REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

242

A MANAGEMENT REVIEW OF THE CALIFORNIA COMMUNITY MENTAL HEALTH SYSTEM

FEBRUARY 1975

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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February 11, 1975

Honorable Bob Wilson
Chairman, and Members of the
Joint Legislative Audit Committee
Room 4126, State Capitol
Sacramento, California 95814

Dear Mr. Chairman and Members:

Transmitted herewith is our report on the Department of Health's management of the California Community Mental Health System. This program, commonly referred to as the Short-Doyle program, became effective in 1969 and is comprised of the Lanterman-Petris-Short Act and a revision of the Short-Doyle Act of 1957. The 1974-75 total budget for this program including federal, state and county funds is $311 million.

Our review of five representative county programs (Los Angeles, Orange, San Mateo, Sacramento and Butte Counties), and the Department of Health's supervision of those programs disclosed numerous deficiencies in the Department of Health's ability to effectively supervise the administration of the California Community Mental Health System. As a result, there is a lack of cost consciousness and a lack of accountability throughout the Community Mental Health Program. Communication between the Department of Health and county mental health programs is inadequate for effective management. Furthermore, the Department of Health's data bank of information, known as the Cost Reporting/Data Collection System (CR/DC), is an ineffective management tool.

For example, CR/DC produces a series of 51 different management reports. Our interviews with local mental health staff in the five counties we visited disclosed that these reports were not used at the local level for any aspect of management decision-

making. Furthermore, interviews at the Department of Health disclosed that only six to ten of these 51 reports were requested or used frequently at the state level.

We have made a series of recommendations to correct these deficiencies.

Neither the Department of Health, the counties, nor the providers are taking the steps within their capacity to utilize non-state and non-county funding sources. As a result, the state and counties lose estimated funds between $12.6 million and $25.1 million annually.

There is insufficient incentive for a county or a provider to apply their resources to revenue collection since such providers receive the same total program dollar amount regardless of fund sources. An increase in non-state and non-county revenue results in a corresponding decrease in state and county funds. The result is that all providers are not consistently applying revenue collection efforts. The specific deficiencies and the corresponding forfeiture of revenue follow:

Item	Estimated Loss Of State and County Funds
Federal monies were lost since counties had not developed formalized intake processes which work closely with the county welfare departments to ensure that eligible patients become Medi-Cal recipients.	$3 to $11 million
Patient fee forfeitures resulted from providers not sufficiently evaluating the ability to pay by all patients and responsible relatives, not keeping billings current, and not effectively pursuing bad debt accounts.	$1.6 to $3.6 million
Revenue from private insurance is not adequately pursued.	$1.6 to $4.1 million

Procedures have not been developed to enable Short-Doyle programs to bill the federally provided Medicare insurance program for doctor-related nonhospital services.	$1.3 million
There is insufficient incentive for groups or individuals to make gifts and contributions to community mental health programs because that program would not benefit directly. Further, this type of revenue designated "other" is not adequately pursued.	$2.8 million
Advance payments of federal funds were not requested in sufficient amounts due to poor coordination between the Short-Doyle accounting function and the benefit payments recovery function. As a result, interest income is lost by the state.	$2.3 million
Total loss of state and county funds	$12.6 to $25.1 million

We have made a series of recommendations to increase state and county revenue from these sources.

Based on our program review at the five counties, it was determined that approximately 44.5 percent of the expenditures for community mental health treatment are directed toward 24-hour care; however, only 3.4 percent of these expenditures was spent on alternatives to hospitalization, such as nonhospital 24-hour residential treatment centers. In our judgment, sufficient emphasis is not being placed on developing alternative nonhospitalization facilities at the county level. As a result, releasing state hospital patients into the community where adequate nonhospital services often are not available results in the placement of that patient in a local hospital. The net effect of this is the replacement of a $39 per day state hospital cost with a $125 per day local hospital cost.

We recommend that county Short-Doyle directors develop residential treatment centers as alternatives and as followup to state and local hospitalization.

Contrary to specific legislative intent, the Department of Health is not giving "special consideration" to the providing

of mental health services to children. We conclude that the lack of data on children's services results in the Department of Health and many counties being unable to determine the current level of children's services and more significantly being unable to plan for the mental health needs of children and adolescents.

County Short-Doyle programs do not provide sufficient residential treatment alternatives to local hospitalization for children, and therefore do not effectively utilize state funds since the daily cost of local hospitalization is over three times as much as the daily cost of residential treatment services.

We recommend that the Department of Health require as a condition to the receipt of Short-Doyle funds for hospital services that counties be required to arrange for the local or regional development of non-hospital alternatives such as residential treatment services for children.

Respectfully submitted,

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INTRODUCTION

In response to a legislative request, we have conducted a management review of the Department of Health's delivery of community mental health services under the Short-Doyle program.

The Community Mental Health Services Act became effective in 1969 (Division 5, commencing with Sec. 5000, W.& I. C.). The law is comprised of two acts, the Lanterman-Petris-Short Act and a revision of the Short-Doyle Act of 1957. The Short-Doyle Act was intended to provide mental health services in local communities. The Lanterman-Petris-Short Act was intended to end the inappropriate and involuntary commitment of the mentally disordered to the state hospitals. Both acts envisioned moving away from state hospitalization toward prevention and local community treatment. The 1974-75 total gross budget, including federal, state and county funds, was $311 million.

Our review focused on the following five areas: (1) the relationship and the lines of communication between the State Department of Health and county mental health programs, (2) the Department of Health's Cost Reporting/ Data Collection System, (3) revenue collection efforts by the counties, (4) use of inpatient services, and (5) the priority given children's services.

In addition to interviewing personnel and examining records in the Department of Health, we have also reviewed community mental health programs in Los Angeles, Orange, San Mateo, Sacramento and Butte Counties. The total gross budgets of the programs in these five counties for the fiscal year 1973-74 was an estimated $135 million.

We received excellent cooperation from the Department of Health, both in terms of access to personnel, and in our efforts to analyze the Department of Finance's Audit of Community Mental Health Services and the Department of Health's Response to the Audit. Also our staff was included in the meetings of the Governor's Task Force on Community Mental Health Funding which met from August to December 1974. We received excellent cooperation from the directors and staff of the five county programs we reviewed.

FINDINGS

COMMUNICATION BETWEEN THE DEPARTMENT OF HEALTH AND COUNTY MENTAL HEALTH PROGRAMS IS INADEQUATE FOR THE EFFECTIVE JOINT MANAGEMENT OF THE COMMUNITY MENTAL HEALTH SYSTEM.

Within the Short-Doyle Act, the county is designated as the local unit of government to provide mental health services. The county mental health agency must prepare an annual plan specifying services to be provided in county programs, state hospitals and private contract agencies. The county program is financed with 90 percent state funds and 10 percent county funds. The services include inpatient treatment, outpatient treatment, partial hospitalization, diagnostic services, rehabilitation services, emergency services, consultation and education services, precare and aftercare services, training and research and evaluation.

While local community mental health programs are each administered by a county mental health director, the overall responsibility for mental health services is assigned to the Department of Health. This responsibility includes setting the standards and regulations with which the community programs must comply to receive reimbursement, allocating funds, and improving the quality of service to the community. The Department of Health also provides state hospital services directly to the county.

There Is No Centralized Method Within The Department of Health to Record Recommendations Made to the Director of Health by the Conference Of Local Mental Health Directors, and To Document Subsequent Analysis and Implementation By the Department.

