REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE STATE'S MENTAL HEALTH SYSTEM COULD BE OPERATED MORE COST-EFFECTIVELY AND COULD BETTER MEET THE NEEDS OF CLIENTS

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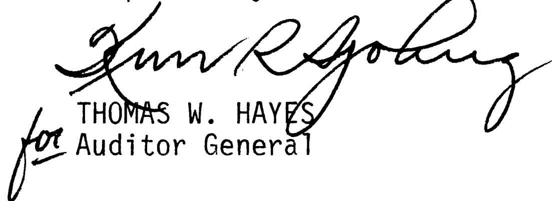
Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the State's mental health system. The report indicates a need for the Department of Mental Health (DMH), the Department of Health Services (DHS), and the counties to improve the cost-effectiveness of mental health services. Specifically, mental health clients are left in more acute and more expensive facilities than they need because appropriate, less intensive care is unavailable. Further, the DMH, the DHS, and the counties are not doing all they can to increase revenue collection. Finally, the DMH and the DHS need to improve their monitoring of mental health facilities to enforce compliance with state regulations.

Respectfully submitted,



for THOMAS W. HAYES
Auditor General

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SUMMARY

The State's mental health system could be operated more cost-effectively and could better meet the needs of mental health clients. Because appropriate care is not available, some mental health clients are kept in more acute, more expensive facilities than they need. Our analysis of three acute psychiatric facilities shows that during one year, the State and the counties would have saved at least $812,000 if a lower, more appropriate level of care had been available. These savings could have been used to provide treatment for mental health clients who did not receive the services they needed because of the counties' limited resources. Additionally, the Department of Mental Health and the counties are not aggressively pursuing service fees from mental health clients and reimbursements from insurance firms and the federal government. In fiscal year 1982-83, the three counties we audited collected from clients, insurance firms, the federal portion of the Medi-Cal program, and the federal Medicare program only $43.2 million of the $148.7 million that it cost to provide mental health services. Finally, because of the limitations in the State's systems for monitoring mental health treatment facilities and enforcing compliance with state regulations, mental health clients must often deal with inappropriate and dangerous conditions, such as overcrowding and having to sleep on couches or floor pads until beds become available.

Placement of Mental Health Clients

Mental health clients are sometimes kept in acute, expensive facilities longer than they need to be because appropriate, less intensive care is unavailable. These clients, the majority of whom are inpatients at acute care facilities operated by the counties, are receiving a higher level of care than their conditions require, at a higher public cost than necessary. The counties experience difficulties in trying to discharge these mental health clients to

lower levels of care because of the shortage of mental health resources below the acute care level, clients' reputations for being troublesome, and problems in securing funding for treatment.

Our analysis of three acute care facilities shows that during one year, the availability of a lower, more appropriate level of care would have saved the State and the three counties in which these facilities are located a total of $812,000. Moreover, the mental health clients would have benefitted from a level of care more appropriate to their needs. The counties involved could have used the savings to provide acute care for clients who otherwise would not receive the treatment they need. The counties' need to care for these additional clients is demonstrated by the fact that two of the acute care facilities we visited were cited by the Department of Health Services for accepting more clients than they were able to care for.

Revenue Collection

Despite the shortage of resources for mental health programs, the counties and the Department of Mental Health are not ensuring that mental health programs receive all possible revenue in service fees from clients and in reimbursements from insurance firms and the federal government. The three counties we reviewed are not billing patients and insurance firms promptly or completely, and they are not following up to determine why delinquent bills are not paid. In some instances, counties do not even attempt to bill insurance firms even though the firms have paid for similar services in the past. Further, counties do not routinely refer delinquent debts to county collection agencies, and county collection agencies collect only a small percentage of the debts that county mental health departments refer to them for collection. The Department of Mental Health is responsible for developing collection procedures and for monitoring counties' collection of mental health debts, but the Department of Mental Health has not adequately enforced its standards for revenue collection.

Furthermore, until recently, the Department of Mental Health had not assisted counties to obtain access to the Department of Health Services' Medi-Cal Eligibility Data System (MEDS). Access to the MEDS would enable counties to determine quickly and accurately if a recipient of county mental health services is eligible for federally funded benefits under the Medi-Cal program. We tested a sample of 310 mental health clients who the counties had determined, based on information available to them, were ineligible for Medi-Cal benefits. Using the MEDS, we found that 32 (10 percent) of these clients were in fact eligible for Medi-Cal benefits. For one county, we estimated that the State would have saved an average of $759 a year for each client who received services during the time that they were, according to our analysis, eligible for Medi-Cal. County administrators said that the MEDS would be cost-effective if it enabled them to identify 2 percent of those clients who are eligible for Medi-Cal benefits but who are currently not receiving them.

The Department of Mental Health also has not actively pursued resolving the problems that the counties have in claiming reimbursement from insurance firms. All three counties we reviewed have had problems in collecting reimbursements from insurance firms. For example, some firms have refused to reimburse counties for outpatient services provided to insured clients and for services provided to insured clients suffering from chronic mental illnesses. Another firm does not pay counties if they submit claims more than 15 days after providing services.

Because the counties and the Department of Mental Health have not aggressively pursued reimbursements from clients and third parties, the State may be losing millions of dollars in annual revenues. The three counties we reviewed collected from clients, insurance firms, the federal portion of the Medi-Cal program, and the federal Medicare program only $43.2 million (29 percent) of the $148.7 million it cost them to provide mental health services in fiscal year 1982-83. These three counties collected $4 million (3 percent) of their total cost

from clients and insurance firms, and $39.2 million (26 percent) from the federal government through the Medi-Cal and Medicare programs. Although counties would not be able to collect reimbursements for all of their costs, our analysis indicates that the counties could collect substantially more than they presently are collecting.

State Monitoring and Enforcement

Finally, the State's system for monitoring mental health treatment facilities and enforcing compliance with state regulations is limited. Although the Department of Health Services makes required visits to mental health treatment facilities and follow-up visits on complaints, the Department of Health Services does not always take enforcement action against facilities that violate state regulations. Further, substantial reductions in staff during the past few years have restricted the Department of Mental Health's on-site review of mental health treatment programs in each county. The Department of Mental Health had previously visited each program once every three years, but now makes visits only once every five years.

Additionally, neither the Department of Health Services nor the Department of Mental Health always has the proper mechanism to force facilities to comply with state regulations. When the Department of Health Services finds problems in a hospital's mental health program, its only options are to revoke the hospital's license or to exclude the facility from participating in the Medi-Cal and Medicare programs. Likewise, when the Department of Mental Health finds problems in a county's mental health program, it has no enforcement authority other than withholding that county's appropriation of funds under the Short-Doyle Act. Administrators of both departments believe that these actions are often too harsh and that they would only result in hardships for mental health clients.

Recommendations

To increase the effectiveness of the State's mental health treatment system, the Department of Mental Health should develop and implement alternative ways of expanding mental health services below the acute level. To ensure that counties increase their collection of revenues, the Department of Mental Health should require counties to comply with state requirements for billing for and collecting fees and reimbursements. The Department of Mental Health should also work with the Department of Health Services to grant the county mental health departments access to the MEDS, and the Department of Mental Health should negotiate with insurance firms to reduce administrative requirements for claiming reimbursements and to improve coverage of mental health services. Finally, to protect the rights of the State's mental health clients, the Department of Health Services should take formal enforcement action when mental health facilities violate state regulations. The Department of Health Services should also coordinate efforts with the Department of Mental Health to compel the county mental health departments to resolve the problem of overcrowding at county-operated acute care facilities.

INTRODUCTION

Public mental health treatment programs in California are administered through shared responsibilities of the Department of Mental Health (DMH), the Department of Health Services (DHS), and each of the 58 counties. The DMH directs and coordinates statewide efforts to treat and prevent mental disabilities, oversees the programs that the counties develop, distributes state funds to counties, and provides direct services to mental health clients in state hospitals. The DHS licenses most mental health treatment facilities and monitors the quality of care that they provide. The counties provide or contract to provide services directly to mental health clients.

Legislative Authority

As the agency responsible for coordinating the State's mental health program, the DMH administers the Lanterman-Petris-Short Act and the Short-Doyle Act. The Lanterman-Petris-Short Act guarantees certain civil and legal rights of patients, and it limits the use of involuntary treatment. The Short-Doyle Act sets up a system to provide a continuum of support services at the community level for mental health clients. Our audit focused on the administration of the Short-Doyle Act.

The Short-Doyle Act makes counties responsible for providing services to mental health clients. The services that counties provide

include prevention and control of mental illness through consultation and community education, crisis intervention and emergency care, 24-hour treatment and care, "day" treatment and outpatient care, and other support services. The DMH also operates three state hospitals for the mentally disabled and manages programs for the mentally disabled at two other state hospitals. Each county must annually submit to the DMH for approval a plan indicating the types of services that the county will provide and explaining how it will provide them.* The DMH receives an appropriation from the State's General Fund for services for the mentally disabled and then allocates funds to the counties on the basis of the approved county plans.

Recent legislation, Chapter 1327, Statutes of 1984 (Assembly Bill 2381), makes some significant changes in the State's mental health system. This legislation increases counties' flexibility in designing local programs, and it reduces indirect services and administrative requirements. Under the new law, the DMH will no longer be required to conduct certain evaluations of county programs, and it will no longer audit county mental health programs. Instead, county mental health departments will conduct or obtain audits by independent organizations and forward the results of these audits to the DMH.

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*As authorized by Welfare and Institutions Code Section 5705.2 (SB 900), three counties receive Short-Doyle allocations without submitting an annual plan to the DMH.

Organization, Budget, and Staffing of the Department of Mental Health

The DMH carries out its responsibilities through three divisions: the Administration Division, the State Hospitals Division, and the Community Programs Division. The Administration Division allocates and disburses state and federal funds, budgets and accounts for expenditures, and audits county expenditures. The State Hospitals Division, which has its headquarters in Sacramento, provides hospital services to those mental health clients whom counties refer to state hospitals. The DMH operates three state hospitals--Atascadero, Metropolitan, and Patton--and manages programs for the mentally disabled at two other state hospitals, Camarillo and Napa. The Community Programs Division is responsible for overseeing county operations and community programs, assuring the quality of mental health services, and managing federal grants.

The Governor's Budget for fiscal year 1984-85 estimated that the DMH's 1983-84 expenditures were $632.3 million, of which $556.4 million was provided by the State's General Fund. For fiscal year 1984-85, the Budget Act provides the DMH with $641.1 million, of which $623.3 million is from the General Fund. Of the DMH's total budget for fiscal year 1984-85, $625.8 million will go to local programs and state hospitals, and $15.3 million will pay for departmental administration.

Over the last few years, the DMH has had significant reductions in staffing. The DMH had 805.7 authorized positions in fiscal year 1981-82; in fiscal year 1984-85, it had 619.7 authorized positions, a decrease of 23 percent. In addition, by June 30, 1985, some DMH staff will be transferred to county governments to carry out local programs. The projected staffing for the DMH for fiscal year 1985-86 is approximately 300 authorized positions.

