendix 1 provides the language of the legislative mandate and the audit Scope and Objectives.

LEGAL OVERVIEW

The legal framework for the state public mental health system encompasses both federal and state statutes. Title XIX of the Social Security Act provides medical assistance for certain individuals and families through the jointly-funded Medicaid program. Washington provides mental health coverage to its Medicaid-eligible population through a 1915(b) waiver to federal regulations. The waiver, originally granted in 1993 and renewed on a biennial basis, is administered through the Health Care Financing Administration (HCFA). This HCFA waiver permits Washington to operate its mental health services for Medicaid clients using a

managed care health plan, rather than a fee for service system traditionally used to reimburse providers. In Washington the prepaid health plans are the 14 Regional Support Networks (RSNs) authorized by RCW 71.24, the Community Mental Health Act (2SSB 5400). The Act and its implementing regulations contained in Washington Administrative Code (WAC) 275-057, established a community mental health system for adults who are acutely, chronically, or seriously mentally ill and seriously disturbed children who are acutely mentally ill, seriously emotionally disturbed, or seriously disturbed. The Act, which shifted responsibility for day-to-day management of the public mental health system from the state to regionally managed systems, was a major change in state mental health policy.

FINANCIAL OVERVIEW

In FY 1999, the public mental health system spent approximately $486 million, allocated among the major categories shown in Exhibit 1 on the following page.

According to a recent survey by the National Association of State Mental Health Program Director's Association, Washington's public mental health expenditures per capita were within the highest quartile of all states.[1] Exhibit 2 shows how Washington's expenditures compared with the rest of the nation for FY 1997.

Exhibit 3 on page 4 shows historical funding for public mental health in Washington (adjusted for inflation) compared to growth in the average number of clients served per month. While inflation-adjusted funding has grown substantially, the growth in the number of clients served has been somewhat faster.

Exhibit 4 on page 4 shows that expenditures for community mental health services have grown much faster than expenditures for state hospitals. Outpatient services in the community are less costly than inpatient services in the state hospitals. Therefore, while the growth in clients has somewhat exceeded the growth in inflation-adjusted funding, the trend toward a higher proportion of lower-cost community services allows for client growth to exceed expenditure growth.

ROLES AND RESPONSIBILITIES OF THE MHD

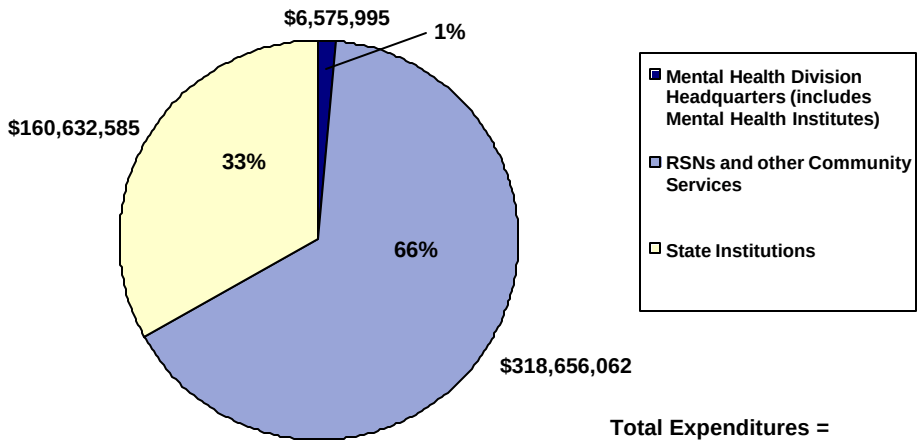
The Department of Social and Health Services (DSHS), Mental Health Division (MHD) is the state mental health authority. The MHD is responsible for management and delivery of public mental health services to assure access to treatment for priority populations identified in the Act. The four major roles of the MHD are:

- Planning and service coordination;
- Allocation of funding to RSNs;
- System oversight (accountability) activities; and
- Operation of the state public mental health hospitals.

JLARC's review focused on the first three roles and a limited review of state hospital discharge planning coordination activities.

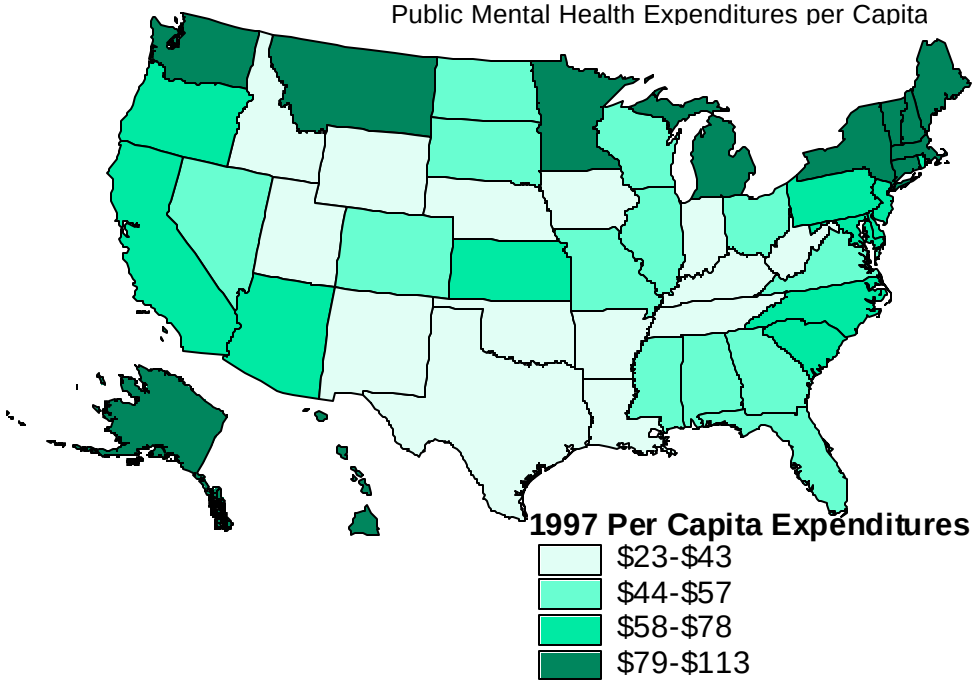
[1] See *Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 1997.* National Association of State Mental Health Program Directors Research Institute, Inc. This association surveys states requesting detailed expenditure information on their public mental health systems. States are asked for information on expenditures that are controlled by the state mental health authority. Therefore, expenditures for public mental health that are not under the control of the state mental health authority are not included. For example, in Washington, expenditures for psychiatric medications to public mental health clients are not under the control of the Mental Health Division, and are thus excluded.

Exhibit 1
FY 1999 Mental Health Expenditures



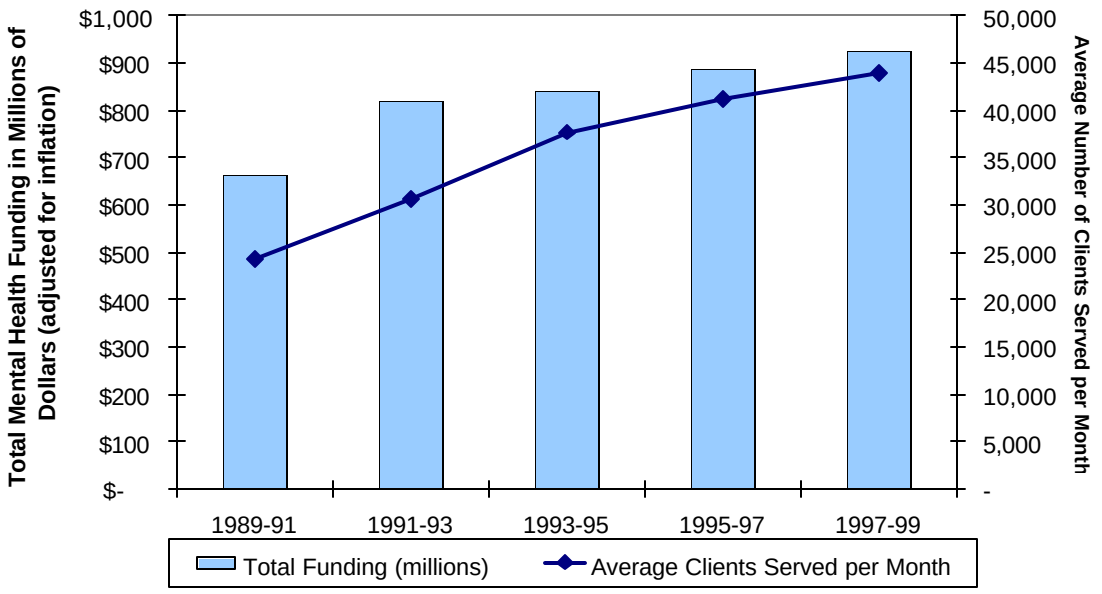
Source: MHD fiscal records.

Exhibit 2
Public Mental Health Expenditures per Capita



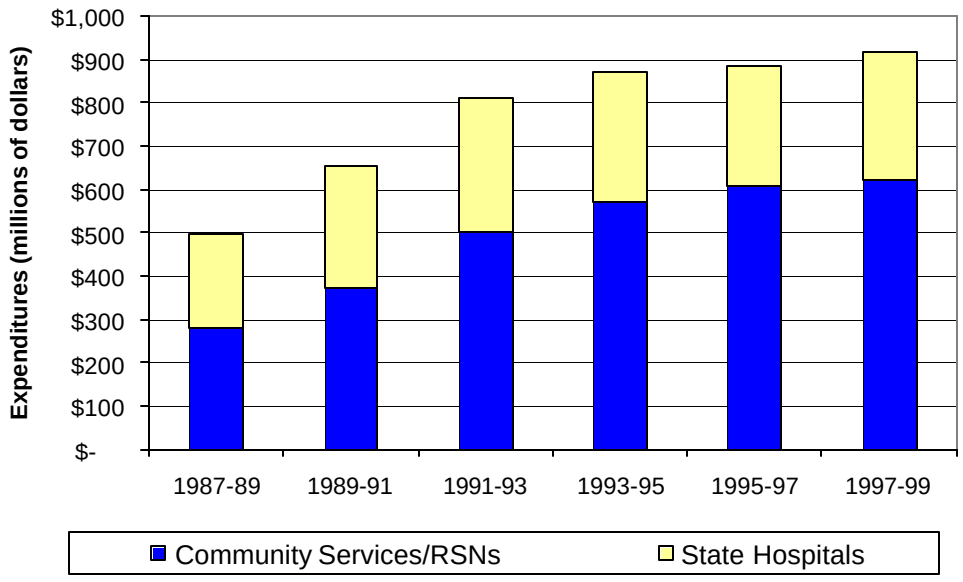
Source: National Association of State Mental Health Program Directors.

Exhibit 3
Number of Clients Served Has Grown Somewhat Faster Than Inflation-Adjusted Funding



Source: LEAP fiscal data and legislative budget notes.

Exhibit 4
Expenditures for Community Services Have Grown Much Faster Than State Hospital Expenditures



Source: LEAP fiscal data.

SECTION 2 – STATEWIDE PLANNING AND SERVICE COORDINATION

Washington State is required by the 1999 HCFA waiver renewal to provide an integrated mental health system with "seamless" mental health care for people covered by Medicaid. RCW 71.24.015 and 035 and WAC 275-57 require that the MHD conduct statewide mental health system planning and advocate for cross-system collaboration and sharing of resources for priority population consumers eligible for services from allied service providers.

A statewide mental health system plan was developed by the MHD in 1998 and is now being updated. Other planning activities are taking place to address specific system-wide issues, such as system oversight improvements and data system workgroups. As a result of our surveys and interviews with RSNs and case managers, we focused our review on the MHD's planning and coordination activities with three other DSHS divisions: the Division of Developmental Disabilities (DDD), Division of Alcohol and Substance Abuse (DASA), and Aging and Adult Services Administration (AASA). Our findings indicate there is limited collaboration between different types of social service providers at the at field and client levels.

The legislative intent is that services from multiple programs are coordinated so that they are not at cross purposes with each other, are not duplicative, are accessible, and lead to improvement in client functioning. For example, a client with both chronic mental illness and a developmental disability should be able to access appropriate community DDD services (community work experience activities), and also access mental health system services such as medication management or counseling. The intent is that coordinated and effective community supports should improve the client's functioning. Overall the anticipated system impacts would be fewer hospital admissions, better medication management, rapid transition from the hospital to the community, and connection of clients to educational and vocational resources. The legislative intent in the Community Mental Health Act is consistent with approaches to system performance measurements recommended later in this report.

MHD COORDINATION WITH DDD

The MHD began a formal process of coordination with the Developmental Disabilities Division (DDD) in 1999 as a result of HCFA and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey findings at Western State Hospital, and later, the filing of a lawsuit.[2] The suit seeks "appropriate and adequate" services for developmentally disabled clients at the state hospital and in the community. A stay in the lawsuit was filed in December 1999, pending DSHS implementation of a three-phase service coordination plan. Phases 1 and 2, funded in 1999, are underway. The goals for Phases 1 and 2 are:

- Improve crisis response for developmentally disabled/mental health clients by adding staff with specialized

[2] Allen, et al. v. Western State Hospital, C99-5018RJB, United States District Court, Western District, Tacoma, WA.

expertise at the hospital and regional DDD levels.

- Teach case managers for developmentally disabled/mental health clients about available services and eligibility requirements for the developmentally disabled and mental health systems, and tie the DDD and MHD data systems together to facilitate coordination of services.
- Establish 18 diversion beds for developmentally disabled clients who may be at risk for hospital admission.

Phase 3 of the plan includes development of a specialized training and education model for developmentally disabled/mental health clients committed under RCW 71.05. DSHS will report to the Legislature on this in December 2000. DDD reports progress in establishing cooperative working agreements and contracts with nine of the RSNs to implement the coordination plan. However they do note difficulties establishing working agreements with some RSNs.

MHD COORDINATION WITH DASA

The MHD and the Division of Alcohol and Substance Abuse (DASA) have an implementation plan for improving services for individuals who are seriously mentally ill and chronically use drugs and/or alcohol. The plan was developed in December 1998. Implementation and availability of treatments for persons with serious mental illness and chronic substance abuse varies across the state. DASA reports complications associated with working with multi-county RSNs and/or RSNs with boundaries that overlap multiple DSHS regions. DASA indicates that the variability of mental health service eligibility among the RSNs makes development of joint statewide efforts difficult. The MHD is planning training for the RSNs regarding how to develop services for clients who are both seriously mentally ill and abusing substances. The MHD also plans to establish indicators in RSN contracts that identify whether the RSNs are coordinating with DASA.

MHD COORDINATION WITH AASA

The MHD and the Aging and Adult Services Administration (AASA) report that coordination at DSHS headquarters between the two organizations formally began in August 2000. Identification of cross-system issues such as the development of community placement options, and strategies to address them, is planned to begin by the end of this year. These coordination efforts are in the beginning stages, as reflected in the findings from our surveys and interviews with RSNs, case managers, and staff from the MHD and AASA.

Regional Support Networks and case managers report that a lack of suitable community placement options, such as nursing, adult family, or boarding homes, reduces alternatives to state hospital admission and could delay hospital discharge. Developing these alternatives will likely require regulatory refinements and funding approaches that encourage development of community resources. Training for nursing home, adult family home, and boarding home staff who work with clients with serious or chronic mental illness, and access to RSN mental health services for clients living in such facilities were suggested by AASA as strategies that may reduce hospital admissions.

Summary of Findings Regarding Planning and Service Coordination

The MHD has been slow to meet the intent of the HCFA waiver, state statute, and WAC. Coordination and planning between the MHD and other divisions at the DSHS

headquarters level are at various stages of development. Findings from surveys and interviews with RSNs and case managers indicate there is limited implementation of cross-system collaboration and sharing of resources at the field/direct client service level. DDD and DASA report that cooperative approaches and working agreements are established with some RSNs, but that these efforts are challenging and highly dependent on reciprocal cooperation by the RSNs. The MHD has not routinely been involved with forging cooperative working relationships between the other DSHS divisions and RSNs.

DSHS also has not developed strategies to work with organizational issues relating to its regional boundaries. The legislative intent for coordinated services is that services from multiple programs are coordinated so that they are not at cross purposes with each other, are not duplicative, and are accessible and lead to improvement in client functioning.

Recommendation 1

The Department of Social and Health Services should comply with legislative intent and coordinate allied services provided to mental health clients. It should implement strategies for resolving organizational, regulatory, and funding issues at all levels of the system—state, regional, and local.

Recommendation 2

In its contracts with Regional Support Networks (RSNs), the Mental Health Division (MHD) should require RSNs to collaborate and work with allied service provider agencies in providing mental health services and identify RSN responsibilities to achieve collaboration. The MHD should enforce the provisions of those contracts.

COORDINATION OF STATE HOSPITAL DISCHARGE PLANNING

The HCFA waiver, state statutes, and DSHS regulations require that a care coordination structure "promote rapid and successful reintegration of recipients into the community" and provide residential services that emphasize the least-restrictive, stable living situations appropriate to the age, culture, and residential needs of each consumer.

The MHD has partially complied with the intent of the waiver and statutes. The RSNs and the state mental hospitals have working agreements describing admission and discharge responsibilities, and hold bi-monthly meetings to improve coordination efforts. However, despite these efforts, our surveys and interviews with the RSNs and MHD staff indicate problems remain:

- RSNs who work with Western State Hospital report data reliability problems. Data from the hospital often indicate an individual is at the hospital, but the RSN becomes aware through other means that the patient is in the community.
- RSNs report that Western State Hospital often assigns clients to the incorrect RSN. This is of concern to RSNs as they attempt to manage the number of clients they have at the state hospital.

A number of problems specific to hospital discharge planning activities at both Eastern and Western State Hospitals were identified. The state hospital, RSN, and Aging and Adult Services Administration staffs all typically have responsibilities associated with hospital discharge evaluations and planning for community supports. Our surveys indicate that among the three entities responsible for hospital discharge there is:

- Lack of consistency or understanding of criteria used by the hospital when assessing a client for discharge.

- Difficulty in obtaining timely and appropriate pre-release evaluations from AASA if a client needs an evaluation for placement in a nursing, boarding, or adult family home.
- Discrepancy of views or lack of understanding between hospital staff, the RSN, and AASA Home and Community Services staff about when a client is eligible for placement in a community facility as a client of AASA.
- Delays in receiving patient chart information at the RSN from the hospital after release.

RSNs report that discharge-planning problems hamper client opportunities for placement in a nursing, boarding, or adult family home when it becomes available and sometimes unnecessarily extend hospital stays. AASA Home and Community Services is responsible for evaluating whether a client is eligible for community placement in a nursing, boarding or adult family home as a client of AASA. AASA contends that on occasion the RSNs want to move a client from the state hospital into a nursing, boarding or adult family home and that the client may not meet AASA's criteria for community placement. Consistent with our findings regarding coordination of allied services, we conclude that improvement of coordination by the three entities responsible for hospital discharge is warranted.

Recommendation 3

The Mental Health Division, Aging and Adult Services Administration, state hospitals, and Regional Support Networks should meet legislative intent to ensure hospital discharge and community placement for eligible clients occur in a timely manner. This will require developing an understanding of both the hospital discharge and the community placement criteria and how they relate to one another on a case-specific basis.

SECTION 3 – SYSTEM OVERSIGHT AND ACCOUNTABILITY

MHD ACCOUNTABILITY PROCESSES

Together, the federal Heath Care Finance Administration (HCFA) waiver and RCW 71.24 require the Mental Health Division (MHD) to ensure access to efficient and effective services. The waiver and state statute require the MHD to have a management information system that ensures data integrity and systematic data collection, and that can be used to ensure appropriate services and outcomes. They also require the MHD to streamline the administrative oversight process and move toward monitoring the system using outcomes. The 1995 Legislature, with the passage of ESSB 6547, directed DSHS to address "administrative layering, duplication and administrative costs" negatively impacting the "community mental health service delivery system."

The federal government, state, RSNs, and providers all maintain a variety of processes in order to promote accountability in the provision of public mental health services. HCFA has an extensive waiver application and renewal process and occasionally conducts onsite system reviews. The MHD has an extensive accountability review process which includes: certification of RSNs, contracting with RSNs, integrated reviews (medical audits and administrative reviews) of RSNs and providers, RSN fiscal and client data reporting requirements, and provider licensing reviews. RSNs, in turn, exercise a range of oversight activities on their contracted providers. These include medical audits and chart reviews, reviews of specific approaches or treatment programs, follow-up reviews of complaints, and reviews based on provider client and fiscal data. Finally, providers frequently employ their own quality assurance activities including certification by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other professional organizations and independent financial audits.