The Community Mental Health Services Act was intended to provide a comprehensive statewide single system of care that coordinates all mental health services delivered by local government, state hospitals and private agencies. The coordination requires a high degree of communication between state officials responsible for mental health services and county mental health directors if it is to be effective.

The Director of the Department of Health is required to consult with the California Conference of Local Mental Health Directors in establishing standards, rules and regulations under the Community Health Services Act. According to the department's handbook on the California Mental Health Services Act, the Conference was established to ensure that local needs and points of view are considered in state planning and policy making. It serves as a link between the local programs and the Department of Health. The Conference uses quarterly meetings at which recommendations, in the form of resolutions, are made to the director of the department, as its primary vehicle of communication. The Conference is staffed by an Executive Secretary who is a Department of Health employee.

In order to determine the effectiveness of communication between the Department of Health and the Conference, we examined 24 conference recommendations made to the director between July 1972 and June 1974. In most cases responses by the Department of Health were able to be documented, but only after extensive investigation which led well beyond the Office of the Executive Secretary of the

Conference. Some responses were able to be documented by the Executive Secretary of the Conference, but other responses were traced to eight other units within the Department of Health; these other units were: the Local Programs Services Section, Mentally Ill Hospital Services Section, the Substance Abuse Program, the Office of Evaluation Procedures, the Budget Section, Fiscal Analysis and Accounting Systems Section, Patient Benefits and Accounts Section, and the Manpower Development and Training Section.

Our investigation revealed that there was no central file in which could be found both the Conference recommendations made specifically to the Director of Health and his responses to them. The minutes of the Conference are kept in the Office of the Executive Secretary, and both the Executive Secretary and the Chief of the Local Programs Services Section are familiar with many of the recommendations. It is the opinion of both, however, that the fragmentation of information concerning the recommendations is due to the reorganization of the department, in which responsibilities formerly under the Department of Mental Hygiene were divided among various offices within the Health Administrative and Health Treatment Systems.

Furthermore, in coordinating the ten June 1974 Conference recommendations, the Executive Secretary attempted to funnel them to the appropriate offices and sections for analysis and suggested responses, to be returned to him for forwarding to the director by August 21. As of January 3, 1975, the analysis and suggested responses to four of the ten recommendations had not been returned. He attributed this again to the organizational structure of the department and to the fact that he had no authority over the various units that deal with the subject matter of the recommendations.

CONCLUSION

The overall result of the lack of a centralized recording method is two-fold: First, there is no feasible way for the Conference to determine their effectiveness and impact on the Department of Health. The purpose of the Conference, to ensure that local points of view are given full consideration in state level decision making, is therefore substantially negated. Second, because there is no centralized record, the Department of Health is unable to systematically evaluate its own performance in responding to recommendations for change and improvement in the mental health delivery system. In short, neither the state nor the county programs are equipped with an adequate structured channel of communication.

The Community Program Analysts on the Staff Of the Local Program Services Section Lack The Strong Combination of Program and Fiscal Experience that is Required to Perform Their Duties Effectively.

Our interviews with state and local officials indicate that both the Department of Health and the county mental health programs perceive the role of the community program analyst as a channel to facilitate communication between the state and the county, equally important as the Conference of Local Mental Health Directors. Such a role would call for a thorough grasp of the program and clinical aspects as well as the fiscal and administrative complexities of the mental health delivery system.

The State Personnel Board job specification requires the community program analyst, who is assigned to the Local Programs Services Section of the Department of Health, to be responsible for local mental health program planning development, and evaluation, as well as budget review. The community program analyst is required to work closely with the local mental health program serving both an an interpreter of state policies and requirements as well as an advocate of local program needs. The job specification calls for experience in mental health planning, budget analysis, personnel management or administrative analysis.

We examined the academic training and job experience of 21 of the community program analysts on the staff of the Local Programs Services Section. It was not our intent to judge the competence of the community program analysts, but rather to point out the specific academic training and job experience that they have brought to the community program analyst position. Of the 21 individuals examined, five had a strong fiscal background but no program background; 12 had a strong program or clinical background but no fiscal background. One had neither program nor fiscal background. Only three community program analysts had backgrounds, which included both fiscal and program experience.

CONCLUSION

Community program analysts are called upon to analyze and interpret multi-million dollar programs with diverse funding sources and a complex budgeting and reimbursement process. While individual community program analysts may have developed competence in areas in which they had no prior experience, the single system of mental health care is

considerably weakened if these state-county liaison officials do not bring to their jobs a strong combination of fiscal and program experience.

RECOMMENDATIONS

We recommend that the Department of Health's Executive Secretary of the Conference of Local Mental Health Directors should be authorized and required to develop and maintain a record of recommendations of the Conference and of the Department of Health's responses. He should be given the administrative authority to require from any section within the department, analyses and suggested responses to Conference recommendations.

The Department of Health, in conjunction with the State Personnel Board, should ensure that candidates for the community program analyst position have both fiscal and program or clinical experience as required by the position description.

BENEFITS

Implementation of these recommendations will improve the channels of communication between state and local levels of government, thus improving the efficiency of the community mental health programs. Furthermore, implementation of these recommendations is the first of many necessary steps the Department of Health must take if it is to improve its management of this program.

THE DEPARTMENT OF HEALTH COST REPORTING/ DATA COLLECTION SYSTEM (CR/DC) IS AN INEFFECTIVE MANAGEMENT TOOL.

The CR/DC system consists of a computer data bank of information containing data collected from county reports. The system uses this data to produce a series of management reports. The system also edits the budget, claims, and cost report data to assure proper coding and arithmetical accuracy. It was designed to meet the functions of data collecting, revenue, and reimbursement processing, and management information reporting for the Community Mental Health Delivery System. The major objectives of the system according to the Department of Health's Community Services Systems Manual are to:

- Supply fiscal and patient related information
- Permit analysis and comparison of facilities within a common frame of reference
- Provide both counties and the state with data required for effective budgetary control
- Be flexible and adaptable so that it can apply to all providers.

The CR/DC System Does Not Provide Timely, Accurate, or Meaningful Comparative Data For Effective Planning, Management, And Evaluation at the State and County Levels; The Result is a Lack of Cost Consciousness And a Lack of Accountability Throughout The Community Mental Health Program.

To meet the requirements of the community mental health services law and answer state and county management information needs, a series of

51 different CR/DC management reports are generated. These reports, which are issued at various intervals ranging from weekly to annually, fall into the following four categories:

Category	Number of Reports
Budget	13
Claims	12
Budget-Claims Comparison	9
Year-End Comparative and Funding	17
Total	51

Our interviews with local mental health staff in the five counties we visited disclosed that these reports were not used at the local level for planning, control, or any other aspect of management decision-making.

Furthermore, interviews at the Department of Health disclosed that only six to ten reports were requested or used frequently at the state level. A study is currently being conducted by the department's Fiscal Analysis and Accounting Systems Section to review this demonstrated lack of usage.

In the community mental health system some services are provided by the county mental health program and some services are provided by private contractor agencies. Thus, there are county "providers" and private "providers". The major problem identified in the system is that there is a lack of standardization as to what each provider reports as a unit of service. For example,

some providers report a unit of service for outpatient treatment as any patient contact, another reports each 15 minutes as a unit, while another reports an hour contact. The outpatient care definition in the Department of Health's Community Services Systems Manual makes no reference to the length of the contact.