Funding Sources for the Mental Health System

The State's mental health system is funded by a number of sources including the State's General Fund, county funds, federal funds from the Medi-Cal and Medicare programs, client fees, and payments from clients' insurance firms. The State's General Fund provides most of the money for the mental health programs. The Short-Doyle Act provides reimbursement from the State's General Fund for 90 percent of the net costs of local mental health services (excluding hospital services); the counties provide the remaining 10 percent.* For services provided at the state and local hospitals, the Short-Doyle Act through the General Fund supplies 85 percent of the funding, and the counties supply 15 percent.

*For counties with a population of less than 110,000, the requirement for 10 percent county funding is waived except for local hospital inpatient and state hospital services. However, the Legislature intends for these counties to provide as much of the 10 percent funding as possible. Also, for these counties, state funds pay for 90 percent of the state hospital services, and county funds pay for 10 percent. Effective July 1, 1985, these provisions will apply only to counties with a population of less than 100,000.

Certain services provided to mental health clients qualify for federal reimbursement under the Medi-Cal and Medicare programs. To qualify for this federal reimbursement, services must conform to federal regulations and must be provided only to mental health clients who meet the eligibility requirements of the Medi-Cal and Medicare programs. The federal government reimburses approximately 50 percent of the costs of mental health services eligible under the Medi-Cal program and 100 percent of the services eligible under the Medicare program.

The Short-Doyle Act also stipulates that the DMH must charge clients and other liable parties for mental health services. Although the DMH has delegated this responsibility to the counties, the DMH is still responsible for overseeing the counties' collection of fees for mental health services. To assess clients' financial responsibility for services, the DMH has developed a sliding scale that takes into account the size of a client's family and the client's income. The scale differs somewhat among the counties to reflect geographic cost-of-living factors. Nevertheless, no client can be denied services because of an inability to pay for them.

Responsibilities of the Department of Health Services

The role of the DHS in the State's mental health system is to license local mental health treatment facilities and to monitor the quality of care that these facilities provide. The DHS' Licensing and

Certification Division develops, implements, and enforces standards to promote quality health care in hospitals, clinics, long-term care facilities, home health agencies, and adult day health centers throughout the State. The DHS' Licensing and Certification Division evaluates and reports on services and conditions of the facilities, it cites deficiencies, it approves plans for correction, and it issues, denies, or revokes licenses. The DHS inspects each facility to ensure compliance with licensure requirements at least every two years, except for hospitals, which it inspects every three years. In addition, the DHS conducts annual surveys to determine whether facilities that apply for Medicare and Medi-Cal reimbursement, meet the requirements for participation in those programs. The DHS also conducts investigations when responding to complaints about a facility. The DHS may fine facilities, except hospitals, for violating standards.

SCOPE AND METHODOLOGY

Our objective was to evaluate the State's system for providing treatment to mental health clients. We reviewed the effectiveness of the system in securing appropriate treatment for clients and in operating as cost-effectively as possible. We also tested the effectiveness of the efforts of the DMH and the counties to collect reimbursements from mental health clients, insurance firms, and the federal government. Finally, we reviewed the State's system for licensing mental health treatment facilities and for monitoring the care provided by these facilities. We conducted our review in three

counties: Alameda, Los Angeles, and Sacramento. For fiscal year 1982-83, these three counties received approximately 39 percent of the state funding for mental health programs and served approximately 40 percent of the mental health clients in the State.

We reviewed the pertinent sections of the Welfare and Institutions Code, the Health and Safety Code, and Title 22 of the California Administrative Code, and we reviewed departmental policies and procedure manuals.

In evaluating the appropriateness of the placement of clients and the availability of resources, we visited three county-operated acute care facilities, two state hospitals, and three locked skilled nursing facilities. We interviewed the facility directors and their staffs and reviewed client files and other data at the facilities. Additionally, we interviewed the staff of a fourth county-operated acute care facility. We also interviewed county staff in charge of placing mental health clients and reviewed the placement records, and we interviewed staff and reviewed records at the county Conservator's Office.* The data we used in our analysis covered the period from July 1983 through July 1984.

*Each county has an appointed public conservator or public guardian. The conservator or public guardian is responsible for overseeing the placement and care of those mental health clients who the courts have declared are gravely disabled and unable to care for themselves.

To evaluate the effectiveness of the DMH and the counties in collecting fees for mental health services, we reviewed each county's procedures for billing and collecting these fees. We interviewed staff and reviewed records at each county's billing office and collection office, and in some instances, we reviewed records and interviewed staff at the offices of those who provide mental health services. We reviewed client files, monthly billing records, payment records, and correspondence related to collections. We also interviewed staff and reviewed the policies and procedures of the DMH's Revenue Enhancement Section.

From the three counties, we selected a total of 115 client files to review. Since the counties bill each time a client receives services, we counted the charges for each period of service separately. The 115 client files we reviewed contained a total of 594 charges; 84 percent of these charges were for services provided during fiscal year 1983-84. One county implemented new billing procedures in July 1984, after we had completed our file review for this county. To test the effectiveness of the new procedures, we reviewed a second, smaller sample of files at this county in October 1984. We met with a deputy director of the DMH and a division chief of the DHS to discuss the issue of granting county mental health departments access to the DHS' Medi-Cal Eligibility Data System so that they can increase federal reimbursements.

Finally, to evaluate the State's system for monitoring care in mental health treatment facilities, we reviewed the monitoring activities of both the DHS and the DMH. We visited four of the DHS' six district offices and contacted the administrators of the other two offices by telephone. In two of the four offices that we visited, we reviewed the case files for each mental health treatment facility that the two offices regulated. In the other two district offices, we reviewed a sample of the mental health treatment facilities that the offices licensed. In total, we reviewed 30 facility files. We also reviewed monitoring and enforcement actions taken by the four district offices between July 1981 and August 1984, and we reviewed the DMH monitoring reports of county mental health programs.

In each county, we interviewed representatives of the management of the county mental health department. We also contacted representatives of the U.S. Department of Health and Human Services, and we interviewed several advocates for patients' rights for mental health clients.

AUDIT RESULTS

I

MENTAL HEALTH CLIENTS DO NOT ALWAYS RECEIVE THE LEVEL OF CARE THAT IS APPROPRIATE FOR THEIR NEEDS, AND SOME CLIENTS COULD BE CARED FOR IN LESS EXPENSIVE SETTINGS

Some of the State's mental health clients could be transferred more promptly from costly acute care facilities to less costly forms of treatment. At three facilities we reviewed, the State and the counties could have saved approximately $812,000 in one year if the facilities had been able to discharge clients promptly to lower levels of care. The savings could have been used to provide care for clients who needed treatment but who could not receive it because of the counties' limited resources. Facilities have not promptly discharged clients to lower levels of care because of relative shortages of mental health resources below the acute level, clients' reputations for being troublesome, and problems in arranging funding for treatment.

State Law Requires That Clients Be Placed in Least Restrictive, Most Cost-Effective Settings

Under the provisions of the Short-Doyle Act, counties are responsible for providing a full range of mental health services either directly or by contract. These services may include the following: acute psychiatric care; other forms of 24-hour inpatient care and

treatment, such as that provided by a skilled nursing facility with a special treatment program for mental health clients; "day" services that provide alternatives to 24-hour care and that supplement other modes of treatment and residential care; outpatient services that provide short-term or sustained therapy; and residential treatment. Residential treatment can range from 24-hour crisis treatment provided by trained professional staff to nearly independent living arrangements in which the client lives in the community and receives only minimal support, such as psychological treatment and subsidized rent.

Where a client is placed in this continuum of services depends upon the client's specific needs. For example, a client who is severely disturbed would most likely be placed in a hospital's psychiatric ward or in some other type of acute care facility. An acute care facility constitutes one of the most restrictive settings that a client can be placed in. Acute care facilities generally maintain a relatively large number of staff who supervise virtually all of a client's daily activities; consequently, this level of care is generally the most costly. In contrast, a client who is more stable may be able to live alone or in a group home and receive outpatient services at a mental health clinic. Residential care facilities employ fewer staff and encourage clients to live as independently as their capabilities will allow. As the client's mental health improves and the client progresses across the continuum from acute care to residential care, the setting becomes less restrictive for the client, less supervised, and thus less costly.

The Welfare and Institutions Code also establishes principles for the administration of mental health services. Sections 5358 and 5600.4 require that mental health clients receive treatment in the least restrictive setting that is appropriate for their needs. In addition, Section 5600.5 requires the Department of Mental Health to encourage the development of high quality, cost-effective services.

Some Mental Health Clients Could Be Cared for in Less Costly Settings

Our review of mental health programs in three counties revealed that some mental health clients should be transferred more promptly from acute care facilities to less costly, less restrictive settings that are more appropriate for their needs. During one year, the State and the three counties spent an estimated $812,000 more than was necessary to provide acute care for approximately 630 mental health clients who remained at three acute care facilities longer than they needed to. Although placement staff stated that these clients needed acute care at the time they were admitted to the facilities, the clients could not be transferred to less costly, less restrictive settings as soon as their conditions permitted because such care was not available. As a result, the State spent approximately $728,000 more than was necessary, and the counties spent an excess of $84,000.

To estimate potential savings, we used a cost model that assumed the clients would be transferred to a locked skilled nursing facility, which is generally the next level of care below an acute care

facility. We also assumed that the locked skilled nursing facility received supplemental funds under the Short-Doyle Act to provide additional services to mental health clients. Although some of the clients in our sample should have been transferred to even less costly residential care, we were not able to determine which sources of funds would have been used to pay for the residential care that these clients needed. Funds could have come from the Supplemental Security Income/State Supplemental Program, county general assistance, or the Short-Doyle Act. As a result, our estimate of potential savings is conservative. Table 1 below summarizes the potential savings that could have been generated during one year if the counties had been able to transfer clients promptly to more appropriate settings and thus use acute care resources efficiently.

TABLE 1

**THREE SAMPLE COUNTIES
POTENTIAL SAVINGS OF TRANSFERRING CLIENTS
PROMPTLY TO APPROPRIATE PSYCHIATRIC CARE**

	State			Counties			
	Cost of Acute Care	Cost of Alternative Care	Savings	Cost of Acute Care	Cost of Alternative Care	Savings	Total Savings
Facility 1	$ 598,000	$ 360,000	$238,000	$ 42,000	$31,000	$11,000	$249,000
Facility 2	210,000	91,000	119,000	23,000	8,000	15,000	134,000
Facility 3	924,000	553,000	371,000	112,000	54,000	58,000	429,000
Total	$1,732,000	$1,004,000	$728,000	$177,000	$93,000	$84,000	$812,000

Three factors impede the prompt transfer of mental health clients from acute care facilities to less restrictive settings. The barriers to prompt placement are the relative shortage of resources below the acute care level in settings other than hospitals, clients' reputations for being troublesome, and problems involved in arranging funding for treatment. Staff responsible for placing mental health clients attributed the delays that occurred in each of the cases in our sample to one or more of these causes. The following examples illustrate each of the three causes.

