STATE OF WEST VIRGINIA

FULL PERFORMANCE EVALUATION OF THE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Behavioral Health Services

Fee-for-Service Payments made Directly by Clients and their Private Insurers are not an Under-Utilized Source of Revenue for Behavioral Health Services

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation and Research Division
Building 1, Room W-314
State Capitol Complex

CHARLESTON, WEST VIRGINIA 25305
(304) 347-4890

December 2000

PE-00-34-192

JOINT COMMITTEE ON GOVERNMENT OPERATIONS

House of Delegates

Vicki V. Douglas, Chair
Earnest (Earnie) H. Kuhn, Vice Chair
Scott G. Varner
Douglas Stalnaker
James E. Willison

Senate

Edwin J. Bowman, Chair
Billy Wayne Bailey Jr., Vice Chair
Oshel B. Craigo
Martha Y. Walker
Sarah M. Minear

Citizen Members

Dwight Calhoun
John A. Canfield
Mayor Jean Dean
W. Joseph McCoy
Willard (Bill) Phillips, Jr.

Aaron Allred, Legislative Auditor
Office of the Legislative Auditor

John Sylvia, Director
Performance Evaluation and Research Division

Brian Armentrout, Research Manager
Russell Kitchen, Research Analyst
Chris Nuckols, Research Analyst

December 2000

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

December 3, 2000

The Honorable Edwin J. Bowman
State Senate
129 West Circle Drive
Weirton, West Virginia 26062

The Honorable Vicki V. Douglas
House of Delegates
Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

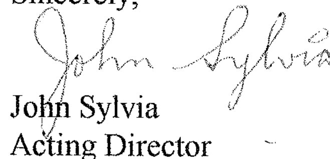
Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Full Performance Evaluation of the *Department of Health and Human Resources - Office of Behavioral Health Services*, which will be presented to the Joint Committee on Government Operations on Sunday, December 3, 2000. The issue covered herein is *"Fee-for-Service Payments made Directly by Clients and their Private Insurers are not an Under-Utilized Source of Revenue for Behavioral Health Services."*

We conducted an exit conference with *DHHR* on November 27, 2000. We received the agency response on November 28, 2000.

Let me know if you have any questions.

Sincerely,



John Sylvia
Acting Director

JS/wsc

TABLE OF CONTENTS

Executive Summary 3

Objective, Scope and Methodology 5

Background 7

Issue Area 1: Fee-for-Service Payments made Directly by Clients and their Private Insurers are not an Under-Utilized Source of Revenue for Behavioral Health Services 9

LIST OF TABLES

Table 1: Sources of Behavioral Health Services 8
Table 2: Living Status of Behavioral Health Clients 14
Table 3: Employment Status of Behavioral Health Clients 17
Table 4: Percentage of Clients with Medicaid as Their Insurance 18
Table 5: Duration of Adult Client Mental Illness 18

FIGURE 1: Revenue Sources for Fiscal Year 2000 From a Sample of 13 Behavioral Health Centers 9

APPENDIX A: Transmittal Letter to Agency 21
APPENDIX B: Survey Figures for Individual Behavioral Health Centers 25
APPENDIX C: Behavioral Health Clients as a Percentage of County Population Table 31
APPENDIX D: Demographic Data Table 35
APPENDIX E: Statewide Summary of Adults and Children for FY 1998, 1999 and 2000 39
APPENDIX F: FY 1998, 1999, and 2000 Provider Financial Information 47
APPENDIX G: Agency Response 51

Executive Summary

Issue Area 1: Fee-for-Service Payments made Directly by Clients and their Private Insurers are not an Under-Utilized Source of Revenue for Behavioral Health Services.

The Legislative Auditor conducted a survey of the 18 comprehensive behavioral health centers in West Virginia. The survey involved gathering data for private sources of revenue, accounts receivable from clients and third-parties, and total annual revenue for fiscal years 1998, 1999, and 2000. The private sources of revenue consist primarily of payments made by behavioral health clients and third-party payments. The data indicate that revenue from private sources constitutes a relatively small portion of total revenues for CBHCs. Centers serving only persons with mental retardation and/or developmental disabilities do not collect fees from clients. The Legislative Auditor's analysis of the survey revealed that, overall, the amount of private source revenue and accounts receivable fluctuated from year to year but remained a relatively small proportion of total revenues for most responding centers.

The writing off of accounts receivable is a standard procedure after fees are owed for a certain period of time. The percentage and the age of receivables written off varies from center to center according to their individual accounting practices. Data on write offs were obtained from seven CBHCs. Those seven centers were divided between two categories with one exception: three centers that wrote off approximately 70%-80% of private pay receivables and those that wrote off approximately 40%. One center wrote off an average of nearly 50% of private pay accounts during the three years examined.

It is clear that a large percentage of private pay receivables are routinely written off by providers each year, although the percentages vary widely among providers. This further demonstrates the inability of many clients to pay for services rendered to them. In addition, it appears that write offs from private pay sources account for a disproportionate share of all amounts written off by CBHCs each year. Although a large percentage of private pay debt is written off each year by CBHCs, the OBHS does provide additional funding to support services for which providers are not otherwise compensated. This includes uncompensated care funding amounting to $3,000,000 each year during fiscal years 1998, 1999, and 2000.

Analysis of statewide adult client demographic data indicates clear patterns with respect to client characteristics (see Table 2). For FY 2000, only 55.96% of clients owned or rented their own house or apartment. Another 5.59% relied on subsidized rental. Other clients, constituting 20.15% of the total, lived in the home of a relative. Other smaller categories of living arrangements included living in a friend's home, group homes, supported apartments, foster care homes, halfway houses, adult family care facilities, and residential group treatment facilities. It is clear that a large segment of the client population does not live independently.

Also, a correlation analysis was conducted on various client variables. The analysis indicated

a relatively strong correlation coefficient of +0.64 between county poverty rates and the percentage of county population who are behavioral health clients. This correlation indicates that counties with high poverty rates usually have a high proportion of behavioral health clients. **This also suggests a relatively low ability to pay of many clients of behavioral health facilities.**

Some conclusions can be drawn from the data. It is clear that at any given time approximately 1/5 of clients are employed in competitive work. Between 10 to 14% of clients are not employed and are not currently looking for employment. Another 7 to 8.5% of clients are unemployed and looking for employment. Around 7% of clients are physically impaired, while 2% are retired. This means that during FY 2000, nearly 70% of clients were either unemployed or were limited by age and physical impairment in their ability to become employed.

The unemployment rate for clients does not compare favorably with that for the State as a whole. The average unemployment rate for the State was only 6.7% in both fiscal years 1998 and 1999 while it fell to only 6% in fiscal year 2000. This contrasts strongly with the fact that a maximum of only 20% of clients were employed in competitive work during the three years examined. Over half of clients are routinely not a part of the labor force.

The percentage of clients with Medicaid as their insurance coverage (see Table 4) is another measure of their economic status. **Approximately half of adult clients, 51.2%, are covered by Medicaid each year, as are over 80% of children.** This illustrates the behavioral health system's strong reliance on Medicaid funding as was discussed in the first installment of this review. This statistic also indicates that a large proportion of behavioral health clients are indigent. The proportion of behavioral health clients who are Medicaid recipients greatly exceeds the percentage of the State's total population who are Medicaid recipients. During FY 2000, out of an estimated population of 1,806,928 a total of 337,433 (18.7%) West Virginians were Medicaid recipients. In both fiscal years 1998 and 1999, 18.9% of the State's population were recipients.

Objective, Scope and Methodology

The agency reviewed is the Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. The emphasis of this report is on the Office of Behavioral Health Services (OBHS), which lies organizationally under the authority of the Bureau. The OBHS is responsible for the coordination and monitoring of behavioral health services in the state as well as administering state and federal funds.

Objective

The objective of this review is to examine the following issues:

1. What is the composition of revenue received by behavioral health centers?
2. How much of the centers' revenues are determined uncollectible?
3. What are the demographic characteristics of the clients treated by behavioral health centers?

The purpose for answering these questions is to determine how much of private source revenues is uncollectible.

Scope

The scope of this review is from FY 1998 to FY 2000. The review focuses on fee-for-service payments made by behavioral health clients and their private insurers and the resulting revenues and uncollected receivables accrued by behavioral health providers. Demographic characteristics of clients which are indicators of their ability to pay for services are another focus of this report.