Findings Regarding MHD Accountability Processes

Legislative enactments in 1995 directed the MHD to streamline process-oriented oversight activities and focus on consumer and system outcomes. Process-oriented oversight activities, such as verifying entries in charts or checklists, are grounded in HCFA requirements. The MHD has improved its oversight activities and in 2001 will implement further streamlining initiatives by possibly allowing RSN and JCAHO oversight to replace MHD oversight, and combining MHD licensing and integrated reviews with RSN reviews. Based on our survey, the MHD's oversight improvements are more extensive as compared to those of other states with similarly organized systems. However, while efforts have been made to streamline accountability activities, these activities focus on processes of care rather than outcomes of care. We believe the MHD should focus its accountability efforts on outcomes and negotiate with HCFA to do so as well by replacing current process-oriented accountability activities with an approach that is outcome-based. Implementing an outcomes-focused system of accountability would demonstrate Washington's compliance with the HCFA mental health system waiver.

Recommendation 4

The Mental Health Division (MHD) should continue to streamline and reduce process-oriented accountability activities. The MHD should negotiate with the Health Care Finance Administration regarding how to replace process-oriented system accountability requirements with system and client outcomes reporting.

The existing process-oriented accountability activities result in a great deal of effort on the part of the MHD, RSNs, and providers. While a great deal of effort is expended in the name of system accountability, the current accountability processes do not provide information concerning whether the system as a whole, individual RSNs, or individual providers are operating efficiently or achieving positive client outcomes. Beginning on page 13 of this report, we recommend a framework for a performance measurement system that can be used to manage the system based on outcomes. Additionally, we note that while the Legislature has provided direction that the system evaluates outcomes, expectations that the system operates efficiently and effectively could be bolstered in statute. Therefore we recommend that the statute be amended as described below.

Recommendation 5

The Legislature should further clarify its intent that the mental health system should be efficient and effective by amending RCW 71.24.015 as follows:

> ***"71.24.015 Legislative Intent and Policy***. *It is the intent of the Legislature to establish a community mental health program which shall help people experiencing mental illness to retain a respected and productive position in the community. This will be accomplished through programs which provide for….*
>
> *(2) Accountability of <u>efficient and effective</u> services through statewide standards for monitoring and reporting of information <u>that bears directly on system and client outcomes</u>;…"*

SYSTEM DATA ISSUES

The MHD collects a great deal of data in its efforts to promote system accountability. Most of this data is generated from service providers, who report the data to the RSNs. The RSNs aggregate the data from providers and send it to the Mental Health Division. The data collected include:

- Fiscal data;
- Client characteristics; and
- Amounts and types of services provided to clients.

Financial Reporting Issues

The MHD requires community mental health providers and RSNs to provide information on revenues and expenditures. It also defines several categories of revenues and expenditures that must be reported. The MHD's contracts with RSNs require that 75 percent of funds received by the RSN be spent for direct services.[3] Direct services are defined in accounting guidelines provided to the RSN.

A major focus of the legislative mandate for this audit involves analyzing RSN and service provider costs. Because of concerns expressed by RSNs and providers that the fiscal data they report to the MHD are not consistent, JLARC retained a consulting firm, Sterling Associates, to assess the consistency of the financial information provided by providers and RSNs. Sterling was also charged to recast the fiscal data, if necessary, for each RSN and a sample of providers to make it consistent. The Executive Summary of Sterling's report to JLARC is provided in Appendix 3. In general, Sterling found that:

[3] Beginning in July 2000, this standard was changed to cap administrative costs at 20 percent.

- The decentralized approach to public mental health care leads to inconsistent cost reporting among providers and RSNs.
- MHD cost reporting instructions do not provide adequate direction for consistent cost reporting.
- The MHD requires that several detailed categories of costs to be reported, but uses only two categories (direct services and administrative costs) for accountability purposes.
- RSNs and providers make little use of the cost information generated for MHD.
- Counties serving as RSN fiscal agents are not required to separate RSN accounts from other county accounts. This increases the difficulty of verifying that state-provided mental health funds are used solely for RSN purposes.
- Costs reported by RSNs do not include expenditures for inpatient services in community or state hospitals.

In addition to Sterling's findings regarding the reporting of financial information, JLARC also has findings related to MHD's fiscal accountability standard that 75 percent of revenues must be spent for direct services:

- The MHD's definition of direct service costs is too broad and includes elements such as information services costs related to patient tracking, costs of quality assurance activities, and training costs that might be more accurately categorized as direct service support.
- The calculation of administrative costs used for MHD's accountability standard (that 75 percent of revenues must be spent for direct services) does not include administrative costs of the MHD, state hospitals, or community hospitals. Additionally, "direct services" includes the costs such as information services, quality assurance activities, and training that might be more accurately categorized as "direct service support." We conclude, therefore, the reporting of this standard may mislead others (e.g., the Legislature and HCFA) to believe that 75 percent of total system expenditures are for direct services.
- After accounting for the administrative costs not counted by MHD, and separating direct service support costs from direct services, we estimate that 61 percent of total system costs are for direct services, 19 percent for direct service support, and 20 percent for administration. This will be discussed in more detail at Section 5, "System Cost and Operations Analysis."

Recommendation 6

The Mental Health Division (MHD) should implement the following Sterling Associates recommendations to improve the consistency of cost reporting:

(6-1) MHD should reduce the number of reported cost elements to those directly linked to the accountability process.

(6-2) MHD should clarify the definition of the "provider administration" cost category to improve the consistency of assigning organizationally complex items to either administrative or non-administrative categories.

(6-3) MHD should issue instructions to Regional Support Networks (RSNs) to ensure that reported cost information is collected in a manner that reconciles with actual county-maintained (RSN) fiscal records.

(6-4) MHD should collaborate with the State Auditor's Office to ensure that all RSNs are using appropriate accounting procedures to segregate RSN revenues, fund balances, and reserve accounts from other county funds.

(6-5) MHD should work with the State Auditor's Office and counties to explore the feasibility of using the

Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process.

(6-6) MHD should develop a process for quantifying and reporting the costs of RSN utilization of state-operated mental hospitals. This data should be integrated with other cost information collected from the RSNs.

Recommendation 7

The Mental Health Division (MHD) should change its fiscal accountability standard (which requires 75 percent of revenues to be spent for direct services) to provide uniform definitions that reflect the following:

(7-1) The definition of direct services should be narrowed to include only those expenditures directly related to client services.

(7-2) A new category of expenditures should be created to include direct service support expenditures (e.g., patient tracking system, quality assurance activities, and training) that are currently categorized as direct service.

(7-3) The reporting of the standard should include the administrative and support costs of the MHD, the state hospitals, and community hospitals that are currently either not part of the calculation or are counted as direct services.

Client Service Data Issues

Similar to the problems with fiscal data, we heard similar concerns regarding the client service data collected by the MHD. Comparable financial and service data are needed in order to make valid comparisons of cost per unit of service among RSNs and their providers. In the case of the financial data, our contractor was able to provide consistent financial comparisons of RSNs and a sample of providers.

In order to make the financial data consistent, JLARC's contractor worked with each RSN and a sample of 35 community mental health providers to recast expenditures consistently into common categories. This was a labor-intensive exercise for JLARC's consultants and the providers who were part of the sample group. Recasting financial information for consistency is less difficult than recasting client service data in that there is a known total (total expenditures) within which expenditures are sorted into consistent categories. In the case of counts of the minutes of services provided to clients, there is no known total that can be used as a bottom-line. Given the amount of resources necessary to produce consistent financial information for RSNs and a sample of providers, and the additional difficulty of recasting client service information, JLARC decided to survey RSNs and providers to document inconsistencies in the reporting of client service data, rather than attempt to recast the data.

The results of our survey confirmed the concerns that had been expressed regarding the lack of comparability of the client service data collected by the MHD. We noted inconsistencies in how many minutes of service providers count under several circumstances. For example, if a client is seen face-to-face by a clinician for 45 minutes and, following the meeting, the clinician spends 15 minutes on paperwork relating to that client, some providers code this circumstance as 45 minutes of service, and others code it as 60 minutes of service. We noted inconsistencies in other circumstances including:

- Whether travel time for clinicians associated with client meetings is counted;
- Whether time spent with unidentified clients is counted;
- Whether time spent responding to calls on a crisis hotline is counted;

- Whether time spent by clients in residential treatment is counted; and
- Whether time spent by clients in clubhouse service (less formal drop-in centers) is counted.

The inconsistencies noted above relate to how the providers count the *amount of service* provided to clients. Additionally, we noted an inconsistency in how providers count the *number of clients* they serve. Some providers report all clients they serve within the information provided to the MHD, regardless of whether the client is a public-pay client or not. Other providers only report public-pay clients in the information provided to the MHD.

The inconsistencies in how providers and RSNs count clients and the amounts of service provided to clients result in questions regarding the validity of basic comparisons among providers and RSNs relating to cost per client, service hours per client, or cost per service hour. This is true particularly for comparisons involving amounts of service hours provided to clients. Additionally, inconsistencies in client service data make it impossible to identify trends in costs over time.

Recommendation 8

The Mental Health Division should develop uniform client and client service data definitions to address the inconsistencies noted in this report.

SYSTEM PERFORMANCE MEASUREMENT

Inconsistencies in the fiscal and client service data collected by the MHD make comparisons of *service efficiency* (cost per client, cost per service hour, service hours per client) among providers and RSNs difficult. However, while there are problems with consistency in the cost and service data collected by the MHD, the MHD collects almost no information on client or system outcomes. Therefore, it is not possible to make any comparisons of *service effectiveness*: (e.g., did the services provided have a positive effect on the clients served?) Nor is it possible to relate service effectiveness to service efficiency.

Recognizing these problems, JLARC retained consultants to evaluate performance information collected by both the public and private sector in Washington and other states. We also charged them to develop recommendations for implementing a practical and useful performance measurement system in Washington State. JLARC emphasized the need for *practical* and *useful* measures in its contracts with its consultants because we often find these common-sense characteristics missing from performance measurement efforts.

Analysis of Current Conditions

JLARC retained Clegg and Associates, Inc. (with the Health Policy Analysis Program at the University of Washington as a subcontractor) and the Center for Clinical Informatics to:

- Analyze the current performance measurement efforts in Washington's public mental health system.
- Review best practices of performance measurement in other public and private mental health systems.
- Review performance measurement literature for public mental health.
- Develop criteria for mental health performance measures.
- Analyze current data elements collected as well as those required for a performance measurement system.

The consultants found a variety of performance measurement efforts underway throughout Washington. They also found that confusion exists at all levels of the system regarding what performance measures are. Because current efforts are not uniform or coordinated, they do not allow comparability across the system.

Framework for Measurement

Based on findings regarding current system conditions and their review of performance measurement systems elsewhere, the consultants recommended a framework for a practical and useful system to measure performance. The Executive Summary of these consultants' report (Clegg/CCI) is included in Appendix 4.

In general, the consultants found that creation of an effective performance measurement system involves balancing the need for the information collected with the cost of collecting it, while focusing measures on results and avoiding concentration on the processes by which the system attained these results. The framework developed by Clegg/CCI recognizes the needs of the Legislature and the MHD to be able to track progress in implementing a system that meets legislative intent and HCFA requirements; is accountable to stakeholders; is useful to RSNs and providers; and allows for comparison of measurement results between RSNs and other states. Clegg/CCI built the recommended framework using the existing research, knowledge, and practical application of performance measurement in public and private mental health settings.

Clegg/CCI's framework organizes 23 performance measures into four categories that are consistent with national efforts for the performance measurement of public mental health systems. The categories are:

- System Access
- Service Quality/Appropriateness
- Client Outcomes
- System Structure/Plan Management

The consistency of the framework with national practices in mental health system performance measurement will allow the state to benchmark itself with other systems and identify best practices within Washington and other states.

A key component of the framework is the measure for client outcomes. Clegg/CCI provide direction on how to collect data to assess a client's change in symptoms as a result of the services provided and how to analyze those results. Public and private mental health systems have used this approach and have generated data that are used to manage system services and resources.

Many of the measures recommended by Clegg/CCI do not require additional data collection on the part of MHD, RSNs, or providers. However some of them will. Once a performance measurement system consistent with the framework developed by Clegg/CCI is implemented, the opportunity will be available to greatly reduce the current process-oriented accountability activities now being conducted by the MHD and RSNs as we suggested in Recommendation 5.

Recommendation 9

The Mental Health Division (MHD) should comply with legislative intent and Health Care Finance Administration requirements to use outcomes information in managing the state's public mental health system. Implementation of a uniform performance measurement system should be a requirement of each contract between the MHD and Regional Support Networks.

Recommendation 10

The Mental Health Division (MHD) should implement an outcome-oriented performance measurement system consistent with the framework described in this report. In addition, the MHD should report back to the Joint Legislative Audit and Review Committee on the status of the system's implementation on an annual basis over the next five years and indicate how it is using the information to manage the system.

SECTION 4 – ALLOCATION OF RESOURCES TO RSNS

Under the federal Medicaid waiver, the MHD has implemented a managed care approach for allocating funding to the RSNs. The RSNs are designated as "Prepaid Health Plans" under the Medicaid waiver. This means the RSNs receive a payment of federal Medicaid dollars for each Medicaid-eligible person within the RSN, regardless of whether the Medicaid-eligible person needs or receives mental health services.

The RSNs also receive state funding for outpatient services that is purportedly based on an estimate of the regional prevalence of mental illness in Washington State (see box on prevalence estimates on page 20). As Prepaid Health Plans, RSNs are required to make: 1) a full range of mental health services available to any Medicaid-eligible person who needs service, 2) crisis services available to anybody (regardless of Medicaid eligibility), and 3) a broader range of services available to non-Medicaid-eligible persons on a "funds available" basis.

In addition to the funding allocated to RSNs, the MHD also allocates the majority of the beds at the two state hospitals to the RSNs for use by their clients. Funding for the state hospital beds is appropriated to the MHD. Therefore, RSNs do not have to pay directly for their usage of state hospital beds, unless they exceed their total capacity at the state hospital. Beds at Eastern State Hospital are allocated to the Eastern Washington RSNs who, as a group, decide how the beds will be allocated to each RSN. The MHD allocates beds at Western State Hospital to each of the Western Washington RSNs.

There are several individual components to the methodology for allocating resources to the RSNs. These components are described in Exhibit 5 on the following page.

ROLE OF FUNDING METHODOLOGY IN THE GENERATION OF FEDERAL REVENUE

The amount of federal Medicaid revenue received by the state (and allocated to the RSNs) for mental health services is a function of the number of Medicaid-eligible persons times a payment rate per person for each RSN. Thus, the same methodology that *generates* federal Medicaid revenue is also used to *allocate* the federal revenue to the RSNs.

This methodology was first implemented for outpatient services funding in 1993. A similar capitated funding system for inpatient services was phased in beginning in 1997 and fully implemented in 1999. Prior to 1993, federal Medicaid revenues were generated on a fee-for-service basis with individual service providers reimbursed for their costs when they provided services to Medicaid-eligible persons. Exhibit 6 on the following page shows that federal revenues have grown over time as a percentage of total funding.

Tying the amount of federal Medicaid revenues to the number of Medicaid-eligible people (rather than the number of Medicaid-eligible persons served) may have generated additional federal revenues than would have been received under the previous fee-for-service system. For example, after tying Medicaid revenue to the number of Medicaid-eligible persons in 1993, Washington has expanded its Medicaid eligibility criteria (e.g., by expanding Medicaid eligibility for children to 200 percent of the federal poverty level in 1994).

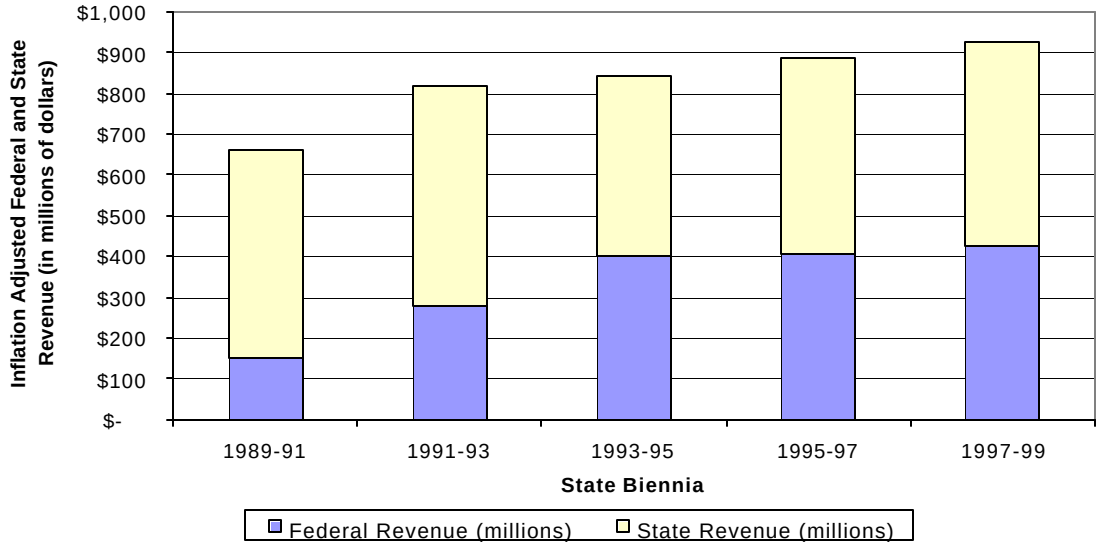
Additionally, according to information from the National Association of State Mental

Exhibit 5
Description of How Resources are Allocated To RSNs

	Federal Revenue	State Revenue
Outpatient Services	Allocated based on a dollar amount per Medicaid-eligible person within the RSN*. The dollar amount per Medicaid-eligible person varies widely among RSNs.	Allocated through a formula that is purportedly based on an estimate of the regional prevalence of mental illness, and historical fee for service costs.
Community Hospital Inpatient Services	Allocated based on a dollar amount per Medicaid-eligible person within the RSN*. The dollar amount per Medicaid-eligible person varies widely among RSNs.	Allocated based on a dollar amount per Medicaid-eligible person within the RSN*. The dollar amount per Medicaid-eligible person varies widely among RSNs.
State Hospital Inpatient Services	Eastern State Hospital beds allocated to Eastern Washington RSNs as a group. The Eastern Washington RSNs decide how many beds each particular RSN may use. Western State Hospital beds are allocated by the MHD among the Western Washington RSNs based primarily on historical usage.	

*Federal revenues per Medicaid-eligible person vary by the person's category of eligibility. For example, payment rates for people who are eligible for Medicaid because they are disabled are different than payment rates for people who are eligible for Medicaid because of low income.
Source: JLARC analysis.

Exhibit 6
Growth Rate of Federal Revenue has Exceeded Growth Rate of State Revenue



Source: LEAP fiscal data.

Health Program Directors, Washington received $36.94 of federal revenue per capita (total population) in 1997, which was 248 percent of the national average of $14.87 per capita, and second highest in the nation.

EQUITY OF FUNDING ALLOCATION TO RSNS

While each RSN is required under its contract with the MHD to provide a full array of public mental health services to Medicaid-eligible residents (and a narrower array of services to all residents), the amount of funding provided per Medicaid-eligible person varies substantially among RSNs. In FY 2000, total funding (both federal and state) allocated to RSNs varied from $277 to $539 per Medicaid-eligible person. Exhibit 7 on the following page illustrates the amount of FY 2000 funding per Medicaid-eligible person by RSN. Exhibit 8 provides a map of the RSNs.

Explanation of Funding Variations

The variation in funding amounts per Medicaid-eligible person among RSNs is an artifact of the old fee-for-service system of funding. The capitated rates for each RSN were largely determined based on the amount of money paid to providers within that RSN under the previous fee-for-service system. The total amount of fee-for-service revenue generated by providers within an RSN's boundaries was divided by the number of Medicaid-eligible persons within that RSN. Therefore, ***the capitated payment rates (***used for allocating federal outpatient, and federal and state inpatient revenue***) were set to maintain the previous geographic distribution of funds under the fee-for-service system.***

The allocation of state outpatient revenue is based on a methodology that purports to estimate the prevalence of mental illness in each RSN, but MHD does not have a copy of the study supporting this methodology. Consequently, we were unable to assess its validity. Additionally, MHD staff indicate that the allocation rates resulting from this prevalence study were also adjusted to reflect historical expenditure levels.

