REPORT TO THE

UTAH LEGISLATURE

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A Performance Audit

of

Utah's Local Mental Health System

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A Performance Audit of
Utah's Local Mental Health System

Public funds accountability of Utah's local mental health system can be increased with improved oversight.

State agencies, local mental health authorities (LMHAs), and mental health centers (MHCs) need to provide better assurance that the more than $132 million in primarily public funds entrusted to the MHCs are being used efficiently and effectively and as dictated by law, policy, and contract terms. Oversight of Utah's local mental health system needs to improve at both county and state levels to ensure that these public funds are used appropriately.

The MHCs may need to improve accountability and adherence to contract provisions and state laws. Improved, coordinated monitoring will provide more information to the governmental units sharing oversight responsibility; better reporting is important to enable assessment of whether the locally operated MHCs efficiently and effectively use the funds they receive from multiple sources.

State and County Oversight of MHCs Needs to Improve

State and county oversight lacks coordination and understanding.

While overall MHC expenditures appear to be appropriate, the lack of detailed information on some activities warrants more oversight by county authorities and state funding agencies. Effective LMHA oversight is hampered by misperceptions among some county officials as to their responsibility and authority over the MHCs. For their part, state funding agencies can do a better job of providing policy direction as well as better coordinating between themselves. The main points of Chapter II include the following:

- LMHAs need to improve oversight of the MHCs
- MHC information provided to oversight authorities can improve as can LMHA review of that information
- State policy direction is needed for the development of compliant MHC administrative policies

Recommendations include developing ongoing training for LMHAs, developing a common statewide structure for reporting from MHCs to LMHAs, clarifying contract language, developing state level policy on MHC administrative areas, and improving MHC reporting to the state.

Policy Improvements Needed for Untraditional Activities

Lack of oversight has resulted in one MHC's activities going beyond the traditional mission of mental health services.

Public policy clarification is needed for mental health center (MHC) involvement in activities other than direct mental health care. One MHC in particular is involved in projects that extend beyond traditional mental health services. The MHC, not the local mental health authority (LMHA), initiated the move into these untraditional activities. This involvement raises concerns about the best use of scarce public funds, a determination that should be made by the LMHA, not its contractor. Chapter III makes the following main points:

- Policy is needed on MHC involvement in untraditional and non-services investment practices
- MHC funds support the operations of some external, affiliated nonprofit organizations, including a foundation and a statewide mental health professional association

Recommendations include developing state level policy on MHC involvement in outside, non-services activities, increasing reporting and oversight requirements for those activities in contracts, requiring MHC foundation compliance with state investment guidelines, and ensuring LMHA oversight of the professional association.

Some Administrative Practices Fail to Ensure Best Use of Public Funds

Some MHC policies and practices need tightening.

A number of administrative practices at MHCs are of concern. These practices range from the development of employee retention incentive policies to inadequate procurement and contracting controls at some MHCs. Specifically, these main points are covered in Chapter IV:

- A retention incentive plan implemented by one MHC raises concerns because of the increased compensation of a small group of executive staff provided through retirement benefits not available to other MHC employees or to state employees

- Another retirement-related concern is the enrollment of non-MHC employees in the state retirement system by processing non-employees' payroll through an MHC payroll system

- Procurement, contracting, record keeping, dual employment, and conflict of interest controls all need improvement

Recommendations include directing the Utah Retirement Systems to study the issues raised and report back to the Legislature, clarifying to the MHCs the necessity of following competitive procurement rules, and clarifying LMHA expectations of the MHCs regarding conflicts of interest and dual employment.

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Chapter I
Introduction

Utah's local mental health system needs improved oversight to increase the accountability of public funds.

State agencies, local mental health authorities (LMHAs), and mental health centers (MHCs) need to provide better assurance that the more than $132 million in primarily public funds entrusted to the MHCs are being used efficiently and effectively and as dictated by law, policy, and contract terms. Oversight of Utah's local mental health system needs to improve at both county and state levels to ensure that public funds are used appropriately.

- At the county level, LMHAs, the main point of oversight, must take a more active approach to monitoring the local mental health centers as required by law to ensure contract compliance and appropriate expenditure of public funds

- At the state level, policy guidelines are needed to provide better direction to both LMHAs and MHCs, while state agencies funding the MHCs need to better coordinate among themselves

Further, the MHCs may need to improve accountability and adherence to contract provisions and state laws. Some current MHC practices, including the creation and/or support of external organizations, use administrative resources for activities with limited benefit to clients. Improved, coordinated monitoring will provide more information to the governmental units sharing oversight responsibility; better reporting is important to assure that the locally operated MHCs efficiently and effectively use the funds they receive from multiple sources.

Utah's Mental Health System Is Run Locally

Mental health services are provided under the auspices of the counties.

The provision of public mental health services to Utah's residents is the responsibility of the counties' legislative bodies, which are statutorily designated as local mental health authorities (LMHAs). The county authorities turn actual service provision over to ten local mental health centers which are a mix of private, nonprofit contractors and public, county-affiliated organizations. Most of the MHCs serve more than one county; interlocal cooperation agreements between the counties provide

the framework for multi-county mental health service areas. These agreements create a separate legal and administrative entity to provide mental health and, in some cases, other services to residents of the counties. Each county retains its LMHA responsibility under the interlocal agreement.

MHCs are either county-affiliated or private, nonprofit organizations answerable to county authorities.

Originally components of county government, the mental health centers have become more independent units. As county units, the mental health agencies were subject to the same controls and oversight as other government agencies. Some MHCs remain closely associated with counties and have much the same level of control and oversight exerted by county authorities as they had previously. MHCs that operate as private, nonprofit corporations, however, are primarily under the control of an appointed board of directors; county authority oversight is more indirect in these cases, though the responsibility is still there.

Each MHC provides a range of services to residents within a geographic area defined by single or multiple county boundaries. Until changes made in the 2003 Legislative Session, the following services as found in ***Utah Code*** 17A-3-602(4)(b) were mandated:

MHCs provide statutorily listed mental health services and other services to area residents.

- Inpatient, residential, and outpatient care and services
- 24-hour crisis care and services
- Psychotropic medication management
- Psychosocial rehabilitation including vocational training and skills development
- Case management
- Community supports including in-home services, housing, family support services, and respite services
- Consultation and education services, including but not limited to case consultation, collaboration with other service agencies, public education, and public information

The ***Utah Code*** language now reads that mental health services *may* include those listed above. Most of the MHCs provide other services beyond those listed above as part of a continuum of services often called wraparound services by the centers. Wraparound services, in addition to traditional therapy, include services such as housing and employment assistance.

County authorities' responsibility includes providing primary oversight and conducting compliance and financial reviews of the MHCs. Figure 1 lists the mental health centers and the counties for which each provides services. The type of each MHC, whether county-affiliated or private nonprofit, is also indicated.

Figure 1. Services Are Provided by 10 Mental Health Centers. Four MHCs are private, nonprofit entities, while six are public entities. Most MHCs serve multiple counties. Each county retains its LMHA status within an interlocal cooperation agreement.

Mental Health Center	Counties Served	Description
Private, Nonprofit		
Bear River MHC	Box Elder, Cache, Rich	interlocal agreement creates a separate legal, administrative entity
Four Corners MH	Carbon, Emery, Grand	interlocal agreement
Valley MHC	Salt Lake County, Summit, Tooele	Summit and Tooele counties contract directly with Valley MHC
Davis Behavioral Health	Davis	single county MHC
Public Centers		
Central UT Counseling	Juab, Millard, Piute, Sanpete, Sevier, Wayne	interlocal agreement
Northeastern Counseling	Daggett, Duchesne, Uintah	interlocal agreement
Southwest Center	Beaver, Garfield, Iron, Kane, Washington	interlocal agreement
Wasatch MHC	Utah, Wasatch	interlocal agreement
Weber MHC	Weber, Morgan	interlocal agreement
San Juan MH	San Juan	single county MHC

As noted, 60 percent of the MHCs in Utah are public entities with strong administrative ties to the counties served, while 40 percent operate as private, nonprofit corporations. Even though four of the ten MHCs are private entities, they were created by county government and exist primarily because of their contracts to provide government services. Additionally, should an MHC cease to exist for some reason, all its assets would revert to the counties once liabilities were paid. Thus, in many ways, even though they are private entities, the four nonprofit MHCs can be viewed as extensions of government, especially in terms of the need for accountability.

MHCs Funded by Mix of Federal, State, Local Funds

Utah's local mental health centers receive funding from several public and private sources. Federal funds come from Medicaid through the state Division of Health Care Financing (DHCF), the agency responsible for organizing, implementing, and maintaining the Medicaid program in Utah. There are also special purpose federal grants. State funds include appropriations to the Division of Substance Abuse and Mental Health or DSAMH (formerly the Division of Mental Health) and funds from state agencies, including the Division of Youth Corrections and the Division of Child and Family Services, which contract with the MHCs for services. Local funds include the counties' required match to appropriated state funds. Other primarily private sources of revenue include fees, third party insurance payments, investment earnings, and donations.

The state provides one-third of total mental health center funding.

Figure 2 shows the major sources of funding for mental health services to the local MHCs for fiscal year 2002. Some MHCs also provide substance abuse and aging services. Funding to the MHCs for services other than mental health are not shown.

Figure 2. Utah's Local Mental Health System Is Funded Primarily by Federal, State, and Local Funding Sources. Medicaid and other federal funds are about 52% of mental health funding; Medicaid funds are matched by state and/or county funds. State funds also require a match from local government.

Funding Source	Amount
Federal (Medicaid & other)	$ 68,113,500
State (appropriations & contracts)	47,264,600
Local (match & extra contributions)	8,549,500
Other (fees, interest, insurance payments)	8,372,300
Total	**$132,299,900**

NOTE: Data are for fiscal year 2002 and reflect MH operating revenues. Substance abuse and aging services funds are not included. Some federal funds are included within the contracts with state agencies.

The data reflect only operating revenues for mental health funds for one fiscal year; data were self-reported by the MHCs to DSAMH. Revenues for other programs (such as substance abuse) are not included in the figure above. However, since fiscal year 2001 financial statements show total revenues of $144 million, it is reasonable to assume that those additional revenues in fiscal year 2002 would be in the range of $12 million.

Mental health centers serve over 40,000 Utahns each year.

The funding provides services to approximately 42,000 people a year. Services are provided to children and adults, with emphasis on seriously emotionally disturbed (SED) children and seriously and persistently mentally ill (SPMI) adults. According to data from DSAMH, about 75 percent of total expenditures were for the SPMI and SED clients. Funding for services to the mentally ill has increased rapidly as the number of clients served and the cost of their treatment has increased.

Figure 3 provides a sense of the growth in mental health funding from fiscal year 1996 to 2002. The rapid growth in Medicaid funding shown in the figure resulted in a proportionately larger increase in expenses for services to low-income, Medicaid-eligible clients compared to others. (In addition to the Medicaid growth shown, additional Medicaid and other federal funds are commingled with state funds in the contracts between the MHCs and state agencies.)

Figure 3. Estimated Mental Health Revenues Have Grown 46% from Fiscal Year 1996 to 2002. Medicaid funding has grown 68%; state pass-through funding has grown 22%. Local funds have increased by 14%.

Revenue Source	FY 1996**	FY 2002**	Growth
Federal Medicaid (net)	$38,548,434	$ 64,752,735	68%
Other Federal	4,470,425	3,360,719	-25
State Formula Funds	15,973,477	19,480,235	22
Other State (contracts)*	18,307,036	27,784,354	52
Local Authority Funds	7,495,642	8,549,547	14
Collections	3,872,697	6,285,306	62
Other Revenue	2,064,592	2,087,019	1
Total	**$90,732,303**	**$132,299,915**	**46%**

** Other State (contracts) line would include some federal funds that are paid within state contracts to MHCs.*
***Unaudited data submitted to DSAMH from MHCs; limited checks found corrections were needed to data for both MHCs contacted; a further illustration of concern over system data. See page 9.*

Medicaid's federal funding growth has resulted in more state funds being committed to the match.

These data from DSAMH show that decisions within Utah's system have resulted in the state accepting more federal Medicaid funds for mental health. As a result, federal Medicaid support has grown 68 percent from 1996 to 2002 while the state mental health match to Medicaid funding has grown by 22 percent. This growth in federal funding has altered state and county funding use. In 1996, the state and counties had to provide $9.5 million, but in 2002 they had to provide $20.4 million, to support the Medicaid program. The shift of state and local funds to the Medicaid match resulted in a decrease in funding available for non-Medicaid clients from $14 million to $7.6 million between 1996 and 2002.

Federal Funding Is Primarily from Medicaid

In Utah, the federal Medicaid program is a major source of mental health services funding, providing at least $65 million in fiscal year 2002. While provision of mental health services is an optional service under Medicaid, Utah, along with most states, has opted to provide Medicaid coverage for mental health services.

Utah MHCs have opted to accept Medicaid funds on a prepaid basis to gain greater flexibility over their services.

Medicaid funding is provided to the local mental health system through DHCF in the Department of Health (DOH) via a prepaid capitated system instead of a fee-for-service system. A waiver agreement with the federal government allows Utah to distribute Medicaid funds on a prepaid basis, based on a negotiated rate per person that is multiplied by the number of Medicaid eligibles in each county. The MHC is then responsible to evaluate and offer appropriate mental health services, as needed, to any Medicaid eligible person seeking diagnosis or treatment services.

Capitation payments are recalculated monthly to reflect current Medicaid enrollment. The capitated system allows for more latitude in the services that can be provided than fee-for-service Medicaid allows. Traditionally, Medicaid funds are paid on a reimbursement basis for a set of allowable services determined by Medicaid. By going to a prepaid system, the MHCs are now "at risk" which essentially means that the centers must serve any Medicaid client requesting and needing services with the provided funds. Under the fee-for-service reimbursement system, the funding agency assumed the risk of determining that funds were properly used. Additionally, with the capitated system, the MHCs have an incentive to use Medicaid funds efficiently; they can use any remaining fund balances to build service infrastructure and capacity. According to federal Medicaid staff, whether the term "infrastructure" means actual buildings or not is unclear and has been left to the states to determine and then set policy.

Eight MHCs were operating with a prepaid capitated system by 1995, and another center switched from fee-for-service to capitated in 2001. One small rural MHC continues to operate with a fee-for-service system.

Federal grants also provide funds to the local centers.

Other federal funding includes both direct grants from federal agencies and funds passed through Utah's Department of Human Services (DHS). Community Mental Health Block Grant funds are an example of a direct grant to the county authorities from the US Department of Health and Human Services. Federal funds passed through DHS include block grants and special purpose grants.

State Funding Includes Required Match And Some Contracts

State funds include $19.5 million from DSAMH and $28 million in contracts with other agencies.

State funds used for mental health services include $19.5 million in appropriated funds that are passed through DSAMH to the MHCs on a population-based formula. Part of this appropriation, along with some county funds, provides the required match to Medicaid funds. Other state funds include a variety of contracts for specific services between the MHCs and several state agencies. In fiscal year 2002, state agencies paid $27.8 million for contracted services for mental health.

Other agencies contracting for services include the Division of Child and Family Services and the Division of Youth Corrections in DHS, which need services for youth in state custody. Many mental health clients also have substance abuse problems and a number of the MHCs provide substance abuse services under contract with the state; according to DSAMH, these revenues are not reflected in the mental health data above.

The state and counties combine to match Medicaid funds in a 70-30 split.

Medicaid requires a state funding match. Utah's match requirement is currently about 70-30; that is, the state's share of Medicaid expenditures is about 30 percent. The portion of the state appropriation used for the match is committed to serving Medicaid clients.

This ratio is adjusted periodically at the federal level. The Medicaid match can be paid by a combination of state and county funds. State funds to match Medicaid funds are appropriated to DSAMH in the Department of Human Services, then allocated to the MHCs. For fiscal year 2002, the combined state and county funds paid as match to Medicaid totaled $20.4 million.

Local Funds Are Required To Match State Money

Each county must match state funds at 20% of its state allocation. Most counties contributed 22% of state funds.

The counties, as local mental health authorities, are required to provide funding for a percentage of the state pass-through appropriation. Each county is currently required to provide 20 percent of its state allocation. In fiscal year 2002, counties provided about $8.5 million to the MHCs.

Some counties direct additional funds to mental health services beyond the 20 percent match. According to data provided by the Division of

Substance Abuse and Mental Health, on average, the counties (except Salt Lake County) contributed about 22 percent of the state allocation. Salt Lake County provided a 77 percent match to its state mental health appropriation in fiscal year 2002.

State Agencies Do Not Collect Complete Expense Data

The state is not receiving a full picture of MHC operations although DSAMH and DHS are charged with state-level oversight responsibilities. As a result, staff are unable to completely assess the operational efficiency of the centers. Comprehensive data, other than that from audited financial statements, were not available from state agencies providing funding to the MHCs.

For example, DSAMH fiscal year 2002 revenue and expense data reports identify MHC expenses by revenue source within functional areas (adult and youth, inpatient, clinic, and so on). These state-level reports do not break the expenses out in any way that is useful in identifying efficiency. Costs such as administrative support, equipment, and buildings are combined into the service areas and cannot be separately identified or reviewed. This reporting format was developed by the division because the division's interest is to demonstrate how funds are allocated for program services and not primarily for assessment of efficiency.

Current level of available data is insufficient to allow an accurate assessment of system efficiency.

We believe that the state should be reviewing administrative costs to determine the level of efficiency in the service delivery system while assessing services for effectiveness. Data received from another division, Health Care Financing in the Department of Health, provided only Medicaid-related revenues and also did not provide sufficient expense information to adequately review MHC operations.

The lack of information makes it difficult to ascertain how much the various centers spend on administrative versus program areas. General administrative and support costs, when reported in MHC financial statements, appear to average around 12 percent of total costs. The range of administrative costs is quite broad, ranging from 10 to 32 percent.

