Section 7: The Hospital Deficit

Part of the scope of this project was to gather information to help explain why the hospital appropriation has been in deficit the last two fiscal years. This section of the report is not a comprehensive review either of the hospital appropriation or of the deficit. Rather, it is commentary on the factors that came to the team's attention during its three months of interviews and data collection. However, the team did work with the hospitals to project what the deficit for 2011-12 would be, assuming no corrective action is taken. That projection is included in this section.

This section is organized as follows:

- ✓ Hospital appropriation background
- ✓ 2009-10 deficit
- ✓ 2010-11 deficit
- ✓ 2011-12 deficit
  - Key assumptions
- ✓ Factors influencing the deficit
  - Appropriation reductions
  - Expenditure increases
  - Factors that offset the full extent of the deficit
  - Organizational and management factors that contribute to the deficit
  - Process factors that contribute to the deficit
- ✓ Observations, conclusions, and recommendations

Hospital appropriation background: Hospitals are funded separately from headquarters. Item 4440-011-001 in the 2011-12 Budget Act provides $1,168 million in General Fund support for the hospitals and psychiatric programs. Total spending authority is larger, including $81.5 million in reimbursements from counties for Lanterman-Petris-Short (LPS) patients. Of the total authority of $1,246 million, 6 percent is for LPS patients, and 94 percent is for penal code and judicially committed patients.[1] Budget language requires DMH to revert excess caseload funds unless Finance approves retention and redirection. Legislative notification is required.

The hospital appropriation is divided among the hospitals based on actual caseload. Amounts are withheld for caseload that has not yet materialized. Caseload is reassessed quarterly. A portion of the appropriation is retained at headquarters to pay for state agency billings for hospital activities. The calculation of each hospital's share of the appropriation is made by the LTCS fiscal unit (see Section 4, #7 for more detail). This split is given to the accounting office which requests the State Controller's Office to set up sub-accounts under the main hospital item.

[1] Budget data for 2011-12 do not include executive orders.

2009-10 deficit: Signs of an impending deficit were noticed several years ago. In 2008, the Department of Finance's Office of State Audits and Evaluations (OSAE) conducted a budget estimates audit which observed that the "current staffing model may not adequately reflect hospital workload," and that "funding is insufficient for annual operating expenditures."[2] OSAE concluded that "DMH is at risk of incurring significant budget deficiencies in the near future."[3]

The team was not advised of any hospital deficits prior to 2005-06. From 2005-06 through 2008-09, the hospitals ended the fiscal year with savings. However, between 2008-09 and 2009-10 the hospital budget dropped by about $75 million.[4] In 2009-10, the hospitals overspent their appropriation by $34.2 million.[5] A six-year summary of the hospitals' ending balances is provided below:

7.1: History of hospital system budget balance (dollars in millions):

Fiscal year	Hospital Appropriation[6]	Expenditures[7]	Balance
2005-06	$851.7	$803.7	$48.0
2006-07	980.1	923.5	56.6
2007-08	1,137.7	1,106.0	31.7
2008-09	1,203.8	1,173.5	30.3
2009-10	1,127.5	1,156.4	-34.2
2010-11	1,174.3	1,293.9	-119.6

The possibility of a deficit reportedly was raised to the attention of the Health and Human Services Agency and Finance during the fiscal year. However, the projected deficit was small as a percentage of the overall budget, so it was not clear to the control agencies it would actually materialize. The source of the problem was not pinpointed but was believed to be related to overtime. The department was directed to curb spending. In late June despite cutting back on travel, contracts and supplies, it became evident that vendor payments would need to be stopped

[2] *California Department of Mental Health State Hospital Budget Estimate Review*, November 2008, pages 7 and 8.
[3] Ibid., page 9.
[4] The largest adjustment was a reduction of $136.7 million related to the furlough program. (There were offsetting increases.) In theory, this reduction was a pass-through cost to employees. In actuality overtime for LOC positions likely was increased, contributing to the 2009-10 deficit.
[5] This amount was initially reported as $27 million, later revised to $28.9 million at year-end closing. However, claims continued to come in throughout the following year, and with processing penalties totaled $34.2 million.
[6] Final allocations data were provided by the LTCS fiscal unit. For 2010-11, the appropriation does not include the $50M deficiency appropriation or EO reversals authorized by Finance to help fund the shortfall.
[7] Expenditures per CALSTARS. Expenditures grew over this time period for caseload adjustments; the opening of Coalinga SH; the funding of the Enhancement Plan; the addition of new plan requirements; salary parity adjustments pursuant to Coleman, Plata and Perez court orders; and the expansion of the Salinas Valley PP.

in order to meet payroll. The deficit at the time was reported as $27 million and unpaid vendor invoices were sent through the Board of Control for payment, in lieu of deficiency funding.[8]

2010-11 deficit: At the beginning of the 2010-11 fiscal year, hospitals advised the LTCS division that they once again projected a deficit. The issue was raised through agency to Finance as part of the fall budget process. In the spring of 2011, unable to get a detailed estimate or reason for the deficit from DMH, Finance set aside the hospital projections and requested the department to prepare a straight-line forecast which resulted in a deficiency estimate of $50 million.[9] This additional funding was provided through a deficiency bill, but by late June it was evident that the estimate was low. The team began work in July and was asked to assist with establishing the size of the 2010-11 hospital deficit and providing insight where feasible on the causes.

The team met with each hospital to 1) reconcile 2010-11 expenditures to the State Controller's records, 2) review accruals, 3) review the hospitals' expenditure projection processes, and 4) assess each hospital's response to data collection drills coming from headquarters. The team determined that the hospitals differed in their forecast processes and treatment of accruals. In addition, in the absence of written instructions from headquarters, hospitals differed in how they responded to data collection drills related to the deficit. The team standardized projection processes for 2010-11 and assisted the hospitals with their year-end expenditure forecasts.