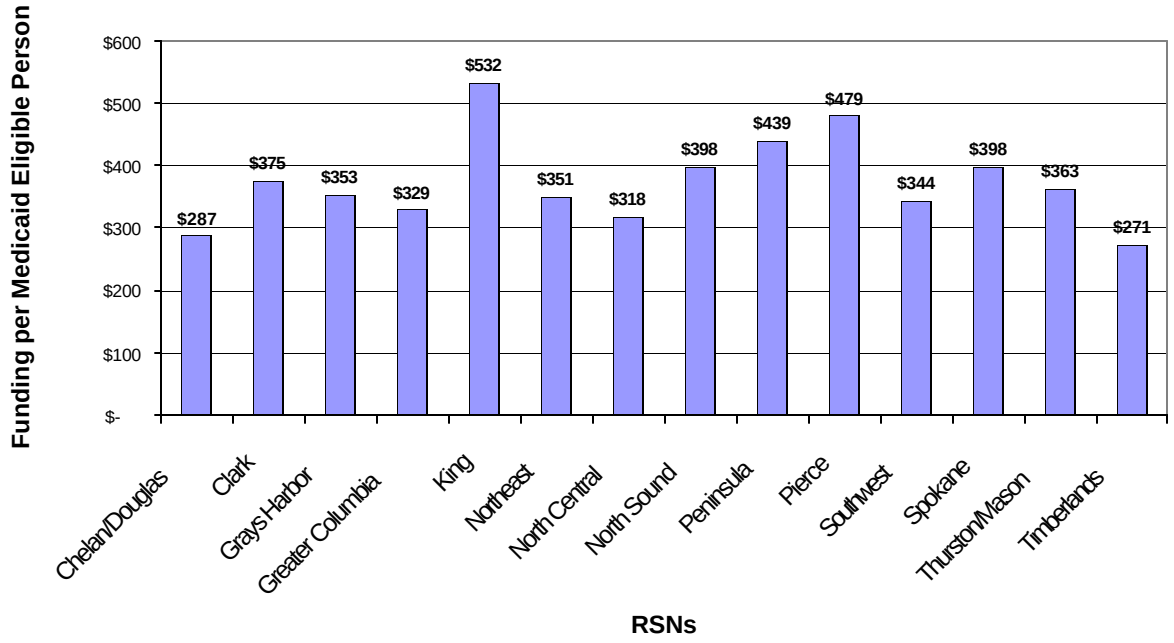
RSNs currently receiving high payment rates (primarily King and Pierce) make several arguments in support of the disparity in rates. They argue that because of a higher availability of services in urban areas, a disproportionate number of the homeless and parolees from state prisons, and their geographic proximity to state hospitals, they have a higher proportion of the seriously mentally ill residing within their boundaries.

RSNs with lower rates argue that there is no less of a need for mental health services in less urban areas, that they must travel long distances to serve clients, and that the high payment rates in the urban areas may simply reflect the relative sophistication of the providers in urban areas in generating revenue under the old fee-for-service system (which translated into higher payment rates under the current capitated system).

JLARC Assessment of RSN Funding Equity

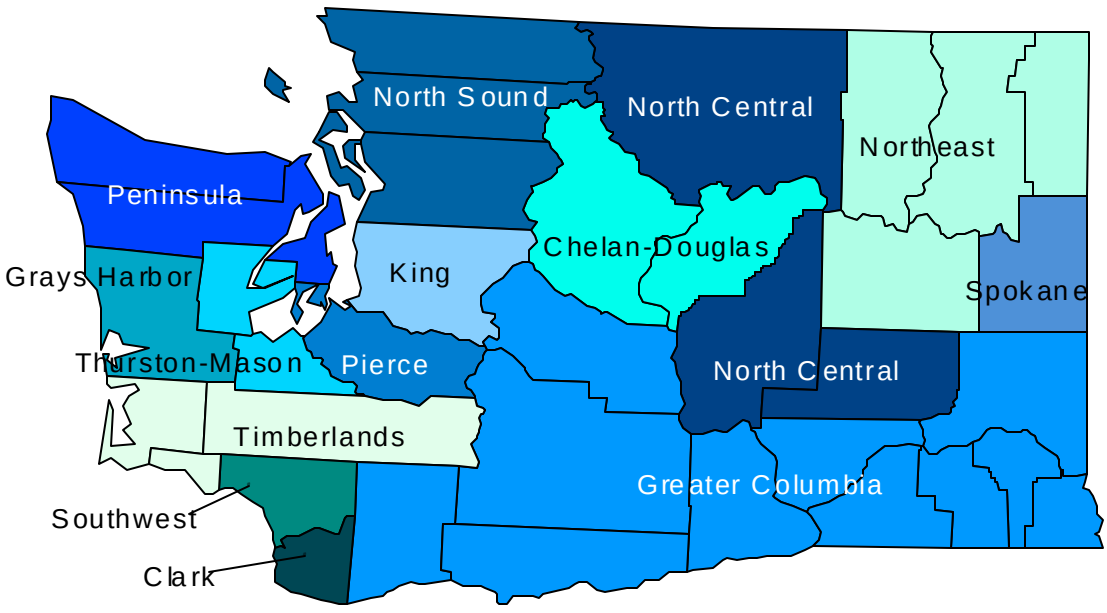
In order to evaluate the arguments for and against the disparities in payment rates to RSNs, we conducted a statistical analysis to identify factors that are associated with variations in payment rates to RSNs. The analysis utilized information regarding RSN funding and expenditure levels, RSN expenditure patterns, the amounts and types of services provided in each RSN, geographic and demographic factors, and the estimated number of people needing public mental health service within each RSN (based on the PEMINS study discussed in box on page 20). A detailed description of the methodology and data used in this analysis is provided in Appendix 5. Appendix 6 provides comparisons of funding, expenditure levels, and client services provided among the RSNs.

Exhibit 7
FY 2000 Total Funding per Medicaid Eligible Person Varies Substantially Among RSNs



Source: JLARC analysis of MHD fiscal and client data.

Exhibit 8
Map of RSN Boundaries



Our analysis found no evidence to support the wide disparities in payment rates among RSNs. In fact, the evidence suggests that disparities in payment rates lead to inequities in client services among the RSNs.

Following is a summary of the findings of our assessment of the equity of resource allocation to the RSNs. A more detailed discussion of these findings follows.

- Disparities in funding (per Medicaid-eligible person) among RSNs are not associated with differences in the estimated number of people needing public mental health services or the severity of the clients served among RSNs. Disparities in funding are most closely associated with the population of the RSN (large RSNs receive more money per Medicaid-eligible person than small RSNs).
- Regardless of funding level, there is a strong association between the estimated number of people who need public mental health services in each RSN and the number of people actually served.
- The proportion of Medicaid-eligible persons is a good proxy for the estimated proportion of persons needing public mental health services in each RSN.
- RSNs with higher funding levels spend more per person served than RSNs with lower funding levels.

RSN Size Associated with Disparities in Funding

Our analysis found that the population of the RSN is the strongest factor associated with the variations in payment rates among RSNs. In other words, large RSNs (in terms of population) receive higher funding, small RSNs receive less funding per Medicaid-eligible person. Factors that were *not* strongly associated with variations in funding rates include the estimated number of people needing public mental health services in each RSN or the severity of the clients served.

Estimated Number of People Needing Public Mental Health Services Related to the Number of People Served

We also found that there is a strong relationship between the estimated number of people needing public mental health services and the number of people being served in each RSN. The strength of this relationship, in spite of the wide variation in funding levels (per Medicaid-eligible person) to RSNs, suggests that RSNs are attempting to serve the people who need service, regardless of the amount of funding received.

Medicaid Eligibility is a Proxy for Prevalence

We found a strong association between the estimated proportion of people needing public mental health services within each RSN and the proportion of Medicaid-eligible persons within each RSN. RSNs with a higher proportion of their population estimated to be in need of public mental health services also had a higher proportion of their population eligible for Medicaid. The strength of this relationship does not suggest that everybody who is eligible for Medicaid is in need of public mental health services. In fact, the number of persons eligible for Medicaid is approximately ten times the number of people estimated to be in need of public mental health services. But the strong relationship between these variables suggests that the number of Medicaid-eligible persons is a good proxy for the prevalence of those needing public mental health services among RSNs.

Estimates of the Regional Prevalence of Mental Illness in Washington State

There are two estimates of regional differences in the prevalence of mental illness within Washington State that are discussed in this report:

The older estimate of regional differences in the prevalence of mental illness in Washington State is a methodology used by the MHD to allocate portions of state funding among RSNs. The allocation is based on a formula that purportedly uses a methodology developed in 1981 to estimate the regional prevalence of mental illness in Washington State. MHD fiscal staff do not have a copy of the study supporting this methodology and we are unable to assess its validity. The MHD uses historical percentages for allocating state funds among the RSNs that are purported to be based on this methodology.

The newer estimate of the regional prevalence of mental illness is from a 1999 study titled, *The Prevalence Estimation of Mental Illness and Need for Services (PEMINS) Study*. The study was conducted by University of Texas professor Charles E. Holzer III on behalf of the Research and Data Analysis Office of DSHS. The estimated regional prevalence of mental illness within Washington State is based on a telephone survey of 7,000 Washington State residents. Trained clinicians conducted follow-up interviews with those respondents whose initial responses indicated the potential for a psychotic disorder. The response rates for both the initial and follow-up surveys were over 70 percent. The study estimates the prevalence of serious mental illness among adults in each county, and then estimates the number of adults needing public mental health services by estimating the number of seriously mentally ill whose income is less than 200 percent of the federal poverty level.

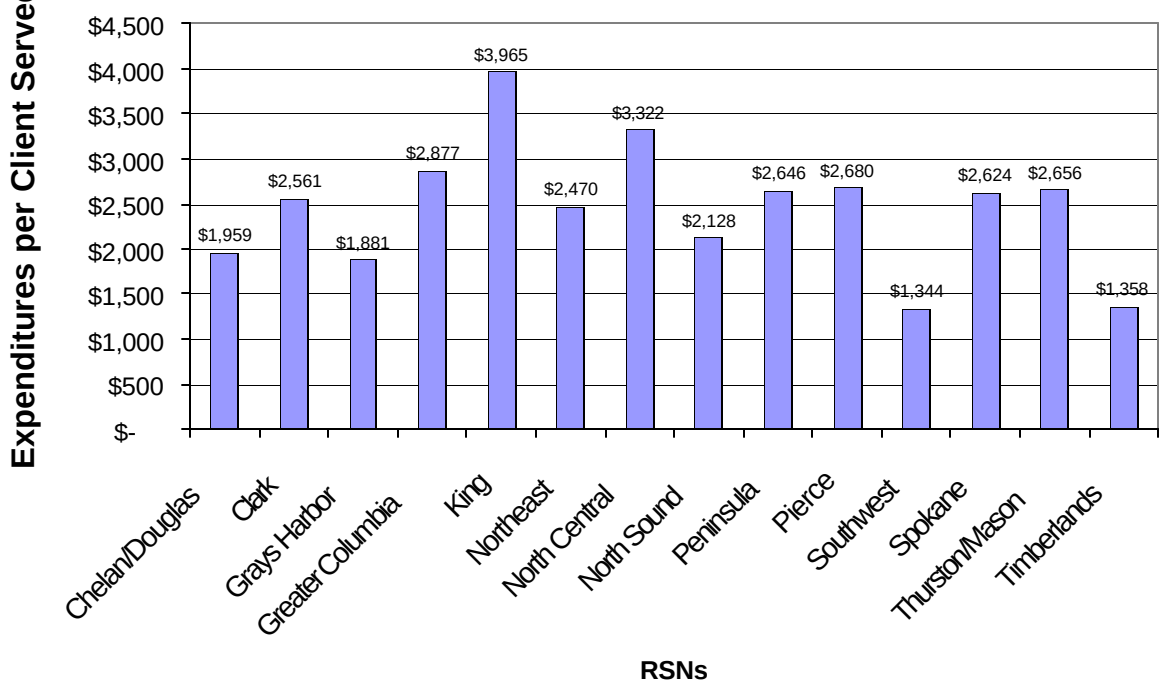
The study uses three definitions (narrow, medium, and broad) of "need for public mental health service." For our regression analyses, we used the estimated need for service under the medium definition of need. The income standard (200 percent of the federal poverty level) is broader than the income standard used to determine Medicaid eligibility. Therefore, the methodology is generous in estimating need for public mental health services if Medicaid eligibility is a criterion for public mental health services. However, Washington statute does not limit service eligibility to only those eligible for Medicaid, but Medicaid funding comprises the vast majority of total funds for the system. King RSN has criticized the survey for not adequately representing the homeless population and for not including all diagnoses of mental illness in its estimates of the prevalence of severe mental illness. While these criticisms have some merit, to our knowledge this study is the only credible source of information regarding the regional prevalence of serious mental illness within Washington State. Additionally, our analysis found a strong association between the estimated regional prevalence of serious mental illness and the number of people being served within each RSN. This association supports the validity of the regional prevalence estimates of the PEMINS Study

The exclusion of the homeless and certain diagnoses of serious mental illness could result in an underestimate of the total number of people in need of public mental health services in Washington State. Therefore, we do not believe the PEMINS study should be used as an indicator of the absolute number of people in need of public mental health services. However, there is no reason to believe that these shortcomings of the study would disproportionately affect the estimated need for service in any particular region of the state. Therefore, we believe the estimates of the PEMINS study are a valid indicator of relative differences in the need for mental health services among different regions of the state.

Variations in Funding Associated with Variations in Expenditures per Client

We found that the funding level of the RSN is strongly associated with expenditures per client served. RSNs with higher funding per Medicaid-eligible person (or per person estimated to be in need of service) spend more per client served than RSNs with lower funding per person needing service. Exhibit 9 on the next page illustrates the differences in expenditures per client among RSNs.

Exhibit 9
Wide Variations in Expenditures per Client Among RSNs



Source: JLARC analysis of MHD fiscal and client data.

The funding level of the RSN was the only statistically significant factor (among those we tested) associated with variations in expenditures per client served among RSNs. Factors that were ***not*** associated with variations in expenditures per client include: the severity of the clients served, geographic wage differences, the size of the RSN, the nature of services provided (e.g., individual versus group treatment), the number of community or state hospital inpatient days per client served, and administrative costs at the RSN or provider level.

The variation in funding levels among RSNs, and the fact that higher-funded RSNs tend to have higher expenditures per client served than lower-funded RSNs, leads to questions about whether disparities in funding result in inequities of services available to clients. However, we note that in the absence of information on client outcomes, we cannot determine whether higher expenditures per client is associated with better client outcomes.

ADDITIONAL ISSUES REGARDING FUNDING ALLOCATION

In addition to the equity of the distribution of funding to RSNs, we assessed other issues relating to the funding methodology.

These issues relate to the incentives and complexities created by using separate funding methodologies for different components of funding, and whether the funding methodology results in a conflict with the Legislature's priorities for who should receive public mental health services. Our findings regarding these issues are summarized below.

A more detailed discussion of each issue follows.

- Separation of outpatient and community hospital inpatient funding is contrary to the goal of a capitated funding methodology and adds unnecessary complexity.
- Different methodologies for allocating federal and state dollars for outpatient services result in some RSNs receiving insufficient state funds to match federal Medicaid revenue. This also adds unnecessary complexity.
- There is little evidence to support concerns regarding the conflict between the Legislature's priorities for who should receive public mental health services and the methodology of the funding system.

Separation of Outpatient and Inpatient Funding

The current RSN funding methodology uses two sets of calculations for allocating funding for outpatient services and inpatient services at community hospitals. One of the goals of a managed care funding methodology is to promote the provision of services in the most cost-effective setting appropriate for each client. Using separate funding allocations for outpatient and community inpatient services is contrary to this goal because it reduces the flexibility for RSNs to deliver services in less-costly settings. It also adds unnecessary complexity to the funding methodology and process.

Different Methodologies for Allocating State and Federal Outpatient Funding

Federal Medicaid revenues are generated by multiplying the number of Medicaid-eligible persons within each RSN by that RSN's payment rate per Medicaid-eligible person. These revenues must be matched by state or local revenue in accordance with the state's Medicaid matching percentage. In aggregate, the amount of state revenue allocated to RSNs is more than adequate to match federal Medicaid revenue.

Some RSNs may not receive enough state funds to match their federal Medicaid revenue because of the different methodology by which state funds are allocated. This could reduce the amount of federal revenue available to these RSNs. Using a separate methodology (of unknown validity) to allocate state funds may result in some RSNs not receiving adequate state funds to meet Medicaid matching requirements and creates unnecessary complexity.

Conflict Between Medicaid Funding and the Legislature's Priorities?

The question of whether a client's income should factor into the state's priorities for who should be eligible for public mental health services is a matter of legislative policy, and current statute does not recognize income as a factor in prioritizing service. In general, the statutory priority is that the system should serve adults who are acutely, chronically, or seriously mentally ill, and children who are acutely mentally ill, seriously emotionally disturbed, or seriously disturbed. Concerns have been raised that there is a conflict between the Legislature's priorities for who should receive public mental health services (which do not include Medicaid eligibility as a criterion) and the fact that nearly all of the state funding provided is necessary to match federal Medicaid revenues.

The MHD attempts to address this apparent conflict by requiring in its contracts with the RSNs that a full-range of services be made available to Medicaid-eligible persons, crisis

services to anybody who needs them, and broader services to non-Medicaid-eligible persons on a "funds available" basis.

We found little evidence to support the concern about the conflict between statutory priorities and the dominance of Medicaid funding. While federal Medicaid revenue (and the necessary state match) comprised about 89 percent of total funding available to RSNs in FY 2000, approximately 40 percent of the clients served and 17 percent of total service hours were associated with services to non-Medicaid-eligible clients.

Additionally, while we might have expected to find that RSNs with higher funding levels were able to serve a higher proportion of non-Medicaid-eligible clients, this was not the case. In fact, RSNs with lower funding per Medicaid-eligible person tend to serve a higher proportion of non-Medicaid-eligible clients than higher funded RSNs. Therefore, it appears that (1) RSNs are able to devote resources to serve non-Medicaid-eligible clients in excess of the proportion of funding available after Medicaid matching requirements, and (2) that ability is not constrained by the funding level of the RSN.

ALLOCATION OF STATE HOSPITAL BEDS TO RSNS

Most beds at the state hospitals are allocated for use by the RSNs. RSNs do not pay for the use of state hospital beds; the Legislature appropriates funds directly to the MHD for the state hospitals. Since use of the state hospital beds is available to the RSNs at no cost to the RSN (to a limit), there is an incentive for RSNs to utilize costly state hospital beds up to the limit of the beds available at no cost. This is contrary to the managed care approach used for the allocation of funding to RSNs for community mental health services. Additionally, this is contrary to a provision of the Community Mental Health Services Act, which requires RSNs to "…administer a portion of funds appropriated by the Legislature to house mentally ill people in state institutions" (RCW 71.24.300(1)(d)).

Equity of Allocation of State Hospital Beds to RSNs

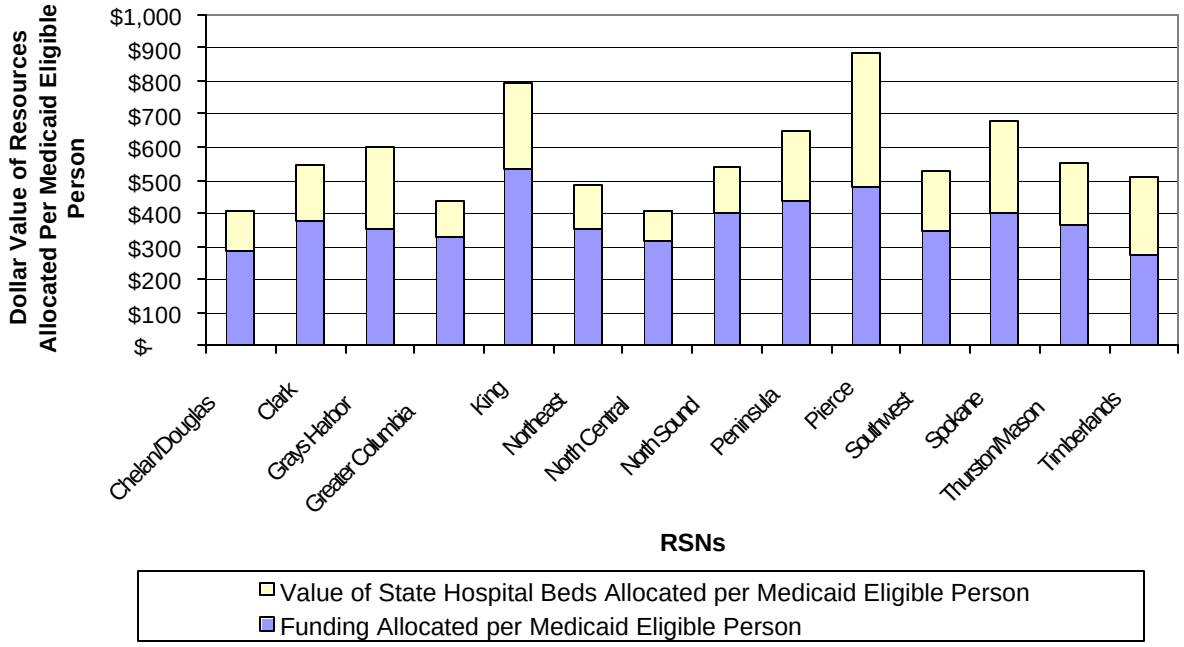
Similar to the issues of equity relating to the allocation of community outpatient and inpatient *funding* to the RSN, there are also issues relating to the equity of the allocation of *state hospital beds* to the RSNs. Beds at Eastern State Hospital are allocated to the Eastern Washington RSNs as a group; they decide among themselves how those beds are split among each RSN. Until recently, beds at Western State Hospital were allocated to the Western Washington RSNs as a group.