The first example involves a client who was in a county hospital and who was ready to be placed in a locked skilled nursing facility, which provides a lower level of care than a hospital. Placement staff stated that, because there were no vacancies in any of the locked skilled nursing facilities in the area, the client remained at the hospital for 32 days longer than necessary until such a vacancy developed. We estimate that the State and the county would have saved approximately $4,400 if the client had been cared for in a locked skilled nursing facility rather than in a hospital for the 32 days.

In another case, a client's reputation for being troublesome made it difficult to place him in an appropriate facility. This client should have been transferred from a county hospital to a board and care facility, which is among the least restrictive facilities. However, placement staff stated that the client had a history of assaultive behavior and molesting and that residential facilities were reluctant

to accept him because he could endanger their other clients. Consequently, the client remained at the county hospital for 35 additional days before staff could locate a board and care facility that believed it could handle him. If the client had been transferred to a locked skilled nursing facility, the State and the county would have saved approximately $4,800. If the county had been able to place this client in a board and care facility, as hospital staff recommended, the savings would have been even greater.

A final example illustrates how insufficient resources, a client's reputation, and problems in arranging funding can combine to cause significant delays in transferring a client from an acute care facility to a less restrictive setting that better suits the client's needs. A client at a county hospital was ready for transfer to a locked skilled nursing facility. However, placement staff stated that this transfer was delayed because of the client's history of being violent, which made some facilities unwilling to accept him, and because of the lack of vacancies at skilled nursing facilities that were willing to accept the client. Moreover, the transfer was further delayed because the courts granted conservatorship for the client to the county Public Guardian's Office, which took several weeks to estimate the client's financial assets.* Placement staff at the county hospital said that they could not apply for the public funds needed to

*The superior court in a county establishes conservatorship by granting a third-party the legal authority to require a gravely disabled client to receive treatment.

pay for this client's treatment until the conservator in the Public Guardian's Office completed the investigation of the client's assets. As a result of this combination of factors, the client remained in an acute care facility for at least 60 days longer than necessary. If this client had been promptly transferred to a locked skilled nursing facility, which would have provided the level of care appropriate to his condition, the State and the county would have saved $5,000.

Staff members of mental health treatment facilities and county staff responsible for placing clients indicate that problems similar to those just discussed also impede placement efforts at lower levels of care. For example, staff members at one locked skilled nursing facility for mental health clients said that they have problems in discharging young male schizophrenic clients because there are not enough residential care facilities willing to accept them. Clients discharged from this facility often need to be placed in a residential care setting that can assist them in becoming as independent as they are capable of being. Placement staff in another county said that their efforts to place clients at every level of care are hindered by similar circumstances.

Because of these impediments to the placement process, some mental health clients are not transferred to less restrictive levels of care as soon as their conditions permit. Consequently, the clients do not receive the level of care that is most appropriate to their needs

and most likely to facilitate their return to the community. Furthermore, the State and the counties spend more than necessary to care for these clients.

Cost Savings Could Be Used To Serve Additional Clients

Although the prompt transfer of mental health clients to the least restrictive level of care appropriate to their needs would generate cost savings for the State and the counties, such savings are not likely to result in a net reduction of expenditures for mental health services. County administrators told us that they would use these savings to provide care for mental health clients who need treatment but who currently cannot receive it because of the counties' limited resources.

The problems that the counties face in attempting to meet the demand for public mental health services are most evident in the psychiatric units of county-operated acute care hospitals. These hospitals accept the clients that other hospitals will not admit, and in many instances, they are the last resort for these clients. Our review revealed that at least four county-operated hospitals have been forced either to admit more clients than their licenses allow or to maintain clients in emergency waiting rooms for more than 24 hours. These actions violate the California Administrative Code, and three of the four facilities have been cited by the Department of Health Services' Licensing and Certification Division for such violations.

Moreover, the directors of psychiatric services at two of the three acute care facilities we visited said that clients who require additional treatment must sometimes be discharged from an acute care facility because of the pressing need to provide treatment for new clients. The released clients return to the streets but are often readmitted to the acute care facility relatively quickly because they are unable to live successfully in an independent situation. Two of the three directors further stated that county-operated acute care facilities sometimes cannot admit clients who need treatment because there are no acute care beds available.

Thus, because the demand for acute psychiatric care exceeds currently available resources, counties would use any savings generated by the prompt transfer of acute care patients to less restrictive settings to provide additional public mental health services.

Counties Need Additional Mental Health Resources Below the Acute Care Level

Although the demand for acute care presently exceeds its supply, counties could provide acute care for more clients without expanding acute care resources if counties had more resources below the acute care level. If such resources were available, counties could transfer more quickly those clients currently in acute care facilities who are ready for less restrictive levels of care, thereby creating space for other clients who need acute care.

The Department of Mental Health (DMH) could pursue several different strategies to produce additional mental health resources below the level of acute care. First, the DMH could ask the Legislature to increase the number of beds for mental health clients below the acute care level at the state hospitals. The directors of both state hospitals that we visited indicated that they could add more beds if they could refurbish existing structures. At present, the DMH allocates to each county a fixed number of days per year for state hospital care for the county's clients. During fiscal year 1983-84, 25 counties exceeded their allocations, even though each county may have to pay some of the cost of care at the state hospital for each day that the county exceeds its allocation. This arrangement causes some counties to limit their use of the state hospitals even when these facilities are most appropriate for clients. Both of the state hospital directors whom we interviewed and the directors of the three acute care facilities we visited said that some counties need greater access to state hospitals.

The DMH's second option is to encourage and assist counties in developing additional resources that would enable them to reduce their use of expensive hospital beds for acute psychiatric care. For example, the DMH could help counties increase the revenue they collect, thereby providing funds for additional mental health programs.* The

*Chapter II discusses ways in which the DMH and the counties can increase the revenue collected for mental health services.

DMH could also disseminate information about successful model programs, such as the program operated by a licensed skilled nursing facility in one county. This "psychiatric residential treatment program," in which 75 percent of the clients require acute psychiatric care, is administered jointly by the county mental health department and a private contractor. This program provides treatment at a cost that is substantially lower than the cost of similar treatment provided by a hospital. The program can provide less costly treatment because its overhead expenses are lower and because a portion of the facility's operating costs are eligible for reimbursement under the Medi-Cal program. This program's staff is composed of psychiatrists, clinical social workers, psychiatric nurses and technicians, recreation therapists, and nursing personnel. According to the deputy director of the county mental health department, this program has been successful in stabilizing clients' conditions to the point where most clients can be transferred to less restrictive settings.

A third option concerns the establishment of differential rates for residential care facilities based on clients' needs. If facilities received supplemental payments for troublesome clients, the facilities could hire the additional staff needed to care for these clients. As a result, acute care facilities could transfer more promptly to less restrictive settings those clients who have a history of behavioral problems. These rates could be based on the findings of the DMH's "Residential Care Rate Proposal," a study of proposed rate changes for residential care mandated by Section 4075 of the Welfare

and Institutions Code. When the Legislature enacted this statute, it declared that "due to insufficient payments, operators of private residential care facilities are not given any incentive to serve the more severely disturbed, and it is difficult to recruit sufficient private residential care facilities." The Legislature further stated that the rates established for these facilities should include an amount for hiring additional staff to care for clients who need to be closely supervised.

Finally, for those areas of the State that absolutely need to increase their resources for acute care, the DMH should encourage the development of psychiatric health facilities, a specific, less costly type of treatment facility. Psychiatric health facilities provide acute care in a nonhospital setting, thereby eliminating some overhead costs. Section 5652.5 of the Welfare and Institutions Code requires these facilities to provide psychiatric care at a cost that is approximately 40 percent less than the average cost of similar care provided by a general hospital. Although the Legislature required the Department of Health Services to develop final regulations for psychiatric health facilities six years ago, this department has still not done so.

Psychiatric health facilities have not been attractive to some counties partly because the services they provide are not eligible for federal reimbursement under the Medi-Cal program. Both federal and state officials have stated that, as they presently operate under the

DMH's interim standards, psychiatric health facilities do not meet federal standards for any of the different types of health facilities that are eligible for federal reimbursement. Both the Secretary of the State Health and Welfare Agency and the Department of Mental Health have sought federal reimbursement under the Medi-Cal program for clients in psychiatric health facilities. In both instances, the federal Health Care Financing Administration replied that current law and regulation prohibited federal funding under the Medi-Cal program for clients in psychiatric health facilities.

CONCLUSION

The State's mental health treatment system could operate more effectively and more efficiently. Some mental health clients could be transferred more promptly from costly acute care facilities to less restrictive, less expensive types of care if such care were available. The State and the counties could have saved an estimated $812,000 in one year if the three facilities we reviewed had been able to transfer clients promptly to lower levels of care. Such prompt transfers would generate savings that counties could use to provide care for mental health clients who need treatment but who currently cannot receive it because of counties' limited resources. In addition, prompt transfers would benefit mental health clients by moving them to treatment settings that are more appropriate to their needs.

RECOMMENDATIONS

To improve the State's mental health treatment system, the Department of Mental Health should encourage the development of mental health resources below the acute care level by implementing a plan that will enable counties to reduce their use of expensive acute care facilities. This plan should examine the relative costs and benefits of increasing the number of state hospital beds below the acute care level, increasing the resources below the acute care level in the counties, and initiating a pilot project to establish residential care rates based on the level of care needed by mental health clients who have a history of behavioral problems. The DMH should submit this plan by December 31, 1985, to the Senate Health and Welfare Subcommittee on Mental Health, Developmental Disabilities, and Genetic Diseases and to the Assembly Subcommittee on Mental Health and Developmental Disabilities.

To reduce the days that mental health clients under conservatorship remain unnecessarily at the acute care level while their financial assets are being evaluated, the DMH should require counties to place in a revolving fund a portion of the funds allocated to them each year by the Short-Doyle Act. Staff at county-operated acute care facilities should use this revolving fund when conservatorship proceedings delay

the efforts to secure funding for clients who should be transferred to less restrictive settings.

Finally, to ensure that psychiatric health facilities operate at the minimum cost and to ensure that there are means to effectively regulate their activities, the Department of Health Services should issue final regulations governing the operations of psychiatric health facilities as soon as possible. Once the final regulations have been issued, the Legislature should enlist the assistance of the California Congressional Delegation to petition the U.S. Congress to amend Title 42 of the United States Code to make psychiatric health facilities, which represent a cost-effective alternative to acute psychiatric care in hospitals, eligible for federal reimbursement under the Medicaid program (referred to as the Medi-Cal program in California).

II

THE COUNTIES AND THE DEPARTMENT OF MENTAL HEALTH COULD INCREASE REVENUE FOR MENTAL HEALTH SERVICES

Counties are not collecting all possible revenue for mental health services from clients, insurance firms, and the federal government. Moreover, the Department of Mental Health is not adequately enforcing state requirements for revenue collection, and the DMH needs to do more to assist counties to increase the revenue they collect from the Medi-Cal program and from insurance firms. Consequently, counties are losing millions of dollars in revenue that could be collected from clients and third-party sources, and the State is unnecessarily spending General Fund monies.