Audited financial statements do not allow for comparisons across the system; thus, other data are needed.

Part of the explanation for the range is that the MHCs' auditors do not classify costs the same way; these differences in reporting illustrate one difficulty of relying on financial statements to assess how well the local mental health system is doing. For example, the center with the highest administrative percentage had a large amount of Medicaid matching funds in the administrative category while other centers spread the matching funds among various service areas. This center (a private nonprofit) also had significantly higher administrative personnel costs than a public center with the same size budget.

A review of service provision was outside the scope of this audit, but both state and MHC officials have commented that Utah has achieved recognition for its mental health services. Therefore, we focused on administrative areas – the service delivery mechanism – to assess how efficiently this area operates and whether improvements are possible to ensure more effective use of funds.

Scope and Objectives

This audit was requested by legislative intent language in the second Supplemental Appropriations Act of the 2002 General Session. An additional request to review retirement policies at the MHCs was added to the intent language directives. On-site work was conducted at four MHCs, selected to represent urban and rural, large and small, county-affiliated and private, nonprofit MHCs; annual budgets for sampled centers ranged from $10 to $70 million. Additional information was obtained from the other centers. Comparison information was obtained from nearby states and national and regional sources of data on mental health services.

In order to better understand the flow of funds to the MHCs and how they are used, the audit also reviewed the interaction between the state divisions and the local mental health centers. Interviews with state staff, review of documentation including oversight reports, observation of board meetings, and rate negotiation meetings were conducted. Discussions with county level staff and county commissioners were also held.

The audit's objectives included the following:

- Review the sources and uses of federal, state, and local funding to the local mental health system (pages 4-10)
- Review the sources and uses of funding to the system's professional association, the Utah Behavioral Healthcare Network (UBHN) (pages 40-42 and 51-52)
- Determine how much funding is spent on administrative costs versus services (pages 9-10)
- Determine whether MHCs' retirement policies are appropriate uses of public funds (pages 45-51)
- Review the appropriateness of salary and lobbying expenses (pages 15, 42)
- Review the Medicaid rate negotiations between the local mental health centers and the Division of Health Care Financing (pages 26-28)
- Review the statutorily set funding formula for allocation of appropriated funds to the local mental health centers (pages 25-26)

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Chapter II
State and County Oversight of MHCs Needs to Improve

While overall mental health center (MHC) expenditures appear to be appropriate, the lack of detailed information on some MHC activities warrants more oversight by county authorities and state funding agencies. Effective local mental health authority (LMHA) oversight is hampered by misperceptions among some county officials as to their responsibility and authority over the MHCs. State funding agencies can also do a better job of providing policy direction as well as better coordinating between themselves.

The Division of Mental Health (recently renamed the Division of Substance Abuse and Mental Health or DSAMH) and the Division of Health Care Financing (DHCF) have recently taken some steps to better coordinate their oversight, but more needs to be done to ensure MHCs' accountability. MHCs, particularly the private non-profits, need to provide more information to their authorities on administrative costs, service provision, and activities in other fields. The lack of oversight activity and lack of MHC-provided information has resulted in legislative concerns with MHC spending of public funds.

The Legislature has shown it wants improved oversight of MHCs by both state and local authorities.

In 1999, the Legislature passed amendments to the ***Utah Code*** to strengthen and clarify county and state oversight of MHCs. Additional amendments clarifying LMHA oversight and increasing MHC accountability were passed in the 2003 Legislative Session. According to statute, county authorities are the primary oversight agencies charged with ensuring that public funds entrusted to the MHCs are spent as intended. At the state level, the Department of Human Services (DHS) and DSAMH, as the state mental health authority, also have statutorily assigned responsibilities for oversight of the mental health system.

Local Authorities Need to Improve MHC Oversight

County officials sometimes lack understanding of their role as authorities over their mental health service providers. As a result,

oversight is insufficient, more often with the private nonprofit than the publicly affiliated MHCs. For example, LMHA oversight, enabled by review of MHC operational information, is inadequate either because sufficiently descriptive data are not made readily available to the counties or because the county authorities do not review the information provided.

Local officials are responsible for MHCs' use of public funds.

LMHAs are responsible for the MHCs' use of public funds. In Utah, county legislative bodies – or in two cases, elected officials – are designated as local mental health authorities and are responsible to provide mental health services to the needy in their areas. County authorities are charged to ensure that those services are provided efficiently and appropriately, whether provided internally or via an outside provider. The LMHAs are clearly charged with performing oversight activities regarding the expenditure of public funds and compliance with relevant federal and state law, state rules and policies, and contract provisions. Specifically, the ***Utah Code*** (17-43-403(2)) requires that:

> Each local mental health authority is responsible for oversight of all public funds received by it, to determine that those public funds are utilized in accordance with federal and state law, the rules and policies of the department [of Human Services] and the Department of Health, and the provisions of any contract between the local mental health authority and the department, the Department of Health, or a private provider.

The LMHAs and the service providers must comply with state directives re: use of public funds for mental health purposes.

The LMHAs are also responsible to comply with all directives issued by DHS and DOH regarding the "...use and expenditure of state and federal funds received from those departments for the purpose of providing mental health programs and services" (***Utah Code*** 17-43-301(3)); and further, to require compliance by their services providers. As a starting point, the LMHAs are charged with requiring the MHCs (prior to their receiving any public funds) to agree in writing that they will comply with all directives issued by DHS and DOH.

Counties Often Lack Understanding of Role

Some local mental health authorities' representatives have misperceptions about their authority and responsibilities in relation to the mental health services providers. The lack of understanding of oversight roles is a barrier to effective oversight, with county officials and staff frequently not exerting statutory authority over the MHCs.

Some county officials have mistaken beliefs about their role in relation to the MHCs.

Some authorities have expressed a mistaken belief that the MHCs are autonomous and beyond county control. For example, one county commissioner stated that the MHC does not have to follow county procedures because it is a separate company which runs its own operations. This commissioner also stated that his county did not perform thorough reviews of MHC contracts or expenditures because it wasn't his job or the county's job to do so. However, he did state that the county auditors could conduct reviews as needed. More significantly, in a recent meeting of county authorities, a commissioner expressed surprise upon hearing that commissioners, not the MHCs themselves, are the local authorities.

MHC compensation practices are seen as beyond LMHA authority or influence.

MHC compensation practices are an area where LMHAs have expressed a lack of authority. Staff at one county stated they look at the level of compensation but have no authority to do anything about it. However, this county's contract with the MHC states that the MHC's pay scale and benefits must be comparable to those offered by other public mental health systems in the region. Review of the total compensation paid to the MHC executive directors in Utah showed that the executive director at this MHC is paid significantly more than any other in-state MHC director. In our opinion, the LMHA responsibility to ensure appropriate expenditure of public funds includes review of and input into MHC compensation practices. If necessary, contracts should be modified to include a requirement for county approval of MHC pay plans and compensation levels.

The comments of a county attorney provide an example of county staff not understanding their statutory scope of authority. The attorney stated that once organizations like their MHC "get outside of government control," the county does not feel it has a great deal of control over what is going on. However, the MHCs are not "outside" of government control. By state statute and contractual agreement, MHCs are required to submit to and comply with county and state oversight. Effectively exerting that oversight, however, can be difficult.

In fact, in some ways Utah's MHCs can be seen as extensions of government since they exist principally because of a contract or interlocal cooperation agreement to provide state services. However, this relationship is not well understood. In one county, staff told us that mental health services would suffer if they didn't renew the contract with the current services provider because they would be forced to recreate the

entire service infrastructure. The staff seemed not to understand that, if the contract were terminated, the MHC assets would belong to the county (after liabilities were paid off). The staff had this misperception even though the contract included a provision for MHC assets to revert to the county.

In response to these and other misperceptions, the Department of Human Services has indicated it is developing a training program for county authorities in conjunction with the Utah Association of Counties. The intent is to provide information on the scope of authority and the nature of the responsibilities that county officials have as local mental health, substance abuse, and aging authorities.

Oversight by LMHAs Is Sometimes Insufficient

Oversight varies between public and private MHCs. Resource limitations often restrict county oversight abilities.

In part because of the misperceptions in scope of authority and also because of limited county resources, current oversight levels may be less than what is needed to assure appropriate expenditure of funds. Oversight also varies between public and private MHCs with some private, nonprofit MHCs undergoing less complete oversight review by counties or the state. Private, nonprofit MHC oversight is largely dependent on voluntary boards and external financial audits.

Few of the LMHAs have the luxury of staff to provide MHC oversight. A staff member in one county's Human Services department has part-time responsibility to coordinate with the area MHC, but in the rest of the state, the elected officials themselves, with occasional assistance from staff, are responsible for MHC oversight along with meeting all their other responsibilities.

MHC boards are relied upon for oversight but may have limited objectivity.

MHCs' Boards Are Relied Upon for Oversight. County officials in areas with private, nonprofit MHCs often rely on the governing boards to perform oversight of the MHCs. However, objective assessment of MHC operations may be difficult when performed by MHC board members who are both strong supporters of and generous donors to the MHC. Further, private, nonprofit MHC boards may lack official county representation.

Of the private, nonprofit boards, two have no county officials as members while the other two have a county commissioner as a non-voting member. One county recommends individuals to the board to provide

county representation, but the recommendation is subject to board approval; this arrangement introduces the possibility that a county's nominee will not be approved, which could affect the county's input to the board. A county executive noted that the counties in his area formed an oversight committee since there are no county representatives on their MHC's board. Most of the time this committee agrees with the board's decisions. Occasionally, however, the committee "has to find ways" to exercise authority if they disagree with the board on an issue (even though counties are given the authority by statute).

Commissioners expressed a desire to be more involved, but a 1988 legal opinion is a possible barrier.

Lack of board membership doesn't necessarily preclude oversight. Most commissioners understand that they should be performing more active monitoring even though some told us they feel excluded from involvement. Increasing commissioner involvement through active participation on MHC boards may, however, be a problem. A 1988 informal opinion from the Attorney General's Office raised the issue of possible conflicts of interest if county commissioners served on MHC boards. Assuming this opinion is still valid, oversight can increase only through strengthened contracts.

County commission membership on boards of publicly affiliated MHCs is the norm.

Oversight Is More Direct with Public MHCs. On the public side of the mental health system, the relationship between the MHC and the county or counties it serves is a closer one. Governing boards are comprised of county commissioners who represent each county in the center's service area and may also include citizen appointees. Thus, the board and the LMHA are essentially the same entity so that the oversight authority has full and instant access to all information given to the center's board.

MHC boards, whether publicly affiliated or private nonprofit, perform similar functions but frequently have different approaches to spending, controls, and administrative decisions. As controls over spending and generally more conservative administrative decisions show, boards of the public MHCs emphasize accountability to taxpayers. Examples of oversight and accountability include the following:

- Board review of the check register at each meeting
- Submission of all contracts to the board for approval before signing the agreement
- Determination of use of surplus funds or fund balances

- Review of detailed expenditure and departmental reports each month
- Decisions to keep financial resources in services rather than non-services activities

Clearly, the above functions are performed by board members or commissioners for the various MHCs. The difference lies in what is viewed as important and to whom the board members or commissioners believe they are answerable, as well as in how well the authority and responsibilities of the LMHAs are understood.

MHC Information and LMHA Review Can Improve

Information given to oversight authorities can improve.

Some mental health center administrative reports provide inadequate information to oversight authorities, which hampers the oversight process. County oversight authorities need access to complete and reliable information from MHCs to fulfill their oversight role. However, current MHC data presentation sometimes creates obstacles to a determination that funds are spent appropriately. Staff in one county also reported difficulties in obtaining requested information from their MHC. The MHCs need to generate detailed operational reports on a regular basis for the LMHAs and fully comply with county requests to provide information for review.

Operational Data Review Can Be More Thorough

Some county officials and staff as well as state staff with oversight responsibility indicated they rely on the annual financial statements prepared by each MHC's external auditor to determine how well the MHC is doing financially. This heavy reliance on after-the-fact financial statements is a concern; the audited financial statements often fail to provide the sufficient and timely data needed to provide effective oversight.

Reliance on financial statements is inadequate for oversight purposes.

The MHCs' audited financial statements generally do not provide sufficient detail to allow a reviewer to assess whether funds have been spent appropriately or as required in state statute or county contract provisions. As examples:

- Some statements fail to distinguish among federal, state, and local funding sources, combining all government funds into one total
- Several audited financial statements fail to clarify and separate mental health from substance abuse expenditures
- Some fail to provide a functional breakdown between program and administrative expenses
- Financial statements do not typically provide expenditure data on client services

Audited financial statements' timing limits their use as oversight tools.

In addition to having too little usable information for oversight purposes, these reports are not available until months after the end of each fiscal year. An ongoing monitoring program is not possible with such untimely reporting.

Local oversight authorities should obtain and review detailed operational reports on a monthly basis as part of their oversight role. For example, monthly reports showing account detail with a comparison of budgeted to actual revenues and expenditures are generated internally for MHC management purposes. These reports would provide more detailed information to reviewers on a more timely basis than annually produced financial statements. It should be noted that the boards of the private, nonprofit MHCs typically review monthly expenditures in some detail, and because of this review, they often have more information provided to them than the LMHAs have.

MHCs Don't Always Comply with County Directives

MHCs do not always comply with county information requests.

Some mental health centers fail to comply with directives or requirements spelled out in county contracts. According to county staff, one MHC has not always complied with requests for information. Specifically, county staff requested minutes of a board's executive committee meetings but were told the minutes did not exist. The staff also indicated the MHC had questioned what meeting minutes the county had a right to see. We also requested the meeting minutes from the MHC but were told that minutes are not kept. The executive director asserted that each board executive committee meeting is "his time with his bosses," and as such, minutes are neither required nor kept.

While discussion of the professional competence of an individual is a valid reason to hold a closed meeting, discussions of MHC operating

issues do not fall under the specific requirements for holding a closed meeting as listed in the ***Utah Code*** 52-4-5. Numerous items on reviewed agendas were not personnel-related. In addition, even if the professional competence of the director was discussed in some portion of each executive committee meeting, the statute indicates that discussion of any other subjects requires either tape recording or keeping detailed minutes of the closed portion of the meetings (***Utah Code*** 52-4-7.5).

This county's staff raised other informational or reporting concerns. For example, although the county asked the MHC's external auditor to review a retirement policy to determine if it saved the MHC money, the auditor performed a limited review and passed along calculations internally generated by the MHC. (The auditor was reluctant to fulfill the county's request which was beyond the auditor's area of expertise.) The MHC also has numerous affiliations with other organizations, including a fund-raising foundation. County staff indicated they have not had access to the foundation's financial information because the MHC's staff asserted that the county has no right to review private funds. However, the funds held by the foundation are a mix of public funds and private donations.

Contract Clarity Can Improve

LMHA contracts with MHCs should spell out state directives and legal requirements.

Agreements between the counties and the MHCs do not always include clear references to state requirements placed on the LMHAs. LMHAs need to ensure that relevant directives to them in their state contracts are, in turn, incorporated into the contracts or otherwise passed on to the MHCs. Such an action would ensure that administrative and reporting requirements are clearly specified.

State statute says that, among other things, the LMHAs are responsible for the following:

- Requiring providers to establish administrative, clinical, personnel, financial, and management policies in accordance with state and federal law and state policy (amendments passed during the 2003 Legislative Session added procurement policies to those listed above)

- Requiring that providers agree in writing that the state division may examine and the county auditor may audit their financial records, and that providers will comply with all directives issued by

DHS or DOH regarding the use and expenditure of state and federal funds

- Requiring that neither a services provider nor its employees violate any applicable rule or policy of DHS or DOH or any provision of the contract between the LMHA and the state, or appropriate public funds for a use that doesn't comply with contract provisions

However, some contracts between LMHAs and mental health providers fail to include these requirements. For example, one contract states that "the Center shall accept and comply with all appropriate and applicable laws, standards, regulations, and conditions associated with County funds..." but does not clearly require the MHC to abide by any specific laws, regulations, or directives issued by DHS and DOH. The contract provision related to required reporting to the county states only that "the Center shall provide such periodic or other reports as the County may from time to time request regarding the provision of services, the mental health funding and Area Plan, and any other relevant matters," but it does not specify what information is required for oversight review.

Other contracts between MHCs and counties contain varying degrees of specificity in references to statutory requirements and the expectations of the county authority. County authorities should refer to statutory requirements and also consider comparing their contracts to other counties' contracts to identify needed language or provisions. Another possibility is that the state could develop and provide "boilerplate" language on oversight responsibilities to county authorities for inclusion in contracts with MHCs.

State Policy Direction Needed

DSAMH should take the lead in setting MHC administrative policies.

Many of the concerns described above can be addressed by providing clear policy direction to the county authorities and the MHCs. Using mandated oversight responsibilities as a guide, the Division of Substance Abuse and Mental Health (DSAMH) should develop administrative policies that reduce confusion regarding counties' authority over the MHCs. To identify areas needing policy guidance, DSAMH governance and oversight reviews need to improve. Further, better coordination needs to occur between the major funding agencies. State agencies have failed to consult with each other regarding MHC funding, thus allowing

the MHCs to exert disproportionate influence in funding decisions that affect agencies not included in the decision-making process.

State Policy Direction Is Authorized

The *Utah Code* gives DHS and DSAMH the authority to examine the operations of the MHCs and issue needed directives for improvement.

The Legislature has delineated state-level oversight responsibilities in the ***Utah Code***. To begin with, DHS has authority to do the following:

> Examine and audit the expenditures of any public funds provided to local substance abuse authorities, local mental health authorities ...and any person, agency, or organization that contracts with or receives funds from those authorities or agencies.... The department is further authorized to issue directives resulting from any examination or audit to local authorities, area agencies, and persons or entities that contract with or receive funds from those authorities with regard to any public funds. (***Utah Code*** 62A-1-111(20))

Thus, not only should DHS examine MHC expenditures, but it can also issue directives or policy statements as needed to the recipients of those funds.