Because Western Washington RSNs were unable to agree on the allocation of the hospital beds among themselves, they requested that the MHD allocate beds at Western State Hospital among the individual RSNs. The MHD indicated that its methodology for allocating the Western State Hospital beds to the RSNs was based primarily on historical usage of state hospital beds. At least one RSN that is not satisfied with the MHD's allocation of state hospital beds reportedly is considering a lawsuit against the state regarding this allocation method.

Exhibit 10 on the following page illustrates the allocation of total resources among the RSNs, including allocated funding and state hospital beds. We calculated a dollar value of the state hospital beds available to each RSN, and added this dollar value to the funding for community outpatient and inpatient services allocated to each RSN.[4]

[4] The value of state hospital beds was calculated by dividing total state hospital expenditures by the number of state hospital beds.

Exhibit 10
Comparison of Total Resource Allocation (Funding and Value of State Hospital Beds) Among RSNs



Source: JLARC analysis of MHD fiscal and client data.

In order to identify factors associated with the distribution of state hospital beds per Medicaid-eligible person among RSNs, we conducted a statistical analysis similar to the one we employed in our assessment of the allocation of funding. ***We found a strong relationship between an RSN's proximity to a state hospital and the allocation of state hospital beds***. Those RSNs located nearby state hospitals are allocated a relatively large number of state hospital beds (per Medicaid-eligible person, or per person needing public mental health services), while those RSNs located at a distance from state hospitals are allocated fewer beds.

Factors that were ***not*** strongly associated with the allocation of state hospital beds include the population of the RSN (which was strongly associated with allocation of funding), the estimated number of people within each RSN in need of public mental health services, the severity of the clients served by the RSN, and the proportion of Medicaid-eligible persons within the RSN who are disabled.

CONCLUSIONS REGARDING RESOURCE ALLOCATION TO THE RSNS

The managed care approach for allocating funding to RSNs creates incentives for the provision of cost-effective care and is relatively easy to administer.

Because of the strong association between the number of Medicaid-eligible persons and the estimated number of people needing public mental health services, the number of Medicaid-eligible persons within an RSN is an equitable indicator to use as the basis for allocating resources to RSNs.

- Separate allocations for community outpatient and inpatient funding adds unnecessary complexity to the process and is contradictory to the goals of a managed care funding approach.
- Separate allocation methods for federal and state outpatient funds results in some RSNs receiving insufficient state funds to match federal Medicaid revenue, and adds unnecessary complexity.
- The disparities in funding to RSNs are not associated with differences in the number of people needing public mental health services or differences in the severity of the clients served.
- The disparities in funding are associated with differences in expenditures per client served among RSNs, which leads to questions about service equity.
- Allocation of state hospital beds at no cost to RSNs is contrary to the goals of a managed care funding approach and contrary to statutory expectations.
- There are similar questions regarding the equity of the allocation of state hospital beds and regarding allocation of funding.

Recommendation 11

The Mental Health Division should continue to use a capitated payment methodology for allocating funds to Regional Support Networks (RSNs). However, the following changes should be made:

- *Eliminate the separate methodologies for the allocation of federal and state outpatient funding.*
- *Eliminate the distinction between outpatient and community inpatient funding.*
- *Substantially reduce the disparity in payment rates per Medicaid-eligible person.*
- *Allocate funding for state hospital beds to the RSNs.*

Recommendation 12

The Mental Health Division should conduct periodic studies of the estimated regional prevalence of mental illness in order to determine whether the association between the number of Medicaid-eligible persons in a Regional Support Network and the number of people needing service remains intact. Future prevalence studies should address shortcomings of the Prevalence Estimation of Mental Illness and Need for Services study, including a methodology for capturing the homeless and the prevalence of mental illness among those incarcerated in county jails, and should utilize a broader range of diagnoses and weight the diagnoses by severity.

SECTION 5 – SYSTEM COST AND OPERATIONS ANALYSIS

The legislative mandate for this audit requires JLARC to identify the administrative costs of the public mental health system. Identifying system administrative costs is not a simple task due to the number of different entities involved in administering and operating the system. The Mental Health Division provides overall system oversight and operates the state hospitals. The RSNs plan and administer the system at the local level. Three RSNs subcontract a portion of their administrative activities to United Behavioral Health, a private-sector firm.

Each RSN contracts with private community mental health providers to furnish community mental health services. Some counties act as providers of public mental health services. RSNs also utilize community hospitals for the provision of community inpatient services. In order to identify the administrative costs of the public mental health system, an analysis of the costs of each of these different types of entities is required.

Our estimate of the administrative, direct service, and direct service support costs of the public mental health system is provided in Exhibit 11 on the following page and is based on the following components:

- JLARC's contractor, Sterling Associates, analyzed cost data from all 14 RSNs and a sample of 35 outpatient service providers (who represent about 65 percent of all expenditures for outpatient services).
- JLARC utilized community hospital cost data reported to the Department of Health to analyze expenditures for community hospital inpatient services.
- JLARC analyzed state hospital cost data to analyze expenditures of the state hospitals.
- All expenditures of the Mental Health Division headquarters, and the Eastern and Western branches of the Washington Institute of Mental Illness Research and Training, were considered to be administrative costs.

RSN ORGANIZATION, COST, AND SERVICES ANALYSIS

As a result of the Legislature's decision to decentralize the operation of the public mental health system to the RSNs, there are wide differences in how each RSN chooses to operate its local system. JLARC analyzed a variety of different practices related to how each RSN operates its system. The practices we reviewed included:

- RSN contracting practices with its providers;
- Methods RSNs use to pay their providers;
- Amount of oversight the RSN exercised over providers;
- RSN administrative costs (including the impact of subcontracting for administrative services);
- RSN fund balance practices;
- RSN expenditures per client
- RSN expenditures per service hour; and
- Clients served by RSNs as a percentage of total population.

Exhibit 11

Estimate of Administrative, Direct Service, and Direct Service Support Costs of the Public Mental Health System

	Total Expenditures	Percent Direct Service Expenditures	Percent Direct Service Support Expenditures	Percent Administrative Expenditures
MHD Headquarters	$6,575,995	0%	0%	100%
RSNs	$33,090,403	39%	4%	58%
Outpatient Service Providers	$236,491,423	63%	21%	16%
Community Hospital Inpatient Services	$49,074,236	70%	13%	17%
State Hospital Inpatient Services	$160,632,585	64%	21%	15%
Total Public Mental Health Expenditures	$485,864,642	61%	19%	20%

Source: Sterling Associates analysis of MHD, RSN and provider fiscal data and JLARC analysis of MHD and community hospital fiscal data.

Our analyses found wide differences among RSNs relating to how each RSN carries out its role. For example, administrative costs of the RSN ranged from 2 percent to 10 percent of total RSN funding. Methods of paying and the amount of oversight exercised over providers vary substantially from RSN to RSN. Appendix 6 provides financial and client service comparisons of the RSNs. Appendix 7 provides comparisons of RSN contracting practices.

Observations Relating to RSN Operating Practices

Some of our observations relating to RSN operating practices are described below:

- RSNs that subcontract some of their administrative functions with an Administrative Service Organization tend to have higher administrative costs and exercise greater oversight over providers than RSNs that do not subcontract administrative functions.
- There are no economies of scale demonstrated by RSNs (large RSNs do not have a lower percentage of administrative costs than small RSNs).
- A higher proportion of RSN administrative costs is not strongly associated with a reduction in clients served, nor is it associated with higher costs per client served.

- As discussed in the section on resource allocation, higher expenditures per client are associated with higher funding levels.

While we have noted wide differences in how the 14 RSNs operate their local mental health systems, we are not able to say whether certain practices are preferable (i.e., more effective) to others because, again, there is no information collected on client outcomes. For example, an argument could be made that RSNs should minimize their administrative costs and provider oversight activities in order to maximize funds available for client services. However, without information on client or system outcomes, we cannot say whether RSNs with lower administrative costs are getting better results than RSNs with higher administrative costs, or vice versa.

RSN Fund Balance Practices

Some RSNs have fund balances (including reserves and undesignated fund balances) that appear to be more than a reasonable amount necessary for prudent fiscal management. According to information provided by the RSNs, RSN fund balances ranged from 7 to 34 percent of annual revenue.[5] Maintaining revenue in a fund balance means that the revenue is not being spent on services to clients. While we are not aware of a commonly-accepted standard for the amount of fund balance that should be maintained, we are aware that 5 percent of revenue is often used as a rule of thumb among governmental entities. For example, the Legislature's policy is to maintain a minimum of 5 percent of annual revenue in the state's Emergency Reserve Fund.

An argument for RSNs maintaining a higher fund balance is that the MHD's contracts with RSNs requires them to provide a full range of services to all Medicaid-eligible persons (and a more limited range of services to any resident), while funding is capitated. Therefore, RSNs assume a risk that more people will need services than funding allows for. However, this risk (of a higher demand for services than anticipated) is also faced by many other governmental entities (e.g., the state must provide matching funds for federally-mandated entitlement programs, such as Medicaid, regardless of whether the number of people eligible for services is greater than anticipated). Additionally, many of the RSNs pass this managed care risk on to the community mental health providers by requiring them to make services available to all eligible persons.

Recommendation 13

The Mental Health Division should require that Regional Support Network fund balances (including all reserve funds and

[5] JLARC requested the RSNs to provide five years of fiscal data to include beginning fund balances, revenues, and expenditures. The ending fund balance for any particular year should reflect the beginning fund balance, plus revenues, minus expenditures. The reliability and completeness of historical financial information provided by RSNs to JLARC, including information regarding fund balances, varied widely. Some RSNs provided complete information in which changes in fund balances reconciled with revenues and expenditures. Other RSNs did not provide complete information, or the information regarding fund balances did not reconcile with the revenue and expenditure information. JLARC's observation about the completeness and validity of the financial information provided by RSNs bolsters the finding by Sterling Associates that the lack of separation of RSN financial information from the other finances of the county acting as the RSN fiscal agent leads to difficulties in auditing and difficulties in verifying that RSN funds are being used solely for public mental health purposes. While we have no evidence to suggest that RSN funds are not being used solely for public mental health purposes, the inability of some RSNs to provide reliable and complete basic fiscal information is a concern.

undesignated fund balances) be restricted to a maximum of 10 percent of annual revenue. This policy should be implemented over time so as not to create a "bow wave" of unsustainable spend-down of fund balances.

COMMUNITY MENTAL HEALTH PROVIDER COST AND SERVICE ANALYSIS

Similar to our findings regarding differences in practices among RSNs, we also found large differences in the types and amounts of expenditures and the types and amounts of service provided among the 35 outpatient service providers sampled for this study. The methodology and data used in the analysis is discussed in greater detail in Appendix 8, while Appendix 9 provides comparisons among the 35 sampled providers.

Observations Regarding Outpatient Provider Costs and Services

- Administrative expenditures as a percentage of total expenditures varied from 8 to 35 percent among the 35 sampled providers.
- Larger providers tend to have a lower percentage of administrative costs.
- Expenditures per client among the 35 sampled providers varied from $858 to $6,681.
- Expenditures per client are strongly related to the number of service hours per client and the cost per service hour. The more service hours provided per client and the higher the cost per service hour, the higher the expenditures per client.
- We were unable to find strong explanations for variances in service hours per client and cost per service hour. A higher amount of service hours per client is moderately associated with the nature of the service provided (e.g., individual vs. group treatment) and with higher severity clients. Also, we were only able to find factors to explain a small amount of the variation in cost per service hour among the sampled providers. Factors that were *not* associated with variations in cost per service hour include staff compensation levels, the nature of the service provided (e.g., group versus individual treatment), and the amount of administrative expenditures at either the RSN or provider level.
- Therefore, while we know that there are wide variations in the amount of expenditures per client among the sampled providers, we don't know *why* these expenditures vary so much.

The fact that we were unable to find explanations for variations in expenditures per client among providers is probably related to the inconsistencies in the fiscal and client service data that are reported by providers to the MHD. Additionally, in the absence of information on client outcomes, even if we were able to find explanations for the differences in expenditures per client among providers, we would not know whether higher expenditures are associated with better client outcomes.

The MHD, as the state's mental health authority, is required by its Medicaid waiver with HCFA to assess the cost-effectiveness of the services provided by the system. This audit demonstrates that MHD does not have the information necessary to make such an assessment, nor were we able to do so. We believe that as the MHD implements the recommendations of this report to improve the consistency of the fiscal and client service data that are collected, and begins to collect consistent information on client and system outcomes, they will then be in a position to compare the cost-effectiveness of the services provided among providers and RSNs. Once the MHD identifies providers who are achieving favorable outcomes at a relatively low cost, the MHD could attempt

to identify the best practices that are being used by these providers.

Recommendation 14

Concurrent with the implementation of the data and performance measurement recommendations of this report, the Mental Health Division (MHD) should periodically analyze performance information to identify providers and Regional Support Networks (RSNs) that operate efficiently and effectively and the best practices used by such RSNs and providers. The MHD should disseminate these practices to all RSNs and providers, and create a pool of incentive funds to provide financial incentives for efficient and effective service.

AGENCY RESPONSE

The Department of Social and Health Services (DSHS and the Office of Financial Management (OFM) have responded to the recommendations contained in this report. DSHS concurs with Recommendations 1, 2, 3, 5, 6.2, 6.3, 6.6, 7.1, 7.2, 8, 9, 13, and 14; and partially concurs with Recommendations 4, 6.1, 6.4, 6.5, 7.3, 10, 11, and 12. OFM concurs with Recommendation 1 through 10 and 13, and partially concurs with Recommendations 11, 12, and 14.

Their written responses and Auditor's Comments are included at Appendix 2.

ACKNOWLEDGEMENTS

We appreciate the assistance provided by the Washington Community Mental Health Council, the 35 community mental health providers who provided data for the audit, the Washington Association for the Mentally Ill, the National Association for the Mentally Ill, staff of the Mental Health Division and the 14 Regional Support Networks, as well as other staff and management within the Department of Social and Health Services. We are also thankful to Sterling Associates, Clegg and Associates, the Center for Clinical Informatics, and University of Washington Health Policy Analysis Program for their assistance with this study.

Thomas M. Sykes
Legislative Auditor

This report was approved for distribution by the Joint Legislative Audit and Review Committee.

Senator Georgia Gardner
Chair

COMMITTEE ADDENDUM

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Services and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.

RECOMMENDATIONS

Recommendation 1

The Department of Social and Health Services should comply with legislative intent and coordinate allied services provided to mental health clients. It should implement strategies for resolving organizational, regulatory, and funding issues at all levels of the system—state, regional, and local.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 2

In its contracts with Regional Support Networks (RSNs), the Mental Health Division (MHD) should require RSNs to collaborate and work with allied service provider agencies in providing mental health services and identify RSN responsibilities to achieve collaboration. The MHD should enforce the provisions of those contracts.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 3

The Mental Health Division, Aging and Adult Services Administration, state hospitals, and Regional Support Networks should meet legislative intent to ensure hospital discharge and community placement for eligible clients occur in a timely manner. This will require developing an understanding of both the hospital discharge and the community placement criteria and how they relate to one another on a case-specific basis.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 4

The Mental Health Division (MHD) should continue to streamline and reduce process-oriented accountability activities. The MHD should negotiate with the Health Care Finance Administration regarding how to replace process-oriented system accountability requirements with system and client outcomes reporting.

Legislation Required:	None
Fiscal Impact:	Unknown amount of cost reductions for MHD, RSNs, and providers
Completion Date:	June 2001

Recommendation 5

The Legislature should further clarify its intent that the mental health system should be efficient and effective by amending RCW 71.24.015 as follows:

> **71.24.015 Legislative Intent and Policy**. It is the intent of the Legislature to establish a community mental health program which shall help people experiencing mental illness to retain a respected and productive position in the community. This will be accomplished through programs which provide for….
>
> (2) Accountability of efficient and effective services through statewide standards for monitoring and reporting of information that bears directly on system and client outcomes;….

Legislation Required:	Yes
Fiscal Impact:	None
Completion Date:	2001 Session

Recommendation 6

The Mental Health Division (MHD) should implement the following Sterling Associates recommendations to improve the consistency of cost reporting:

6-1 MHD should reduce the number of reported cost elements to those directly linked to the accountability process.

6-2 MHD should clarify the definition of the "provider administration" cost category to improve the consistency of assigning organizationally complex items to either administrative or non-administrative categories.

6-3 MHD should issue instructions to Regional Support Networks (RSNs) to ensure that reported cost information is collected in a manner that reconciles with actual county-maintained (RSN) fiscal records.

6-4 MHD should collaborate with the State Auditor's Office to ensure that all RSNs are using appropriate accounting procedures to segregate RSN revenues, fund balances, and reserve accounts from other county funds.

6-5 MHD should work with the State Auditor's Office and counties to explore the feasibility of using the Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process.

6-6 MHD should develop a process for quantifying and reporting the costs of RSN utilization of state-operated mental hospitals. This data should be integrated with other cost information collected from the RSNs.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 7

The Mental Health Division (MHD) should change its fiscal accountability standard (which requires 75 percent of revenues to be spent for direct services) to provide uniform definitions that reflect the following:

7-1 The definition of direct services should be narrowed to include only those expenditures directly related to client services.

7-2 A new category of expenditures should be created to include direct service support expenditures (e.g., patient tracking system, quality assurance activities, and training) that are currently categorized as direct service.

7-3 The reporting of the standard should include the administrative and support costs of the MHD, the state hospitals, and community hospitals that are currently either not part of the calculation or are counted as direct services.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 8

The Mental Health Division should develop uniform client and client service data definitions to address the inconsistencies noted in this report.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 9

The Mental Health Division (MHD) should comply with legislative intent and Health Care Finance Administration requirements to use outcomes information in managing the state's public mental health system. Implementation of a uniform performance measurement system should be a requirement of each contract between the MHD and Regional Support Networks.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	November 2001

Recommendation 10

The Mental Health Division (MHD) should implement an outcome-oriented performance measurement system consistent with the framework described in this report. In addition, the MHD should report back to the Joint Legislative Audit and Review Committee on the status of the system's implementation on an annual basis over the next five years and indicate how it is using the information to manage the system.

Legislation Required:	No
Fiscal Impact:	$730,000 to $950,000 start-up costs in first biennium, $250,000 annual costs thereafter; to be offset by cost savings as a result of the implementation of Recommendation 4.
Completion Date:	November 2001 and ongoing

Recommendation 11

The Mental Health Division should continue to use a capitated payment methodology for allocating funds to Regional Support Networks (RSNs). However, the following changes should be made:

- Eliminate the separate methodologies for the allocation of federal and state outpatient funding.
- Eliminate the distinction between outpatient and community inpatient funding.
- Substantially reduce the disparity in funding per Medicaid-eligible person.
- Allocate funding for state hospital beds to the RSNs.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	2001-03 Biennium

Recommendation 12

The Mental Health Division should conduct periodic studies of the estimated regional prevalence of mental illness in order to determine whether the association between the number of Medicaid-eligible persons in a Regional Support Network and the number of people needing service remains intact. Future prevalence studies should address shortcomings of the Prevalence Estimation of Mental Illness and Need for Services study, including a methodology for capturing the homeless and the prevalence of mental illness among those incarcerated in county jails, and should utilize a broader range of diagnoses and the weight the diagnoses by severity.

Legislation Required:	No
Fiscal Impact:	$500,000
Completion Date:	November 2004

Recommendation 13

The Mental Health Division should require that Regional Support Network fund balances (including all reserve funds and undesignated fund balances) be restricted to a maximum of 10 percent of annual revenue. This policy should be implemented over time so as not to create a "bow wave" of unsustainable spend-down of fund balances.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	2001-03 Biennium

Recommendation 14

Concurrent with the implementation of the data and performance measurement recommendations of this report, the Mental Health Division (MHD) should periodically analyze performance information to identify providers and Regional Support Networks (RSNs) that operate efficiently and effectively and the best practices used by such RSNs and providers. The MHD should disseminate these practices to all RSNs and providers, and create a pool of incentive funds to provide financial incentives for efficient and effective service.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	December 2001 and ongoing

COMMITTEE ADDENDUM

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Services and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.