In fiscal year 1982-83, the three counties we reviewed spent $148.7 million to provide mental health services. However, from clients and third-party sources, the three counties collected approximately $43.2 million, only 29 percent of the total cost of providing the services. Of this $43.2 million, counties received approximately $39.2 million (91 percent) from the federal portion of the Medi-Cal program and the federal Medicare program; only $4 million (9 percent) came from clients and insurance firms. Although counties would not have been able to collect all of the $148.7 million, they could have collected significantly more than they did, especially from insurance firms.

Counties Are Required To Collect Revenue for Mental Health Services

State law requires the DMH to charge clients and liable parties for mental health services. However, as allowed by Section 5718 of the Welfare and Institutions Code, the director of the DMH has delegated to the counties the responsibility for collecting the revenue for these services. Counties collect revenue from clients, from insurance firms, and from the federal government through the Medi-Cal and the Medicare programs. State law also requires the DMH to establish policies and procedures that the counties must follow in collecting revenue. The importance of counties' efforts to collect revenue for mental health services was emphasized in 1983. The Governor eliminated from the 1983-84 Budget Act $9.2 million for local mental health services, stating that the counties should aggressively pursue revenue to compensate for the reduced funding.

The DMH provides the counties with manuals specifying the billing and collection procedures that the counties must follow. The DMH requires a county to send a client a monthly bill for the cost of services up to the amount of the client's liability. The county should also submit a claim to the client's insurance firm and to the federal government whenever possible. The county should send bills both to clients and to third parties one month after the month in which the services were provided. If the client or the insurance firm does not pay, the county must notify the client or firm that the account is delinquent and determine whether the debt is collectible. If the debt

can be collected, the county should take appropriate steps to collect the debt, such as referring the case to the county collection agency.

According to DMH requirements, the county must determine a client's liability by completing a financial questionnaire that identifies the client's income, expenses, insurance coverage, and eligibility for the Medi-Cal program. The county has the authority to request proof of any financial information that the client provides. The county must also use a fee schedule, approved by the DMH, that is based on income and family size. The following example illustrates how a county assesses a client's financial liability. Currently in Los Angeles County, a client who has three dependents and a monthly income of $1,200 has a maximum annual liability of $96 for mental health services. If the cost of services for the year exceeds $96, the county must recover the additional costs by billing an insurance firm, by seeking reimbursement from the Medi-Cal and Medicare programs, or by spending the county's appropriation from the Short-Doyle Act.

Counties Have Deficient Billing and Collecting Procedures

Counties could collect additional revenue from clients and insurance firms if they improved their billing and collecting procedures. As seen in Table 2 below, for fiscal year 1982-83, the three counties we reviewed collected less than 3 percent of the cost of

providing services from client fees and insurance payments.* Statewide, counties collected less than 5 percent of their costs from client fees and insurance payments.

TABLE 2

THREE SAMPLE COUNTIES
REVENUE FROM CLIENT FEES AND INSURANCE PAYMENTS
FISCAL YEAR 1982-83

	Cost of Services	Client Fees	Insurance Payments	Total Revenue From Clients and Insurance Firms	Total Revenue As Percent of Cost
Alameda	$ 24,850,756	$ 308,861	$ 342,982	$ 651,843	2.6%
Los Angeles	114,166,569	1,422,370	1,720,850	3,143,220	2.8%
Sacramento	9,733,857	79,308	145,654	224,962	2.3%
Total	$148,751,182	$1,810,539	$ 2,209,486	$ 4,020,025	2.7%
Statewide Total	$386,503,360	$7,611,692	$11,039,512	$18,651,204	4.8%

Source: Department of Mental Health.

In addition to the revenue that counties collect from clients and insurance firms, the counties also collect reimbursements for services from the federal government through the Medi-Cal and Medicare programs. In fiscal year 1982-83, the three counties we reviewed collected approximately $39.2 million in federal reimbursements through the Medi-Cal and Medicare programs.

*Figures for fiscal year 1983-84 were not available until January 1985 because the DMH does not require counties to report costs until six months after the fiscal year ends.

Deficient Billing Procedures

The three counties we reviewed do not always obtain enough information to bill clients or third-party sources. In addition, the counties do not bill clients or insurance firms promptly, and in many instances, the counties do not bill insurance firms even though a client is insured. We reviewed the files of 115 clients in our three sample counties. Since the counties bill each time a client receives services, we counted the charges for each period of service as a separate case. The 115 client files that we reviewed contained a total of 594 cases. Table 3 below illustrates some problems that we found in the cases we reviewed.

TABLE 3

THREE SAMPLE COUNTIES
PROBLEMS PERTAINING TO BILLING PROCEDURES

County	Cases Reviewed	Lack of Billing Information	Late Billings	Insurance Not Billed
Alameda	88	5	5	24
Los Angeles	434	55	88	136
Sacramento	72	19	37	22
Total	594	79	130	182

Of the 594 cases we reviewed, 79 (13 percent) lacked sufficient information for counties to bill clients or insurance firms

as required by the DMH. The three counties were unable to bill properly for mental health services because they did not obtain the following from some clients: completed financial forms that are used to determine clients' liability and third-party coverage, signed authorizations for treatment, and signed insurance claim forms. In one county, for example, a client's charges for services totaled $694. However, during the three months that the client received services, the provider did not get the client to complete a financial form. As a result, the county could not bill the client, and the county was forced to use funds appropriated to it by the Short-Doyle Act. Another county did not obtain a completed financial form from the client even though the client received outpatient treatment for two months. Consequently, the county could not bill the client for charges totaling $822.

For 25 of the 79 cases that lacked required information, the counties could not bill insurance firms for services totaling $5,568 because the counties failed to have clients sign the insurance claim forms. For example, one county notified a client in October 1983 that the client had to sign a claim form so that the county could bill the client's insurance firm. As of October 1984, the client had not returned the claim form although she continued to receive services from the county. The county still cannot bill the insurance firm for $158 in service charges.

Besides failing to obtain all necessary information from clients, the three counties did not bill clients or insurance firms

promptly in 130 of the 594 cases, 22 percent of the time. Instead of billing clients within one month, two counties billed clients two to five months after the services had been provided. Billing supervisors for the three counties indicated that, if clients are not billed promptly after they receive services, clients either become angry because they are being billed so late or they forget that they had received services. Consequently, clients are less likely to pay.

In one instance, a county failed to regularly bill a client even though the client's conservator wanted to pay. This client was a conservatee and had an estate. In a letter to the county, the conservator stated that the county had sent only seven bills in 19 months. The conservator requested prompt billing each month so that monthly payments could be made.

Counties billed insurance firms between 2 and 26 months after services had been provided. On the average, counties billed insurance firms 4 months after services had been provided. Billing supervisors provided us documentation confirming that some insurance firms will not accept insurance claims if counties submit claims more than 30 to 60 days after clients received treatment.

Finally, in 182 (42 percent) of the 437 cases in which a client was covered by insurance, the three counties never billed the insurance firm for mental health services. Service charges that the counties could have claimed ranged from $19 to $1,734. For example,

one county did not bill an insurance firm for charges totaling $1,240 even though the county had obtained an insurance claim signed by the client. This county also did not bill another insurance firm for $937 despite the fact that the firm had paid the county 31 percent of the amount that the county had previously billed the firm for services provided to the same client. In total, the three counties failed to bill insurance firms for $33,677.

In two of the three counties, staff who prepare the bills decide whether to bill an insurance firm. Billing staff said that they make these decisions on a case-by-case basis and without the aid of any written policy. Billing staff base their decisions on second-hand information from other billing staff and staff in the clinics and on their previous experiences in billing insurance firms. In addition, some billing staff stated that they would not bill an insurance firm if the firm had previously denied a claim for services. For example, one county did not bill an insurance firm for services provided to a client in 1984 because a clinician placed a note in the client's file in 1981 stating that, in a telephone conversation, the insurance firm's representative said the firm would not reimburse the clinic for services provided to the client. Consequently, the county did not bill the firm for $281 in services provided to this client in 1983 and 1984. The head of the county mental health department's district office agreed with us that a three-year old telephone conversation is insufficient basis for deciding not to bill an insurance firm. A telephone conversation does not constitute an official policy statement

from the insurance firm, and it is possible that the firm's policy may have changed in the interim or that the client may be receiving different types of services.

Deficient Collection Procedures

Counties also need to strengthen their procedures for collecting revenue once an account has become delinquent. Counties do not identify delinquent accounts, notify the client of the delinquency, follow up with the insurance firm to secure payment, or refer debts to county collection agencies. In addition, county collection agencies collect only a small percentage of the mental health debts that are referred to them.

The DMH requires that counties establish procedures for monitoring delinquent accounts. According to DMH requirements, the counties should perform the following steps to monitor accounts: maintain a record of delinquent accounts, indicating the age of the debts and whether they have been written off or adjusted; contact the clients to notify them of the delinquency and establish a payment plan; follow up with the insurance firm to obtain a payment; reconsider whether the debt should be pursued if the client or the insurance firm does not pay; and refer the debt for collection.* Prudent fiscal

*Counties "write-off" debts when they declare them to be uncollectible. Counties adjust debts when they reduce or eliminate the debtor's liability based on the debtor's ability to pay.

management also requires that records be maintained on the status of all delinquent accounts and that there be written procedures for writing off or adjusting a debt.

The three counties we reviewed are not monitoring accounts to identify those that are delinquent. Billing supervisors from each of the three counties we visited said that they do not have procedures for identifying the status of individual accounts. Instead, the counties rely on billing staff to identify older debts, to contact the client or the insurance firm for payment, and to refer the account to the collection agency. However, because the counties are not routinely monitoring delinquent accounts, the counties are not promptly contacting clients and insurance firms or referring the accounts for collection. Table 4 below illustrates the magnitude of the revenue collection problems we found in three counties.

TABLE 4

THREE SAMPLE COUNTIES
PROBLEMS PERTAINING TO COLLECTION PROCEDURES

County	Delinquent Cases	Delinquent Notices Not Sent	Cases That Should Have Been Referred for Collection	Cases Not Referred for Collection
Alameda	39	14	33	7
Los Angeles	137	125	125	125
Sacramento	31	30	18	18
Total	207	169	176	150

For 169 (82 percent) of the 207 cases that were delinquent, counties did not contact clients promptly when bills were not paid. One county, for example, billed a client in May 1984 for $200 in services that had been provided in March and April 1984. The client's annual liability was $168, but the client had not made a payment, and the county had not sent the client a delinquent notice as of October 1, 1984. Moreover, counties do not contact insurance firms promptly when claims have not been paid. One county billed an insurance firm in 1981 and 1982 for $14,280 in services provided to a client in 1981. Although the insurance firm did not pay the claim, the county did not contact the firm until May 1984 to determine whether the firm had received the claim and to determine the status of the claim.

The counties we reviewed also do not refer many debts to county collection agencies. As Table 4 above showed, counties did not refer to county collection agencies 150 (85 percent) of the 176 cases that should have been referred. In one case, a county did not refer an unpaid debt of $985 to the county collection agency even though the debt was five months old. Another county sent a delinquent notice to a client who had owed $112 for eight months, but the county did not refer the account to the county collection agency. Although the amount of the debt was relatively small in some cases we reviewed, the DMH requires that counties make a reasonable effort to collect all monies owed.