Without standardizing units of service by length of contact, diversity of the professional level of staff administering treatment, and type of treatment (group, individual -- therapy, consultation, etc.), clear delineation of local programs is not possible. A community services system bulletin, dated June 1, 1974, provided optional outpatient care service category codes that would permit individual counties at their option to record more detailed information regarding specific treatment methods. None of the five sample counties were using these empty cost center codes that had been made available. If they were being used, however, the flexibility given the counties in labeling codes would create yet another example of lack of standardization that would preclude the usefulness of the data at the state level. Meaningful analysis and comparison of facilities within a consumer frame of reference, requires an instrument that is able to collect standardized data. CR/DC is not such an instrument.

The claim report of one county we audited showed 17,301 units of 24-hour care at an average cost of $16.22 per unit; however, an individual patient in this system was counted in at least four cost centers for each single day, and could be counted in as many as four others. Since each cost center is counted as a separate unit of 24-hour care, duplication of service units are reported in the CR/DC system. Actual 24-hour days of unique patient

care in this county was 4,394 units at an average cost of $60.98. An actual count of the number of individuals served cannot be determined by CR/DC reports -- only by an audit at the county level. This duplication of counts and lack of standardization prevents evaluation of effectiveness and efficiency and prevents an understanding of a county's delivery system. The result is a complete lack of accountability at both the county and the state level.

The problem of lack of standardized units of service was identified in the December 20, 1972 Department of Finance audit, and acknowledged in the Department of Health response of January 29, 1973. In a follow-up review by the Department of Finance in March 1974, it was noted that the recommendation to standardize units was 50 percent complete; it was scheduled for full completion by January 1974.

Although new definitions of units of services were made, they were not refined into discrete segments, nor do they provide for the unduplicated counts that are necessary for meaningful management information to be generated by the CR/DC system.

The lack of comparable data prevents the Department of Health from determining what services it is purchasing or measuring the cost effectiveness of similar services. As a result, the Department of Health's systems for allocations and reimbursements are based on the counties' and providers' costs of services. For example, a provider with a higher paid staff, higher overhead, and inefficient operation is paid more than a less costly, more efficient

provider performing the same treatment. To illustrate, in one county an outpatient treatment of service for methadone maintenance cost $5.69, but in another county the same service was $12.73. The major difference for this variation was in the allocation of overhead and administrative costs, not "treatment" costs. The result, however, was that the county with the higher cost was receiving almost two and a half times the state support per unit as the other county for providing essentially the same service. Similar cost variations were found in all treatment areas, especially 24-hour hospitalization where costs ranged from $100 per day to over $200 per day.

The system used for reimbursements and allocations obviously does not instill cost-consciousness. Claims for reimbursement are based on the number of units of service provided, applied to a provisional rate for billing. The provisional rate is based on an estimated number of units of service divided into the approved gross program for the particular treatment mode. This is not an adequate cost factor to use in determining cost-effectiveness. Reimbursement adjustments are made after actual cost of services are identified in the year-end cost report which is prepared three to six months after year-end close. During the year, some providers were being reimbursed at a higher rate than actual cost, while other providers were receiving less than their costs. Wide variations were found in actual cost as compared to the provisional rate and also between budgeted and actual units of service.

For example, one county provided 24.4 percent of their budgeted units of inpatient services but spent 73.7 percent of the budget. This is not to indicate counties are providing one-fourth the units of inpatient service

at three times the cost, but to point out that the state does not know how much service it is buying nor at what cost.

CR/DC does not provide suitable cost-effectiveness data from which to make an intelligent and equitable distribution of the allocation. As a result, the Department of Health has been forced to make ongoing allocations based only on prior expenditures and projected cost-of-living increases.

Within the five sample counties, we found that gross expenditures per capita ranged from $20.47 to $6.03. We realize there is a direct relationship between the age of a county program and a local demand for services and that a newer program may have a smaller per capita expenditure for the county as a whole than a more established program. Allocations based on determination of cost-effectiveness which is currently beyond the capacity of CR/DC, tempered with an understanding of the growth demand, would be necessary to introduce equitable funding.

Management control is further hampered because the first claims are not submitted until halfway through the fiscal year, many counties are late on claims submissions, supplemental claims are common and true costs of services are not identified until after year-end. Control cannot be based on management information in the CR/DC system because the information is not timely or accurate enough to be used at the state or county level.

The date of the first CR/DC run of fiscal year 1973-74 management reports was not made until January 25, 1974 and the last run was September 30, 1974; however, many counties still did not have all their claim reports

submitted; in fact, their budgets for fiscal year 1971-72 and 1972-73 were still not closed as of January 24, 1974. The allocation data (approved budget amounts) on these reports reflected the original allocations and did not reflect changes resulting from the budget revisions, roll-over funds (unexpended funds allowed to carry over to the next year), or one-time money provided counties, unless the Community Program Analyst initiated the change. These charges were not initiated in most cases and the reports reflected inaccurate allocations; thus, comparisons on the reports are invalid.

It should be noted that the Department of Health, as mandated by Sections 5656 through 5661 of the Welfare and Institutions Code, has developed a cost effectiveness study instrument. The major objective of this study was to formulate, develop and test a method of evaluation which would enable the Department of Health to compare the relative cost effectiveness of similar mental health services provided in different counties. Five sample counties were used in the study, and the final instrument is to be applied to all the Short-Doyle programs.

We question whether the Department of Health instrument can really determine cost effectiveness, and whether, in its present form, its application should be mandated to the counties. Interviews with staff in the five sample counties who were familiar with the study indicate a number of concerns: (1) the high cost of statewide implementation and the time and manpower burden placed upon the counties, (2) the usefulness of the global impairment scale (an index of overall sickness used extensively in the report) as an objective and meaningful measurement of a patient's progress in treatment, and (3) the

lack of adequate followup to determine if a patient maintained the progress he made during treatment. One county director felt that in spite of the wealth of data generated in the report, comparative cost effectiveness was largely ignored.

CONCLUSION

The CR/DC reports are not timely, accurate, or meaningful. The system is not responsive to top management information needs and is not a useful tool at county or state levels. The result is a lack of accountability at both levels, inequitable allocations, and reimbursement delays.

The Department of Health's Budgeting And Allocation Process Further Limits The Capacity of the CR/DC System as an Effective Management Tool.

Three major problems created by the complexity of the budgeting, allocating, and reimbursement claiming processes are as follows:

- The state's budget is finalized too late to be utilized in the development of county budgets. This requires revisions and approvals at the county level by the board of supervisors well after the start of the fiscal year.

- Claim processing is delayed at both the state and local levels and counties are experiencing cash flow problems because reimbursement for services usually takes from three to nine months.

- The delay by the Department of Health in approving final budgets until as late as September prevents counties from gearing-up new programs at the start of the budget cycle, thus generating fund surpluses.

The budget is the primary fiscal document of the county Short-Doyle Plan and is a legislative requirement for state funding participation in the delivery of community mental health services.

The budget process for a county begins in January with a preliminary budget allocation from the state. The county then reviews the allocation and develops a budget in the county plan for the next fiscal year. After it is approved by the county board of supervisors, it is sent to the State Department of Health. The county plan is due to the state by March 15 for review and preparation of the final budget allocations to be issued in July. This "final" allocation often results in a revision of the county's budget to conform to the state's final funding allocation which again requires approval by the county board of supervisors. There actually may be several revisions, each requiring approval. The county's amended budget is due by September 1. The process is completed when the Department of Health approves the final revision. These final revisions may not be approved until the end of the fiscal year for which the funds were appropriated or even after year-end close.

The budget objectives are to:

- Provide for management control
- Establish state and county liabilities
- Provide a basis for reimbursement.