APPENDIX 1 – STUDY MANDATE & SCOPE AND OBJECTIVES

LEGISLATIVE MANDATE

Section 103 of the 1999-2001 Omnibus Appropriations Act (Chapter 309, Laws of 1999) included the following proviso in the appropriation for the Joint Legislative Audit and Review Committee:

The appropriations in this section are subject to the following conditions and limitations: $280,000 of the general fund--state appropriation is provided for conducting a study of the mental health system. The study shall include, but not be limited to:

(1) An analysis of the roles and responsibilities of the division of mental health in the department of social and health services, with regard to regional support networks (RSNs) and community mental health providers;

(2) An analysis of the funding of the RSNs through contracts let by the division of mental health, including the basis for per capita payment rates paid to the regional support networks and any federal requirements related to the federal Medicaid waiver under which the current mental health system operates;

(3) An analysis of actual and contractual service levels, outcomes, and costs for RSNs, including the types and hours of services provided, costs of services provided, trends in per client service expenditures, and client outcomes;

(4) An analysis of RSN and subcontractor service and administrative costs, fund balances, contracting practices, client demographics, and outcomes over time;

(5) An analysis of contracts between RSNs and community mental health providers, with emphasis on costs, services, performance, and client outcomes, including any accountability standards, performance measures, data requirements, and sanctions and incentives currently in the contract between the regional support networks and the mental health division; and

(6) Recommendations for modifying the basis on which RSNs and community mental health providers are funded, including a funding formula that will result in a greater relationship of the funding distribution formula to the prevalence of mental illness in each RSN service area, to efficiency as demonstrated by performance measures and to effectiveness as demonstrated by patient outcome.

The joint legislative audit and review committee may contract for consulting services in conducting the study.

The study shall be submitted to the fiscal committees of the Legislature by December 1, 2000.

SCOPE AND OBJECTIVES

Background

Chapter 205, Laws of 1989 required the creation of local Regional Support Networks (RSNs) to decentralize the administration of publicly funded mental health services. RSNs are operated by counties, or groups of counties. There are 14 RSNs in Washington. The Mental Health Division of the Department of Social and Health Services provides overall policy guidance and allocates approximately $650 million of state and federal funds per biennium to the RSNs. This study was mandated by the 1999 Legislature due to concerns about how funding is allocated among the RSNs, and an interest in examining the performance of the public mental health system.

SCOPE

The study will assess several aspects of the publicly funded mental health system as directed in ESSB 5180 (1999-2001 Biennial Budget).

OBJECTIVES

1. Assess whether the Mental Health Division of the Department of Social and Health Services provides administrative services and policy leadership that promotes efficient and effective mental

2. Health services consistent with legislative intent.

3. Assess whether the current funding methodology allocates funds among RSNs in an equitable manner.

4. Compare the amount and types of services provided, costs of service, and client outcomes among the RSNs.

5. Compare RSN and subcontractor service and administrative costs, as well as fiscal and contracting practices, and assess whether differences in these factors among RSNs are related to client demographics and client outcomes.

6. Compare contracts among RSNs (and/or administrative subcontractors to RSNs) and community providers to determine how these contracts vary in terms of costs, payment methodologies, performance and outcome incentives or standards, and how these factors may be influenced by the contracts between the Mental Health Division and the RSNs.

7. Identify whether there are sufficient and reliable data available on the prevalence of mental illness, service efficiency, and program effectiveness to use as a basis for a new method of allocating funds to RSNs, and develop recommendations for a new allocation system.

APPENDIX 2 – AGENCY RESPONSE

- Department of Social and Health Services
- Office of Financial Management
- Auditor's Comments

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia WA 98504-5000

November 20, 2000

Thomas M. Sykes, Legislative Auditor
Joint Legislative Audit and Review Committee
P.O. Box 40910
Olympia, Washington 98501

Dear Mr. Sykes:

I am pleased to enclose the Department of Social and Health Services' response to the Joint Legislative Audit and Review Committee report entitled **Mental Health Performance Audit**.

We appreciate the opportunity to respond to this report. If you need additional assistance, do not hesitate to contact me.

Sincerely,

DENNIS BRADDOCK
Secretary

Enclosure

MENTAL HEALTH PERFORMANCE AUDIT

Thomas M. Sykes, Legislative Auditor
Joint Legislative Audit and Review Committee (JLARC)

The Department of Social and Health Services (DSHS) position on each of the study's 14 recommendations follows:

RECOMMENDATIONS	AGENCY POSITION	COMMENTS
1. DSHS to coordinate allied services at all levels for mental health clients. DSHS should strategize to resolve organizational, regulatory, and funding issues at all levels of the system.	Concur	• Coordination efforts started with DASA in 1998, DDD in 1999, AASA in 2000, CA planned. • A challenge to all DSHS service systems that serve persons with mental illness. • Regional boundary variance is one challenge. **Fiscal Impact** • MHD staff time will be needed to implement this recommendation. Request is included in MHD policy level budget request. This item is titled "RSN Monitoring and Support" and totals six FTEs and $909,000 ($450,000 state).
2. MHD to require RSNs to collaborate with allied systems and identify RSN responsibilities to achieve collaboration. MHD to enforce these contract provisions.	Concur	• In current contract – will be strengthened to identify RSN responsibilities in 01-03 contract.
3. MHD, AASA, state hospitals and RSNs to ensure hospital discharge and community placement occur in a timely manner, including work on discharge and community placement criteria.	Concur	• See comments in #1. MHD has started work on this recommendation. **Fiscal Impact** • Adult family home and boarding home operators are not satisfied with the current rate structure and will continue to advocate for higher rates especially for persons with challenging behaviors.

RECOMMENDATIONS	AGENCY POSITION	COMMENTS
4. MHD to continue to streamline and reduce process-oriented accountability activities and replace with client outcomes. MHD to negotiate with HCFA.	Partially concur	• MHD is in year 3 of a performance indicator grant working towards in-system agreement on indicators and data collection. • 01-03 contract will include performance indicators. • MHD oversight activities have been reorganized to reduce duplication. • MHD will follow up with HCFA on this recommendation. **Fiscal Impact** • The JLARC report anticipates an unknown savings amount. MHD does not anticipate any savings related to this recommendation.
5. The legislature should clarify its intent that the system be "efficient & effective" by amending RCW 71.24.015.	Concur	
6. MHD to implement the following so as to improve the consistency of cost reporting:	See below	**Fiscal Impact** • Requires additional staff requested in 01-03 budget. See the six FTEs referred to in comments on recommendation #1.
6-1. MHD to reduce the number of reported cost elements to those directly linked to the accountability process.	Partially concur	• Requires phase-in process.
6-2. MHD to clarify the definition of "provider administration" to improve consistency in reporting.	Concur	• Requires work with the State Auditor's Office regarding the Budgeting, Accounting and Reporting System (BARS) definitions.
6-3. MHD to instruct RSNs to report cost information so it reconciles with county-maintained RSN records.	Concur	
6-4. MHD to collaborate with Auditor's Office to ensure RSNs segregate RSN revenues, fund balances and reserves from other county funds.	Partially concur	• MHD will follow up on this recommendation with the Auditor's Office.

RECOMMENDATIONS	AGENCY POSITION	COMMENTS
6-5. MHD to work with the Auditor's Office and counties to explore feasibility of Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process.	Partially concur	• MHD will follow up on this recommendation with the Auditor's Office.
6-6. MHD to develop a process to quantify and report costs of RSN utilization of state hospitals and integrate this with other RSN cost information.	Concur	
7. MHD to change its fiscal accountability standard requiring 75 percent of revenues be spent for direct serves so as to provide uniform definitions that reflect the items below:	See below	**Fiscal Impact** • Requires additional staff requested in 01-03 budget. See the six FTEs referred to in comments on recommendation #1.
7-1. MHD to narrow the definition of direct services to include only those expenditures directly related to client services.	Concur	• Implemented in 7/1/00 contract amendment. • Further clarification in 01-03 contract.
7-2. MHD to create a new expenditure category to include direct service support expenditures.	Concur	• Implemented in 7/1/00 contract amendment. • Further clarification in 01-03 contract.
7-3. MHD to include in its fiscal accountability standard the reporting of administrative and support costs of MHD, state hospitals and community hospitals not currently part of the calculation or not counted as direct services.	Partially concur	• MHD agrees that these costs should be part of a fiscal accountability standard. However, the descriptions used by JLARC in exhibit 11, (Percent Direct Service Expenditures), include the services needed to maintain accreditation, certification and sound clinical practice. Also, the community hospital descriptions do not take into account the differences between medical and psychiatric practice.

RECOMMENDATIONS	AGENCY POSITION	COMMENTS
8. MHD to develop uniform client and client data definitions to address inconsistencies.	Concur	• MHD anticipates that this recommendation will take a significant amount of time due to variations among RSN data systems and due to the need for extensive work with stakeholders. **Fiscal Impact** • Requires additional staff requested in 01-03 budget. See the six FTEs referred to in comments on recommendation # 1.
9. MHD to incorporate a uniform performance measurement system in RSN contracts so as to manage the system with outcome information.	Concur	• 01-03 contract will include performance indicators as recommended by the JLARC consultants.
10. MHD to implement outcome based performance measurement system and report to the legislature annually over five years on how it is using the information to manage the system.	Partially concur	• MHD is in year 3 of a performance indicator grant. **Fiscal Impact** • The JLARC report assumes that this will cost up to $950,000 to start and $250,000 annually thereafter. These amounts are reasonable. JLARC also assumes that the ongoing costs can be paid for with savings generated from recommendation 4. MHD does not expect savings from recommendation 4 and even JLARC states that those savings amounts are "unknown".
11. MHD to continue capitated payment methodology with the following changes: a. Use the same methodology for allocation of federal and state outpatient funds. b. Eliminate the distinction between outpatient and community inpatient funding. c. Reduce the disparity in payment rates per Medicaid-eligible person.	Partially concur	• Regarding a, b, and c: 01-03 budget planning combines funding streams and reduces funding disparity by using statewide average rates;

RECOMMENDATIONS	AGENCY POSITION	COMMENTS
d. Allocate funding for state hospital beds to the RSNs.		• Regarding d: Allocating funding for state hospital beds to the RSNs will require development, research and stakeholder work with labor and others. MHD would also need to work with HCFA on the use of DSH funds. **Fiscal Impact** • MHD estimates $100,000 to develop an initial plan that sets forth a detailed implementation strategy.
12. MHD to conduct periodic prevalence studies.	Partially concur	• Benefit of these studies may not justify cost. **Fiscal Impact** • The JLARC report estimates $500,000 for each study.
13. MHD to restrict all RSN fund balances and reserves at maximum of 10 percent of annual revenue.	Concur	• To initiate in 01-03 contract.
14. MHD to periodically analyze performance information from RSNs and providers so as to identify and disseminate information on efficient and effective operations and best practices. MHD to create a pool of incentive funds and distribute them as incentives for efficient and effective services.	Concur	• Requires definition of best practices and development of standards. • Requires designation of current funds to be held back from the RSNs as an incentive pool, or requires new money. **Fiscal Impact** • Requires additional staff requested in 01-03 budget. See the six FTEs referred to in comments on recommendation #1.

STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT
Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555

November 21, 2000

Tom Sykes
Joint Legislative Audit and Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323

Dear ~~Mr. Sykes~~ Tom:

Thank you for the opportunity to review the Joint Legislative Audit and Review Committee's preliminary report entitled Mental Health System Performance Audit. Below we have provided our comments.

RECOMMENDATION	OFM POSITION	COMMENTS
Recommendation 1	Concur	
Recommendation 2	Concur	
Recommendation 3	Concur	
Recommendation 4	Concur	
Recommendation 5	Concur	
Recommendation 6	Concur	
Recommendation 7	Concur	
Recommendation 8	Concur	
Recommendation 9	Concur	
Recommendation 10	Concur	We suggest that macro level performance measures be developed from the outcome performance information and be added to the current performance measure now reported by the Mental Health Division in the PMTES system. In this way, JJLARC may access to this information electronically.
Recommendation 11	Partially Concur	We suggest the Mental Health Division further review the funding for state hospital beds to consider all options including direct payments to RSNs.
Recommendation 12	Partially Concur	While future prevalence studies have merit any study that includes mentally ill offenders in county jails will require considerable resources and might be better undertaken in conjunction with criminal justice organizations.
Recommendation 13	Concur	
Recommendation 14	Partially Concur	We feel a strong recognition program might serve as an adequate substitute for a pool of incentive funds.

In addition, we note the fiscal impacts regarding several JLARC recommendations enumerated in the Department of Social and Health Services' response to the study. We believe the fiscal impact estimates are realistic and must be considered in light of equally compelling challenges facing the department.

If you have any questions, please contact Tom Lineham at 705-0456.

Sincerely,

Marty Brown
Director

cc: Cathy Wiggins, Executive Policy

AUDITOR'S COMMENTS ON DEPARTMENT'S RESPONSE

Recommendations 1, 6, 7, 8, 11 and 14: These recommendations pertain to improving the coordination of services for clients with multiple needs (Recommendation 1), improving the consistency of fiscal data collected from RSNs and providers (Recommendation 6), changing the fiscal accountability standard for RSNs (Recommendation 7), improving the consistency of client and service data collected from RSNs and providers (Recommendation 8), allocating state hospital funds to RSNs (Recommendation 11-d) and to use fiscal and outcome data to identify and reward best practices at RSNs and providers (Recommendation 14).

Department Position and Comments: The DSHS response indicates that six FTE's and $909,000 are needed to implement recommendations 1, 6, 7, 8, and 14, and another $100,000 is needed to implement recommendation 11-d.

Auditor's Comments: The Preliminary Report estimated no fiscal impact for any of these recommendations because we believe that the Mental Health Division should already be doing many of these things as a matter of course (and in some cases is already mandated to do so by statute), and should be able to implement these recommendations within existing resources.

Recommendations 4 and 10: Recommendation 4 said that the MHD should continue to streamline and eliminate process-oriented accountability activities. Recommendation 10 is that the MHD should implement an outcome based performance measurement system in accordance with the performance measurement framework provided in the Preliminary Report. The Preliminary Report identified a fiscal impact of $730,000 to $950,000 in start-up costs, and $250,000 in annual ongoing costs to implement Recommendation 10, to be offset by cost savings as a result of implementing Recommendation 4.

Department Position and Comments: The DSHS response indicates that they do not expect cost savings as a result of implementing Recommendation 4 that could be used to offset the cost of implementing Recommendation 10.

Auditor's Comments: The intent of these two recommendations is to *replace* the current system accountability activities that assess ***processes*** of care with a system of measuring the ***outcomes*** of care (e.g., did care plans include certain required elements versus did the client improve?).

The fact that DSHS anticipates no cost reductions in association with the implementation of Recommendation 4 suggests that DSHS does not anticipate making any real reductions in process-based oversight activities as it implements outcome measurement.

We think outcome measurement should replace, rather than add to, the current process-based oversight activities because the current oversight activities involve a substantial amount of resources at the MHD and RSNs, are burdensome to community mental health providers, yet do little to ensure that the services provided are efficient or effective. Therefore, while these activities are nominally conducted in order to promote system accountability, they actually do little to ensure actual accountability of providers and RSNs. We think that the accountability of the system could be enhanced, without additional ongoing costs to DSHS, or additional burden to providers, by ***replacing*** process-oriented activities with a system of measuring outcomes.

APPENDIX 3 – EXECUTIVE SUMMARY: COST ACCOUNTING REVIEW OF THE WASHINGTON STATE PUBLIC MENTAL HEALTH SYSTEM; CONDUCTED BY STERLING ASSOCIATES, LTD.

EXECUTIVE SUMMARY

Scope and Objectives

Sterling Associates, Ltd. was engaged by the Joint Legislative Audit and Review Committee to assist with analyzing financial and cost issues for services delivered through the Regional Support Networks (RSNs) and their subcontracted providers. The review by Sterling Associates was conducted with the objectives of:

- Assessing the adequacy of financial reporting processes for collecting consistent cost information from entities involved in the system,
- Providing recommendations to improve financial reporting processes,
- Collecting information on administrative and service costs in the system,
- Analyzing cost information, and
- Assisting JLARC staff with using the cost information to compare costs among RSNs.

Background on Financial Reporting Processes

The Mental Health Division (MHD) of the Department of Social and Health Services (DSHS) is responsible for the public mental health program, and MHD contracts with 14 county-based RSNs for the local delivery of care. MHD lists general financial management stipulations in its contracts with RSNs, including a requirement that at least 75% of public mental health funds should be spent on direct services.

MHD provides specific financial reporting details through a supplement to the State Auditor's Budget, Accounting and Reporting System (BARS). The BARS supplement currently itemizes 17 cost categories to be reported to MHD. The Revenue/Expenditure forms submitted by RSNs

in accordance with the BARS supplement are used to measure compliance with the requirement to spend 75% of funds on direct services.

Findings on Financial Reporting Processes

Based on a detailed review of the reporting instructions and related materials, and interviews with MHD, RSN, and provider staff, Sterling Associates observed the following findings on the current financial reporting processes:

1. The decentralized, community-based approach to public mental health care is the result of a purposeful policy choice to encourage local flexibility and innovation. However, this conscious policy decision to move away from standardization means that detailed cost information is less likely to be reported comparably by RSNs and providers.
2. MHD requires several detailed categories of costs to be reported, but only two major categories (direct versus indirect costs) are actually used by MHD for accountability purposes.
3. The RSNs and providers generally make little use of the cost information that is currently generated for MHD.
4. In the financial information reported to MHD, RSNs and providers focus most of their attention on ensuring reported costs are split into direct and indirect areas. However, much less attention is spent on classifying direct and indirect costs into the various subcategories.
5. MHD cost reporting instructions do not provide adequate direction for identifying how costs for "organizationally complex" items at the provider level (e.g., building rents, clerical and supervisory support for clinicians) are to be classified as administration or direct service.
6. Provider costs reported by RSNs may or may not reconcile with how much providers were reimbursed by RSNs. Information reported to MHD includes in-house RSN costs and provider costs. Since provider level expenses may not reconcile with RSN reimbursements, total costs reported to MHD may differ from actual RSN costs in county financial records.
7. RSNs are less organizationally complex than most licensed providers. Consequently, there is less confusion regarding which costs are indirect versus direct at the RSN level than there are at the provider level.
8. Counties serving as RSN fiscal agents are not currently directed to use BARS accounts that separately identify RSN-related fund balances or revenues from other county programs. This increases the difficulty of

verifying that public mental health funds are used solely for RSN purposes and activities and complicates audit work.

9. Costs reported by RSNs do not include expenditures for inpatient services at community hospitals and DSHS operated mental hospitals.

Recommendations on Financial Reporting Processes

The following recommendations are offered to improve the financial reporting process:

1. MHD should reduce the number of reported cost elements to those directly linked to the accountability process.
2. MHD should clarify the definition for the "provider administration" cost category, to improve the consistency of assigning organizationally complex items to either administrative or non-administrative categories.
3. MHD should issue instructions to RSNs to ensure that reported cost information is collected in a manner that reconciles with actual county-maintained RSN financial records.
4. MHD should collaborate with the State Auditor's Office to ensure that all RSNs are using appropriate accounting procedures to segregate RSN revenues, fund balances, and reserve accounts from other county funds.
5. MHD should work with the State Auditor's Office and counties to explore the feasibility of using the Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process.
6. MHD should develop a process for quantifying and reporting the costs of RSN utilization of state operated mental hospitals. This data should be integrated with other cost information collected from the RSNs.

Methodology for Collection of Cost Data

Based on findings that existing historical cost information had comparability weaknesses, Sterling Associates pursued a separate data collection process to obtain improved cost data.

For RSNs, a data request was issued to identify actual costs attributed to the financial ledgers of the RSNs and to differentiate the costs to pay licensed providers. Sterling Associates communicated closely with RSN staff to disaggregate the in-house costs for RSNs, and cost information prepared from supplementary data sources was shared with RSN staff for comment.

Further, MHD provided information on costs for inpatient treatment of RSN clients at community hospitals.

Sterling Associates also worked with mental health providers to obtain additional information on their internal costs. A standardized data collection instrument was developed to ensure providers segregated cost information for non-RSN clients, distributed shared costs, and submitted information on sixteen functional cost areas. Site visits were conducted with each provider to discuss the data responses and review supporting documentation. When possible, Sterling Associates made further adjustments to provider data to help improve its comparability.