Methodology

The Legislative Auditor's Office surveyed the 18 comprehensive behavioral health centers (CBHCs) requesting data on fee-for-service payments made by behavioral health clients and their private insurers for fiscal years 1998 through 2000. When selecting a survey sample, a survey of CBHCs was clearly representative of the state's adult client population's ability to pay for services. This was due to the fact that over 91% of adult clients are treated by CBHCs. The survey questionnaire requested three categories of financial data: total payments made by clients and their private insurers, uncollected accounts receivable from client payments, and total revenues. Other data examined for this review included demographic data collected at intake from all behavioral health clients and reported to the OBHS. Summary reports of this data were provided by the OBHS for each of the three fiscal years. Drawing information from provider financial data and OBHS demographic data was required to study the amounts actually collected from clients and the client population's overall ability to pay. Statistical analysis of variables affecting the demand for behavioral health services was conducted using data from the Bureau of the Census and OBHS demographic data. This evaluation was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States.

Background

There are five bureaus within the West Virginia Department of Health and Human Resources (DHHR). Those bureaus are: Public Health, Children and Families, Behavioral Health and Health Facilities, Child Support Enforcement and Medical Services. Each bureau is administered by a commissioner who reports directly to the Deputy Secretary and Secretary. Since the Bureau for Medical Services (BMS) is the single state agency that administers the Medicaid Program and the Bureaus for Public Health, Children and Families and Behavioral Health and Health Facilities serve behavioral health consumers covered by Medicaid, it is essential that these agencies work closely together and have good communication and close coordination.

The Office of Behavioral Health Services

The focus of this report is the Office of Behavioral Health Services (OBHS) which lies organizationally under the authority of the Commissioner of the Bureau for Behavioral Health and Health Facilities. This report covers the period from fiscal year 1998 to fiscal year 2000. The OBHS is responsible for the development, coordination and monitoring of departmental policy for all behavioral health services in the state. It sets directions for clinical practice, evaluates the efficiency of services, ensures service quality, helps defray cost of indigent care and develops methods to ensure that other department funds are targeted to those most in need of services and used in the most cost-effective manner. The OBHS administers state and federal funds for the operation of community-based services. Services are provided in the home, the community, hospitals, residential facilities and long-term care facilities operated by the state or by contract agencies. The OBHS also contracts with the Bureau for Medical Services to manage the Mental Retardation/Developmental Disabled (MR/DD) Waiver Program.

Community Mental Health Centers

In West Virginia, there are 18 designated nonprofit, comprehensive community behavioral health centers (CBHC), each with its own catchment area. This includes four centers that serve only persons with mental retardation and/or developmental disabilities. The term CBHC is used interchangeably with the term Behavioral Health Center (BHC) in this report. The OBHS contracts with a CBHC in each of the Service Areas for the delivery of mental health, substance abuse and mental retardation/ developmental disability services. The Department also has the authority to contract with other service providers within a Service Area. There are approximately 90 licensed behavioral health providers in West Virginia. Contracts are performance-based and focus on attaining specific goals and objectives identified through negotiations between the providers and the Department.

Each of the contract CBHCs administers services in a geographic Service Area of two to eight counties. Although the main site of the CBHC is usually comprehensive in its service delivery, the sites it administers throughout its region are usually organized around the provision of one or more specific services which address the particular needs in the surrounding locality or community. The areas of focus for adult programming at the CBHC level includes case management, housing,

employment and crisis services. Areas of service focus for children at the CBHC level include case management, family preservation, crisis services and assessment services. Although each CBHC is funded to provide a comprehensive array of services, it is the option of the CBHC to provide services directly or through a contract to a community-based agency.

As Table 1 illustrates, CBHCs consistently treat in excess of 91% of adult clients. Financial data for this report was gathered from a survey of these centers because they treat the overwhelming majority of adults. A survey of CBHCs, therefore, is highly representative of the ability of the total adult client population to pay for services.

Table 1: Sources of Behavioral Health Services

	FY 1998		FY 1999		FY 2000	
	Adults	Children	Adults	Children	Adults	Children
Comprehensive Community Mental Health Centers*	32,784 (91.9%)	11,038 (56.3%)	38,662 (91.4%)	13,147 (55.8%)	38,218 (91.3%)	13,689 (56.2%)
Other Behavioral Health Providers	2,881 (8.1%)	8,581 (43.7%)	3,634 (8.6%)	10,413 (44.2%)	3,649 (8.7%)	10,660 (43.8%)
Total	35,665	19,619	42,296	23,560	41,867	24,349

**Also includes the four centers serving only persons with mental retardation and/or developmental disabilities.*

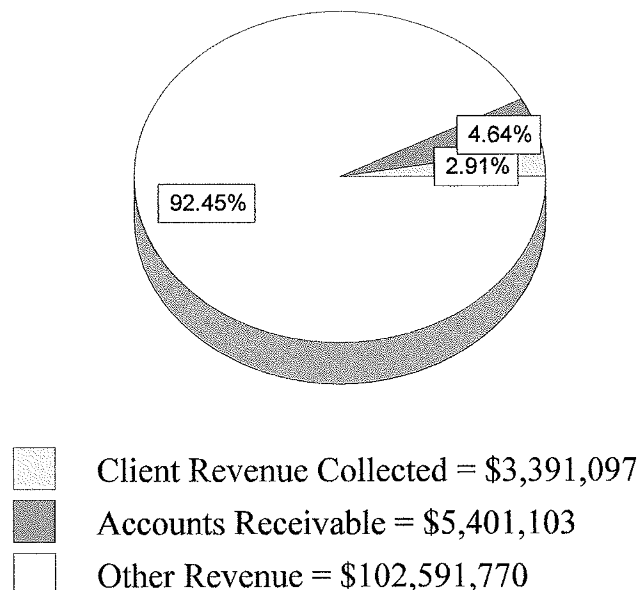
Issue Area 1: Fee-for-Service Payments made Directly by Clients and their Private Insurers are not an Under-Utilized Source of Revenue for Behavioral Health Services.

This study focuses on funding received by behavioral health providers from fee-for-service payments made by clients and their private insurers. Given the behavioral health system's dependence on Medicaid funding which was established in the first installment of this review, it is important for providers to make feasible attempts to collect payments from individuals who are not on Medicaid. Clients who are not on Medicaid are charged for services. This report analyzes the amount actually collected from those clients, as well as the potential ability to pay of the client population. Based on a survey of 14 of the 18 comprehensive behavioral health centers, revenue collected from non-Medicaid clients and their private insurance is a small percentage of total revenues (see Figure 1).[1] Over 90% of funding comes from other revenues which are mostly Medicaid funds and government grants. Payments collected from non-Medicaid clients and accounts receivable are less than 8% of total funding. However, 40% to 80% of accounts receivable typically become uncollectible and amounts to millions of dollars. Furthermore, the demographic characteristics of clients suggests they have a relatively low ability to pay. This suggests that **client fees are not an under-utilized source of revenue.**

Figure 1

Revenue Sources for Fiscal Year 2000

From a Sample of 13 Behavioral Health Centers



[1] *For the figures of individual behavioral health centers that were surveyed, see Appendix B.*

As much as 70% to 80% of Private Pay Accounts Receivable are Written Off as Uncollectible

The writing off of accounts receivable is a standard procedure after fees are owed for a certain period of time. The percentage and the age of receivables written off varies from center to center according to their individual accounting practices. Data on write offs were obtained from seven CBHCs. Those seven centers fell into two categories with one exception: those that wrote off approximately 70%-80% of private pay receivables and those that wrote off approximately 40%. Once center wrote off an average of nearly 50% of private pay accounts during the period examined.

The Prestera Center writes off approximately 20% of total accounts receivable each year, although the percentage varies by funding source. The percentage of private pay receivables written off each year is much higher. During the three years examined, Prestera wrote off the following amounts of private pay debt: FY 1998: $1,492,742 (82%), FY 1999: $1,150,745 (76%), and FY 2000: 1,119,561 (72%). Prestera wrote off a total of $1,913,151 in bad debt from all sources during FY 2000. That means that private pay debt accounted for 58.5% of all write offs for FY 2000. Typically, Prestera sends a client's account to a collection agency after 3 or 4 months of unpaid billings. Medicaid, Medicare, and insurance debt are usually written off after 4 to 6 months.

The United Summit Center wrote off a similar percentage of private pay receivables during the three-year period from calendar year 1998 to 2000. Private pay write offs were: 1998: $1,449,273 (85%), 1999: $1,479,367 (78%), and 2000: $1,920,431 (88%). Accounting records are maintained by calendar year and 2000 data is for the first 10 months of the year. The United Summit Center immediately writes off some private pay receivables, while waiting up to a year for others.

