Section 4: Weak Administrative Processes

The team reviewed selected administrative processes to determine whether they were impeding fiscal accountability and overall performance. The team did not re-engineer these processes; that task is left to the department.

There are many other DMH processes that need attention. The department will need to continue the search for and correction of weak processes, particularly internal controls.

Regarding internal controls, the team advises that DMH review the 2008 internal audit report prepared by the Office of State Audits and Evaluations (Finance) for processes the report identified as flawed. The team believes that the department's implementation of its audit response was inadequate and that many problems called out in the audit have not been addressed.

This section addresses the following processes and systems:

Fiscal

1. Appropriation control
2. Base budgets
3. Cost centers
4. Expenditure projections/year-end closing/cash management
5. Preventing the unintentional loss of LOC position authority
6. Reconciling allocations and hospitals' authorized positions; salary savings
7. Reconciliation of hospitals' allocations, the hospital appropriation, and State Controller accounts
8. Staffing standards used for the population BCP
9. Planning and resource acquisition for operating expenses
10. Resource acquisition for NLOC positions
11. Deficit management
12. Internal controls auditing/response to audits
13. Incorrect application of benefit rates
14. Reimbursement of County Beds through Fund 872
15. Unused Balances in Fund 942 (Audit Exceptions)

Personnel

16. Overtime payments
17. Out-of-class assignments
18. Recruitment
    a. Exams and job analysis
    b. Hiring freeze exemptions

c. In-lieu personal service contracts (aka registry contracts)

Contracts

19. Contract timeframes
20. Delegation and signature levels
21. Encumbering external registry contracts

Weak Administrative Processes: Summary Findings

- ✓ The department's overall system of appropriation control (attitudes, processes, IT systems, and analytic staff) is deficient. A formal plan needs to be prepared to regain fiscal control.
- ✓ Base budgets are missing for both headquarters and the hospitals. This impairs budget management.
- ✓ The department does not have an overall cost center plan for tracking expenditures by program or activity to address management information needs or better fiscal control.
- ✓ The department lacks documented methodologies, and in some cases procedures and timeframes, for producing expenditure analyses and forecasts.
- ✓ Budget procedures for managing LOC positions need to be revised to prevent the inadvertent loss or overuse of the positions.
- ✓ Incomplete position control can result in deficits. Processes for position control need to be modified to create a connection between position actions and budgetary review.
- ✓ Hospitals are not managing their salary savings correctly, in part because they need budget training.
- ✓ Resource acquisition is flawed because processes used to request resources do not reflect actual operations. For example, the staffing standards used to update hospitals' LOC positions and budget annually do not include the full range of LOC operations. This is a deficit factor (see Section 7).
- ✓ Three headquarters units which are jointly responsible for the accuracy of hospitals' allocations and sub-appropriations at the State Controller's Office have not worked effectively together. The result is that hospitals in 2010-11 did not have correct allocations.
- ✓ The department does not have procedures to reassess periodically its need for operating expenses and NLOC positions.
- ✓ The department does not have procedures for effective management of deficit situations.
- ✓ The department is not using its single auditor effectively nor does it appear to be following through with its audit responses in some cases. With limited resources, the department needs to establish achievable audit objectives and processes that provide reasonable assurance that responses for major audit findings are actually implemented.
- ✓ The department is using incorrect processes for budgeting of benefits.
- ✓ Two funds that the department uses have built up excess balances that need to be addressed (Funds 872 and 942).
- ✓ Overtime fraud is a risk in departments with high overtime usage. Hospital and headquarters staff need documented processes to perform periodic audits.

- ✓ A blocked exam process has created a serious problem for hospitals. A rapid solution is needed.
- ✓ Recruitment remains a significant problem for remote locations. The use of contract registries is an expensive alternative that fosters incentives that actually make permanent recruitment more difficult. The department needs to explore other approaches to the recruitment problem.
- ✓ Contract processing timeframes are unreasonably long (9 to 12 months) and approval levels vested too high in the organization. In addition, available delegations which would help with this problem were not fully implemented at the time of this report.

Fiscal

1. **Appropriation control**

Observations

- ✓ Appropriation control is the sum of many separate processes: sound base budget management which includes accurate documentation of appropriation and allocation changes; correct identification and costing of budgetary needs; position control and salary savings management; expenditure analysis and projections; and documented assignment of fiscal responsibilities.
- ✓ Appropriation control also depends on the willingness of the executive office to hold managers accountable for their budgets.
- ✓ Good fiscal management processes rely on IT systems support.
- ✓ The department's overall system of appropriation control (processes, attitudes, and IT systems) is failing.
- ✓ Revising entire systems of appropriation control is a task that needs to be planned carefully. Hospitals, the LTCS fiscal unit, the budget, and the accounting office all need to work together.
- ✓ There is insufficient analytic staff support to assist with systems and process planning (see Section 3).

Conclusions

- ✓ The department needs to comprehensively review all fiscal control systems and redesign those that are deficient.
- ✓ This redesign needs to begin with the budget office and extend to the connecting processes between budgets, accounting, and the LTCS fiscal unit.
- ✓ Simultaneously, the hospital fiscal officers should begin the same exercise for the hospitals.
- ✓ Headquarters and the hospitals need to coordinate their plans for system improvements as soon as the headquarters has worked out its coordination issues.

Recommendations

- ➢ Prepare a formal plan for regaining appropriation control. Review all fiscal control systems. Triage necessary process changes, assign responsibility and timeframes for resolution, and monitor progress.
- ➢ Evaluate duty statements and make changes to clearly assign responsibility for process management and for fiscal accountability. Then hold management accountable.
- ➢ Document procedures and processes—the failure to do so is the number one problem that hospitals report.
- ➢ Until the department has the IT resources to focus on appropriation control systems, it should ensure that hospitals share their "best of breed" IT desktop systems. Share appropriate headquarters tools as well.