The team then assessed whether the hospital allocations matched the Controller's sub-appropriations set up by the accounting office. It became apparent that at some point during the year internal reconciliation processes had broken down, because the allocations given to the hospitals did not match those set up by the accounting office at the Controller's.

Eventually records were reconciled and towards the end of August the 2010-11 hospital deficit was sized at $119.6 million. To allow the hospitals to close their books, Finance reversed a portion of the budget cuts made by executive order during 2010-11, providing enough additional funding to cover the deficit. It should be noted that the deficit would have been higher except that Finance permitted the department to apply unused caseload funding towards the deficit. Unused caseload funding in 2010-11 totaled $46.4 million, of which $29.2 million was for penal code and judicial court commitments, and $17.2 million was for CDCR commitments. Absent that funding, the deficit would have been $166 million.[10]

2011-12 deficit: The next question was how much of the deficit would resurface in 2011-12. Each of the hospitals was asked to develop 2011-12 expenditure projections *assuming the same basic level of operations as in 2010-11* and using a line-item projection worksheet the team prepared.[11]

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[8] See footnote 5.

[9] A description of the department's projection process and the problems with the 2010-11 deficiency estimates is provided in Section 4, #4 (expenditure projections/year-end closing).

[10] Records for the prior year deficiency are included in Appendix 7.A.

[11] Individual hospital expenditure estimates for 2011-12 are in Appendix 7.B. This will also be used by state hospitals as the worksheet for projections in the future.

The hospitals were directed to include essential purchasing that had been deferred. These projections accomplished two purposes:

- ✓ When compared with hospital allocations, the projections provide an estimate of the deficit by hospital; and
- ✓ The projections are the first step towards creating balanced, detailed budgets for the hospitals. The department is developing a savings plan which will be used to bring the expenditure forecasts in line with the appropriation on a detailed (line-item) basis. The creation of realistic line-item budgets is a critical step in reestablishing fiscal accountability for the hospitals.

Using these projections, the deficit estimate for the total hospital appropriation is as follows:

Table 7.2: Estimated Hospital System Deficit, 2011-12 (dollars in millions)

Fiscal year	Hospital Appropriation	Hospital Expenditure Projections	Coleman Reserve	Census Reserve	Deficit
2011-12	$1,250.0[12]	$1,318.9[13]	$29.5[14]	$35.9[15]	$133.6[16]

- ✓ **Comparing the 2010-11 and 2011-12 deficits**. Table 7.3 below compares the deficits for current and prior years removing factors that distort the comparison. As noted above, the final deficit for 2010-11 was $119.6. However, it would have been $166 million had unused patient caseload funding not been available. Setting aside the Board of Control claims totaling $34.2 million, the adjusted gross deficit for 2010-11 was $131.8 million and the net deficit after application of the reserves (i.e., unused census funding) was $85.4 million.[17]

  In comparison, the estimated gross deficit for 2011-12 is $133.6 million, and the net deficit assuming the reserves remain available is $68.9 million. The availability of the reserves varies from year to year, so the most valid comparison is between the adjusted gross deficit in 2010-11 and the gross deficit in 2011-12. The difference of $1.8 million is insignificant. [18]

[12] The appropriation does not include any 2011-12 executive order (EO) adjustments, as none had been made at the time of the report (although salary and other EO adjustments are anticipated).
[13] This is the sum of the hospitals' estimates (excluding an EO adjustments), plus anticipated growth in non-Coleman beds (66 patients, $6.6M). The estimate assumes that EO adjustments would be matched by corresponding spending adjustments by the hospitals (i.e., no net impact on the deficit estimate). However, some of the hospitals' projections anticipated EO adjustments which the team estimated at $9.1 million and removed from the projections to keep comparisons equal.
[14] 146 beds (does not include empty beds in the two psychiatric programs).
[15] The census reserve equals 352 patients.
[16] This is the appropriation minus the sum of expenditures and reserves.
[17] The Board of Control claims are set aside because they were actually 2009-10 expenses.
[18] See data by hospital in Appendix 7.C.

Table 7.3: Comparison of 2010-11 Actual and 2011-12 Projected Deficits
(Dollars in Millions)

	2010-11	2011-12
Year-end deficit (net)	$119.6	$68.9
Add back expenses offset by unused funding for:		
✓ Coleman beds	17.2	29.5
✓ Other census beds	29.2	35.9
Gross deficit	$166.0	$133.6
Reduce by Board of Control claims	-34.2	--
Adjusted Gross Deficit	**$131.8**	**$133.6**

Key assumptions for the 2011-12 hospitals' expenditure projections. The assumptions used to create the hospitals' expenditure estimates are as follows:

- ✓ **Hospitals projected 2011-12 correctly according to instructions given by the team**. As noted above, hospitals were asked to project 2011-12 expenditures, adjusting for known changes and including essential purchases that may have been deferred in 2010-11. They were asked to project realistically but leanly, given overall budget constraints.

  At the time of this report, the department was developing a savings plan, and for that purpose it would be better to have an expenditure projection that is slightly too high rather than too low. Given the insignificant year-over-year growth in the deficiency estimate, the question is whether the hospitals' projections were too low. To assess this, the most appropriate statistic is the cost per patient since this considers changes in caseload. The table below compares cost per patient for the five main hospitals individually and in the aggregate for 2010-11 and 2011-12 (projected).[19]

  The average cost per patient for the main hospitals in 2009-10 was $201.7 thousand, in 2010-11 was $213.7 thousand and in 2011-12 is projected to be $222.4 thousand. The year-over-year growth rate is 4.1 percent. Therefore, the team concludes that hospitals' expenditure estimates are not too low and are appropriate for reduction planning. See also Table 7.7 which graphs the average cost per patient for the five stand-alone hospitals.