Logan-Mingo Mental Health, Inc. writes off approximately 80% of all amounts billed to clients each year. Any amounts not paid by third party insurance are rebilled to clients. Clients can pay the bill, enter into a repayment plan, or if they are financially unable to pay, the balance is written off after six months. Amounts initially billed to insurance companies remain in accounts receivable for approximately four months before the amounts are rebilled to the respective private pay clients. Billings to private pay clients remain in accounts receivable for approximately six months before the balances are adjusted to amounts the client is financially able to pay. Logan-Mingo Mental Health, Inc. wrote off the following amounts: FY 1998: $567,443, FY 1999: $654,504, FY 2000: $761,307.

Westbrook Health Services wrote off the following amounts: FY 1998: $361,088, FY 1999: $137,199, and in FY 2000: $248,603. Private pay write offs amount to 40% each year. Amounts are not written off until they remain unpaid for at least 90 days, but usually much longer. Private pay write offs were equal to 10.8% of total write offs, from all sources, during FY 2000.

Northwood Health Systems writes off approximately 36% of private pay receivables each year. Northwood writes off accounts paid directly by clients after they remain unpaid for 120 days. Insurance balances are transferred to the clients themselves after 60 days. Private pay write offs for Northwood totaled $714,762 in FY 1998, $514,251 in FY 1998, and $434,565 for FY 2000. Private pay write offs accounted for 51.7% of all write offs during FY 2000.

Valley Health Care writes off 39% of private pay receivables each year. Accounts are written off after they remain unpaid for six months to a year. Valley Health Care wrote off the following amounts: FY 1998: $133,276, FY 1999: $178,353, and FY 2000: $405,018.

Healthways wrote off an average of 49.8% of private pay debt during fiscal years 1998, 1999, and 2000. If payment from private insurance is not received within sixty days an account will be considered self-pay and collected according to the client's ability to pay. Once an account is 180 days past due a decision regarding the proper collection procedure is made by the CEO. If the decision is made to write off an account without turning the account over for collection, all accounts over $500 should be approved by the CEO. Accounts greater than $500 that are to be turned over for collection should also be approved by the Administrator. The CEO reviews account under $500 to determine whether the procedure is appropriate. Accounts with small residual balances are written off routinely each month. All accounts 120 past due, with balances under $25 should be written off each month without prior approval. The CEO should review these write offs at least quarterly to determine whether they are appropriate. At various times, the CEO may approve "Administrative Adjustments" so that certain accounts can be written off on an individual basis due to the particular situation. Healthways wrote off the following amounts: FY 1998: $152,286, FY 1999: $143,648, and FY 2000: $206,116.

It is clear that a large percentage of private pay receivables are routinely written off by providers each year, although the percentages vary widely among providers. This further demonstrates the inability of many clients to pay for services rendered to them. In addition, it appears that write offs from private pay sources account for a disproportionate share of all amounts written off by CBHCs each year.

Additional State Funding Received By Centers

It is important to point out that while considerable portions of private pay debt are written off by CBHCs each year, the OBHS does provide uncompensated care funds to provide services for which centers are not otherwise reimbursed. The amount of funding provided to 14 centers is based on the population of the provider's catchment area, an estimate of the number of eligible individuals to be served and an estimate of the value of the eligible services provided to the population. The funding methodology gives an equal weight to each of the three factors. The four MR/DD centers are allocated uncompensated care funds based on program needs that are not otherwise funded. The Legislature appropriated $3,000,000 in uncompensated care funding each year during FY 1998 and FY 1999. During FY 2000, a further $3,000,000 was provided by a transfer approved by the Legislature of DHHR funds. A total of $9,000,000 has been made available for FY 2001.

Some state funds are awarded to provide support for core services, which are services required by law. The funds are allocated for the development and delivery of core services described in a grant agreement and are to be used by the provider to cover any services they provide that are not otherwise reimbursed. For FY 2001, $4,853,126 was allocated and includes $1,643,047 for

developmentally disabled client needs.

Other OBHS funding to providers includes $1,878,482 allocated in FY 2001 for developmentally disabled targeted clients which includes unmet needs funding. There is an additional $3,433,963 for the community placement of individuals from the Colin Anderson Center. Nearly $13,000,000 in federal and special revenue funds are also available.

Analysis of Provider Information

The Legislative Auditor conducted a survey of the 18 comprehensive behavioral health centers in West Virginia. One of the 18 centers, Appalachian Community Center, did not fully respond to the survey and provided no data for FY 2000. **Four CBHCs: Eastern Panhandle Training Center, FMRS Mental Health Council, Shawnee Hills and Southern Highlands Community Mental Health Center failed to respond and provided no data.** The survey involved gathering data for private sources of revenue, accounts receivable from clients and third-parties, and total annual revenue for fiscal years 1998, 1999, and 2000. The private sources of revenue consist primarily of payments made by behavioral health clients and third-party payments. The data indicate that revenue from private sources constitutes a relatively small portion of total revenues for CBHCs. Centers serving only persons with mental retardation and/or developmental disabilities do not collect fees from clients.

The Legislative Auditor's analysis of the survey revealed that, overall, the amount of private source revenue and accounts receivable fluctuated from year to year but remained a relatively small proportion of total revenues for most responding centers. Total revenue levels remained rather stable for most centers with a few exceptions. Only two of the centers experienced an increase in private source revenue from FY1998 to FY1999 and from FY1999 to FY2000. Also, only two of the centers encountered a decrease in accounts receivable each fiscal year from 1998 to 2000. In addition, three of the surveyed behavioral centers saw their total annual revenue increase each of these fiscal years. Incidentally, all three of these centers serve only persons with mental retardation and/or development disabilities. Overall, four of these centers were contacted and three responded to the survey. Since these particular centers serve only persons with mental retardation and/or development disabilities, they have no private sources of revenue. It is highly likely that the same holds true for the one center which did not respond. According to a representative of Autism Services Center,

No Autism Services Center's clients are private pay. ASC does not bill any third parties for our services. All services are billed to the WV Medicaid program or reported internally as charity care.

Since the aforementioned centers do not have any private sources of revenue, they also do not have any accounts receivable. This is due to the fact that behavioral health clients and third-parties are the main contributors in determining the amount of private revenue and accounts receivable that a behavioral health facility encounters.

Analysis of the Client Population Served by Behavioral Health Providers

Beginning in fiscal year 1998 the OBHS, within the Department of Health and Human Resources, began to collect data from licensed behavioral health providers who are certified to provide services reimbursed by Medicaid and/or contracted for by the OBHS. The data are collected from demographic and assessment instruments filed for each individual served. Information is provided at the initial appointment, periodically afterward, and at discharge from treatment. During the first two years examined in this report, fiscal years 1998 and 1999, incomplete data collection resulted in large numbers of clients listed as unknown for many categories of demographic data. By FY 2000 data collection had improved, but problems with obtaining complete data for the previous years makes it difficult to draw clear conclusions regarding long-term demographic trends among clients.

Analysis of statewide adult client demographic data indicates clear patterns with respect to client characteristics (see Table 2). For FY 2000, only 55.96% of clients owned or rented their own house or apartment. Another 5.59% relied on subsidized rental. Other clients, constituting 20.15% of the total, lived in the home of a relative. Other smaller categories of living arrangements included living in a friend's home, group homes, supported apartments, foster care homes, halfway houses, adult family care facilities, and residential group treatment facilities. It is clear that a large segment of the client population does not live independently. The living status of 9.57% of clients was unknown for FY 1998 and FY 1999. This number had been reduced to 1.73% by FY 2000. The collection of more complete data could account for some of the changes in certain categories during FY 2000.

The fact that only approximately 56% of clients own or rent their own house or apartment contrasts with home ownership rates for the State as a whole. During both calender years 1998 and 1999, the home ownership rate in West Virginia was 74.8%. Given that such a large percentage of the State's residents own their own homes, the fact that just over half of clients own or rent their homes sets them apart from the general population.