For example, if DHS has concerns about the uses of public funds as a result of its expenditure reviews, it is authorized to direct the LMHAs and/or their providers as to appropriate uses of the funds. Options for issuing such direction include issuing policy and/or revising contract language. In addition, the law authorizes DHS to withhold funds if it finds any failure to comply with state or federal law, policy, or contract provisions.

Public funds transferred by an LMHA to an MHC remain public.

Thus, state statute provides that the state can review any area of MHC expenditures that uses any public funds. It should be noted that the 1997 clarifications to the laws governing mental health funding defined "public funds" as follows:

> ...Public funds means (i) federal money received from the department [of Human Services] or the Department of Health; and (ii) state money appropriated by the Legislature to the department, the Department of Health, a county governing body, or local mental health authority for the purposes of providing mental health programs or services; and includes that federal and

state money: (i) even after the money has been transferred by a local mental health authority to a private provider under an annual or otherwise ongoing contract to provide comprehensive mental health programs or services for the local mental health authority, and (ii) while in the possession of the private provider. (***Utah Code*** 17-43-303(1))

DSAMH is the state mental health authority; statute has given it a number of oversight responsibilities.

Within the department, DSAMH is the specific agency named as the state mental health authority and is charged to conduct the state-level reviews outlined above. The division's responsibilities include the following, excerpted from the ***Utah Code*** (62A-15-103):

- Providing direction over public funds for mental health services
- Monitoring and evaluating mental health programs provided by LMHAs
- Examining expenditures of any local, state, and federal funds
- Monitoring the expenditure of public funds by LMHAs and their contract providers
- Reviewing and approving each LMHA's annual plan to assure, among other things, appropriate expenditure of public funds
- Reviewing LMHAs' contracts with providers to assure compliance with state and federal law and policy
- Withholding funds from LMHAs for contract noncompliance or failure to comply with division directives regarding the use of public funds
- Withholding funds if an LMHA contract with its provider fails to comply with state and federal law or policy
- Ensuring that LMHAs are complying with their oversight and management responsibilities

This list illustrates the level of oversight expected by the Legislature and underscores legislative concern that oversight is currently inadequate.

DSAMH should take steps to improve oversight reviews and develop policies as needed to clarify state expectations of LMHAs and service providers.

State Direction to Counties Can Improve

Because of the previously discussed misperceptions existing at the county level, DSAMH should clarify the authority and responsibilities of the LMHAs. First, DSAMH's governance and oversight reviews need to be more in-depth. Then, with better information provided as a result of the improved reviews, DSAMH should develop and promulgate

Policy review work needs to review both policy and implementation.

administrative policy as needed to clarify state expectations of the LMHAs and their service providers.

DSAMH governance and oversight reviews of MHC administrative functions can provide insight on areas needing better policy guidance to LMHAs and MHCs. However, the oversight reviews need to be more substantive to improve the likelihood of identifying areas of concern. Our audit work at two MHCs, conducted close to the same time frame as the division's oversight visits, identified concerns that had not been found by the division's reviews.

Division governance and oversight reviews lack depth.

For example, at one center, consulting agreements were being entered into without written contracts or required competitive bidding. Review of vendor invoices and check registers led us to request additional documentation on consultants, which in turn revealed the noncompliant contracting practices. The division's reviewer did not identify these concerns during staff interviews. MHC staff told him there were very few contracts to review (which was true, since they were operating without written agreements). The reviewer understood this statement to mean the center did not do much subcontracting and the area was not pursued further.

The division's review checks for the existence of required policies in several areas. However, the reviews need to go beyond ascertaining the existence of policy to verifying that policies are complete and are being followed. As an example, a governance report stated that the MHC discussed above had a comprehensive procurement policy in place, but we found that the policy did not cover procurement of services. A more detailed review by the division would have shown that the policy does not include requirements for procurement of services and that there were numerous instances of noncompliance.

More time should be given to each governance and oversight review.

Such omissions are possible because the typical length of the division's on-site work at each MHC is one day; on-site work at the largest, most complex MHC lasted four days. Taking more time would allow for thorough review of source documentation and other records not currently being reviewed.

If governance reviews identify problem areas, the state division should then develop administrative policy direction for the LMHAs and MHCs as it has previously developed program and services policies. The

following areas could be addressed as a start, based on concerns identified in our audit work:

As concerns are identified, policy can be set or clarified to give direction to the MHCs.

- Development of documentation requirements for administrative expenses such as procurement and contracting
- Determination of whether public funds should be used in areas such as non-client housing construction, loans to affiliates, investment practices that differ from the state's, and support of non-services activities
- Development of a process to obtain approval from counties or the state for activities that go beyond the core mission of providing mental health services to the needy
- Development of policy on acceptable uses of MHC fund balances, including unspent Medicaid funds since federal officials state these uses are to be set by the states

Policy clarification on these and other areas of concern would provide additional direction to LMHAs as they pursue their oversight responsibilities. Once state policy has been set, the LMHAs would be responsible to implement the policy at the local level, directing the MHCs through contract provisions and/or oversight activity.

State funding formula issues were resolved early in the audit, but the policy may still need clarification.

State Funding Formula Policy May Need Clarification. State statute calls for apportioning mental health service funds according to need and "determination of need shall be based on population unless the board establishes, by valid and accepted data, that other defined factors are relevant and reliable indicators of need." (***Utah Code*** 62A-15-108(1)) The administrative rule on the funding formula further provides for distributing funds on a per capita basis according to the most recent population data available from the Governor's Office of Planning and Budget (GOPB). Funding formula updating did not initially meet these requirements.

After discussion and input on the funding formula, the State Board of Mental Health (now the State Board of Substance Abuse and Mental Health) passed a resolution in April 2002 stating the following main points:

- There would be no adjustments made for one year to the funding formula used for distribution of state funds allocated to the MHCs

- Funds were to be held back from some MHCs and given to three MHCs in financial difficulty.

By this resolution, the board decided to continue using outdated population information and also decided not to distribute funds on a per capita basis. This action, proposed by the Utah Behavioral Healthcare Network (UBHN), a professional association of mental health and substance abuse providers, was taken against the advice of the state division.

In effect, the proposal recommended making no change to the funding formula for one year so a study could be done and proposed using some formula funds to address financial problems being experienced in three rural centers. Both statute and rule clearly provide that funds be distributed based on recent population data, which was available in the form of 2000 census data. In addition, state staff pointed out that the formula was not intended to address Medicaid match funding problems.

Agreement of state statute and board action was not reached until the executive director of the Department of Human Services wrote the board, pointing out that their action did not meet the requirements of law or rule. Subsequent board action replaced the first resolution with one proposed by the division. It is of concern, however, that the state board initially chose to bypass the options presented by division staff as well as the advice implicit in a letter from the department's attorney which stated that the UBHN option did not appear to meet statutory requirements.

Better Coordination Between State Agencies Is Needed

More coordination between DSAMH and DHCF is needed in the Medicaid rate negotiation process.

The two state agencies providing the majority of funding to the MHCs need to improve communication regarding mental health funding issues. DSAMH and DHCF should coordinate funding discussions and decisions, including Medicaid rate negotiations held with the MHCs, because Medicaid funding (determined by HCF) affects the uses of mental health funds appropriated to DSAMH. The lack of coordination is apparent in the reporting of MHC information to the two divisions. Neither division was able to provide complete system-wide information.

Though DSAMH funding is affected by the negotiation results, the division has not been involved in the process until recently.

Medicaid Rate Negotiation Process Needs Increased DSAMH Participation. Until 2002's negotiations, representatives from DHS did not participate fully in the rate negotiation process. The recent

involvement of DSAMH staff is a step forward in coordinating available funds for mental health services. Actions taken by GOPB to further change the funding process should help even more in coordinating mental health funding.

DSAMH rate negotiation involvement is needed because increases in MHC prepaid Medicaid rates create pressures on DHS to increase funding for mental health in order to maximize the match of federal Medicaid dollars. This pressure could conceivably mean taking funds from other programs to give the Medicaid match top priority.

To illustrate, the MHCs have indicated that as they use more state funds to match federal Medicaid dollars, fewer state funds are left to serve non-Medicaid clients. The MHCs have repeatedly asked for more state funding from DHS, stating that non-Medicaid clients are going unserved because DHS has not contributed sufficient funds to cover both the growing requirements of the Medicaid match and the needs of the MHCs' non-Medicaid clients. We wanted to assess whether and how much of a decline has occurred in systemwide funding for non-Medicaid clients but found that DSAMH lacks reliable data to prove or disprove the centers' assertion. Available unduplicated client data for fiscal years 2000 and 2002 do show a six percent increase in Medicaid clients served with the concurrent decline of six percent in non-Medicaid clients served.

GOPB recently altered the process for approving rate increases; requests will now go through the budget and appropriations process.

Requests for Medicaid Rate Increases Will Now Go Through the Budget Process. Until this year, rate increases have been determined prior to and independently of the state budget and appropriations process for mental health funding. GOPB recently stated that proposals for rate increases should be submitted for review in the state budget and appropriations process. This change to the rate negotiation process was instituted prior to the 2003 Legislative Session. GOPB's approach should benefit the Human Services system because all requests will be presented and considered together during the budgeting process on a "level playing field." The MHCs should also benefit by having the opportunity to participate in developing budget proposals that reflect their needs.

Once appropriations decisions are made, the state agencies would know what state funds have been appropriated for mental health services. DHCF would be able to make more informed decisions on Medicaid rate increases by considering not only cost increases documented by the

MHCs, but also whether rate increases are realistic based on DHS funding levels.

Finally, county authorities have not been involved in rate negotiations, although they are required to provide matching funds to the state funds appropriated for mental health services. Recent testimony in a task force on funding local health and human services brought out this point --- the counties want to be involved in funding discussions that affect them as local service providers. The state could consider involving county representatives in the meetings leading to the development of MHCs' funding requests.

DSAMH and DHCF each get partial reports on revenues and expenditures.

Coordination of Reporting Would Enhance Oversight Efforts. It appears that both DSAMH and DHCF receive incomplete reporting of mental health revenues and expenditures. These divisions should compare their MHC-reported information to determine whether accountability is sufficient; reports should then be improved where needed.

Early in the audit, we requested reports on the overall funding and expenditures of the local mental health system, first from DSAMH and then from DHCF. DSAMH staff stated they looked over the MHCs' annual financial reports prepared by external CPA firms, but that there had been little systematic collection of data from the MHCs since 1996. Improvements were planned for 2003. In fact, the division has worked with the centers to develop a standardized reporting format for mental health expenditures; these data were used in Figure 2 in Chapter I. However, these data do not provide total revenues or expenditures; for those, DSAMH staff referred us to DHCF.

DHCF provided data on Medicaid funds dispersed to the MHCs but could not provide system totals for revenues or expenditures. Staff at DHCF referred us to DSAMH, stating they were sure the other division had systemwide data. Each division believed the other had received and reviewed full revenue and expenditure data.

Without full financial information, any assessment of MHC efficiency will be limited.

The lack of complete information means that the current ability of state agencies to adequately assess MHC operational efficiency is limited. With the level of funding involved in the local mental health system's operation, it is essential that an oversight agency be able to ascertain how much revenue is in the system and how it is being used. With DSAMH statutorily designated as the state's mental health authority, this division

should take the lead in developing reporting requirements that go beyond the annual financial statements and currently required reports.

Recommendations

1. We recommend that DHS and DSAMH, in conjunction with UAC, develop an ongoing training and information dissemination program for the LMHAs to explain their statutory authority and oversight responsibilities.

2. We recommend that DHS review state contracts with the local mental health authorities to clarify provisions regarding the authority and responsibility of the authorities for oversight and the requirement for the MHCs to comply with county and state directives.

3. We recommend that DHS seek to amend the administrative rule governing the funding formula to specify how frequently the population data must be updated.

4. We recommend that DSAMH develop and promulgate policies in MHC administrative areas, including:

    - documentation requirements for expenses such as procurement and contracting

    - appropriateness of non-services activities (non-client affordable housing, loans to affiliates, investment practices that differ from the state's, support of other non-services activities)

    - process for MHCs to obtain LMHA approval for activities that go beyond the core mental health services mission

    - acceptable uses of appropriated funds and fund balances

5. We recommend that DSAMH improve its governance and oversight reviews to include more in-depth review of MHC operations.

6. We recommend that DSAMH develop a comprehensive reporting format for use by the MHCs, with emphasis on ensuring adequate data is provided to enable state assessment of MHC operational efficiency as well as service effectiveness.

7. We recommend that LMHAs develop a common report structure that provides information needed to enable the LMHAs to fulfill oversight responsibilities.

8. We recommend that the LMHAs include in their contracts with the MHCs any directives from DHS and DOH and relevant statutory requirements including, for example, the state's open meeting statute.

Chapter III
Policy Improvements Needed for Untraditional Activities

MHC involvement in non-services activities needs guiding policy.

Public policy clarification is needed for mental health center (MHC) involvement in activities other than mental health services. One MHC in particular, Valley Mental Health (VMH), is involved in projects that extend beyond traditional mental health services. The MHC, not the local mental health authority (LMHA), initiated the move into untraditional activities. This involvement raises concerns about the best use of scarce public funds, a determination that should be made by the LMHA, not its contractor. The following activities are of concern:

- Development of untraditional investment practices, including non-client affordable housing and partnership in a human resources/ employee assistance training corporation, without policy direction or adequate oversight by LMHAs

- Supporting external non-profit organizations that have ties to VMH

Investing in activities that extend beyond traditional mental health care may result in future benefits; however, the MHC has pursued these projects with insufficient involvement by the oversight authority. While the MHC's director stated the LMHA agreed with the initial concept of developing non-client affordable housing facilities years ago, the county has not fully reviewed these activities recently, nor has it developed a policy on MHC involvement in activities that go beyond mental health services. In addition, the contract between the LMHA and the MHC does not reflect LMHA policy or priorities relating to these and other outside activities. Further, MHC reporting on these activities to the LMHA is inadequate, making oversight and accountability a concern.

Policy Needed on Involvement in Untraditional Investment Practices

LMHAs should decide whether non-services activities fit within an MHC's mission.

Mental health oversight authorities should set policy on MHC involvement in outside activities and should be more involved in the

oversight of such projects. VMH has become a partner in several business ventures, some of which have little relation to mental health services. Public policy needs to be developed to guide MHC involvement in untraditional investments. Further, sufficient studies were not done to fully determine the development costs of one of these projects, a consulting and training corporation. With the justification of developing alternative sources of revenue, VMH has gone beyond its core mental health mission, taking on roles of landlord, business consultant, and banker. One such outside endeavor, however, has provided clients with therapeutic employment opportunities.

VMH has financial and management interests in seven limited liability corporations (LLCs) and three non-profit Housing and Urban Development (HUD) projects that provide affordable housing. Most of these provide client housing. Additionally, VMH is a 24 percent owner in a behavioral risk management consulting and training LLC. This organization's purpose is not to provide mental health services, but VMH is attempting to develop clinical applications of the organization's products.

Housing Projects' Goal Is Revenue Generation, Not Client Care

VMH hopes for a future revenue stream from three affordable housing complexes.

VMH has assisted in the formation of three LLCs created primarily to provide low income housing, not housing specifically for mental health clients. VMH entered into these long-term commitments in order to develop a future revenue stream to use in client services, but did so in the absence of a state or county policy guiding MHC involvement in activities beyond core mental health services. VMH's initial cash investment in these facilities is minimal (less than 1 percent) with some non-quantified staff time also devoted to the LLCs; most importantly, VMH provided the availability of tax credit financing which will result in ownership of these projects reverting to VMH in the future.

The three non-client housing facilities -- Hidden Oaks in Salt Lake County, Iron Horse in Park City, and Valley Meadows in Tooele -- are affordable housing complexes. Only Valley Meadows has any units reserved for VMH clients, with 8 of 40 units (20 percent) set aside. VMH expects to obtain ownership of these entities from the primary investors when the owners' tax credits have been exhausted; Hidden Oaks, created in 1993, will be the first one to come available.

VMH, as the managing partner, currently has only a small ownership in these LLCs, ranging from 0.5 to 0.75 percent. Other entities financed construction of the three facilities in exchange for low-income housing tax credits obtained by VMH on the basis of its nonprofit status. The financing corporations will use up the tax credits over 10-15 years. At that point, VMH would be offered first right of refusal or could pay a nominal amount for each facility to assume full ownership, thus receiving the income but also providing the maintenance. VMH will also be required to comply with a number of federal guidelines on the use of the properties after assuming ownership.

VMH's board approved the LLC projects and supports them, based on the belief that future revenues will be used to help VMH's clients. In fact, VMH's director referred to the Hidden Oaks project as an annuity. VMH's executive director stated and board members concurred that board discussions were held to assess whether VMH should become involved in a non-client, low-income housing venture; the director indicated that detailed cost-benefit analyses had not been done. He also recalled that some county commissioners were informed of VMH's intent in 1993; however, he does not feel that VMH needed to get permission from the county. With board approval, VMH moved forward.

Though major costs were paid by tax credit investors, VMH incurs a variety of expenses.

Although VMH's executive director maintains that Valley entered into these projects at minimal cost, each project involves some ongoing cost to VMH. Among other things, according to the Valley Meadows management agreement, VMH is responsible to do the following:

- Pay for fidelity bonds, various insurance policies and benefits, and legal costs
- Provide accounting staff assistance to the management entity to set up and maintain accounts and books
- Review and approve annual budget and budget variances
- Meet quarterly to discuss budget and operations

Because VMH does not track staff time by project, management was unable to quantify these ongoing costs. In addition, VMH has loaned funds to one of these LLCs: Hidden Oaks has a $372,000 note payable to VMH. Figure 4 lists VMH's housing projects and their housing support of clients.

Figure 4. VMH Has Interests in 10 Housing Projects. Two of the first three have no units designated for VMH clients, and the third has just 20% reserved for clients. The other facilities provide housing specifically for clients.