[19] The psychiatric programs are not included in this comparison because they are funded differently. CDCR provides security, food, medication, and most other operating expenses for the psychiatric programs. In addition, they are not subject to the Enhancement Plan.

Table 7.4: Hospital Cost-per-Patient Growth Rates, Year over Year 2009-10, 2010-11 and 2011-12 (Dollars in Thousands)

Hospital	2010-11		2011-12	
	Cost per patient	Growth rate	Cost per patient	Growth rate
Atascadero SH	$208.3	-3.8%	$219.6	5.4%
Coalinga SH	192.5	6.1	195.4	1.5
Metropolitan SH	263.2	15.7	279.0	6.0
Napa SH	218.2	7.0	225.3	3.0
Patton SH	206.2	8.6	215.6	4.5
Hospital System Average	$213.7	5.9	$222.4	4.1

- ✓ **Hospitals projections were correctly adjusted by the team.** Some hospitals included pending salary adjustments for 2011-12 and others did not. The team removed $9.1 million from the hospitals' estimates so that no projections included the pending adjustment. (The goal was to project expenses without salary increases in order to compare with an unadjusted appropriation.) These adjustments were discussed with hospitals so the team concludes they are neither an upward or downward pressure on the deficit estimate.
- ✓ **Pending EOs and other technical adjustments will not affect the deficit estimate**. A key assumption in preparing the hospital expenditure estimates was that pending EO adjustments such as for salary and benefit changes in 2011-12 will match actual costs. To the extent that EO adjustments do not fully fund corresponding changes in hospitals' expenditures, the deficit will increase.
- ✓ **Hospitals understood that workforce cap positions could not be used to generate salary savings.** At the time of projection, the department had not yet reduced positions in the Schedule 7A by an amount equal to the workforce cap reduction of the prior year. As noted elsewhere, hospitals have a tendency to quantify salary savings (more specifically, excess salary savings) by examining unfilled positions on their Schedule 8s. In hindsight, the team is not sure that hospitals fully understood that (at the time of projection) their Schedule 8s were underfunded both by a normal salary savings requirement and also by the value of the workforce cap. Hospitals may have overestimated excess salary savings from vacant positions that could be applied to offset shortfalls. In other words their final expenses might be higher than projected, which would increase the deficit.
- ✓ **The reserve estimates will not change**. If inaccurate, this assumption affects the net deficit not the gross deficit. The likelihood is this assumption is wrong—that at least some portion of the reserve *will* be allocated throughout the year based on census changes, which would increase the net deficit.
- ✓ **The full extent of the fiscal impact of unfunded activities has manifested in expenditures**. Unfunded activities related to the Enhancement Plan probably have fully manifested in the

expenditure data. The team is less sure about overtime related to other concerns such as about workplace safety. Hence, there is an upside risk to this assumption.

- ✓ **The department does not undertake any new, unfunded activities**. This seems a reasonable assumption given current management's intent to balance the budget.
- ✓ **The hiring freeze remains in effect**. If vacant NLOC positions being held open due to the freeze are filled, salary costs increase, potentially increasing the deficit.[20]
- ✓ **Any current year savings plan will not offset the deficit.** At the time of this report, the department was preparing a savings plan with the hopes of a significant current year impact. The 2011-12 deficit may be reduced by this plan, but that possibility was not included in the estimate.

In summary, most of the assumptions have an upside risk that might result in a higher deficit. A savings plan, on the other hand, might materially reduce the deficit.

Factors influencing the deficit: The team identified a number of factors contributing to the hospital deficit as well as factors that have offset or masked the full extent of the deficit.

- ✓ **Appropriation reductions**: The team did not track down all appropriation reductions over the last five years. However, several large ongoing reductions—unrelated to population changes—occurred in 2010-11:
  - **$55 million for DMH's share of workforce cap**. The "workforce cap" refers to an unallocated reduction imposed on departments by executive order for 2010-11 and made permanent thereafter by a reduction in each department's 2011-12 appropriation. Per Finance budget letter, departments are required to make a corresponding reduction to their positions in 2011-12.[21]
  - **$9.4 million for PLP overtime**. $55.4 million was removed from the department's budget based on employee compensation changes. Most of this impact was passed through to the employees via salary reductions and did not have a net impact on the appropriation balance. However, part of the employee compensation adjustments for 2010-11 included a personal leave day for employees. The department estimates that the cost in overtime to fill behind level-of-care employees taking their PLP day is $9.4 million. See Appendix 7.D for the calculations behind this cost.
  - **$10 million for outside medical costs** was removed from the department's budget based on reimbursement rate caps set by W&I Code Section 4101.5 (see the discussion of outside medical costs in Section 6 of this report). However, outside medical expenses continued to rise in 2010-11, probably because the effect of the rate change occurred late in the fiscal year. Thus, in 2010-11 the $10 million

[20] The assumption is that LOC positions, even if vacant, are generating a cost to overtime, temporary help, or external registries.

[21] DMH made this adjustment in November 2011, after the hospitals' expenditure projections were made for this report.

reduction contributed to the deficit because savings did not offset the reduction. Whether the reduction continues as a deficit factor in 2011-12 is not yet known.

