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2. Executive Summary

Myers and Stauffer, a certified public accounting firm that specializes in health care consulting, has been engaged by the Kansas Department of Social and Rehabilitation Services (SRS) to perform the rate study, required under the developmental disabilities (DD) reform act of 1995. The rate study is required on a biennial basis to provide a review of the rate structures and a recommendation regarding rate adjustments.

SRS contracts with Community Developmental Disabilities Organizations (CDDO) to coordinate services and supports provided for persons with developmental disabilities. The CDDO are each assigned a particular county or counties and work with affiliated community service providers (CSP) to ensure choice and access to services for those individuals.

The current rate structure, developed by Deloitte and Touche and implemented in 1992, incorporates the concept of payment based on acuity factors of the individual consumers. The system uses the Developmental Disabilities Profile (DDP) to assess need and a tier level methodology to group consumers with similar needs. Rate models developed during the original 1991 cost study are used as the basis to establish rates.

To provide oversight for this rate study, an Advisory Committee that includes three representatives from SRS and three from the provider community, was impaneled. The committee provided guidance on the timeline, methodology, data collection tool and training activities.

Myers and Stauffer staff attended three orientation and discussion meetings with representatives from the provider community and had monthly conference calls with the Advisory Committee. The study design incorporated recommendations from these interactions to:

1. Include any enrolled Medicaid provider serving five or more people.
2. Not include children's residential, self-determination or limited license providers.
3. Allow providers to report data from the provider's fiscal year rather than the state's fiscal year.
4. Use the most recent fiscal year end, those ending in calendar year 2005.
5. Pilot test the data collection tool.
6. Provide training on completion of the tool.

Additional meetings were held to discuss the development of the data collection tool and review draft hardcopy versions of the form. Once the final layout was decided, the tool was developed and then pilot tested by four providers. Only minor changes to the form were suggested following the pilot study.

Training sessions were held in Hays, Topeka and Wichita in May and the data collection tool was distributed statewide on May 22 with a July 3, 2006 completion deadline. Myers and Stauffer staff were available to answer questions and to assist in the completion process.

Seventy-nine tools were submitted, including the four pilot providers, from the 141 potential submissions. The responses represent 100% of the CDDO, and 56% of all possible providers. Seventy of the 79 submissions were included in the analysis. The other nine submissions were either incomplete, determined to be inaccurate or received too late to be included in the analyses. The included submissions represent approximately 72% of waiver revenue.

For the study, data was collected on following three separate services.

- Residential services that assist individuals to live successfully in a community setting.
- Day services provided away from the home that increase independence, integration, inclusion and personal accomplishment
- In-home support designed to defray the cost and stress of supporting a family member with a developmental disability living in the family home.

Statistical data collected from the providers included days by tier level for residential and day services. Forty-seven providers reported residential services and 52 providers reported day services. In-home support providers reported days based on the billing methodology, either bundled or unbundled services. There were 38 providers who reported providing in-home support services.

The rate analyses for residential and day services included

- A comparison between the hours of service per day as reported and as calculated using hours from the rate structure formula.
- An evaluation of cost coverage in total and per provider per service level.
- Analyses of the quartiles arrayed first by cost and then by cost coverage.
- A further evaluation of the quartiles by the proportion of days within each tier level.
- Developing per diem costs per tier level
  - Using a ratio established from the hours per day in the rate formula times reported days to distribute costs
  - Using the detailed tier level day information reported by each setting.

The differences in billing methodology and the subsequent reporting differences limited the rate analyses for in-home supports to an evaluation of the cost coverage in total, per provider and a per diem costs per tier level analysis using the ratio of established hours per day in the rate formula to distribute costs.

Additional information collected on the tools submitted by the providers included

- Employee health insurance

- Worker's compensation insurance
- Staff training
- Turnover and vacancies

For the required review of wage rates and benefits, information was collected from the providers on the data collection tools, the two state hospitals in Kansas and the US Bureau of Labor Statistics and Kansas Department of Labor websites.

The rate study requires an evaluation of risk management costs, which include employee background checks and drug testing, driver's safety training, fire and life safety requirements and worker's compensation.

At the orientation meeting, there was discussion about the increasing acuity level of consumers now being provided services. Certain health data is collected in the Developmental Disabilities Profile (DDP) assessment required to be completed on all consumers annually. This information is then maintained in the Basic Assessment Services and Information System (BASIS). Data for calendar year 2003 and fiscal year 2006 was obtained from SRS to be used in some comparative analysis, which included a review of the distribution of the health care component for all consumers and for all consumers age 65 and older.

Some additional statistics on program growth since 1984 and spending rates per participant were included from a national prospective and for the states in the Center for Medicare and Medicaid Services (CMS) Region VII.

Rate study recommendations include to:

1. Use the data collection tool developed under this study, with potential adjustments, to standardize the cost data collection process. A standardized, annual collection process that was desk reviewed or audited and stored in a database structure, would assure better more consistent data to be used in rate evaluations.

2. Either augment the DDP to enhance its ability to monitor changes in acuity and add an evaluation of supports needed or consider implementing a new tool that better assesses and predicts needed resources.

3. Re-evaluate or redesign the rate structure to address the apparent disconnect between the assumed resource needs, imbedded in the current tier level rate formula and the level of support needed.

4. Develop and apply an appropriate annual adjustment to the rates that estimates the inflation the provider community will experience during the rate period.

5. Use the newly evaluated or designed system to establish rates or evaluate the pool to be paid for services covered by State General Fund.

3. Introduction

Report requirements

The provisions of K.S.A. 39-1801 through 39-1810 are known as the developmental disabilities (DD) reform act of 1995. The state policy, detailed in this act, is to assist persons with a developmental disability to have access to a range of services and supports, which allow opportunities of choice to increase their independence, productivity, integration and inclusion into the community and the same dignity and respect as persons who do not have a developmental disability.

This act defines developmental disabilities, details the powers and duties of the Department of Social and Rehabilitation Services (SRS) and the community developmental disability organizations, and describes the contracting, funding and quality assurance systems. The act also requires an independent, professional review of the rate structures on a biennial basis resulting in a recommendation to the legislature regarding rate adjustments. Such recommendation shall be adequate to support:

1. A system of employee compensation competitive with local conditions
2. Training and technical support to attract and retain qualified employees
3. A quality assurance process, which is responsive to consumers' needs and maintains the standards of quality service
4. Risk management and insurance costs
5. Program management and coordination responsibilities[1]

Myers and Stauffer

Myers and Stauffer has been engaged by SRS to perform the currently required rate study. Our certified public accounting practice was established in 1977 and has provided cost report verification, rate setting and consulting services to state and federal agencies for close to 30 years. We previously performed the 2001 rate study in which we developed a financial, staffing and service delivery data collection instrument for Community Developmental Disabilities Organizations (CDDO) and Community Service Providers (CSP), that collected and compiled the financial and staffing data reported by these entities.

Our staff have extensive knowledge and hands-on experience performing audits, desk reviews and a wide array of rate setting, data management, analysis and consulting services. We have performed engagements addressing many different categories of health care providers, including nursing facilities, hospitals, home health agencies, federally qualified health centers, rural health clinics and intermediate care facilities for the mentally retarded.

[1] Chapter 39 Mentally Ill, Incapacitated And Dependent Persons; Social Welfare Article 18-Developmental Disabilities Reform

CDDO/CSP program

SRS contracts with CDDO in all areas of the state to coordinate services and supports for persons with developmental disabilities. The CDDO work with affiliated community service providers to ensure choice and access to services.

The CDDO are to

1. Provide a single point of entry for people seeking services
2. Determine eligibility for services
3. Maintain a list of persons waiting to receive services
4. Assist people in accessing needed services
5. Provide information and referral services
6. Coordinate the relocation of people living in state hospitals who wish to return to their home community
7. Work with affiliate agencies to ensure consumer-driven, quality services

Kansas currently has 27 CDDO each assigned a particular county or counties in which they are the primary gatekeepers of DD services.

Current rate structure development

Originally payments for traditional adult services were made on a flat daily rate. The current rate structure, developed from a cost study performed by Deloitte and Touche and implemented in 1992, incorporates the concept of payment based upon acuity factors of the individual consumer, the consumer's level of need or case mix. The study sample included approximately 50% of the Home and Community Based Services (HCBS) waiver recipients at the time. It evaluated the then current service program costs, staffing patterns, service delivery characteristics, state and federal licensing standards and other applicable data. The service categories evaluated were Day Habilitation, Residential Habilitation, Supported Employment and Supported Family Living.

The main components needed to develop a case mix rate structure include a methodology to assess consumer needs, a system that groups consumers with similar resource needs, and a method to link reimbursement to the predicted resource usage. The decision was to use the Developmental Disabilities Profile (DDP), a tier level grouping methodology and rate models developed through cost study.

The DDP was selected as the tool to assess consumer needs. It is an instrument designed by New York's Office of Mental Retardation, over a two-year period finalized in 1990, to record important characteristics of individuals with developmental disabilities. The information collected via the DDP includes a broad range of adaptive functioning skills as well as behavioral challenges and health factors.

The instrument yields a score in each of three indexes: adaptive functioning, maladaptive behavior and health needs. Because the indexes are not equivalent numerically (unequal number of questions in each index) the index scores are converted, thus the maximum

possible converted score is 300. The higher the score, the greater (more severe) is the disability of the individual.

In the Deloitte Touche study, individual scores were converted to percentiles and ranked against the identified population set. These percentiles were divided into levels, which corresponded to consumer's service level needs. The highest percentile ranking corresponded to the highest level of need.

Rate models were developed for each service category. The models included direct personnel costs, direct administration costs, non-personnel operating costs, transportation costs, facility related costs and indirect administration costs. To link the identified levels of need to projected resources, reimbursement models were developed that included staffing ratios and hours of direct service delivered per day per consumer in the various service programs.

At the time of the Deloitte Touche study, Day Habilitation services were typically provided in Adult Day Care /Life Skills, Sheltered Workshops, Mobile Enclaves or Retirement Programs, while Residential Habilitation were provided in Special Case Group Homes, Group Homes, or Semi-Independent Living sites. The decision was made to treat all settings of Day Habilitation as one service and all settings of Residential Habilitation as one setting, varying the rate based on the tier level of the consumer rather that the various settings.

Staffing ratios recommended in the study for Day Habilitation and Residential Habilitation are as follows[2]:

Day Habilitation		
Levels	Ratio	Hours per Day
I	1:2.5	3.20
II	1:3.5	2.29
III	1:4.5	1.78
IV	1:6.5	1.23
V	1:8.0	1.00

Residential Habilitation		
Levels	Ratio	Hours per Day
I	1:2	5.14
II	1:2.5	4.11
III	1:3.5	2.94
IV	1:5.5	1.87
V	1:8	1.29

Table 1: Staffing Ratios

[2] Deloitte & Touche Cost Study and Development of Standard Unit of Service Reimbursement Rates for Services to Persons with Developmental Disabilities September 1991

The study recommended residential rates be developed using the wage rate for an MR trainee with three years experience for direct service staff with a benefits ratio of 20% of gross; a 15% relief factor to account for vacation, sick leave, holidays, training and meetings; a holiday coverage or client sick/snow day coverage factor; the wage rate for an MR specialist for the direct personnel supervision with a benefits ratio of 20% of gross; non-personnel operating, transportation and indirect administration based on a percentage of total unit cost; a vacancy factor; and an amount for over night awake staff.

The recommended day service rates did not include the holiday coverage factor or the over night awake staff amounts. It did include a facilities related cost, based on a fixed dollar amount per consumer per year.

The basic rate structure has changed little from the original recommendation. When transportation was removed from the rate structure, the dollars were left in and renamed "other reimbursement." Dollars were added for staff training and medical and therapeutic consultation. The benefit factor was increased to 25%. Wage rates and hours per tier level have also been increased and the vacancy factor has been reduced.

4. Methodology

Oversight committee

An Advisory Committee that includes three representatives from SRS and three from the provider community provided advisory services to the contractor in the development of the timeline, methodology, data collection tool and training activities. The formation of this Advisory Committee was a newly added component to the scope of work for this rate study. A listing of Advisory Committee members is included in Appendix A

The Advisory Group conducted monthly conference calls with the contractor to discuss the progress of the study and to make recommendations. The following recommendations were implemented in the study:

1. Include any enrolled Medicaid provider serving five or more people.
2. Do not include children's residential, self-determination or limited license providers in the study. *Note: Statistics on children's residential and self-determination were collected for completeness of records and comparison to source documentation.*
3. Allow the providers to report data from their fiscal year rather that the state fiscal year.
4. Use the most recent fiscal year end or those ending in calendar year 2005.
5. Once the collection tool is developed to have a pilot testing.
6. Hold a minimum of two training sessions on use of the data collection tool.

Orientation sessions

At least one provider education meeting was required in the project scope of work. The meetings were to facilitate and expand the contractor's understanding of the Kansas DD Service System. The Advisory Committee was responsible for arranging these meetings.

Prior to developing the data collection tool, Myers and Stauffer attended three orientation and discussion sessions with a representative group from the provider community. The sessions were an opportunity for providers to advise Myers and Stauffer regarding the environment in which they operate and address concerns about prior rate studies. In addition the providers gave Myers and Stauffer their input on how the data collection tool could be improved for the current rate study.

Data collection tool development

Myers and Stauffer performed the rate analysis in 2001 and we used the collection tool developed for that study as a starting place for the current study. In addition we received chart of accounts from several CDDO and recommendations on the layout and functionality of the tool. At least two meetings were held with the Advisory Group and other representatives from the provider community to discuss the development of the collection tool and review hardcopy drafts of the form.

Data collection tool and instructions

All CDDO and all CSP providing service to more than five consumers were asked to complete the tool. In order for the rate study to yield the most complete and accurate information, we encouraged all providers meeting the above criteria to complete the tool with as much detailed information as possible.

Particular areas of interest were the tier levels, hours, and salary information including benefits, wages and overtime. Costs divided among service types or service settings could either be the actual direct cost, if identifiable, or distributed using an allocation formula.

The data collection tool was developed as an EXCEL workbook organized with separate tabs or worksheets for each schedule. These include "Provider Data", schedules to collect units of service, by service category, revenues and expenses, a macro to add additional columns to the report and a "DO NOT USE" tab containing the formulas used throughout the tool to simplify completion of the tool and the cost allocation process.

All data entry fields were highlighted in yellow and fields not intended for data entry were grayed out. Data entry fields that could either use an allocation formula or direct costing were clearly identified.

The data collection period was to be twelve consecutive months for the provider's fiscal year ending in 2005. New providers not having twelve months of operation were to complete the tool for the period from the beginning date of operation through the fiscal year ending in 2005.

Completed forms were to be sent electronically to Myers and Stauffer. Additional hard copy information was received by mail including the Provider Data signature page. The original completion date was to be on or before July 3, 2006, however several extensions were granted. Copies of the tool and instructions are included in Appendices B and C.

Pilot testing

The advisory committee suggested a test run of the re-designed data collection tool and selected four providers to complete the form. The pilot was to test the function of the data collection tool and usefulness of the written instructions prior to sending the forms to all eligible participants. The pilot providers were given a written set of instructions, a brief training session and a completion time of two weeks. They were able to complete the data collection tool within the allotted time line and suggested only minor changes, which Myers and Stauffer incorporated into the final design of the form.

Training

Myers and Stauffer offered four training sessions prior to start of the data collection process. Information and invitations to the training sessions were forwarded to each CDDO from SRS. The CDDO were responsible for informing their affiliates. The sessions were held in Hays, Topeka (two sessions) and Wichita. Training included a walk-through of the written instructions and specific examples on completing the form

based on the provider type including CDDO only, CDDO and CSP, CSP Only and In-home Support providers.

Data collection

On May 22, 2006 a diskette containing the data collection tool and instructions was sent to each eligible provider. The package was sent certified mail so the receipt of the tool and instructions could be tracked. The provider's were given a deadline of July 3, 2006 to complete the form and return to Myers and Stauffer. Through out the completion period the project staff were available to instruct and advise the providers regarding the completion and submission of the data collection tool.

A review of the data collection tool and supporting documentation was performed as the tools were received. The review included verifying the revenue and expense to the provider's audit or other documentation and checking that all schedules of the tool were completed. In addition we reviewed the amounts for reasonableness and in accordance with the instructions. The providers were contacted when data was missing or there appeared to be errors in the amounts reported.

Distribution listings were provided to Myers and Stauffer by the CDDO. We sent out a total of 151 data collection tools. Of those:

- Seven providers reported they had less than 5 consumers.
- Three providers were duplicated on Myers and Stauffer's list of eligible participants.

The result is a potential 141 providers that could have completed the data collection tool.

- Three providers reported they would not participate in the study.
- Three packets were returned as undeliverable.
- Seventy-nine providers submitted information, including the four pilot sites.
- Fifty-six providers did not submit the data collection tool.

Following the review and subsequent queries and requests to the providers there were still some submissions that did not comply with requirements. These included tools with incomplete schedules, missing data, or data that did not appear reasonable or correct based on our review. These submissions were excluded from further analysis. We also received some tools too late to be included in the analysis.

We determined that seventy of the data collection tools received contained adequate data for inclusion in the analysis. This includes the providers that participated in the pilot program. The following chart reflects the collection tools received by CDDO area.