A sample of thirty-five licensed mental health providers submitted data, and thirty-one of these respondents provided information that Sterling Associates considered reasonably comparable for further analysis. Overall, these thirty-one sample providers represented 63% of the costs paid to licensed mental health providers in CY 1999.

Cost Analysis for RSNs and Providers

Based on analysis of the collected cost data, Sterling Associates reached the following conclusions:

1. Overall, the RSNs and providers submitted financial information that materially complied with the data requests, including segregating costs for non-RSN clients and distributing shared costs appropriately.
2. Approximately $302 million in funds were spent for RSN managed services during CY 1999. This figure includes payments to reimburse community hospitals for RSN services but does not include RSN utilization of DSHS-operated mental hospitals.
3. Four providers submitted information with data prepared using estimates that were less precise than the other providers. Excluding these providers from the sample does not significantly reduce the size of the sample.
4. The cost information that was collected can be used to construct a wide range of scenarios for estimating administrative costs. This illustrates how provider administrative costs could be portrayed very differently depending upon how the definition of administration was interpreted.
5. There is considerable variation in administrative costs for providers. Using the recommended administrative scenario definition, individual provider administrative rates average 16% and range from 9% to 32%.
6. There appear to be economies of scale for providers, and larger providers in our sample tend to have lower administrative costs.

7. There is considerable variation in administrative costs for RSNs. Using the recommended administrative scenario, RSN in-house administration averages 7%, and depending upon the RSN ranges from 2% to 10%. This variation does not appear to be related to the size of the RSN, the number of counties associated with the RSN, or whether the RSN was charged by their member counties for county overhead, rent, or utilities.
8. Two of the three RSNs that have contracted with a managed care entity for providing administrative services are among the three RSNs with the highest administrative cost percentages.
9. There are no strongly apparent patterns from the cost data that was collected which would indicate how RSNs may be impacting the administrative costs for their providers.
10. Providers have increased the amount of funds for serving RSN clients by 14%, by locating additional resources and/or integrating RSN programs with ones funded by other parties.
11. When combining RSN in-house administrative costs with provider administration, a reasonable scenario indicates these costs represent roughly 19% of total RSN costs. This administrative rate is somewhat understated, since it does not include estimates of administration for non-licensed direct service providers or community hospitals.
12. Without further analysis of cost information relative to service levels and performance measures, readers should be cautioned about judgments on appropriate levels of administration. This portion of the study did not analyze to what extent investments in administrative resources may have been related to the quality of care, amount of care, or outcomes achieved for RSN clients.

Utilizing Cost Information to Calculate Operating Ratios

The information collected for this technical appendix was focused on identifying certain categories of cost. It has not yet been compared to service units such as numbers of clients served or hours of client service provided.

When using the information in this technical appendix to calculate operating ratios from service units, care should be taken to select the type of costs appropriate for the intended analysis.

APPENDIX 4 – EXECUTIVE SUMMARY: PERFORMANCE MEASURES FOR MANAGING WASHINGTON STATE'S PUBLIC MENTAL HEALTH SYSTEM

Executive Summary

Prepared for the

Joint Legislative Audit and Review Committee

by

The Center for Clinical Informatics

Clegg and Associates, Inc.

The University of Washington Health Policy Analysis Program

July 2000

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Introduction

The 1999 Washington State Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a performance audit of the state's public mental health system. The audit covers many aspects of the mental health system's functioning, including the status of its performance measurement functions. JLARC contracted with Clegg and Associates, Inc. (with the Health Policy Analysis Program at the University of Washington as a subcontractor) and the Center for Clinical Informatics to conduct the performance measurement portion of the audit.

The scope of work for the performance measurement component includes the following activities:

- A review of the literature regarding current performance measurement practices in mental health services in the public and private sectors;
- An analysis of the systems implemented by states who are viewed as leaders in public mental health performance measurement;
- An assessment of the system's current performance measurement activities;
- The development of criteria to guide design of a performance measurement system for Washington State's public mental health system; and
- The formulation of recommendations for a practical and useful performance measurement system for the public mental health system.

The Purpose of Performance Measures

Creation of an effective performance measurement system involves balancing the need for the information collected with the cost of collecting it. At a systems level, the measures must focus on results and avoid concentrating on the processes by which the system attained these results. The performance measures put in place for Washington State's public mental health system must be sufficient to provide the Department of Social and Health Services' Mental Health Division (MHD) and the State Legislature with the information each requires to fulfill its roles and responsibilities as system leaders.

Specifically, the information must enable the MHD and the Legislature to perform the following functions:

1. Track progress in implementing a system that reflects the intent of State mental health statutes.
2. Assess progress toward achieving the MHD's mission and goals.
3. Assess compliance with HCFA requirements.
4. Inform the Legislature's and the MHD's mission-critical decision-making.
5. Enable appropriate and timely reporting on the system's performance to the Legislature and the mental health system's key constituencies.
6. Allow comparison of measurement results to established standards and benchmarks, among Regional Support Networks (RSNs), and against other states.

Best Practices in Mental Health Performance Measurement

A review of the literature regarding performance measurement reveals some basic components that are key to success. These *best practices* are based on lessons learned by those who have conducted performance measurement in many different work settings – including both the public and private sector. They are key to implementing an effective, user-friendly, and trusted performance measurement system:

- Incorporate a mission, goals, and objectives. These give an organization something against which to measure its performance. An organization can adopt industry standards or benchmarks as its objectives. Objectives, standards, and benchmarks establish the level of performance that defines success for the organization.
- Involve internal and external stakeholders. For mental health services, this includes administrative staff, clinicians, consumer advocates, consumers, and families, among others.
- Promote leadership support. Leadership is critical to successfully conducting performance measurement, including leadership of those within the organization taking on performance measurement and those with organizational oversight, such as regulators.
- Employ a simple, manageable and consistent approach. Create a system that is simple to use now and that can evolve as experience is gained and resources become available.
- Provide ongoing technical assistance. Those whose performance is being evaluated and those implementing the performance measurement system need technical assistance to understand and carry out performance measurement activities.

Best practices also suggest that two types of measures are most appropriate for mental health services performance measurement:

- Process measures, which assess what an organization does as part of the delivery of services; and
- Outcome measures, which assess a change, or lack of change, in a person's physical or mental status, or in the ability of a person to function in society. Clinical outcomes reflect psychological and physical changes related to the symptoms of an individual's clinical disorder; functional outcomes reflect how a person is succeeding in his or her community or with his or her life.

Process measures and clinical and functional outcome measures are best used in combination for mental health services performance measurement, to give a more complete picture of the performance of an organization.

And finally, the literature points out that performance measures for mental health services should be valid, reliable, and responsive. This means they should measure what they say they are measuring; be very likely to produce the same results every time they are used, and be able to detect change – either toward a goal or away from it.

Principles to Guide Selection of Performance Measures

The information regarding best practices can be translated into a set of principles to guide development of Washington State's public mental health performance measurement system. These principles offer a straightforward means of incorporating the experiences of other public and private systems into the approach used in this state. The principles are as follows:

1. Measure to manage;
2. Management requires frequent feedback over time;
3. Keep it simple and consistent, make it matter;
4. Keep it brief, measure often;
5. Create benchmarks, compare results;
6. Minimize opportunity for feedback-induced bias;
7. Provide the right information at the right time to the right person to make a difference;
8. Build in the flexibility so that the system evolves with the experience of the users;
9. Maintain central control of data and reporting; and
10. Establish and protect a core data set.

Building on Existing Knowledge

National Collaborations in Mental Health Performance Measurement

Research, development, and testing of performance measures for public mental health services are plentiful and ongoing. Many different organizations are involved, including the federal government, state mental health agencies, professional mental health associations, not-for-profit accreditation firms, and for-profit health plans.

Five large-scale, collaborative efforts have contributed to the current direction in mental health performance measure research, development, and testing: the Mental Health Statistics Improvement Program (MHSIP); National Association of State Mental Health Program Directors (NASMHPD), President's Task Force on Performance Indicators; U.S. Center for Mental Health Services (CMHS), Five-State Feasibility Study and 16-State Pilot Study; National Research Council Panel on Performance Measures and Data for Public Health Performance Partnership Grants; and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Performance Measurement in Other States and Private Mental Health Systems

Eleven states and four managed care companies were surveyed for examples of best practices in performance measurement and management.

Areas of Consensus

The survey revealed broad areas of consensus with regard to financial indicators such as utilization and cost per unit of services. Likewise, there is widespread use of certain process indicators such as time between hospital discharge and outpatient contact, hospital readmission rates, and wait time to first appointment.

Client Outcomes and Consumer Satisfaction Show Less Agreement

With regard to indicators of consumer satisfaction and outcomes of care, there are two parallel and potentially complementary lines of research and development. The first is the concerted initiative by a number of states to develop and test indicators based on the NASMHPD framework and the MHSIP Consumer Survey. The survey is administered after the consumer has been in treatment for some period of time and assesses consumer perception of ease of access, appropriateness, and outcomes of care.

The MHSIP initiative is supported by CMHS. The survey is relatively simple to implement. Since it inquires retrospectively, it requires only a single administration to obtain a snapshot of consumer satisfaction. The widespread use of the survey has resulted in a large national sample and CMHS is currently supporting the work of investigators to create performance benchmarks based on this sample.

The second line of research focuses on clinical outcomes and involves the use of standardized clinician rating scales and consumer self-report questionnaires administered at specified intervals over the course of treatment. The rating scales and questionnaires measure severity of problems in a number of areas including symptoms, interpersonal relationships, and role functioning at work or school.

While some states have recently implemented this approach, most of the effort has been supported by commercial managed care companies. This is true, in part, because these companies are actively involved in managing care on a case by case basis. In addition, a managed care company has considerable leverage over its providers to require compliance with the data collection protocols.

Over the last five years several companies have invested in development of clinical information systems designed to collect these data and actively manage patient outcomes by monitoring the rate of improvement for each case. The massive quantity of data generated by this approach has resulted in large databases that serve as benchmarks for outcomes. At least one managed care company is presently evaluating the performance of its senior management by benchmarking its outcomes against a large national sample of cases treated by other managed care companies. The performance target is to achieve greater improvement per case than the national norm.

Use of patient self-report measures also has shown promise in improving both the allocation and the outcome of care. Recent research suggests that when therapists are provided information on the rate of patient improvement using a consumer self-report measure, the clinicians are more likely to focus their time on the cases that are most symptomatic and at risk for a poor outcome. The cost of the increased services to these at risk cases is more than offset by a complementary tendency to reduce the intensity of services to patients reporting low levels of distress.

No site in the survey has fully integrated these two broad approaches to evaluating satisfaction and outcomes, though there are promising starts. The next logical step is to create performance management systems that provide continuous performance feedback on clinical outcomes and consumer perception of care. Such a system could provide the decision support tools to enable clinicians and administrators to systematically and measurably improve consumer satisfaction and outcomes while benchmarking performance against national norms.

Federal and State Mandates

Performance measurement in Washington State takes place in the context of state and federal directives regarding the intent of the state's public mental health system. Washington State (through the RCW and the WAC and the federal government (through the Health Care Financing Administration's Medicaid and waiver application), specify whom the public mental health system is mandated to serve, the types of services to be provided, and the desired client outcomes.

In terms of implementing a performance measurement system, the mental health system's Medicaid waiver states that the Mental Health Division will use a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement a set of performance measures to track the system's results. The MHD is currently working with stakeholder groups to identify the performance measures it will require as part of the 2001 – 2003 biennial State contract. The Division is using the measures included in the NASMHP President's Task Force recommendations as the starting point for its work.

Current Status of the State's Performance Measurement Activities

Setting System Direction

An assessment of the state's progress in setting direction for an effective performance measurement system for public mental health reveals the following:

- A number of efforts are underway to measure performance at the MHD, RSN, and provider levels. At each level, the individual organizations have established their own systems to provide the information they believe is necessary to meet internal needs (e.g., quality improvement), or external requirements (e.g., HCFA waiver or contract compliance). Efforts across the state are not coordinated, and as a result, there is inefficiency and a lack of comparability across the system.
- Confusion exists at all levels of the system regarding what performance measures are and which measures are required. For instance, RSNs and providers are required to collect and report data that they describe as performance measurement data. However, the MHD does not view all of this data as related to performance measurement and therefore does not use it in this manner.
- The MHD does not report a strong relationship between the collection of performance measurement data and use of the data to support decision-making. Most RSNs and providers report using performance measures both for decision-making and to meet reporting requirements.
- Current MHD performance measurement efforts focus on implementing a set of measures (the NASMHPD initial set of indicators) based, in part, on their ease of collection and

comparability across states. However, many RSNs and providers place more emphasis on indicators that may be more difficult to measure (and therefore will be less comparable across states), but that they consider more useful for decision-making and evaluating performance.

- Utilization/penetration rates, and the time from initial contact to first service were reported as the most useful measures of access by RSNs and providers. Client satisfaction was an important measure of quality for both RSNs and providers. RSNs also reported hospital utilization as an important quality measure, while providers reported the time from hospital discharge to first face-to-face contact as a useful indicator of quality. Improved level of functioning and symptom relief, as measured by standardized instruments, were reported by providers to be important measures of client outcomes. Hospital utilization (as it affects cost) was reported by many RSNs and providers to be important.
- The Washington Community Mental Health Council, an organization made up of provider agencies, is implementing a performance measurement system (the "Accountability Project") using a standardized consumer survey. The Accountability Project offers participating agencies the opportunity to develop a valid, reliable, and comparable set of data describing how they perform. The data produced through this effort are intended to be comparable across providers and across states.

Status of Current Data Collection

The ability to collect data that describe the status of each performance measure is essential for an effective performance measurement system. An assessment of the status of current data collection by the MHD reveals the following:

- There is a great deal of variation in the data collection instruments used by system participants. The MHD, RSNs, and providers all use tools customized to their needs to measure performance; such customized tools do not yield comparable information and may not be valid, reliable, and/or responsive. Some RSNs and many providers also use standardized tools, which have been tested for validity, reliability, and responsiveness and offer the best opportunities for comparability.
- There is also great deal of variation in standards for performance. For some performance measures, there was no standard reported by either RSNs or providers. And in general, providers have more specific benchmarks/standards than RSNs, and RSNs have more specific standards than the MHD.
- While most RSNs and providers have voluntarily begun performance measurement efforts, a few measure only what they are required by their state contract to report. The cost of data collection and questions about the reliability of data are reported as the biggest obstacles to performance measurement activities. A lack of feedback on the results of performance measurement efforts also leads to questions about the usefulness of the data collection efforts.
- The MHD currently requires RSNs to report information through a central information system (the "Data Dictionary") that could be used to provide performance measures of access, as well as limited measures of quality and outcomes. Additional information required in the RSN contracts to be collected and reported could, if standardized, provide additional

quality measures as well as limited structure/plan management performance measurement data. This data is partially adequate to meet some of the criteria for an effective performance measurement system but could be significantly improved through:

- Clearer, uniform definitions;
- consistent data entry across the system;
- use of valid, standardized tools;
- additional quality, outcome, and structure/plan management measures; and,
- regular and useful analysis and reporting of the data.

Conclusions

As these findings indicate, the public mental health system does not yet have an effective performance measurement system in place. The current measurement approach does not produce information that is comparable within the mental health system. Comparisons among service providers are difficult to conduct, as are comparisons among the Regional Support Networks. Similarly, it is not currently possible to make reliable comparisons between Washington State's mental health system and those of other states.

Looking at the measurement system in comparison to the five key components noted in the literature review reveals that improvement is needed in all of the five key components:

- Clarity of the mental health system's mission, goals, and objectives;
- Leadership in defining and implementing an effective performance measurement system;
- Use of a simple, manageable approach;
- Involvement of stakeholders in performance measurement planning activities; and
- Provision of technical assistance.

Recommended Performance Measures

The table below summarizes the set of recommended performance measures for the public mental health system. These measures employ the taxonomy used by the National Association of Mental Health Programs Directors (NASMHPD), including domains and measures within each domain. For each measure, the recommended "decision-making use", i.e., for Legislative oversight or for system management, is shown. Information concerning performance for specific age and ethnic groups should be available for each measure.

Most of the measures are described here in their generic format. The intent is that this basic set of measures can be used to analyze performance related to specific sub-populations within the mental health system, e.g., children, the elderly, adults, ethnic groups. The importance of conducting this type of focused analysis is essential – the status of children in the system is of vital importance, as is the status of ethnic minorities, the elderly, and other groups.

Domain/Measure	Appropriate Source of Data					
	Current Data Dictionary Item	Addition to the Data Dictionary	Standardized Instruments	Study	Inter-System Data Request	RSN and/or Hospital Financial Reports
Domain: Access						
1. Penetration rates	✓				✓ OFM census updates	
2. Utilization rates	✓					
3. Consumer perception of access			✓			
4. Average time from first contact to first service		✓				
Domain: Quality/Appropriateness						
1. Consumer perception of quality/ appropriateness			✓			
2. Percentage of consumers who actively participate in decision making regarding treatment			✓			
3. Percentage of consumers linked to physical health services		✓		✓		
4. Percentage of consumers contacted by community providers within seven days of hospital discharge		✓			✓ Hospital data	
5. Percentage of consumers who are psychiatrically rehospitalized within 30 days of discharge	✓				✓ Hospital data	

Domain/Measure	Appropriate Source of Data					
	Current Data Dictionary Item	Addition to the Data Dictionary	Standardized Instruments	Study	Inter-System Data Requests	RSN and/or Hospital Financial Reports
6. Percentage of jailed/detained consumers receiving mental health services while in jail/detention		✓				
Domain: Outcomes						
1. Consumer change as a result of services measured via: • Consumer self-report ▪ Clinician assessment			✓			
2. Consumer perception of hope for the future and personal empowerment			✓			
3. Percentage of adults employed for one or more days in the last 30 days	✓			✓		
4. Percentage of available school days attended in the past 30 days (for children)		✓		✓		
5. Percentage of consumers who have safe and stable housing			✓			
6. Percentage of consumers without a jail/detention stay					✓ Criminal Justice	
7. Percentage of consumers without a psychiatric hospitalization	✓					
Domain: Structure/Plan Management						
1. Average annual cost per consumer served						✓

Domain/Measure	Appropriate Source of Data					
	Current Data Dictionary Item	Addition to the Data Dictionary	Standardized Instruments	Study	Inter-System Data Requests	RSN and/or Hospital Financial Reports
2. Average annual cost per unit of service						✓
3. Percentage of revenues spent on direct services						✓
4. Percentage of professional positions throughout the mental health system held by people of color and ethnic groups the system serves			✓			
5. Percentage of consumers with dual diagnoses who have service plans coordinated with other systems		✓		✓		
6. Overall community partner satisfaction			✓			

Conclusions

Success in implementing performance measurement in large complex systems requires strong leadership, technical expertise, and focus. To be effective, performance measurement must be viewed as an essential tool for managing the system and evaluating its success in achieving its mission.

Implementation of the performance measures recommended in this report will require a major effort on the part of the MHD, the RSNs, and the provider agencies. In particular, leadership at the MHD level will be of paramount importance in achieving success.

APPENDIX 5 – METHODOLOGY AND DATA USED FOR JLARC'S RSN–LEVEL ANALYSES OF RESOURCE ALLOCATION AND EXPENDITURES

This appendix provides further information about the methodology and data used in the ***Allocation of Resources to RSNs***, and ***RSN Organization, Cost, and Services*** sections of the report.

Overview of JLARC Analysis of Resource Allocation

As mentioned in the text of the report, there is a wide variation in the amount of funding per Medicaid-eligible person that is allocated to the RSNs. Total funding per Medicaid-eligible person in FY 2000 varied from $271 to $532 per Medicaid-eligible person. Additionally, when including the value of state hospital beds allocated to RSNs, the value of total resources allocated to RSNs varied from $403 to $793 per Medicaid-eligible person. The purpose of this analysis was to assess the equity of the MHD's allocation of resources to the RSNs. In order to assess the equity of resource allocation, JLARC conducted multiple regression analysis using Statistical Package for Social Science statistical software in an attempt to determine (a) what factors are associated with variations in funding to RSNs, and (b) whether differences in the amount of resources allocated to RSNs result in differences in the amount or type of services provided by RSNs. For example, a variation in the amount of resources allocated to RSNs might be equitable if there are differences in the prevalence of serious mental illness, differences in the severity of clients served, or differences in the cost of providing service among RSNs. Multiple regression was used to determine whether differences in funding are associated with differences in such factors, and thus to assess the equity of the distribution of funding.