- ✓ **Expenditure increases**: The following issues came to the team's attention over the three months of the study but do not represent a comprehensive listing of possible reasons for expenditure increases.
  - **$34.2 million in 2009-10 expenses carried into 2010-11**. The 2009-10 deficit was carried forward for payment from the 2010-11 appropriation via Board of Control claims. This amount includes processing penalties (see Appendix 7.E). This is a one-time deficiency factor—i.e., not a factor for 2011-12.
  - **Enhancement Plan**: As noted elsewhere in the report, the department received over $40 million in funding in 2006 for the Enhancement Plan, but expenses rose beyond that as the court monitor imposed additional workload requirements not considered in the 2006 BCP (see Appendix 7.F). The department met these additional requirements by redirecting LOC positions. The department has prepared a list totaling $75 million in positions redirected to the Enhancement Plan (see Appendix 7.G). The deficit related to the plan shows up as unfunded overtime (or temporary help and registry contracts) used to fill behind a portion of these positions. There is currently no analysis to determine how much overtime was used to fill behind the redirected positions, although one hospital executive director advised that it was less than the $75 million. A separate data collection drill involving hospital research would be required, since the department has not set up cost centers in CALSTARS for the Enhancement Plan redirection.
  - **Unfunded staffing patterns**.
    - **Enhanced observations**: Enhanced observations refer to a 1:1 staffing pattern that exceeds minimum (budgeted) staffing and is required for the duration of the following situations:
      - "Behavioral" is typically protection from self-harm or protection from others. Elevated actions may become seclusion and restraint.
      - "Seclusion and restraint" is monitoring after more extreme violent behavior or threatening actions. Usually the patient is in restraints or locked-room seclusion until calmer.
      - "Medical" addresses situations such as protection from falls.
      - "Hospital escorting" is transport to and from hospitals, sometimes at a 2:1 ratio (nursing and security staff). Escorting to court is a separate, funded category and not addressed here.

      According to the department, about 40 percent of enhanced observation shifts can be managed within regular shift staffing. The balance of enhanced observations results in overtime or the use of temporary help (internal registry staff). Enhanced observations are currently not in the population estimate. Data on usage are provided below.
    - **Annual enhanced observation shifts, by type of coverage**. Table 7.5 below shows average monthly enhanced observation shifts for the five stand-alone hospitals (data consolidated for 2009-10 and 2010-11). The number of

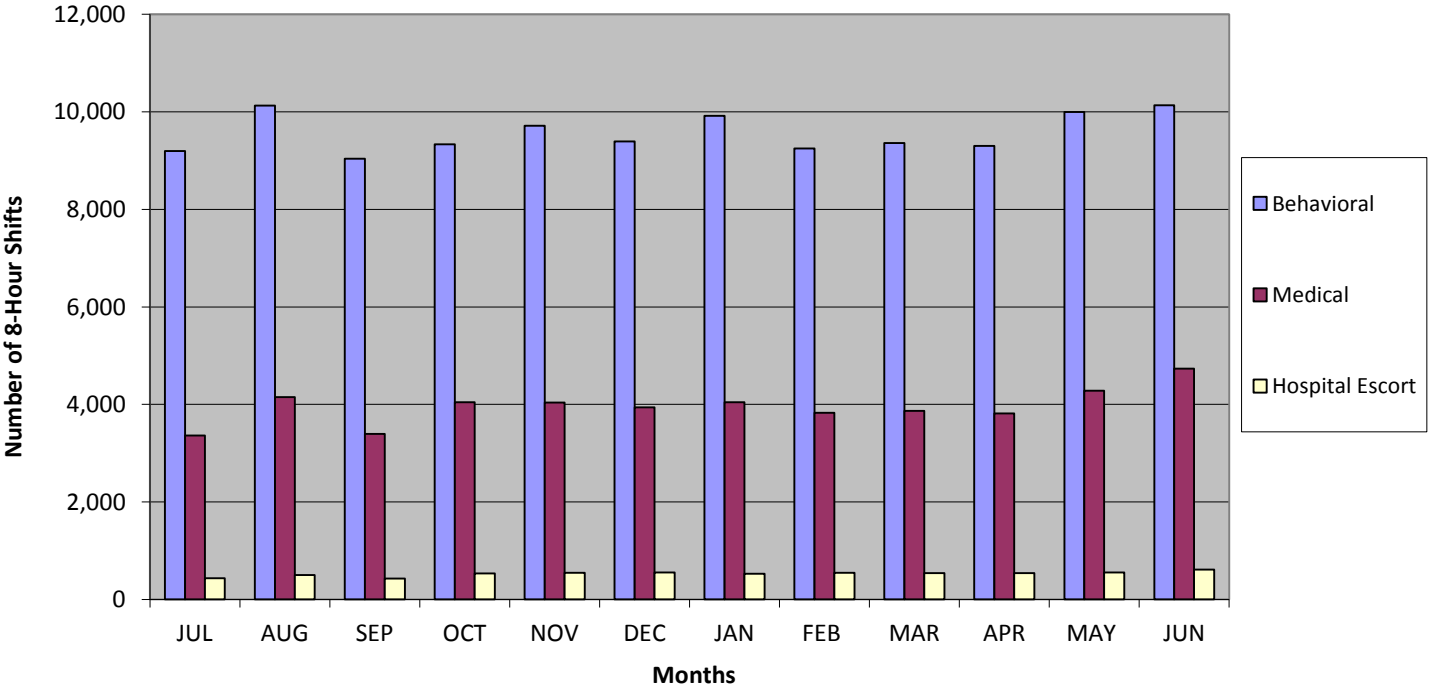
monthly shifts ranges from about 13,000 to 15,500. The added cost (i.e. non-absorbed) is about $28.9 million. If the entire hospital systems' budget for overtime and temporary help were applied to this single operational need, the net unfunded expense would be about $12.5 million. See the discussion below on overtime and temporary help.