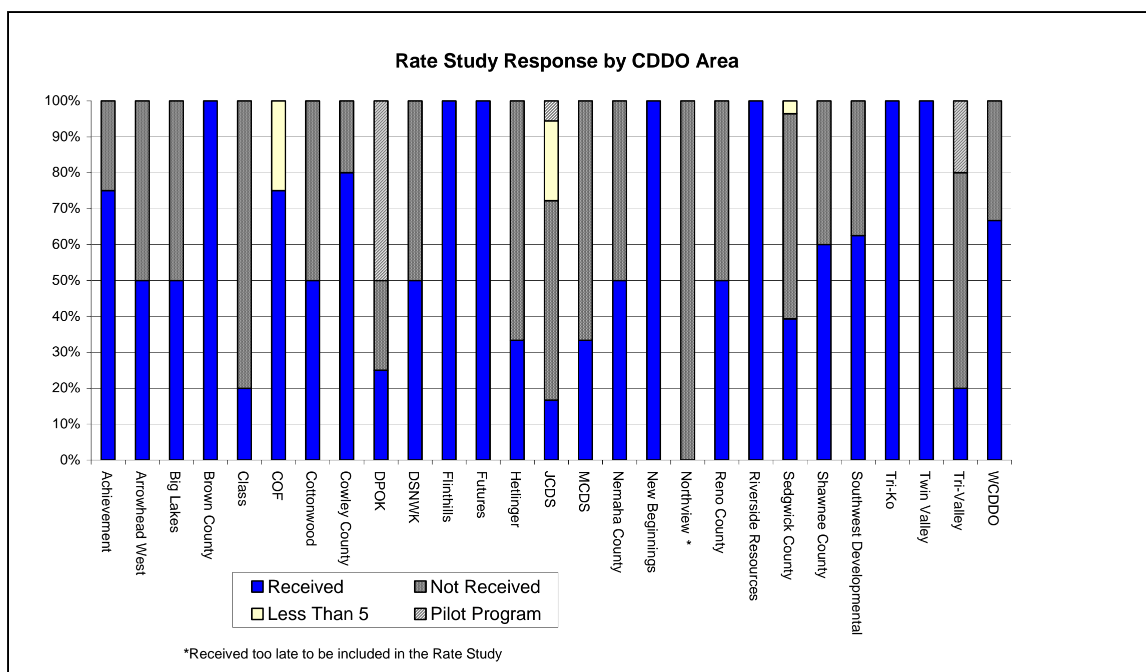


Chart 1: Rate Study Responses by CDDO Area

Template development

The submitted data collection tools were in individual EXCEL workbooks, which were merged into one file and organized so that statistical data could be easily retrieved and analyses could be completed. This process involved an extensive review of the data submitted to ensure the reliability and completeness of the data. Several issues were found that needed to be corrected before the data was usable. Some of the tools were incomplete or were completed incorrectly. Because the data is to be merged into one file, it is important that all workbooks submitted are completed correctly. Every effort was made to resolve the issues so that the data could be used in the current study.

Examples of problems encountered include:

- Workbooks had been altered or formulas were changed.
- The number of settings reported were not consistent among Schedules A, D, G, and J.
- The sum of the detail columns did not equal the total columns. If this occurred on schedules where allocation ratios were calculated, then expenses were allocated incorrectly to the individual settings.
- In one case, the schedule D reported total expenses, rather than residential only.
- Numbers were entered in gray shaded cells.
- Check figures were calculated in the area to the right of columns, which created a problem during the merge with schedules where additional settings could be added.
- Total expenses were reported, but no allocations were made.

To obtain tier level cost information not driven by the staffing hour ratios built into the existing rate structure, the tool collected costs and service days were reported by tier level and by setting. Costs distributions were determined either by direct costing or an allocation methodology selected by the provider to be the most appropriate method for allocating the particular costs. The most common allocation method used was Consumer Days, followed by Total Personnel Costs, Direct Service Hours and Accumulated Costs. Other methods that were defined by the providers include Direct Service and Targeted Case Management Hours, Number of Clients Served, Total Number of Staff and Percentage of Insurance Per Setting. The detail by setting was imported into Oracle database tables, which were used to distribute the costs and calculate a per diem cost by per tier level.

Additional data sources

BASIS Data

The Basic Assessment Services and Information System (BASIS) is a data collection system that includes demographic information, assessment information from the DDP, service and service system information and information of psychotropic drug use. We requested and obtained BASIS data from SRS that included the age of the consumer, the date of the DDP assessment, the three component scores, adaptive, maladaptive and health, the converted score and the tier level. We requested the data for two distinct periods, one current year's worth of data and one prior year's worth of data. The files received were for state fiscal year 2006 and for calendar year 2003.

Economic Data

SRS provided data salary and benefit data from the two state mental retardation hospitals, Parsons State Hospital (PSH) and Kansas Neurological Institute (KNI). Other sources of wage and occupational data include:

- Downloads from The US Department of Labor Bureau of Labor Statistics http://www.bls.gov/
- Guide for Evaluating Your Firm's Jobs and Pay October 2003
- Downloads from The Kansas Wage Survey http://laborstats.dol.ks.gov\
- 2012 Kansas Occupational Outlook, Kansas Department of Labor
- 2005 Kansas Job Vacancy Survey, Kansas Department of Labor, Labor Market Information Services

Literature Review

We reviewed various books, articles and websites during the development of this report. A listing is included in Appendix D.

5. Analyses and Findings

Usability of sample

The financial information collected and used in this evaluation is self reported by the providers. The contracts between the CDDO and SRS do not specifically mention completion and submission of the data collection tool used in the biennial rate study, but do require maintenance of cost records and the submission of any required reports. As of August 16, we did receive 100% of the CDDO submissions. Data for all CDDO, except the late submission, are included in the analysis. Completion and submission of the collection tool by the service providers would have to be addressed in each CDDO affiliate agreement.

The lack of specific language to mandate participation creates a voluntary process. Ideally, we would like 100% participation, however, given the following information, we believe we have a representative sample.

Percent of providers

All providers had an equal opportunity to submit data. All geographic areas of the state are included with the exception of Harvey and Marion counties, which represent 98% of the state's population served by a CDDO. As of August 16, we received 100% of the data collection tools from the CDDO. One hundred fifty collection tools were distributed but it was determined that we had a possible 141 submissions. We received 79 submissions or 56%.

Review procedures

The financial information was self-reported by the providers. We did not audit the data, but did review for reasonableness. We traced and reconciled the data reported to supporting documentation, contacted the providers when necessary to verify or correct data or to provide additional documentation. Of the 79 submissions, 70 providers submitted data that was both prior to the cut-off date for inclusion in the analyses and contained useable data per our review procedures.

Percent of waiver revenue

Total HCBS waiver revenue reported on the collection tools received and included in the analysis was $156,227,541. For comparison purposes, we requested revenue data from SRS. Given the variance in fiscal years being reported, we requested an 18-month review of revenues from July 1, 2004 through December 31, 2005. We calculated and then annualized the monthly average. This resulted in an estimated annual expenditure of $219,625,176. We also received the MARS average monthly expenditures for DD waiver services for the same period. Annualizing that number results in an estimated annual expenditure of $218,353,176. Using these two estimates of total waiver revenue, we calculate the data collection tools submitted represent between 71-72% of the total waiver revenue. We believe it is fair to estimate that we have collected a similar portion of the

provider expenditures. However, without 100% submission we have no available check figure to verify this assumption.

We also compared the revenue distribution among residential, day and in home supports from the report from SRS and the information submitted on the data collection tools. Considering the timing differences, they were very close. The report from SRS for July 04 till December 05 showed 58.5% residential, 27% day and 14.5% in home supports. The data from the collection tools, completed based on the providers fiscal year ends, has 56.3% residential, 28.6% day and 15% in home supports.

General statistics

Expenditures and individuals served

Annual expenditure data from the SRS[3] shows per person expenditures of $30,223 for fiscal year 2003, $31,391 for fiscal year 2004 and $31,114 per person for fiscal year 2005. The average per person expenditure shown for Kansas in the State of the States in Developmental Disabilities, 2005 was $33,000 (6300 participants). This report shows an average waiver spending per participant in 2004 in the United States of approximately $37,800, ranging from a low of $11,900 (429 participants) in the District of Columbia to a high of $82,400 in Delaware (625 participants). It is important to note that there is much variability among states in the services offered.

Also for the SRS expenditure report, it shows 238.3 individuals per 100,000 population served in fiscal year 2003, 241.7 for 2004 and 258.5 for 2005. The State of the State report shows there were approximately 148 individuals per 100,000 population in the United States served through a HCBS DD waivers in 2004.

The following charts detail average expenditures and individuals served by CDDO area.

[3] http://www.srskansas.org/admin/mapprogram.html

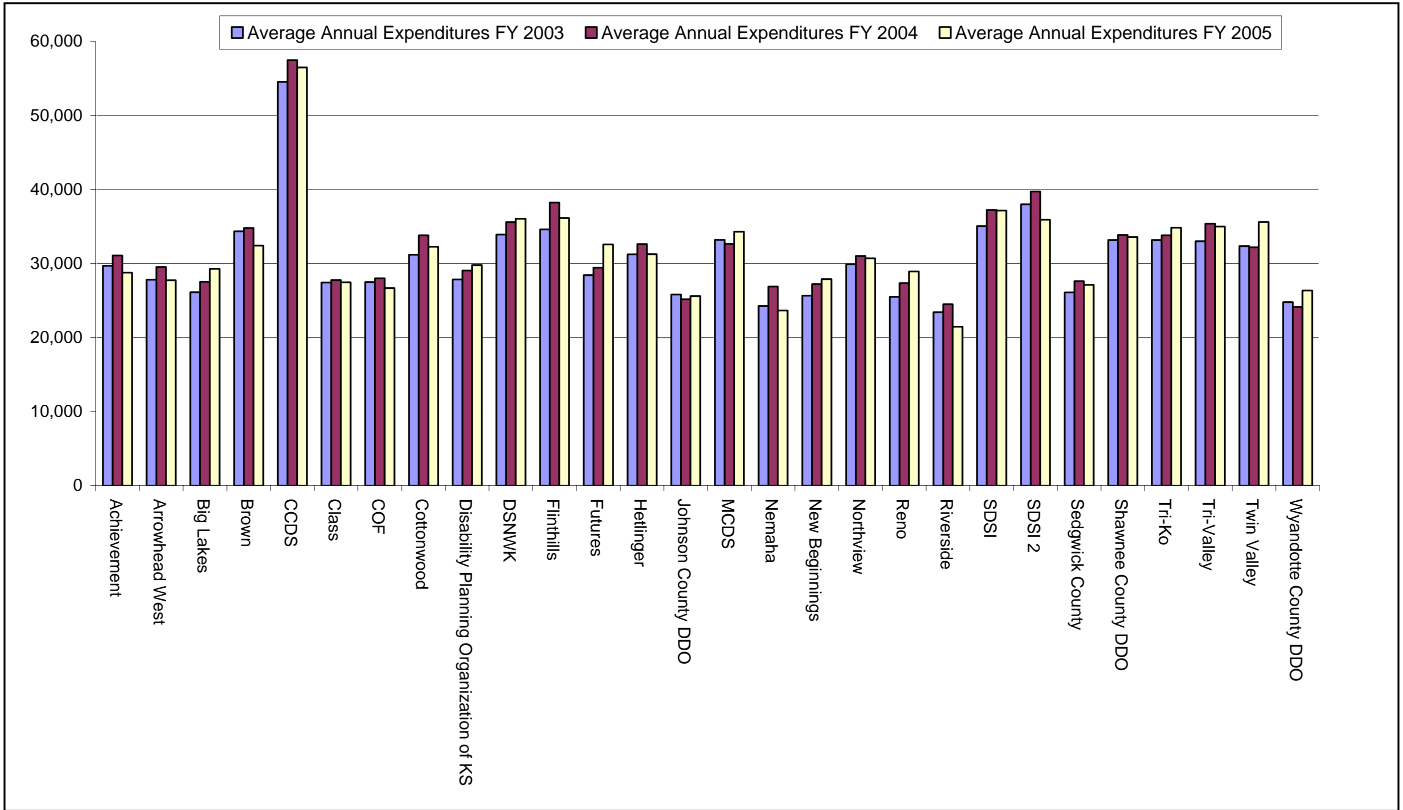


Chart 2: Average Annual Expenditures FY 2003, 2004 and 2005

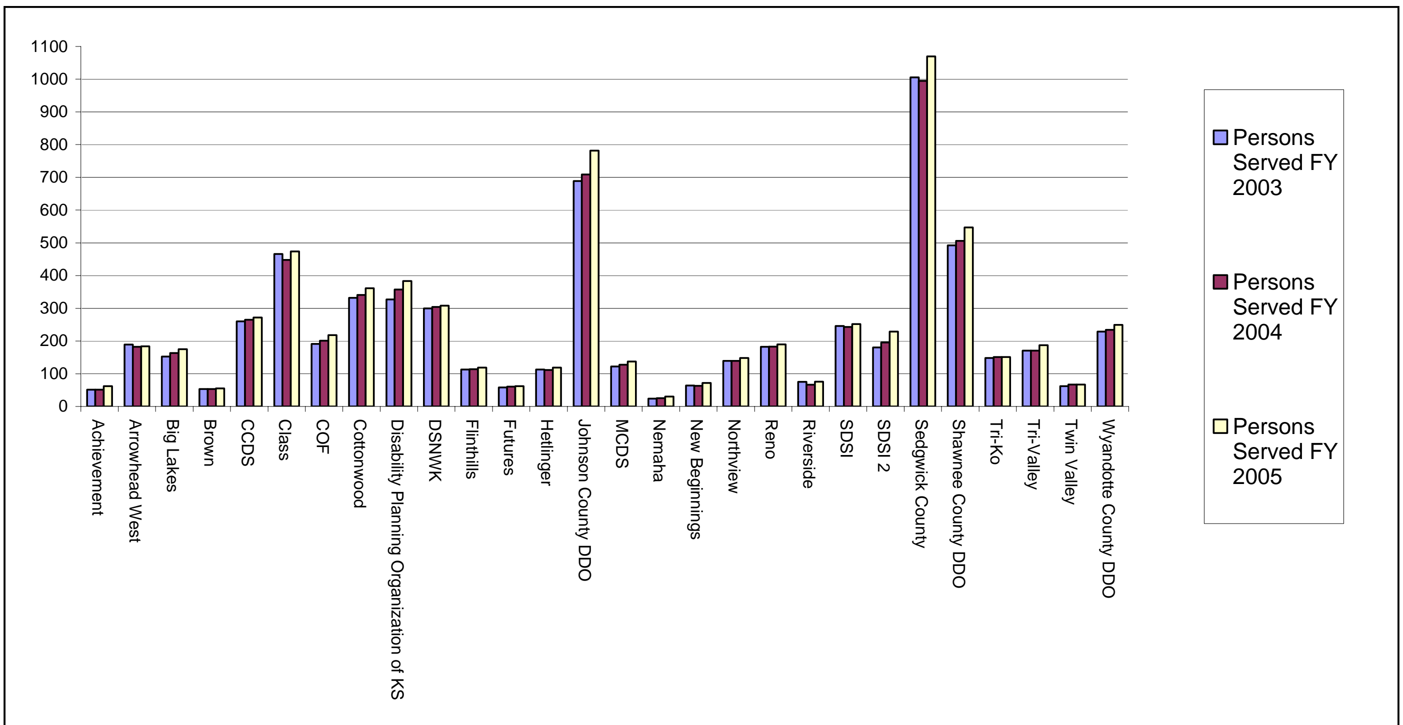


Chart 3: Persons Served FY 2003, 2004 and 2005

Collection tool responses

As recommended by the Advisory committee, the report period was designated as the entities fiscal year ending in 2005. The following lists the various report year-ends as well as provider type and type of control of those providers submitting a collection tool.

	Provider Type					
Counts of responses by provider type	CDDO Only	CSP Only	CDDO & CSP	In-Home Supports		
	5	34	21	10		
	Report Period Ends					
Counts of responses by report period	30-Jun	31-Jul	31-Aug	30-Sep	31-Dec	
	28	1	1	3	37	
	Ownership Type					
	Proprietary For Profit					
	Sole Proprietor	Partnership	Corp-Profit		Other	
	1	1	11		1	
	Volunary Not For Profit		Government			
Counts of responses by ownership type	Corporation	Other	State	County	City	Other
	52	1	0	3	0	0

Table 2: Provider Data Responses On the Data Collection Tool

Days by service and tier level

Statistical data was collected from the providers including days by tier level for Residential and Day services. There were 47 providers that reported Residential services and 52 providers that provided Day services. The following charts illustrate the percentage of days by tier level for both Residential and Day services.