The most significant problems created by the budgeting process occur because of the timing between the June allocation, revision of the county budget and resubmission by September 1 for final approval. For example, the concurrence of the state and county budget cycle means that the June allocation from the state is received too late to be utilized in the county budget request presented to the board of supervisors.

The delay caused by a county not receiving an approved budget and allocation until after September 1 creates significant problems.

County claims for reimbursement cannot be submitted until after September; however, the five counties we visited submitted their claims even later than that. The earliest first claim that was submitted was November and the latest was in January. This results in cash flow problems for the counties and especially the private providers, although some counties were given advances. Once a claim has been submitted, the state will take from five weeks to five months to reimburse the county for those services. Some counties pay a provider when the claim is submitted, but many providers do not get paid for services on Medi-Cal patients until after the state approves the county claim. This delay has been as much as six to ten months after delivering treatment.

The California Medical Assistance Program (Medi-Cal) was designed to provide medical care for public assistance recipients and medically needy individuals. Approximately 80 percent of the services rendered to patients eligible for Medi-Cal are shared by the state and federal governments on a 50-50 basis. The other 20 percent classified non-federal Medi-Cal is currently 100 percent state funded. However, a portion of the state's funds in fiscal year 1973-74 were paid from county funds.

Besides causing a cash flow problem, delays in receiving Medi-Cal reimbursement could cause a provider to prematurely reach his maximum expenditures by year-end. Because Medi-Cal revenue is not reported by a provider until reimbursement is received, the county is for forced to reimburse provider with straight Short-Doyle funds (90 percent state, 10 percent county) rather than make use of federal funds (50 percent federal, 50 percent state) for Medi-Cal. Thus, there is a 90 percent state contribution to a service that should only require a 50 percent state contribution. To illustrate the reason this occurs, in one sample county, the time lag in receiving state approval for Medi-Cal caused providers to report only eight to nine months of Medi-Cal reimbursements as revenue in fiscal year 1973-74. This result for some providers was deficit spending for that year, but the same providers will probably have a surplus in fiscal year 1974-75 because of receiving 14 to 16 months of Medi-Cal revenue. The county simply had to pay out more state funds than necessary, because some of the Medi-Cal revenue generated by services performed in fiscal year 1973-74 would be reimbursed or counted as revenue when received in the next fiscal year.

Another problem of delaying claim reporting is that no data enters the CR/DC system until the year is nearly half over. Even then, the problem is compounded because many counties are late in submitting claims. For example, the July 26, 1974 CR/DC management report run was for the month of April 1974, but as of that date, 25 of the 59 Short-Doyle programs had claims outstanding; some were behind by as many as four monthly reports. Over 200 supplemental claims were submitted during the year which resulted in changes in reported data already in the system. One county submitted 25 supplemental

claims. The Department of Health received between five and 24 supplemental claims each month. The reliability of data in the reports is therefore affected by requirements for supplemental claims and by claim delays.

Many claims are inaccurate when submitted and must be returned to the county for resubmission, while others can be corrected at the state level. These problems create an incomplete picture of a county's program. Reasons for the state returning the claims to the county often are because of discrepancies in the biostatistics (client information) rather than the claim information; therefore, reimbursement to the counties can be delayed because of errors in the management data portion rather than claim data.

Not only does the delay of receiving the allocation after September 1 create claiming and reimbursement problems but it also prevents the counties from entering into contracts with existing providers and makes gearing-up of new programs very difficult. If an annual allocation is made for these new programs, there is insufficient lead time for organizing, staffing, and starting new programs. As a result, fund surpluses are generated. The State Department of Finance audit report of December 20, 1972 recommended that allocations of new programs begin on January 1 to allow for ample lead time. The Department of Health response stated that new or expanded programs will be funded for the first year for a more realistic period; however, the December 30, 1974 Report of the department's own Task Force on Community Mental Health Funding shows the problem still remains unresolved, some two years after it was first reported.

Another problem identified in the claiming process related to the state's use of four separate allocations for county funds (Short-Doyle, State Drug, Federal Drug Abuse, Alcoholism) although the Short-Doyle law requires a single appropriation. This creates a complicated accounting and claiming process for the counties and especially for the small providers. During fiscal year 1973-74, the counties and providers had to prepare separate claims to show the amount charged to each of the three fund sources for alcohol programs; however, in fiscal year 1974-75, alcohol has been condensed into a single allocation which requires a single claim. Drug abuse funds are still divided into two different allocations. As a result, each drug group must report two separate claims each month, separate statistics, and prorate units of service and revenue just to identify services for separate appropriations. We question the real value of this additional workload.

CONCLUSION

Delays by the Department of Health both in making allocation to the counties and finally approving their budgets, create significant problems for the counties in the planning and management of local programs. Allocations are not received in time to be utilized in the county budget process, cash flow problems are created and surpluses are generated. Claim processing is delayed at both the local and state levels.

RECOMMENDATIONS

We recommend that the following actions be taken by the Department of Health:

- Standardized unit of service definitions should be subdivided into discrete segments and redefined to identify diversity of the professional level of staff administering treatment, length of contact, and type of treatment (group, individual -- therapy, consultation, etc.).

- Request the legislative authority that would permit them to determine a reasonable and fair cost schedule for services. Reimbursements to counties and providers should then be based on those rates and not on provisional rates.

- Allocations should be based on a determination of cost-effectiveness for existing programs, but priority for new or expanded programs should be given to those counties where per capita expenditures are lower especially where there is a demonstrated need to develop a greater depth of basic services.

- A system should be developed to ensure that changes in allocations, roll-over funds, one-time money, etc., are reflected in the CR/DC reports as the changes occur.

- A new allocation procedure should be implemented to enable the counties to utilize the Department of Health's budget in the development of their local budgets and enable the budgeting process time to be shortened. The recommended procedure is as follows:

a. In January, the Department of Health would provide the counties with an allocation that generally would be based on a "continuing level" budget.

b. By March 15 the counties would return a two-part plan to the state. Part one would be based on a continuation of ongoing programs. Part two would list by priorities a budget for starting new programs or expanding existing programs.

c. Between March and June, the counties seek board of supervisor approval for both parts of their spending plan.

d. Between July 1 and July 20, the Department of Health allocates the excesses, if any, over the continuation allocation to counties based on the priorities of each county and availability of actual funds appropriated. Counties would have their budgets approved in July.

- During the first few months of a fiscal year before the county claims begin being submitted, the state should make advances to the counties based on a special claim or a fixed percentage of the current year's allocations. Adjustments should be made when the reimbursement claims are submitted.

- The Department of Health, in conjunction with the Conference of Local Mental Health Directors, should determine the minimum biostatistical data required for management information and program evaluation. This data should be reported quarterly separate from the claims process.

- Local Short-Doyle programs should develop their own management information system not only to readily provide the required state level of biostatistical data, but also to provide more detailed data for their own planning, decision-making and evaluation.

- The state should make a single allocation to the county for drug abuse funds and not require two separate claims each month for each drug group.

BENEFITS

Implementation of these recommendations will:

- Provide timely and accurate comparative data which will substantially improve the Department of Health's capability for effective planning, management and evaluation of the community mental health program

- Introduce a new awareness of cost consciousness and accountability throughout the community mental health system

- Alleviate serious cash flow problems at the county level.

NEITHER THE DEPARTMENT OF HEALTH, THE COUNTIES NOR PROVIDERS ARE TAKING THE STEPS WITHIN THEIR CAPACITY TO UTILIZE NON-STATE AND NON-COUNTY FUNDING SOURCES. AS A RESULT, THE STATE AND COUNTIES LOSE ESTIMATED FUNDS BETWEEN $12.6 MILLION AND $25.1 MILLION ANNUALLY.