2. Base Budgets—no processes in place to establish and maintain base budgets

Observations

- ✓ Line item organizational budgets are the first step in fiscal control. They establish expenditure targets.
- ✓ Neither headquarters nor hospitals have base budgets .[1] In a deficit situation, meaningful base budgets cannot be created by simply prorating expenses. The result would not have an operational corollary.
- ✓ The team worked with the hospitals to construct *operational* budgets as a first step.[2]
    - The operational budget is a line-item summary of what each hospital is currently spending to support present operations. This review uses two years of expenditure data for analysis.
    - Negative adjustments and/or funding augmentations are applied to the operational base until the operational base aligns with a base approved by Finance and the Legislature.
    - This first step proved difficult because hospitals have coded expenditures in non-standard ways (a problem resolved prospectively, but not for the historical data).
- ✓ There are currently no procedures in place to assist hospitals with maintaining line-item budgets accurately over time.

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[1] The 2008 Finance internal controls audit recommended that DMH "develop organization and programmatic budgets and an indirect cost allocation plan" (*California Department of Mental Health –Internal Control Review*, January 1, 2008, prepared by the Office of State Audits and Evaluations, Department of Finance, p. 10). In response, DMH reported, "DMH has completed the organizational and programmatic budgets as of June 2009. The indirect cost allocation plan for FY 2008-09 was completed, but not loaded into CALSTARS. The FY 2008-09 indirect cost allocation plan will be used as the baseline for FY 2009-10. The indirect cost allocation plan was completed and submitted to the Federal Department of Health and Human Services (HHS) for review as of 8/31/09. DMH is currently in the process of responding to questions from HHS" (DMH Corrective Action Plan, Appendix 4.A, December 30, 2010). Despite its assertion, the department did not implement this recommendation.

[2] No similar exercise has begun for headquarters.

- ✓ The budget office is the likely candidate for assisting hospitals with learning how to maintain line item budgets, but the office itself needs training.

Conclusions

- ✓ Base budgets that tie to a defined service level must be established for headquarters and the hospitals as quickly as possible. The longer this process takes, the longer it will take to establish fiscal control.
- ✓ Written guidelines are needed to ensure that once established base budgets are not lost through neglect or mismanagement.
- ✓ All adjustments to the base must be documented reliably by line item and purpose. Each hospital should maintain a permanent file of its adjustments, and copies of hospitals' adjustments should be kept by the budget office. Each division at headquarters should maintain the same type of permanent file.

Recommendations

- ➢ By March 2012, implement hospital and headquarters division base budgets by line-item for 2011-12.
- ➢ Set up cross-organizational systems and processes that support line item control of the hospitals' and headquarters' allocations. This may require hiring or contracting for assistance.
- ➢ Provide necessary training to the budget office, headquarters' managers, the LTCS fiscal unit, and the hospitals in base budget maintenance.

3. Cost Centers

Observations

- ✓ A cost center is a distinctly identifiable department, division, or unit of an organization whose managers are responsible for all its associated costs and for ensuring adherence to its budgets.[3]
- ✓ A chart of accounts is a table identifying cost centers the organization uses by selected criteria such as agency code, program, location (index) and fund source.
- ✓ The department has no process by which it evaluates when it should set up a cost center.
- ✓ Headquarters has established too many cost centers, given that managers have little or no understanding of how to monitor even a summary budget for their division using CALSTARS, much less sub-budgets.
- ✓ Each hospital has implemented CALSTARS somewhat differently.
- ✓ There is no plan that defines what the common core of accounting data should be for hospitals.

[3] Hyperlinks to definitions from BusinessDictionary.com

- ✓ Any plan for altering the collection of cost data would need to consider workload impacts on program managers, accounting staff, and budget staff in headquarters and at the hospitals.

Conclusions

- ✓ Streamlining headquarters cost centers will reduce workload in both the budget and accounting office. Currently, this workload has little benefit. The streamlining cannot, however, impede fiscal control.
- ✓ As the divisions gain budget expertise, they should be encouraged to expand or change their cost centers as necessary to improve management information and fiscal control.
- ✓ The department needs a plan that identifies management and operational uses for hospital cost data. It also needs a process for adjusting that plan. The plan and the process should be developed collaboratively with the hospitals. The hospitals have a better sense of their cost collections needs than headquarters.
- ✓ Introducing additional cost centers for the hospitals will have a workload impact.

Recommendations

- ➢ Develop a plan (as described above) for each of the divisions and hospitals that sets an achievable starting point for their respective charts of accounts, considering workload impact and experience. Develop a vision of where information collection, and therefore cost centers, should be in three years.
- ➢ Provide necessary training and assistance so that 1) the plan is well-informed on costs (workload) and benefits (improved program information, fiscal control) and 2) implementation has a good prognosis for success.
- ➢ Phase in the plan as necessary.
- ➢ Become familiar with FI$Cal, the state's new comprehensive fiscal management system. If implementation of FI$Cal proceeds according to schedule, the state hospital department should be transitioned to it within 5 to 7 years. The goal is to have a well-developed structure of cost centers and sound data collection in place in advance of that time.

4. Expenditure projections/year-end closing/cash management

Observations

- ✓ The budget office projects expenditures for headquarters as a whole, by fund source and by program, but not by division or unit. The team is not aware of any written process or any attempt to project costs by division (since there are no approved division or unit allotments).
- ✓ There is no process that establishes how often headquarters expenditure projections are made, who that information goes to, in what format, and how corrective actions are to be made for maintaining fiscal control.

- A formal expenditure projection for headquarters appropriations would have revealed several over-expenditures that needed concurrence by Finance for category transfers (per budget act language).
- The team has identified unauthorized transfers of expenditures made during headquarters' year-end closing. See Section 8.

✓ The hospitals send expenditure projections to the LTCS fiscal unit monthly, beginning late in the calendar year.

✓ The expenditure data is on a single allotment/expenditure ledger (i.e. roll-up) for each hospital and is submitted on hospital-generated spreadsheets (not CALSTARS).

✓ The level of expenditure detail varies between hospitals.[4]

✓ The LTCS fiscal unit monitors total expenditures in relation to the allocations.[5]

✓ High-level expenditure reports are provided to LTCS management and executive management when requested.

✓ There are no written procedures or other guidance for how expenditure projections should be made.
- There is no training offered to the hospitals on sound principles of expenditure projection.
- The hospitals do not receive assistance from the budget office with projections.

✓ The LTCS fiscal unit does not reconcile the expenditure data with CALSTARS, nor does it reconcile the allocations with the State Controller's accounts.

✓ The budget office does not participate in the LTCS fiscal unit's review of expenditure projections.