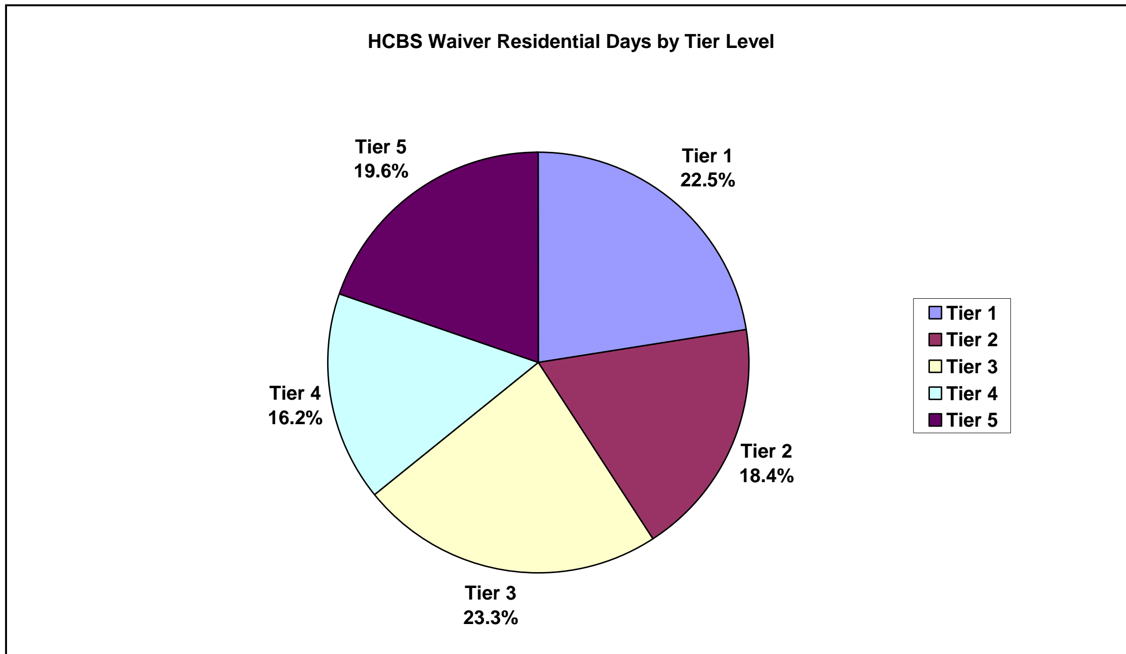


Chart 4: HCBS Waiver Residential Days by Tier Level

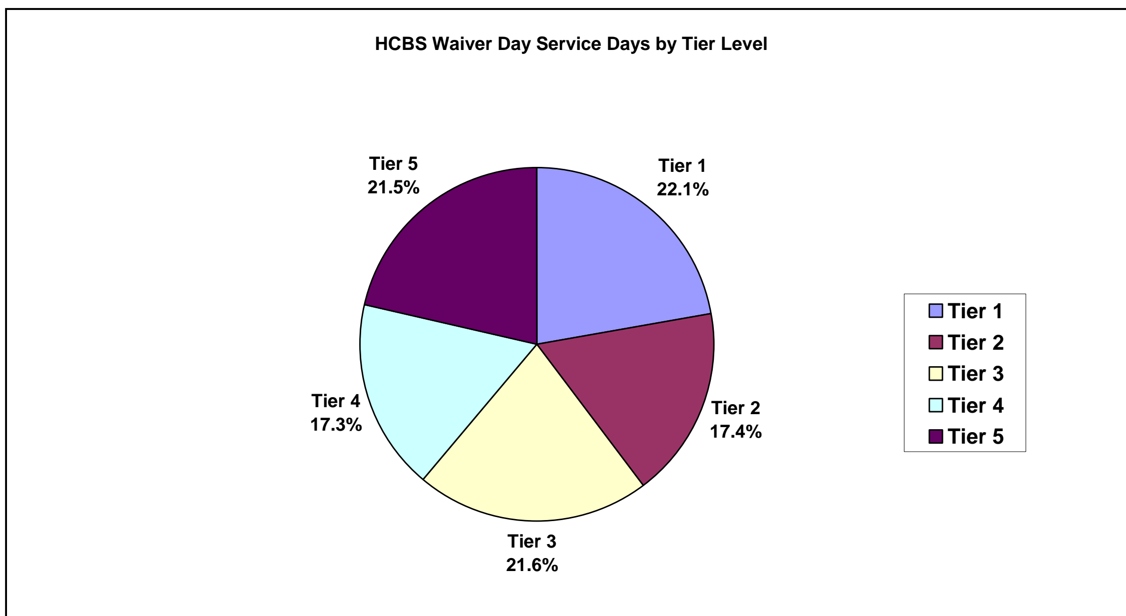


Chart 5: HCBS Waiver Day Service Days by Tier Level

The individualized rate days for residential services comprise 1% of the total days for all tiers. The super tier rate days are 4.7% of the total, with the majority of those within Tier 1 or Tier 2. In day services, the individualized rate days are slightly less than 1% and the super tier rate days are 3.9%, also with the majority in Tier 1 and Tier 2. See Appendix E.

Non-waiver days were also collected by tier level for both Residential and Day services. As expected the majority of the days are in Tier 0 and Tier 5.

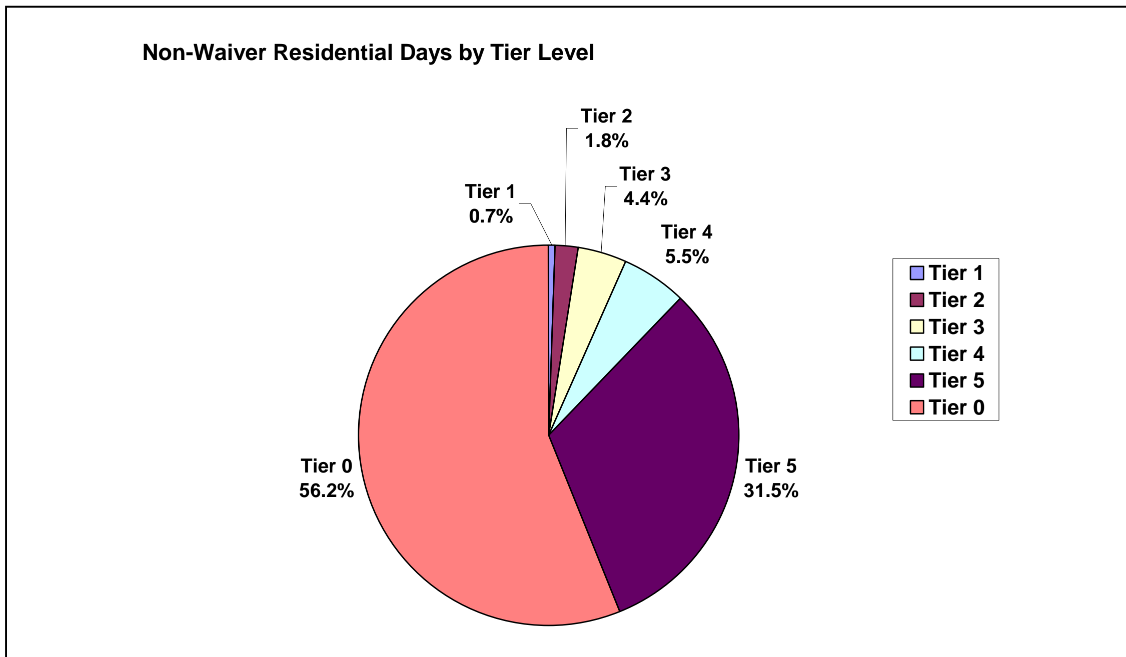


Chart 6: Non-Waiver Residential Days by Tier Level

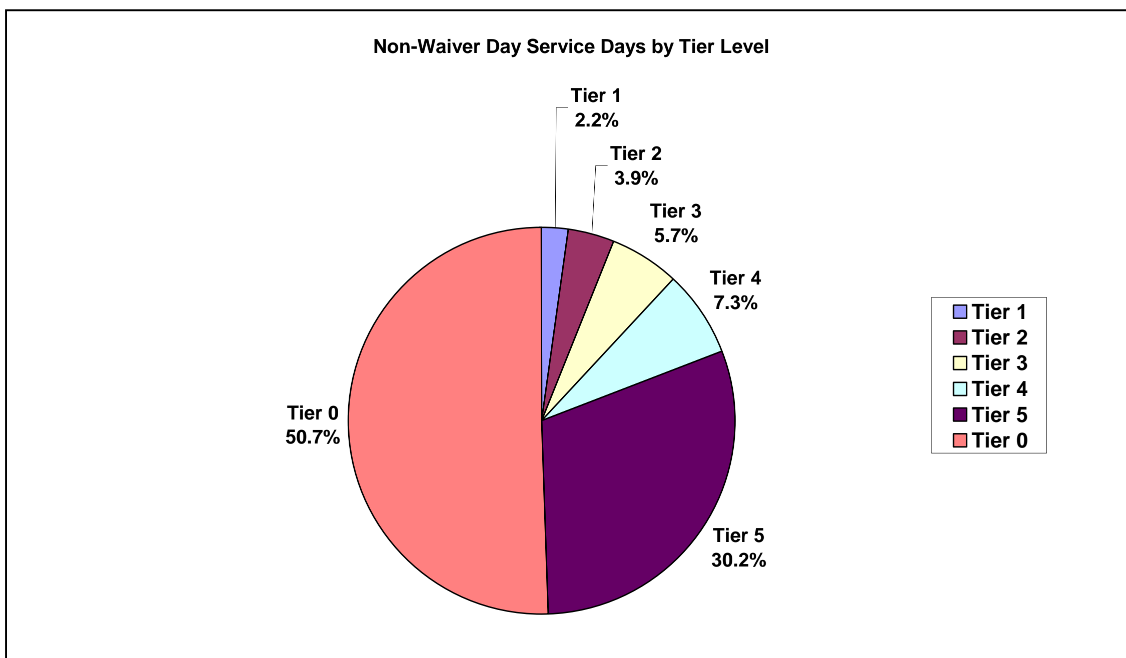


Chart 7: Non-Waiver Day Service Days by Tier Level

In-home Support providers reported days based on the billing methodology, either bundled or unbundled services. The bundled services are billed at a rate per day and include all of the services provided. The unbundled services are billed by service type including supportive home care, respite care and night support. There were 38 providers that reported providing In-home support services. The following tables show the number of total days/hours that were collected by the providers who submitted rate study information.

In-Home Supports - HCBS Waiver Services Only	Adult Days	Children Days
Tier 1 Consumer Days	4,422	6,599
Tier 2 Consumer Days	2,514	1,369
Tier 3 Consumer Days	4,569	1,285
Tier 4 Consumer Days	3,504	2,081
Tier 5 Consumer Days	4,425	533
Total Consumer Days	19,434	11,867

Supportive Home Care - HCBS Waiver Services Only	Hours	
Tier 1 Consumer Hours	522,175	
Tier 2 Consumer Hours	129,292	
Tier 3 Consumer Hours	119,750	
Tier 4 Consumer Hours	86,116	
Tier 5 Consumer Hours	83,176	
Total Consumer Hours	1,276,189	*

**Total does not foot because some providers only reported total and not tier level.*

Respite Care - HCBS Waiver Services Only	Temporary/ Emergency Respite Hours	Overnight Respite Days	
Tier 1 Consumer Hours/Days	15,558	88	
Tier 2 Consumer Hours/Days	3,853	50	
Tier 3 Consumer Hours/Days	2,557	12	
Tier 4 Consumer Hours/Days	2,287	-	
Tier 5 Consumer Hours/Days	1,569	109	
Total Consumer Hours/Days	35,393	259	*

**Total does not foot because some providers only reported total and not tier level.*

Night Support - HCBS Waiver Services Only	Days	
Tier 1 Consumer Days	7,856	
Tier 2 Consumer Days	1,374	
Tier 3 Consumer Days	1,148	
Tier 4 Consumer Days	4	
Tier 5 Consumer Days	1,240	
Total Consumer Days	11,622	*

**Total does not foot because some providers only reported total and not tier level.*

Table 3: In-Home Support Days and Hours

Revenues

Revenue information was collected by revenue category including DD Waiver funds, State General Funds and all other revenue sources, including targeted case management, CDDO administration, county mill levy, and production. The following two charts show the distribution of waiver and state general fund revenues and the distribution of total reported revenues.

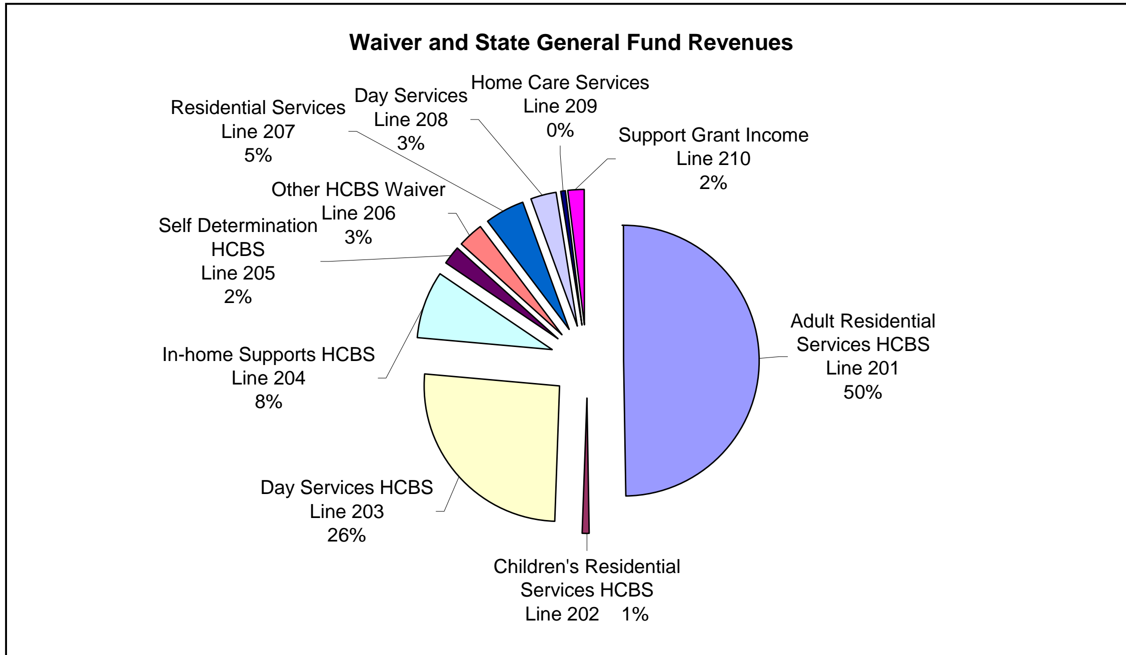


Chart 8: Waiver and State General Fund Revenues from Data Collection Tool

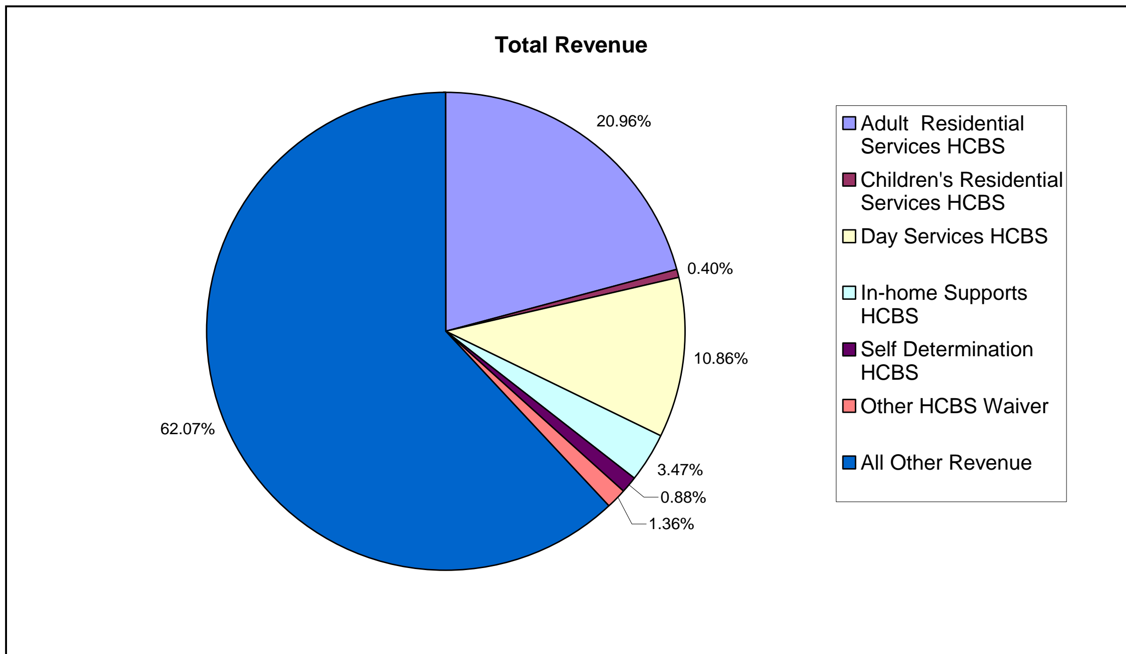


Chart 9: All Revenue

Rate analysis[4]

Residential

These services are provided in the residence of persons who are not living in the family home and are designed to assist individuals to live successfully in a community setting they have chosen and can afford. They help persons with their daily living needs, which will vary depending on the individual receiving services and their age.

The following reflects the residential services rate history from the development of this payment methodology to the current fiscal year.

	Nov-92	Jul-93	Oct-95	Jul-98	Jul-99	Jul-00*		Jul-05		Jul-06	
						Regular	Super	Regular	Super	Regular	Super
Tier 1	$ 95.24	$ 113.04	$ 127.03	$ 132.12	$ 135.03	$ 135.03	$ 162.60	$ 138.69	$ 166.26	$ 144.70	$ 173.46
Tier 2	$ 76.64	$ 94.44	$ 105.33	$ 109.43	$ 111.77	$ 111.77	$ 146.51	$ 113.61	$ 148.35	$ 118.53	$ 154.77
Tier 3	$ 50.81	$ 68.61	$ 75.94	$ 78.91	$ 80.61	$ 80.61	$ 130.56	$ 82.12	$ 132.07	$ 85.68	$ 137.79
Tier 4	$ 37.93	$ 44.73	$ 48.82	$ 50.76	$ 51.87	$ 51.87	$ 114.63	$ 53.03	$ 115.79	$ 55.33	$ 120.80
Tier 5	$ 37.93	$ 33.74	$ 35.58	$ 36.95	$ 37.74	$ 37.74	$ 98.59	$ 38.32	$ 99.17	$ 39.98	$ 103.46

*Rate increases but a reduction in the vacancy factor from 10% to 7%

Table 4: Residential Services Rate History

Direct Service Hours Per Day

The rate structure is based on an anticipated number of hours of direct service per day. Our initial analysis compared the direct service staff hours for residential services, as reported on the data collection tool, to hours we calculated, using base projected hours from the rate formula. Data available for the analysis included:

- Reported direct service hours by service
- Reported days by service and tier level
- Base projected hours per service and tier level from the rate formula

Since direct service hours were not broken out by tier level, the comparison was based on an overall average hour per resident day. To develop the comparison number, we took the reported days for each tier level times the hours in the rate structure. We then summed the result to calculate the total direct service hours from the rate formula. That total was then divided by the number of total reported days to arrive at a comparable residential direct service hours per diem.