It is the counties' responsibility to ensure that all providers consistently apply revenue collection efforts and ensure all sources of non-state and non-county funds are utilized. The basic revenue sources are grants, Medi-Cal, patient fees, patient insurance, Medicare, and "other" which includes gifts, donations and income earnings. Within the five counties we reviewed, we found that many providers were not effectively collecting revenue, but other providers were successful. Our study was directed to identifying why some county providers and private providers were generating more revenue proportionately than others.

The upper range of our estimated revenue and savings was based on Orange County averages. Not only was Orange County most effective of the five sample counties in revenue collection efforts, but it had adopted formalized procedures that enabled us to determine the reasons for the more effective performance. It should be noted that excluding grants, there were 16 other counties in the state that collected proportionately more revenue than Orange County in fiscal year 1973-74.

The lower range of our estimates of forfeited revenue is based on raising collection efforts to the statewide average. In our judgment, this method produces a very conservative estimate of the total revenue lost because of various existing barriers to efficient collection procedures which are discussed below.

The Funding Relationship Between The State Department of Health and Local Community Mental Health Programs Actually Discourages Counties from Utilizing Alternate Funding Sources.

The county's and the provider's allocations are based on an approved gross program budget and an approved net program budget. The net program is based on a gross allocation less estimated savings and revenue. Neither county provider nor private provider is reimbursed for expenditures over the total of the gross program budget (without state approval and reallocation), but will be funded up to that amount or actual costs, whichever is less. One problem of this system is that a provider which does a poor job of collecting revenue would simply receive a proportionately larger percentage of Short-Doyle funds than would be received if more revenue had been collected. Because an increase in revenue results in a corresponding reduction in state and county funds, there is no incentive for applying resources to revenue collection since a provider receives the same amount from the program regardless of fund sources. Thus, a county to increase alternate sources of revenue must divert funds allocated for treatment to the administrative function of revenue collection. This diversion, though beneficial to the state, actually reduces the level of funds available for services.

Regular Short-Doyle patient costs, as distinguished from Medi-Cal patient costs, are shared by the state and counties on a 90 percent to 10 percent basis (no federal participation). The only incentive a county has for revenue collection is a 10 percent savings on each revenue dollar collected. This savings is the only direct benefit of emphasizing revenue collection.

Within the five sample counties, state Short-Doyle funds accounted for 70.5 percent to 83.4 percent of the total adjusted gross costs of providing mental health services for fiscal year 1973-74. The percentage of adjusted gross costs that were offset by different revenue sources are as follows:

Percent of Adjusted Gross Cost Provided
By Non-State and Non-County Funds
(Does Not Include State Hospitalization)

Revenue Sources	Orange	Sacramento	San Mateo	Butte	Los Angeles*
Grants**	0 %	9.4%	10.9%	0 %	4.3%
Patient fees	3.8	1.5	2.3	2.0	1.3
Patient insurance	4.6	2.6	1.8	1.6	1.4
Medicare	.6	.1	.6	.7	.2
Medi-Cal**	18.8	7.6	8.1	4.7	8.9
Other	1.7	2.6	2.0	11.1	.5
Total	29.5%	23.8%	25.7%	20.1%	16.6%

*Estimated (year-end cost report not finalized)

**Federal funds only

Effective Procedures Have Not Been Developed to Ensure That Eligible Patients Become Medi-Cal Recipients. As a Result, the State Has Forfeited Annually Between $3 Million And $11 Million in Federal Funds.

Costs of services rendered to patients eligible for the California Medical Assistance Program (Medi-Cal) are shared by the state and federal governments on a 50-50 basis (a portion of the state share is paid from county funds). This program, implemented in 1966 and modified in 1971 by the Medi-Cal Reform Act, provides the largest single source of revenue to the community mental health delivery system. The program was designed to provide medical care for public assistance recipients and medically needy individuals.

Where formalized intake processes included determination of potential Medi-Cal recipients, the best systems appeared to be those where the county welfare department works closely with the community mental health program. Some hospitals and providers have welfare eligibility workers assigned to identify and process Medi-Cal patients. In one county the eligibility workers also perform the UMDAP (uniform method of determining ability to pay) reviews for the county. In another, the community mental health intake clerk would actually take a Medi-Cal application and forward it to the county welfare department. The result of these systems is a high ratio of Medi-Cal revenue to the adjusted gross cost of services. Counties and providers without a formalized intake process did not have a proportionately high percentage of Medi-Cal revenue.

The 59 county Short-Doyle programs on an average collected 20.8 percent of their gross expenditures from Medi-Cal revenue in fiscal year 1973-74. Had the 28 programs that were below average been able to increase their revenue to the statewide average, an additional $7.8 million in services would have been charged against the Medi-Cal program which is in part financed with federal funds. This method of charging for services would have earned approximately $3.3 million in federal funds and reduced state and county expenditures by an equal amount.

The savings would be more significant if counties had collected revenue proportionate to Orange County collection efforts. Orange County recovered 30.4 percent of their expenditures from Medi-Cal revenue. If the 53 counties below this level had equalled Orange County's performance, over $24 million more Medi-Cal revenue would have been identified, generating

a savings to the state of over $11.3 million.* These results could be achieved if the local programs would develop formalized intake procedures closely coordinated with county welfare departments.

Some types of nonhospital medically related treatment services are not eligible for Medi-Cal reimbursement. However, those same services, if provided in a hospital setting, would be reimbursable. One county divided their residential treatment 24-hour care program into different categories of treatment so that they could bill Medi-Cal for at least a portion (medical-professional) of the 24-hour care cost. Other counties could do the same. One county was operating under the misconception that if a patient had private insurance, that person was not eligible for Medi-Cal; therefore, Medi-Cal revenue was lost.

Before a provider can claim Medi-Cal funds, the patient's eligibility must be established for each separate month of treatment. This proof is provided by a "proof of eligibility" (POE) sticker on the patient's Medi-Cal card. Without the sticker or a copy, no claim can be submitted for that patient. Increases in revenue should result because of a change in 1974 derived from the Department of Health's effort with the Department of Benefit Payments to allow the county providers to obtain POE labels directly from the county welfare department if a patient failed to deliver the label during any month. Noncounty providers are still not allowed this procedure.

*These savings would be slightly less than 50 percent of the total revenue amount because there are a relatively small number of Medi-Cal recipients who do not meet the federal standards of eligibility and whose care is therefore not subject to federal reimbursement.

The Uniform Method of Determining Ability To Pay (UMDAP) System is Not Conducive To Effective Revenue Collection of Patient Fees and It is Not a Suitable Tool For Evaluating Liability for Short-Term Treatment Services Which Are Most Common Under Short-Doyle. As a Result, Between $1.6 Million and $3.6 Million In Revenue is Forfeited Annually.

Section 5717 of the Welfare and Institutions Code states, "fees shall be charged in accordance with the ability to pay for mental health services rendered but not in excess of actual cost." The Director of the Department of Health has adopted the "Uniform Method for Determining Ability to Pay" (UMDAP) to establish patient fee liability. This method was designed to identify the ability of patients, their estates, or responsible relatives to pay for services received under the Short-Doyle program other than in a state hospital. The amount charged is based on family size, income, assets and allowable deductions, exclusive of third-party liable sources. After evaluation, if a patient is determined to have a personal liability, a maximum annual charge payable in equal monthly installments is established.

The 59 county Short-Doyle programs on the average collected 2.6 percent of their gross expenditures from patient fees. If the 22 counties below the level had met the average, $1.6 million in increased revenue would have been collected. If the 43 counties below Orange County's performance of 3.8 percent had equalled that level, an excess of $3.6 million would have been generated.