LLC Name	Type of Project	% Reserved for Clients
Hidden Oaks	LLC/ Tax Credit	0%
Iron Horse	LLC/Tax Credit	0
Valley Meadows	LLC/Tax Credit	20
Valley Woods	LLC/Tax Credit	100
Valley Horizons	LLC/Tax Credit	100
Safe Haven	LLC/Tax Credit/HUD	100
Safe Haven II	LLC/Tax Credit/HUD	100
Valley Villa	Non-profit/HUD	100
Oquirrh Ridge East & West	Non-profit/HUD	100
Valley Crossroads	Non-profit/HUD	100

Oversight authority involvement in outside activities needs to improve.

While it appears from a review of limited scope financial statements that VMH will achieve a revenue stream after taking ownership of these three projects, the following concerns exist about the current level of oversight:

- State level policy regarding untraditional activities has not been developed to provide general parameters for all MHCs.
- County contract reporting and accountability requirements for LLC and other untraditional activities have not been enforced.
- While past county authorities accepted VMH's move into untraditional activities, the LMHA has not formally reviewed and approved the appropriateness of the MHC's continuing involvement in major, long-term, non-mental health services activities.

- County staff indicate they have not been able to obtain annual financial statements, revenue and expenditure reports, or budget variance reports for the LLCs.

In addition to the oversight concerns, we are concerned that a shift in focus from the provision of direct services to the creation and management of an increasing portfolio of facilities could result in fewer resources being available for service provision.

VMH-affiliated LLC Focus Is Organizational Behavior Training

VMH is a part owner in a for-profit, West Virginia consulting and training firm.

VMH is a partner with four mental health centers in other states in a for-profit, West Virginia-based behavioral risk management consulting LLC titled Behavioral Health Strategies (BHS). To date, the venture has not provided significant financial return to VMH, though the director anticipates future revenue that he states would be used for client services. BHS markets a human resources product called Performance Enhancement Solutions (PES), which provides consulting on employee and organizational behavior areas to non-mental health related businesses. A clinical mental health application of PES was not part of the original mission of the LLC. VMH, however, believes that developing such an application may help in socializing its clients.

The profit projections for BHS, due to uncertainty in the data, are questionable. BHS projected a fiscal year 2003 profit of $568,000, but shows a $9,400 profit for the first half of the fiscal year. In fiscal year 2002, BHS showed a net loss of $1 million.

VMH invested in BHS, then began to develop a mental health application for BHS's product.

In 1998-99, VMH invested $50,000 to assist in creating the LLC; other costs to VMH include staff time and the unknown costs of developing a clinical application of the PES product. (Limited clinical testing of this application is in progress using VMH clients.) Although VMH received a $25,000 grant for clinical testing costs, total development and testing costs have not been tracked, making it difficult to determine how much public mental health funding may have been put into this effort.

In addition to investing $50,000 in BHS, VMH provided the corporation a $125,000 loan in 2000, which has been repaid with interest. VMH has also contracted with BHS to train VMH personnel in

the use of PES and a component evaluation tool called EQi (emotional quotient). Training costs to date for 30 VMH employees total $56,800; an additional $68,000 was used to purchase training materials and online training for staff and patients. VMH has earned $10,000 in consultation fees from the Salt Lake County Department of Human Services, but by the end of our audit work, no other contracts had been put in place.

Valley Services Provides Positive Experience for Clients

Valley Services appears to be an outside activity that benefits clients.

One enterprise that VMH has spun off appears to provide a services-related benefit by employing clients. VMH contracts with Valley Services (VS) to clean and maintain VMH facilities and grounds. VS is a nonprofit corporation created by VMH to provide therapeutic employment to VMH clients. Currently, about 77 percent (103 of 133) of VS employees are also VMH clients.

VMH pays the maintenance costs of cleaning its offices and clinical locations and also pays some costs for unusual maintenance costs at the separately owned LLCs. From 1994 to 2001, payments from VMH to Valley Services increased by 269 percent as facilities have expanded. The VS director indicated that one goal of the company is to expand by providing maintenance services to other businesses. Eventually VS hopes to be less reliant on VMH's business, which comprised about 80 percent of VS sales in 2001. According to VS's director, services are provided at rates that are competitive with the private sector.

According to VMH's executive director, employment is one component in the "wraparound services" espoused by VMH and other mental health centers. Though not a core mental health service, wraparound services are designed to increase clients' independence and social functioning and include not only treatment but also housing and employment services.

Mental Health Funds Support Operations of Affiliates

Mental health funding supports operations of nonprofit corporations that do not directly provide mental health services. These funds, placed in private, affiliated organizations, are further removed from oversight and

accountability. In particular, Valley Mental Health has placed its foundation, which is used for private fund raising, outside the organization. Further, a statewide professional association, supported by dues from all the MHCs, also receives substantial amounts of mental health funds.

Foundation's Success Is Questionable

Valley Foundation's viability is dependent upon funds transferred from VMH.

The goal of Valley Foundation is to develop and increase alternative funding sources for VMH. It does not appear, however, that the foundation has yet been a successful endeavor. First, the foundation's operating costs have been supported by transfers from VMH, casting doubts on the foundation's organizational independence. Second, the foundation's investment practices allow public funds to be put into investments that carry more risk than either the state's or VMH's own practices and do not appear to meet State Money Management Act requirements.

The foundation's program is intended to generate donations and then invest those funds so the interest earned will benefit VMH's client population. While this goal could be achieved within VMH's structure, it was believed that donors would be better accommodated by an independent foundation where the donors could direct their donations toward specific projects.

VMH's support provides operating funds, including the director's pay, to the foundation.

Valley Foundation, Created in 1994 as a Separate Nonprofit Organization, Is Not a Stand-alone Organization. From 1994-2002, at least $987,000 were transferred from VMH to the foundation to pay for operating expenses; in 2001, the foundation would not have been able to cover its expenses without the transfer. In addition to covering the foundation's operating expenses, in 2001, some of the transferred funds were also used to meet a condition of a private donation matching agreement.

VMH's CFO indicated the transfers allow the foundation director to concentrate on fund raising. He stated VMH hopes the foundation will one day support itself. The foundation also receives VMH staff assistance for accounting needs and as needed for special events. Without VMH support, the foundation would have no administration and greatly diminished assets.

The foundation has received large donations from a few individuals for two specific projects, but over half of the foundation's revenues have been transfers from VMH. VMH states that funds were transferred to meet certain stipulations and match requirements tied to donations from private individuals. The largest of the foundation's donations was given by a member of the VMH board. The foundation's first director also gave about $1 million. His departure, according to VMH staff, resulted in the loss of foundation financial information.

Information on VMH's transfers to the foundation is limited due to poor record keeping prior to 1998. However, a history of transfers between VMH and the foundation was developed from audited financial statements. Figure 5 reflects the reported transfers to the foundation as found in VMH's audited financial statements.

Figure 5. Transfers from VMH to Its Foundation Total $5 Million Since 1994. Total foundation income in the same period is $9,147,000.

Year	Amount	Purpose
1994	$ 300,000	Prepaid Fund Raising/Operating Exp.
1995	150,000	Prepaid Fund Raising/Operating Exp.
1996	1,729,979	Safe Haven and Autism Endowments
1997	100,000	Development Fee to Be Used for Operating Expenses
1998-99	1,000,000	Safe Haven Residential Facility
1998	500,000	Carmen Pingree Autism School
2000	1,000,000	Safe Haven and Carmen Pingree
1999-2001	300,000	Operating Expenses
TOTAL	**$ 5,079,979**	

Valley Foundation obtained a total of $9,147,000 in revenues from 1994 to 2001, of which 55.5 percent was transferred from VMH. According to VMH's limited records, about $980,000 of its transfers came from donations or fund raising done by VMH and not from public funds. The lack of historical information on VMH–to–foundation

transfers resulted in both VMH's chief financial officer and controller initially understating VMH's transfers by about $2,000,000.

Valley Foundation's Investment Practices Place Funds in Comparatively Volatile Investment Tools. The foundation lost $423,000 on $3.8 million in investments in 2001 because of a drop in stock prices. At the same time, the foundation's government bond investments matured and were liquidated, removing a low risk investment from the portfolio. As a separate nonprofit corporation from VMH, the foundation has adopted a different, more aggressive investment policy than is permitted for VMH or for state-affiliated organizations; the foundation's policy may not meet legal requirements.

The foundation's investment policy states that the portfolio will be diversified, and "...therefore investment approaches from higher risk to lower risk may be required for segregated funds within the overall portfolio." The policy lists the investment categories that may be used:

- growth equities
- value equities
- international equities
- aggressive equities
- laddered fixed income securities
- convertible and income growth securities
- cash

A review of a first quarter 2002 foundation investment report showed investments in a global (international) fund, a large cap growth fund, a large volume capital fund, and a small-to-mid cap growth fund; three of the funds lost value over the year prior to the report, while the recently acquired large cap growth fund showed a four-month gain. Two of the three funds that were held long enough to permit comparison performed worse than comparable indices; the third, while still losing value, performed better than the similar indices. This report did not include the $1.7 million in cash listed on the foundation's 2001 financial statements.

Foundation practices permit investment in higher risk instruments than allowed by the state.

We question the appropriateness of the investment practices, however, given that the foundation is supported by public funds and also has endowments. According to the state treasurer, most public funds are placed in highly liquid and low risk money market investments. Further, the State Money Management Act (***Utah Code*** 51-7) lists authorized

investments for public funds; stock funds are not authorized and restrictions are placed on investments in government bonds. The foundation's investment policy, which permits investment in higher risk stocks and bonds, does not meet these criteria. In addition, some of the foundation's holdings are endowments. While an endowment fund is not required to be invested in low risk investments, prudent investment practices call for protection of endowment principal; thus, endowment monies should not be placed in high-risk investments.

Private Advocacy Organization Supported with Public Funds

UBHN should be subject to some level of LMHA oversight.

As a private professional association, the Utah Behavioral Healthcare Network (UBHN) has evolved from two voluntary professional associations to a staffed private, nonprofit corporation with its operating budget paid for by mental health and substance abuse provider organizations. UBHN represents Utah's mental health centers and is controlled by the MHC directors but is funded, in large part, by public mental health and substance abuse funds. Therefore it seems reasonable that the use of these funds should be subject to some level of oversight. UBHN's budget and activities should be subject to review by county authorities because much of UBHN's efforts are directed toward mental health policy, a responsibility of local authorities.

Prior to UBHN, two other organizations existed for mental health and substance abuse services providers.

UBHN Was Created to Serve Mental Health and Substance Abuse Providers. Prior to UBHN's formation in 1998, two voluntary organizations (one for mental health and one for substance abuse) fulfilled its purpose. According to its mission statement, UBHN is committed "to preserve local autonomy of individual mental health and substance abuse programs under the direction of the local authorities by enhancing service capacity, financial viability and quality of care." Activities include lobbying public officials, organizing provider training, providing a forum for bettering services systemwide, and organizing a group health/dental insurance plan for the centers.

One center director commented that UBHN has been particularly helpful to small centers with limited resources. Other MHC directors commented that UBHN's director has saved money for the centers by taking on tasks such as attending meetings and communicating with the Legislature that would otherwise have to be done by each center.

UBHN dues are much higher than dues of the prior associations.

The budgets of the original voluntary professional associations were nominal. MHC directors recall that, at most, the dues were $2,000 a year for the mental health association; the substance abuse association had a three-tiered annual dues structure of $100 to $500 per center, depending on the size of the center. In contrast, the lowest UBHN dues to be paid for fiscal year 2003 are $1,100 and the highest are $83,000. Figure 6 shows the sources of UBHN funding in fiscal year 2001.

Figure 6. UBHN's Operating Funds Come from Dues and Other Funds Paid by Publicly Funded Provider Organizations. This figure shows revenue for Fiscal Year 2001.

Revenue Type	Amount	Percent of Total
Dues Paid by Local Centers	$ 345,137	66.3%
UBHN Conference Fees	119,623	23.0
Interest Income	36,123	6.9
Sponsorships/Donations	1,000	0.2
Other Revenue	3,331	0.6
Pioneer Hotline Contract	15,330	2.9
Total	**$ 520,544**	**100.0%**

Total does not include $761,512 passed through UBHN from the MHCs to DHS or $750 in pass-through dues.

96% of UBHN's funds are public funds, either paid as dues or earned as interest on investments.

The first three lines of the figure show monies paid by the mental health and substance abuse providers; since the vast majority of funding comes from the centers, the interest income shown on the third line is arguably earned from unspent portions of those funds. Thus, 96.2 percent of UBHN's operating funds are public money.

UBHN has experienced increasing operating costs. From 1999 to 2001, salary and benefits increased 47 percent to $152,599 (an administrative assistant was added). Rent expense increased from $3,823 to $44,984 when UBHN moved to a larger office. In addition, operational changes resulted in office expense increasing 103 percent to $16,449 and entertainment and travel increasing 97 percent to $30,875.

When asked about the difference between the old and new organizations, UBHN's director stated that the difference is his position. A substance abuse director made a similar comment, stating that the difference between UBHN and the old associations is that UBHN now has a director with excellent management skills that are used to further the cause of behavioral health issues.

Some UBHN Activities Are Uncharacteristic of a Publicly Supported Organization. For example, UBHN's director lobbies public officials primarily on behalf of the local mental health and substance abuse providers, not county authorities. Other expenses mimic private industry practices, a legitimate concern in an organization supported by public funds, particularly because such expenses are not subject to review by public officials.

UBHN's lobbying activities are supported by public funds.

It appears that some UBHN lobbying activities focus on local mental health and substance abuse concerns from the perspective of the MHCs. It further appears that lobbying for the interests of the centers may not always be congruent with the interests of county authorities. For example, UBHN's 2002-2003 work plan directed UBHN to focus legislative effort on the Medicaid match and on cost of living adjustment increases for MHC employees, both of which are funding concerns of interest primarily to the local centers. In fact, the success of these lobbying efforts might well require increased funding from county authorities.

Additionally, some UBHN expenses would be limited if UBHN operated in the public sector. UBHN gives gifts to the outgoing directors of its various committees; UBHN's director stated it is customary to give outgoing committee chairs gifts worth about $100 when their terms are completed. UBHN also pays for monthly catered board lunches, provides donations, and co-sponsors legislative fund-raising activities for both parties. Finally, UBHN's director is paid a $12,000 bonus in quarterly payments based on successful job performance.

Recommendations

1. We recommend that DHS develop policy and LMHAs develop related policies regarding MHC involvement in outside, non-services activities.

2. We recommend that, when needed, guidelines concerning MHC non-services activities and related reporting and oversight requirements be included in contracts.

3. We recommend that LMHAs emphasize to service providers that MHC foundations are required to comply with state investment guidelines.

4. We recommend that a mechanism be developed to ensure that UBHN's budget and operations are subject to LMHA oversight.

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Chapter IV
Some Administrative Practices Fail to Ensure Best Use of Public Funds

Employee retention incentive plans implemented by two MHCs meet statutory requirements, but one of these plans raises concerns. One implementation increases the compensation of a small group of executive staff via retirement benefits not available to other MHC employees or to state employees. The MHC's board supported this plan, and the LMHA allowed it to be implemented without accurate cost information, making it questionable whether the plan promotes the best use of public funds. Another retirement-related concern is the enrollment of non-MHC employees in the state retirement system; specifically, an MHC has processed non-employees' payroll through its payroll system, allowing the non-employees to participate in the state retirement program.

Other administrative practices at the MHCs reveal a lack of controls to ensure that public funds are spent appropriately. Procurement, contracting, record keeping, dual employment, and conflict of interest areas all need improvement.

Retirement and Retention Plans Are Questionable Use of Public Funds

One MHC's retention plan for six senior executives involved significant buyout costs to the center.

One MHC's development of a retention incentive plan combines early retirement and return to work provisions into a costly policy offered only to senior executive staff. While the plan appears to follow statute, the intent of the Legislature has been circumvented, and significant monetary gain has been provided to a select group of senior executives. In allowing this plan to go forward, it appears that MHC board and county oversight failed to focus sufficiently on the best use of public funds.

Statute Defines Early Retirement And Retention Abilities

Utah statute allows early retirement with employer purchase of service credit.

State laws allow for the development of early retirement and return to work policies. According to ***Utah Code*** 49-11-504, a retirement system member who has retired may be re-employed by the same agency under

certain conditions. An employee returning within six months on a full-time basis will be reinstated to active member status, essentially cancelling his/her retirement. Otherwise, an employee can retire and immediately return to work for the same employer for six months on a part-time basis (less than 20 hours), while drawing retirement benefits, subject to the following restrictions:

State statute also allows retirement and subsequent return to the same employer.

- Re-employed member may earn compensation not to exceed exempt earnings permitted by Social Security
- Member may not accrue additional service credit
- Employer shall contribute to a defined contribution plan for the employee

After the six months, the organization can reinstate the retiree to full-time status at its discretion. Utah Retirement Systems (URS) staff stated that the six-month period was sufficient to ensure that so-called "back room deals" to guarantee the worker future employment would not be struck between the agency and retiring employee. The assumption was that the agency could not afford to leave a needed position empty for six months, and an individual needing income could not wait that long for employment.

Separate statutory provisions allow for employer participation in the purchase of service credit.

Other statutory provisions allow for the purchase of retirement credit. ***Utah Code*** 49-13-408 provides that a member can purchase or a member and employer can jointly purchase up to five years' retirement service credit. The legislative intent was to allow agencies to reduce personnel costs by replacing higher cost employees who were close to retirement with lower cost individuals. This provision essentially allows an employee to retire between 25 and 30 years of service, as long as the remaining years' contributions are paid. The member must pay at least 5 percent of the cost of the purchase, so employers are limited to a maximum participation in a buyout cost of 95 percent. An employer must adopt a purchase policy that includes nondiscriminatory participation standards for all regular full-time employees.

State agencies have been instructed not to purchase service credit.