We also found during our review that county collection agencies collect only a small percentage of the debts referred to them by county mental health departments. Table 5 below shows the debts referred to and the revenue collected by the three county collection agencies in fiscal year 1983-84.

TABLE 5

THREE SAMPLE COUNTIES
DEBTS REFERRED AND REVENUE COLLECTED
BY COLLECTION AGENCIES
FISCAL YEAR 1983-84

County	Debts Referred	Revenue Collected	Percent Referred That Was Collected	Written-Off or Adjusted	Not Yet Collected
Alameda	$ 730,378	$ 33,084	4.5%	$ 121,945	$575,349
Los Angeles*	751,128	112,362**	15.0%	727,978**	Not Available
Sacramento	573,763	20,311	3.5%	382,267	171,185
Total	$2,055,269	$165,757	8.1%	$1,232,190	$746,534

*Figures for Los Angeles County do not include amounts due for the majority of outpatient services; these amounts are collected by providers.

**These amounts include some collections and write-offs that were made in fiscal year 1982-83.

As the table shows, the counties collected only $165,757 (8.1 percent) of the $2.06 million that county mental health departments referred to county collection agencies. Thus, approximately 92 percent of the debts referred were not collected. Counties have written off, adjusted, or not yet collected the remaining $1.89 million. When these debts are not collected, counties must pay for the cost of mental health services from funds allocated under the Short-Doyle Act.

Each of the three counties we reviewed had different procedures for collecting debts for mental health services. Two of the three counties refer debts for both inpatient and outpatient care to the county central collection agency, which is a unit of the county government. One of these two counties refers mental health debts to the county collection agency each month. However, supervisors of this county collection agency state that they may not pursue all mental health debts because the collection agency has a backlog of about 12,000 delinquent accounts; these accounts include mental health debts as well as other debts owed to the county. In addition, this collection agency allows its collectors to decide which accounts they will pursue and whether they will use county or state data to determine if the client either has other debts to the county or owns any real property. According to the supervisors, the collection agency promotes collectors based on the total revenue they collect. Therefore, collectors prefer to pursue debts such as court fines because these debts involve more money per case and less troublesome debtors than mental health debts involve. Thus, collectors have less incentive to collect mental health debts.

The second of the two counties that refer debts to the county collection agency refers debts irregularly. According to the manager of this county's collection agency, collection efforts have been hindered by the poor quality of the accounts referred by the billing office. The accounts referred to this collection agency during fiscal year 1983-84 frequently lacked sufficient information to locate a

debtor; for example, an account might not include a client's current address. In addition, the accounts often involved amounts under $25 and were often delinquent for more than a year before they were referred. According to the manager of this collection agency, it was not cost-effective for the county to try to collect these types of accounts. At his suggestion, the county billing office has somewhat improved the condition of the accounts it is referring to the collection agency. The manager also stated that, although his collection agency does not have a backlog of accounts, collectors have little incentive to pursue mental health debts. Collectors decide which debts they will pursue using the collection agency's formula for rating debts. Since the formula is based on the age and the amount of the debt, collectors are less likely to pursue older debts for smaller amounts, such as those referred by the county mental health department.

The third county we reviewed refers to the county collection agency only debts for inpatient care. We found some of the same problems in this county's collection agency that we found in the other two counties. For debts for outpatient care, this county allows each provider delivering outpatient services to collect the revenue for its own delinquent accounts. However, the providers we reviewed did not have adequate procedures for collecting revenue. In one clinic, for example, a clerk attached to clients' account records the delinquent notices that the postal service returned as undeliverable. However, the clerk did not ask the clinical staff, who were still treating these clients, to send the clients to the billing office so that the clerk

could correct the addresses. In addition, in 52 cases in which insurance firms did not respond to claims, the clerk did not contact the insurance firms to determine the status of the claims or to ascertain why the claims had not been paid. At another clinic, clerks did not contact insurance firms in 35 cases in which the firms had not responded to the claim. Staff at both clinics stated that they did not have written procedures that required follow-up action on delinquent accounts. Moreover, the staff said that supervisors did not instruct them to give insurance claims a top priority.

We discussed our findings with the administrators of this third county. The administrators stated that allowing county staff in each region to pursue debts through a more centralized billing and collecting system would be more effective than allowing each outpatient provider to bill and collect independently. With centralized operations, the county could more easily enforce policies for billing and collecting debts for mental health services.

Finally, collection agencies in all three counties do not ask clients to document their statements about their income and expenses when the counties seek payment for delinquent accounts. Instead, to determine whether clients are liable and the debts are collectible, collectors rely on clients' statements that they are not able to pay. In addition, staff who interview clients are told by their supervisors to evaluate clients' statements about income and expenses based on what sounds "reasonable." According to county staff, some clients claim

they are unable to pay because they know that the county will not ask them to support their claim.

In contrast to the above examples, the billing office of one county that we reviewed determines a client's ability to pay by asking clients to provide independent verification of the statements they make about their income. The county's billing office requests that clients bring in documents such as payroll or Unemployment Insurance check stubs and tax returns to establish their financial liability.

Reasons for Not Emphasizing the Collection of Revenue

According to county administrators, counties have not emphasized collecting revenue for mental health services for several reasons. First, county administrators state that the DMH did not enforce its requirement that counties collect this revenue.* Further, county administrators reported that, before the passage of a 1984 law amending Section 5714.2 of the Welfare and Institutions Code, counties had no fiscal incentive to increase the revenue they collected.

According to a DMH deputy director, in the past the DMH provided each county with a basic allocation of funds available under the Short-Doyle Act. Then, to this base, the county added its share of

*This and other responsibilities of the Department of Mental Health are discussed in detail in the next section.

costs and estimated revenues from all sources to establish a gross level of estimated expenditures for its mental health program. Once established, this level could not be exceeded without approval in advance from the DMH. If a county collected more revenue than it had anticipated when it developed its budget, it would find both the state and the county contributions reduced.

As interpreted by the DMH, the 1984 amendment allows counties to use in a subsequent fiscal year any funds (including revenue) that are not spent in the current fiscal year. A DMH deputy director stated that this policy will apply to unexpended balances of allocations at the end of fiscal year 1984-85.

County administrators stated that counties have nearly reached the maximum revenue that they can collect. They indicated that most clients are not liable to pay for services because the clients have insufficient income. These county administrators also said that the number of clients who are unable to pay may be growing because reduced state funding has forced counties to focus treatment on clients with the most severe mental illnesses; these clients are also the least likely to be able to pay for mental health services. Finally, the county administrators added that the counties have improved their procedures for collecting revenue from the Medi-Cal program and from clients who have private insurance.

As discussed earlier in this chapter, the three counties we reviewed collected from clients and insurance firms only about $4 million of the $148.7 million that it cost these counties to provide mental health services. Moreover, the counties collected only $165,757 of the $2.06 million in debts that they referred to county collection agencies. Although the counties may not be able to recover all of the costs of providing mental health services, our review of counties' billing and collecting procedures shows that the counties could substantially improve these procedures to increase the mental health revenue that they collect.

A conservative estimate, based on the results of our analysis indicates that statewide the counties could save millions of dollars if they improved their billing and collecting procedures. Counties should particularly increase their efforts to collect revenue from insurance firms. If we project the results of our analysis statewide, the 58 counties could have billed insurance firms for an additional $1.5 million by always having clients who have insurance sign the claim forms. Similarly, if the 58 counties billed insurance firms every time they could, they could have billed for an additional $8.6 million. As we stated earlier, the three counties we reviewed did not even attempt to bill insurance firms for 42 percent of the clients who had insurance. We could not project an exact amount of savings if the counties improved their billing and collecting procedures because of the many variables involved in each claim. For instance, the amount an insurance firm might pay for a service would differ depending on the insurance firm and the terms of the insurance policy.

The DMH Is Not Sufficiently Assisting Counties To Increase Revenue

The DMH is not adequately enforcing state requirements for collecting revenue for mental health services, and until recently, the DMH and the DHS have done little to help counties obtain access to the DHS' Medi-Cal Eligibility Data System. Moreover, the DMH needs to do more to assist counties in increasing the revenue they collect from insurance firms, especially by helping counties to determine the reimbursement policies of insurance firms and to negotiate statewide issues with those firms. We found that counties have not collected as much revenue as they could have collected. Consequently, the State had to appropriate more money from the General Fund to pay for mental health services than it would have had to appropriate if the counties collected more revenue.

The DMH Has Not Adequately Enforced State Requirements for Billing and Collecting Revenue

Although Section 5718 of the Welfare and Institutions Code requires the DMH to establish and maintain policies and procedures for the counties to use in collecting revenue, the DMH is not adequately enforcing the policies and procedures that it has established. Presently, the DMH conducts reviews of each county's mental health program once every five years. One part of this review entails an examination of the county's billing and collection procedures. The review analyzes the programs and recommends corrective action that the

county should take. The DMH reviewed the three counties in our sample in the last three years. All three of the reviews noted problems in the billing and collecting procedures, and all three recommended corrective action. However, as we have discussed, not one of the three counties has fully met DMH policy or standards for billing and collecting revenue.

By state law, the DMH can withhold a county's appropriations under the Short-Doyle Act if the county does not take the action recommended by the DMH to comply with state requirements. However, DMH staff state that they view funding reductions as the DMH's most drastic enforcement mechanism and one likely to cause harm to clients of mental health services. DMH administrators say that the DMH prefers to work with the county mental health directors to alter county policies and procedures.

Another reason that the DMH has not taken a more active role in monitoring counties' procedures for collecting revenue is that before October 1983, the DMH delegated its responsibility for monitoring the counties' collection of revenue to the Department of Developmental Services. However, in October 1983, the DMH established a Revenue Enhancement Section (section) to formulate and direct a statewide program for collecting revenue. The Chief of the Revenue Enhancement Section said that the section is responsible for serving as an information source for the counties and for proposing new policies and procedures for the counties to increase revenues collected throughout the State.

In the past year, this section has conducted workshops for county administrators to discuss problems and issues pertaining to counties' billing and collecting procedures. The section has sent to the counties data presented at the workshops, and it has proposed that the DMH fund a $76,000 film to train county staff in billing and collecting procedures. The section is also visiting selected counties to gather data about revenue collection, and intends to request that all counties provide information on their accounts receivable for the last two quarters of fiscal year 1984-85.* The DMH does not currently require any county to submit these data. In addition, the section is planning to develop a revised and simplified fee schedule for establishing clients' liabilities for mental health costs. Finally, the section is providing some information to the counties to assist them in collecting revenue from insurance firms.

DMH Has Done Little to Help Counties To Obtain Access to the MEDS

The Department of Health Services has not allowed counties access to its Medi-Cal Eligibility Data System (MEDS), and until recently the DMH has done little to assist counties in gaining access to the MEDS. The MEDS is the State's latest computerized information system that the DHS uses to determine whether an individual is eligible to receive benefits under the Medi-Cal program.