✓ Determining the hospitals' deficit for 2010-11 was time-consuming and fraught with error.
- Hospitals' own estimates were not used for costing the first formal deficit estimate that resulted in a supplemental appropriation of $50 million. In part this was due to differences among the hospitals in projection methodology. Instead, a straight-line estimation process was used which did not use expenditure patterns or include month 13 in CALSTARS, i.e., accrued expenses. Hence, the estimate was low.
- For year-end projections, the hospitals' estimates were used, but it was necessary for the team to create a template and visit each hospital to ensure that application was consistent.
- Reconciliation of allocations to the State Controller's accounts was difficult. See #7 below.

✓ The accounting office does not, as a practice, provide assistance to the hospitals during year-end closing. It does shift allocations among hospitals to help ensure

[4] Areas where hospitals' projections differ include 1) the line item of expenditure used for projections; 2) the number of prior year's data used for projections; 3) sophistication of projection techniques.

[5] However, the unit does not analyze hospital expenditures in detail.

that payroll can be met. It does not necessarily inform the LTCS fiscal unit or the hospitals of these shifts, thereby making accurate estimates of available balances and reconciling to the State Controller's accounts difficult. See #7 below.

- ✓ In each of the last two years the hospital appropriation has ended the year in deficit. Vendor payments have been stopped. Meeting payroll has been difficult and has required moving funds between sub-appropriations and assistance from Finance through reversal of executive orders.
- ✓ Timely analysis of cash status, with appropriate communication to the executive office and planning of impacts including vendor notification, has not occurred.
- ✓ Ongoing analysis of cash status is essential in order to manage tight budget or actual deficit situations. Part of this analysis is review of anticipated versus actual reimbursements. This review is needed for each DMH appropriation and (for hospitals) sub-appropriation.
- ✓ Cash flow statements are not currently required of each hospital or of headquarters.
- ✓ There are no documented procedures for cash flow analysis.
- ✓ Clearing accounts appear to be used when not necessary.
- ✓ Contracts for outside registry employees, per DGS instruction, are executed for the maximum feasible amount, which is many times final liquidation. For example, Coalinga SH may encumber more in registry contracts than its entire budget. The reason for this is that the hospital does not know in advance final distribution of use. In addition, contract processing timeframes are so long that routine amendment for cost is infeasible. This approach complicates accurate cost projection. See #21 below for additional discussion.

Conclusions

- ✓ Headquarters and the hospitals need written procedures for expenditure projections. Procedures should address:
    - what will be projected and why,
    - methodologies,
    - sources of data,
    - assignment of responsibilities for preparation and review,
    - frequency of estimates, and
    - management reports to the executive office and operations division.
- ✓ Hospitals and headquarters should document the reasons for significant changes in their expenditure projections.
- ✓ Headquarters and the hospitals also need written procedures for cash flow analysis. Cash flow statements should be required of each hospital and headquarters on a monthly basis, consolidated by the administrative division, and summarized into management reports for the executive office and operations division. If a hospital believes it cannot meet normal payment timeframes due to a cash shortage (including a reimbursement problem), the statement should identify when the

shortfall will occur and why, what the payment priority is and why, and the steps to resolve the problem.

- ✓ Hospitals are projecting expenditures without guidance. The hospitals would benefit from developing their own written procedures and training on expenditure projections, with headquarters' input.
- ✓ Responsibilities should be assigned and documented for different portions of the hospitals' expenditure projection process.
    - The goal is coordination between the hospitals, LTCS fiscal unit, budget office, and accounting office.
    - Primacy should be given to the hospitals' estimates since they have the detailed knowledge.
    - Headquarters should form an independent assessment of hospitals' projections.
- ✓ The hospitals are thinly staffed for making expenditure projections. If more cost centers are required over time, this workload imbalance will grow.
- ✓ To improve accuracy of expenditure projections, a different method of encumbering registry contracts is needed.
- ✓ The administrative division moved category over-expenditures without required authorizations during the year-end closing process. Correct processes may not have prevented the over-expenditures, but they would have made the over-expenditures easier to detect and address.
- ✓ The department should review its use of clearing accounts.

Recommendations

- ➢ For expenditure projections, assign and document responsibilities, develop and document procedures, and train as necessary in how to read CALSTARS reports and to prepare estimates and analyses.[6] This is true for both headquarters and the hospitals.
- ➢ For cash flow analysis, assign and document responsibilities, and develop and document procedures. Train staff. See Appendix 4.B for the cash flow form the team developed with hospitals.
- ➢ Develop standardized management expenditure reports distributed on a regular basis that identify significant issues. This recommendation applies both to hospitals and headquarters.
- ➢ Minimize the use of clearing accounts to reflect costs more accurately and timely. Additional CALSTARS training might eliminate this problem.
- ➢ Charge the hospitals with collaboratively standardizing their hospital expenditure reporting and projection methodologies.
    - Have the fiscal officers develop a plan for standardization and documentation of processes with timelines.

[6] Training should also be offered on transaction reconciliation, particularly for headquarters.

  - It would be appropriate for headquarters to participate but not to lead, given current lack of experience with hospital budgets.
- ➢ Address staffing requirements of expenditure analysis as resources permit (both headquarters and the hospitals).
- ➢ Revise external registry encumbrance processes to improve expenditure forecasting accuracy (See #21 below).

5. Preventing the unintentional loss of LOC position authority

Observations

- ✓ The department uses LOC staffing standards in the population BCP and the internal allocation process. The standards apply to most, but not all, LOC positions.[7]
- ✓ The current population BCP methodology recalculates or "zero-bases" each year those LOC positions that are driven by staffing standards.
- ✓ Adjustments are made on the margin by comparing these projections to the last approved population BCP.
- ✓ The Schedule 7A does not distinguish LOC positions driven by staffing standards from those that are not.
- ✓ When the budget office updates the Schedule 7A for the incremental change in LOC positions per the population BCP, it can inadvertently include in its base calculation the LOC positions that are not driven by staffing standards. (See Appendix 4.C for the Schedule 7A and staffing standards comparison.)
- ✓ The team is advised that the Schedule 7A is short by 210 LOC positions system-wide. The team has not independently verified either the number or the cause. However, in interviews with one hospital, the human resources chief pointed to more than 15 supervisory LOC positions (not driven by staffing standards) that disappeared in subsequent allocations presumably because of this problem.
- ✓ There are no documented procedures or assignments of responsibility for LOC position control.