The resulting average hours of direct service per day, calculated using the rate structure, was 3.44 per day and the average hours of direct service per day as reported by the providers was 4.79.

This would indicate, the provision of 1.35 hours of service per day above that derived using the base direct service hours in the rate formula.

[4] All data analyses for the section are included in Appendix F

Residential	
Total Calculated Hours	3,968,971
Total Direct Service Hours	5,539,856
Total Residential Days	1,152,987
Calculated Hours Per Day	3.44
Reported Hours Per Day	4.79

Table 5: Residential Service Hours Per Day

Compare total payments to total cost
To get a broad understanding of how much of the provider's cost for services are covered by payments, we made a comparison of total payments to total costs. For this comparison, we included revenues from "Adult Residential Services HCBS" Line 201 on the data collection tool and "Residential Services" Line 207.

As reported on the data collection tools, total includable residential costs were $96,383,782 and residential revenue was $91,210,870 or a cost coverage percentage of 94.63%

Cost coverage per provider
To evaluate the adequacy of rates, however, it is important to understand cost coverage at the individual provider level. To evaluate this, we used the same revenue and cost definitions used in the total payment to total cost comparison. We then calculated a cost coverage percentage for each provider.

Our findings show cost coverage, at the provider level, ranging from a low of 38.73% to a high of 161.27% with over 50% of providers with 100% cost coverage or better.

The data on the collection tool is self-reported and un-audited and the wide range of cost coverage suggests a need for further review and testing. This is a complex program with many potential funding sources including waiver funds, state general funds and county funds. The cost of services, though are not tracked by funding source. Incorrect identification or allocation of revenues and costs could be potential reasons for the rage of cost coverage.

For example, when we evaluate reported revenue for the provider with the lowest cost coverage, we calculate an average per day revenue per consumer for all tier levels of $74. To evaluate for reasonableness of that number, we calculated an estimated per day revenue using the July 2000 rates. (A higher rate would have been paid for a portion of the days so our estimate is slightly understated.) Taking the rates times reported days, we calculated estimated average revenue of $71. The reported and calculated numbers are comparable. However, the reported average per day expense for all tier levels, Tier 0 – Tier 5, is $191, which includes an indirect administration cost of $44.50 per day and a calculated average per hour direct service cost of $14.20. However, the data reported for

this provider on Schedule L shows report period average per hour costs of $11.92 for direct service staff. These types of issues would need to be reviewed before making any conclusion on the data.

Quartile analysis of cost coverage
To analyze the various levels of cost coverage, we developed two arrays, one sorted by cost and one sorted by the percent of cost coverage. We then divided the arrays into for groups or quartiles to evaluate the differences between high cost and low cost providers and providers with a high percentage of cost coverage and those with low percentages of cost coverage.

We were looking for potential relationships that might explain the high and low cost coverage providers. Does the distribution of consumers among the tiers affect cost coverage? For example if the rates for Tiers 3-5 provided better cost coverage (as has been a finding in previous rate studies), you would expect providers with a higher percentage of cost covered to have more days in Tier 3-5.

To test this assumption, we identified the number of days per tier level (regular, individual and super). The total per tier was then divided by the total reported days (all providers) to arrive at the percentage of days represented in each tier level for that quartile.

This analysis indicates just the opposite of what we described in the paragraph above. Providers with the lowest cost coverage (1st quartile) serve more consumers in tier levels 4 and 5 and have more total consumers than the providers with the best cost coverage (4th quartile). While the 2nd and 3rd quartile providers represent 54% of the total residential days with their consumers making up more of consumers served in tiers 1, 2 and 3.

Per diem costs per tier level
The study is to result in a recommendation on potential rate adjustments. Accomplishing this requires a cost coverage analysis at the tier level. As costs are not maintained at the tier level, they must be distributed in some manner. Prior studies have used the ratio of hours in the rate formula to distribute costs. Any reliance on this type of distribution requires an assumption that the ratio of hours contained in the rate structure is accurate.

To evaluate that assumption, we distributed the costs using the detailed cost and day information collected for each individual service setting. We took consumer days per tier level times the direct service staff hours in the rate structure, resulting in weighted consumer days. The weighted consumer days by tier level were divided by total weighted consumer days to get percentage. Each percentage was then multiplied by total includable costs to get total includable cost per tier. The results were then divided by total un-weighted days per tier to arrive at the per diem cost per tier level.

We compared the calculated cost per day by the rate per day (July 2004). Using this method of cost distribution it would appear that the rates for Tiers Level 1 and 2 are not

covering costs and Tiers 3- 5 are over the cost from $.32 to $2.47 per day. Because these findings are not consistent with the findings from our previous quartile analysis, we have also distributed the cost using the cost and day information by setting reported on the data collection tools.

The analysis of costs distributed by the detailed cost and day information by setting is quite complex, but should produce the best available distribution of costs between the tier levels. Providers reported costs and tier level days by setting. From that data we distributed each settings costs by the percentage of days in each tier level within that setting. Those results were aggregated by tier level for all providers and all settings and divided by total days in each tier level.

The results, detailed in the chart below, demonstrate very different tier level costs than we calculated using the rate formula. There is much less differential in the costs between Tier 1 and Tier 5 and the results appear to be supported by the quartile cost coverage analysis. As with all allocation methodologies, they are only as good as the assumptions and the underlying data. Further evaluation is recommended to fully understand and respond to this finding.

Tier Level	Expenses	Days	Per Diem
Tier 0	4,150,319	79,053	52.50
Tier 1			
Regular	18,329,749	175,278	104.58
Individual	351,016	2,819	124.52
Super	3,278,418	27,706	118.33
Tier 2			
Regular	12,451,790	133,566	93.23
Individual	289,675	2,398	120.80
Super	1,149,941	9,511	120.91
Tier 3			
Regular	16,107,584	194,093	82.99
Individual	176,022	1,774	99.22
Super	520,785	4,088	127.39
Tier 4			
Regular	10,506,971	137,673	76.32
Individual	184,269	1,448	127.26
Super	167,888	1,219	137.73
Tier 5			
Regular	12,350,231	198,070	62.35
Individual	49,434	796	62.10
Super	80,304	729	110.16

Table 6: Per Diem Costs Per Tier Level Using Reported Setting Detail

Day Services

Day services are provided away from the person's home, typically during working hours to increase the person's independence, integration, inclusion and personal accomplishment. These daytime services are structured activities, which may include workplace training, socialization, recreation, and community inclusion.

The following reflects the day services rate history from the development of this payment methodology to the current fiscal year.

	Nov-92	Jul-93	Oct-95	Jul-98	Jul-99	Jul-00*		Jul-05		Jul-06	
						Regular	Super	Regular	Super	Regular	Super
Tier 1	$ 65.50	$ 74.36	$ 77.40	$ 80.95	$ 82.54	$ 82.54	$ 101.01	$ 86.17	$ 104.64	$ 89.90	$ 109.17
Tier 2	$ 46.92	$ 55.75	$ 57.94	$ 60.52	$ 61.66	$ 61.66	$ 94.13	$ 63.72	$ 96.19	$ 66.48	$ 100.36
Tier 3	$ 36.43	$ 45.26	$ 46.98	$ 49.01	$ 49.90	$ 49.90	$ 87.27	$ 51.24	$ 88.61	$ 53.46	$ 92.45
Tier 4	$ 29.93	$ 34.02	$ 35.24	$ 36.68	$ 37.30	$ 37.30	$ 80.36	$ 37.71	$ 80.77	$ 39.34	$ 84.27
Tier 5	$ 29.93	$ 29.31	$ 30.30	$ 31.50	$ 32.00	$ 32.00	$ 73.50	$ 32.35	$ 73.85	$ 33.75	$ 77.05

*Rate increases but a reduction in the vacancy factor from 10% to 7%

Table 7: Day Services Rate History

Direct Service Hours Per Day

The same methodology used to compare the direct service staff hours per day for residential services was used for the day services Resulting in average hours of direct service per day calculated using the rate structure of 1.91 per day and the average hours of direct service per day as reported by the providers of 2.57.

This would indicate the providers are providing .66 hours of service per day above that derived using the base projected direct service hours in the rate formula.

Days Services	
Total Calculated Hours	1,813,831
Total Direct Service Hours	2,444,779
Total Day Service Days	948,597.6
Calculated Hours Per Day	1.91
Reported Hours Per Day	2.57

Table 8: Day Service Hours Per Day

Compare total payments to total cost

Cost coverage comparisons of total payments to total costs were also done for day services. For this comparison, we included revenues for Day Services HCBS Line 203 on the data collection tool and Day Services (SGF) Line 208. We identified total includible costs for all providers and total payments to arrive at a percentage cost coverage. As reported, total day service costs were $56,071,438 and day service revenue was $49,083,189 or a cost coverage percentage of 87.54%

Cost coverage per provider
In aggregate, the cost coverage may not appear to be adequate however, it is important to understand cost coverage at the individual provider level. We used the same revenue and cost definitions and determined a cost coverage percentage for each provider. Cost coverage at the provider level ranges from a low of 54.54% to a high of 213.87% with close to 50% of providers at 100% cost coverage or better.

As with residential services, the day service data is self-reported and un-audited and the wide range of cost coverage suggests a need for further review and testing. The possibility of identification and allocation issues also exists here. For example the provider with the highest cost coverage in residential services is one of the providers with the lowest cost coverage in day services, which may suggest an allocation issue.

Quartile analysis of cost coverage
We preformed the same analysis for day services as with residential to see if there was a relationship between the high and low cost coverage providers and the tier levels in which they provide services.

We took the providers in each quartile and identified the number of days in each tier level (regular, individual and super). Those days were then totaled and divided by the total number of reported days (all providers) to arrive at the percentage days represented by each tier level for that quartile.

The findings were similar with those for residential services, the analysis indicates that the low cost coverage (1st quartile) providers serve more consumers in the tier levels 4 and 5 and have more days than the providers at the high end of the cost coverage (4th quartile). The 2nd and 3rd quartile providers make up 48% of the total days.

Per diem costs per tier level
Recommendations on potential rate adjustments are also required for day services. Cost distribution methods, identical to those used in the residential services analyses were performed.

The method of distributing costs using the rate formula would suggest that rates for Tiers Level 1 - 4 are not covering costs and tier 5 is over by $.34 per day. Again, this methodology assumes the ratio of hours contained in the rate structure is accurate and is not consistent with our findings in the quartile analysis.

We again employed the method of cost distribution that uses reported cost and day information by setting to determine a per diem cost per tier level. Using this methodology, we see no clear link in the cost of service per day to the assignment of the regular tier levels, tier 5 costs were equivalent to costs in tier 1. As allocated, the super tier costs were also comparable to the regular tier costs.

Day Services - All Categories

Tier Level	Expenses	Days	Per Diem
Tier 0	3,323,076	56,846	58.46
Tier 1			
Regular	5,201,786	92,804	56.05
Individual	615,965	2,273	270.99
Super	283,489	4,657	60.87
Tier 2			
Regular	4,707,181	84,428	55.75
Individual	416,200	1,810	229.94
Super	125,614	1,730	72.61
Tier 3			
Regular	5,633,978	102,890	54.76
Individual	230,184	1,075	214.13
Super	93,929	1,678	55.98
Tier 4			
Regular	4,768,777	88,509	53.88
Individual	80,798	261	309.57
Super	2,793	73	38.26
Tier 5			
Regular	7,764,435	135,371	57.36
Individual	-	-	-
Super	-	-	-

Table 9: Per Diem Costs Per Tier Level Using Reported Setting Detail

We also looked at each setting individually and with the exception of supported employment, obtained very similar results. The supported employment did show some variability of costs between tier levels 1-4, however tier 5 had the highest per day cost of the regular tiers.

In-Home Support

These services are designed to defray the cost and stress of supporting a family member with a developmental disability who is living in the family home and may include direct subsidy, respite care, in-home supports and assistance in purchasing durable equipment and supplies. The service could include assistance with health care needs such as taking medications, therapy service continuation, health observation and evaluation, household maintenance and self care activities.

The following reflects the in home support rate history from the development of this payment methodology to the current fiscal year.

		Jul-00	Jul-05	Jul-06
In-Home Supports	Tier 1	$72.16	$77.51	$80.97
	Tier 2	$66.65	$71.60	$74.40
	Tier 3	$59.18	$63.58	$66.33
	Tier 4	$54.53	$58.58	$61.12
	Tier 5	$49.13	$52.77	$55.05
		Supportive Home Care	$10.40	$11.17
		Temp Respite	$9.10	$9.77
		Emergency Respite	$9.10	$9.77
		Overnight Respite	$49.50	$53.17
		Night Support	$26.00	$27.93

Table 10: In-Home Support Rate History

The differences in billing methodology and the subsequent reporting differences limited the rate analyses for in-home supports to an evaluation of the cost coverage in total and per provider.

Compare total payments to total cost

Cost coverage comparisons of total payments to total costs were also completed for In-home support services. For this comparison, we included revenues for In-home Supports HCBS Line 204 on the data collection tool and Supportive Home Care Services (SGF) Line 209. We understand the Family Support Grant Income reported on line 210 could either be used for stipends paid directly to families or for services. We excluded these revenues from our cost comparisons although we have included the comparison in the appendix. We then identified total includible costs for all providers and arrived at a percentage of cost coverage. As reported, total in-home support costs were $14,917,168 and in home support revenue was $13,326,058 or a cost coverage percentage of 87.46%

Cost coverage per provider

We performed the same analysis for In-home supports using the revenue and cost definitions form the total cost coverage analysis. We then determined a cost coverage percentage for each provider. Cost coverage at the provider level ranges from a low of 14.61% (for providers reporting revenue) to a high of 120.34% with close to 50% of providers at 100% cost coverage or better. This review is complicated by grant revenue that may or may not be used to purchase services.

Quartile analysis of cost coverage

Unlike residential and day services we could not analyze the providers by the number of days in each tier level. This is due to the fact that a majority of the in-home support providers do not track days at the tier level.

Per diem costs per tier level

Unlike residential and day services we could not distribute costs using reported costs and tier information, as the majority of the in-home support providers do not track days at the tier level. We did an analysis using the rate structure for distribution of costs, however

given the results of the residential and day services we could not base a rate recommendation on those findings.

Staffing analysis

Employee health and worker's compensation insurance

Staffing costs comprise approximately 58% of the costs. To better understand the environment, Schedule L of the data collection tool contained several questions on staffing, including information on health insurance and workers compensation, staff training, turnover and vacancies. The information from the submitted collection tools has been aggregated and is detailed below.

Employee Health Insurance and Worker's Compensation Insurance	Yes	No	Average Increase
Did your employee health insurance costs increase?	30	27	27.9%
Did your employee benefit structure change?*	16	41	
Did your worker's compensation insurance increase?	29	37	22.5%
Are you currently in a high-risk pool?	28	32	
Have any other significant expenses impacted your organization?*	21	34	
**If yes, please explain*			

Table 11: Health and Worker's Compensation Insurance Questions – Schedule L

In addition to the yes and no responses, the tool collected further explanation on the changes in the benefit structure. Of the 16 providers that responded yes to a change in benefit structure, only one provider reported enriching the benefit by increasing the benefit percentage and assuming the premium cost for a single policy. One provider reported changing insurance carrier and one became partially self-insured. The responses did not mention the impact these changes had on the underlying benefit structure.

The remainder of the responses reduced benefits, increased the cost to the employee or added an option for reduced benefits to keep from increasing the cost to the employee. The tally of those responses is as follows:

- 2 - increased the deductible
- 5 – increased the employee share of the premium
- 2 – increased the co-pay
- 3 – added an optional plan with higher co-pay and deductibles

The rate structure includes a per diem amount for benefits, calculated at 25% of gross pay. The average per diem cost using reported days and direct care staff costs for residential and day services combined is $31.35 with employee benefits and taxes at $7.93 or 25.3%. The average per diem cost of personnel supervision staff using is $4.33 with employee benefits and taxes at $.96 or 22.2% of gross pay. The average per diem

cost of health services staff of $1.31 with employee benefits and taxes of $.28 or 21.4% of gross pay. Data for this is found in Appendix F.

Further explanation of other significant expenses impacting the provider were also requested in Schedule L. Expenses identified include auto insurance, fuel and transportation costs, utility costs, and the unemployment contribution rates. A couple of providers, included in the high-risk pool, mentioned that the high-risk rating was driven by the type of service provided rather than by experience rating.

Staff training

Staff recruitment, staff development and training were also items of additional interest. Schedule L requested the number of hours of training received by staff during their first year of employment and then annually thereafter. The provider was asked to use the number of hours typical for each level of staff and include in-house curriculum as well as external training activities. The following details the information submitted.

Staff Training	Average Hours of Staff Training	
	First Year	Annual
Direct Care Staff	61.4	23.1
Professional Staff	54.3	24.6
Supervisory Staff	55.3	25.2

Table 12: Staff Training – Schedule L

The data collection tool included several lines to identify staff recruitment and training costs. These include lines 307, 507, 707, - Staff Recruitment, 312, 512, 712, - Staff Development and 335, 535, 735, - Professional Services and Direct Service Staff Training. The combined per diem for both residential and day services for these areas is $.11 per day for staff recruitment, $.11 per day for staff development and $.32 for staff training. Using the data provided on Schedule L, we also calculated an estimated per diem cost of training (Appendix G) that would be included in reported salaries, which resulted in a per diem cost of $1.11 or a total staff recruitment, development and training of $1.65 per day. The rate formula includes $2.30 per day for training.