While the law allows agency purchase of service for individuals, state agencies have been instructed by the Governor and legislative leadership not to offer retirement "buyouts." After the retirement provision amendments to state law were passed in 1995, the Governor, together with legislative leadership, sent a memorandum to state agencies indicating their concern with potential costs and significant loss of

experienced employees, stating that agencies should not offer financial participation in retirement buyouts to their employees.

MHC Implementation of Retention Incentive Policy Is of Concern

Early retirement with return to work gave senior executives retirement benefits plus regular pay at the same time.

One private, nonprofit MHC has combined the two retirement provisions described above to develop a "retention incentive" plan that combines the early retirement purchase of service credit with an employee's return to the same position after retirement for the benefit of senior executive staff. While the retention incentive plan appears to follow state statute, concerns remain. These concerns include the cost to the MHC, whether the policy is the best use of public funds, whether board and LMHA oversight at the time of implementation was appropriate, and whether the program's retention component violates the statute's intent.

The MHC first developed an early retirement plan.

First, the MHC implemented an early retirement plan in 1997 that allows for agency participation in the purchase of up to five service years for employees; no limit was set as long as the MHC paid no more than 95 percent of the cost. The rationale for this plan was to control personnel costs by offering higher cost employees early retirement so the MHC could hire lower cost employees. As of the end of 2001, 36 employees had retired early. According to the calculations of the MHC's chief financial officer, savings in 1997-2002 from these early retirements range from $960,000 to $1.9 million. The board approved the early retirement plan based on the expectation of savings to the organization.

We have concerns with the early retirement plan savings calculations, including counting savings for positions that were not filled, presumably for a reduction-in-force, and one for which no purchase of service years was needed. Further, projected savings fail to take into consideration merit increases or promotions for replacement staff.

Later, the retention incentive plan was created to increase compensation for "critical" staff with the hope of retaining their services longer.

MHC Board Became Concerned That the Management Team Would Take Early Retirement. Expressing concern that "critical" staff might take advantage of the early retirement buyout offer, the MHC's board decided in late 2000 to adopt a separate retention incentive plan to be offered to critical need staff. Critical need staff would need to meet four of the following six criteria:

- Budget authority of $5 million or more
- Direct responsibility for five or more programs
- In present job for past ten years or more
- Interaction with policy makers
- Clinical competencies
- Support of the MHC mission and beliefs

In addition, the plan was limited to one percent of the center's full-time equivalent employees. These criteria effectively limited participation to senior executive staff.

The retention incentive plan included employer participation in the purchase of up to five years of service credit so the eligible participants could begin collecting retirement payments. Each senior staff then returned to work on a part-time basis for six months without benefits, at their previous hourly rate. The staff agreed to return to modifications of their prior positions, continue to draw retirement payments and receive their prior benefits, and work for an additional three to five years.

Plan included MHC purchase of service years, giving 96 hours of annual leave, reinstating balance of sick leave, and full payment of incentive awards.

The MHC granted five of the six staff 96 hours of vacation time and restored to all six the balance of sick leave not used to pay for health insurance over the past six months. The employees would have earned 96 hours of vacation leave at full-time status during the six months. Payment of their annual incentive awards, as if the employees had been working full-time for the entire year, was also included. The MHC also paid an amount equivalent to the retirement contribution plus three percent into a 401(k) plan for each retiree.

Concerns with some aspects of the retention plan were raised by LMHA legal staff. The URS was consulted and was concerned that the plan included provisions guaranteeing the retirees jobs after six months and requiring volunteer hours to be donated during the six months of part-time work. URS concerns were then addressed by the MHC and its board of directors by revising the retention plan in February 2002. It does not appear that URS was aware of the succession plan requiring three to five years' additional employment.

The board was most concerned about keeping the director from retiring.

Board Focused on Desire to Keep Incumbent Director. Board records reveal that the rationale for offering the retention incentive plan was to maintain the continuity of the MHC's administration. Board meeting handouts state that changes to the state retirement law provided

an "...opportunity for critical staff to realize significant financial benefits and remain working for [the center] without any increased financial expectations from the organization." Records show that the board believed the MHC would not incur added costs, making it acceptable to keep the six highly paid administrators by garnering them early retirement benefits in combination with full compensation.

The board thought the retention plan wouldn't increase the MHC's costs, but buyout costs were substantial.

Although board members apparently believed the incentive plan would increase staff compensation without cost to the MHC, costs were incurred because the MHC participated in the purchase of service years for four of the six participating executive staff. An MHC-prepared cost-benefit analysis lists MHC-paid buyout costs for four of the six executive staff as $447,000, while savings were $482,000, for a net savings of $35,000. The costs include the purchase of service years and the six-month costs of paying others to cover some duties relinquished by the part-time executives.

Our calculation of the cost/benefit of the retention plan, however, differs significantly from the calculation by the MHC. To begin with, some amounts included in the MHC's calculations should not have been included as savings for the retention plan: volunteer time worked by three executives ($96,528), donations promised by one and reduction in hours by another (totaling $152,754). Requiring volunteer hours was removed from the plan in response to URS concerns, and the other amounts were not part of the retention plan as adopted by the board.

A cost that should have been included (but was not) is a lump sum award of 96 hours of vacation time to five of the retirees (worth $19,550) when they returned to full-time status. The payment to the retirees of $106,500 in accumulated vacation leave and $114,500 for 25 percent of sick leave balances is an accelerated expense to the MHC since the amounts were paid out years earlier than would have happened without early retirement. Finally, there are anticipated future costs of the final retirement of these executives.

Policy Focus Should Be Best Use Of Public Funds

Oversight activity focused on desire to keep an incumbent director and on meeting URS stipulations.

Both the MHC's board of directors and the local mental health authority reviewed the retention incentive plan and approved it. However, neither oversight body focused on assessing whether the plan

was the best use of public funds. Rather, the board focused on the perceived need to retain its executive director and the county authorities withdrew its objections once URS technical concerns had been resolved. In comparison, a public MHC's retention plan incorporates more controls and less cost.

Oversight Activity Failed to Focus on the Best Use of the Funds. The MHC board implemented the retention incentive plan primarily as a way to keep the center's senior management staff in place. A board member stated that the plan was approved to keep the incumbent executive director from leaving; the board felt it was imperative that he be retained and that he develop a management transition plan. The board saw the retention incentive plan as a way to offer him increased compensation. Meeting minutes do not document any discussion of actual costs or savings from the plan.

It appears there was little consideration of whether the retention plan was the best use of limited public funds.

The county oversight related to the implementation of this incentive plan fell short of full public stewardship as well. County staff expressed concerns with provisions of the plan and ensured that the URS was consulted. However, once the plan was revised to address the concerns expressed by the URS, county staff responsible for oversight were satisfied. It appears that the issue of the best use of these funds (e.g., for services) was not considered. In fact, although county and state staff remember the director stating that money would be saved in aggregate (combining the retention incentive plan for executive staff with the separate early retirement plan), none of the staff saw specific costs or an analysis of the plan before it was implemented.

A Public MHC Has Implemented a Retention Incentive Policy With Different Requirements. In fact, this public MHC has two mutually exclusive policies, one dealing with retention of key staff and the other with service credit purchase or early retirement "buyout."

In contrast, another MHC adopted a plan that doesn't allow the employer to buy service credit.

The retention policy offers a retirement and return to work option for key staff with more than 30 years' service, allowing for retention of experienced staff. This policy precludes the need for financial participation by the agency in a purchase of service since it requires that the individual must have 30 or more years in the retirement system to be eligible.

The other policy allows for limited employer assistance in the purchase of service years for employees wishing to retire early. The policy limits agency participation to $25,000 per person, "...subject to the availability of funds and the best interests of the agency." This policy does not include a return to work option.

Administrative Issues Require Improved Controls

Our review of MHC administrative processes found several concerns needing improved controls. Policy and procedure development and implementation are needed to increase accountability and allow oversight authorities to assess how public funds are being used. Concerns include inadequate controls in the following areas:

- State retirement benefits provided to non-employees
- Administrative areas including procurement, contracting, record keeping, conflict of interest and dual employment

LMHA enforcement of contract provisions and the clarification of oversight directives are needed in some cases, while the MHCs need to develop or improve their policies and how they adhere to them as well.

State Retirement Benefits Being Extended to Non-employees

Non-employees have been put on an MHC's payroll, allowing them to receive state retirement benefits.

Two employees working for UBHN and the directors of two nonprofit corporations are compensated through the payroll system of one MHC, Valley Mental Health (VMH). VMH administrators stated this was done for the convenience of the external organizations and to allow those individuals to receive state retirement benefits. Though the number of people involved may not be enough to cause a problem with the retirement system, this practice sets a precedent of some concern. If other participating employers chose to bring non-employees into the retirement system, actuarial changes could affect costs to current system participants.

Employees of organizations which are not participating employers in the URS should not be paid through a qualifying organization for the

benefit of those individuals. This practice is a benefit that URS indicates is not extended to other private nonprofit organizations. All three organizations --- UBHN, Valley Services, and Valley Foundation --- are private, nonprofit corporations, and none of them are listed as a participating employer in URS's 2001 annual report.

MHC staff were not concerned that they were running other organization's staff through their payroll system.

VMH's chief financial officer and the director of human resources both stated that the two employees of UBHN, the director of the Valley Foundation, and the director of Valley Services are paid through VMH's payroll system in order to receive URS benefits. When questioned, the CFO clearly stated that the directors of UBHN and the foundation are not VMH employees, but they are paid through VMH because with VMH as a participating employer in the URS, the practice allows the non-employees to receive state retirement benefits. Funds are transferred from UBHN and the foundation to VMH for the payroll expenses. VMH has ties to each organization as a member of UBHN, user of Valley Services, and recipient of funds acquired by the foundation.

The people in question do not meet an IRS employee definition rule.

The IRS gives a general rule to determine who is an employee: anyone who performs services for an organization is an employee if the employer can control what will be done and how it will be done. Each of the listed employees report not to VMH but to their respective boards, who oversee and evaluate their work. In the case of Valley Services, the director is termed a "loaned executive" who worked for VMH prior to going to Valley Services. However, he reports to the Valley Services board and takes his orders from that board.

UBHN's director referred to the agreement between UBHN and VMH as a "convenient management agreement" set up for VMH to process UBHN's payroll since there are only two staff. Other UBHN expenses are not regularly run through VMH's systems. It appears to us that the primary purpose of these payroll transactions is to provide benefits to individuals whose employers do not participate in the URS.

Some Administrative Practices May Not Be Appropriate

Some MHC administrative policies and practices need improved controls and better adherence to procedural requirements. Procurement activity, particularly for services, does not follow required competitive procedures; associated record keeping also needs to improve. Further,

dual employment and conflict of interest practices fail to comply with county contract requirements. The inadequate communication of requirements from state and county oversight authorities to the MHCs has contributed to these weaknesses.

Procurement and Contracting Controls Are Weak. Two of the sampled MHCs do not follow public procurement procedures as required, and one fails to put written contracts in place. In addition, record keeping and documentation of these processes needs to improve; at present, the centers cannot document, nor can oversight authorities be sure, that proper procurement procedures have been followed or that goods and services were obtained at the best possible prices.

In one center, documentation on proposal processes for consultant services contracts was virtually nonexistent for the simple reason that the MHC did not follow required procurement procedures. When questioned about the lack of bidding or Request for Proposal (RFP) documentation, staff stated that since they were not required to follow public procurement requirements, they didn't keep any records of how they obtained consultants. However, the MHCs are required, by statute and in contract provisions, to follow public procurement procedures and to maintain records of those transactions.

One MHC not only didn't bid work as required, but also failed to write and sign contracts that defined the terms of the agreement.

This MHC often failed to enter into written contracts as well. The lack of contract documents is a concern because there is no proof of the services to be rendered, payment to be made, or agreement terms. State statute calls for written contracts to protect both parties' interests; an unwritten contract is unenforceable.

Rather than contracts, the MHC staff often relied on after-the-fact invoices from the consultants as proof of an agreement. Our review of invoices would often find no more than the contractor or consultant's name and address, billed amount, and the notation "For Services Rendered." These invoices did not outline services, duration, total amount, or the payment process.

One troubling procurement involved hiring a computer consultant who was known to an MHC board member without a competitive procurement process. We found no evidence that an RFP was sent out, and, in fact, staff admitted there had been no RFP because the consultant was retained on the advice of the board member. Further, there was no

contract in place until after we raised concerns about this procurement. An agreement was signed after work had started and payments had been made. While the MHC director stated the decision to retain this consultant was administrative, not from the board, it remains clear that the process does not meet the requirements of a publicly announced, competitive procurement. In fact, we were contacted by another firm which had concerns about the irregular nature of this procurement process.

A large construction contract was entered into without bidding the project out.

Another MHC Has Bypassed Competitive Procurement on Large Construction Contracts. Although the contract between the local authority and this private MHC requires the MHC to conduct procurements in compliance with the Utah Procurement Code, the County Procurement Ordinance, or its own similar policy, this MHC has entered into numerous services contracts for both architect and construction services without issuing requests for proposals.

In one case, the MHC justified not conducting a public bidding process for construction services because a contractor who had a personal interest in being involved with the project offered to forego profit for his company (originally estimated at $240,000). The MHC did not request other proposals to ensure that this offer was the best available. The MHC's director indicated that the offered savings were reasonably close to the markup normally associated with the estimated cost of the building (which was $4 million at the time the $240,000 figure was established), so they proceeded to enter into an agreement with the construction company. The contractor is now a member of the MHC's board of directors.

Although the MHC did not send out an RFP for construction services, the contractor did obtain subcontractors for the project through a bidding process. However, in addition to failing to bid out the primary construction services, the MHC did not ensure that the construction contract for this building included a fixed cost or "cost not to exceed" provision. Setting a fixed price in contracts is required by the contract between the MHC and the county authority and is standard practice in state construction contracts as well.

The building (estimated to cost $5 million about four months before the construction contract was signed) cost $6.4 million, not including the architect's fees of nearly $373,000. Additional costs for the project (e.g.,

furnishings and extra interior design) took the cost over $7 million. It should be noted that the construction company did not profit from the increased costs.

The architect's services for this project were also not competitively bid. The MHC staff stated they use this architect regularly without bidding projects out because they don't have the staff to conduct RFPs each time they build something. In addition, the executive director explained that the architects in this firm understand the needs of the MHC's mentally ill clients. The architect is also a board member of the MHC's foundation.

Further, an out-of-state construction firm has been repeatedly used by this MHC for construction and remodeling projects that have not been competitively bid. In 2001, the firm earned over $1 million on projects that had not been put through a competitive bidding process. Finally, in another instance of procurement concerns, a board discussion about retaining a financial consultant ended with approval of a motion to find the consultant "without the usual time-consuming bidding process." In our opinion, a policy board should ensure that required procedures are being followed, rather than propose circumventing them.

Bid files for equipment and other procurements were incomplete at one MHC.

Documentation of Purchasing Processes Can Be Inadequate. A review of procurement files at one MHC found incomplete documentation on purchases made in 2001. Information provided by staff dealt only with computer equipment purchases. The staff person responsible for bidding and contracts acknowledged that the files were incomplete and indicated the MHC was taking steps to improve record keeping that had been neglected by a previous employee.

Incomplete records make it difficult to assess the adequacy of MHC procurement procedures. The file did show that the staff person contacted a selective list of three to five vendors to request bids. However, limiting requests to the same few vendors may not ensure sufficient competition. The MHC is not following state and county procurement procedures and may not get the best price for the goods. State procurement rules allow lists of qualified bidders to be compiled, but do not allow bid solicitations to be restricted to prequalified bidders, as it appears was done here. MHCs need to follow required procurement procedures and maintain documentation sufficient to show that they have done so.

Our review of executive staff travel produced few concerns.

In another area, MHC travel-related records were almost always in order. However, the exceptions included the following:

- An MHC whose executive staff were not obtaining required pre-travel approvals needed so that accounting staff could determine that sufficient funds were available in relevant travel accounts

- An MHC where one member of the executive team regularly failed to submit required travel receipts and documentation but was nonetheless reimbursed for travel costs, though at a preset per diem rate

Several instances of conflict of interest or dual employment were found.

Conflict of Interest and Dual Employment Controls Need Improvement. Some MHCs do not require all employees to complete and update conflict of interest and dual employment disclosures. One MHC does not require its part-time employees to complete the forms, using the rationale that part-time employees are not in a position to affect policy decisions. Another MHC requires only supervisors to complete the forms. As a result, MHCs can't judge whether conflicts exist or if action should be taken to minimize resulting problems.

Some employees have outside businesses that perform services for an MHC. One center contracts with two employees (husband and wife) for medical transcription services; this contract pays the employees over $264,000 a year in addition to their regular compensation. The contract was originally set up without competitively bidding the service out; recently, the MHC issued a request for bids and again awarded the contract to the employees as low bidders. These employees have completed disclosure forms. While the employees assert that others perform the work, the level of their involvement or whether any MHC work time is devoted to the contract is unknown. We are concerned with the appearance or perception of bias in such a contract being awarded to employees.

In a limited conflict of interest review, we also found the following:

- One MHC has a board member who is also an owner of a construction company with contracts for MHC facility construction; the contracts were not competitively bid

- An architect who has designed several projects for an MHC is also a board member of the MHC's nonprofit foundation

- A member of an MHC board sold land to the MHC and appears to have made a profit; this board member has also made large donations to the center

- A center purchases food from a restaurant owned by an employee; these purchases totaled $5,000 in 2001. The employee had no conflict of interest or dual employment form on record.

- One MHC has an employee with a private practice in a nearby state. This employee had no current dual employment form on file; the most recent information was a 1993 memo in which he asked for permission to initiate the outside practice.

- The sister of an executive staff member at one MHC holds a $132,000 contract to manage the center's client transportation services.