Conclusions

- ✓ Procedures and assignment of responsibility are needed. In general, the budget office needs control over the Schedule 7A, but lacking system knowledge it reportedly has inadvertently caused the loss of LOC position authority.
- ✓ This is a system problem easily resolved by including two categories for LOC positions in the Schedule 7A for each hospital (standards-driven and fixed).
- ✓ A system resolution does not solve the base shortage.
- ✓ The team is advised this problem occurred several years ago. A budget adjustment was made, but the underlying process problem was not fixed.

[7] LOC positions not covered by the standards include pharmacists, dieticians, dentists, and food service workers.

Recommendations

- The department needs to detail the reported discrepancy between staffing standards and LOC authorized positions and verify the cause so that correct system solutions are implemented.
- If there is a shortage, the department will need to negotiate a solution to the problem with Finance.
- Whichever process alternative the department and Finance agree to, the conclusion and related procedures should be documented and communicated to the hospitals, the budget office, and the LTCS fiscal unit.
- The budget office, LTCS fiscal unit, and the hospital human resources directors should jointly reconcile standards-driven and fixed LOC each year.

6. Reconciling allocations to hospitals' authorized positions; salary savings

Observations

- ✓ The discussion below is premised on the assumption that gross misalignments of the budget with authorized staffing have been rectified and the Schedule 7A is basically in maintenance mode. This is not currently the case, since as of October 2011 the department has not addressed the following:
  - Workforce cap;[8] and
  - Unfunded normal operating patterns, such as enhanced observations, admissions suite, and acuity staffing.
- ✓ Hospitals tend to view their authorized positions as equivalent to their funded positions. They understand they have a salary savings requirement, but they do not appear to regard it as a dynamic number that can change based on position and funding allocation changes throughout the year.
- ✓ A hospital's LOC position authority in the Schedule 7A may deviate from the number of LOC positions funded in the allocation process. If a hospital's census has dropped at the time of the next allocation cycle, its allocation will be reduced but its Schedule 7A will not be adjusted until the beginning of the next fiscal year.
- ✓ For other reasons, funding for positions may become misaligned with staffing authority.
  - Overall population decreases can result in a system-wide funding constriction that leaves positions unfunded during the course of a year.[9]
  - Unallocated reductions reduce funding but not staff.
  - Salary or benefit adjustments that are not fully funded reduce the ability to use positions. The team was advised that salary adjustments in previous years were not fully funded.[10]

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[8] Subsequently addressed in November 2011.

[9] If census drops by more than 2.5 percent of budgeted levels, the department may be required to move an equivalent amount of the hospital appropriation to an unallocated account.

[10] *Coleman*, *Plata*, and *Perez* salary adjustments for overtime and temporary help were not funded.

- ✓ Hospitals and the LTCS fiscal unit do not regularly compare hospital funding with position authority and adjust position usage accordingly.
  - Hospitals approach position control entirely as a personnel office function. They do not verify funding availability for reclassifications.
- ✓ When positions for LOC are not fully funded, but the hospital does not adjust position deployment, this becomes a deficiency pressure.
- ✓ The team is advised that the hospitals have permanent positions in the blanket, unrelated to temporary issues like disability leave.

Conclusions

- ✓ Hospitals need to understand that the final authority to fill positions is not the Schedule 7A but the budget. This requires a different approach to management of salary savings.
- ✓ Currently, hospitals are deploying staff without sufficient funding (a deficit factor).
- ✓ The LTCS fiscal unit, the budget office, and the hospitals need to develop procedures and IT systems to link position control to allocations and to manage salary savings.

Recommendations

- ➢ Require hospitals to reconcile their allocations and the Schedule 7A as part of the quarterly allocation process. Develop and document reconciliation processes.
- ➢ Require the LTCS fiscal unit to redistribute positions between hospitals based on census changes. Use the Form 607 process to implement this when allocation adjustments are made. Notify hospitals in advance of these changes.
- ➢ Bank positions that exceed system-wide census until the census justifies their redeployment. Report movement in and out of this bank to Finance.
- ➢ Require funding certification for position reclassifications.
- ➢ Remove permanent positions from the blanket where that placement is not justified by temporary needs such as disability leave.
- ➢ Require that the hospitals, budget office, and LTCS fiscal unit reconcile the staffing standards to the Schedule 7A, and the Schedule 7A to available funding for each hospital at the beginning of each year. Discrepancies between staffing standards, position authority, and funding—beyond normal salary savings—should be identified to the hospitals and the senior management team and a corrective plan developed.
- ➢ Train hospitals on correct management of salary savings.

7. Reconciliation of hospitals' allocations, the hospital appropriation, and State Controller accounts

Observations

- ✓ The budget office reports the annual hospital appropriation to the LTCS fiscal unit, with periodic updates for technical adjustments during the year.
- ✓ The LTCS fiscal unit makes an initial allocation to the hospitals based on the hospital appropriation and updates the allocation quarterly for census changes and technical

changes to the overall appropriation. See Appendix 4.D for allocation rollup data and Appendix 4.E for sample allocation sheets.

- The unit withholds a portion of the allocation for emergencies and census changes.
- A portion of the appropriation is also withheld for consolidated purchase agreements that headquarters enters into on behalf of the hospitals.

✓ The LTCS fiscal unit gives the allocation information to the accounting office which sets up corresponding sub-appropriations at the State Controller's Office.

✓ The LTCS fiscal unit, budget office, and the accounting office are expected to coordinate with each other on any changes to the appropriation, the allocations, and the sub-appropriations. The team observed that this coordination did not work in the latter part of 2010-11.

✓ The hospitals use their allocations to set up annual spending plans. In 2010-11, the allocations given to the hospitals did not match the sub-appropriations set up at the State Controller's Office.

✓ The hospitals frequently do not receive a reason for allocation changes related to technical budgeting adjustments, e.g., employee compensation changes. As a result, they do not know which line item in their budgets to adjust.

Conclusions

✓ When allocations do not match the State Controller's accounts or do not match the overall hospital appropriation, fiscal control is compromised. The hospitals are working with the wrong expenditure target and projections of year-end balances are inaccurate. The team observed this directly for 2010-11 year-end closing.