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*"Accounts receivable" are monies owed to the counties for services provided. The DMH will be asking counties to report on their quarterly accounts receivable, including total service charges, amounts collected, and amounts written off or adjusted.

Counties can claim reimbursement from the Medi-Cal program for clients who are eligible for Medi-Cal as long as these clients receive services approved by Medi-Cal at facilities certified by Medi-Cal. Reimbursements from the Medi-Cal program account for a sizable portion of counties' revenue for mental health services. For example, for fiscal year 1982-83, the three counties we reviewed collected approximately $34 million from the federal government in Medi-Cal reimbursements for mental health services costing $149 million. For the same year, all counties in the State collected approximately $89 million in federal reimbursements from the Medi-Cal program. Since the Medi-Cal program is approximately 50 percent federally funded and 50 percent state funded, counties want to increase their collection of Medi-Cal reimbursements. Additionally, because the federal government funds approximately 50 percent of the Medi-Cal program, the State also has an incentive to increase Medi-Cal reimbursements.

In providing services to clients, county mental health departments try to determine whether these services could be paid for by the Medi-Cal program. Counties use several methods to determine clients' eligibility for Medi-Cal. Counties ask clients to provide proof that they are receiving Medi-Cal benefits and counties can then verify this information using county data systems. However, these data systems are not as complete or updated as frequently as the MEDS and are thus less accurate than the MEDS. Each month, counties also submit to the DHS a list of clients who may be eligible for Medi-Cal. The DHS matches this list against the DHS' Medi-Cal Eligibility History File.

However, the DHS revises the Medi-Cal Eligibility History File less frequently than it revises the MEDS; thus, the information in this file is less accurate than the information in the MEDS. Because their methods for verifying clients' eligibility for Medi-Cal were not the most accurate, some county mental health departments asked the DHS over a year ago to grant them access to the MEDS. The DHS allows all county welfare departments to use the MEDS to determine whether their clients are eligible for Medi-Cal benefits, but the DHS has not allowed county mental health departments access to the MEDS.

We selected 310 clients who the three counties in our review had determined were ineligible for Medi-Cal using the data available to them. Using the MEDS, we found that 32 of the 310 clients (10 percent) were eligible for Medi-Cal at the time they received services. For one county, we estimate that the State would have received an average of $759 in federal reimbursements for each client who received services during the time we identified them as eligible for Medi-Cal. Administrators for the counties we reviewed stated that a 2 percent increase in the number of clients identified as eligible for Medi-Cal reimbursement would make using the MEDS cost-effective.

Although the MEDS would provide the counties with more accurate information for determining Medi-Cal eligibility, DHS administrators believe that state law prohibits them from granting county mental health departments direct access to the MEDS. DHS administrators said that Section 14100.2 of the Welfare and

Institutions Code prevents the DHS from providing confidential data on clients to any agency not directly administering the Medi-Cal program. According to a DHS division chief and her staff, the DMH provides services that are subject to Medi-Cal reimbursement, but the DMH does not administer the Medi-Cal program. In contrast, the DHS has permitted all county welfare departments to use the MEDS because, according to the division chief, the county welfare departments are the agents of the State in determining Medi-Cal eligibility. However, DMH officials argue that the county mental health departments also directly administer the Medi-Cal program because they provide services that are eligible for Medi-Cal reimbursements and because they bill for and collect these reimbursements. By law, the DHS is responsible for making rules and regulations pertaining to the Medi-Cal program and, therefore, for deciding who may have access to the MEDS.

Until recently, the DMH has done little to assist the counties in obtaining access to the MEDS. During our audit, one county that we reviewed requested access to the MEDS, and the DMH arranged a meeting between county staff and DHS staff to discuss the county's access to the MEDS. Based on its understanding of state law regarding the confidentiality of Medi-Cal data, the DHS denied granting the county direct access to the MEDS. However, the DHS did agree to compare a sample list of the county's mental health clients with the MEDS master tape. If this comparison identifies a significant number of mental health clients who are eligible for Medi-Cal, the DHS will develop a system enabling counties to send their lists of potentially eligible

clients to the DMH for referral to the DHS. The DHS will match the list of potentially eligible clients against the MEDS and send the results to the DMH, which will pass the results on to the counties.

DMH officials recently told us that they intend to actively pursue obtaining access to the MEDS for the county mental health departments. In December 1984, the DMH requested the DHS to estimate how long it would take to compare the list of potentially eligible clients to the MEDS. The DHS reported that it would complete the comparison and analyze the results by April 1, 1985. At that time, the DHS, with the involvement of the DMH, will determine the process that the counties will use to determine Medi-Cal eligibility.

The DMH Has Not Helped Counties To Maximize Reimbursements From Insurance Firms

The DMH has not actively worked with insurance firms to resolve statewide issues related to reimbursement, such as improving coverage or reducing administrative requirements for claiming reimbursement. Some insurance firms do not reimburse counties for certain outpatient services or for services to individuals suffering from chronic mental illness. In addition, insurance firms require counties to follow various procedures for claiming reimbursement, but the counties are not fully aware of or cannot follow these procedures. County administrators for the counties we reviewed say that the counties are losing revenue because the DMH is not negotiating with

insurance firms to resolve issues such as the above. County administrators could not estimate how much revenue the counties are losing, however.

Counties' administrators for the three counties we reviewed state that the counties are losing insurance revenue because insurance firms do not pay for some clients and services. For instance, a county administrator said that one insurance firm does not reimburse the county for the services it provides each year to about 700 clients who are insured by this firm. Because this firm excludes from certain types of insurance coverage those clients whom it considers "chronically mentally ill," the firm does not reimburse the county for the mental health services that it provides these clients. In addition, the firm will not pay for crisis intervention or outpatient services. As a result of the insurance firm's refusal to reimburse for services, the county administrator estimates that the county loses $1 million each year.

Counties also contend that they lose revenue because they are not aware of or cannot meet the reimbursement requirements of health care systems or insurance firms. For example, a county administrator said that the county cannot meet one health care system's requirement that claims for emergency treatment be submitted within 15 days from the date the county provided the service. To meet this deadline, the county would need additional staff, and both the county's providers and the county's central billing office would have to process claims almost

immediately. The county's billing supervisor states it may be feasible for a physician's office to process claims this quickly, but it is not reasonable to expect such expeditious processing for claims that must be routed through the county billing process.

Recently, the DMH did work with two insurance firms to assist counties in claiming reimbursement. One insurance firm believed that California's system for determining clients' financial liability conflicted with the firm's policies. This firm required those whom it insured to pay 25 percent of the costs of mental health services. The insurance firm was concerned that California counties collected less than 25 percent of the costs from clients. The director of the DMH wrote the insurance firm explaining California's system for determining clients' financial liability and assuring the insurance firm that the counties do attempt to collect the clients' share of costs. As a result of correspondence and conversations with DMH officials, the insurance firm agreed to accept the counties' claims for reimbursement.

In another case, the DMH helped clarify information about the reimbursement policies of a large insurance firm that operates health care facilities. The billing staff in one county had received conflicting information from various facilities operated by this insurance firm. Consequently, counties had problems complying with the requirements for claiming reimbursement, and the insurance firm was denying claims. For example, one facility that this insurance firm operated notified the county that the firm did not offer "partial

hospitalization" as a benefit. Another facility operated by the same insurance firm informed the county that the insurance firm would cover partial hospitalization but only under certain circumstances. The DMH contacted the insurance firm and obtained clarification of its policies and procedures on a number of issues. The DMH then informed counties of the insurance firm's policies and the procedures that the counties must follow to meet the firm's requirements for claiming reimbursement.

Although the DMH assisted the counties in the two instances discussed above, DMH staff stated that they have no immediate plans to pursue other issues with insurance firms. However, they also stated that they recognize the need to increase insurance revenue, and they intend to pursue insurance issues at some time in the future. If the DMH were to work with insurance firms to resolve problems affecting counties throughout the State, it may be able to resolve some of the problems that counties have been experiencing in obtaining reimbursements from these firms. Our analysis of counties' activities in billing and collecting from insurance firms indicates that both the DMH and the counties should focus more of their efforts on collecting reimbursements from insurance firms. By not taking a more active role in assisting counties, the DMH has not assisted the counties to collect as much insurance revenue as possible.

CONCLUSION

Counties are not collecting all possible revenue for mental health services from clients, insurance firms, and the federal government. The three counties we reviewed are not securing sufficient information to bill clients, insurance firms, or the Medi-Cal program. In addition, the counties are not billing clients or insurance firms promptly, and in many instances, the counties are not billing insurance firms even when a client is insured. Counties also need to improve their procedures for collecting revenue. The counties we reviewed are not identifying delinquent accounts, notifying clients of the delinquency, following up with insurance firms to secure payment, or referring debts to county collection agencies. Moreover, county collection agencies collect only a small percentage of the debts referred by county mental health departments.

In addition, the Department of Mental Health is not adequately enforcing state requirements for collecting revenue, and the DMH needs to do more to assist counties to increase reimbursements from the Medi-Cal program and from insurance firms. Until recently, the DMH has not actively tried to assist counties in gaining access to the Department of Health Services' Medi-Cal Eligibility Data System. Also, the DMH has not actively pursued resolution of problems that the counties have with insurance firms.

As a result, the State has had to spend General Fund monies because counties have not collected millions of dollars in revenue that they could have collected from clients, insurance firms, and the federal government. The three counties we reviewed collected from clients, insurance firms, the federal portion of the Medi-Cal program and the federal Medicare program only about $43.2 million of the $148.7 million it cost them to provide mental health services. The counties collected only $4 million of that amount from clients and insurance firms.

RECOMMENDATIONS

The Department of Mental Health should assist counties to increase the collection of mental health debts by enforcing state requirements for billing and collecting revenue. The DMH should ensure that counties do the following:

- Obtain complete billing information from clients at the time and place they receive mental health services;

- Bill clients and insurance firms promptly;

- Provide complete information to support insurance claims;

- Maintain records on the status of delinquent accounts, identifying the age of the debt and whether it has been written off or adjusted; and

- Promptly notify debtors that their accounts are delinquent and make subsequent contact with clients and insurance firms to secure payment.

The DMH should also work with the Department of Health Services to grant all county mental health departments access to the Medi-Cal Eligibility Data System as soon as possible. If the DHS and the DMH cannot reach agreement by April 1, 1985, on granting the county mental health departments access to the MEDS, the Secretary of the Health and Welfare Agency should initiate action to resolve the issue.

Finally, the DMH should meet with the counties to determine the problems the counties have in claiming reimbursements from insurance firms. The DMH should determine which issues would benefit from statewide negotiation and then try to resolve those issues with the insurance firms. Further, the DMH should negotiate with insurance firms to reduce the firms' administrative requirements for submitting claims for reimbursement and to improve coverage for clients suffering from mental illnesses.