Also, a correlation analysis was conducted on various client variables. The analysis indicated a relatively strong correlation coefficient of +0.64 between county poverty rates and the percentage of county population who are behavioral health clients. This correlation indicates that counties with high poverty rates usually have a high proportion of behavioral health clients. **This also suggests a relatively low ability to pay of many clients of behavioral health facilities.**

Table 2: Living Status of Behavioral Health Clients

Living Status	FY 1998		FY 1999		FY 2000	
	Number of Clients	% of Clients	Number of Clients	% of Clients	Number of Clients	% of Clients
Own or Rent House or Apartment	17,997	50.46	21,726	51.36	23,431	55.96
Subsidized Rental	2,011	5.64	2,465	5.82	2,341	5.59
Rooming House, Hotel, YMCA	367	1.03	178	.42	141	.33
Homeless Shelter	367	1.03	408	.96	412	.98
Homeless (Live on Streets)	234	0.66	197	.46	278	.66
Home of Relative	6,604	18.52	7,902	18.68	8,438	20.15
Home of Friend	1,019	2.86	1,289	3.04	1,394	3.33
Adult Family Care	310	0.87	341	.80	306	.73
Resident Group Treatment	529	1.48	512	1.21	570	1.36
Large Group Board and Care Home	72	0.20	99	.23	64	.15
Small Group Board Care Home	146	0.41	156	.36	164	.39
Rest Home	1	0.00	9	.02	5	.01
Nursing Home	249	0.70	242	.57	255	.60
Long-Term Psychiatric Hospital	9	0.03	24	.05	30	.07
Short-Term Acute Care Facility	19	0.05	14	.03	11	.02
Specialized Family Care Home	235	0.66	250	.59	297	.70
Foster Care Home	70	0.20	65	.15	102	.24
ICF/MR Group Home	513	1.44	503	1.18	500	1.19
Individualized Staff Setting (ISS)	182	0.51	195	.46	232	.55
Supported Apartment	192	0.54	229	.54	429	1.02

Living Status	FY 1998		FY 1999		FY 2000	
	Number of Clients	% of Clients	Number of Clients	% of Clients	Number of Clients	% of Clients
Personal Care Home	254	0.71	255	.60	286	.68
Correctional Facility	83	0.23	174	.41	220	.52
Dependent Living (Includes Halfway Houses)	308	0.86	404	.95	242	.57
Other	482	1.35	610	1.44	994	2.37
Unknown	3,412	9.57	4,049	9.57	725	1.73
Total	35,665	100	42,296	100	41,867	100

The examination of employment statistics (see Table 3) gives indications of patterns in adult client characteristics. During FY 1998, only 14.5% of clients were engaged in competitive, non-subsidized work. Another 33.5% were not considered involved in the labor force by the OBHS. Another 10.9% were categorized as not employed and were not looking for employment while 8.40% were not employed but were looking for employment. Given that 10.9% of those categorized as unemployed were not looking for employment, a total of 44.3% of clients were not actually part of the labor force. Another 9.3% were either physically impaired or retired. The employment status of 13.3% of clients was unknown. The other 10.2% of clients included those involved in supported work, sheltered work, employment training, homemakers, students, and volunteer employment. The data clearly indicate that only a small proportion of clients are currently employed. If homemakers, students, retired persons, and the disabled are added together with the 44.3% mentioned earlier, over half of clients were not active in the labor force.

The collection of more complete data during FY 2000 must be considered. While the employment status of 13.3% of clients was unknown in FY 1998, only 1.9% of clients were in this category in FY 2000. This means that the employment status of 11.4% more clients was properly identified during FY 2000 and would have had a resulting impact on various categories. ***If the total percentages for clients' not in the labor force and those not employed and not looking are combined, 52.6% of clients were not effectively part of the labor force in FY 2000.***

Some conclusions can be drawn from the data. It is clear that at any given time approximately 1/5 of clients are employed in competitive work. Between 10 to 14% of clients are not employed and are not currently looking for employment. Another 7 to 8.5% of clients are unemployed and looking for employment. Around 7% of clients are physically impaired, while 2% are retired. This means that during FY 2000, nearly 70% of clients were either unemployed or were limited by age and physical impairment in their ability to become employed.

The unemployment rate for clients does not compare favorably with that for the State as a whole. The average unemployment rate for the State was only 6.7% in both fiscal years 1998 and 1999 while it fell to only 6% in fiscal year 2000. This contrasts strongly with the fact that a maximum of only 20% of clients were employed in competitive work during the three years examined. As was stated earlier in this report, over half of clients are routinely not a part of the labor force.

Table 3: Employment Status of Behavioral Health Clients

Employment Category	FY 1998		FY 1999		FY 2000	
	Number of Clients	% of Clients	Number of Clients	% of Clients	Number of Clients	% of Clients
Competitive Work	5,164	14.5	7,389	17.5	8,370	20.0
Supported Work	513	1.4	533	1.3	576	1.4
Sheltered Work	665	1.9	672	1.6	736	1.8
In Employment Training	204	0.6	252	0.6	194	0.5
Homemaker	1,188	3.3	1,200	2.8	1,107	2.6
Student	872	2.5	1,146	2.7	1,063	2.5
Retired	646	1.8	941	2.2	953	2.3
Physically Impaired	2,671	7.5	2,956	7.0	2,944	7.0
Not Employed, Not Looking	3,872	10.9	4,285	10.1	5,877	14.0
Not Employed, But Looking	2,996	8.4	3,360	7.9	2,873	6.9
Not in Labor Force	11,940	33.5	14,756	34.9	16,158	38.6
Volunteer	193	0.5	197	0.5	241	0.6
Unknown	4,741	13.3	4,609	10.9	775	1.9
Total	35,665	100	42,296	100	41,867	100

The OBHS separates client income data for those who make over $10,000 per month from clients who make less than that on a monthly basis. Income statistics are then calculated for those who make less than $10,000 per month. Data indicate that the average client belonging to the group making less than $10,000 monthly, makes just over $600 per month. The average income for FY 1998 was $611, for FY 1999 $606, and for FY 2000 it was $650. During this same period, approximately 2,000 to 3,000 clients each year reported no monthly income at all. This amounted to 7.5% of adult clients in FY 2000.

The percentage of clients with Medicaid as their insurance coverage (see Table 4) is another measure of their economic status. **Approximately half of adult clients are covered by Medicaid**

each year, as are over 80% of children. This illustrates the behavioral health system's strong reliance on Medicaid funding as was discussed in the first installment of this review. This statistic also indicates that a large proportion of behavioral health clients are indigent. The proportion of behavioral health clients who are Medicaid recipients greatly exceeds the percentage of the State's total population who are Medicaid recipients. During FY 2000, out of an estimated population of 1,806,928 a total of 337,433 (18.7%) West Virginians were Medicaid recipients. In both fiscal years 1998 and 1999, 18.9% of the State's population were recipients.

Table 4: Percentage of Clients with Medicaid as Their Insurance

FY 1998		FY 1999		FY 2000	
Adults	Children	Adults	Children	Adults	Children
51.2%	85.7%	48.4%	84.1%	48.1%	82.8%

The duration of adult mental illness (see Table 5) indicates that a large portion have long-term treatment needs. Table 5 also includes data for those undergoing substance abuse treatment, therapy for relationship problems or who are otherwise not permanently mentally ill. Those who suffer from mental illness for less than one year accounted for only 21.2% of clients in FY 2000. Approximately 11% suffered from mental illness for one to three years. Clients who are mentally ill for four to six years generally make up 8-9% of the total. Those who are mentally ill for more than six years represent as many as half of clients. Finally, the duration of the clients' mental illness was unknown in 26.3% of the total for FY 1998. This was reduced to 6.2% in FY 2000. As has been mentioned earlier, more complete data for FY 2000 has affected the totals for some categories.

Table 5: Duration of Adult Client Mental Illness

Duration of Mental Illness	FY 1998	FY 1999	FY 2000
Less than 1 Year	13.0%	11.8%	21.2%
1-3 Years	11.1%	10.7%	11.8%
4-6 Years	7.7%	8.1%	8.9%
More than 6 Years	41.9%	44.4%	51.9%
Unknown	26.3%	25.0%	6.2%

Conclusion

Taken as a whole, the available demographic data collected by the OBHS indicates that fee-for-service payments from the majority of adult clients are not a promising source of revenue due to low income and labor market participation levels as well as the long-term nature of many clients' mental illness. The average client has a monthly income of only $600-$650 per month. Only about 1/5 of clients are involved in unsupported employment. The duration of adult clients' mental illness indicates that a large portion have long-term treatment needs. Those who are mentally ill for more than six years represent as many as half of clients.

Factors affecting the demand for behavioral health services were analyzed in this report. The poverty level appears to be the most important factor in determining the demand for behavioral health services in a county. Given that tendency, the OBHS should pay particular attention to the quantity of services provided by providers in poorer counties.

The financial information provided by the surveyed behavioral health centers further demonstrates that client fee-for-service payments do not contribute significantly to a respective facility's overall revenue. Only one center had at least 10% of its total revenue account for private revenue each of the three fiscal years that were analyzed. Overall, the amount of accounts receivable for each of the facilities is small compared to their total revenue. Due to the factors mentioned above such as low income and high unemployment, the chances of significantly enhancing revenue are minimal.

APPENDIX A

Transmittal Letter to Agency

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

November 17, 2000

Ms. Joan E. Ohl, Cabinet Secretary
Department of Health and Human Resources
Building 3, Room 206
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

Dear Secretary Ohl:

Enclosed is a draft of the performance evaluation of the Office of Behavioral Health Services. An exit conference has been scheduled for Wednesday, November 22, 2000 at 1:30pm in our office with the Office of Behavioral Health so that it can be presented during the December 3, 2000 Interim meeting of the Joint Committee on Government Operations. We would also like to have the agency response by Wednesday, November 29, 2000 so that it may printed with the final report.