Type of Coverage:	Table 7.5: FY 2009-10 and FY 2010-11 Average Number of Enhanced Observation Shifts												Annual Shift Total
	JUL	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	
Regular Coverage	5,363	6,425	5,647	5,940	5,896	5,701	6,092	5,634	5,628	5,595	6,179	6,432	70,532
Temp Help (TH)	1,987	2,322	1,807	2,257	2,306	2,171	2,316	2,196	2,235	2,174	2,516	2,693	26,979
Overtime (OT)	5,644	6,027	5,406	5,718	6,101	6,014	6,085	5,793	5,906	5,887	6,139	6,353	71,072
TOTALS	**12,994**	**14,774**	**12,859**	**13,914**	**14,303**	**13,886**	**14,494**	**13,623**	**13,769**	**13,656**	**14,834**	**15,477**	**168,583**

- **Annual enhanced observation shifts, by purpose**. Table 7.6 below consolidates behavioral observation with seclusion and restraint. The behavioral category is a measure of violence since it includes aggressive acts to other staff or patients and/or harm to self. While this is not trend data, it does show that about two-thirds of enhanced observation shifts for the five stand-alone hospitals in 2009 and 2010 resulted from an assessment of danger to self or others.
- **Acuity staffing above minimum:** Operating at minimum staffing standards is not always feasible for a variety of reasons. For purposes of this report, *acuity staffing above minimum* is defined as additional staffing on units for reasons other than enhanced observations. In some cases (such as for the hearing-impaired at Patton SH), units are permanently operated at levels above licensing minimums. In other cases a unit or program area may need additional staffing for a shift because of group, rather than individual, behavioral problems. The team did not collect cost data either on units permanently assigned at higher staffing levels or on the periodic need to elevate staffing to address potential behavioral issues. Acuity staffing is not specifically funded, yet it is a necessary component of safe operation of the hospitals. Logically some portion of the base overtime and temporary help budgets for the department is for these types of costs, but the funding basis for these allocations is no longer known. In any event, costs for enhanced observations alone greatly exceed the budget for overtime and temporary help.
- **Admissions suite:** The term *admissions suite* describes where patient intake occurs and the required discipline-specific assessments are performed. The average annual number of admissions is about 3,460 patients. The budget

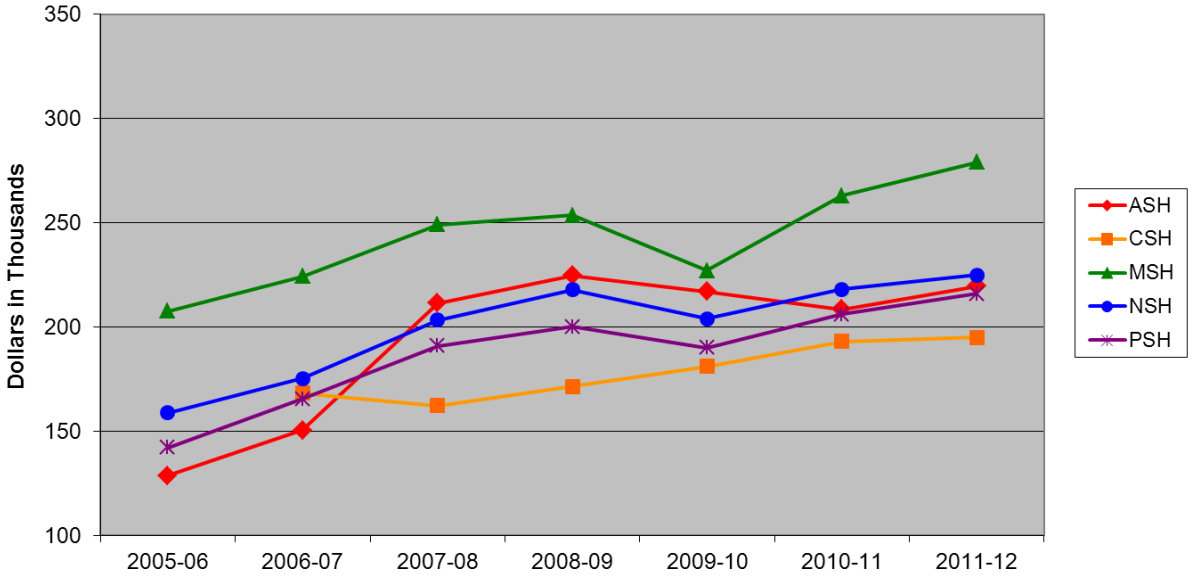
process to date has not recognized admission suite workload, estimated by the department as costing $4.8 million annually.

Table 7.6: Reasons for Enhanced Observations
Fiscal Years 2009-10 and 2010-11, Combined



- **Hospital management differences as a possible deficit factor:** In its review of hospital expenditure projections for 2011-12, the team noticed significant differences in the average cost per patient, with a low of $195 thousand per patient for Coalinga SH to a high of $279 thousand per patient for Metropolitan SH. In addition, hospitals anticipated different growth rates in their year-over-year average cost per patient. Table 7.7 below compares the five main hospitals.

Table 7.7: Hospital System Average Cost Per Patient[22]



These statistics do not consider important factors such as facility layout and patient mix.[23] However, they do pose the question of whether management differences affect the deficit. Headquarters has not analyzed cost per patient statistics, so answers based on data are not available.

- **Outside medical**: Outside medical services include hospitalization, skilled nursing facilities (SNFs), and medical appointments for health care that cannot be provided in hospitals. Section 6 (medical issues) provides a table summarizing outside medical costs for the five stand-alone hospitals for 2007-08 through 2010-11.[24] In 2010-11, outside medical costs totaled $41.3 million, about two-thirds for hospitalization and the balance for office visits. Over the four years, the average annual cost increase was 10 percent for each of the categories. The base budget for outside medical services is not known, but a proxy base might be the average of final expenses for 2005-06 and 206-07, taken from CALSTARS.[25] Using that as a base, the unfunded cost increase for outside medical between 2005-06 and 2010-

[22] Data Source: Expenditures = CALSTARS; Census = ADT; Budget = DMH Greensheets; Population = May Revision Pop Estimate Average Patient Cost Methodology: Total Expenditures/Average Annual Daily Census
FY 2009-10 and 2010-11 modified to reflect year in which Board of Control claims were incurred. 2005-06 totals impacted by activation of CSH.