As with state agencies, the MHCs need to be aware of and minimize conflicts of interest; by their nature, conflicts of interest may result in divided loyalties in employees or board members and in procurement decisions that are not in the best interests of taxpayers. The MHCs should be held to the same standard that state agencies are because MHCs are publicly funded and provide services on behalf of government agencies.

Recommendations

1. We recommend that the Legislature direct the Utah Retirement Systems to study the issue of a retention incentive plan to determine whether this practice is acceptable and then report back to the Legislature.

2. We recommend that the Legislature direct the Utah Retirement Systems to review the practice of processing non-employees through a participating employer's payroll to determine whether this practice is acceptable and then report back to the Legislature.

3. We recommend that the LMHAs of private, nonprofit MHCs clarify to their service providers the requirement to follow competitive public procurement rules, including procurement of services contracts.

4. We recommend that the LMHAs clarify to the service providers their expectations related to conflicts of interest and dual employment issues with the goal of minimizing these occurrences.

Agency Responses

June 11, 2003

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412 Capitol
Salt Lake City, Utah 84114

Dear Mr. Welsh:

Thank you for the opportunity to review and comment on the Performance Audit of Utah's Local Mental Health System, Report No. 2003-05. The work and time invested as well as the quality of the report and professionalism demonstrated by your staff are appreciated.

The Department of Human Services and Division of Substance Abuse and Mental Health are supportive of the recommendations outlined in the audit report and have initiated efforts to implement them. As noted in the report, the Department has initiated steps, in coordination with the Utah Association of Counties (UAC) to provide updated information to all commissioners and elected officials who are responsible by statute as the Local Mental Health Authority so that they may more fully understand their responsibilities. This educational effort will extend to their roles as Local Substance Abuse Authorities and Area Agencies on Aging as well. In addition the following steps have been initiated to address other areas of concern:

- The Division is developing ongoing governance and monitoring requirements training for the State Board of Substance Abuse and Mental Health and Local Authorities.

- The Division has strengthened contract and governance oversight staff by increasing the level of expertise required and scope of authority.

Again we appreciate the opportunity and look forward to addressing the recommendations in order to strengthen the oversight and guidance to Local Mental Health Authorities.

Sincerely,

Robin Arnold-Williams, Executive Director
Department of Human Services

Randall Bachman, Director
Division of Substance Abuse and Mental Health
Department of Human Services

June 16, 2003

Wayne L. Welsh, Auditor General
Office of the Legislative Auditor General
130 State Capitol
PO Box 140151
Salt Lake City UT 84114-0151

Dear Mr. Welsh:

Thank you for the opportunity to review and comment on your draft report "A Performance Audit of Utah's Local Mental Health System" (Report No. 2003-05). In general, I find the report to be professionally done with solid recommendations that will help strengthen our mental health system. Most of the audit recommendations which affect the Division of Health Care Financing relate to enhancing our collaboration with the Division of Substance Abuse and Mental Health (DSAMH) and the local mental health authorities (LMHAs).

The suggestion that the State needs to enhance coordination across State agencies will help us improve what we have been doing over the past several years. Examples of how we have already been collaborating include our ongoing efforts to monitor and improve the quality of care at the Utah State Hospital, the role played by DSAMH in the clinical quality oversight in the Medicaid capitation quality review process, and the DSAMH role in the pre-admission screening process. Based on the audit's recommendations, we will focus more closely on coordination of funding direction, data collection and reporting, as well as continue to strengthen the coordinated efforts in rate setting.

It is also suggested that the state consider involving county representatives in the meetings leading to the development of funding requests. One of the strengths of our Medicaid mental health program is our ability to pool funding and services available from State and local sources. Involving the LMHAs in our discussions with DSAMH should strengthen our relationships as well as keep the counties involved in funding requests which impact county budgets. Consequently, we support this recommendation and will involve county representation through the Utah Association of Counties in our rate negotiations.

Again, thank you for the opportunity to comment. I would be happy to discuss with you any of the above issues in more detail.

Sincerely,

Michael Deily, Director
Division of Health Care Financing

June 10, 2003

Wayne L. Welch
Legislative Auditor General
130 State Capitol
P.O. Box 140151
Salt Lake City, UT 84114-0151

Dear Auditor General Welch:

These comments are submitted to you on behalf of the Utah Association of Counties in response to a Performance Audit of Utah's Local Mental Health System, **dated May 14, 2003**.

At the outset you need to be aware that the Association and its member counties appreciate the efforts of your office to understand the roles which the various levels of government play in providing mental health services to our dependent populations. You undertook a very complicated task and generally speaking, we believe you demonstrated fairness in your findings and recommendations.

We will not comment on all of your findings and conclusions, as we think most of them as they apply to counties relate to oversight of mental health providers – those who actually perform the services on behalf of local authorities. The audit suggests this is a glaring weakness and while we do not generally disagree with that critique, you need to be aware of efforts that have been undertaken to improve local authority oversight of local providers.

Prior to the 2002 Legislative Session the Association advocated for, and the legislature approved, creation of a task force to study the relationship of local and state roles in providing human services at a local level. Much of the time of that task force was devoted to mental health related issues. Coming out of that yearlong task force study were several recommendations and legislative proposals enacted in the 2003 Legislative Session. Among those was H.B.44, which provided for a comprehensive reorganization of existing statutory provisions relating to providing mental health and substance abuse services. Further, it clarified the responsibilities of the Division of Substance Abuse and Mental Health with respect to monitoring and oversight of local mental health

and substance abuse authorities. It provides some specific time frames for local mental health and substance abuse plan submission, annual audits and reporting by the Division to the legislature of the annual audit and review, the financial expenditures of local authorities, the status of compliance of local authorities with their plans and other oversight responsibilities.

Additionally, in the 2003 Legislative Session the Association drafted and advocated to final passage S.B.191. This legislation consolidates and enhances county oversight of local substance abuse and mental health authorities. It mandates increased controls by county governing bodies over such entities. For counties that participate in multi-county interlocal agreements establishing such authorities, the changes will require significant rewrite of the interlocal agreements.

Further, the Association of Counties and the Department of Human Services working together, have scheduled two training sessions for local mental health authorities and other county officials to be held June 27, and July 17, 2003. We anticipate these sessions will be the first of several training sessions for county officials relating to their mental health oversight responsibilities.

On page 15 of the audit document, you point out that a deficiency to exercising appropriate oversight of private nonprofit agencies by county officials was a 1988 informal opinion from the Attorney General's office which suggests a "possible conflict of interest if county commissioners served on MHC (Mental Health Centers) boards. Assuming this opinion is still valid, oversight can increase only through strengthened contracts." But you do acknowledge that commissioners expressed a desire to be more involved, but this informal Attorney General's opinion constrained them.

We suggest that the Department of Human Services ask for a formal Attorney General's opinion to see if the informal rendering in 1988 is still valid.

Finally, you have declared that "Public Policy Clarification is needed for mental health center (MHC) involvement in activities other than mental health services." (page 29) We concur.

You specifically point to the Utah Behavioral Healthcare Network (UBHN) as an example of those activities being financed with public funds. The use of public funds appropriated for provider services, but not used to provide services for the needy population is a concern of local officials as well. We fully support your recommendation "that a mechanism be developed to ensure that UBHN's budget and operations are subject to Local Mental Health System oversight." (page 41)

Again, we appreciate your efforts to be even-handed and fair in this audit. We think its findings and recommendations, if implemented, can go a long way toward improving the Local Mental Health System and much needed oversight.

Further, we appreciate the opportunity to comment on this draft document and would like to reserve the right to comment, after review, on the final report.

Sincerely,

Gary Herbert
President, Utah Association of Counties

June 11, 2003

Wayne Welsh
Legislative Auditor General
130 State Capitol
Salt Lake City, Utah 84114

Dear Mr. Welsh,

Subject: **Performance Audit of Utah's Local Mental Health System**

Salt Lake County appreciates the opportunity to comment on the **Legislative Audit of Utah's Local Mental Health System.** As public officials, we take seriously the challenge and responsibility of administering programs that serve the mentally ill. The recommendations contained in the audit can help strengthen and clarify the responsibilities of the different players in the mental health system. We look forward to participating with our partners in developing appropriate policies and procedures to further improve services.

Throughout the audit there were several themes presented that warrant further comments by Salt Lake County. They are listed below by category.

Public Vs Private Operation of Mental Health Services

Moving from a publicly operated mental health system to a private non-profit model was a decision not taken lightly by Salt Lake County. The change occurred after years of research and deliberation. The County Commission, in 1981 commissioned a Blue Ribbon Task Force comprised of citizens and stake holders to study this topic. In June of 1982, after months of review, the committee recommended to the Board of County Commissioners that mental health services be delivered in a different way other than by county government. The rationale for their recommendations was: (1) To improve the quality of care, (2) Increase the operational efficiencies, (3) Save county tax dollars, and (4) To diversify funding as public dollars decline. Those goals have remained constant and consistent throughout the years since.

After further debate and discussion, Salt Lake County issued a Request for Proposals (RFP) for mental health services in the fall of 1986. Valley Mental Health (VMH) was one of the organizations that responded to the RFP. In July of 1987, the County Commissioners, with the support of the State Board of Mental Health, entered into a contract with Valley Mental Health for the delivery of mental health services. The contract had the full review and input of the County Commission, County Attorney, and the Salt Lake County Auditor.

Public/private partnerships are not new to Salt Lake County or Utah State government. The Division of Child and Family Services (DCFS), the Division of Services to People with Disabilities (DSPD), and the Utah State Fair are three examples within State government where contracting with a variety of private non-profit organizations is used to deliver services.

Private non-profit organizations, in addition to the terms and conditions contained in their contracts with governmental agencies, are also governed by IRS rules and regulations; particularly if they are a 501 (c) (3) organization. Those rules and regulations must be followed if the organizations are to retain their private non-profit status. The State recognizes 501 (c) (3) organizations as viable mental health service delivery organizations. In the state law establishing Local Mental Health Authorities, UCA 1 7A-3-603.5 (3) it states, "Nothing in this section limits or prohibits an organization exempt under Section 501 (c) (3), Internal Revenue Code, from using any public funds for any business purpose or in any financial arrangement that is otherwise lawful for that organization." Salt Lake County is not aware of Valley Mental Health having its tax status questioned by the IRS for non-compliance with IRS rules and regulations governing its 501 (c) (3) designation.

Valley Mental Health is a separate, independent organization from Salt Lake County. As such, they provide services not only for Salt Lake County but for other jurisdictions as well. They are responsible to their board of directors for the operation as a 501 (c) (3) organization and to Salt Lake County as delineated by the terms and conditions of the contract. As a 501 (c) (3) organization, Valley Mental Health is governed by an independent board of directors, three of which are appointed by the Local Mental Health Authority.

In 1998, as per county purchasing policies, Salt Lake County went out to bid again for mental health services. Valley Mental Health was selected from the responses to the RFP and is the current provider.

Public Oversight

Since the inception of the contract with Valley Mental Health, Salt Lake County has taken steps to provide effective and ongoing oversight. In 1987, a new senior management position was created in Salt Lake County called the Salt Lake County Mental Health Director. This position is part of the Mayor's operations. The majority of the Mental Health Director's time is spent on mental health activities that includes monitoring the contract between the county and Valley Mental Health. The director attends the monthly meeting (public) of the Valley Mental Health board, budget meetings, and other meetings as necessary and assigned by the Mayor's office. He also receives and follows through on complaints regarding service delivery.

As part of contract monitoring, the County Mental Health Director reviews the compensation levels of Valley Mental Health employees. This is done in comparison to the local market as well as to other employees within the Salt Lake County work force. National comparisons are also a part of the analysis because the other mental health centers within the State of Utah are not nearly as large or complex as Valley Mental Health.

To aid in monitoring the contract, a monthly mental health coordination meeting is held and staffed by the County Mental Health Director. Attendees include representatives from Valley Mental Health, the County Auditor, District Attorney, State Division of Substance Abuse and Mental Health, Utah Behavioral Health Network (UBHN) and the County Council. Issues reviewed in the meeting include monthly expenditure and revenue reports, programs and services, facility development and construction, service changes, complaints and concerns. Items for the agenda are gathered from those invited to attend. The Mental Health Coordination Committee meeting is public. As such an agenda and minutes are prepared and maintained.

The annual contract between Valley Mental Health and the County is amended each year to reflect the next year's work plan. The work plan details by program, the number and amount of service units to be provided. The work plan is adopted after the budget appropriation is made by the County Council.

At least four-five times per year, Valley Mental Health and specifically mental health services are discussed in official County public meetings. Examples of the types of issues reviewed in these meetings are: budget requests and adjustments in November and June with the Mayor and Council, presentation of the outside audit findings of Valley Mental Health to the Mayor and Council, sharing of the results of the goveming and administrative oversight report done by the State Division of Mental Health and Substance Abuse with the Mayor and Council, and sharing the results of the single audit of Salt Lake County (of which Valley Mental Health is a part) with the Mayor and Council.

Additionally, the Salt Lake County Auditor's staff in conjunction with the County Mental Health Director and the District Attorney's Office develops a separate list of agreed upon procedures. These procedures are reviewed by the auditing firm Valley Mental Health's Board of Directors contracts with to do their annual audit. Among the items included in the agreed upon procedures are compensation, purchasing, conflict of interest, construction of facilities, etc. This information is also shared with the Mayor and County Council.

Use of Public Funds

Annually Valley Mental Health supplies a funding matrix in conjunction with their budget request. The funding matrix outlines the various programs and services provided by Valley Mental Health and the various funding sources. This is one method the county uses to see where the tax dollars received from the state and the county are spent as well as funds from non-tax sources such as contributions, fees, insurance, contracts, etc.

Each year preceding the budget submittal, a public hearing is held. The hearing is co-sponsored by Salt Lake County and Valley Mental Health. The purpose is to gather information on specific mental health needs. Citizens, clients and affiliated organizations attend. The information gathered at the hearing is used by the County and Valley Mental Health to help focus the expenditure of public mental health dollars.

Valley Mental Health submits all reimbursement requests (generally monthly) for state and county funding to the County Mental Health Director for review before being processed for payment.

The annual audit of Valley Mental Health that is done by an outside accounting firm has both an entrance and exit conference. The entrance conference is open to all funding partners and other interested parties. Suggestions are made and input received as to what aspects of Valley Mental Health's financial systems and controls ought to be reviewed. The State Departments of Health and Human Services, Salt Lake County Mayor and Auditor's offices have been well represented at both the entrance and exit conferences.

Since its inception as a 501 (c) (3) organization some 16 years ago, Valley Mental Health has received a "clean audit" statement annually from the outside auditor.

Untraditional Activities/Services

One of the primary goals of Salt Lake County in privatizing the delivery of mental health services was to diversify the funding resources. County Commissioners back in the mid 1980's could see that there was no way to increase county tax funding sufficient to meet the demands for service. There were and are too many competing interests for limited tax dollars. Valley Mental Health was encouraged to develop non-county funding sources.

Coinciding with the diversification of revenues was the request by Valley Mental Health to develop additional services. In their response to the County's RFP issued in 1998, Valley Mental Health committed to provide, "safe, affordable and decent housing, job skills training and employment, social and educational skills training, money management, family involvement and participation, and fundamental participation in life's activities." The acceptance of Valley Mental Health's response to the RFP and the subsequent contract for service evidences the Local Mental Health Authority's awareness of Valley Mental Health's efforts to provide untraditional services.

As part of the first contract with Valley Mental Health in 1987, an annual work plan describing the number or units of service to be delivered was adopted. This established a base line against which service increases/decreases could be measured. This work plan is still in use. Each year a final report is prepared and compared to the work plan projected some 15 months earlier. Review of the actual units of service provided demonstrates that Valley Mental Health continues to meet or exceed the number of projected units of service. Basic services have not diminished with the provision of untraditional services.

Each time Valley Mental Health intended to develop a new program or service, contact was made with the County Commission (now County Mayor/Council). In some instances, the County augmented Valley Mental Health's efforts by providing additional funding through Federal HOME or Community Development Block Grant (CDBG) funds both of which are appropriated by County elected officials.

Comments received at the annual public hearings continually mention these untraditional services. Clients state that untraditional services make them feel that they can live a normal life and function in society. Having an apartment of their own, a group of friends they can associate with, and ajob gives them a sense of dignity and respect. The untraditional services have made a world of difference in their lives.

Untraditional activities and the resulting revenues from those activities have made it possible to provide services that would otherwise not have been funded through public funds. A recent example is the Carmen B. Pingree School for Autism. Without establishing a private foundation and subsequently an ongoing endowment, this magnificent facility could not have been constructed or operated. This is exactly what Salt Lake County expected when mental health services were privatized.

Misuses of State Retirement

Salt Lake County does not have authority or control over the state rules and regulations governing the operation of the Utah State Retirement System. As a participant in the system, the County is either allowed to or restricted from participating in certain activities based on the laws adopted by the Utah State Legislature.

A law was passed by the Utah State Legislature allowing participating organizations in the Utah State Retirement System to buy out employee's retirement. The same law allowed the rehire of retired employees under certain conditions. This benefit was extended in the law to all organizations that participate in the Utah State Retirement System. Valley Mental Health is one of those participating organizations. Their board of directors chose to offer employees these opportunities afforded in State law. When concerns were raised, Salt Lake County worked with Valley Mental Health and their board to clarify and change any questionable procedures, practices and policies.

Valley Mental Health's current procedures, practices and policies regarding these issues have been submitted to the director of the Utah State Retirement System for review and comment. To date, there has been no response.

Although perhaps lengthy, these comments demonstrate Salt Lake County's sincere and on-going commitment to be responsible stewards of mental health services. We appreciate your interest and welcome an opportunity to discuss this further should you so desire.