Staff turnover and vacancies

Staff turnover and vacancy statistics are also of interest. The 2005 Kansas Job Vacancy Survey lists civilian labor force estimates from data collected during the months of April, May and June of 2005. Both personal and home care aides and home health aides were included in the top 25 occupations with the most job vacancies.

Job Title	Number of Vacancies	Job Vacancy Rate	Average Wage Offer	Requires Education Beyond High School	Requires License or Certificate	Always Open	Open More Than 60 days
Personal & Home Care Aides	336	3.7%	$8.03	12%	0%	72%	0%
Home Health Aides	334	6.6%	$8.12	13%	8%	24%	2%

Table 13: Selected Job Vacancy Data

According to this report, the average wage offer for all vacancies is $10.93 with 9% at less than $6.00 and 6% at $20.00 and over. Thirty-six percent of job openings were reported as being positions that are always open, where these employees are continuously being recruited. The average wage offered for positions always open is $9.37.

The data collection tool included questions on the employee headcount, employees not positions, on the first and last days of the reporting period. It also collected information on the number of hires and terminations during the period. Using this information, we calculated a turnover percentage.

Staff Turnover	Headcount 1st Day of Report Period	Employees Hired During Report Period	Employees Terminated During Report Period	Headcount Last Day of Report Period	Turnover Percentage
Direct Care Staff	4832	2763	2617	4997	51.02%
Professional Staff	924	153	144	932	17.41%
Supervisory Staff	343	64	78	329	35.94%

Table 14: Staff Turnover – Schedule L

Staff Vacancies	1st Day of Report Period	Last Day of Report Period
Direct Care Staff	1187.5	810.8
Professional Staff	92	58
Supervisory Staff	58	99

Table 15: Staff Vacancies – Schedule L

The instructions defined a vacancy as a position that was budgeted but not filled even if the duties were being covered. Data from the Kansas Job Vacancy Survey defined vacancies as openings being recruited.

Combining the headcount on the last day of the report with the staff vacancies on the last day to determine the number of available positions, we can calculate a vacancy percentage for each staff category. Direct care staff showed 811 vacancies out of a possible 5808 positions or 14%, the professional staff showed 58 vacancies out of a possible 990 or 5.9% and the supervisory staff showed 99 vacancies out of a possible 428 or 23%. The information on Schedule L was not traced to any supporting documentation. Further evaluation and verification would be required for reliance on the statistic.

The most common reasons cited by direct support staff for leaving, according to American Association on Mental Retardations study, "Staff recruitment and retention: Study results and intervention strategies", are problems with co-workers (17%), inadequate pay, benefits or incentives (16%), problems with supervisors (13%) and scheduling problems (13%).

Wage and benefit analysis

Staff wages

A requirement of the rate study is a review of salary information. Providers were asked to provide starting salary, average salary and a salary range for direct care staff, professional staff, and supervisory staff for both the report and current periods. The responses provided included per hour, per month and annual amounts. To aggregate the information, monthly amounts were converted to hourly using 173.33 hours and annual amounts were converted using 2080 hours. The following table details the results for the report period.

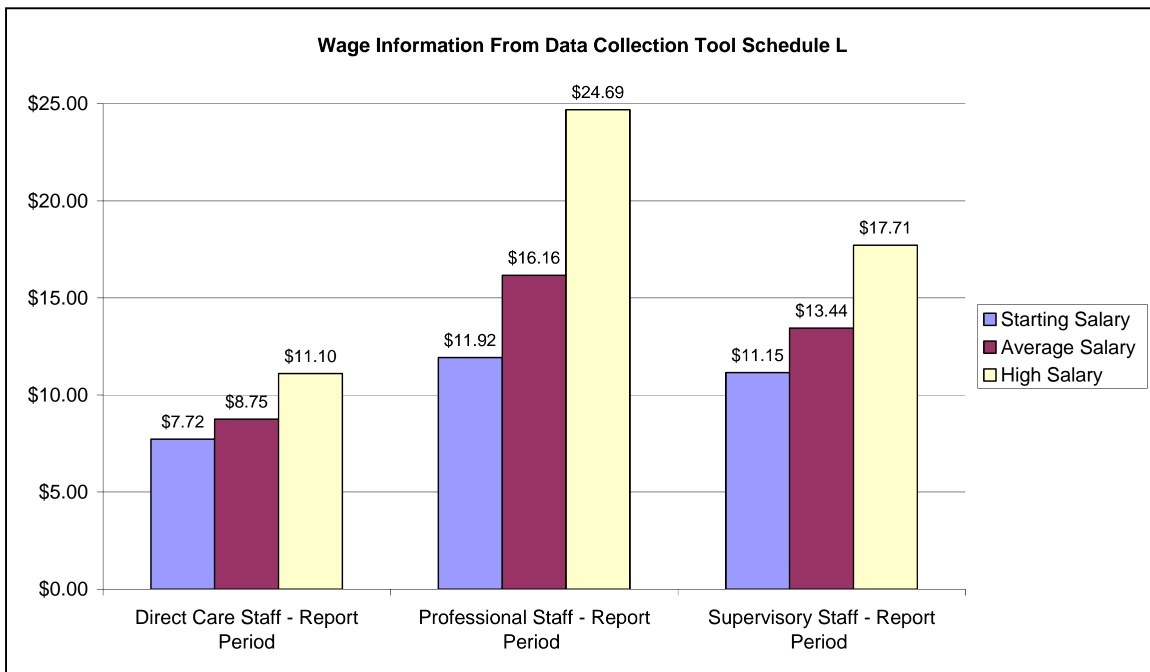


Chart 10: Wage Information - Schedule L

We also requested wage and benefit data from SRS on the two state mental retardation hospitals, Parsons State Hospital (PSH) and Kansas Neurological Institute (KNI). The following two charts detail the information provided.

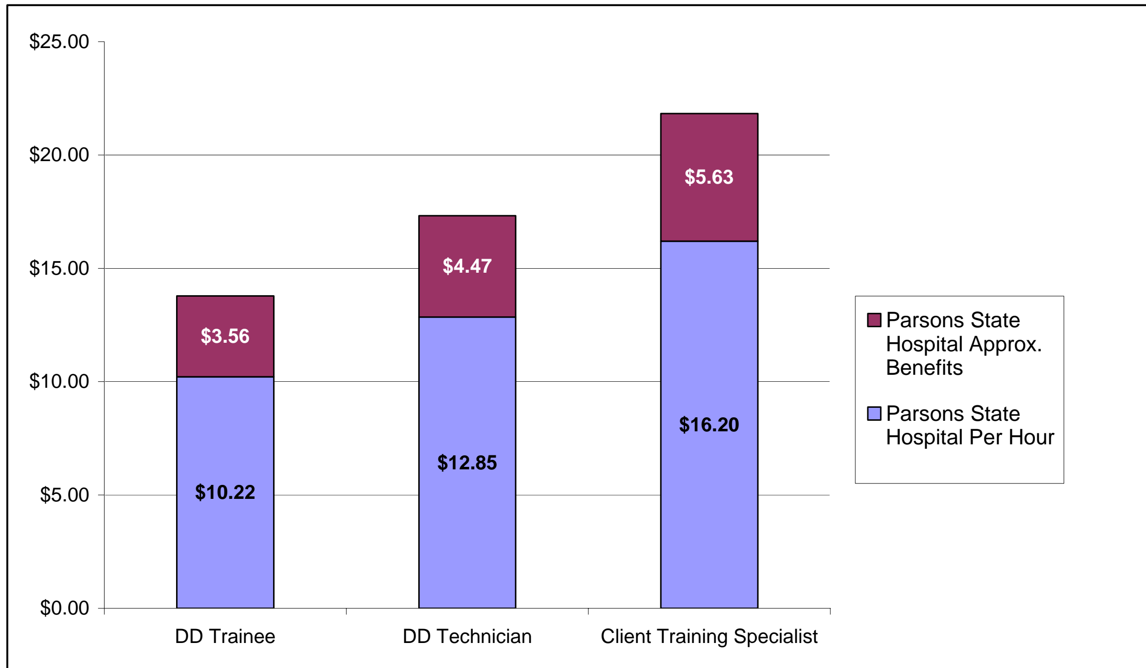


Chart 11: Wage and Benefit Information PSH

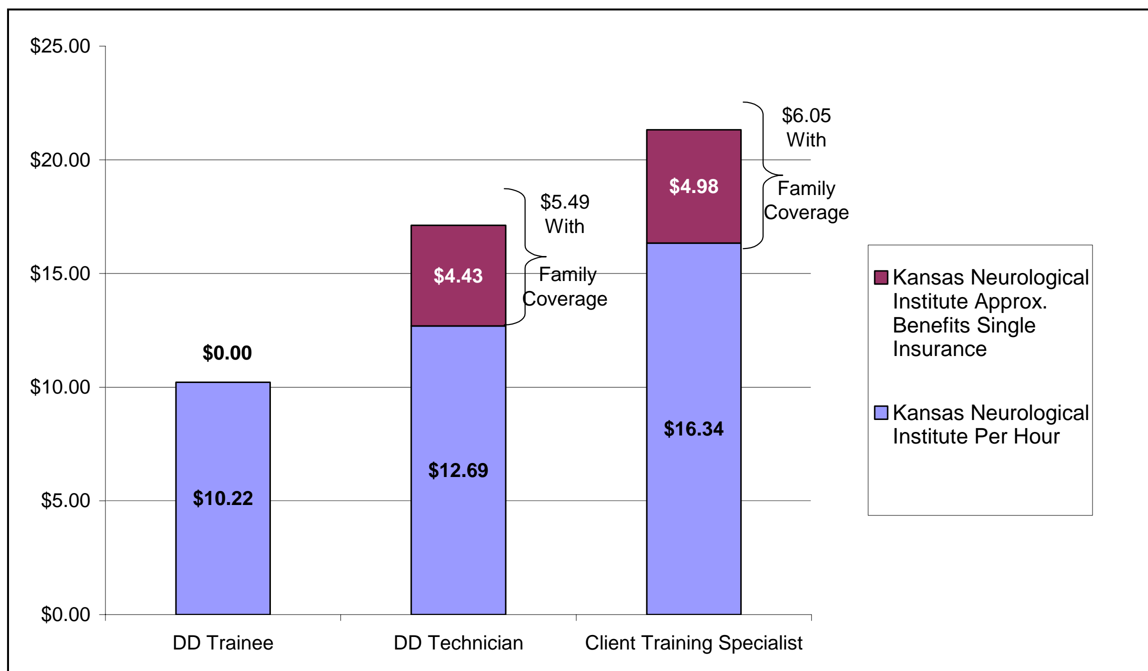


Chart 12: Wage and Benefit Information KNI

The following charts detail wage information for the Bureau of Labor Statistics from May 2005 and The Kansas Wage Survey, 2005 Edition.

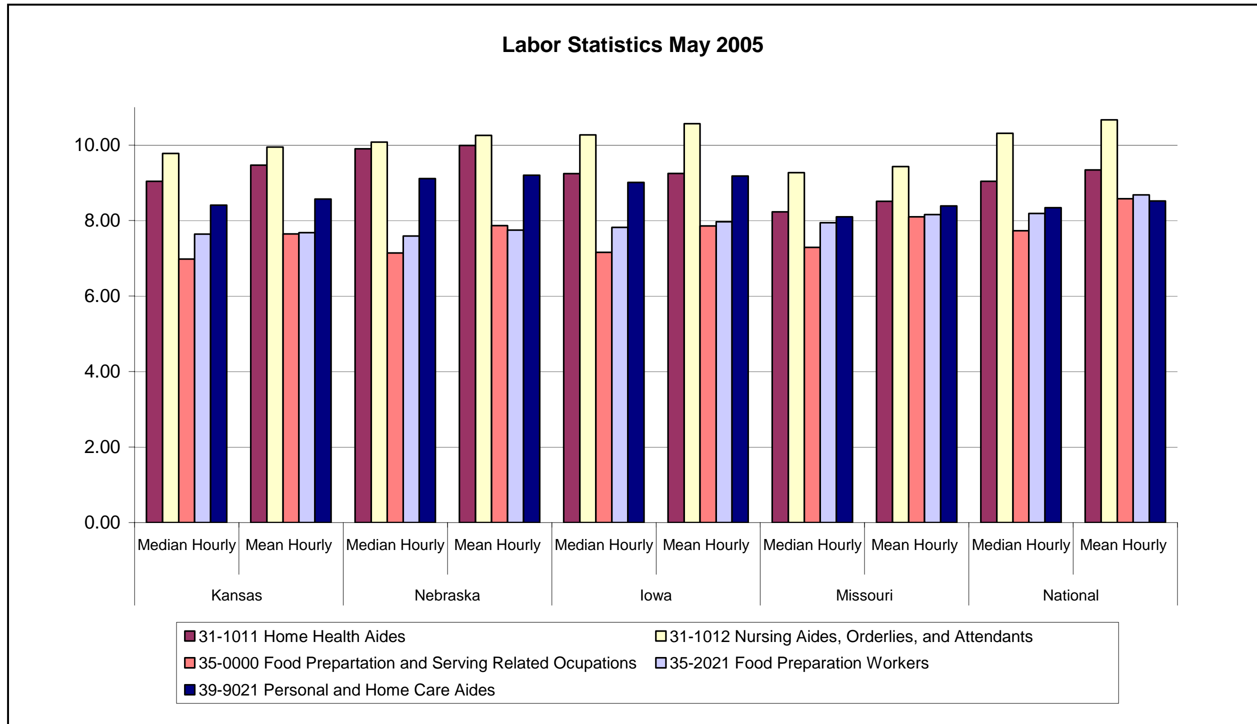


Chart 13: Selected Labor Statistics May 2005

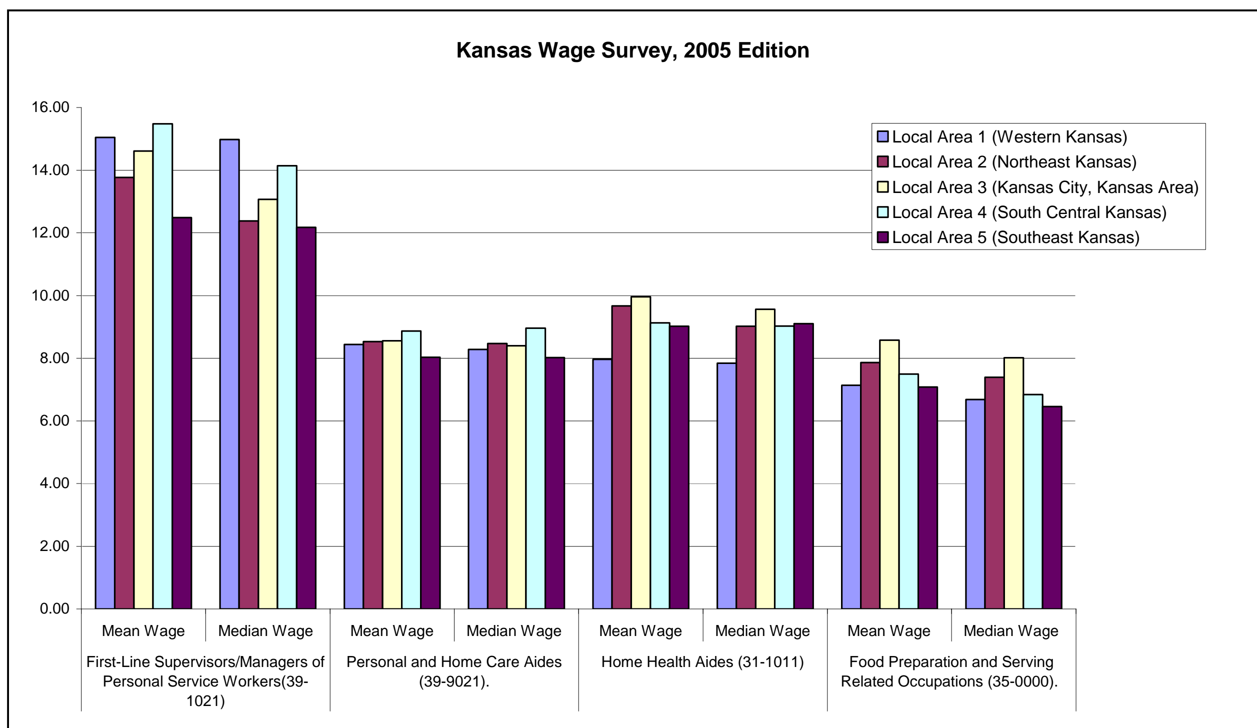


Chart 14: Selected Labor Statistics Kansas Wage Survey 2005

The following definitions can be used when reviewing the Kansas Wage Survey

- *First-Line Supervisors/Managers of Personal Service Workers (39-1021)* Supervise and coordinate activities of personal service workers.
- *Personal and Home Care Aides (39-9021)* Assist elderly or disabled adults with daily living activities at the person's home or in a daytime non-residential facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide meals and supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities. Blind Escort; Caregiver; Geriatric Aide.
- *Home Health Aides (31-1011)* Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility. Home Attendant.

Risk factor analysis

The rate study requires an evaluation of risk management costs, which include employee background checks and drug testing, driver's safety training, fire and life safety requirements and worker's compensation. As reported, the total cost of risk management is $2.04 per resident day with the majority of that in property and liability insurance and worker's compensation insurance.