[23] The statistics also do not consider average length of stay.

[24] Patients in the two psychiatric programs receive medical care provided by the prisons. Data in the table was provided by hospitals since the CALSTARS that the team collected does not distinguish between hospitalization and office visits.

[25] This amount excludes contracts for outside registry medical staff. The average is used because Coalinga SH started up during this time period. The average of the two years is about $21.5 million.

11 would be about $20 million. W&I Section 4101.5 is expected to attenuate future growth and may even shrink the $20 million shortfall somewhat.

- **Pharmaceuticals:** Over the past six years pharmaceutical costs have increased about 8 percent a year without a corresponding budget increase. Per CALSTARS, in 2010-11 system-wide costs were $49.6 million, versus $35.6 million in 2005-06.[26] Taking an average of 2005-06 and 2006-07 expenditures as a proxy base ($36.6 million), the unfunded cost increase has been about $13 million. As discussed in Section 6 on medical issues, a number of factors influence pharmaceutical costs, but one of the most important is the use of generic versus proprietary drugs. Several antipsychotics are going generic in 2011 which should help slow future cost growth, provided the department can devise ways to encourage the prescription of generic antipsychotics over proprietary alternatives. Master contract constraints that make the use of generics more difficult are discussed in Section 6.
- **Workers Compensation:** The table below shows workers compensation costs per CALSTARS for 2005-06 through 2010-11.[27]

Table 7.8: Hospital System Workers Compensation Costs

Fiscal Year	Expenditure
2005-06	$ 20,156,410
2006-07	20,991,594
2007-08	20,560,996
2008-09	20,628,268
2009-10	12,943,577
2010-11	27,344,285

Over the six years workers compensation costs grew about $7 million, from $20.2 million to $27.2 million (an average annual rate of 7 percent). The base budget for hospitals in 2011-12 is $26.2 million. The net shortfall is projected to be about $1 million.

- **Incomplete funding for salary parity adjustments:** As noted in Section 4 (#6), the team was advised that salary parity adjustments pursuant to the Coleman, Plata, and Perez court judgments were not applied to overtime and temporary help used for affected classes. This issue is also noted in OSAE's 2008 budget estimate review.[28] The team does not have cost data for this factor.
- **Loss of LOC authority through budget office error**: The department reported that LOC authority has been inadvertently lost through budget office error (see Section 4, #5). The team did not verify this assertion, although based on a description of processes recognizes that the loss could have occurred. The team has

[26] See the table for departmental pharmaceutical costs in Section 6.
[27] Does not include industrial disability leave. See Appendix 7.H. for CALSTARS data on workers compensation by hospital.
[28] Ibid., page 8. See Appendix 7.I for supplemental budget estimate review information.

recommended that the department detail the discrepancy and, if a shortage is verified, negotiate a solution with Finance and the Legislature since shortages in LOC positions can lead to unbudgeted overtime costs. This is potentially a deficit factor.

- **Security costs**: Hospitals advised the team that overtime for hospital police has increased without budget support. This issue is related to violence in the hospitals. No data has been collected to create a cost estimate for unfunded overtime for security personnel.
- **Relief factors:** The hospitals report that leave time charged to the Family Medical Leave Act has grown substantially as a result of overtime pressures on the staff. The team examined different ways to cost out this and other workforce management factors and did not come up with a straightforward solution. The real question is whether the 1.77 relief factor used for budgeting purposes on LOC positions is adequate. Reportedly it has not been updated in years and may contribute to the deficit. A separate study is needed to support or disprove the assertion that the relief factor is too low.
- **Operation expenses in general**: The State has been unable to afford operating increases for departments for several years due to the recession. According to the LTCS division, there have been almost no operating expense increases since 2005-06 except for activation of new beds. Yet the hospitals must continue to feed, clothe, medicate, and provide regular health care for the patient population, as well as maintain complex plant operations. The team did not conduct an analysis of operating expense costs other than for pharmaceuticals and outside medical cost. However, it is reasonable to conclude that there are other areas of operating expense in deficit besides those. (See also the discussion of special repairs in Section 8.)
- **Cost review of overtime, temporary help, and outside contracted services**:[29] Unfunded costs for the staffing deficiencies described above (Enhancement Plan, enhanced observations, acuity staffing, admissions suite staffing, security workload, and filling behind LOC employees taking family medical leave) manifest in the accounting system as unbudgeted overtime and temporary help usage (and in some cases external registry use). However, CALSTARS as implemented in DMH does not provide adequate information on the underlying cause for these objects of expenditure.[30] The six-year summary for overtime, temporary help and registry contracts is provided in Table 7.9 below. The team concluded that all four of the hospitals under the Enhancement Plan used significantly more staffing resources than budgeted but met the need differently based on local staffing availability and recruitment opportunities.

[29] See Appendix 7.H. for CALSTARS temporary help, overtime, and registry services data by hospital.

[30] Moreover, this issue may be more than a question of how CALSTARS is implemented. Staff may work overtime outside their assignment in CALSTARS labor distribution tables. Tracking the movement of staff via CALSTARS may be too cumbersome. The team considered data drills outside CALSTARS to try to sort overtime expenses by cause, but time frames for the project were too short, and the workload impact on the hospitals would have been too great.