JLARC selected total funding per Medicaid-eligible person as the primary indicator for RSN funding levels as opposed to other possible indicators such as total funding per capita. Total funding per Medicaid-eligible person was chosen as the primary indicator for RSN funding levels because the MHD's contracts with RSNs require the RSNs to make a full range of mental health services available to all Medicaid-eligible residents who need service. In other words, the MHD's managed care contracts with the RSNs require the RSNs to insure the Medicaid-eligible population for mental health services. While a more limited range of services are required to be provided to the entire population, most of the system resources are dedicated to the Medicaid-eligible population. Additionally, the strong correlation between the number of people needing public mental health services and the number of Medicaid-eligible people in each RSN suggests that the number of Medicaid-eligible people is a very good proxy for the number of people needing public mental health services in each RSN.

Overview of JLARC Analysis of RSN Expenditures

Similar to the variation in RSN funding per Medicaid-eligible person, there are also wide variations in RSN expenditures per client served. RSN expenditures per client served in CY 1999 ranged from $1,344 to $3,965. The purpose of the JLARC RSN expenditure analysis was to identify factors that are associated with variations in expenditures per client among RSNs. For example, factors such as economies of scale, the severity of the clients served, the nature of the service provided (e.g., individual versus group service), the amount of administrative costs, or

geographic cost differences might help to explain differences in expenditures per client among RSNs.

Overview of the Data Used in the JLARC Analyses

The variables used in JLARC's RSN-level analyses were based on data in the following categories:

- *RSN demographic information* (e.g., population of RSN, average wage levels of counties within the RSN)
- *RSN funding information* (e.g., inpatient and outpatient funding levels, state hospital beds allocated)
- *RSN expenditure information* (e.g., total expenditures, direct service expenditures, administrative expenditures)
- *RSN client characteristic information* (e.g., number of Medicaid-eligible persons, numbers of clients served, breakdown of clients by age group, severity levels of clients)
- *RSN service information* (e.g., hours of service provided, hours of services by type of service provided, number of clients served as a percentage of total population)
- *RSN prevalence of mental illness information* (e.g., the estimated number of people within each RSN who are seriously mentally ill, need mental health services, and are eligible for public mental health services)

Using multiple linear regression, we attempted to determine which factors (among the variables discussed above) were associated with differences in funding per Medicaid-eligible person among RSNs.

List of Variables and Sources of Data

A complete list of the variables JLARC used in its RSN-level analyses is provided on the pages that follow. The list includes the source of data used for each variable and our comments (if any) on the data used.

RSN Demographic Information

Variable	Source of Data	Comments
RSN Population	Office of Financial Management 1999 county population estimates.	JLARC added together the population of each county for multi-county RSNs to arrive at the RSN total population.
Average County Wage	Employment Security Department calculations of the 1999 average wage for covered employees for each county.	JLARC calculated the average wage for each RSN by weighting the average wage for each county within an RSN by the population of that county.
RSN Proximity to a State Hospital	JLARC calculation.	RSNs that contain a state hospital within its boundaries were given a score of "0." RSNs that are adjacent to an RSN containing a state hospital were given a score of "1"—except for Greater Columbia RSN. (Although portions of Greater Columbia RSN are located adjacent to Spokane RSN, much of the population of the RSN is located at a considerable distance from Eastern State Hospital.) The RSNs located at greater distances from a state hospital were given a score of "2" or "3".

RSN Funding Information

Variable	Source of Data	Comments
FY 2000 Outpatient Funding	MHD budget information provided by MHD fiscal staff.	
FY 2000 Inpatient Funding	MHD budget information provided by MHD fiscal staff.	
FY 2000 Total Funding	MHD budget information provided by MHD fiscal staff.	
FY 2000 Outpatient Funding per Medicaid-eligible Person	JLARC calculated by dividing outpatient funding by the number of Medicaid-eligible persons.	
FY 2000 Inpatient Funding per Medicaid-eligible Person	JLARC calculated by dividing inpatient funding by the number of Medicaid-eligible persons.	
FY 2000 Total RSN Funding per Medicaid-eligible Person	JLARC calculated by adding outpatient and inpatient funding per Medicaid-eligible person.	
FY 2000 Total RSN Funding per Capita	JLARC calculated by dividing total funding by the RSN population.	

Variable	Source of Data	Comments
FY 2000 Total RSN Funding per Person Needing Service	JLARC calculated by dividing total RSN funding by the number of people needing service in each RSN as estimated in the PEMINS study.	Comments regarding the PEMINS study are made in the RSN Prevalence section below.
Allocated State Hospital Beds	Information provided by the MHD.	
Allocated State Hospital Beds per Medicaid-eligible Person	JLARC calculated by dividing allocated state hospital beds by the number of Medicaid-eligible persons in each RSN.	
Imputed Value of State Hospital Beds	JLARC calculated by dividing total FY 99 state hospital expenditures by the total state hospital beds to arrive at a value of each state hospital bed, and then multiplied that value by the number of beds allocated to each RSN.	
Total RSN Actual and Imputed Funding	JLARC calculated by adding total RSN funding and imputed value of state hospital beds.	
Total RSN Actual and Imputed Funding per Medicaid-eligible Person	JLARC calculated by dividing total RSN actual and imputed funding by the number of Medicaid-eligible persons in each RSN.	
Total RSN Actual and Imputed Funding per Person Needing Service	JLARC calculated by dividing total RSN actual and imputed funding by the number of people needing service as estimated by the PEMINS study.	Comments regarding the PEMINS study are made in the RSN Prevalence section below.
Total RSN Actual and Imputed Funding per Capita	JLARC calculated by dividing total RSN actual and imputed funding by the RSN population.	
Adequacy of Medicaid Match (amount by which state funding is sufficient or insufficient to match federal Medicaid revenue).	Information provided by MHD fiscal staff.	
Percent Funding Generated by Disabled Medicaid-eligibles	JLARC calculated by dividing the amount of (federal) funding generated by disabled Medicaid-eligibles into total federal funding.	

RSN Expenditure Information

Variable	Source of Data	Comments
RSN Total Expenditures	From work performed by JLARC contractor Sterling and Associates.	
Percent RSN Administrative Costs	From work performed by JLARC contractor Sterling and Associates.	
Percent Provider Administrative Costs	From work performed by JLARC contractor Sterling and Associates.	
Expenditures per Client Served	Calculated by JLARC by dividing RSN total expenditures by the number of clients served in each RSN.	Issues regarding the consistency of how providers count the number of clients served are discussed in the RSN Service section below.
Expenditures per Service Hour	Calculated by JLARC by dividing RSN total expenditures by the number of service hours provided within each RSN.	Issues regarding the consistency of how providers count the number of clients served and the number of service hours provided are discussed in the RSN Service section below.
RSN Uses Administrative Service Organization	Calculated by JLARC based on whether an RSN subcontracts with an Administrative Service Organization (ASO).	

RSN Client Characteristic Information

Variable	Source of Data	Comments
Number of Total Medicaid-eligibles	Data provided by MHD fiscal staff.	
Number of Disabled Medicaid-eligibles	Data provided by MHD fiscal staff.	
Medicaid-eligibles as a Percent of Total Population	Calculated by JLARC by dividing the number of Medicaid-eligibles into the total RSN population.	
Proportion of Disabled Medicaid-eligibles	Calculated by JLARC by dividing the number of disabled Medicaid-eligibles into the number of total Medicaid-eligibles.	
Disabled Per Capita	Calculated by JLARC by dividing disabled Medicaid-eligibles into total RSN population.	

Variable	Source of Data	Comments
Unduplicated Clients Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Unduplicated Medicaid Clients	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Unduplicated Non-Medicaid Clients	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Unduplicated Children Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Unduplicated Adults Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Unduplicated Elderly Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Priority 1 Clients Served (Priority is a measure of the level of severity of the client)	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs. Additionally, JLARC survey of RSNs found that definitions of Priority Codes are not clear to RSNs.
Priority 2 Clients Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Priority 3 Clients Served	CY 1999 data provided by MHD information services staff.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Average Priority of Clients Served	Calculated by JLARC by dividing total priority score of all clients by the number of clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Percentage Priority 1 Clients Served	Calculated by JLARC by dividing Priority 1 clients served by unduplicated clients served.	MHD's definition for "Priority 1" clients appears least ambiguous. Therefore, the percentage of Priority 1 clients served is likely the best indicator of the relative severity of the clients served.

Variable	Source of Data	Comments
Percentage Priority 2 Clients Served	Calculated by JLARC by dividing Priority 2 clients served by unduplicated clients served.	The MHD definition for "Priority 1" clients appears to be least ambiguous. Therefore, the percentage of Priority 1 clients served is likely the best indicator of the relative severity of the clients served among RSNs.
Percentage Priority 3 Clients Served	Calculated by JLARC by dividing Priority 3 clients served by unduplicated clients served.	The MHD definition for "Priority 1" clients appears to be least ambiguous. Therefore, the percentage of Priority 1 clients served is likely the best indicator of the relative severity of the clients served among RSNs.
Percentage Medicaid Clients Served	Calculated by JLARC by dividing Medicaid clients served into unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Percentage Children Served	Calculated by JLARC by dividing children served into unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Percentage Adults Served	Calculated by JLARC by dividing adults served into unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Percentage Elderly Served	Calculated by JLARC by dividing elderly served into unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Clients Served Per Capita	Calculated by JLARC by dividing unduplicated clients served into total RSN population.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Clients Served as a Proportion of Total Medicaid-eligibles	Calculated by JLARC by dividing unduplicated clients served into total Medicaid-eligibles.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.

RSN Service Information

Variable	Source of Data	Comments
Day Treatment Hours	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Group Hours	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Individual Service Hours	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Medication Management Hours	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Total Service Hours	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours to Medicaid Clients	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours to non-Medicaid Clients	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours to Children	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours to Adults	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours to Elderly	Provided by MHD information services staff.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.
Service Hours per Medicaid Client	JLARC calculated by dividing service hours to Medicaid clients by Medicaid clients served.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours. Additionally, JLARC survey of RSNs found some inconsistencies in how providers count the number of clients served.

Variable	Source of Data	Comments
Service Hours per non-Medicaid Client	JLARC calculated by dividing service hours to non-Medicaid clients by non-Medicaid clients served.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours. Additionally JLARC survey of RSNs found some inconsistencies in how providers count the number of clients served.
Service Hours per Child Served	JLARC calculated by dividing service hours to children by children served.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours. Additionally JLARC survey of RSNs found some inconsistencies in how providers count the number of clients served.
Service Hours per Adult Served	JLARC calculated by dividing service hours to adults by adults served.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours. Additionally JLARC survey of RSNs found some inconsistencies in how providers count the number of clients served.
Service Hours per Elderly Client Served	JLARC calculated by dividing service hours to elderly clients by elderly clients served.	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours. Additionally JLARC survey of RSNs found some inconsistencies in how providers count the number of clients served.
Days Inpatient Service – State Hospitals	Provided by MHD information services staff.	
Days Inpatient Service – Community Hospitals	Provided by MHD information services staff.	
State Hospital Inpatient Days per Client Served	JLARC calculated by dividing state hospital inpatient days by unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers.
Community Hospital Inpatient Days per Client Served	Calculated by dividing community hospital inpatient days by unduplicated clients served.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers.
Total Inpatient Days per Client Served	Calculated by adding state hospital inpatient days per client and community hospital inpatient days per client.	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers.

RSN Prevalence of Mental Illness Information

Variable	Source of Data	Comments
RSN Prevalence Rate	PEMINS study.	The RSN prevalence rate estimate is from the 1999 study entitled "Prevalence Estimate and Need for Service Study" (PEMINS), authored by University of Texas Professor Charles E. Holzer III on behalf of the Research and Data Analysis Office of DSHS. Our comments regarding this study are noted in the section of the report that discusses prevalence studies.
Number of Persons Needing Service	JLARC calculated by multiplying the RSN prevalence rate (using the estimated prevalence rate under the medium definition of need from the PEMINS study) by the RSN population.	
Number of People Needing Service per Medicaid-eligible	JLARC calculated by dividing the number of people needing service into the number of Medicaid-eligible persons.	
Number of People Needing Service per Capita	JLARC calculated by dividing the number of people needing service into the RSN population.	

General Comments on Data Validity

As noted, there are a variety of sources for the data used in JLARC's RSN-level funding and expenditure analyses. In every instance, JLARC attempted to use the most valid data available. Nevertheless, we are aware of problems with some of the data used. The most significant issues with data reliability regard the client service data from MHD, particularly the data relating to the hours of service provided to clients. These problems are described in the report and are the subject of recommendations in the report. Because of the substantial issues related to the comparability of RSN client service hour data, we limited our usage of this data in our analyses, and none of our major findings (findings leading to recommendations) from the regression analyses are based on client service hour data.

Regression Analysis Results – Resource Allocation

Correlation Between Number of People Needing Service and the Number of Medicaid-Eligible Persons

We noted that there is a very strong correlation between the number of people needing public mental health services (as measured by the PEMINS study) and the number of Medicaid-eligible persons in each RSN. In fact, the correlation between these variables was greater than .99. The strength of this correlation remains very strong when accounting for differences in RSN population (by looking at the correlation between the number of people needing service and the number of Medicaid-eligibles as a proportion of the total population in each RSN). The correlation between the proportion of the RSN population needing public mental health services, and the proportion of the RSN population eligible for Medicaid was .93.

To some extent, the strength of this correlation is attributable to the methodology used by the PEMINS study to identify those who are in need of public mental health services. To determine which proportion of the total seriously mentally ill population that is eligible for public mental health services, the PEMINS study assumed that only those whose income was at 200 percent of poverty or less would be eligible for public mental health services. While there is no statutory income limitation for public mental health services in Washington, the limitations of resources

available for public mental health services results in a limitation of the services available for non-Medicaid-eligible persons. While the income limitation (200 percent of the federal poverty level) used in the PEMINS study is somewhat more generous than Medicaid eligibility standards, the methodology of the PEMINS study to limit the estimates of need for public mental health services based on income probably is a factor in explaining the high correlation between the number of Medicaid-eligibles in each RSN and the number of people needing public mental health services.

The high correlation between the number of Medicaid-eligibles within an RSN and the number of people needing public mental health services supports the use of the number of Medicaid-eligibles as a basis for allocating funds for public mental health services to RSNs. ***In other words, Medicaid eligibility is a good proxy for the regional prevalence of those needing public mental health services***. This is not to say that everybody who is eligible for Medicaid is in need of public mental health services. In fact, in any given RSN, there are approximately ten times the number of Medicaid-eligible persons as there are people in need of public mental health services. But the number of people needing public mental health services rises proportionately with the number of Medicaid-eligibles, making the number of Medicaid-eligible persons a reasonable basis for allocating funds to RSNs.

Factors Associated with Variations in Funding per Medicaid-Eligible Among RSNs

As mentioned above, funding per Medicaid-eligible person ranges from $271 to $532 among RSNs. This variation in funding is an artifact of the previous fee for service method of funding providers, since the capitated payment rates per Medicaid-eligible person to RSNs were originally set to maintain the previous geographic distribution of funds. There is considerable concern among many of the RSNs that these rates are not equitable. In order to assess the equity of the allocation of resources to RSNs, our regression analysis attempted to determine whether differences in payment rates to RSNs per Medicaid-eligible person reflect differences in RSN mental illness prevalence rates, or differences in the severity of the clients served. These are factors that might justify substantial differences in payment rates to RSNs.

We found that the prevalence of mental illness (as measured by the PEMINS study) and the severity of the clients served (as measured by the percentage of Priority 1 clients) are not strongly associated with variations in payment rates per Medicaid-eligible person to RSNs. In fact, higher prevalence was actually negatively correlated with RSN payment rates per Medicaid-eligible person (although this negative correlation was not statistically significant). The strongest factor we found in explaining variations in payment rates was RSN population. The higher the population of the RSN, the higher the payment rate per Medicaid-eligible person. This factor alone explained 63 percent of the variation in RSN payment rates.

Factors Associated with Variations in State Hospital Beds to RSNs

There are also questions concerning the equity of the allocation of state hospital beds to RSNs. JLARC calculated the value of a state hospital bed by dividing total state hospital expenditures by the total number of state hospital beds. Based on this value, the value of the state hospital beds allocated to RSNs ranges from $90 to $403 per Medicaid-eligible person.

We found that that allocation of state hospital beds is strongly associated with the RSNs proximity to the state hospital. RSNs that contain state hospitals are allocated the greatest number of beds per Medicaid-eligible person, while RSNs located more distantly from the state hospitals are allocated fewer beds per Medicaid-eligible person. This variable alone explains 68

percent of the variation in state hospital beds per Medicaid-eligible person. Variables that were not significant in explaining variations in the allocation of state hospital beds include the proportion of Medicaid-eligible persons who are disabled, the proportion of the RSN population needing public mental health services, the proportion of high priority clients served, and the population of the RSN.

Summary of Regression Results – Resource Allocation

- The number of Medicaid-eligibles is a good proxy for the number of people needing public mental health services.
- Allocation of funding per Medicaid-eligible person to RSNs is strongly associated with RSN population. It is not associated with the number of people needing service or the severity of the clients served.
- Allocation of state hospital beds to RSNs is strongly associated with the proximity of the RSN to the state hospital. It is not strongly associated with the number of people needing service or the severity of the clients served.

Regression Results – Number of Clients Served Among RSNs

The proportion of the total RSN population served by the public mental health system varies between 1.4 percent and 3.2 percent among RSNs. We attempted to identify whether differences in the proportion of the population served are associated with (1) differences in the proportion of the population needing public mental health services, (2) differences in RSN funding levels, (3) differences in the severity level of the clients served, (4) differences in expenditures per client served, (5) differences in RSN population, (6) geographic cost differences (as measured by the average wage for all employees in each county within an RSN), or (7) differences in administrative costs at the RSN or provider level.

We found that differences in the proportion of the total population served were strongly associated with differences in expenditures per client, the proportion of the population needing service, RSN funding per person needing service, and geographic cost differences. These variables explain 96 percent of the variation in the proportion of the population served. The amount of expenditures per client served was most strongly associated with the proportion of the population served. ***Higher expenditures per client are associated with a lower proportion of the population served***. The proportion of the population needing service was also strongly associated with the proportion of the population served. ***A higher proportion of the population estimated to need public mental health service is associated with a higher proportion of the population served*** (note: this association tends to support the validity of the regional prevalence estimates of the PEMINS study). Higher RSN funding per person needing service is associated with a higher proportion of the population served. Also, higher average wages for all employees within an RSN is somewhat associated with a higher proportion of the population served. Factors not associated with the proportion of the population served include the severity level of the clients served, administrative costs at the RSN or provider level, or the population of the RSN.

We might have expected to find that RSNs with higher funding levels per Medicaid-eligible person are able to serve a greater proportion of non-Medicaid-eligible clients. This was not the case. In fact, higher levels of funding per Medicaid-eligible person are associated with a higher proportion of Medicaid-eligible clients served. This, along with the strong relationship between the number of people needing public mental health services and the number of people served, suggests that RSNs are attempting to serve those who need service regardless of funding level.

Regression Results – RSN Expenditures Per Client Served

RSN CY 1999 expenditures per client served range from $1,344 to $3,965. We attempted to identify whether factors such as the nature of the clients served, RSN economies of scale, administrative costs at the RSN and provider level, the nature of the service provided, or the extent of utilization of inpatient services in community or state hospitals affects variations in expenditures per client served.

We found that the amount an RSN is funded per person needing service was most strongly associated with variations in expenditures per client. This factor alone explains 56 percent of the variation in outpatient expenditures per client among RSNs. Factors considered, but not found to be significant in explaining variations in expenditures per client, include the severity of the clients, administrative costs at the RSN or provider level, geographic cost differences, the nature of the services provided within an RSN, and usage of state and community hospital beds.

Conclusions Regarding RSN-Level Analyses of Funding, Proportion of Population Served, and Expenditures per Client Served

- The number of Medicaid-eligible persons among RSNs is a good proxy to use as the basis for funding allocation for the number of people needing public mental health services.
- Variations in funding per Medicaid-eligible person are most closely related to RSN population. Funding variations (per Medicaid-eligible person) are not associated with the proportion of the population needing mental health services or the severity of the clients served.
- Higher funding per Medicaid-eligible person is associated with a higher proportion of total clients served that are Medicaid-eligible.
- The strong association between the number of people estimated to need public mental health service and the number of people served suggests that RSNs are trying to serve the people who need service, regardless of the amount of funding provided.
- RSNs with higher amounts of funding spend more per client served while RSNs with lower funding spend less. Since RSNs are attempting to serve the people who need service regardless of funding level, and higher-funded RSNs spend more per client served than lower-funded RSNs, the results of this analysis support the argument that disparities in funding among RSNs lead to inequitable service.

APPENDIX 6 – RSN FUNDING, EXPENDITURES, AND CLIENT SERVICE COMPARISONS

See following pages (86-87).