The billing procedures varied for revenue collection. Some providers were months behind in billing while others were current. Policies for billing potential bad debt accounts varied from stopping billing after the second billing produced no response to billing indefinitely. Followup collection efforts for some providers ranged from nonexistent to turning the account over to collection agencies. Some providers and counties would not pursue problem accounts because of confidentiality. All counties examined were losing patient fee revenue because of collection deficiencies in their systems as well as insufficient evaluation of the ability of patients and responsible relatives to pay their fees.

Revenue From Private Insurance is Not Adequately Pursued. As a Result, Between $1.6 Million and $4.1 Million in Revenue Was Forfeited During Fiscal Year 1973-74.

Of all the 59 local Short-Doyle programs, 30 were below the state average in collecting patient insurance revenue, and 39 were below the percentage collected by Orange County. Had counties been able to collect up to the average, the additional revenue would have been $1.6 million. Had counties been able to equal Orange County's performance, $4.1 million in additional revenue would have been generated.

Orange County is using a standardized insurance claim form which can be completed at the treatment facility rather than depending on the patient to bring in a claim form from his insurance company. As a result of this method, insurance revenue increased from 3.4 percent of adjusted gross costs in fiscal year 1972-73 to 4.6 percent in fiscal year 1973-74. All counties should be made aware of this form. This could be especially important in small counties where the only mental health facilities and services are

county provided and where patients with insurance use county facilities rather than private providers.

Some of the reasons that counties are not collecting revenue from private insurance sources are as follows:

- Providers do not know which insurance companies reimburse for mental health treatment nor for which kinds of treatment.
- Most providers rely on the patient to return copies of their own insurance company's claim form -- many were never returned.
- Some insurance companies will not reimburse for services not provided in a "hospital" setting.

A list of insurance companies that will reimburse for mental health treatment services is being compiled by Orange County. This list, when completed, should be disseminated by the Department of Health to all counties.

Revenue from Medicare is Not Adequately Pursued. As a Result, $1.3 Million In Revenue was Forfeited During Fiscal Year 1973-74.

The Medicare insurance program (federally funded) reimburses for 24-hour services in a "hospital" setting for people receiving social security benefits, but in most counties Medicare will not pay for "nonhospital" treatment such as residential care centers, regardless of whether the services were "doctor" related. After considerable effort, at least two counties have

been issued an RVS (relative value study) code number to bill nonhospital services if doctor-related. The result is increased Medicare revenues.

If the 34 counties below the state average of collecting Medicare revenue (1.4 percent of adjusted gross expenditures) met that average, an additional $1.3 million would have been collected. If procedures can be developed to enable counties to obtain RVS codes to bill Medicare for "nonhospital" services, the savings to the state would be more significant.

There is Insufficient Incentive for Groups Or Individuals to Make Gifts and Contributions. Further, This Type of Revenue Designated "Other" Is Not Adequately Pursued. As a Result, An Estimated $2.8 Million is Forfeited Annually.

Revenue generated by gifts, donations and "other" sources are treated the same as patient fees, insurance, etc., in that the amount collected results in a corresponding reduction in the state's support to the program. The impact is that gifts and donations benefit the state -- not the provider; therefore, there is insufficient incentive for individuals or groups to make such contributions.

Some counties have developed "other" revenue sources by developing income-producing services in workshops. For example, San Mateo has a provider that cleans and repairs airline passenger headsets. Similar income-producing workshops and rehabilitative programs could be pursued with the proper incentive in other Short-Doyle programs.

The state average for collecting revenue from the source designated as "other" (gifts, donations, earnings) was 5.6 percent of the adjusted gross

costs. Had the 33 counties below the state average collected up to that average, an additional $2.8 million in revenue would have been generated.

The State Lost $2.3 Million in Short-Term Interest Income as a Result of Poor Coordination Between The Short-Doyle Accounting Function and Benefit Payments Recovery Function.

The Health Care Deposit Fund (HCDF) was established for making expenditures for health care and administration upon order of the Controller in accordance with certification made by the director. Short-Doyle funds for Medi-Cal recipients are a part of the total cost for health services, and their expenditures are made by the HCDF.

Once each quarter, the state sends an estimate of federal fund expenditures to receive advance payment for the federal share. The Controller transfers money as needed into the HCDF. The Department of Benefit Payments is responsible for the actual management of the fund. Advance payments of federal funds were not requested in sufficient amounts to avoid using state funds to finance expenditures eligible under Medi-Cal.

During fiscal year 1973-74, state funds were being used in place of federal and county funds because of slowness in collecting funds from the federal government. The federal share is based on claims reported in prior quarters and an estimation of the next quarter. Two problems were identified:

1. Many counties are not reporting claims monthly as requested through the CR/DC system; therefore, estimations for Medi-Cal were low. Although the federal reimbursement systems make adjustments semiannually, the state must substitute federal funds with state monies until the adjustments are made. At the end of June 1974, the amount due the state for the federal

share was in excess of $22.5 million. The adjustment process takes six months to recover this amount.

2. A second problem identified was that only one transfer request was made for Short-Doyle Medi-Cal in fiscal year 1973-74. This was made in late June 1974. Until this time, state funds had been used while federal funds should have been used. The federal portion in this billing was actually for three fiscal year periods:

Fiscal Year	
1971-72	$ 290,507.37
1972-73	5,295,374.92
1973-74	16,190,671.00
Total due	$21,776,553.29

As a result of poor coordination between the Short-Doyle accounting function and Benefit Payments' recovery function, the state lost $2,324,000 of interest income in 1973-74 that could have been generated by investment of the $21,776,553 by the Pooled Money Investment Board.

CONCLUSION

In our study we found some counties and providers more effective than others in generating non-state funds. The counties however are not ensuring that all providers are consistently applying revenue collection efforts. The Department of Health has not taken all the steps

necessary to aid the counties in fully utilizing non-state funding sources. They should support the counties by disseminating information statewide regarding revenue collection procedures that have proven effective in individual counties. The Department of Health has not developed the regulations necessary to ensure that the counties effectively pursue the collection of third-party revenue. Furthermore, existing regulations provide no incentive for counties to expend sufficient resources for increasing revenue determination and collection efforts. The result of neither the Department of Health nor the counties taking all the steps within their capacity to fully utilize non-Short-Doyle funding sources in fiscal year 1973-74 was a forfeiture of between $12 million and $25 million.

RECOMMENDATIONS

We recommend the following actions:

- As an incentive to generate larger proportions of non-state and non-county fund revenue, allow the counties and providers to implement service expansion by retaining a portion of excess revenue generated beyond some determined standard or estimate. Improved performance should be encouraged through financial incentives or penalties.

- Counties should develop an intake procedure which assures determination of Medi-Cal eligibility, certification of noneligibility, and determination of patient and responsible

relatives fee liability under UMDAP. Where practical, welfare eligibility workers should augment the county Short-Doyle program.

- Where practical, counties should insure that Medi-Cal eligible patients are treated in facilities eligible for reimbursement under Medi-Cal, and the county director should be required to explain why it is not feasible to treat Medi-Cal eligible patients (inpatient) in a facility approved for reimbursement in that program.

- The State Department of Health needs to develop a process for determining and disseminating information about systems and procedures that counties have developed internally that might be beneficial to other counties not aware of them.

- The Department of Health should identify which insurance companies cover mental health treatment and provide counties with a sample of a standard insurance form being used for billing insurance companies.