Sincerely,

Nancy Workman
Salt Lake County Mayor

Michael Jensen, Chair
County Council Executive Committee

Agency Response to
Utah Legislative Report No. 2003-05

A Performance Audit of Utah's
Local Mental Health System

Submitted by:

Valley Mental Health
Board of Directors

June, 2003

A Summary of Agency Response
Valley Mental Health (VMH)
To a Performance Audit of
Utah's Local Mental Health System

VMH Board of Directors supports the Legislative Audit recommendations. An active Board will continue to work with our oversight agencies to improve the mental health system.

The Board of Directors and staff of VMH appreciate the recommendations contained in the Legislative Auditor's report. VMH recognizes that the public mental health system is complicated with its multiple funding sources, wide variety of services, diversity in people served and differing organizational and governance structures across the State. Such a system of care presents some unique challenges in developing processes and mechanisms to ensure that public funds allocated to provide critical mental health services are used appropriately.

VMH is prepared to work in cooperative ways with the Local Mental Health Authorities (LMHA), with whom we contract, as well as the Division of Substance Abuse and Mental Health (DSAMH) to ensure appropriate implementation of processes and procedures that will provide for an improved public mental health system.

VMH is governed by an active and dedicated policy-making Board. Each member participates on at least one working committee. Salt Lake, Summit, and Tooele counties appoint five of the 18 members. The members of the VMH Board bring a variety of expertise and experience relevant to the decision-making process.

Provided with this summary is a "Matrix of the Legislative Auditors Recommendations to the State, County, and Utah Retirement Board" with VMH's response. It contains a synopsis of past and present activities, which have been or are in the process of being implemented.
(See Attachment A)

In order to address unmet critical mental health needs in our communities, not only must the system be concerned about the appropriate use of public dollars, it must also encourage the leveraging of those dollars with other private resources.

The mental health community's best practice guidelines for meeting the recovery needs of the **severely mentally ill** dictate a broad based, integrated model of care. This model includes a wide array of interventions. Recovery not only includes traditional mental health and medical services, but encompasses the following: basic social living skills, education, employment, supported housing and financial management. Government funding does not have the ability to fund the required services of this growing population, let alone support the services described above. **The LMHA directed VMH to pursue ways of expanding the public dollar to meet this critical community need.**

VMH has demonstrated the importance and benefit of public and private partnerships in the provision of critical human services.

Following the direction from the LMHA to enhance the resource base available for client services, VMH has worked in partnership with public and private individuals, and agencies to raise a variety of dollars. In the last seven years, in excess of **$25,000,000** have been raised from non-government sources for the benefit of the individuals we serve. These dollars include a combination of charitable gifts, investments, affordable housing financing tax credits, endowments, and other funding that would not have been possible by a public agency.

The private sector dollars raised have been used to build new facilities that provide desperately needed housing for the severely mentally ill. Safe, decent and affordable housing has been developed since 1996 for over 134 individual supported apartment units. This is in addition to public/private partnerships established since the inception of VMH as a private organization. Prior to 1996 over 162 supported housing apartments were made possible because of these public/private relationships. **Without this housing for the severely mentally ill, which has been developed by VMH and its private partners, the clients living in these facilities would most likely be residing in institutions or jails at a significant cost to the State of Utah, or living on the streets.**

In addition to the supported housing developments, a state of the art school for children with autism and their families has been built and primarily funded by non-public sources. The school provides opportunities for children with autism to receive the unique and intense services their illness requires to be able to live productive lives.

Facilities have been developed, with the help of private money, to provide office space for clinical care. Non-public dollars have not only been used for facility development, but have been used to provide expanded core mental health treatment services for adults, children, youth and their families.

The ability to engage private and public community partners has not only offered VMH clients the opportunity to receive tangible resources, it has provided VMH the forum to educate these partners and diminish the stigma associated with mental illness.

VMH's accounting system tracks public and private money separately. In an effort to clearly separate these activities and optimize non-public contributions, Valley Foundation was formed. $ 5,000,000 of non-public funds was transferred from VMH to Valley Foundation. This transfer was made to fund the following: Foundation operations; autism school; autism endowment; Safe Haven endowment and the Valley Foundation endowment. By 2003, the $5,000,000 will be returned to VMH. By 2008 (when the current Salt Lake County contract ends) over $8,000,000 will be transferred from the Foundation to VMH for facility and program operation costs At that time, the Foundation will have at least $3,700,000 remaining in the endowments. **In other words, the original non-public funds of $5,000,000 will be returned to VMH in 2003 and over $12,000,000 dollars will be available by 2008 for the benefit of public mental health clients.**

The outcome of these efforts tells a powerful story of significant benefits that have accrued to the public mental health system. Evidence in the growth of units of care demonstrate that the mentally ill have and will continue to benefit from services that would otherwise not have been available to them if the system were reliant solely on the traditional public funding sources. *(See Attachment B)*

Significant opportunities for service expansion and efficiencies have been demonstrated as a result of the direction and oversight provided by Local Mental Health Authorities of Salt Lake, Tooele, and Summit counties to deliver public mental health services in a privatized model.

The Board of Directors of VMH has negotiated with the LMHA (Salt Lake, Tooele, and Summit Counties) specific contracts that require levels of performance and reporting obligations. The contracts include requirements for compliance with State laws, policies, and rules. Requirements that assist the LMHA in their contract monitoring and oversight are included.

VMH is allocated an amount of dollars from the counties that are specified in our annual contract amendments. We are required by the LMHA to prepare a service plan detailing the specific number and type of mental health services to be provided by program and cost. These production goals become a contractual requirement. **There has been no occasion when VMH has been out of compliance with these production requirements**.

Public funds have never been diverted by VMH from core mental health services to engage in speculative non-service activities or inappropriate practices. If funds were diverted there would be an expected loss of productivity. Our records demonstrate that this is not the case. Attachment C of this response demonstrates that VMH's revenue budget in a seven-year period grew by 40%; and yet, the amount of services VMH contracted with the LMHA to provide, increased by 70%. It is noted that the LMHA receives monthly reports of VMH's productivity. In the aggregate, over that seven-year period of time the services provided were 21% above the required contracted levels. **In the seven-year period, used in this example, not only was VMH more efficient, but it also exceeded the contractual service requirements each year**. *(See Attachment C)*

Attachment A **Matrix of Recommendations from**
Legislative Auditors to State, Counties, and Utah Retirement Board Regarding Utah's Public Mental Health System

# & Page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
1. p. 29	Training for LMHA on duties			*Support recommendation*
2. p. 29		Develop report for oversight		*Support recommendation* **VMH <u>currently</u> provides LMHA with oversight report annually, monthly productivity reports and has regular coordination meetings**
3. p. 29	Review contracts with LMHA to clarify oversight responsibilities			*Support recommendation*
4. p. 29		Contracts with MHC include State directives and requirements		*Support recommendation* **VMH contracts with LMHAs <u>currently</u> include *HB 102, **SB 191 requirements**

# & Page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
5. p29	Promulgate administrative policies for MHC — Documenting procedures — Appropriateness of non service activities — Process for MHC to obtain LMHA approval beyond core mission — Acceptable use of funds and fund balance			*Support recommendation* **VMH has been directed by LMHA to pursue non-traditional activities and other public private partnerships.** Statewide guidelines for acceptable and non-acceptable activities would be beneficial.
6. p 30	Improve governance and oversight reviews			*Support recommendation*
7. p 30	Amend funding formula rule to specify frequency of adjustment for population			*Support recommendation*
8. p 30	Develop comprehensive reporting format			*Support recommendation*

# & Page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
9. p. 42 (1)	Policy development regarding MHC involvement in outside non-service activity	Policy development in cooperation with State regarding MHC involvement in outside non-service activity		*Support recommendation* **LMHA participates with VMH in planning of non-service activities**
10. p 43 (2)		Require MHC, by contract, to report non-service & related activities		*Support recommendation* **VMH currently reviews non-service activities with LMHA** VMH supports a more formalized and consistent reporting

# & Page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
11. p 43 (3)		Emphasis to MHC, by contract, that Foundations are required to comply with State investment guidelines		**VMH recommends the following: Explore with the 3 LMHA's alternative organizational structures that would achieve resource development purposes as well as the protection of present assets and investment. In addition VMH requests discussion with LMHA's regarding the 5013C regulation regarding investment guidelines**
12; p. 43 (4)		Develop mechanisms to ensure UBHN has oversight from LMHA		***Supports recommendation*** **VMH as a UBHN member participate with the Utah Association of Counties in developing their Legislative agenda as well as discussion of other topics**

# & Page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
13. p. 57 (1)			Study issue of retention incentive and report back to Legislature	*Support recommendation* **VMH has communicated with URS regarding retirement practices** **VMH has used the retirement purchase of service as a cost savings - presently over one million dollars have been saved** **All retirement practices have been Board approved with the knowledge of the LMHA's and are statutorily allowed** **VMH present policy on hiring of retired employees has been provided to URS as well as LMHA**
14. p. 57 (2)			Review practice of processing non-employees through a participating employer's payroll and report to Legislature	*Support recommendation* **Correspondence has been sent to URS regarding these issues**

# & page	**DHS/DSAMH** (State Agency)	**LMHA** (Counties)	**URS** (Retirement)	**VMH Response, Action and Current Practice**
15. p. 58 (3)		Clarify to providers requirements on procurement rules		*Support recommendation* **VMH has adopted Salt Lake Counties Procurement Policies and Procedures**
16. p. 58 (4)		Clarify to providers expectations on conflict of interest and dual employment		*Support recommendation* **VMH has revised our Conflict of Interest form in compliance with DHS requirements** **LMHA reviews all of VMH's conflict of Interest Declarations on an annual basis**

*HB 102 – House Bill 101 – Requires the Division of Substance Abuse and Mental Health to determine that Local Substance Abuse and Mental Health Authorities, (counties) are in compliance with their oversight of contracted providers.

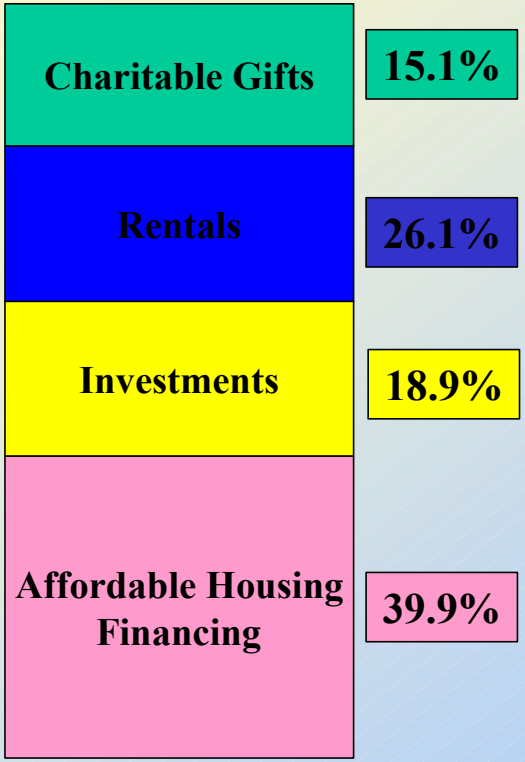
**SB 191- Senate Bill 191 – Requires additional oversight of Division of Substance Abuse and Mental Health to determine that Local Substance Abuse and Mental Health Authorities (counties) are in compliance with their oversight of contracted providers.

Attachment B

Valley Mental Health's Private Partnership

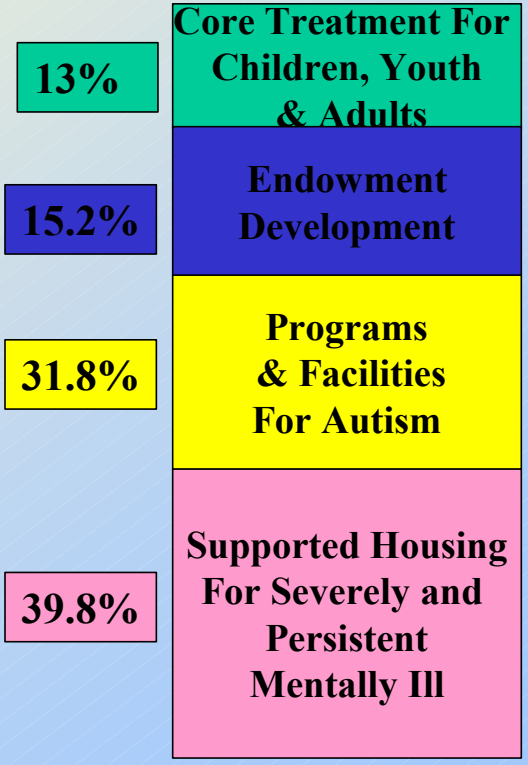
Public Mental Health Benefits

Funds From Non Public Sources
$25,051,781



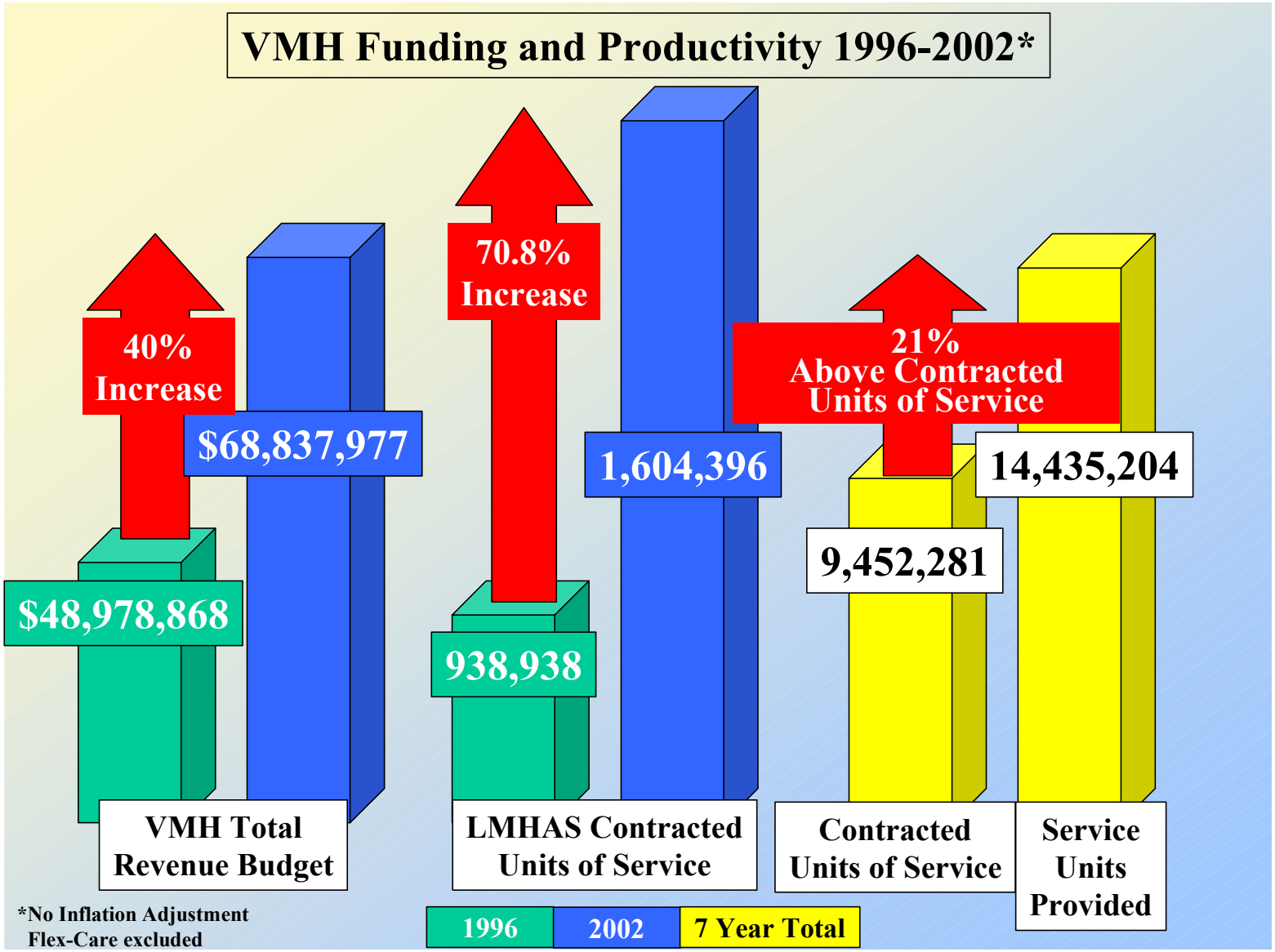
1996 – 6/2003

Use of Non Public Funding
For Critical Public Mental Health Needs
$25,051,781



1996 – 6/2003

Attachment C



June 9, 2003

Mr. Wayne Welsh
Auditor General
130 State Capitol
Salt Lake City, Utah 84114-0151

Dear Mr. Welsh;

Thank you for the opportunity to respond to the *Performance Audit of Utah Local Mental Health System* as prepared by your office. This letter represents only the opinions of Michael Deal, Chief Financial Officer, and myself. The response is not intended to represent Southwest Center Staff, Authority Board, nor colleagues from around the state.

The audit points out the fact that Utah's Public Mental Health System is financed primarily with public funds in excess of over $132 million. This is certainly a substantial sum, but not excessive given the extensive mission of the system. Utah has consistently been identified as one of the top ten state mental health systems in the United States while being ranked between 47th and 49th in per capita funding for mental health. This gives further credence to the report's observation that ...overall MHC (Mental Health Center) expenditures appear to be appropriate.

Southwest Center management is committed to having a program that exemplifies the highest integrity. We employed an independent consultant over eighteen months ago for the sole purpose of insuring compliance with all applicable laws, rules, and best business practices. We appreciate the input from this audit and, along with feedback from all sources, we will continue our goals of improving effectiveness and efficiency.

The elected officials who comprise Southwest Center's Authority Board have the daunting task of trying to deal on a part time basis, and with minimal administrative support, the myriad of responsibilities and issues that confront their individual counties. They remain, however, very dedicated and committed to their responsibilities as authority board members. The Board and Executive Staff of Southwest Center will continue to do whatever is needed to insure that our citizens who suffer with mental health needs receive services on a par with any in the country. We will comply with all Legislative and/or Executive Branch suggestions and recommendations as to ways to improve, but we ask

that all expectations and requirements reflect the challenges experienced by our rural counties.