RSN Funding, Expenditures, and Client Service Comparisons						
RSN	Peninsula	Pierce	Southwest	Spokane	Thurston/Mason	Timberlands
RSN Population	323,200	700,000	94,100	414,500	251,300	94,400
Average Wage for Counties Within RSN	$ 26,722	$ 27,499	$ 28,131	$ 26,561	$ 27,641	$ 23,270
RSN Proximity to State Hospital[6]	2	0	2	0	1	2
Outpatient Funding per Medicaid-eligible	$ 379	$ 395	$ 254	$ 311	$ 277	$ 213
Inpatient Funding per Medicaid-eligible	$ 54	$ 75	$ 84	$ 81	$ 81	$ 54
Total Funding per Medicaid-eligible	$ 439	$ 479	$ 344	$ 398	$ 363	$ 271
Value of Allocated State Hospital Beds per Medicaid-eligible	$ 207	$ 403	$ 184	$ 283	$ 187	$ 238
Total Funding and Value of Allocated State Hospital Beds per Medicaid-eligible Person	$ 646	$ 882	$ 528	$ 681	$ 550	$ 509
Expenditures per Client Served	$ 2,646	$ 2,680	$ 1,344	$ 2,624	$ 2,656	$ 1,358
RSN Administrative Expenditures as a Percent of Total Expenditures	2%	8%	6%	10%	7%	8%
Provider Administrative Expenditures as a Percent of Total Expenditures	16%	10%	7%	10%	12%	17%
Medicaid-eligible Persons as a Percent of Total Population	11%	13%	15%	14%	12%	17%
Number of Clients Served	5,858	16,471	3,058	9,457	3,936	2,823
Client Served as a Percentage of Total Population	1.8%	2.4%	3.2%	2.3%	1.6%	3.0%
Percentage of Clients Served Who Are Priority 1	24%	45%	15%	36%	37%	21%
Percentage of Clients Served Who Are Medicaid-eligible	57%	53%	56%	58%	66%	47%
Percent Children Served	25%	26%	28%	23%	26%	30%
Percent Adults Served	60%	64%	65%	55%	62%	50%
Percent Elderly Served	14%	9%	6%	18%	9%	19%
Estimated Number of People Needing Public Mental Health Services	4,686	10,780	2,014	8,249	3,770	2,143
Estimated Number of People Needing Service as a Percentage of Total Population	1.4%	1.5%	2.1%	2.0%	1.5%	2.3%

[6] RSNs that contain a state hospital within its boundaries were given a score of "0." RSNs that are adjacent to an RSN containing a state hospital were given a score of "1"—except for Greater Columbia RSN. (Although portions of Greater Columbia RSN are located adjacent to Spokane RSN, much of the population of the RSN is located at a considerable distance from Eastern State Hospital.) The RSNs located at greater distances from a state hospital were given a score of "2" or "3".

RSN Funding, Expenditures, and Client Service Comparisons								
RSN	Chelan-Douglas	Clark	Grays Harbor	Greater Columbia	King	Northeast	North Central	North Sound
RSN Population	94,700	337,000	67,700	581,000	1,677,000	66,400	124,900	931,200
Average Wage for Counties Within RSN	$ 20,821	$ 29,323	$ 24,895	$ 24,679	$ 41,274	$ 23,712	$ 20,168	$ 26,406
RSN Proximity to State Hospital[7]	3	2	2	2	1	2	3	3
Outpatient Funding per Medicaid-eligible	$ 217	$ 293	$ 285	$ 268	$ 441	$ 272	$ 242	$ 340
Inpatient Funding per Medicaid-eligible	$ 66	$ 78	$ 64	$ 56	$ 82	$ 75	$ 69	$ 52
Total Funding per Medicaid-eligible	$ 287	$ 375	$ 353	$ 329	$ 532	$ 351	$ 318	$ 398
Value of Allocated State Hospital Beds per Medicaid-eligible	$ 116	$ 171	$ 248	$ 107	$ 261	$ 136	$ 90	$ 140
Total Funding and Value of Allocated State Hospital Beds per Medicaid-eligible Person	$ 403	$ 547	$ 601	$ 436	$ 793	$ 486	$ 408	$ 538
Expenditures per Client Served	$ 1,959	$ 2,561	$ 1,881	$ 2,877	$ 3,965	$ 2,470	$ 3,322	$ 2,128
RSN Administrative Expenditures as a Percent of Total Expenditures	9%	10%	5%	6%	7%	10%	6%	5%
Provider Administrative Expenditures as a Percent of Total Expenditures	11%	13%	20%	14%	12%	17%	20%	12%
Medicaid-eligible Persons as a Percent of Total Population	16%	11%	19%	18%	9%	18%	22%	11%
Number of Clients Served	2,014	6,032	2,134	12,161	22,758	1,531	2,416	18,168
Client Served as a Percentage of Total Population	2.1%	1.8%	3.2%	2.1%	1.4%	2.3%	1.9%	2.0%
Percentage of Clients Served Who Are Priority 1	26%	41%	48%	36%	53%	31%	18%	26%
Percentage of Clients Served Who Are Medicaid-eligible	40%	67%	50%	66%	81%	52%	50%	43%
Percent Children Served	24%	41%	32%	30%	28%	27%	31%	27%
Percent Adults Served	62%	51%	55%	57%	53%	62%	58%	63%
Percent Elderly Served	13%	7%	12%	10%	14%	8%	8%	8%
Estimated Number of People Needing Public Mental Health Services	1,733	5,325	1,638	11,562	17,776	1,527	2,960	12,012
Estimated Number of People Needing Service as a Percentage of Total Population	1.8%	1.6%	2.4%	2.0%	1.1%	2.3%	2.4%	1.3%

[7] RSNs that contain a state hospital within its boundaries were given a score of "0." RSNs that are adjacent to an RSN containing a state hospital were given a score of "1"—except for Greater Columbia RSN. (Although portions of Greater Columbia RSN are located adjacent to Spokane RSN, much of the population of the RSN is located at a considerable distance from Eastern State Hospital.) The RSNs located at greater distances from a state hospital were given a score of "2" or "3".

APPENDIX 7 – PROVIDER CONTRACTING PRACTICES MATRIX

See following pages (90-91).

Appendix 7—Provider Contracting Practices Matrix

		Chelan-Douglas	Clark	Grays Harbor	Greater Columbia	King	North Central	Northeast
	Payment Method	Flat monthly payment for outpatient, other payments for crisis services	$ per service hour	Flat monthly payment	Flat monthly payment	$ per client varies by level of service (tier) authorized by UBH, other specific services paid by flat monthly or daily rate	Contractor receives a fixed percentage of monthly RSN funds.	Flat monthly payment
Does RSN pass on insurance risk to the provider?	**Provider required to serve all Medicaid eligibles within fixed payment amount?**	Yes	No, payment for authorized service is based on a $ amount per service hour	Yes	Yes	No, payments for authorized tier service is based on a $ amount per client; client may also receive carveout services, e.g. residential	Yes	Yes
	Provider required to serve Non-Medicaid eligible people within fixed payment amount? (Note: crisis services must be provided to all in all RSNs)	Services to priority populations based on available resources	No, provider paid on a per service hour basis for all clients authorized for service	Yes, provider required to serve 340 non-Medicaid eligible persons	Services to priority populations based on available resources	No, same tier funding is add-on provided to serve authorized non-eligibles, who may also receive carveout services	Services to priority populations based on available resources	Services to priority populations based on available resources
Are payment rates for services identified in the contract?	**Does contract identify a payment rate per client or service hour?**	Yes	Yes	No	No	Yes	No	No
	Amount of payment per client or per service hour	$269.82-$350 per outpatient client/month (contingent upon serving a minimum # of clients)	$45-$58 per service hour	N/A	N/A	$280-$8976 per client annually based on tier; client may also receive carveout services	N/A	N/A
In addition to incentives created by the general payment mechanism, are there other financial incentives created by contractual provisions?	**Other payment incentives in contract?**	Yes	Yes	Yes	No	Yes	No	Yes
	Describe other payment incentives	Funds withheld if minimum # of clients and svc hrs not met. Funds added if output targets met.	20% of total funds contingent upon meeting goals related to admin. cost %, Medicaid svcs, satisfaction, readmissions	Penalties for not meeting detailed standards relating to staffing, filing required reports, state hospital census, priority population svcs, etc.	N/A	Incentives for increase in number of Asian/Pacific Islander children served, reduction in inpatient days, increase in age-appropriate activities, decrease in psychiatric symptoms, decrease in homelessness. Penalties for not meeting detailed contractual requirements	N/A	Incentive for early contact w/ hospital discharges
Who authorizes client eligibility for service?	**Describe who authorizes outpatient services**	Provider authorizes lower levels of services, RSN authorizes higher levels	UBH	Provider	Provider	UBH	Provider	Provider
	Describe who authorizes inpatient services	RSN	UBH	Provider	RSN	UBH	Provider (RSN authorizes elective inpatient placements)	RSN

Appendix 7—Provider Contracting Practices Matrix

		North Sound	Peninsula	Pierce	Southwest	Spokane	Thurston-Mason	Timberlands
	Payment Method	Provider network paid fixed percentage of PHP funds, other specific services paid flat monthly rate	$ per Medicaid eligible	$ per Medicaid-eligible (pays for Level I service), $ per clients authorized for Level II, plus fee and cost related rates for specific services	Flat monthly payment for crisis, $ per outpatient service hour	Flat rate per month (broken into various categories of service)	$ per client per month, subject to a maximum monthly payment	Flat rate per month
Does RSN pass on insurance risk to the provider?	**Provider required to serve all Medicaid eligibles within fixed payment amount?**	Yes	Yes	Yes	No, payments for authorized service is based on a $ amount per service hour	Yes	Yes, to the extent that the amount of clients X the case rate exceeds the payment limit	Yes
	Provider required to serve Non-Medicaid eligible people within fixed payment amount? (Note: crisis services must be provided to all in all RSNs)	Services to priority populations based on available resources as based on RSN approved contractor plan	Services to priority populations based on available resources	Level I priority populations served within available resources; services for Level II priority populations funded as a % of total Level II Medicaid persons served	No, payments for authorized service is based on a $ amount per service hour	Services to priority populations based on available resources	Yes, to the extent that the amount of clients X the case rate exceeds the payment limit	Yes, must serve low income clients eligible for service
Are payment rates for services identified in the contract?	**Does contract identify a payment rate per client or service hour?**	No	Yes	Yes	Yes	No	Yes	No
	Amount of payment per client or per service hour	N/A	$5.87 to $110.24 per eligible (per 9-month billing period)	$1.59 to $4.15 per eligible per month, Level 1, $500 to $520 per recipient per month authorized Level II	$70 per standard hour	N/A	$333 to $370 per authorized recipient per month	N/A
In addition to incentives created by the general payment mechanism, are there other financial incentives created by contractual provisions?	**Other payment incentives in contract?**	Yes	No	Yes	No	No	No	No
	Describe other payment incentives	Detailed penalties/sanctions for not meeting contract requirements. % inpatient savings directly related to providers hospital diversion program successes	N/A	Incentive for keeping WSH census down	N/A	N/A	N/A	N/A
Who authorizes client eligibility for service?	**Describe who authorizes outpatient services**	Provider	Provider	Provider authorizes lower level of care (Level 1), RSN authorizes higher level of care (Level II)	Third party contractor	UBH	RSN	Provider authorizes lower levels of services, RSN authorizes higher levels
	Describe who authorizes inpatient services	Provider network	Provider	RSN	RSN	UBH	RSN	Provider authorizes initial placement, RSN authorizes extensions

APPENDIX 8 – METHODOLOGY AND DATA USED FOR JLARC'S ANALYSIS OF PROVIDER-LEVEL EXPENDITURES

This appendix provides additional detail about the methodology and data used in the ***Community Mental Health Provider Cost and Service Analysis*** section of the report.

Overview of JLARC's Analysis of Provider-Level Expenditures

The text of the report describes the work of JLARC's contractor, Sterling Associates, to recast the expenditures of a sample of 35 community mental health providers in order to provide consistent comparisons of direct service, direct service support, and administrative costs among providers. Sterling Associate's analysis provided consistent cost information for these 35 providers. JLARC combined the cost data with client service data collected by the MHD to compare expenditures per unit of service (e.g., cost per client, cost per service hour) among the sampled providers.

There is a wide variation in the unit cost of service among the sample providers. CY 1999 expenditures per client ranged from $858 to $6,681 among the 35 sample providers, while expenditures per service hour ranged from $57 to $285. The goal of JLARC's provider-level expenditure analysis was to use multiple regression analysis to identify whether factors such as economies of scale, geographic cost differences, the nature of the clients served, or the nature of the services provided are associated with differences in unit costs among providers. Ideally, this type of analysis could determine why the costs of services (*efficiency*) differ among providers. Such information, combined with outcome information (*effectiveness*) would help to identify best practices that could be used as a benchmark to improve the efficiency and effectiveness of the public mental health system.

However, our analysis is limited for two reasons. First, as noted in the report, there are inconsistencies in how providers report cost and client service information to the MHD that make any comparisons of cost per unit of service suspect. The inconsistencies in cost reporting were addressed in the work done for JLARC by Sterling Associates, which involved recasting cost data for the 35 sampled providers. However, we did not attempt to recast client service data, primarily because we knew of no reasonable way to do so. Therefore, the comparisons of the unit costs of providers are suspect, particularly those comparisons involving the number of service hours provided (where the greatest inconsistencies of the data were noted). Second, there is almost no consistent information collected on client outcomes, making comparisons of service effectiveness impossible. In spite of these limitations, we conducted this analysis with the data that were available.

Overview of the Data Used in JLARC's Provider Expenditure Analysis

The variables used in JLARC's provider-level analysis were based on data in the following categories:

- *Provider-level expenditure information* (e.g., total expenditures, expenditures per client)
- *Provider-level client characteristics information* (e.g., severity level of the clients served, whether clients served are Medicaid-eligible)
- *Provider-level service information* (e.g., service hours provided, types of services provided)
- *RSN-level fiscal and demographic information* (e.g., RSN funding level, RSN administrative costs, average wages for counties within RSN)

The following tables illustrate the variables used in JLARC's provider expenditures analysis, the source of the data, and JLARC's comments on the validity of the data.

Provider-Level Expenditure Information

Variable	Source of Data	Comments
Total Expenditures	Sterling Associates Analysis	
Direct Service Expenditures	Sterling Associates Analysis	
Direct Service Support Expenditures	Sterling Associates Analysis	
Administrative Expenditures	Sterling Associates Analysis	
Percent Direct Service Expenditures	Sterling Associates Analysis	
Percent Direct Service Support Expenditures	Sterling Associates Analysis	
Percent Administrative Expenditures	Sterling Associates Analysis	
Average Clinician Salary and Benefits	Data provided to Sterling Associates from sample providers	Some missing data, other data appears to be inaccurate.
Expenditures per Client	JLARC calculated based on Sterling Associates cost data and MHD client data	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Expenditures per Service Hour	JLARC calculated based on Sterling Associates cost data and MHD client data	JLARC surveys of RSNs and providers found substantial inconsistencies in how providers count service hours.

Provider-Level Client Characteristics Data

Variable	Source of Data	Comments
Medicaid clients served	MHD client service data	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Non-Medicaid clients served	MHD client service data	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Percent Medicaid clients served	JLARC calculated from MHD client service data	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.
Number of Priority 1 Clients Served	MHD client service data	JLARC survey of RSNs found some inconsistencies in how clients are counted by providers within RSNs.

APPENDIX 9—FINANCIAL AND SERVICE COMPARISONS OF SAMPLED PROVIDERS

SEE FOLLOWING PAGE (98).

Appendix 9
Financial and Service Comparisons of Sampled Providers

Provider	Expenditures per Client	Expenditures per Service Hour	Percent Direct Services Costs	Percent Administrative Costs	Percent Direct Service Support Costs	Average Clinician Salary and Benefits	Clients Served	Percent Priority 1 Clients Served	Service Hours per Client	Percent Medicaid Clients	Percent Group Service	Percent Individual Service	Percent Day Treatment	Percent Medication Management
1	$ 3,722	$ 222	74%	16%	10%	$ 32,868	195	2%	16.8	52%	8%	92%	0%	0%
2	$ 3,645	$ 198	59%	21%	20%	$ 30,039	388	18%	18.5	74%	20%	79%	0%	1%
3	$ 858	$ 83	58%	25%	17%		1,200	45%	10.3	82%	29%	63%	8%	1%
4	$ 1,968	$ 57	65%	16%	18%	$ 29,878	4,408	43%	34.5	64%	10%	44%	43%	3%
5	$ 1,932	$ 111	59%	24%	17%	$ 20,065	2,103	49%	17.4	51%	11%	86%	0%	4%
6	$ 3,555	$ 163	60%	16%	24%	$ 37,678	3,736	44%	21.9	71%	32%	42%	19%	7%
7	$ 1,563	$ 67	79%	17%	5%	$ 38,772	659	23%	23.4	71%	22%	35%	37%	6%
8	$ 2,460	$ 90	76%	21%	3%	$ 39,655	96	19%	27.2	58%	19%	31%	49%	1%
9	$ 1,869	$ 194	51%	32%	17%	$ 47,267	177	33%	9.7	73%	0%	91%	0%	9%
10	$ 6,681	$ 206	60%	25%	16%	$ 41,857	155	45%	32.5	76%	52%	48%	0%	1%
11	$ 2,674	$ 66	71%	11%	18%	$ 50,764	457	16%	40.3	59%	8%	26%	65%	2%
12	$ 2,649	$ 107	75%	12%	12%	$ 47,102	5,079	50%	24.7	92%	19%	76%	0%	6%
13	$ 4,259	$ 82	63%	16%	21%	$ 29,868	2,548	80%	52.1	85%	17%	75%	3%	5%
14	$ 2,855	$ 111	55%	22%	24%		4,099	65%	25.7	92%	9%	71%	15%	4%
15	$ 2,002	$ 275	53%	14%	33%	$ 26,793	277	6%	7.3	44%	9%	89%	0%	2%
16	$ 2,428	$ 123	57%	32%	12%		1,077	21%	19.7	52%	32%	67%	0%	1%
17	$ 3,075	$ 285	61%	19%	21%	$ 25,240	1,002	19%	10.8	53%	13%	82%	0%	5%
18	$ 1,650	$ 163	53%	19%	28%	$ 35,754	1,939	36%	10.1	43%	19%	74%	0%	7%
19	$ 3,157	$ 250	48%	13%	38%		6,857	34%	12.7	62%	30%	66%	0%	4%
20	$ 2,048	$ 87	61%	18%	21%	$ 31,031	207	34%	23.5	41%	19%	72%	7%	3%
21	$ 1,885	$ 62	54%	24%	21%	$ 30,102	248	21%	30.5	49%	29%	71%	0%	0%
22	$ 2,195	$ 113	65%	23%	12%		638	37%	19.4	56%	9%	91%	0%	0%
23	$ 1,882	$ 96	64%	17%	19%	$ 27,843	1,596	14%	19.6	53%	17%	44%	33%	6%
24	$ 3,822	$ 124	67%	16%	16%	$ 32,582	3,320	30%	30.9	62%	14%	34%	48%	4%
25	$ 1,420	$ 80	47%	35%	19%		635	19%	17.6	49%	2%	55%	35%	8%
26	$ 2,619	$ 124	68%	16%	16%	$ 38,015	4,505	41%	21.1	62%	41%	56%	0%	2%
27	$ 2,162	$ 112	52%	13%	35%	$ 42,809	4,827	56%	19.4	57%	36%	60%	0%	4%
28	$ 3,025	$ 107	67%	8%	24%	$ 37,500	5,044	50%	28.4	63%	13%	83%	0%	4%
29	$ 867	$ 78	70%	11%	19%	$ 51,770	1,928	19%	11.1	48%	29%	64%	0%	6%
30	$ 2,359	$ 120	72%	15%	13%	$ 41,502	6,894	45%	19.7	62%	18%	27%	50%	5%
31	$ 1,018	$ 69	63%	13%	23%	$ 18,317	638	18%	14.8	69%	18%	82%	0%	0%
32	$ 2,772	$ 87	77%	15%	8%	$ 37,455	1,900	46%	32.0	94%	19%	45%	34%	3%
33	$ 1,263	$ 116	65%	22%	13%	$ 36,106	647	38%	10.9	59%	0%	97%	0%	3%
34	$ 1,821	$ 190	67%	27%	6%	$ 39,615	135	21%	9.6	49%	4%	94%	0%	3%
35	$ 1,073	$ 124	67%	21%	12%	$ 31,905	2,014	16%	8.7	44%	9%	75%	8%	9%