Risk Management Per Diem	Residential and Day Service		
	Total Cost	Total Days*	Per Diem
Property and Liability Insurance	786,500	2,109,827	0.37
Employee Background Checks	92,658	2,109,827	0.04
Employee Drug Testing	92,991	2,109,827	0.04
Off Site Computer File Storage	678	2,109,827	0.00
Drivers Safety Training	8,298	2,109,827	0.00
Worker's Compensation Insurance	2,823,152	2,109,827	1.34
Employee Physical/Medical Tests/Immunizations	80,515	2,109,827	0.04
CPR Instruction	22,641	2,109,827	0.01
First Aid Supplies	94,606	2,109,827	0.04
Fire/Life Safety	29,234	2,109,827	0.01
Depreciation on Life Safety Equipment	19,450	2,109,827	0.01
Other (Please Specify)	244,210	2,109,827	0.12
Total Risk Management Cost Center	4,294,932		2.04

*Total Residential and Day Service Days

SRS does not participate in the costs of room and board or transportation provided through community providers. Adults who use these services are responsible for their costs, generally paid for with Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). The cost of these services may be supplemented with other

state or local funds. This information was included on the data collection tool and we have included the per diem summary information for review.

Residential Room and Boad Per Diem

	Total Cost	Total Days	Per Diem
Supplies	482,492	1,156,797	0.42
Food/Non Food Costs	3,318,451	1,156,797	2.87
Rent - Real Estate	2,043,288	1,156,797	1.77
Communications	299,840	1,156,797	0.26
Utilities/Trash/Cable	1,559,590	1,156,797	1.35
Repairs and Maintenance	968,939	1,156,797	0.84
Repairs to Equipment	84,410	1,156,797	0.07
Rent - Equipment	28,225	1,156,797	0.02
Small Equipment Purchases/Leases	292,465	1,156,797	0.25
Property Taxes	76,879	1,156,797	0.07
Depreciation	1,308,451	1,156,797	1.13
Interest on RE	748,566	1,156,797	0.65
Contract Services	280,491	1,156,797	0.24
Other (Specify)	233,492	1,156,797	0.20
Total Residential Room and Board Cost Center	11,725,579		10.14

There was some discussion in the provider meetings concerning the cost of program related transportation. To assist in identifying this cost, it was included as a separate line item on the data collection tool. The per diem cost of program related transportation for residential and day services calculates to $.52 per resident day.

BASIS data and increasing acuity

One of the areas identified at the orientation meeting that should be addressed in the reimbursement study was the increase in acuity of consumers. The Developmental Disabilities Profile (DDP), completed on each applicant, collects information about adaptive functioning skills, challenging behaviors, and health factors. The DDP yields three index scores (from which a converted score is also calculated), the higher the score the greater (more severe) the disability.

The providers reported that over the years the consumers in their programs have:

- Advanced in age;
- More medically complex conditions;
- Issues with dementia due to the accelerated aging process of this population; and
- Additional nursing needs that must be provided by Registered Nurses to monitor and support their chronic conditions.

We used the two period data extracts provided by SRS to evaluate changes in the health care component of the DDP. The algorithm for conversion uses a high score of 20. Although the current high score for fiscal year 06 is 27, the basic distribution of the scores is almost identical. We have also included graphs, which illustrate the tier mix for each of these health score distributions in Appendix H.

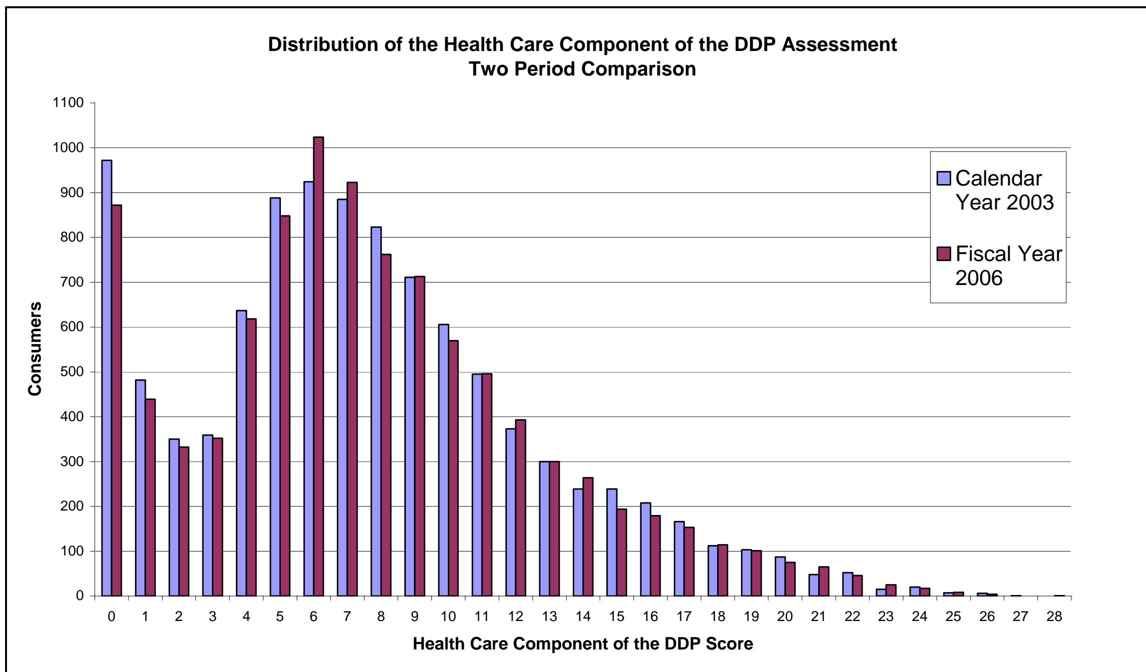


Chart 15: Distribution of the DDP Health Care Component – Two-Period Comparison

There were 7993 individuals, who had DDP scores in both periods. When comparing the two scores 3,221 had increased scores, 2,619 were the same and 2,143 were lower. There is some increased acuity for people assessed during both periods, however with people being added and leaving plus those with reductions in acuity, the overall distribution remained basically the same.

Individuals age 65 and over

We then evaluated the health scores for individuals age 65 and over. The health scores for these individuals were compared for 2003 and 2006. The following graph shows the number of clients, age 65 and over and the health component of the DDP assessment. There were more clients age 65 and over in 2003 than in 2006. The health score distributions for the comparison periods are very similar with few scores in the high teens or twenties.

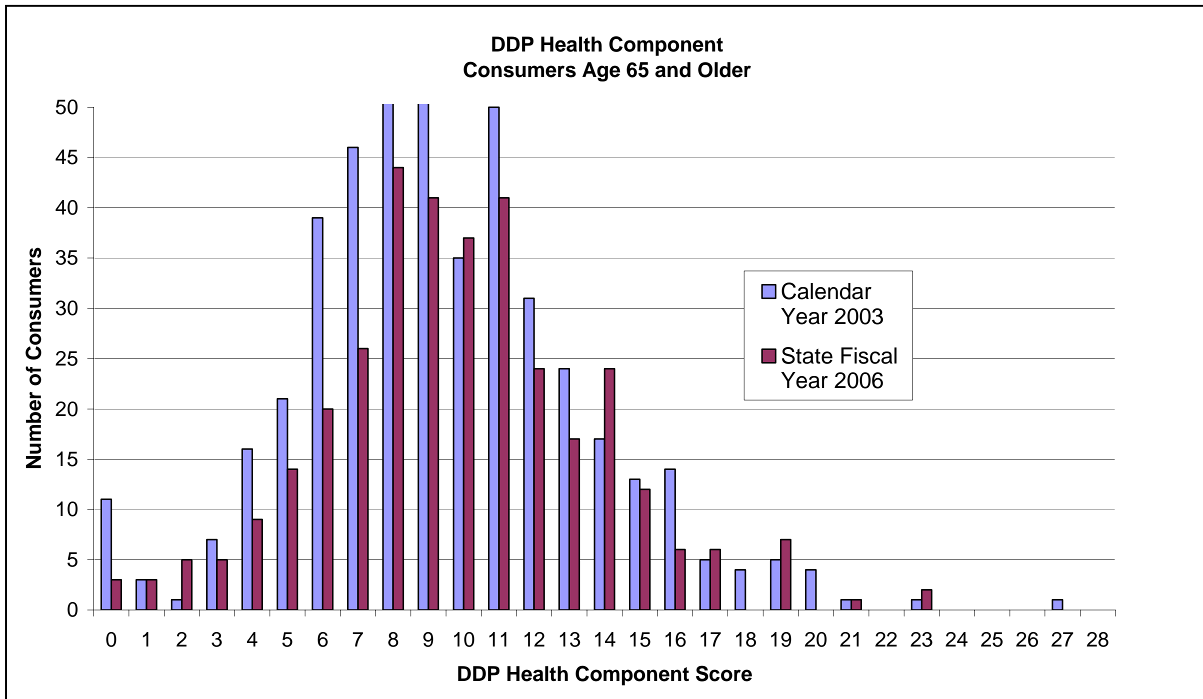
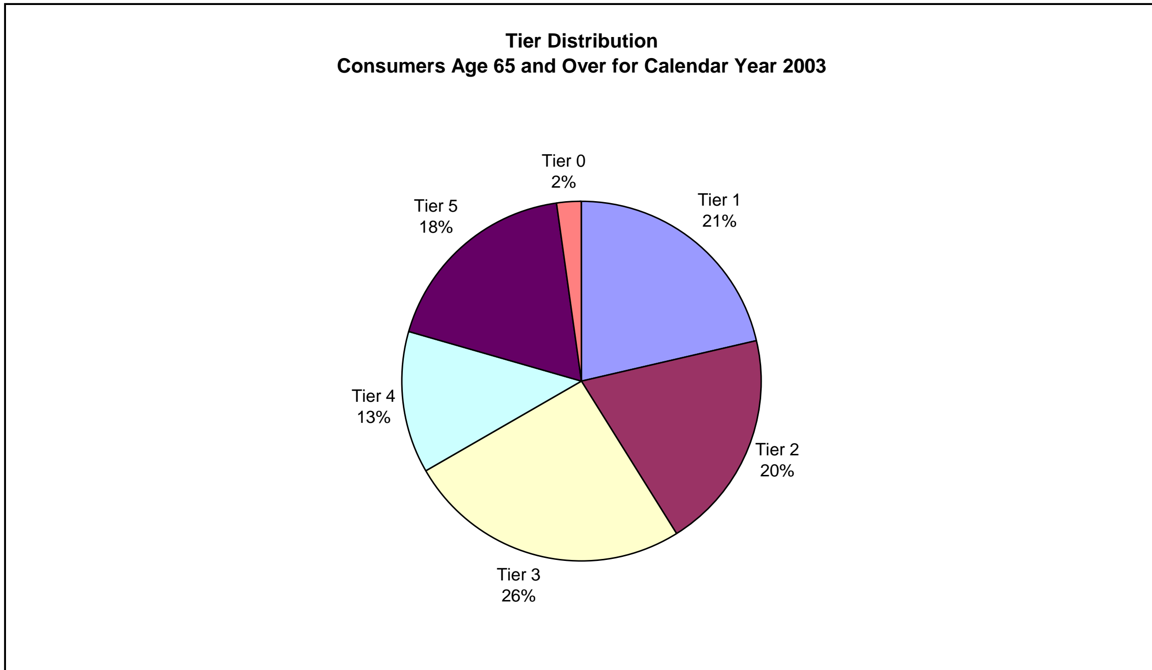
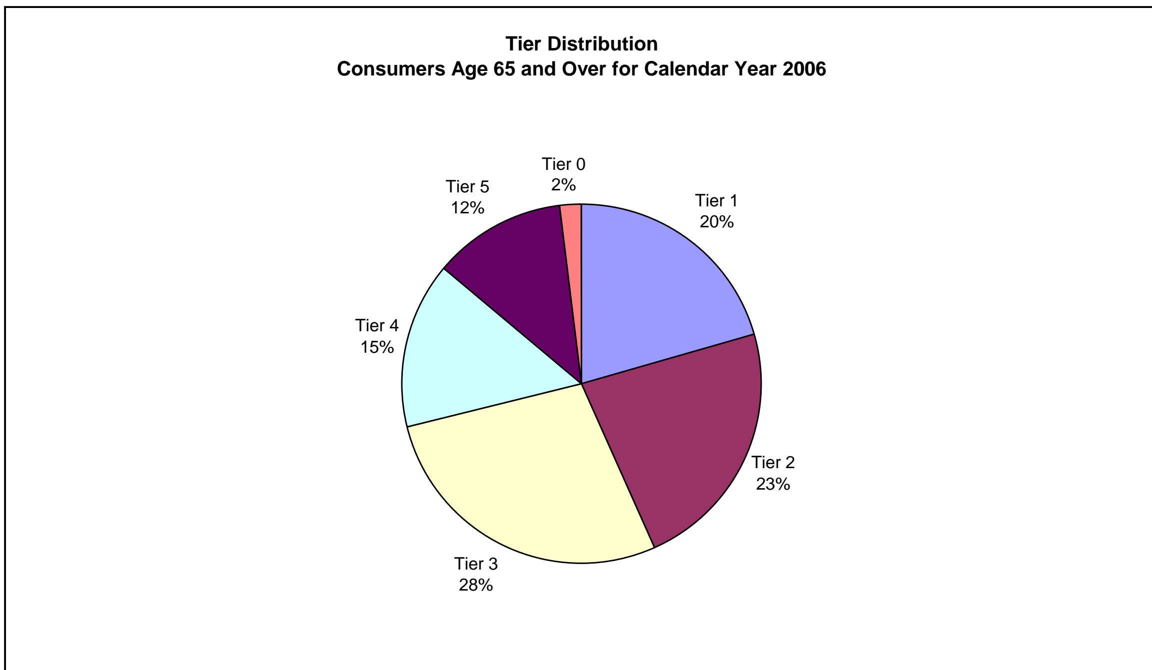


Chart 16: Distribution of the DDP Health Care Component – Two Period Comparison Age 65 and Older

To further evaluate aging and increases in health scores, the data was sorted to show the distribution of the tier levels by age. For consumers' age 65 and older, Tier 1 decreased slightly from 21% to 20%. Tiers 2, 3, and 4 each increased Tier 0 stayed the same and Tier 5 decreased between the two periods.





Charts 17 and 18: Tier Level Age 65 and Older – Two-Period Comparison

We also evaluated the 296 individuals who had DDP scores in both periods. Of those 138 had higher health component scores, 103 were the same and 55 had lower.

Direct CDDO administration costs

We also reviewed CDDO administration costs reported on the data collection tool. Detail for these costs could be reported on lines 301-319 column 7 or in total on line 320. Because we did not have all the CSP reporting, we used persons served as reported on the SRS expenditure report previously referenced to determine an average CDDO administration cost per person served.

Using all reported data, we calculated an average cost of $1248 per report period or an estimated $104.00 per person per month. Again there is a rather wide range of reported costs, ranging from a low of $14.70 to a high of $209.03 per person served per month. This data is also included in Appendix F.

Given that data could be reported without detail, a comprehensive evaluation of the differences cannot be completed. We did observe that some of the CDDO with greater costs per person per month served a smaller number of individuals. Also we observed some central office (or other no description) allocations that were a significant percent of the administration costs.

Comparison states

Nationally, the HCBS Waiver programs provide federal reimbursement for community services and supports, including habilitation training, respite care and other family support, case management, supported employment, supported living, various professional therapies, assistive technology, behavior management and other assistance in homelike community based environments. States participating in the waiver program have options of which services to include. No state has financed all of the available options and there is much variability among states in the services offer. Given the variability and complexity, information provided on other states is limited to participants served, spending per participant and a breakout of community services revenue.

The State of the States in Developmental Disabilities is a nationwide study of the growth of services and funding for persons with MR and MR/DD. We have included selected results from the eighth such study, which covers the period from 2002-2004. Data from this study was collected from budget and program documents from each state, specialized state survey instruments and personal interviews. The following state comparative information is from that study.

According to the report, the HCBS Waiver supported 416,546 participants across the nation. For comparison purposes we selected states within the Centers for Medicare and Medicaid Services (CMS) Region VII. The following chart shows the increase in HCBS waiver participants within the states since 1984.