✓ At one time, coordination between the LTCS fiscal unit, budget office, and accounting office was reportedly sound. The team does not know why this coordination degraded but suspects that staffing changes resulted in lost knowledge.

✓ The allocation process needs to provide detailed reasons for adjustments so that hospitals can load allocations correctly to line items.

Recommendations

➢ Assign responsibilities and document the process of reconciling the LTCS fiscal unit's allocation data with the budget offices' appropriation records and with the State Controller's sub-appropriations for the hospitals.

➢ When funds are moved between sub-appropriations at year-end to ensure payment of payrolls, make sure the LTCS fiscal unit and hospitals are informed.

➢ Release allocation changes with detailed instructions for the correct way to load the adjustment and the reason for the change. Document this process.

8. Staffing standards used for the population BCP

Observations

- ✓ The population BCP estimates the annual need for most LOC staff.
  - The population estimate is divided into two categories based on LOC: acute care and intermediate care. This distribution is based on which housing units are in use, and their LOC designation.
  - The following standards are applied based on the CRIPA Enhancement Plan to establish treatment teams:
    - 1 team for every 15 patients for acute/admissions units (1:15).
    - 1 team for every 25 patients for intermediate care units (1:25).
  - For budgetary purposes, a team is a psychiatrist, psychologist, clinical social worker, rehabilitation therapist, registered nurse, and psychiatric technician.
  - In addition to the team, a nursing standard is applied based on the requirement for licensing by the Department of Public Heath (DPH):
    - 1 nurse per 6 patients for acute care (1:6), and
    - 1 nurse per 8 patients for intermediate care (1:8).
    - When a hospital does not meet the nursing standard for a shift, it is required to report this to the DPH, which at its discretion may impose a fine.
    - Community hospitals have a standard of 1:5 for nurses. A special exemption was provided for state mental hospitals.
  - The application of both CRIPA and DPH nursing standards to the population estimate results in estimates of LOC staffing need by classification.[11]
  - The result is compared to the last approved population BCP and incremental adjustments in approved staffing are made.
  - Some special "fixed" LOC staffing (examples: special program needs) are listed at the bottom of the population staffing estimate.
- ✓ The population BCP does not address the following routine types of staffing adjustments, which are generally filled through overtime, temporary help, or in-house registries:[12]
  - Admission suite staffing—the staff needed to run the intake process.
  - Enhanced observations (generally 1:1 staffing) for medical observation, behavioral observations (danger to self or danger to others), and medical escorting to appointments or for hospitalization (1:1 or 2:1).
  - Acuity staffing beyond minimum staffing—instances in which the minimum staffing standards for a unit are inadequate based on risk assessment.

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[11] The population BCP generally describes the staffing standards as being driven by the CRIPA Enhancement Plan and only displays the ratios of 1:15 and 1:25. Nursing standards required for licensing are not called out separately in the BCP but are factored in the calculation of LOC staff.

[12] In-house registries are a permanent intermittent staff pool hired as temporary help or where multiple employees share one authorized position.

- ✓ Four of the five hospitals have a base budget for overtime and temporary help that can be used to offset these costs, but these base budgets do not cover expenses (see Section 7).[13]
- ✓ These costs can all be tied to the population estimate using data that can be updated annually to describe incidence of special staffing events per patient. See Section 7.

Conclusion

- ✓ The staffing standards incompletely address normal hospital operations.

Recommendations

- ✓ Update the methodology for the population BCP to include a more complete range of staffing requirements for the department. This issue connects with the deficit (see Section 7).
- ✓ The allocation process should parallel any changes made to the population BCP.

9. Planning and resource acquisition for operating expenses

Observations

- ✓ Prior to the current recession, Finance allowed annual adjustments for hospitals' operating expenses.
- ✓ Funding for operating expenses has remained flat for several years. This has contributed to the deficit (Section 7) and to a backlog of special repairs projects (see Section 8). The LTCS division advises that delayed repairs have increased the cost to the state when repairs actually occur.
- ✓ Neither the LTCS fiscal unit nor the budget office analyzes operating expenses for trends or savings opportunities.

Conclusions

- ✓ The department should perform a periodic analysis of hospital operating expenses, regardless of funding policy. This type of analysis can identify trends and support cost containment planning.
- ✓ The analysis should be presented to Finance with the population BCP to establish a history of program need, whether or not funding is granted.

Recommendation

- ➢ Require each hospital to prepare an annual analysis of its operating expenses versus budget, and to submit a copy to the LTCS fiscal unit and the budget office. Use a standard format developed collaboratively by headquarters and the hospitals. Present this analysis to Finance with the annual population BCP, regardless of funding policy.

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[13] The reasons for differences between the hospital's budgets for overtime and temporary help were not clear.

10. Resource acquisition for NLOC positions

Observations

- ✓ The department has not received any changes to its NLOC staffing in several years, other than for newly activated hospitals.
- ✓ The team is not aware of any workload standards for NLOC program areas or any analysis of the impact of failure to receive NLOC adjustments.
- ✓ The department does not have a program analysis unit to help hospitals or divisions with workload analysis.

Conclusions

- ✓ The department is not prepared to make a case for resource adjustment, even if state funding constraints were to ease.
- ✓ The hospitals should identify NLOC program areas with the most serious workload problems and use the funding hiatus as an opportunity to develop workload analyses.
- ✓ It would be more efficient if hospitals worked as a group on this task, dividing up the workload.

Recommendations

- ➢ Use the "build it and they will come" approach for NLOC resource aquisition. Prepare workload standards for programs such as hospital police in anticipation of the time when funding may be available. Workload standards can also assist with program management.
- ➢ Charge the hospital administrators with selecting one or two areas to pilot this effort so that workload impact is manageable.

11. Deficit management

Observations

- ✓ The department has experienced deficits in each of the last two years and is projected to experience one again in 2011-12, absent corrective action.
- ✓ Deficits can be planned for in the sense that good business practices can be identified in advance to mitigate problems.
    - Cash management plans can be set up defining when vendor payments are curtailed, what types of vendor payments should be given priority, and what types of vendor notifications should be made. Hospital input should be solicited for these plans: it is their vendors, employees, and operations that are disadvantaged by a deficit (see #4 above).
    - Coordination plans can be made so that hospitals, the LTCS fiscal unit, the budget office, and the accounting office all understand their operational and communication responsibilities.