- The Department of Health should work with the counties to aid in obtaining RVS (relative value study) codes to bill for Medicare and attempt to make doctor-related services eligible regardless of whether hospital related.

- The Department of Health's accounting function should request sufficient fund transfers in advance from the Health Care Deposit Fund for Short-Doyle Medi-Cal in

order to prevent the use of general funds in place of federal funds.

- The county directors should ensure that collection efforts for all revenue sources are consistently applied among all providers.

SAVINGS

Implementation of these recommendations are estimated to increase state and county revenues by at least $10.6 million and as much as $23.1 million annually, and furthermore provide for an increase in local programs by approximately $2 million annually without a corresponding increase in federal, state or county costs.

LOCAL SHORT-DOYLE PROGRAMS DEPEND HEAVILY ON STATE AND LOCAL HOSPITALIZATION RATHER THAN DEVELOPING AND USING ALTERNATIVE SOURCES FOR INPATIENT SERVICES.

Inpatient services for community mental health services are provided in the following facilities: general hospitals, psychiatric hospitals, residential treatment centers (24-hour nonhospital treatment settings), board and care homes, half-way houses, and state hospitals. Within the state hospitals, only community mental health placements [Lanterman-Petris-Short (LPS) billables] are included in this study. This excludes judicial commitments and the mentally retarded patients in the state hospitals. For example, Los Angeles County spent $71,425,900 for state hospital services in fiscal year 1973-74; of that approximately 40 percent or $29,229,781 was for LPS billables.

Within the five sample counties, 91.7 percent of the inpatient units of service were provided in local and state hospitals. The gross costs of these units, $59,550,474, represents approximately 44.5 percent of the five counties' total gross expenditures. Only 3.4 percent of the gross expenditures of the five counties was a result of nonhospital facilities for inpatient services. Only Butte Coutty had developed a residential treatment delivery system for 24-hour care treatment and the result was an average cost per day per patient of less than half the cost that the other four sample counties averaged for general hospitalization.

State Hospitalization is the Predominant Method Used for Treating Patients Requiring 24-Hour Care.

Although the usage of state hospitalization has decreased approximately 50 percent statewide since fiscal year 1970-71, it still represents 75 percent of the total inpatient units of service within the five counties. The percentages of total inpatient days for each type facility and the average daily cost for these counties' inpatient services in fiscal year 1973-74 were as follows:

	Percentage of Inpatient Units of Service	Average Adjusted Gross Costs
General Hospitals	16.9%	$125.46
State Hospitals	74.7	39.39
Psychiatric Hospitals*	3.2	74.48
Nonhospitals**	5.2	29.77

*Most are used as alcohol detoxification centers

**Half-way houses, residential centers, board and care homes

Section 5663 of the Welfare and Institutions Code states:

> "It is the intent of the Legislature that, to the extent feasible, new and expanded services requested in the county Short-Doyle plan shall provide alternatives to inpatient treatment. It is furthermore the intent of the Legislature that, to the extent feasible, counties that decrease their expenditures for inpatient treatment in any year below the costs of inpatient treatment in the previous year shall receive the amount of such decrease for new and expanded services requested in the county plan."

Two of the sample counties were provided allocations for fiscal year 1973-74 which permitted funds resulting from any reductions in state hospitalization usage to be used in their community programs. One of the counties was able to cut back only .2 percent while the other, rather than reducing the usage, was 61.4 percent overutilized.

State hospitalization is a tool that the counties can use to manipulate gross expenditures, because if they begin overspending their Short-Doyle allocation, they are able to economize by committing what normally would be a local 24-hour care patient to a state hospital.

CONCLUSION

Our study of five counties indicates that nearly half of the expenditures for community mental health treatment are directed toward 24-hour care; however, only 3.4 percent was spent on alternatives to hospitalization. Sufficient emphasis is not being placed on developing alternative nonhospitalization facilities at the county level. As a result, releasing state hospital patients into the community where adequate nonhospital services often are not available results in the placement of that patient in a local hospital. The net effect of this is the replacement of a $39 per day state hospital cost with a $125 per day local hospital cost.

RECOMMENDATION

County Short-Doyle directors should develop residential treatment centers as alternatives and as followup to state and local hospitalization.

BENEFITS

Implementation of this recommendation would implement more fully the intent of the Legislature regarding alternatives to existing hospitalization treatment programs as well as reduce the total cost of providing mental health services.

THE FACT THAT THE DEPARTMENT OF HEALTH IS NOT GIVING SPECIAL CONSIDERATION TO CHILDREN'S SERVICES IN FUNDING COUNTY SHORT-DOYLE PLANS IS CONTRARY TO SPECIFIC LEGISLATIVE INTENT.

The Welfare and Institutions Code (Section 5704.5) states that it is the intent of the Legislature that "special consideration" be given to children's services in the funding of Short-Doyle plans to expand existing programs or to establish new programs. The budgets of local programs have increased 225 percent in the four years since the Legislature adopted this position. In order to determine what priority is given to children's services, we surveyed the 59 local programs (there are 57 county programs and two city programs) by use of a questionnaire. The questionnaire was developed to determine for fiscal year 1973-74: (1) the percentage of county budget going to children, (2) the number of cases and patient days or contacts for local hospitalization, residential treatment, state hospitalization, (3) the percentage of the county day treatment, outpatient treatment, and client population under 18, and (4) the estimated percentage of indirect services going to children. Of the 59 questionnaires, 35 were returned. The data is presented in Tables 1, 2 and 3 in the Appendix at the end of this section.

The Department of Health and Many of the County Short-Doyle Programs Do Not Maintain Adequate Or Complete Data on Children's Services.

Of the 35 questionnaires returned, 16 were incomplete or contradictory. Twenty-one did not provide the requested estimate of the percentage of indirect services going to children.

Aside from the use of the questionnaires, we obtained an estimate from three of our five sample counties that an average of 42 percent of indirect services goes to children. Failure on the part of counties surveyed by

questionnaire to provide such information indicates both the absence of an adequate data system and the low priority given to children's services. Fifteen counties did not distinguish between young children and adolescents.

CONCLUSION

The community mental health system was designed to be preventitive in nature. Prevention can only be successful if it includes early detection and treatment of mental health problems. Because of the lack of substantive data on children's services, the Department of Health and many of the counties are unable to determine the current level of children's services, and more significantly, are unable to intelligently plan for the mental health needs of children and adolescents.

The Percentage of County Gross Budgets Spent on Children and Adolescents Is Considerably Less Than the Percentage Of County Populations Under 18.

Nineteen of the 35 questionnaires did provide usable data. The 19 included eight of the ten largest Short-Doyle programs, seven with total gross budgets ranging from $900,000 to $4.5 million and four programs between $90,000 and $400,000.

The data received from the counties indicates that on the average, only 17.4 percent of county gross budgets is spent on clients under 18; whereas, this age group constitutes 31.2 percent of total county population (see Table 1). It should be noted that since some major mental illness

does not manifest itself until late adolescence or adulthood, it is logical that a significantly large amount of funds are allocated for adult services. The Legislature has recognized the preventative nature of mental health services, that is, the need for early detection and treatment. The legislative mandate that special consideration be given to children's services, in our judgment, constitutes an effort to give priority to the preventative nature of mental health services. The wide discrepancy between the percentage of county budgets spent on clients under age 18 and the percentage of county population under 18 can only be construed as a lack of "special consideration" given to children's services.

CONCLUSION

Not only is there a failure to expend funds for children's services in relation to the children population, but also there is wide variation among the counties as to the dollar priority given to children's services.