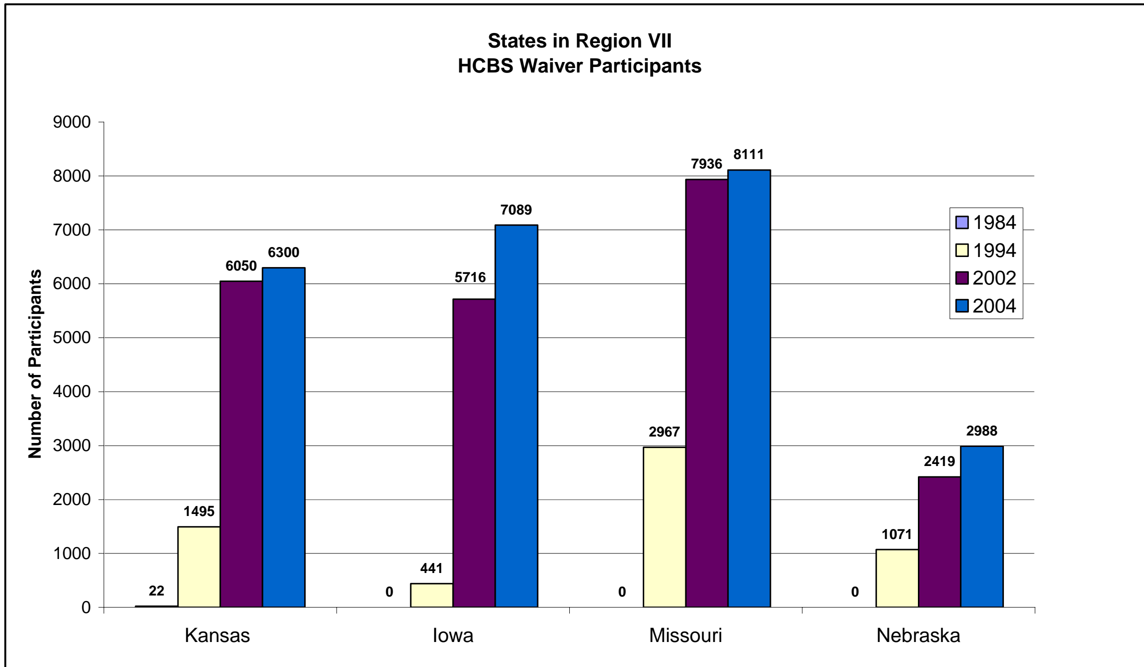
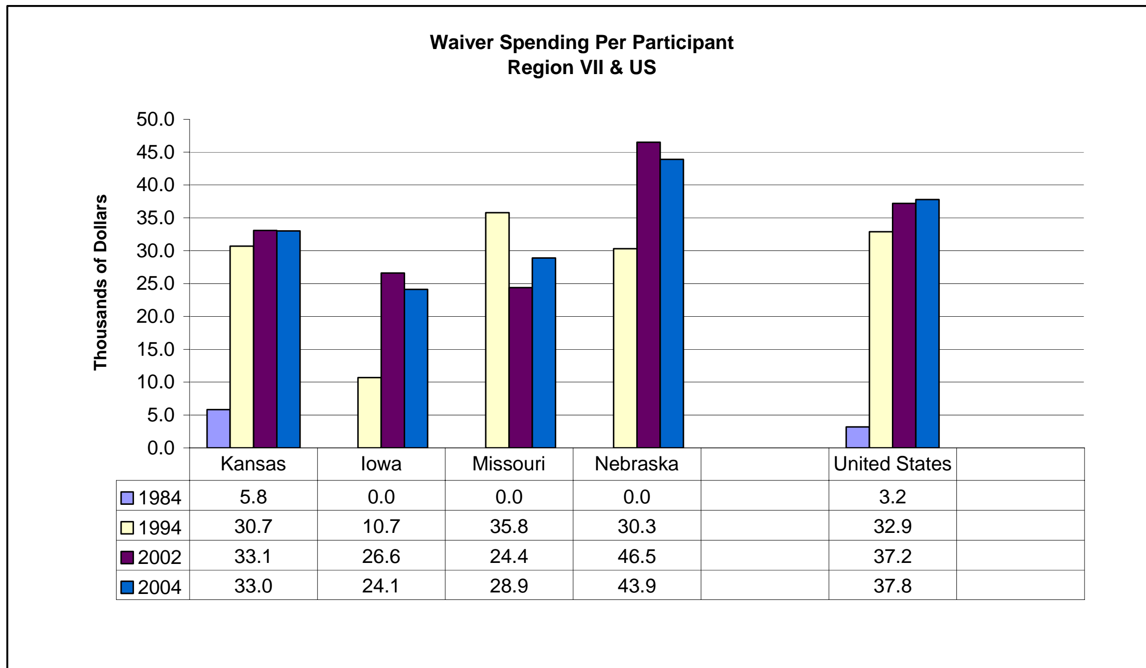


Chart 19: HCBS Waiver Participants - Region VII

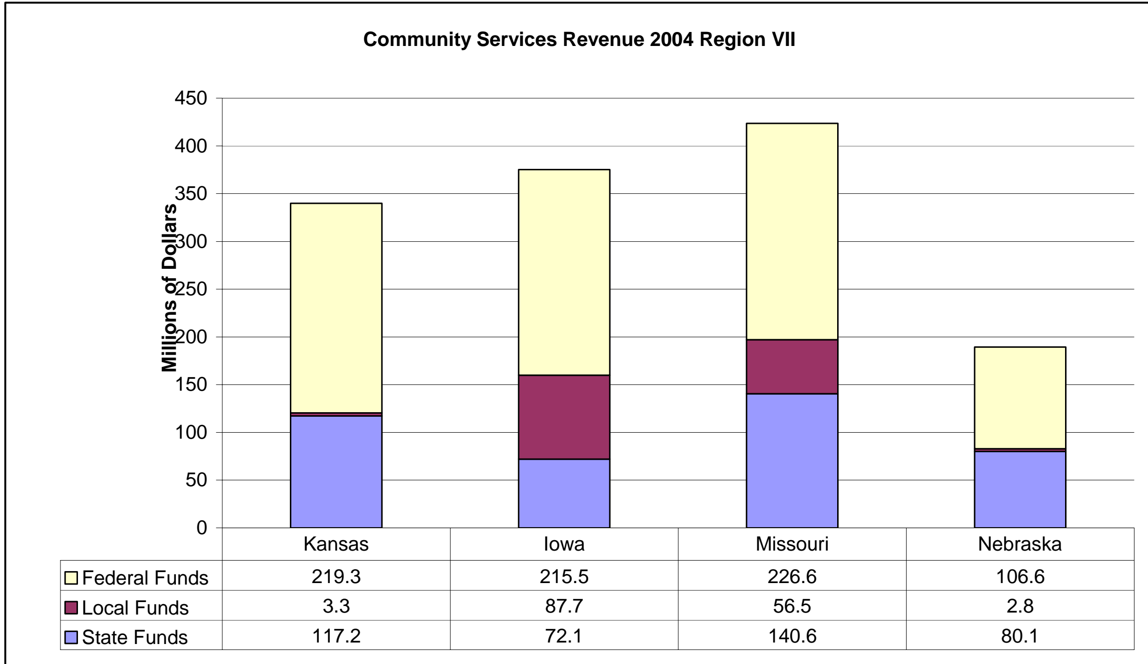
Federal HCBS Waiver spending in the United States grew from 1.2 million dollars in 1982 to 9.2 billion dollars in 2004. With HCBS waiver costs per participant in most states ranging from $21,000 to $40,000 per participant. The following chart shows the average spending per participant in the four Region VII states compared to the average spending per participant in the US.



	Kansas	Iowa	Missouri	Nebraska		United States	
1984	5.8	0.0	0.0	0.0		3.2	
1994	30.7	10.7	35.8	30.3		32.9	
2002	33.1	26.6	24.4	46.5		37.2	
2004	33.0	24.1	28.9	43.9		37.8	

Chart 20: Waiver Spending Per Participant - Region VII

The study also discussed estimates of "unmatched" state and local funding. The average estimated unmatched funds in the US are 14% of the total MR/DD spending. In Iowa the estimate is 18%, Missouri 19%, Nebraska 13% and Kansas 6%. The source of the estimates is Braddock, Hemp and Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005. The final chart we have included is a comparison among the states in Region VII on the distribution of community services revenue in 2004, which with the exception of Nebraska seems to support the above estimation.



	Kansas	Iowa	Missouri	Nebraska
Federal Funds	219.3	215.5	226.6	106.6
Local Funds	3.3	87.7	56.5	2.8
State Funds	117.2	72.1	140.6	80.1

Chart 21: Community Services Revenue 2004 – Region VII

6. Recommendations

General

Establish a standardized data collection process

A large portion of the effort devoted to this study was in obtaining usable data for the study. This included the development of the tool, training on its completion, cleaning and aggregating the data. We believe it would be beneficial to both the State and the providers to develop a standardized data collection process. Also given the importance of the rate study, we would also recommend implementing a desk review and or audit process to be applied to a certain percentage of report data. This would enhance the State's ability to rely on the data for making program decisions.

We would recommend using the data collection tool developed under this study, with potential adjustments, to standardize the cost data collection process. A standardized, annual collection process that was desk reviewed or audited and stored in a database structure, would assure better more consistent data to be used in rate evaluations.

Developing a Developmental Disabilities Information System, a database of statistical, financial and rate information, would provide a tool to assist in monitoring the DD rate system. The information available could provide for quick and efficient compilation and summarization of financial and statistical data for use in developing fiscal estimates.

Reports could be routinely generated that provide information such as provider averages that present a macro view of providers, provider totals that present aggregate cost and statistical data, and expense percentages that provide an aggregate view of a provider's spending. Common applications for such reports would include evaluating the need for changes to the rate structure, providing fiscal estimates of anticipated or proposed changes, and responding to legislative inquiries.

We believe standardization of the process would, in the long run, simplify the process for both the state and the providers, improve accuracy and meet the requirements of the current biennial study design. It would also address the need for quick and efficient retrieval of information related to the DD program.

Evaluation and monitoring of acuity

The DDP has been used as the eligibility tool since July 1, 1990. It was chosen because it is demonstrably reliable and valid as well as brief and easy to administer. The New York Office of Mental Retardation and Developmental Disabilities developed the DDP assessment. The Kansas document appears to have eliminated some of the items from the original New York document such as,

Information on the sensory and motor conditions of the applicant
Information about how often a consumer receives services from specialists such as a psychologist, psychiatrist, speech and hearing pathologist, physical therapy, occupational therapy, physician, nurse and social worker

The Medical Conditions section of the DDP asks for Yes or No answers if the individual has any of the following conditions: Respiratory, Cardiovascular, Gastro-Intestinal, Genito-urinary, Neoplastic disease, and Neurological diseases. Diagnosis does not indicate issues with functioning due to the medical condition and alone does not provide a good indicator of resource needs.

Information is collected on the individual's level of functioning from independent to totally dependent for activities of daily (ADL) living for mobility (walking), transfer, toileting, bathing, dental hygiene, dressing and eating skills. However, information about the number of staff and the level of support needed to assist are not included on the DDP. As the level of support needed is a main determinant of the cost of providing service, it is important to include an evaluation of required support when creating rates designed matched to resources needed.

Also under the current process, reassessment is not linked to changes in acuity. The tier level is re-established annually on the consumer's birth date. Our analysis did not identify large changes in acuity. This may, however, be a measure of the available statistics rather than the population.

Given that concern over increasing acuity is an issue, we would recommend either augmenting the DDP to enhance its ability to monitor changes in acuity and adding an evaluation of supports needed or consider implementing a new tool that better assesses and predicts needed resources.

Rate specific

Recalibrate the tier levels in the rate structure

When costs are distributed using the rate structure it appears that rates for the higher-need tiers are not covering costs and that rates for the lower-need tiers are over the cost. However evaluation of the cost coverage does not support that conclusion. When costs are distributed using the days and costs reported by individual settings, we see very different cost coverage results, which seems to be supported by the cost coverage evaluation.

Although the comparison of as reported total costs to total revenue suggests needing additional funds, the cost coverage by provider shows approximately 50% of providers getting 100% or more of their costs covered. Just adding a rate increase to the existing rate structure, we believe, would not be effective.

Given this finding, we recommend that the rate formula, at a minimum be recalibrated and ideally be completely redesigned. As discussed in the report, the current rate

structure incorporates the concept of payment based upon acuity factors of the individual consumer, or case mix. Acuity based payment requires a methodology to assess consumer needs, a system that groups consumers with similar resource needs, and a method to link reimbursement to the predicted resource usage.

The current rate structure is built on decisions to use the Developmental Disabilities Profile (DDP) as the assessment tool, tier level groups as the classification method and rate models developed during the 1992 cost study. We would recommend re-evaluating each of these decisions during the recalibration or redevelopment process. The per diem per tier level distribution could be a starting place for this re-evaluation but would require further study to determine recalibration details.

We would not anticipate sufficient time to redesign the system prior to the 7/1/07 rate period and would recommend in the interim to add an inflation factor as discussed below, but to distribute the dollars with a greater percentage going to Tiers 4 and 5 in both residential and day services.

Add an inflation factor

Our recommendation to accommodate increasing costs would be to develop and apply an appropriate annual adjustment to the rates that estimates the inflation the provider community will experience during the rate period. The projection requires the recognition that the inflation rate varies over time. Many states use projections of inflation from a published historical economic index. The more widely used indices include

The consumer Price Index – Urban (CPI-U) This index is generally viewed as measuring the cost of living. The Bureau of Labor Statistics (BLS) calculates the index on a monthly basis. The CPI-U attempts to measure changes in prices paid by urban consumers for a constant or fixed bundle of goods and services (market basket) from a base period to the present.

The Data Resources, Inc. (DRI)/McGraw Hill (Now Standards and Poors) Health Care Costs: National Forecast Tables. The index is intended to measure changes in input prices of certain defined costs. The index is published for both historical and forecasted values and is rebased every quarter.

State General Funds

It is our understanding that the current state general funds are not distributed to the CDDO using rates but are instead a pool of funds with CDDO discretion on numbers of consumers served. Our analyses could not differentiate between waiver service costs and non-waiver service costs. The findings would apply to both. We would recommend, the newly evaluated or redesigned system be used to establish rates or evaluate the pool to be paid for services covered by State General Fund

7. List of Appendices

A. Advisory Committee Members
B. Data Collection Tool
C. Instructions
D. Literature Review Listing
E. Proportion of Regular, Super Tier and Individualized Rate Days
F. Spreadsheets and Analyses
G. Training Cost Estimate
H. Distribution of the DDP Health Care Component Including Tier Level Assignment
I. Charts and Tables Listing
J. Response to Comments on Draft Report
K. InterHab Critique of Draft 2006 Rate Study – September 25, 2006

Appendix A Advisory Committee

Sharon Spratt
Cottonwood Inc.
2801 W. 31st St.
Lawrence, KS 66047

Tim Arnold
Johnson County Developmental Supports
10501 Lackman Rd.
Lenexa, KS 66219

Earl McGinn
Southwest Developmental Services, Inc.
1809 Palace Drive, Suite C
Garden City, KS 67846

Brian Bolen
Health Care Policy/ Community Supports & Services
Docking State Office Building – 10th Floor
915 Harrison
Topeka, KS 66612

Greg Wintle
Health Care Policy/ Community Supports & Services
Docking State Office Building – 10th Floor
915 Harrison
Topeka, KS 66612

Frank Stahl
Health Care Policy/ Community Supports & Services
Docking State Office Building – 10th Floor
915 Harrison
Topeka, KS 66612

Appendix B Data Collection Tool

Appendix C Instructions

Appendix D Literature Review Listing

Braddock, D. et al *The State of the States in Developmental Disabilities 2005* Department of Psychiatry and Coleman Institute for Cognitive Disabilities The University of Colorado

US Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy The Supply of Direct Support Professionals Serving Individuals With Intellectual Disabilities and Other Developmental Disabilities Report to Congress, January 2006

Hewitt, A. PhD et al *Issues in the Direct Support workforce and their Connections to the Growth, Sustainability and Quality of Community Supports* Robert Wood Johnson Foundation, May 2001

Policy Research Brief Wages of Direct Support Professionals Serving Persons with Intellectual and Developmental Disabilities: A Survey of State Agencies and Private Residential Provider Trade Associations. Published by the Research and Training Center on Community Living University of Minnesota, March 2003

Olson, K. *Kansans Mobilizing for Direct Support Workforce Change: A statewide workforce development initiative to resolve the direct support workforce crisis – Final Report* Kansas University Center on Developmental Disabilities

Bradley, V. et al *Person-Centered Supports for People with Developmental Disabilities in the Sunflower State* Human Services Research Reinventing Quality Project, July 2002

http://www.srskansas.org/admin/mapprogram.html State of Kansas Department of SRS Annual Report

Deloitte & Touche, *Cost Study and Development of Standard Unit of Service Reimbursement Rates for Services to Persons with Developmental Disabilities*, 1991

Basic Assessment Services Information System (BASIS) 6.0 Forms Instruction Manual Kansas Department of SRS Division of Health Care Policy Community Supports and Services, May 2001

Appendix E Proportion of Regular, Super Tier and Individualized Rate Days

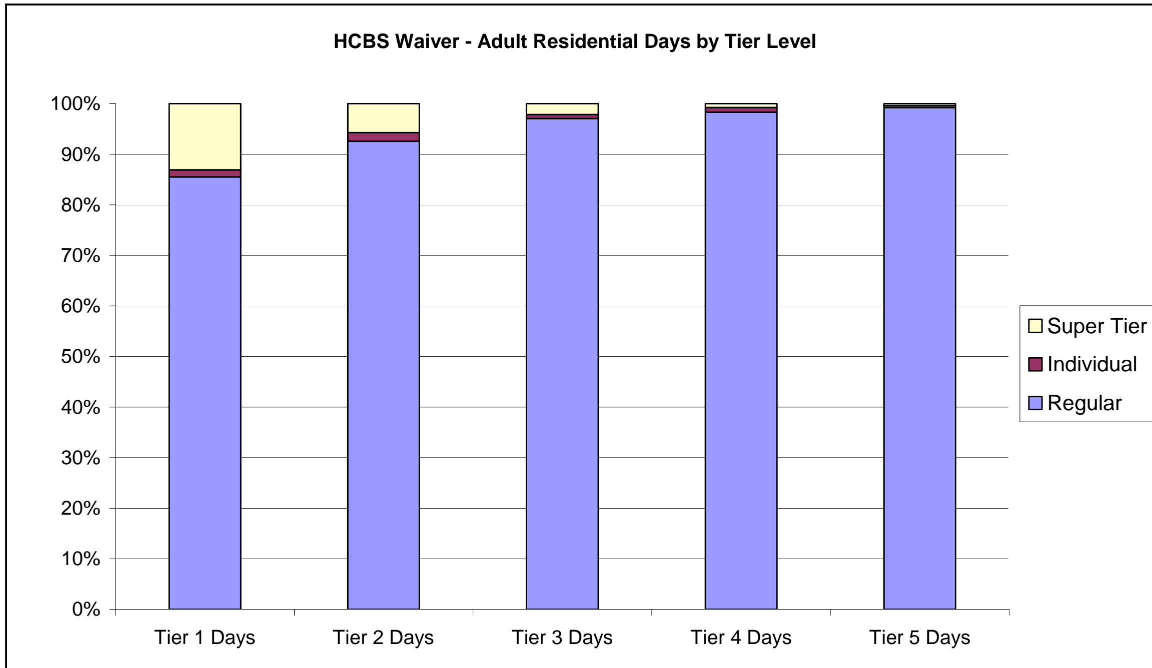


Chart 22: Proportion of Regular, Super Tier and Individualized Rate Days Residential Services