If you have any questions please contact me or Russell Kitchen, Research Analyst.

Sincerely,

Brian Armentrout
Research Manager

cc: John Bianconi, Director, Office of Behavioral Health Services

Joint Committee on Government and Finance

APPENDIX B

Survey Figures for Individual Behavioral Health Centers

Private Revenue Amounts and Percentage of Total Revenue for Surveyed Behavioral Health Providers

Provider	FY 1998 Private Revenue Collected	FY 1999 Private Revenue Collected	FY 2000 Private Revenue Collected
EastRidge Health Systems	$677,156 (10%)	$728,572 (11.54%)	$652,536 (11.07%)
HealthWays	$478,728 (8.6%)	$348,500 (6.48%)	$351,168 (6.40%)
Logan-Mingo Area Mental Health	$146,532 (3.1%)	$252,542 (5.02%)	$256,543 (5.57%)
Northwood Health Systems	$619,828 (3.71%)	$215,908 (1.41%)	$56,606 (.39%)
Potomac Highlands Guild	$264,839 (5.10%)	$244,549 (4.86%)	$211,265 (4.08%)
Prestera Center	$311,130 (2.02%)	$337,152 (2.20%)	$417,699 (2.59%)
Seneca MH/MR Council	$251,639 (2.18%)	$261,083 (2.28%)	$181,193 (1.68%)
United Summit Center	$606,202 (8.39%)	$541,955 (7.56%)	$138,831* (3.25%)
Valley Health Care	$208,310 (1.35%)	$192,639 (1.31%)	$197,635 (1.30%)
Westbrook Health Services	$1,164,188 (8.97%)	$993,051 (8.08%)	$927,621 (8.08%)
Appalachian Community Health Center	NA	$197,348 (3.83%)	NA
Autism Services Center**	$0	$0	$0
Green Acres**	$0	$0	$0
Potomac Center**	$0	$0	$0
*Year 2000 data is 8 months (January - August).			
** Serve only persons with mental retardation and/or development disabilities.			

Accounts Receivable and Percentage of Total Revenues for Surveyed Behavioral Health Providers

Provider	FY 1998 Accounts Receivable	FY 1999 Accounts Receivable	FY 2000 Accounts Receivable
EastRidge Health Systems	$269,355 (3.98%)	$279,770 (4.43%)	$455,686 (7.73%)
HealthWays	$152,397 (2.74%)	$148,161 (2.76%)	$113,117 (2.06%)
Logan-Mingo Area Mental Health	$138,580 (2.94%)	$156,450 (3.11%)	$192,817 (4.19%)
Northwood Health Systems	$1,058,753 (6.34%)	$603,842 (3.95%)	$492,904 (3.37%)
Potomac Highlands Guild	$271,411 (5.22%)	$131,571 (2.62%)	$147,650 (2.85%)
Prestera Center	$916,457 (5.94%)	$1,059,013 (6.90%)	$1,400,644 (8.68%)
Seneca MH/MR Council	$73,322 (.63%)	$64,785 (.57%)	$75,247 (.70%)
United Summit Center	$490,829 (6.79%)	$533,157 (7.44%)	$547,595* (12.82%)
Valley Health Care	$67,405 (.44%)	$52,300 (.36%)	$56,991 (.37%)
Westbrook Health Services	$2,851,166 (21.98%)	$3,004,458 (24.46%)	$1,918,452 (16.71%)
Appalachian Community Health Center	$601,151 (10.83%)	$129,033 (2.50%)	NA
Autism Services Center**	$0	$0	$0
Green Acres**	$0	$0	$0
Potomac Center**	$0	$0	$0
*Year 2000 data is 8 months (January - August).			
**Serve only persons with mental retardation and/or development disabilities.			

Total Revenue for Surveyed Behavioral Health Providers

Provider	Total Revenue for FY 1998	Total Revenue for FY 1999	Total Revenue for FY 2000
EastRidge Health Systems	$6,769,545	$6,312,920	$5,895,467
HealthWays	$5,552,438	$5,377,241	$5,484,261
Logan-Mingo Area Mental Health	$4,715,070	$5,027,717	$4,607,039
Northwood Health Systems	$16,709,829	$15,305,958	$14,621,545
Potomac Highlands Guild	$5,197,976	$5,031,312	$5,174,417
Prestera Center	$15,417,860	$15,338,572	$16,143,693
Seneca MH/MR Council	$11,552,986	$11,452,014	$10,796,109
United Summit Center	$7,223,626	$7,164,883	$4,272,028*
Valley Health Care	$15,483,352	$14,676,203	$15,209,309
Westbrook Health Services	$12,973,441	$12,285,032	$11,483,419
Appalachian Community Health Center	$5,550,495	$5,154,722	NA
Autism Services Center**	$6,815,054	$7,585,424	$7,982,120
Green Acres**	$4,070,024	$4,133,427	$4,447,829
Potomac Center**	$5,000,318	$5,238,799	$5,266,734
*Year 2000 data is 8 months (January - August).			
**Serve only persons with mental retardation and/or development disabilities.			

APPENDIX C

Behavioral Health Clients as a Percentage of County Population Table

Behavioral Health Clients as a Percentage of County Population

	FY 1998		FY 1999		FY 2000	
County	Total Clients	%Pop as Clients	Total Clients	%Pop as Clients	Total Clients	%Pop as Clients
Barbour	789	4.9	838	5.2	891	5.6
Berkeley	2,226	3.2	1,853	2.5	2,334	3.2
Boone	848	3.2	1,014	3.9	1,214	4.6
Braxton	366	2.8	466	3.5	606	4.6
Brooke	643	2.5	813	3.1	653	2.5
Cabell	3,795	4.0	4,898	5.2	4,670	5.0
Calhoun	356	4.5	393	4.9	340	4.3
Clay	466	4.4	557	5.3	546	5.2
Doddridge	168	2.3	238	3.2	293	3.9
Fayette	1,274	2.7	1,427	3.1	1,544	3.3
Gilmer	146	2.1	155	2.2	175	2.5
Grant	210	1.9	231	2.1	270	2.4
Greenbrier	1,128	3.2	1,286	3.6	1,350	3.8
Hampshire	360	1.9	438	2.3	465	2.4
Hancock	676	2.0	956	2.8	849	2.5
Hardy	212	1.8	212	1.8	244	2.0
Harrison	1,580	2.2	2,048	2.9	2,082	3.0
Jackson	608	2.2	750	2.7	737	2.6
Jefferson	800	2.0	773	1.8	1,016	2.4
Kanawha	4,658	2.3	5,511	2.8	5,288	2.7
Lewis	390	2.2	550	3.2	536	3.1
Lincoln	839	3.8	1,264	5.7	1,073	4.8
Logan	1,356	3.3	1,560	3.9	1,862	4.6
Marion	1,425	2.5	1,443	2.6	1,398	2.5
Marshall	639	2.1	1,126	3.2	1,099	3.1
Mason	1,152	4.4	977	3.8	929	3.6
McDowell	982	3.2	1,533	5.2	1,615	5.5
Mercer	1,692	2.6	2,499	3.9	2,554	4.0
Mineral	325	1.2	286	1.1	539	2.0
Mingo	1,579	4.9	2,011	6.4	2,225	7.1
Monongalia	950	1.2	1,177	1.5	1,251	1.6
Monroe	204	1.6	257	1.9	352	2.7
Morgan	536	4.0	225	1.6	372	2.7
Nicholas	810	2.9	856	3.1	997	3.6
Ohio	1,822	3.7	2,223	4.7	1,920	4.0
Pendleton	122	1.5	144	1.8	167	2.1
Pleasants	115	1.5	164	2.2	158	2.1
Pocahontas	499	5.5	563	6.2	491	5.4
Preston	607	2.0	821	2.8	869	2.9
Putnam	733	1.5	928	1.8	955	1.8

County	FY 1998		FY 1999		FY 2000	
	Total Clients	%Pop as Clients	Total Clients	%Pop as Clients	Total Clients	%Pop as Clients
Raleigh	2,659	3.4	3,278	4.2	3,660	4.6
Randolph	1,672	5.8	1,850	6.5	1,763	6.2
Ritchie	335	3.3	418	4.0	458	4.4
Roane	425	2.8	415	2.7	426	2.8
Summers	432	3.1	486	3.5	564	4.1
Taylor	380	2.5	547	3.6	589	3.8
Tucker	214	2.8	236	3.1	249	3.3
Tyler	285	2.9	320	3.3	261	2.7
Upshur	979	4.1	1,181	5.0	1,276	5.4
Wayne	1,447	3.4	1,785	4.3	1,660	4.0
Webster	530	5.1	535	5.3	553	5.5
Wetzel	625	3.4	793	4.4	822	4.5
Wirt	197	3.5	223	3.9	216	3.8
Wood	2,907	3.3	3,307	3.8	3,578	4.1
Wyoming	821	3.0	879	3.3	981	3.0