    - Plans of allocation adjustment can be defined in advance.
    - Early warning systems can be devised so management, staff, and Finance are alerted.
    - Frequency and format of expenditure analyses can be adjusted.
- ✓ The department has no policies or procedures to address deficit management, other than to ensure that payroll is met for as long as possible.

Conclusion

- ✓ Plan for emergencies and disasters. Mitigate consequences whenever possible through anticipatory policies and procedures.

Recommendation

- ➢ Assign the hospital administrators, the accounting office, LTCS fiscal unit, and the budget office the task of identifying how the department can best manage a deficit situation using guidelines described above. Establish a due date of December 15, 2011 since cash shortages may occur this winter.

12. Internal controls auditing/response to audits

Observations

- ✓ The department has a single auditor with no support staff whose time is utilized primarily to schedule and participate in entrance and exit audits.
- ✓ The department has had several outside audits in the last four years, including a major internal controls audit performed by the Office of State Audits and Evaluations.
- ✓ The department's audit responses appear to have sometimes overstated the degree to which audit requirements have been addressed. These responses are passed through the auditor who reports that she reviews them for completeness but for the most part does not have the time to independently verify whether reported corrective actions were actually taken.
- ✓ The team has observed severe problems with the department's fiscal control systems, suggesting the need for active oversight of internal controls.
- ✓ The team is also aware of an investigation into payroll fraud in one of the hospitals.
- ✓ The executive office and the auditor do not appear to confer on best utilization of her time.

Conclusions

- ✓ A $1.2 billion department with high overtime usage and weak fiscal control systems merits more than one internal auditor.
- ✓ Nonetheless, given fiscal constraints even one auditor might follow up on selected major audit findings, if given assistance to handle routine coordination tasks.

Recommendations

- ➢ Make best use of limited resources by providing coordination assistance for the auditor and reshaping her duties to follow up on major audit findings in order to assess whether compliance was achieved.
- ➢ Ensure that the executive office reviews the internal auditor's plans for, and results of, audit follow-up.
- ➢ Consider a team approach to reviewing compliance with major audit finding. These teams might be drawn from the hospitals.
- ➢ Draft a plan and procedures to implement better enforcement of compliance with audit findings.

13. Incorrect application of benefit rates

Observations

- ✓ The IT division downloads the State Controller's Schedule 8 into an Excel file each year and gives that file to the budget office. This file details costs by position, including bargaining unit designation.
- ✓ The budget office has been using that file to calculate salary and benefit adjustments for headquarters, but not for the hospitals. The office intends to start using the file immediately to produce more accurate costing of hospitals' salary and benefit adjustments.
- ✓ Up to now, the hospital employees have been lumped together as one group for the purpose of making salary and benefit adjustments. The budget office had been applying a single set of benefit rates, regardless of classification.
  - Social security benefits were applied to all employees. Safety members are not eligible for social security.
  - Safety retirement rates were applied to all employees. Non-safety employees have their own rates (which in some cases are higher).
- ✓ The team did not review whether the costing of other benefit rates was using correct rates or processes and it did not verify overall correctness of the base benefit budget.
- ✓ Hospitals report they could make use of the Excel file.
- ✓ Benefit costing (source of rates, application) are not documented. As of October 2011, budget staff lacked training on the correct calculation of benefits for the hospitals. Fiscal officers need training as well to allow them to independently verify the accuracy of projected changes for their hospitals.

Conclusions

- ✓ Benefit rates have been applied incorrectly in the past.
- ✓ Based on conversations with the budget office, it appears that the office is now using correct rates.
- ✓ Hospitals should be provided with an Excel file for their share of the Schedule 8. This file could serve as a link between position control and budgeting, which is missing

and needed (see the discussion #6 in this section). It will also allow hospitals to verify headquarters' estimates of benefit adjustments.
- ✓ Processes used to adjust salaries and benefits should be documented and all budget office staff and fiscal officers trained.

Recommendations:
- ➢ Document processes and train hospital and all budget office staff on correct calculation and application of benefit rate changes.
- ➢ Conduct a technical analysis of the base budget in the spring of 2012 (see Section 7).

14. Reimbursement of county beds through Fund 872

Observations
- ✓ In 1991 the first realignment of mental health funding resulted in counties contracting with DMH for patient beds for Lanterman-Petris-Short clients. DMH negotiates contracts with each county; the SCO moves 1/12 of the contract into Fund 872 each month, and the accounting office distributes the funding by plan of financial adjustment (PFA) to each hospital. If beds in excess of the contracted amount are used, the department notifies the SCO, and the following month 1/12 of the contracted amount plus the value of the excess beds is moved into Fund 872.
- ✓ As best the teams' accountants can determine, somewhere around 2000 DMH stopped moving reimbursements related to excess beds from Fund 872 to the hospitals, resulting in a build-up of the fund balance.
- ✓ The current fund balance, setting aside a reserve for lagged payments, is about $40 million.
- ✓ The LTCS fiscal unit reports that it has been aware of the fund balance for a couple of years but was not sure of the reason and was unable to focus the administrative division's attention on the issue. See Appendix 4.F for Fund 872 data.

Conclusions
- ✓ This situation appears to be the result of inattentive budgeting and/or accounting. Prospectively, the department is entitled to an estimated $6 million more per year in reimbursed expenses from Fund 872, provided it submits proper paperwork through Finance to the Legislature to increase its reimbursable authority.
- ✓ The balance the fund has built up would require Finance and legislative approval for access.

Recommendations
- ➢ Increase annual reimbursable expenditure authority to reflect actual expenses under the county contracts.
- ➢ Develop a plan of use for the Fund 872 balance and submit that plan to Finance.

15. Unused balances in Fund 942 (audit exceptions)

Observations

- ✓ In 2007 the department moved $23 million and $1 million from two General Fund appropriations into an audit exception fund (Fund 942), possibly in anticipation of receiving audit exceptions from the federal government for Medicare billings. Nothing has been done with that balance since that point.
- ✓ The $24 million in funds will sit unused until action is taken.
- ✓ There is no process for periodic review of balances for this type of transfer. See Appendix 4.F for Fund 942 data.