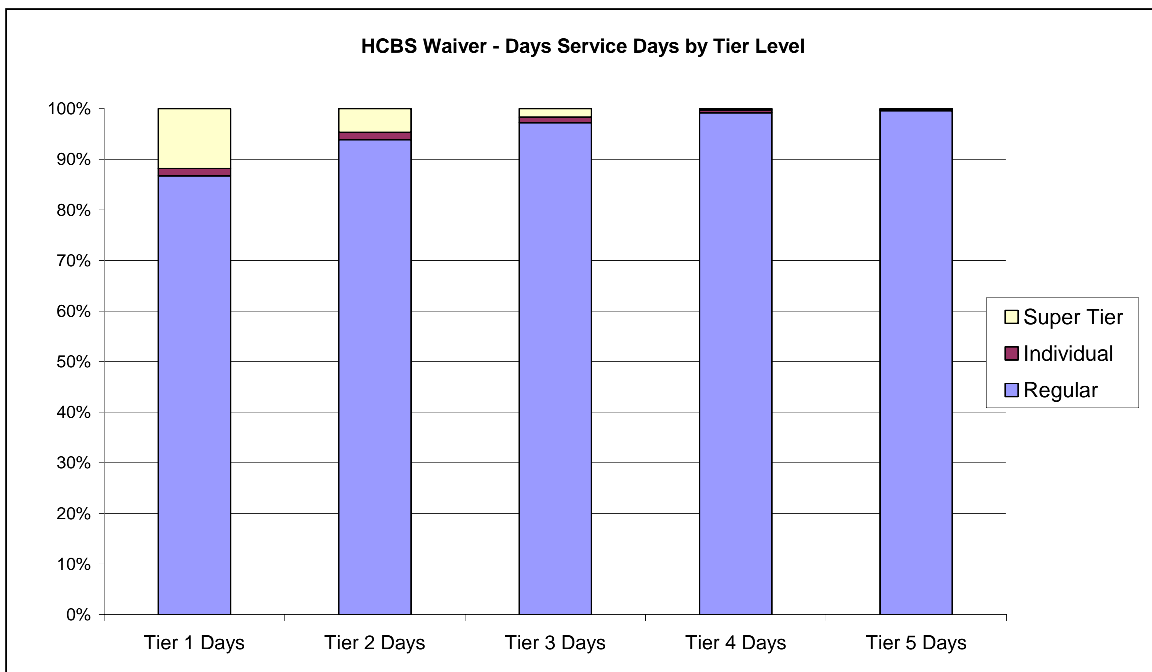


Chart 23: Proportion of Regular, Super Tier and Individualized Rate Days – Day Services

Appendix F Spreadsheets and Analyses

Appendix G Training Cost Estimate

Estimate of Training Costs				
		Direct Service	Professional	Supervisory
Employees Hired Per Schedule L		2763	153	64
	Average Training Hours - 1st Year (rounded up to whole hours)	62	55	56
	Estimate Hours of Training	171306	8415	3584
	Average Starting Salary (Per Schedule L)	$7.72	$11.92	$11.15
	Estimate Cost of 1st Year Training	$1,322,482.32	$100,306.80	$39,961.60
Existing Employees Per Schedule L*		2234	779	279
	Average Training Hours - Annual (rounded up to whole hours)	24	25	26
	Estimate Hours of Training	53616	19475	7254
	Average Salary (Per Schedule L)	$8.75	$16.16	$13.44
	Estimate Cost of Subsequent Years Training	$469,140.00	$314,716.00	$97,493.76
	Total Estimated Costs All Staff	$2,344,100.48		
	Total Days (Residential and Day)	2109827		
	Estimated Per Diem Cost	$1.11		
*The > headcount at 1st or last day minus employees hired				

Table 16: Training Cost Estimate

Appendix H Distribution of the DDP Health Care Component Including Tier Level Assignment

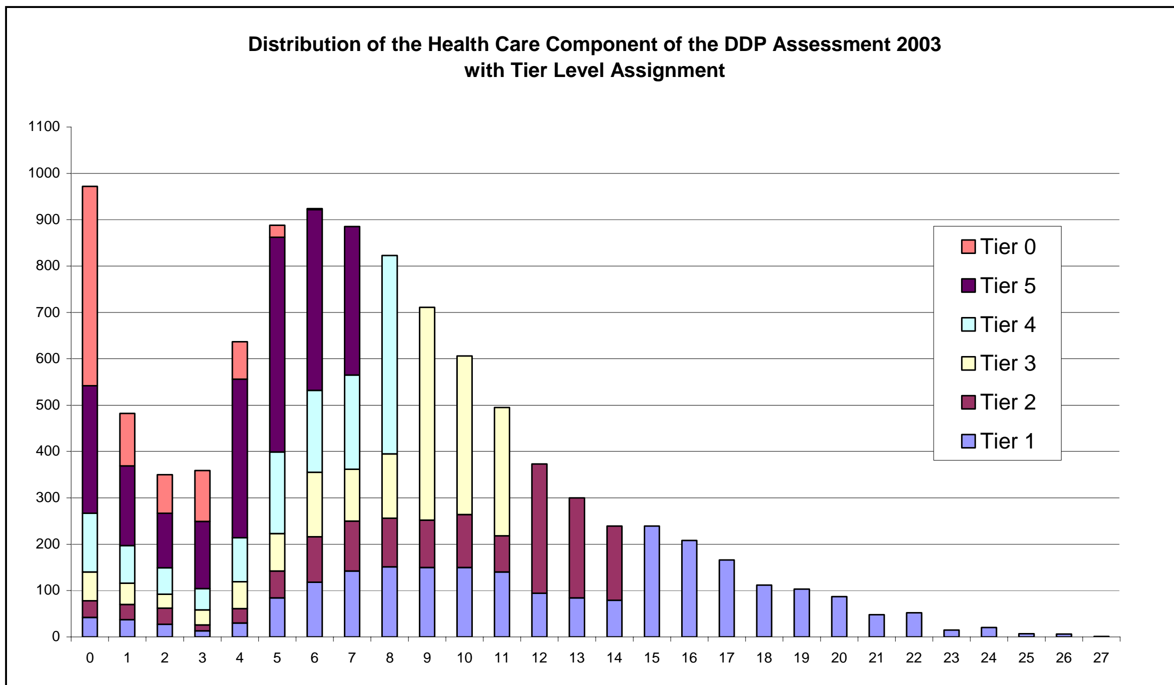


Chart 24: Distribution of the Health Care Component of the DDP Assessment 2003 With Tier Level Assignment

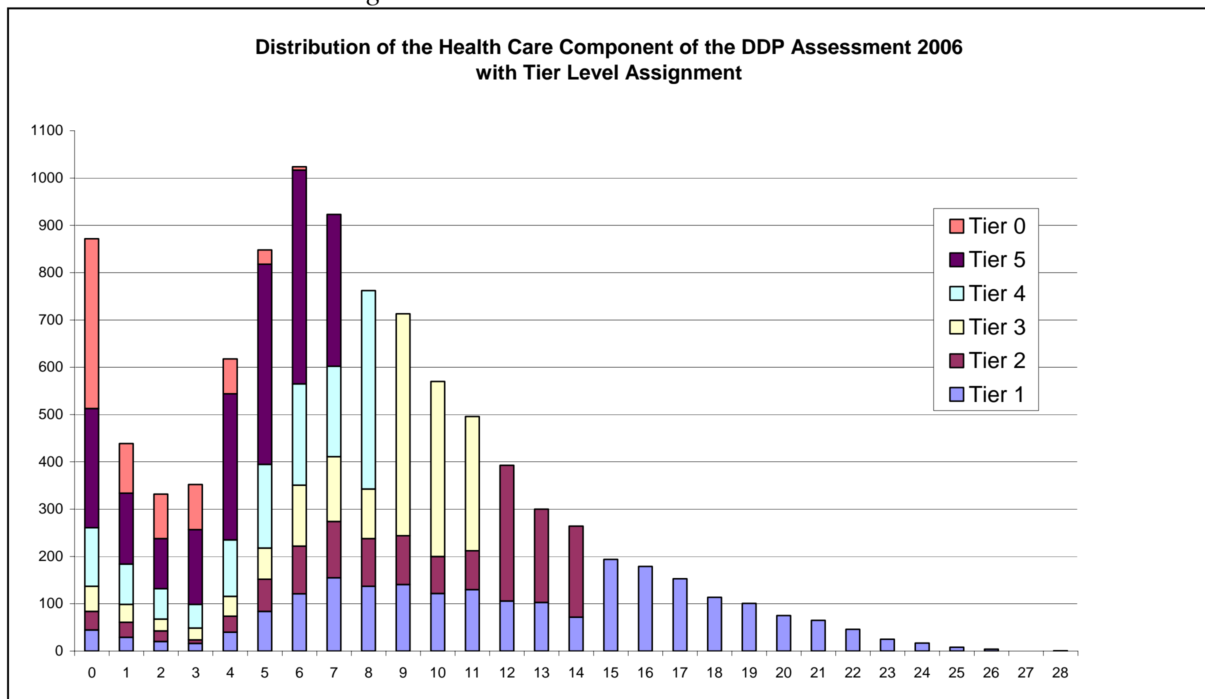


Chart 25: Distribution of the Health Care Component of the DDP Assessment 2006 With Tier Level Assignment

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Appendix J Response to Comments on Draft Report

A draft of the report was provided to the Advisory Committee for review on August 30. A meeting to discuss the group's review of the draft and any issues or comments they had was held on September 6. The Advisory Committee provided a few verbal comments and suggestions that have been incorporated into the final report.

The draft was then shared with other providers and interested parties. We received one written comment via email from InterHab sent September 26, which is included with this report as Appendix K. To respond to issues raised in the InterHab critique, we provide the following:

- The InterHab critique contains references to "actual" hours or costs. It is important to note that these data are "as reported", they have not been reviewed or audited for accuracy. Allocation methodologies are also as reported.

- The InterHab comments are divided into four sections: major issues, other issues, summary and proposed rate calculations. Our comments will follow the same format.

Major Issues

Use of reimbursement rate formula

We are confused by InterHab's position on the use of the rate formula. The critique emphatically asserts any analyses we performed linked to the rate formula be reconsidered, revised or deleted from the report. Yet, the critique itself uses the rate formula to illustrate various points. We believe the analyses of the rates had to logically start with calculations using the rate formula. However, we also looked at costs and cost coverage by service category, in total and by provider. These analyses were not dependent on the rate structure. Further we distributed costs to the various tiers using reported costs at the individual setting level rather than distributing costs using the rate formula. These analyses and findings contributed to our recommendation to, at a minimum recalibrate or ideally completely redesign the rate methodology.

To add to our confusion on InterHab's position, although they recommend the current rate formula not be used as the basis for rates for future rate periods and that an alternative method for allocating funds should be developed, the critique ends with a series of tables with proposed rates that use the current rate formula to develop the suggested rates.

As discussed in the report, the current rate structure incorporates the concept of payment based upon acuity factors of the individual consumer, or case mix. Acuity based payment requires a methodology to assess consumer needs, a system that groups consumers with similar resource needs, and a method to link reimbursement to the predicted resource usage. The current rate structure is built on decisions to use the Developmental

Disabilities Profile (DDP) as the assessment tool, tier level groups as the classification method and rate models developed during the 1992 cost study. We would recommend re-evaluating each of these decisions during the recalibration or redevelopment process.

Improper focus on waiver funding as the full extent of the state's funding obligation

The Advisory Group established the parameters of the rate study and assisted with the design of the data collection tool. Data collection included revenues, consumer day and or hour information and cost data for adult residential services HCBS waiver only and non-HCBS waiver, day services HCBS waiver only and non-HCBS waiver, bundled and unbundled in-home supports HCBS waiver only. Our analyses of total payments to total costs, of cost coverage per provider, and the quartile analyses are based on these reported statistics.

It is our understanding that the current state general funds are not distributed to the CDDO using rates but are instead a pool of funds with CDDO discretion on numbers of consumers served.

The disconnect between the formula rate and cost of providing support

As we understand InterHab's contention, any portion of an hour of service above the direct service hours upon which the rate formula is based are unfunded, whether the cost of the services were actually covered or not. The theoretical concept of funded and unfunded hours is a concept derived solely through the rate structure and does not link to reported costs or revenues. Given that we recommend the rate structure be redesigned, we do not see the merit in discussing how the rate formula currently accounts for base projected hours of direct service. We do think it is important to mention that the current formula includes several adjustment factors and add-ons that do not appear to be considered in the discussion on funded/unfunded hours.

A more meaningful evaluation is cost coverage in total and per provider. Please refer to Appendix F.

Rate study analysis of level of state funding required for adequate reimbursement for all necessary supports provided

The Advisory Group established the parameters of the rate study. Although the concept of measuring the theoretical was discussed, the group consensus was to develop a procedure that would do the best job of evaluating current cost experience. To pursue this type of evaluation in future rate studies would require quality assurance data. We understand quality data is currently being collected and aggregated in a computerized format. Although unavailable for this study, it may be available to be incorporated into the next.

Average Per Day Per Consumer Expense

As discussed previously, the data is "as reported." It has not been desk reviewed or audited. All allocation methodologies were selected and calculated by the providers. We included all providers in the cost coverage analyses. In the analysis of residential services, if we excluded the one provider with the 38% cost coverage from the analysis, the total costs would be $87,430,949 and total revenue would be $88,018,521. This would provide cost coverage of 100.67%. Using that data, the average cost per day cost would be $78.32 and the average revenue per day would be $78.84.

We included data from all providers for this analysis, but do not feel a conclusion about the adequacy of the overall funding could be made without further verification of the submitted data. This data issue, however, resulted in our recommendation for a standardized data collection process with appropriate desk review and audit.

Given the wide range of cost coverage using reported data from a high of 161.27% to the low of 38.73% in residential services, we do feel we can conclude that the current rate formula does an inadequate job of distributing the available funds.

Other Issues

1. Cost coverage analysis

The total differential between cost and revenue for residential services is $5.17 million dollars. The difference in cost coverage for the provider with the 38% cost coverage is $5.76 million. There are similar issues with the differential in the other services categories. Given this, we believe it would not be appropriate to extrapolate those results to the entire population.

2. State Expenditures per person

Additional information has been provided in the report concerning the reported expenditures per person per year. Any conclusion from the data would need to also include an evaluation of the various services provided by each reporting state as these may vary widely.

3. Cost/Revenue Projects

Refer to response to item #1.

4. Compare total payments to total costs

Reported costs included expenditures for both waiver services and those supported by state general funds, as the expenses are not separately tracked. Our comparison of total payments to total costs:

- For the residential service comparison, included revenues from "Adult Residential Services HCBS" Line 201 on the data collection tool and "Residential Services" Line 207.
- For the day service comparison, included revenues for Day Services HCBS Line 203 on the data collection tool and Day Services (SGF) Line 208.

- For the in-home support comparison, included revenues for In-home Supports HCBS Line 204 on the data collection tool and Supportive Home Care Services (SGF) Line 209. We understand the Family Support Grant Income reported on line 210 could either be used for stipends paid directly to families or for services. We excluded these revenues from our cost comparisons.

5. Cost coverage per provider

Refer to item 1.

All supporting documentation was provided with the draft, but was not labeled as Appendix F. This has been labeled in the final report. There are wide ranges of cost coverage for residential, day and in-home support services, but as reported approximately 50% of providers are getting 100% or higher cost coverage.

6. Quartile analysis of cost coverage

Additional explanation has been added. The quartile analysis helped to evaluate relationships among providers with various levels of cost coverage.

7. Per diem costs per tier level

The analysis of per diem costs using the rate structure only helps to illustrate the problem with continuing the rate formula as currently designed. InterHab misinterpreted our comments. We did not say we assumed the accuracy of the hours in the rate formula. We said to depend on this allocation one would need to assume it is correct. The findings show just the opposite and based on our findings we have recommended that the formula be redesigned.

8. Staffing analysis

We divided total reported costs for direct care staff by total days to arrive at an average cost per day. The same calculation was done for supervisory staff and health services staff. All supporting data is included in the Appendix F.

9. Staff Turnover

The as reported per diem cost of staff recruitment, staff development and professional services and direct service staff training was $.54 per day. We imputed a cost for on the job training using the data submitted on Schedule L. That calculation is included in Appendix G. Using that estimated cost, the total for recruitment and training is $1.65 and the current rate formula allows for $2.30 per day.

10. Wage/Benefit Analysis

The data was included in the draft as reported.

11. Wage Survey

The comparisons were to Home Health Aides, Personal Home Care Aides and Nursing Aides, Orderlies and Attendants. Additional data was added for food preparation and serving related occupations as these are occasionally mentioned as alternative work arrangements when discussing the adequacy of wage rates.

12. Risk Management

This cost center was included based on input from the Advisory Committee. All risk management costs were to be included. If life safety code compliance costs were not included or not separately identified it was the provider's decision

Summary

We believe all items in the summary are addressed in the preceding discussions with the exception of the issue of increased acuity of consumers. As discussed in the report, the available data does not support this contention. However, this finding may only be a function of the available data and not a reflection on changes in acuity. We have recommend that the use of the DDP be re-evaluated.

Please refer to the above for discussions on other points.

Proposed Rate Calculation

InterHab's proposed rate calculations use the tier structure and base hours of direct service per tier level from the current rate formula, as well as all adjustment factors and add-ons. The result of their rate calculation would be to develop residential rates, for example, which range from $288.52 per day for Tier Level 1 to $80.60 for Tier Level 5 for services with an average reported per day costs for all tier levels, including all providers, of $83.32 per day. They have a similar calculation for day services.

We understand InterHab is recommending that a new rate formula be developed and do not see the merit in the attached rate calculations. They are very overstated and perpetuate the problems with the current rate structure.

Appendix K InterHab Critique of Draft 2006 Rate Study – September 25, 2006