County Short-Doyle Programs Do Not Provide Sufficient Residential Treatment Alternatives To Local Hospitalization for Children, And Therefore Do Not Effectively Utilize State Funds Since Residential Treatment is Less Than One-Third The Daily Cost of Local Hospitalization.

Nine of the 19 counties, providing usable data, including Los Angeles and San Francisco, did not provide nonhospital 24-hour care for children (see Table 2). Thus, the two major urban areas in California do not include residential treatment for children in their mental health service system. This means that children cannot receive residential treatment services unless they are welfare

eligible, funded privately, or under the jurisdiction of juvenile court. The alternative in these counties is hospitalization, which is not only more expensive, but in many cases, less appropriate. Presently, counties are not required to have nonhospital alternatives to 24-hour care in order to be eligible for Short-Doyle funds.

A few counties have developed or are developing long-term and short-term residential treatment services both as an alternative to hospitalization and as an aftercare service (post-hospitalization). Nevertheless, the data indicates that the counties treat twice as many hospital children's cases as they do residential cases. Not all children who are hospitalized can or should be placed in a residential treatment setting, but if a county does not have sufficient alternative placements, then the decision to hospitalize may be based on availability of facilities rather than the treatment needs of the child.

Furthermore, in our fieldwork, we reviewed eight children's residential centers, all of which contract with county health programs; and we also reviewed eight local hospitals. We found that the average daily cost for residential programs was $40 and the average daily costs for hospitals was $134. Thus hospital services for children cost over three times as much daily as residential treatment services.

CONCLUSION

By not providing sufficient residential treatment alternatives to hospitalization, county Short-Doyle programs are failing to provide the opportunity to decide the most therapeutic form of inpatient care for children; county programs are also failing to maximize state funds for inpatient care.

RECOMMENDATIONS

The Legislature should require the Department of Health and the county Short-Doyle programs to develop and maintain children's services data relating to age distinctions between young children and adolescents, expenditures for direct and indirect services, treatment modes and client population.

The Legislature should specifically define the term "special consideration" in Section 5704.5 of the Welfare and Institutions Code in order to make county expenditures for children more consistent with the under 18 population.

The Department of Health should require that as a condition to the receipt of Short-Doyle funds for hospital services, counties should be required to arrange for the local or regional development of nonhospital alternatives such as residential treatment services for children.

BENEFITS

Implementation of these recommendations will provide the information necessary for the Department of Health to more effectively supervise the administration of local community mental health programs in line with specific legislative intent. Further, it will reduce the costs of treatment in

the short run by substituting, where appropriate, a more therapeutic and less expensive method of treatment for a more expensive one. Finally, it should reduce expenditures in the long run by focusing greater attention on the prevention aspects of mental health services.

SUMMARY OF COMMENTS OF THE DIRECTOR OF THE DEPARTMENT OF HEALTH AND HIS STAFF

1. Department of Health staff generally concurred with the substance of our 23 recommendations. Further, they pointed out that a draft report of a Governor's task force report not yet adopted by the department has made recommendations that are to some extent similar to seven of the recommendations in our report. These seven recommendations are in the areas of budgeting and allocation, reimbursement for claims and revenue collections.

2. The department has established new procedures for acting on resolutions (recommendations) of the California Conference of Local Mental Health Directors. All resolutions from the October 1974 conference will be acted on by the department, and will be reported back to the next meeting of the conference in February 1975.

   It may not be appropriate to have the Executive Secretary of the conference be the individual with authority to require department action on the resolutions.

3. It is very difficult to find people who have both program and fiscal backgrounds for the position of community program analyst. Because this mix of talent is not readily available, the department has tried to recruit people who have either a strong fiscal or a strong program background.

4. If we had CR/DC type information on a timely basis, it might improve the allocation process but the county plan is the basic allocating instrument. In any event, the length of time a county has had community mental health services is the primary factor causing inequitable allocations.

5. Department of Health staff concurred in the need to establish alternatives to 24-hour local hospital programs and pointed out that a pilot project to do this has been launched.

6. Department of Health staff concurred in both the need for greater emphasis on children's programs and the need for alternatives to hospitalization of children but took the position that Short-Doyle services are only one aspect of a much more complicated problem relating to timely and effective services to children.

7. Department of Health staff pointed out that a new policy had been adopted in February 1975 which permits counties and providers to use gifts and contributions (a portion of revenue designated "other") for program expansion. The result is that the gift and contribution portion of the $2.8 million, or approximately $2 million, will result in program expansion at no increase in state costs.

TABLE 1
CHILDREN'S SERVICES DATA
FROM 19 COUNTY SHORT-DOYLE
PROGRAMS (1973-74)

County	% of Gross Budget Spent on Children	% of County Population Under 18
Los Angeles	15.1	31
Orange	13.7	40
San Francisco	13.5	22.4
Santa Clara	12.3	36.6
San Diego	17	31.9
Alameda	10	31.4
San Mateo	18	31.5
Sacramento	10	38
Marin	11.7	30.8
Kern	20.5	37.4
Sonoma	20	30
Santa Cruz	13	29
Solano	16	35
Imperial	18.3	43
Butte	24	29.7
Trinity	34	32.4
Lake	21.7	12
Calaveras	15.3	29
Mariposa	25	20.8
Average	17.4%	31.2%

TABLE 2
CHILDREN'S SERVICES DATA FROM
19 COUNTY SHORT-DOYLE PROGRAMS (1973-74)

County	Local Hospital Cases		Residential Treatment Cases	
	# of Local Hospital Cases	Average Length of Stay (Days)	# of 24-Hr. Non-Hospital Cases	Average Length of Stay (Days)
Los Angeles	450	37	0	0
San Francisco	56	199	3	17
Orange	35	75	0	0
Santa Clara	119	8	25	187
San Diego	68	101	61	136
Alameda	47	11	63	145
San Mateo	49	14	3	18
Sacramento	27	12	28	277
Marin	0	0	56	29
Kern	111	10	0	0
Sonoma	32	9	1	15
Santa Cruz	15	8	0	0
Solano	0	0	174	6
Imperial	12	10	0	0
Butte	0	0	90	14
Trinity	2	15	0	0
Lake	0	0	0	0
Calaveras	0	0	0	0
Mariposa	1	5	0	0
Total	1,024		504	
Average Length of Stay for Those Counties with 24-Hour Care		35.2		67.3

TABLE 3
CHILDREN'S SERVICES DATA FROM
19 COUNTY SHORT-DOYLE PROGRAMS (1973-74)

County	# of State Hospital Cases	Average # Days Stay	# Day Treatment Cases	Average # Days Stay	# of Outpatient Cases	Average # Contacts
Los Angeles	348	323	258	55	11,670	13
San Francisco	100	240	352	20	3,547	13
Orange	82	118	210	62	2,343	11
Santa Clara	41	240	178	176	3,001	7
San Diego	19	245	25	77	1,285	13
Alameda	34	167	39	90	1,535	5
San Mateo	53	191	121	60	3,614	6
Sacramento	17	207	55	61	743	10
Marin	7	169	0	0	1,861	8
Kern	11	67	171	29	1,395	5
Sonoma	20	240	38	109	578	17
Santa Cruz	3	150	61	90	98	13
Solano	14	225	0	0	516	6
Imperial	11	153	8	12	175	6
Butte	0	0	0	0	330	5
Trinity	0	0	0	0	38	11
Lake	4	12	0	0	67	10
Calaveras	1	116	0	0	43	3
Mariposa	0	0	0	0	28	20
Total	765		1,516		32,867	
Average		251		63		10.3