APPENDIX D

Demographic Data Table

Demographic Data Table

County	Total County Population	CBHC Clients	% Population as Clients	% of Population in Poverty	% of Population with High School or Less	CBHC Located in County
Barbour	15,979	891	5.6	26.3	48.7	0
Berkeley	72,846	2334	3.2	13.4	36.6	1
Boone	26,302	1214	4.6	23.2	51.4	0
Braxton	13,211	606	4.6	26.3	51.7	0
Brooke	25,890	653	2.5	13.7	48.1	1
Cabell	93,562	4670	5	19.5	40.4	1
Calhoun	7,982	340	4.3	31.5	52.4	0
Clay	10,609	546	5.2	33.2	49.3	0
Doddridge	7,447	293	3.9	23.3	46.5	0
Fayette	46,785	1544	3.3	25.8	51.6	0
Gilmer	7,143	175	2.5	31.2	47.8	0
Grant	11,140	270	2.4	15.5	48.6	0
Greenbrier	35,310	1350	3.8	19.2	48.4	0
Hampshire	19,418	465	2.4	18.2	42.3	1
Hancock	33,740	849	2.5	13.8	51.4	0
Hardy	11,989	244	2	13.8	50.1	1
Harrison	70,329	2082	3	19.7	44.8	0
Jackson	28,294	737	2.6	18.4	43.3	0
Jefferson	42,271	1016	2.4	11.9	34.6	0
Kanawha	199,263	5288	2.7	17.1	44.5	1
Lewis	17,463	536	3.1	24.2	51.7	1
Lincoln	22,346	1073	4.8	30.1	51.7	0
Logan	40,183	1862	4.6	27.1	53.7	1
Marion	55,939	1398	2.5	18.5	45.9	0
Marshall	34,968	1099	3.1	17.6	51.8	1
Mason	26,018	929	3.6	20.2	51.3	0
McDowell	29,306	1615	5.5	36.8	64.9	0
Mercer	64,132	2554	4	22	47.0	0
Mineral	27,069	539	2	16.3	44.7	0
Mingo	31,480	2225	7.1	29.5	51.7	0
Monongalia	77,006	1251	1.6	16.3	30.8	1
Monroe	13,296	352	2.7	19.1	49.7	0
Morgan	13,895	372	2.7	13.9	44.7	0
Nicholas	27,526	997	3.6	24.1	50.1	0
Ohio	47,719	1920	4	15.4	44.3	0
Pendleton	8,040	167	2.1	16.6	53.1	0
Pleasants	7,518	158	2.1	16.6	50.5	0
Pocahontas	9,065	491	5.4	20.5	53.8	0
Preston	29,814	869	2.9	20.5	49.0	0
Putnam	51,936	955	1.8	11.4	36.0	0
Raleigh	78,947	3660	4.6	21	45.3	1
Randolph	28,654	1763	6.2	22.6	47.0	1
Ritchie	10,480	458	4.4	23.4	51.0	0
Roane	15,413	426	2.8	26.5	52.7	0
Summers	13,863	564	4.1	29.1	55.1	0

County	Total County Population	CBHC Clients	% Population as Clients	% of Population in Poverty	% of Population with High School or Less	CBHC Located in County
Taylor	15,367	589	3.8	23.4	50.7	0
Tucker	7,513	249	3.3	17.6	54.5	0
Tyler	9,717	261	2.7	18.7	48.8	0
Upshur	23,544	1276	5.4	24.4	44.5	0
Wayne	41,860	1660	4	22.1	47.9	0
Webster	10,036	553	5.5	35.6	57.9	1
Wetzel	18,220	822	4.5	20.7	50.8	0
Wirt	5,761	216	3.8	21.2	45.0	0
Wood	86,337	3578	4.1	16.5	42.4	1
Wyoming	26,987	981	3	26.8	55.3	1

APPENDIX E

Statewide Summary of Adults and Children for FY 1998, 1999, and 2000

Statewide Summary of Adults and Children for FY 1998, 1999, and 2000

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldr n	Adults	% Adults	Chldrn	% Chldrn
ARC in Kanawha-Putnam Counties	22	.06	8	.04	28	.06	9	.038	31	.07	6	.025
ARC of Harrison County	23	.06	1	.01	24	.05	1	.004	18	.04	1	.004
Action Youth Care	289	.81	1309	6.67	539	1.27	2240	9.508	596	1.42	2475	10.165
Appalachian Community Health Center	1816	5.09	778	3.97	2009	4.75	781	3.315	1961	4.68	817	3.355
Autism Services Center	206	.58	102	.52	125	.29	45	.191	224	.53	125	.513
Barbour County Health Department	93	.26	114	.58	139	.32	181	.768	163	.38	230	.945
Braley and Thompson	76	.21	378	1.93	0	0	0	0	0	0	4	.016
Braxton County Fellowship Home	2	.01	0	0	2	.00	0	0	15	.03	0	0
Braxton County School Health Service	4	.01	65	.33	5	.01	95	.403	10	.02	138	.567
Burlington United Methodist Homes	14	.04	266	1.36	17	.04	315	1.337	24	.05	303	1.244
Charles W. Cammack Childrens Center	3	.01	86	.44	4	.00	83	.352	3	.00	84	.345
Chestnut Ridge Day Hospital	14	.04	138	.70	0	0	0	0	0	0	0	0
Children and Youth Behavioral Health	6	.02	238	1.21	2	.00	323	1.371	0	0	225	.924

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldr n	Adults	% Adults	Chldrn	% Chldrn
Childrens Home Society of WV	40	.11	974	4.97	50	.11	902	3.829	35	.08	796	3.269
Childrens Home of Wheeling	4	.01	54	.28	0	0	55	.233	4	.01	57	.234
Community Alternatives of WV	126	.35	0	0	109	.25	0	0	57	.13	0	0
Concord	0	0	0	0	0	0	0	0	1	.00	0	0
Coordinating Council for Independent Living	80	.22	8	.04	118	.27	30	.127	147	.35	39	.160
DEAF of WV	3	.01	0	0	6	.01	0	0	10	.02	2	.008
Davis-Stuart	4	.01	94	.48	7	.01	91	.386	4	.01	102	.419
Daymark	7	.02	48	.25	7	.01	34	.144	11	.02	27	.111
Doddridge County Day Treatment Center	65	.18	0	0	89	.21	0	0	48	.11	0	0
EastRidge Health Systems	2235	6.27	446	2.27	1439	3.40	759	3.222	1923	4.59	1158	4.756
Eastern Panhandle Training Center	289	.81	42	.21	260	.61	35	.149	281	.67	42	.172
Elkins Family Counseling Center	73	.21	102	.52	95	.22	110	.467	90	.21	117	.481
Elkins Mountain School	0	0	256	1.31	0	0	281	1.193	0	0	329	1.351
Evergreen Behavioral Health Center	61	.17	42	.21	45	.10	44	.187	55	.13	33	.136
FMRS Mental Health Council	2855	8.01	1028	5.24	3061	7.23	1234	5.238	3677	8.78	1442	5.922

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldr n	Adults	% Adults	Chldrn	% Chldrn
Family Connections	34	.10	107	.55	28	.06	95	.403	27	.06	90	.370
Family Service - Upper Ohio Valley	27	.08	9	.05	35	.08	8	.034	46	.11	10	.041
Family Service Associations, Inc. of Morg.	14	.04	15	.08	0	0	0	0	0	0	0	0
Florence Crittenton Home of WV	271	.76	516	2.63	278	.65	535	2.271	164	.39	449	1.844
Genesis Youth Center	5	.01	48	.25	6	.01	114	.484	1	.00	165	.678
Golden Girl	2	.01	37	.19	1	.00	47	.199	2	.00	34	.140
Green Acres Regional Center	143	.40	0	0	153	.36	0	0	156	.37	0	0
Hampshire County Special Services Center	42	.12	2	.01	35	.08	1	.004	46	.11	1	.004
Healthways, Inc.	760	2.13	232	1.18	1066	2.52	269	1.142	950	2.26	241	.990
Horizons Center for Independent Living	7	.02	0	0	6	.01	0	0	7	.01	0	0
Kanawha Valley Fellowship Home	11	.03	0	0	16	.03	0	0	12	.02	0	0
Kanawha Valley Senior Services	37	.10	0	0	34	.08	0	0	33	.07	0	0
Logan-Mingo Area Mental Health	2291	6.42	299	1.52	2658	6.28	377	1.600	2916	6.96	377	1.548
Mercer County Fellowship Home	19	.05	0	0	8	.01	0	0	44	.10	0	0