Conclusion

- ➢ Given the minimal Medicare billings at the present time, maintaining any significant General Fund balance in the fund is questionable.

Recommendations

- ➢ Justify retention or work with Finance to revert the balance.
- ➢ Develop written procedures that ensure this type of transfer has justification and balances are reviewed periodically.

Personnel

16. Overtime payments

Observations

- ✓ The team is aware of incidences of payroll fraud, past and current, related to overtime.
- ✓ In a department where employees are able to earn large amounts of overtime, high payments to an employee may not stand out as unusual.

Conclusions

- ✓ Formal systems may not always be adequate protection against planned collusion. Audits need to be performed routinely. The BSA audit on overtime called for periodic audits.[14]

Recommendations

- ➢ Review the BSA audit to ensure the department is fully compliant.
- ➢ Establish and enforce a policy for periodic payroll audits.
- ➢ Train hospitals in the correct audit procedure.
- ➢ Require the headquarters personnel office to periodically assess whether hospitals are conducting required audits.

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[14] *High Risk Update—State Overtime Costs: A Variety of Factors Resulted in Significant Overtime Costs at the Departments of Mental Health and Developmental Services*, October 2009, Bureau of State Audits (BSA).

17. Out-of-class assignments

Observations:

- ✓ The exam process was lengthy even before the blockage created by changes in the job analysis requirements.
- ✓ Untimely exams have resulted in a large number of out-of-class assignments in the hospitals. An out-of-class assignment allows a department to put a lower-level person in the position pending the exam. Hospitals have the ability to make an assignment for 120 days, after which the assignment needs to be approved by headquarters and in some cases the Department of Personnel Administration.
- ✓ Particularly for LOC classes as well as those NLOC classes that keep the facilities operational, the ability to make out-of-class assignments is critical.
- ✓ Suspensions of hospitals' out-of-class assignments as recently occurred at the request of the LTCS division disrupt hospital operations. If concerns exist about equity application of the assignments, policies should be put in place to address those concerns.

Conclusion

- ✓ Given slow exam processes, out-of-class assignments are critical to hospital operations, and use of the assignments should be guided by policy.

Recommendation

- ✓ Ensure that proper guidelines are in place for out-of-class assignments, conduct periodic reviews to make sure assignments are made correctly, but do not suspend the hospitals' ability to make these assignments without carefully considering operational impacts.

18. Recruitment

a. **Exams and job analysis**

Observations

- ✓ One of the top problems reported by hospitals is the inability to fill vacant positions due to the exam blockage.
- ✓ The department uses 340 classifications. Of these, 97 are continuously tested and 243 are on a periodic exam schedule.
- ✓ Exams that are periodically tested are currently not progressing because SPB has advised DMH that the department's method for performing job analyses is flawed.
- ✓ In March 2011, DMH headquarters suspended testing for all non-continuously tested classes to allow a review of the advertised knowledge, skills and abilities.
- ✓ The department has never performed full job analyses.

- ✓ Department personnel staff from headquarters and the hospitals were all trained in full job analyses in September 2011.
- ✓ It takes approximately three months to complete a job analysis for a *small* class, using approximately 1/3 of a position. Note that exam specialists have other work to perform, such as giving the exams.
- ✓ All 243 periodic exams are pending full job analyses.
- ✓ With current exams staff at headquarters and in the hospitals, the department believes it will take many years to work through this backlog.[15]
- ✓ Job analyses must be updated every five years.
- ✓ SPB also conducts job analyses on a fee-for-service basis for departments ($25,000 per analysis).
- ✓ Failure to fill positions is a serious operational problem in hospitals.
- ✓ Filling behind vacant positions with overtime is more costly than paying salaries and benefits for a regular appointment. Therefore, vacant positions can burden fiscal management.
- ✓ Working employees out-of-class for over 120 days requires rotating positions among eligible employees, resulting in loss of continuity in job performance. Moreover, the employee who is working out of class will need to be filled behind with an acting assignment or by overtime.

Conclusions

- ✓ The exam blockage is a severe operational problem.
- ✓ The department may need a temporary staffing augmentation to deal with the exams backlog, and perhaps a permanent augmentation (at a lower level) to deal with ongoing job analyses. Alternatively, the department might contract for this assistance.

Recommendation

- ➢ Pursue a possible compromise with SPB that allows the department greater flexibility in dealing with the exam blockage, given overall funding constraints and the operational problems the hospitals are experiencing.
- ➢ Require the headquarters personnel office to submit a quarterly report to the executive directors and the executive office summarizing status on 1) the exam backlog and 2) hiring difficulties using measures such as the number of out-of-class assignments and acting assignments.

b. Hiring freeze exemptions

Observations

- ✓ The State re-imposed a statewide hiring freeze in March 2011 to help curtail costs. The freeze applies to all positions in DMH.

[15] Headquarters has 4 exam specialists. Each hospital has 1 exam specialist (not full-time).

- The team understands that the hospitals previously were not subject to hiring freezes because they provide 24-hour care.
- LOC positions that are required to meet licensed staffing standards cannot go uncovered. Therefore, a vacancy must be covered through the use of overtime, temporary help, or contract registries. No money is saved.
- Likewise, LOC positions providing treatment cannot go unfilled for lengthy periods of time.
- The hospital and Finance give preferential treatment to LOC positions in the hiring freeze exemption process.

✓ The hospitals report that it can take months to obtain approval for a hiring freeze exemption and, by the time the approval is received, the candidate is no longer available. Consequences are similar to those described for the exam process above.

✓ The LTCS division set the priority for which exemption requests are forwarded to Finance. Up through July 2011, the division controlled the processing of exemptions; that role has since been switched to the administrative division.

Conclusions

✓ Untimely processing of hiring freeze exemption requests creates operational problems for the hospitals.

✓ Many NLOC positions at hospitals are critical to safe operations (hospital police, plant operators). Some NLOC positions are essential to fiscal control. However, the process the department has used until recently did not recognize these issues.

✓ The recent process change that now groups exemption requests by purpose appear reasonable.

Recommendations

➢ Allow hospitals to determine which of their positions need priority in the exemption request process.