III

THE STATE'S MONITORING AND ENFORCEMENT PROGRAMS ARE LIMITED

The State's system for monitoring mental health treatment facilities and enforcing facilities' compliance with state regulations is limited. The Department of Health Services and the Department of Mental Health do not always have the staff or the enforcement mechanisms they need to perform these functions fully. As a result, the rights of some of the State's mental health clients have not been fully protected. This problem is especially severe in county-operated acute care hospitals where the demand for mental health services has forced some hospitals to maintain clients in potentially dangerous situations. Additionally, the DHS has not issued final regulations for licensing and monitoring psychiatric health facilities. The interim standards under which the psychiatric health facilities currently operate provide neither sufficient criteria nor adequate enforcement methods to regulate these facilities in all instances.

DHS' Licensing and Certification Division Does Not Always Ensure That Facilities Comply With Standards

Section 1254 of the Health and Safety Code gives the DHS the authority to develop regulations for operating mental health treatment facilities and the responsibility for licensing and inspecting these facilities. In accordance with this law, the DHS has issued standards

that govern the operation of psychiatric wards in general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities. These standards establish the requirements for staff, services, and physical plant in each of these types of facilities that treat mental health clients. To enforce these standards, the DHS Licensing and Certification Division's district offices conduct regular inspections of the facilities. When DHS investigators determine that a facility has violated state regulations, the department issues a "statement of deficiencies" to the facility. The administrators of the facility must then respond by submitting a plan of correction to the department within a specified period of time. If a facility fails to correct the deficiencies, the department can revoke the facility's license to operate or withdraw its certification for participation in the Medicare and Medi-Cal programs. In addition, if the facility is a skilled nursing facility, the department may issue citations that carry a civil penalty of up to $5,000 per violation.

Our review of case files in four DHS Licensing and Certification Division district offices indicates that the DHS does not always enforce standards pertaining to the operation of mental health treatment facilities. In two of the district offices, we found instances in which the DHS did not take enforcement action against facilities that violated state regulations for patient care and safety.

At one district office, we examined the case files of six mental health treatment facilities and found two instances during a

three-year period in which the DHS did not take enforcement actions against facilities that violated regulations. In the first instance, over a four-month period the district office issued statements of deficiencies to a facility for unclean conditions, improper administration of medications, poor patient care, and inadequate nursing staff. DHS staff said that because of these conditions, the DHS should have certified this facility for participation in the Medi-Cal and Medicare programs for only 6 months instead of 12 months, the maximum allowed by law. A DHS district office supervisor said that staff nevertheless certified the facility for 12 months because to do otherwise would have required another on-site review of the facility in 6 months, and the district office did not have enough staff to perform such a review. The second instance involved a facility that reported 12 separate occasions during a two-month period when clients were absent from the facility without permission. DHS staff stated that the district office had resolved this problem informally.

We also reviewed the case files of 10 mental health treatment facilities at a second district office and found two instances during a three-year period in which the DHS did not take enforcement actions against facilities that violated regulations. Both of these cases involved complaints filed against the facilities for improper use of medications. While district office staff substantiated both complaints, the district office did not take any enforcement action against the two facilities. The district administrator stated that, in both of these situations, the district office's physician consultant

advised that the violation was not significant enough to warrant any enforcement actions.

Finally, we reviewed the case files of 10 of the 53 mental health treatment facilities licensed and certified by a third DHS district office and 4 county hospital psychiatric units licensed and certified by a fourth DHS district office. We did not find any instances during a three-year period in which these district offices did not take enforcement action against facilities that violated regulations.

We also found that the DHS cannot always ensure that psychiatric units in county-operated acute care hospitals comply with state standards governing licensed capacity or the use of emergency services. Because mental health clients' demand for acute care exceeds the public supply of these services, psychiatric units in at least four acute care hospitals were forced to violate regulations by admitting more clients than they were able to care for. The DHS' district offices issued statements of deficiencies to three of these facilities. However, because these facilities are hospitals, the only methods of enforcement available to the DHS are revoking a hospital's license and withdrawing a hospital's certification for participating in the Medi-Cal and Medicare programs. The following examples demonstrate the severity of the problem.

On July 20, 1984, a DHS district office issued a statement of deficiency to a county-operated general acute care hospital for maintaining clients for more than 24 hours in its emergency psychiatric services unit on 53 occasions during one month. One of these occasions involved a client who remained in the emergency psychiatric services unit for four days sleeping either in a wheelchair or on a floor pad. On September 4, 1984, another district office issued a statement of deficiency to a county-operated general acute care hospital for admitting more clients to the facility's inpatient psychiatric unit than its license allowed. As of December 10, 1984, one of these two facilities had not yet offered a plan of correction that would solve its problem. The DHS has accepted the other facility's plan of correction, and the DHS district administrator stated that the situation will be closely monitored.

On June 29, 1984, a district office issued a statement of deficiency to a county-operated general acute care hospital for admitting more clients to its psychiatric unit than the available beds could accommodate. Because of the lack of beds in the psychiatric unit, this hospital inappropriately housed mental health clients in other units, thereby subjecting general acute care patients to potentially dangerous situations. This hospital has offered a plan of correction that will address the problem by converting some of its beds for medical/surgical clients to beds for mental health clients. The DHS' district administrator has stated that this plan is acceptable and that the district office will monitor its implementation.

Finally, an administrator of another county-operated general acute care hospital told us that this hospital frequently has to maintain clients for more than 24 hours in its emergency psychiatric services unit. On 99 separate occasions during one year, clients waited for at least 48 hours each in the emergency psychiatric services unit. At times, clients waiting in this unit slept on couches and chairs until a bed became available on a psychiatric inpatient ward. The DHS' district office has not issued a statement of deficiency to this facility.

The administrators and supervising psychiatrists responsible for operating the four facilities discussed above have said that their facilities treat all of the mental health clients that other facilities are not willing to accept. Thus, for many clients, the county-operated acute care hospitals are the last resort. Consequently, the demand for services sometimes forces these hospitals to provide treatment for more clients than their licenses allow. By accepting more clients than allowed, these hospitals do not provide services that meet state standards, and their clients' rights to considerate and respectful care are violated because they are subjected to overcrowded conditions, insufficient staffing, and potentially dangerous situations.

DHS staff stated that, because these facilities are hospitals, the DHS has only two enforcement actions available: revoking the facility's license or withdrawing the facility's accreditation or certification for participating in the Medicare and Medi-Cal programs.

DHS district administrators said that they are reluctant to invoke such measures because revoking facilities' licenses makes it even more difficult for the counties to offer much needed psychiatric services to the public and because decertifying facilities might cause hardships for clients whose treatment is financed by the Medicare or Medi-Cal programs. Therefore, district administrators have attempted to resolve problems informally. In two of the four situations we identified, informal negotiations have resulted in the facilities' preparing plans of correction that will resolve the problems. The other two situations have yet to be resolved, and mental health clients are likely to continue to be at risk.

DMH's Review of County Operations Is Limited

Insufficient staff and relatively few enforcement mechanisms make it difficult for the DMH to review counties' mental health programs. In addition, the DMH does not have adequate standards to regulate psychiatric health facilities, a specific type of treatment facility. The DHS was given the responsibility for developing regulations to license and monitor psychiatric health facilities over six years ago. As of February 1985, the DHS had not issued the final regulations.

Sections 4031 and 4060 through 4068 of the Welfare and Institutions Code authorize the DMH to review counties' mental health programs. The purpose of these reviews is to determine the strengths

and weaknesses of local programs and to ensure that counties comply with state standards. DMH staff stated that, until 1983, the department conducted a review of each county every three years, but reductions in staff during the past few years have forced the DMH to curtail these reviews to once every five years. DMH staffing declined from 805.7 authorized positions during fiscal year 1981-82 to 619.7 authorized positions in fiscal year 1984-85. DMH staff specifically responsible for reviewing county programs was reduced from seven positions to four positions during fiscal year 1983-84.

When DMH staff detect problems in counties' mental health programs, they are reluctant to take enforcement actions for two reasons: first, the DMH's role has historically been that of a consultant to, not a monitor of, the counties; second, the DMH has only one enforcement mechanism available--withholding part of a county's appropriation of funds from the Short-Doyle Act. DMH staff stated that they are reluctant to withhold these funds because such a severe action could cause a county to reduce services, thereby creating hardships for mental health clients.

The DMH is also responsible for monitoring the operations of psychiatric health facilities, which provide acute care services in nonhospital settings. As Section 5652.5 of the Welfare and Institutions Code indicates, the Legislature intended for the DHS to be responsible for licensing and inspecting psychiatric health facilities. However, the law specified that the DMH was to carry out this

responsibility until the DHS developed regulations for monitoring these facilities. The Legislature enacted this measure six years ago, but the DHS still has not issued final regulations for monitoring psychiatric health facilities. DHS officials stated that they first proposed regulations for psychiatric health facilities in 1979, but several factors have delayed their issuance. First, the Department of Finance delayed the progress of the regulations for one year during fiscal year 1980-81. Second, DHS officials said that they did not have staff to work on the regulations. Finally, according to DHS officials, the DHS did not receive the comments from county mental health directors on the proposed regulations. As a result, in October 1984, when the DHS was made aware of the local mental health directors' concerns, the proposed regulations had to be rewritten to incorporate those concerns.

In November 1979, the DMH, in accordance with Section 5652.5 of the Welfare and Institutions Code, informed the counties about the procedures they had to follow to obtain approval for operating a psychiatric health facility. In November 1981, the DMH issued interim standards governing the operation of psychiatric health facilities. The DMH uses these standards as criteria when reviewing facilities' requests for waivers from licensure and for monitoring facilities' activities. Although these interim standards have allowed psychiatric health facilities to operate for the past three years, DMH staff acknowledge that the interim standards provide neither sufficient criteria nor adequate enforcement methods for regulating psychiatric

health facilities in all instances. The results of the DMH's investigation of a recent suicide at one of the psychiatric health facilities illustrate the inadequacy of the interim standards.

DMH staff said that staff at the facility in which the suicide occurred had not received adequate training in suicide prevention, and the facility did not have formal suicide prevention procedures. Although the interim standards for psychiatric health facilities do require that staff receive in-service training, the interim standards do not specifically require that staff be trained in suicide prevention procedures, nor do they require that facilities develop such procedures. According to staff at the DMH and the DHS, the regulations currently being drafted by DHS staff will not require psychiatric health facilities to develop suicide prevention procedures.

The only enforcement mechanism currently available to the DMH to regulate psychiatric health facilities is withdrawing a facility's waiver from licensure. DMH staff have stated that they are reluctant to use this enforcement mechanism because of the hardship that closing a psychiatric health facility might have on clients.

The DHS and the DMH May Need Additional Enforcement Mechanisms

The two state departments responsible for monitoring mental health treatment facilities in California, the DHS and the DMH, do not always have viable enforcement mechanisms at their disposal. The DHS

does not have the authority to impose fines on county hospitals that violate state regulations, and the DMH cannot impose fines on county mental health departments or psychiatric health facilities that violate state regulations. The only options that the two departments have in these situations are to revoke a facility's license or to reduce funding to the facility or the county mental health department.

The DHS and the DMH have been reluctant to use these enforcement measures because they are severe and because they are likely to cause hardships for mental health clients. Therefore, when mental health facilities violate state regulations, there may be a need for the DHS and the DMH to have the authority to impose fines as the DHS currently does when nursing homes violate state regulations. We discussed this option with officials of both the DMH and the DHS. Two DHS officials stated that they believe a system of fines would provide a needed alternative for enforcing facilities' compliance with state regulations. Other DHS and DMH officials were not convinced that a system of fines would ensure that these facilities and programs comply with state regulations.