Table 7.9: Hospital System Overtime, 2005-06 through 2010-11

Fiscal Year	Expenditure
2005-06	$ 58,649,123
2006-07	72,453,011
2007-08	83,179,086
2008-09	81,073,162
2009-10	101,358,249
2010-11	109,501,541

Overtime costs nearly doubled between 2005-06 and 2010-11, rising from $58.6 million to $110 million, an average annual increase of 17.5 percent a year. The single largest jump in costs was in 2009-10 (a $20 million cost rise). The reason for this jump is unknown but likely relates to the Enhancement Plan and salary adjustments that brought many DMH LOC staff into parity with CDCR. In general, hospitals have experienced very different rates of increase, varying from under 5 percent (Atascadero SH) to over 23 percent (Patton SH).[31] In part this variance occurs because some hospitals use external registries more than overtime for meeting additional staffing needs. For example, Patton SH hardly uses external contract registries at all, whereas Atascadero SH relies on them substantially. See the discussion of external cost registries.

Comparing the current budget for overtime ($15 million) with the most recent cost ($110 million for 2010-11), the department overspent its overtime allocation by about $95 million. Some of this cost was covered by vacancies beyond those needed for salary savings, but the team was not able to calculate the net unfunded amount.

Table 7.10 Hospital System Temporary Help Usage, 2005-06 through 2010-11[32]

Fiscal Year	Expenditure
2005-06	$ 12,929,010
2006-07	18,991,381
2007-08	16,879,994
2008-09	19,021,095
2009-10	19,488,811
2010-11	20,487,172

[31] Hospital-specific data for overtime is in Appendix 7.H.
[32] See Appendix 7.H for CALSTARS temporary help usage data by hospital.

Temporary help usage increased by two-thirds between 2005-06 and 2010-11, from $12.9 million to $20.5 million. The average annual increase was about 12 percent. As with overtime, the rate of increase by hospital differed markedly, with Metropolitan SH experiencing the largest average annual increase (26 percent) and Napa SH the least (2 percent). The temporary help budget for 2011-12 is $1.7 million, versus $20.5 million in expenditures per CALSTARS.[33] Not all of this difference necessarily contributes to the deficit, since some of the expenses may be to fill behind vacant positions. However, the team does not have the data to determine the net impact to the deficit.

7.11: Hospital System External Registry Use, 2005-06 through 2010-11[34]

Fiscal Year	Expenditure
2005-06	$ 2,405,961
2006-07	2,278,801
2007-08	38,818,671
2008-09	29,039,398
2009-10	32,653,035
2010-11	35,471,650

The table above shows that external registry contracts increased dramatically between 2005-06 and 2010-11—about 275 percent annually over the base year. Most of that increase was in one year (2007-08) which the team surmises is largely associated with the Enhancement Plan. To the team's knowledge, there is no budget for registry contracts. The expense is typically funded through excess salary savings. As with temporary help, not all of the cost for external registry use contributes to the deficit since the registry is used to fill behind vacant psychiatric positions. However, registry psychiatrists cost about 50 percent more per position than state psychiatrists, so it is reasonable to assume that a significant portion of registry use is unfunded.

- **Positions borrowed by headquarters:** Headquarters is using 31 positions authorized for the hospitals and continuing to charge those positions to the hospital appropriation. The positions are used primarily in the Hospital Oversight and Monitoring Unit (related to the Enhancement Plan), the legal office (related to the AG's Office no longer handling DMH cases) and in the accounting office. The result is 1) hospitals must cover the salary costs as well as the associated salary savings, and 2) the hospital workload for which the positions originally were authorized goes undone or covered by overtime. Thus, this is a deficit factor for the

[33] Per the Schedule 7A, expenses were $19.5 million. The reason for the variance with CALSTARS is unknown.
[34] See Appendix 7.H for CALSTARS external registry usage data by hospital.

hospitals. The positions are listed in Appendix 3.A and with benefits total about $3.4 million.[35]

- ✓ **Factors that offset the full extent of the deficit**
  - **Unused caseload funding:** As noted earlier, Budget Act language requires the department to revert unused funds for caseload that did not materialize, although Finance may authorize redirection for non-caseload purposes. By agreement, Finance allows the department to retain unused caseload funding if actual population on specific census dates is within 2.5 percent of budgeted projections. When patient census is below budgeted projections but above the 2.5 percent threshold, the gap produces a cushion for the hospitals that may offset over-expenditures. As noted earlier, in 2010-11 this gap was worth $17.2 million for all Coleman beds (CDCR commitments) and $29.2 million for other patient populations. In 2011-12 unused caseload funding was estimated in October 2011 to be $29.5 million for Coleman beds and $35.9 million for other patient populations.
  - **High vacancy levels in the department**: Vacancies that exceed salary savings requirements, and that are not filled behind with overtime, temporary help, or external registries, can result in excess salary savings that offset the deficit. The team does not have a cost analysis for this factor, and with the recent reduction of the workforce cap positions, it is questionable whether this factor exists any longer.

- ✓ **Organizational and management factors that contribute to the hospital deficiency** (see Sections 2 and 3):
  - The executive office was not engaged with the hospitals. The program division placed mission before fiscal accountability. For a variety of reasons, the administrative division did not establish itself in a fiscal leadership role. Hence, the management leadership to solve the emerging deficit was not in place.
  - Budget staffing levels are low at both headquarters and the hospitals, and personnel need both training and better tools. Hence, the key organizational structure to provide cost information on the emerging deficit did not function as needed.
  - Headquarters charged a portion of its expenses to the hospitals by borrowing positions.
  - The team noticed very significant differences between hospitals in the average cost per patient. Further review would be needed to determine whether cost/patient differences between the hospitals reflect management attention to the budget or simply differences in facility layout and patient mix.[36]

[35] However, as noted in Section 3, the reallocation of positions across levels of the organization may be the best of difficult choices. If necessary, this reallocation should be based on a workload assessment conducted in cooperation with the hospitals, and the fiscal impact should be approved by control agencies. The cost for the borrowed positions is an estimate based on classifications as used by headquarters, mid-step, with benefits.