➢ Ensure prompt processing of hiring freeze exemptions within the department.

c. In-lieu personal services contracts

Observations

✓ Due to recruitment problems hospitals use external contract registries to fill vacant positions, generally on a short-term basis. For remote hospitals such as Coalinga SH, recruitment problems are so severe that the hospital uses external contract registries constantly to staff certain classifications.

✓ An internal registry, on the other hand, allows civil service employees to work second shifts at straight time or overtime, depending on the class.

✓ Almost all hospitals use external registries to some degree for psychiatrists and specialty medical staff vacancies.

- ✓ Contract rates for psychiatrists were recently adjusted downward through contract renegotiations as the department capped the rate of pay at $180 per hour. Despite this adjustment, it is about 50 percent more expensive to contract for psychiatric services. This cost differential is not addressed in the budget.
- ✓ Hospitals report that in some cases psychiatrists have left civil service to return as a contract psychiatrist, performing the same work as before.
- ✓ Not all classifications cost more through registry. Some classifications are less expensive.
- ✓ There are contracting problems with registry employees. (See #4 above and #21 below).

Conclusion

- ✓ The department should reassess recruitment options for higher-cost registry classes. The current incentive for civil service employees to separate and return to their same job as contract employees perpetuates an already difficult recruitment situation.

Recommendations

- ➢ Develop in-house registries wherever practical.
- ➢ Examine telepsychiatry and telemedicine as an alternative to physician contract registries.
- ➢ Consider internship and residency programs that require placement for a specified time period in remote hospital locations.

Contracts

19. Contract timeframes

Observations

- ✓ Hospital contract units begin their contract processing in September of the prior year in order to have the contract through the process for the following fiscal year. These long-lead times are necessary because contracts take nine months or longer for processing.
- ✓ Long lead times mean that hospitals cannot always anticipate needs correctly. In some cases, contracts have been split so that emergency needs can be met.
- ✓ While DGS can take a couple of months to review contracts, the majority of the time is spent on reviews at the headquarters level.
- ✓ Contracts are required to be reviewed by headquarters three different times in the process: prior to invitation to bid, after selection and prior to award, and when the contract is final and needs headquarters and DGS approval. The contracts office, the legal division, and the administrative deputy director all review the contracts, sometimes multiple times.
- ✓ Most hospitals write their contracts for two years, unless they are trying to stay under their $50,000 delegation amount.

- ✓ Hospitals are experiencing operations problems due to inability to execute contracts on a timely basis. In some cases, service periods have lapsed and vendor payments have been unreasonably delayed.
- ✓ Hospitals report that they are unable to determine where their contracts are in the approval process, despite requests for information.

Conclusions

- ✓ The approval process for contracts must be streamlined. Too many loops through headquarters are required. Correct procedures, instead of repeated review loops, should be the backbone of contract approval.

Recommendations

- ➢ Ensure that procedures are fully documented and that roles and responsibilities are assigned in the hospitals and at headquarters.
- ➢ Reduce contract processing times to three months. Reduce the number of times the contract needs to go through the review loop to once for most types of contracts.
- ➢ Create a tracking system that allows hospitals to know where their contracts are in the review process. This same system would allow auditing of the three-month review timeframe.

20. Delegation and signature levels

Observations

- ✓ The Procurement and Contracting Officer (PCO) for a department is the single position designated to sign off on contracts over the delegated authority, per DGS' requirements. In DMH, the administrative deputy director is the PCO.
- ✓ Most departments designate the business services manager as the PCO.
- ✓ Current statutes allow departments to enter into contracts of up to $250,000 without approval of DGS, if at least two small business vendors bid the contract and one of them is selected.
- ✓ This increase in delegation, with implementing procedures, was not communicated to the hospitals. As a result, contracts that did not need to come to headquarters were caught up in the lengthy review timeframes.
- ✓ Contract signature cards need to be updated to allow hospitals to take advantage of the $250,000 small business delegation.
- ✓ DMH is not using the electronic bid process available through DGS, BidSync.

Conclusions

- ✓ Contract signature authority is placed too high in the organization, contributing to the slow-down in contract processing.
- ✓ Contract delegation needs to be expanded for the hospitals.
- ✓ Headquarters should focus on the development of policies and procedures, training, and program review and audits.

Recommendations

- Place the PCO function with the business services manager.
- Ensure that the hospitals have current policy and procedural references.
- Delegate to the maximum extent practical, subject to periodic performance checks.

21. Encumbering external registry contracts

Observations

- ✓ LOC positions can be difficult to fill due to recruitment issues (remote locations, lower salary levels and lack of candidates) and lengthy exam processes.
- ✓ Leaving these positions vacant is not an option, so some hospitals use personal services contracts (aka external registries) to fill the need when other options are not available.
- ✓ Most of the hospitals have difficulty hiring psychiatrists to some degree and use registry contracts as necessary for this class.
- ✓ Because it is not possible to know at the outset which provider will be available at any given time, hospitals over bid/encumber each registry contract by millions of dollars. While this provides contracting flexibility, the result is that encumbrances for anticipated registry expenses are grossly overstated.
- ✓ Overstated encumbrances can result in inaccurate expenditure forecasts. Whereas the hospital fiscal officer may know to back out excess encumbrances when making an expenditure forecast, reviewers (such as at headquarters) may not.
- ✓ One alternative to this process is ongoing contract amendment, but this is not done due to the current long processing times.
- ✓ Another option is to request DGS to allow the department to develop a master contract for all the hospitals at a set a dollar amount (i.e., not tie the dollars to the individual vendor).
- ✓ Because of the length of time it takes to process contracts ($50,000 and above for non-small business vendors) some hospitals process and use multiple contracts under $50,000 for the same vendor until the main contract is completed. This is contract splitting and should not occur.

Conclusions

- ✓ External registry contracts are currently a necessary business requirement for the hospitals due to recruitment issues.
- ✓ Over bidding/encumbering every contract can create the erroneous impression of a deficit when expenditure forecasts are made.
- ✓ Hospitals should not be issuing multiple contracts for the same service provider in a given fiscal year.
- ✓ Alternatives exist to address the situation of over-encumbering.

Recommendations

- Select one or more of several strategies to reduce or eliminate the need for over-encumbering external registry contracts:
  - Reduce reliance on contracts by addressing underlying problems that make filling authorized positions difficult.
  - Reduce contracting timeframes so that the contract amendment process is workable.
  - Consider master contracting as described above.