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn
Mid-Ohio Valley Fellowship Home	35	.10	0	0	48	.11	0	0	58	.13	0	0
Monongalia County Youth Services Center	0	0	40	.20	1	.00	58	.246	0	0	78	.320
New River Ranch	0	0	17	.09	0	0	15	.064	4	.01	20	.082
Northern Tier Youth Services	0	0	69	.35	0	0	66	.280	1	.00	62	.255
Northwood Health Systems	2442	6.85	733	3.74	3397	8.03	674	2.861	2684	6.41	574	2.357
Olympic Center - Preston	0	0	205	1.05	1	.00	170	.722	0	0	172	.706
Open Doors for the Developmentally Challenged	25	.07	3	.02	31	.07	3	.013	33	.07	2	.008
Outlook America of West Virginia	0	0	0	0	0	0	0	0	28	.06	0	0
PACE Training and Evaluation Center	14	.04	0	0	17	.04	0	0	17	.04	0	0
Potomac Center	21	.06	17	.09	19	.04	26	.110	18	.04	35	.144
Potomac Highlands Guild	753	2.11	133	.68	989	2.33	191	.811	1073	2.56	228	.936
Pressley Ridge Schools	66	.19	860	4.38	109	.25	898	3.812	94	.22	913	3.750
Prestera Center for Mental Health Services	4316	12.10	1280	6.52	5938	14.03	2042	8.667	5141	12.27	2227	9.146
Rainbow House Fellowship Home	24	.07	0	0	17	.04	0	0	9	.02	0	0

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn
Russell Nesbitt Adult Care and Activity	46	.13	3	.02	57	.13	1	.004	85	.20	1	.004
Seneca Mental Health/Mental Retardation	1792	5.03	722	3.68	1853	4.38	720	3.056	1845	4.40	680	2.793
Serenity Fellowship Home	17	.05	0	0	28	.06	0	0	32	.07	0	0
Shawnee Hills, Inc.	4558	12.78	2167	11.05	5206	12.30	2594	11.010	4847	11.57	2269	9.319
Southern Highlands Community MH C	3085	8.65	690	3.52	3382	7.99	751	3.188	3232	7.72	735	3.019
Southern WV	69	.19	0	0	126	.29	0	0	108	.25	0	0
Southwestern Community Action Council	0	0	168	.86	0	0	180	.764	0	0	191	.784
St. Johns Home for Children	0	0	13	.07	0	0	18	.076	0	0	21	.086
Stepping Stone, Inc.	0	0	13	.07	1	.00	19	.081	1	.00	27	.111
Stepping Stones	2	.01	29	.15	2	.00	24	.102	1	.00	33	.136
Sugar Creek Childrens Center	1	0.00	18	.09	0	0	27	.115	0	0	19	.078
Timberline Health Group	165	.46	409	2.09	201	.47	485	2.059	258	.61	519	2.132
Try-Again Homes	9	.03	191	.97	5	.01	175	.743	6	.01	165	.678
United Summit Center	1272	3.57	597	3.04	1726	4.08	812	3.447	1806	4.31	939	3.856
VOCA Corporation of WV	175	.49	0	0	177	.41	0	0	152	.36	0	0
Valley Comprehensive Community MH C	1660	4.65	708	3.61	2737	6.47	748	3.175	2677	6.39	677	2.780

Provider	FY 1998				FY 1999				FY 2000			
	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn	Adults	% Adults	Chldrn	% Chldrn
WV Youth Advocate Program	17	.05	728	3.71	24	.05	871	3.697	28	.06	952	3.910
Westbrook Health Service	2290	6.42	1064	5.42	2644	6.25	1089	4.622	2807	6.70	1123	4.612
Worthington Center	658	1.85	358	1.83	782	1.84	516	2.190	746	1.78	550	2.259
Youth Health Services	0	0	317	1.62	0	0	346	1.469	1	.00	353	1.450
Youth Services System	9	.03	136	.69	21	.05	255	1.082	17	.04	248	1.019
UNKNOWN	71	.20	89	.45	253	.59	692	2.937	266	.63	617	2.534
Total	**35665**	**100%**	**19619**	**100%**	**42296**	**99.99%**	**23560**	**100%**	**41867**	**100%**	**24349**	**100%**

APPENDIX F

FY 1998, 1999, and 2000 Provider Financial Information

FY 1998, 1999, and 2000 Provider Financial Information

Provider	FY 98 Private Source Revenue	FY 98 Uncollected Receivables	FY 98 Total Annual Revenues	% Private to Total	% Uncoll. to Total
Appalachian Community Health Center	NA	$601,151	$5,550,495	NA	10.83%
Autism Services Center*	$0	$0	$6,815,054	NA	NA
Eastern Panhandle Training Center*	NA	NA	NA	NA	NA
EastRidge Health Systems	$677,156	$269,355	$6,769,545	10%	3.98%
FMRS Mental Health Council	NA	NA	NA	NA	NA
Green Acres*	$0	$0	$4,070,024	NA	NA
HealthWays	$478,728	$152,397	$5,552,438	8.6%	2.74%
Logan-Mingo Area Mental Health	$146,532	$138,580	$4,715,070	3.1%	2.94%
Northwood Health Systems	$619,828	$1,058,753	$16,709,829	3.71%	6.34%
Potomac Center*	$0	$0	$5,000,318	NA	NA
Potomac Highlands Guild	$264,839	$271,411	$5,197,976	5.10%	5.22%
Prestera Center	$311,130	$916,457	$15,417,860	2.02%	5.94%
Seneca MH/MR Council	$251,639	$73,322	$11,552,986	2.18%	0.63%
Shawnee Hills	NA	NA	NA	NA	NA
Southern Highlands Community Mental Health Center	NA	NA	NA	NA	NA
United Summit Center	$606,202	$490,829	$7,223,626	8.39%	6.79%
Valley Health Care	$208,310	$67,405	$15,483,352	1.35%	0.44%
Westsbrook Health Services	$1,164,188	$2,851,166	$12,973,441	8.97%	21.98%
Provider	**FY 99 Private Source Revenue**	**FY 99 Uncollected Receivables**	**FY 99 Total Annual Revenues**		
Appalachian Community Health Center	$197,348	$129,033	$5,154,722	3.83%	2.50%
Autism Services Center*	$0	$0	$7,585,424	NA	NA
Eastern Panhandle Training Center*	NA	NA	NA	NA	NA
EastRidge Health Systems	$728,572	$279,770	$6,312,920	11.54%	4.43%
FMRS Mental Health Council	NA	NA	NA	NA	NA
Green Acres*	$0	$0	$4,133,427	NA	NA
HealthWays	$348,500	$148,161	$5,377,241	6.48%	2.76%
Logan-Mingo Area Mental Health	$252,542	$156,450	$5,027,717	5.02%	3.11%
Northwood Health Systems	$215,908	$603,842	$15,305,958	1.41%	3.95%
Potomac Center*	$0	$0	$5,238,799	NA	NA
Potomac Highlands Guild	$244,549	$131,571	$5,031,312	4.86%	2.62%
Prestera Center	$337,152	$1,059,013	$15,338,572	2.20%	6.90%
Seneca MH/MR Council	$261,083	$64,785	$11,452,014	2.28%	0.57%
Shawnee Hills	NA	NA	NA	NA	NA
Southern Highlands Community Mental Health Center	NA	NA	NA	NA	NA
United Summit Center	$541,955	$533,157	$7,164,883	7.56%	7.44%
Valley Health Care	$192,639	$52,300	$14,676,203	1.31%	0.36%
Westsbrook Health Services	$993,051	$3,004,458	$12,285,032	8.08%	24.46%
Provider	**FY 00 Private Source Revenue**	**FY 00 Uncollected Receivables**	**FY 00 Total Annual Revenues**		
Appalachian Community Health Center	NA	NA	NA	NA	NA
Autism Services Center*	$0	$0	$7,982,120	NA	NA
Eastern Panhandle Training Center*	NA	NA	NA	NA	NA
EastRidge Health Systems	$652,536	$455,686	$5,895,467	11.07%	7.73%
FMRS Mental Health Council	NA	NA	NA	NA	NA
Green Acres*	$0	$0	$4,447,829	NA	NA
HealthWays	$351,168	$113,117	$5,484,261	6.40%	2.06%
Logan-Mingo Area Mental Health	$256,543	$192,817	$4,607,039	5.57%	4.19%
Northwood Health Systems	$56,606	$492,904	$14,621,545	0.39%	3.37%
Potomac Center*	$0	$0	$5,266,734	NA	NA
Potomac Highlands Guild	$211,265	$147,650	$5,174,417	4.08%	2.85%
Prestera Center	$417,699	$1,400,644	$16,143,693	2.59%	8.68%
Seneca MH/MR Council	$181,193	$75,247	$10,796,109	1.68%	0.70%
Shawnee Hills	NA	NA	NA	NA	NA
Southern Highlands Community Mental Health Center	NA	NA	NA	NA	NA
United Summit Center	$138,831	$547,595	$4,272,028	3.25%	12.82%
Valley Health Care	$197,635	$56,991	$15,209,309	1.30%	0.37%
Westsbrook Health Services	$927,621	$1,918,452	$11,483,419	8.08%	16.71%