CONCLUSION

The State's system for monitoring mental health treatment facilities and ensuring their compliance with standards is limited. The Department of Health Services does not always enforce compliance with standards, and in some instances, the DHS does not have the mechanism to do so. As a result, the rights of the State's mental health clients are not always protected, and clients are sometimes subjected to dangerous conditions, especially in the psychiatric units of county-operated general acute care hospitals where the demand for services forces overcrowding of clients.

In addition, the Department of Mental Health's efforts to review county programs are limited by lack of staff and by the severity of the DMH's only enforcement mechanism, withholding appropriations available under the Short-Doyle Act. Finally, the DHS has not issued final regulations for psychiatric health facilities, and the interim standards used by the DMH do not provide sufficient criteria for regulating these facilities.

RECOMMENDATIONS

To ensure that the rights of the State's mental health clients are fully protected, whenever a psychiatric unit of a county-operated general acute care hospital violates standards related to licensed capacity or the use of emergency services, the Department of Health Services' Licensing and Certification Division should coordinate efforts with the Department of Mental Health to compel the county mental health department to resolve the problem as soon as possible.

To ensure that psychiatric health facilities provide effective treatment in a safe environment, the DMH and the DHS should issue final regulations governing the operations of psychiatric health facilities. The regulations should include requirements that these facilities develop procedures for preventing suicides and for training their staff in the use of these procedures.

To ensure that county hospitals, county mental health programs, and psychiatric health facilities comply with state regulations, the DHS and the DMH should evaluate the viability of current enforcement mechanisms and determine whether there is a need for an alternative enforcement mechanism, such as a citation system, for instances in which facilities violate state regulations. If the DHS and the DMH determine that

there is a need for an alternative enforcement mechanism, these departments should request authority from the Legislature to use this mechanism.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

Date: March 11, 1985

Staff: Robert E. Christophel, Audit Manager
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March 1, 1985

Thomas W. Hayes
Auditor General
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660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

AUDITOR GENERAL'S REPORT, P-441

We have reviewed Report P-441, "The State's Mental Health System Could Be Operated More Cost-Effectively and Could Better Meet the Needs of Clients," dated March, 1985, and have the following comments:

1. Recommendation: To improve the State's mental health treatment system, the Department of Mental Health should encourage the development of mental health resources below the acute care level by implementing a plan that will enable counties to reduce their use of expensive acute care facilities. This plan should examine the relative costs and benefits of increasing the number of state hospital beds below the acute care level, increasing the resources below the acute care level in the counties, and initiating a pilot project to establish residential care rates based on the level of care needed by mental health clients who have a history of behavioral problems. The DMH should submit this plan by December 31, 1985, to the Senate Health and Welfare Subcommittee on Mental Health, Developmental Disabilities, and Genetic Diseases and to the Assembly Subcommittee on Mental Health and Developmental Disabilities.

   Response: Agree. DMH will continue and intensify its efforts to promote the development of mental health resources below the acute level. Consistent with LPS and Short-Doyle philosophy those activities will focus on the establishment of such facilities at the local level. To increase state hospital beds, would be inconsistent with the intent of the statutes governing mental health in this state. The plan will also include a section describing the Department's efforts related to the implementation of the findings of the residential care rate study required by Welfare and Institutions Code, Sections 4075 et seq. It will be the responsibility of the Division of Community Programs to oversee this function. A high priority will be placed on meeting this commitment.

2. Recommendation: To reduce the days that mental health clients under conservatorship remain unnecessarily at the acute care level while their financial assets are being evaluated, the DMH

should require counties to place in a revolving fund a portion of the funds allocated to them each year by the Short-Doyle Act. Staff at county-operated acute facilities should use this revolving fund when conservatorship proceedings delay the efforts to secure funding for clients who should be transferred to less restrictive settings.

Response: Agree. For many years, DMH's OMHSS offices and some counties have had such revolving funds for their clients. Currently, almost all of these offices have "opted out" and are part of county programs. To further promote the use of revolving funds or similar concepts at the local level, DMH will issue an information letter to all counties. It will be the responsibility of the Division of Community Programs to develop this letter. This action will occur by June 30, 1985.

3. Recommendation: To ensure that psychiatric health facilities operate at the minimum cost to the State and to ensure that there are means to regulate their activities effectively, the Department of Health Services should issue final regulations governing the operations of psychiatric health facilities as soon as possible. Once the final regulations have been issued, the Legislature should enlist the assistance of the California Congressional Delegation to petition the United States Congress to amend Title 42 of the United States Code to make psychiatric health facilities, which represent a cost-effective alternative to acute psychiatric care in hospitals, eligible for federal reimbursement under the Medicaid Program (referred to as Medi-Cal Program in California).

   Response: The issue of psychiatric health facility regulations is addressed in response #8 in this report.

   The Department of Mental Health has sought approval from the federal government for federal participation for services provided by psychiatric health facilities. The response from the federal government has indicated that federal financial participation is not available and the only way to cover such services is to amend the Social Security Act.

   The Department of Mental Health and the Department of Health Services are in agreement on the goal of maximizing federal financial participation within the limits of federal laws and regulations. The Department of Mental Health will continue to coordinate planning efforts and to pursue every alternative possible.

4. Recommendation: The Department of Mental Health should assist counties to increase the collection of mental health debts by enforcing state requirements for billing and collecting revenue. The DMH should ensure that counties do the following:

   - Obtain complete billing information from clients at the

time and place they receive mental health services;

- Bill clients and insurance firms promptly;
- Provide complete information to support insurance claims;
- Maintain records on the status of delinquent accounts, identifying the age of the debt and whether it has been written off or adjusted; and
- Promptly notify debtors that their accounts are delinquent and make subsequent contact with clients and insurance firms to secure payment.

Response: Agree. The Department's Revenue Enhancement Section held six regional workshops last year for clinical managers and administrators to identify statewide revenue problem areas. Scheduling is now in progress to conduct financial screening and fee determination training session as a follow-up to these workshops. This training will focus on financial screening, data verification, and payment plans. Completed insurance claims and patient billing will also be addressed and a timely approach toward the collection of delinquent accounts and follow-up of insurance claims. Additionally, under development is a policy and procedure for identifying and reporting accounts receivable data.

5. Recommendation: The DMH should also work with the Department of Health Services to grant all county mental health departments access to the Medi-Cal Eligibility Data System as soon as possible. If the DHS and DMH cannot reach agreement on granting the county mental health departments access to the MEDS by March 1, 1985, the Secretary of the Health and Welfare Agency should initiate action to resolve the issue.

Response: The Department of Mental Health and the Department of Health Services have held discussions related to the feasibility and the effectiveness of utilizing the Medi-Cal Eligibility Data System (MEDS) to verify client eligibility in relation to county claims for reimbursement for Short-Doyle services provided to Medi-Cal beneficiaries.

The Department of Health Services has determined that it is legally prohibited from allowing county mental health programs direct access to the MEDS computers on the local level, but as an alternative, has implemented a "test" project to compare the effectiveness of verifying claims via MEDS as opposed to the current practice of verifying via the Eligibility History File.

The Department of Health Services is currently analyzing the data from the project and will share the results with the Department of Mental Health in the near future. The intent is to assist county mental health programs maximize Medi-Cal reimbursement by utilizing the most effective mechanism available to verify client eligibility. If the test project proves feasible, implementation will occur statewide as soon as is technically possible.

6. Recommendation: The DMH should meet with the counties to determine the problems the counties have in claiming reimbursements from insurance firms. The DMH should determine which issues would benefit from statewide negotiation and then try to resolve those issues with the insurance firms. Further, the DMH should negotiate with insurance firms to reduce the firms' administrative requirements for submitted claims for reimbursement and to improve coverage for clients suffering from mental illnesses.

   Response: Agree. In dealing with county insurance claim problems, the Department has worked with individual counties and with the Conference of Local Mental Health Directors on selected insurance issues. The Department recently resolved issues related to one HMO and two Federal agencies. In addition, over 1,100 notices were sent to insurance firms advising them of new legislation expanding coverage for mental health services. We will continue to meet with counties to identify and address appropriate insurance issues.

   Work is now in progress for workshops, which will address insurance claims and proper interface with the insurance industry. Also in progress is a letter to counties which will clarify a Medicare/Medi-Cal issue affecting county reimbursement.

7. Recommendation: To ensure that the rights of the State's mental health clients are fully protected, whenever a psychiatric unit of a county-operated general acute care hospital violates standards related to licensed capacity or the use of emergency services, the Department of Health Services' Licensing and Certification Division should coordinate efforts with the Department of Mental Health to compel the county mental health department to resolve the problem as soon as possible.

   Response: Agree. While the Department of Mental Health does not have responsibility for licensure of acute care hospitals, there are times when two departments working cooperatively can bring a provider into compliance. Accordingly, the Chief of the Clinical Standards and Treatment Review Section will be designated by DMH to coordinate this function with Department of Health Services staff.

8. Recommendation: To ensure that psychiatric health facilities provide effective treatment in a safe environment, the DMH and the DHS should issue final regulations governing the operations of psychiatric health facilities. The regulations should include requirements that these facilities develop procedures for preventing suicides and for training their staff in the use of these procedures.

Response: Agree. The Department of Mental Health places a high priority on the promulgation of regulations for Psychiatric Health Facilities. Practically speaking, this effort involves more than the Department of Health Services and the Department of Mental Health. The Conference of Local Mental Health Directors also has a vital role. While a great deal of consensus has been reached concerning the regulations, even greater effort needs to be expended. It will be the responsibility of the Chief, Clinical Standards and Treatment Review to oversee this function for the Department of Mental Health. A high priority will be placed on meeting this commitment no later than the summer of 1986. Moreover, these regulations will include the requirement for training on preventing suicides.

9. Recommendation: To ensure that county hospitals, county mental health programs, and psychiatric health facilities comply with state regulations, the DHS and DMH should evaluate the viability of current enforcement mechanisms and determine whether there is a need for an alternative enforcement mechanism, such as a citation system, for instances in which facilities violate state regulations. If the DHS and the DMH determine that there is a need for an alternative enforcement mechanism, these departments should request authority from the Legislature to use this mechanism.

   Response: Agree. As stated earlier, the Department of Mental Health is currently working with the Department of Health Services to complete regulations for Psychiatric Health Facilities. We anticipate this being completed by mid-summer 1985. Providing this timeline is accomplished, DMH would not require alternative enforcement mechanisms, since we would no longer be involved in the licensing or monitoring of Psychiatric Health Facilities. DHS currently has a range of enforcement procedures, which DMH believes are adequate.

If you have any questions, please contact Douglas G. Arnold, Deputy Director, Division of Community Programs, (916) 323-8176.

Sincerely,

DAVID B. SWOAP
Secretary

cc: D. Michael O'Connor, M.D.
Director
Department of Mental Health

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps