



C A L I F O R N I A   D E P A R T M E N T   O F

# Mental Health

1600 9th Street, Sacramento, CA 95814  
(Area Code) Phone Number

October 31, 2011

Pat Ryan, Executive Director  
California Mental Health Directors Association  
2125 19th Street, 2nd Floor  
Sacramento, CA 95818

Dear Ms. Ryan

In preparation for the conference call to take place November 2, 2011 at 1:00 p.m., below you will find the responses to the issues and concerns that counties have with the current state hospital bed purchase and/or contract process. I believe this will be a great starting point.

**1. Unilateral and Retroactive Changes to the State Hospital Bed Purchase Contract**

It is our understanding that no amendment or modification to the terms and conditions of the contract, whether written or oral, is valid without the written agreement of both parties. There have been recent examples where this agreement in the current contract has not been honored. For example, in the September 1, 2010 letter "State Hospital Rates and Planning Assumptions for Fiscal Year 2010-11," DMH notified counties of a retroactive change to the 2009-10 agreement without any discussion with the counties. In addition to the legal issues involved, we would certainly hope for a more transparent and collaborative discussion with counties whenever there is a significant change in policy or practice that financially and/or clinically affects counties.

DMH Response: DMH concurs will take steps to ensure that the counties are informed of any proposed contract amendments prior to execution of the contract.

**2. Hospital Bed Rate-Setting and Method for Calculating Net Utilization**

Hospital bed rates have risen dramatically in the past year or two. Since these rate increases have a significant impact on county budgets, counties are requesting full transparency about what costs go into the rates, when they are determined, etc. The state expects accountability in rate-setting, and we believe counties should reasonably expect the same consideration.

There is also a concern about the lack of transparency regarding the process of pre-buying a bed vs. purchasing on a fee-for service or as-needed basis. How can counties that purchase a bed, but don't use all of the days purchased, be assured that the bed has not been used

and also paid for by another county, resulting in the state being paid twice for the same bed? Counties would like both a county by county and a collective reconciliation on each bed at least annually, to determine which county has paid for what bed. If it is determined that overpayment by counties has occurred, the state should refund such overpayments.

DMH Response to: "Counties are requesting full transparency about what costs go into the rates when they are determined, etc."

In an effort to increase transparency, DMH proposes the use of a tool that would conform to WIC Section 4330. The tool would show prior fiscal year's actual expenditures for staff, medications, food, clothing, facility costs, security (but security would be calculated partially for the purpose of setting rates), equipment, outside medical care costs, and transportation, as reported by Metro, Napa, and Patton hospitals, the three hospitals that accept patients pursuant to WIC Section 5000, LPS Act. DMH proposes to release this document to the counties during the month of October of each year as a way of complying with WIC Section 4331(b). Additionally, DMH proposes to incorporate this tool as deliverable by DMH in the contract and the rates as specified would be "the final rates shall be subject to the agreement (WIC Section 4331(b))."

DMH Response to: "How can counties that purchase a bed, but don't use all of the days purchased, be assured that the bed has not been used and also paid for by another county, resulting in the state being paid twice for the same bed?"

In the letter dated April 21, 2011 to Ms. Kristy Kelly, DMH specified that, "Counties are only billed for beds they purchased. All counties are simply paying for services as specified in their contracts. No county is billed for another county's bed usage."

The letter also specified that, "if you do not use a bed and are being billed for it, you can always take precautions to reduce your bed purchase before the January 1 deadline. An e-mail was sent to you on February 16, 2011 informing you how to track your actual bed usage. You may use th[ese] data to estimate how many beds you will need after Jan 1. If you underestimate the number of beds you need, you can always obtain another bed (outside of your contracted amount) and be charged for it in the excess bed usage billing that DMH now collects on a monthly basis."

To reiterate, counties may access bed usage data through DMH's ITWS system at <https://mhhitws.cahwnet.gov/>. This system provides counties with monthly reports specifying the patients' names, hospital case numbers, and number of days that these patients were in our system.

That said, DMH recognizes that there is lack of clarity and/or misunderstanding about hospital bed usage by the counties. Therefore, DMH is proposing to institutionalize a simple and clear process to assist counties in tracking and managing the use of the hospital beds purchased.

Specifically, DMH proposes to add language to the contract specifying that the contract between DMH and counties does not prohibit counties from selling/subcontracting with another county or group of counties for any unused bed(s). The final language to be added to the contract should be agreed upon between DMH and counties.

Also, DMH proposes to add language to the contract specifying the process to follow should the counties elect to exercise their ability to sell/subcontract unused hospital beds. The final language to be added to the contract should be agreed upon between DMH and counties

DMH Response to: "Counties would like both a county by county and a collective reconciliation on each bed at least annually, to determine which county has paid for what bed. If it is determined that overpayment by counties has occurred, the state should refund such overpayments."

DMH is committed to strengthen the communication regarding bed usage and recommends working with CMHDA to identifying a tool/process/report DMH could use to assist counties in managing the hospital bed usage, which will also assist counties in determining whether to sell/subcontract any unused beds.

### **3. Mutual Indemnification Clauses Needed in Contract**

There is concern among many county counsels that the contract does not include mutually applicable liability clauses. We believe it is a reasonable expectation that a contract like this would include mutual indemnification clauses.

DMH Response: DMH understands the concern. However, DMH must follow State contract policy set forth by the Department of General Services, which specifies that the State does not mutually indemnify contractors.

### **4. Delayed Admissions and Restrictive Admission Protocols**

Some counties have experienced increasing problems in admitting patients to state hospitals, and have been given a variety of reasons for these delays. It can take weeks or even months before they can get the patient into the hospital, and there doesn't appear to be a set of consistent standards for who can be admitted and who can't. Counties do everything they can to manage clients in the community to avoid state hospitalization, and reserve hospital beds for only the most gravely disabled patients. If the state hospital won't take them, even when the county is paying for the hospital beds, we have a fundamental problem that has both fiscal and clinical consequences. Counties would like to see more transparency and collaboration regarding this process, and would appreciate the opportunity to discuss these issues with the state.

DMH Response: DMH shares the opinion that this is a clinical process rather than a contractual issue. DMH is committed to facilitating a series of discussions to explore the frequency and reason for the delays. DMH looks forward to a suitable solution for DMH and the counties.

**5. Changes in the State’s Management of Felony Defendants Ordered to State Hospitals for Competency Restoration Pursuant to PC 1370**

By law, the state has a maximum of 3 years in which to notify the courts that a PC 1370 cannot be restored to competency. While we understand that the state does not have to take that much time to make this determination, within the past year or so this determination is being made much faster than previously, which results in the courts ordering county public guardians to file for mental health conservatorships for these patients. This determination shifts the fiscal responsibility for these conservatees, commonly referred to as “Murphy’s conservatees,” to counties. Again, while this is not illegal, we would like to encourage more collaboration and transparency between the state and the counties on issues like these, including a discussion about the clinical basis on which these decisions are made so early in their hospital stay.

DMH Response: Similar to issue #4, DMH shares the opinion that this is more a clinical and process rather than a contractual issue. DMH is confident that the process may be improved and is committed to facilitating a series of discussions to reach a satisfactory solution.

Sincerely,

Signature Name(CAPS)  
Title

Enclosures or blank

cc: or blank