*Serve only persons with mental retardation and/or development disabilities

APPENDIX E

Agency Response

RESPONSE TO REPORT OF
PERFORMANCE, EVALUATION, AND RESEARCH DIVISION
WEST VIRGINIA LEGISLATURE

RECEIVED
NOV 2 8 2000
RESEARCH AND PERFORMANCE
EVALUATION DIVISION

NOVEMBER 2000

OFFICE OF BEHAVIORAL HEALTH SERVICES
BUREAU FOR BEHAVIORAL HEALTH AND HEALTH FACILITIES
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Submitted by:

Joan E. Ohl, Secretary
Department of Health and Human Resources

RESPONSE TO REPORT OF PERFORMANCE, EVALUATION, AND RESEARCH DIVISION WEST VIRGINIA LEGISLATURE
Office of Behavioral Health Services

The Department of Health and Human Resources (DHHR) appreciates the report prepared by the Performance, Evaluation, and Research Division of the West Virginia Legislature. The focus of the report, to examine the role of fee-for-service payments made directly by clients and their private insurers, is relevant to the Department and welcome in view of the Department's objectives for behavioral health services.

The report notes the importance of Medicaid in providing reimbursement for many behavioral health services for slightly more than 51% of the adults served and over 80% of the children served. Further information, gathered from a PERD survey of 18 major behavioral health providers, indicates little revenue is received by these providers directly from clients or their private insurers. The data further demonstrates that providers "write off" a substantial portion of fees charged clients or private insurance companies. Finally, the report provides income and employment data for clients served, indicating that the population served is generally unemployed, underemployed, and poor.

DHHR generally agrees with the findings of this report. The Department believes the survey information may be incomplete and that respondent providers did not provide data consistent with audited figures submitted to the Department. However, the point about the role of client and private insurance revenue is well taken — these resources are not a major source of revenue for the major behavioral health providers.

To be fair, the report should indicate that each provider establishes its own methodology, using general accounting principles, for writing off expected revenue; the Department does not, and cannot, prescribe this methodology, as long as the provider and its auditors use accepted principles. Thus, the amount attributed to "charity care" or as "uncollectible" is based more on the policies of the individual provider than on an established formula.

Income and employment data, however, are accurate and reflect the basis for most of the write-offs. It is a fact that people served by the major behavioral health providers are unemployed or underemployed and have incomes at or below the poverty level. This is frequently a consequence for people with behavioral health needs.

It is important to recall that some appropriations to the Department were re-budgeted in Fiscal Year 1993, to move $20 million from the Office of Behavioral Health Services to Medicaid, to serve as State match for a Medicaid-funded behavioral health program. Prior to the re-budget, the Department provided grants for behavioral health centers contracting with the Department to serve individuals who could not afford fee-for-service payments or did not have private insurance. The amount of funding available for this purpose decreased substantially. The availability of Medicaid funding for services greatly expanded

provider capacity to deliver services to Medicaid-eligible individuals. As noted in the report, however, funding has been limited for persons who are poor but are not eligible for Medicaid.

Beginning in Fiscal Year 1998, the Department and the Legislature initiated a funding initiative to increase funding for individuals who are poor and have no source of income or insurance to purchase behavioral health care services. The initiative resulted in an allocation increase of $3 million in Fiscal Year 1998 and $3 million in Fiscal Year 1999. For Fiscal Year 2000, the Department transferred $3 million within its budget to complete the $9 million plan to increase funding for uncompensated care.

Rather than allocate these funds to providers in some arbitrary grant methodology, OBHS has maintained that the uncompensated care dollars should be used for the most vulnerable populations served by the comprehensive behavioral health providers. The characteristics of the populations identified for uncompensated funding include:

- individuals who are at or below 150% of poverty; and
- have no other form of third party payer for the services they receive; and
- have an eligible diagnosis consistent with Medicaid criteria; or
- have a history of hospitalization; or
- live in a controlled setting such as a group home; or
- receive supportive residential services; or
- receive services required by Chapter 27; or
- receive any crisis services.

Uncompensated care funds may be used for services provided to a Medicaid-eligible individual, but not reimbursed by Medicaid. For example, Medicaid will not reimburse for "supervision" in a group home and may not reimburse for many vocationally-oriented services.

The amount of funding awarded to the 14 major providers contracting with the Department is based on the population of the provider's Service Area, an estimate of the number of eligible individuals to be served, and an estimate of the value of the eligible services provided to the population. The value of service provided is based on Medicaid rates. The funding methodology gives an equal weight to each of the three factors. The 4 major MR/DD agencies are allocated uncompensated funds based on program needs that are not otherwise funded.

Each provider is required to report service information on each consumer served regardless of payer. OBHS uncompensated care is a payer source. OBHS now has the ability to identify consumers and the services provided to them as reported by each provider. The services being provided can now be linked with the allocation of uncompensated care funds.

The Department is cognizant of the fact that additional resources and services are needed.

There must be a direct purpose and goal for additional funding to meet these resource and service needs. Thus, the Department is requesting an additional $5.25 million in funding for Fiscal Year 2002. If provided, this funding will be directed as follows:

- $1,250,000 for State match for a special five-year, $7 million Federal grant to serve children with serious emotional disturbance in the DHHR Region II — perhaps the area most in poverty;
- $400,000 to increase then availability of substance abuse residential treatment beds — persons who are chemically addicted are most likely to be unemployed or underemployed, typically without insurance, and are usually not eligible for Medicaid;
- $2,500,000 to provide necessary services which are not reimbursable by Medicaid — this funding would enable the continuation of a many supports which do not fit the definition of "medical necessity" imposed by the Health Care Financing Administration;
- $500,000 to meet special needs for community-based services for persons hospitalized at the Mildred Mitchell-Bateman Hospital or the William R. Sharpe, Jr. Hospital — poor individuals who are not Medicaid eligible or who require services that are not reimbursable by Medicaid;
- $500,000 to expand the Family Support Program for families of individuals with mental retardation or another developmental disability and $100,000 to create a Family Support Program for families of individuals with mental illnesses — families are frequently the primary caretaker and responsible for many services and supports; this fund reimburses families for those supports, which are not reimbursable otherwise.

In addition to the uncompensated care funds and the request for additional funding, the Department made another major change in allocations beginning in Fiscal Year 2001. Another methodology of funding the major behavioral health providers has been the allocation of "discretionary funding," typically divided and allocated for specific disabilities (MR/DD, substance abuse, mental illness). Providers were to use this funding to develop and finance the service delivery system for a specific Service Area.

Starting in Fiscal Year 2001, this funding — about $5 million — has been allocated for the "Core Services" of crisis services, linkages with inpatient and residential treatment services, medical services, diagnostic and assessment services, treatment services, and support services. These Core Services are listed in the law governing community-based behavioral health services. The Department's Grant Agreement with the major behavioral health providers specifies minimum standards for these services and requires a plan of operations describing how they will be delivered in each Service Area.

This method of allocation is designed to assure the availability, in each county of each Service Area, of the primary Core Services for all persons regardless of income or source of payment, if any. The Department's monitoring procedures are designed to assure the

availability of those Core Services and conformance to the minimum standards described in the Grant Agreement. This approach to Core Services is more necessary with the advent of utilization management for Medicaid-reimbursed behavioral health services. The utilization management will further decrease the availability of Medicaid monies to support Core Services, but will be limited to services which are medically necessary and actually delivered.

Despite these measures, as pointed out the PERD report, the service system is not the same in all counties of each Service Area or when comparing Service Areas. The reason for that is generalized to some degree — insufficient funding for persons with little or no income and no insurance coverage to purchase behavioral health services — and specific to Service Areas as a result of continuing historical allocation patterns. The Department is committed to reviewing the funding methodology for community-based behavioral health services. This report from PERD suggests to the Department that the extent of poverty in a Service Area should be one consideration for funding providers. This element will be considered as the Department proceeds with its deliberations on funding.