[36] CALSTARS cannot provide data on the cost per patient by commitment type of level of care. The primary data missing is patient care costs by type of patient. Electronic health records are needed to begin the process of developing more detailed cost data.

- ✓ **Process factors that contribute to the hospital deficiency** (see Section 4):
  - Base budgets are missing for both headquarters and the hospitals, impairing budget analysis and management.
  - The department lacks a uniform cost center plan for the hospitals that supports budget management and deficit analysis.
  - The department lacks documented methodologies, procedures, and timeframes for producing expenditure analyses and forecasts. Absent timely, reliable information, early intervention to prevent a deficit is more difficult.
  - Incomplete position control results in the inability to manage the budget impact of salary savings correctly, which in turn can contribute to deficits.
  - Resource acquisition processes understate actual need, because staffing standards are incomplete and operating expenses are not addressed. Hence, key activities are underfunded.

Observations

- ✓ The adjusted gross hospital deficit for 2010-11 is $131.8 million, compared with $133.6 million for 2011-12. The projected increase in the cost per patient year to year is about $9 thousand, or 4.1 percent.
- ✓ The hospitals' expenditure estimates used for the projection are based on a set of assumptions, some of which have weaknesses. In the aggregate there is an upside risk to the deficit.
- ✓ Because the team did not conduct a complete base budget review, there is no assurance that all significant factors influencing the deficit have been identified.
- ✓ The negative adjustments to the appropriation in 2010-11 totaled at least $74.6 million (the team did not review all adjustments).
- ✓ Some of the possible factors contributing to expenditure increases over the last several years have cost estimates or at least cost parameters. Those that do are the Enhancement Plan (up to $75 million, probably less), enhanced observations ($28 million partially offset by base funding), admission suite ($4.8 million), outside medical (up to $20 million), pharmaceuticals ($13 million), workers compensation ($1 million), and positions borrowed by headquarters ($3.4 million).
- ✓ Some of the deficit factors do not have cost estimates at this time: security overtime, possible loss of LOC authority, outdated relief factors, incomplete funding for salary parity adjustments, other operation expense increases.
- ✓ Unused caseload funding will reduce the 2011-12 gross deficit, but the current estimate of reserves may decline during the year, increasing the net deficit.
- ✓ There is no policy or procedure for how hospitals' cost performances are compared to each other, or how year-over-year changes for a hospital should be evaluated. Hospitals are not accustomed to explaining year-over year changes in their expenditures, and headquarters has not been requesting this information.
  - Costs per patient vary significantly (up to 40 percent) for the five main hospitals.
  - Hospitals have significantly different rates of growth in their average cost per patient.

Conclusions

- ✓ The hospital deficit is the result of reductions to the appropriation coupled with expenditure increases, one of which is for a program expansion that was not authorized by the Legislature. Process and organizational issues contributed to an environment in which a deficit was likely.
- ✓ Some of the expenditure increases that the team identified were unavoidable, such as outside medical and pharmaceutical costs, or salary increases for parity adjustments. Much of the increase, on the other hand, was the result of management direction to achieve full compliance with the court monitor for the CRIPA judgment (Enhancement Plan) without accountability for budget impact.
- ✓ While externally imposed mandates (appropriation reductions, CRIPA judgment) are compelling as reasons for the problem, the team concludes that the department contributed to the deficiency through a lax approach to fiscal management. The department's appropriation control has been inadequate in terms of diligence, processes, systems, and numbers of analytic staff.
- ✓ Because this was not a complete base budget review, important factors affecting the 2011-12 deficit might have been missed.
- ✓ In the team's judgment, there are cost savings opportunities in the department, particularly if DMH and the court monitor can reach agreement on more cost-effective methods of reaching the CRIPA court's expectations. Other areas of possible cost savings include better management of medical expenses through formulary control, utilization review, and other managed care medical model practices. However, the changes described above may take time to implement.
- ✓ The department needs to identify how it will judge cost performance for each hospital and for the system as a whole. Differences between hospitals, and changes in year-over-year performance for each hospital, need to be assessed based on documented standards and review protocols. All managers need to be held accountable for budget performance.
- ✓ If the department reserves payroll funds for all employees through the fiscal year, the team believes that the department will experience cash shortages for operating expenses beginning in the winter.

Recommendations

Short-term

- ➢ Put into place a deputy director structure that will help provide leadership to bring the department's mission and budget into balance.
- ➢ Recognize that it might not be possible to avert a deficiency in the current year through savings alone. Plan appropriately for a deficiency situation. Section 4 of this report (#11) suggests ways to improve the department's deficit management.
- ➢ Since the team did not conduct a technical review of the budget, it recommends that the department do so to ensure that technical budgeting processes are sound and do not contribute to the deficit.

- Periodically assess the department's management team on fiscal performance. Establish review criteria for hospitals, such as cost per patient. Hold managers accountable.
- Adopt transparency principals with other stakeholders who will be influenced by the department's budget situation.
    - Keep employees apprised of the budget and cash situation and whether it might affect them.
    - Prepare a vendor payment plan in cooperation with the hospitals, including methods to advise the vendor community of status.

Long-term

- Improve organizational issues that impair fiscal control following the recommendations set out in Section 3. Key among these is to strengthen the budget offices at headquarters and in the hospitals.
- Improve process issues that impair fiscal control following the recommendations set out in Section 4. A key process goal is the establishment of base budgets at both the hospitals and headquarters.
- Improve medical cost consciousness as recommended in Section 6.
- Simplify and refocus the Enhancement Plan both for savings and for more attention on the forensic mission and clinician/patient interaction, as noted in Section 6.
- Modernize the data management environment in the department so that change—including issues of fiscal control—can be based on more reliable data.