We appreciate the professional manner in which your staff approached this assignment with regard to Southwest Center. They seemed to capture the workings and intricacies of our system very well. The report and its recommendations should help further the effort to make Utah's Public Mental Health System even better.

Respectfully yours,

Paul I. Thorpe
Executive Director

Michael H. Deal
Chief Financial Officer

June 11, 2003

Audit Subcommittee
Of the Legislative Management Committee
State Capitol Building
Salt Lake City, Utah

Dear Members of the Committee,

We appreciate the opportunity afforded to us to respond to A performance Audit of Utah's Local Mental Health System and offer the following comments and clarifications.

UBHN - The Audit Report quotes the Mission Statement of the Utah Behavioral Healthcare Network (UBHN) correctly but does not adequately describe its role and purposes. The goals of the Utah Behavioral Healthcare Network are to:

1. Develop and apply performance development data for policy decisions, and actions to improve the quality of services, ensure consistency in services provided, and assure access to specialized services throughout Utah.
2. Develop consistent and reliable data and information to facilitate state policy decisions and enhance the image and reputation of public mental health and substanôe abuse with public policy and funding bodies, public social service, health and educational systems, clients and families and the general public.
3. Develop funding requests and revisions to policies and laws that address unmet client needs and improve system effectiveness.
4. Develop the organizational capacity within UBHN to respond to the needs of both members and Local Authorities in achieving organizational goals and delivering agreed upon member services and products.

UBHN work plans and activities are in pursuit of these goals as it strives to enhance the service quality and capacity, financial viability and quality of care by providers of public mental health and substance abuse services throughout the state of Utah.

UBHN was formed to accomplish all of these goals. Its predecessor organizations had been involved in lobbying activities throughout their histories. Prior to UBHN it was done by mental health and substance abuse center directors and by a contracted lobbyist. UBHN added the capability of more effectively improving the quality and consistency of services, of assuring access to specialized services throughout the state and of accomplishing its mission statement and goals. It inherited the long history of lobbying as part of its functions.

RISING UBHN OPERATING COSTS — Reference is made to the growth in UBHN operating costs from 1999 to 2001. UBHN was formed in 1998 with the services of one assigned MHC staff member with a cell phone and a post office box. It subsequently rented a single office

within the space of another allied association. The expectations and demands on UBHN soon grew, so the Board of Directors made the decision to add one assigned FTE and to secure office space appropriate to the functions of the organization. The period of increasing operating costs cited in the audit is the time during which this transition occurred. Dues paid to UBHN by its members have remained unchanged for six years. It continues to operate effectively and efficiently and to meet the needs identified in its mission statement, goals and work plans. It continues to meet the expectations of its members and to represent the interests they serve.

UBHN DUES — Each mental health and substance abuse center in Utah is a member of UBHN through payment of dues. In terms of materiality, dues paid to UBIIN to perform its mission and accomplish its goals, account for approximately two-tenths of one percent of all funding for the mental health system in Utah.

AUDIT RECOMMENDATION - UBHN supports the recommendation in the audit for improved coordination with Local Mental Health Authorities. This recommendation is consistent with UBHN's mission statement, which is: "To preserve the local autonomy of individual mental health and substance abuse programs under the direction of Local Authorities and to enhance service quality and capacity, financial viability, and quality of care."

UBHN has already taken active steps to develop a closer relationship with the Utah Association of Counties than currently exists whereby each organization participates more directly in the affairs of the other. Such coordination has long occurred in the development of legislative positions. All legislative positions advocated by UBHN are included in the annual official positions statements of the Utah Association of Counties through a process that is ongoing. UBHN participates with the UAC Health and Human Services Steering Committee that meets throughout the year in preparation for the Annual Meeting of UAC. At the Annual Meeting, the recommendations for legislative action, including UBHN's issue statements, are presented again for final approval by the steering committee. Steering Committee endorsed posiUpn statements then go to the UAC Business Meeting where they are presented for adoption as The UAC legislative platform for action in the next session of the Utah Legislature. All legislative issues addressed by UBHN have been coordinated with UAC in this way. As unanticipated issues emerge during sessions, UBHN presents its perspective, seeks UAC approval through the weekly meetings of the UAC Legislative Committee and maintains daily contact with UAC staff members as issues progress.

UBHN LOBBYING — UBHN presents specific needs for local mental health funding, law and policy and has made a case for these issues to the various committees of the legislature including the Health and Human Services Committee, the Health and Human Services Appropriations Committee and the Executive Appropriations Committee. It has made these proposals with the knowledge that these committees, and the legislature as a whole, must weigh UBHN's proposals against all others.

PUBLIC FUNDS IN SUPPORT OF UBHN - The audit states, "The issue of concern is whether public funds paid as dues should support UBHN's staff and activities." In its lobbying activities, as a registered lobbying organization, UBHN does what is characteristic of many other entities supported with public funding. Twenty-five cities, counties, various elected county offices and intergovernmental organizations are registered lobbying organizations in addition to the Utah Association of Counties and the Utah League of Cities and Towns. Numerous educational associations including those representing teachers, school employees, charter schools and school boards are registered as lobbyists. Other examples are the Utah Public Employees Association, Utah Retirement Systems, Utah Transit Authority, Utah Technology Finance Corporation, water

and water conservancy districts, and a multitude of other public and private entities. Is their right to lobby also *"of* concern" because they are supported by "public funds"?

Counties are, in fact, granted specific statutory authorization for lobbying in the Utah Code, 17-50-3 15. This statute states:

> (1) A county may, individually or in association with other counties, study the processes and methods of county government with a view to improvement and cause to be assembled and presented to the Legislature or the Congress of the United States, or to or before the appropriate committees of either or both, such information and factual data with respect to the effect upon counties, the taxpayers, and the people, of existing, pending or proposed legislation, as in the judgment of county executives and legislative bodies, will be in the interest of and beneficial to counties, taxpayers, and people.
>
> (2) The charges and expenses incurred under Subsection (1) shall be proper claim against county funds, to be audited and paid as other county claims.

Hospitals and healthcare providers receive public funds in Medicaid and Medicare payments. Depending on the specific hospital, twenty-five to sixty percent of all hospital funding comes from these sources that closely parallel those of mental health centers. Requirements for oversight and concerns about lobbying should be no different for UBHN than for the Utah Hospital Association and each of its members. Members of the Utah Hospital Association receive substantially more public dollars than do UBHN's members in performance of their operations. Is their right to lobby also "of concern"?

Attached is an opinion by Roger 0. Tew, Esq. — Special Counsel, regarding lobbying activities of UBHN. The opinion was requested by UBHN in August 2002 because of concerns that had been expressed by some state administrators about UBHN's right to lobby. The conclusion states:

> The political process is inevitably that of competition between interests~ Nowhere is that more noticeable than in the funding arena — especially during difficult financial times. Unfortunately, this situation can create a scenario where there may be winners and losers — even within programs that are otherwise complimentary in nature.
>
> However, the political process is designed to allow policy makers to choose among options after hearing the best arguments from all sides. Only in very limited cases is the law used to restrict actually making the argument.
>
> Federal and state tax law in no way restrict the ability of an appropriately authorized "501 (c)(6)" entity from engaging in lobbying activities that are consistent with that entity's organizational purposes.
>
> UBHN, as an association of service providers, is accountable to its members. Those members are accountable to the counties or other political subdivisions with whom they contract.
>
> Obviously, state law has imposed requirements governing the bid process, the nature of contracts and other operational components. However, within the realm of policy debates, counties are independent entities free to express and advocate their own positions. They are also free to choose the means and methods associated with this advocacy. Candidly, this issue appears much less

about the propriety of UBHN's lobbying activities and much more about the fact that UBHN apparently did a better job than others did.

UBHN asserts not only its right to lobby as part of its activities but that it is morally obligated to do so in behalf of the clients it serves. According to a report by the Legislative Fiscal Analyst, prepared for the Funding of State and County Health and Human Services Task Force, of comparative human services funding from 1997 through 2002, funding for mental health centers increased by 14.5%. By comparison, state funding for all local authority human service programs increased by 20.3%. Funding for state human services programs increased by 30.1%. This funding inequity for local authority mental health programs in relation to other human services programs has required action. We believe that it is in the interest of the State of Utah to be informed about the needs of those providing direct service to its citizens who suffer from mental illness. UBHN gives voice to those needs.

Respectfully submitted,

Dr. Mick Pattinson
Chairman of the Board
Utah Behavioral Healthcare Network, Inc.

Attachment: Memorandum from Roger 0. Tew, Esq. — Special Counsel

Roger 0. Tew, Esq.
60 South 600 East, Suite 200
Salt Lake City, Utah 84102

Memorandum

To: John F. Tanner, UBHN Executive Director,

From: Roger 0. Tew, Esq. _Special Counsel

Date: August 26, 2002

Re: Lobbying Activities of UBHN

You have requested an opinion regarding possible restrictions on lobbying activities that may exist for the Utah Behavioral Healthcare Network (UBHN). It is my understanding that these questions arose in the context of the most recent special session of the Utah State Legislature. Without regard to any specific factual issues, the following are my observations concerning potential limitations.

Background

As a general pnnciple restrictions on free speech for the purpose of petitioning governmental bodies are viewed with significant skepticism by the courts. Candidly, public policy actually argues that such activities are to be encouraged rather than restricted.

In fact, such restrictions are usually tied to situations where the government actually confers a benefit where a lobby limitation is a condition of that benefit. Even here there is a requirement that the limitation must advance the purposes associated with the benefit. The most obvious example is where the tax code affords a tax benefit or exemption but imposes certain lobby limitations as a condition for the benefit. That specific issue will be addressed in more detail later.

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1 Christian Echoes National Ministry, Inc. v. United States, 470 F. 2d 849 (10th Cir.)cert denied,414 U.S. 864 (1973): Regan v. Taxation with Representation of Washington, 461 U.S. 540 (1983); Cameroon v. United States, 358 U.S. 498 (1959). These cases upheld

There are also those situations where the consequences are more matters of practicality rather than issues of law. Employees invested with appropriate policy authority who choose to take public positions before governmental bodies that are in direct opposition to those of an employer cannot expect complete immunity from the consequences of their actions. (I am not referring to protected areas such as whistle-blower activities, etc.) Likewise in the world of government, individuals in policy making positions who publicly advocate positions contrary to or detrimental to positions of their political superiors are likely to face political fallout.

These situations, however, all presume a superior-subordinate relationship. In short, there must be a direct supervisory and managerial responsibility with subordinates knowingly advocating positions contrary to those of their superiors.

This memorandum examines how these two areas: (a) tax-exempt restrictions; (b) organizational restrictions apply to UBHN. My review shows the following:

Although there are statutory responsibilities for coordination and consultation with state government, local mental health authorities are in fact independent political entities. As such, these entities are empowered to adopt and advocate their own policies and positions before the Utah State Legislature. How they choose to undertake lobby efforts is a decision for these independent political subdivisions to determine.

- UBHN is a legally constituted entity whose purpose is to advance the interests of its members. These members are the contract mental health and substance abuse service providers for most counties and associated political entities. The members have knowingly chosen to have UBHN lobby on their behalf.

- UBHN does receive a federal and state tax benefit or exemption. There are some restrictions on lobbying activity associated with receipt of that benefit. However, UBHN's political/lobbying activities are clearly permissible under current tax interpretation.

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lobbying restrictions associated with federal tax exemptions as not violating the 1st Amendment Among the rationale, tax exemptions were privileges and not rights.

UBHN is not an actual service provider. Rather it is an association of mental health/substance abuse service providers. It is supported through dues of its member organizations. UBHN is directly accountable to its members and these members establish the policy positions to be advocated by UBHN in its lobbying role.

UBHN is a Utah nonprofit corporation and is classified as a 501(c) (6) entity under the internal revenue code (Internal Revenue Code 501(c) (6)). This status renders UBHN as tax exempt for state and federal income tax laws. However, it is not considered an exempt charitable organization which would allow for deductions to the organization to be considered a tax deductible. Likewise, UBHN is not eligible for a sales tax exemption on its purchases under Utah law.

Mental Health Care Service Obligations

Title 62A, Chapter 15, known as the Substance Abuse and Mental Health Act, Utah Human Services Codes, establishes the state administrative structure, service obligations and financial oversight obligations associated with state substance abuse and mental services. Among these obligations is that to *"consult and coordinate with local substance authorities and local mental health authorities regarding programs and services"*[2]

Utah Code Ann.17-50-318 imposes a statutory obligation on each county to provide appropriate mental health and substance abuse services:

> *17-50-318. Each county shall provide mental health and substance abuse services in accordance with Title 624, Chapter* 15, *Substance Abuse and Mental Health Act.*

The language of UCA 17A-3-602 designates county legislative bodies as local mental health authorities and delineates their responsibilities in these areas.

Contract Authority

The statutory authorization clearly contemplates the use by counties of contract providers. Statutory provisions outline the procurement bid requirements associated with contract providers.[3] In addition, Utah Code Ann. 17A-3-603.5 further outlines oversight responsibilities between county

[2]Utah Code Ann. 62A-15-103(2(c)(l)

[3]Utah Code Ann. 17A-3-603

mental health authorities and contract providers. Specifically, the language imposes on the county/special district authority the obligation to oversee the appropriate use of the funds.[4]

Lobby Restrictions

The central question is whether UBHN is in some manner restricted in its ability to lobby? I don't believe that there has been any assertion that UBHN does not lobby or that its activities do fall within the applicable definition of lobbying. However, for background purposes it is worth noting how lobbying is defined.

In the case of the Internal Revenue Code definition, the actual term that is used is "attempting to influence legislation". Attempting to influence legislation is defined as:

> Any attempt to influence any legislation through an effort to affect the opinions of the general public or any segment thereof (grass roots lobbying); and
>
> Any attempt to influence any legislation through communication with any member or employee of a legislative body or with any government official or employee who may participate in the formulation of legislation (direct lobbying).[5]

Utah law defines lobbying as "communicating with a public official for the purpose of influencing the passage, amendment, or postponement of legislative or executive action."[6] Neither definition presents a problem and clearly one of the roles played by UBHN is that of lobbying.

Internal Revenue Code Restrictions

The lobby restriction on nonprofit, tax exempt organizations is largely limited to IRC 501 (C) (3) organizations. For other "501(c) "organizations the only limitation is that the lobbying must be related to the organization's exempt purpose.

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[4]Utah Code Ann. 62A-15-110; 62A-15-112, 17A-3-603

[5]IRC 162(e)(4)(A); Reg. 1.162-29(b)(1);associated IRS publications

[6]Utah Code Ann. 36-11-102(8)

The UBHN articles and bylaws outline the purpose and objectives of the organization:

1. To preserve local autonomy of individual mental health and substance abuse programs (under the direction of local mental health and substance abuse authorities), while at the same time enhancing service capacity, financial viability, and competitive edge.

2. To provide seamless services across the State

3. To ensure that the Utah mental health and substance abuse systems are consistent in general operating policies and operations.

4. To bring together the best clinical and program strengths from each member entity.

5. To create a state-wide network for mental health and substance abuse services available to directly contract with purchasers of these services.

6. To take advantage of opportunities from shared infrastructure in order to better control costs associated with publicly funded mental health and substance abuse services.[7]

Simply stated, as long as lobby activities are in concert with and further these objectives, such activities are completely consistent with current IRS laws and regulations.[8] Clearly lobby efforts associated with obtaining funding fall within the scope of the UBHN's corporate purpose.

Operational Restrictions

There is no per se lobby restriction associated with this issue. Rather, the question is whether the relationship between local mental health authorities and Utah State government can be construed as restricting independent lobbying by the local mental health authorities.

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[7] UBHN Article of Incorporation and Bylaws amended 3/1998.

[8] The IRS enunciated this principle in Rev. Rul. 61-177, 1961-2 C.B. 117. That ruling held that a corporation that was organized and operated primarily for the purpose of promoting a common business interest is exempt under IRC 501(c)(6) even though its sole activity is influencing legislation germane to the common business interest. In fact, outside of the 501(c)(3) area the only mention of lobbying is supportive of the activity.

I have previously outlined the general relationship between the state and county governments for the administration of mental health and substance abuse programs. In general, the state's responsibilities are those of oversight, coordination, consultation and funding. This statement is not meant to demean the importance of any of these areas. However, this relationship is clearly not that of direct supervisory, administrative and managerial responsibility over county operations.

Utah Code Ann. 17A-3-603.5 specifically states: "Each local mental health authority is responsible for oversight of all public funds received by it..." Furthermore Utah Code Ann. 17A-3-602 outlines the duties and responsibilities of the county mental health authorities.

In short, county mental health authorities are not and do not operate as merely regional offices of a state agency. Rather, as independently elected political entities with their own statutorily enumerated responsibilities, they are more appropriately characterized as partners with the state in ensuring the delivery of mental health and substance abuse services. However, they are partners with their own independent political voice and capacity to influence policy makers.

These independent political subdivisions are clearly free to advocate and advance their own positions before the Utah Legislature. At issue is how they choose to accomplish this objective. I can find no statutory limitation on how a political entity may choose to advocate its positions. State governmental agencies, divisions and departments regularly employ their own agency leadership and other employees as lobbyists for their positions. Smaller entities, in contrast, may rely on associations to accomplish the same goal.

Obviously, the use of non-employees would be subject to existing laws governing the use of contract providers, etc. However, there is nothing per se inappropriate about their use. Clearly, contract service providers are accountable to the political entity for the provider's actions. In the instant situation, UBHN is ultimately accountable to its members who themselves are accountable to the political leadership of the various subdivisions.

Conclusion

The political process is inevitably that of competition between interests. No where is that more noticeable than in the funding arena — especially during difficult financial times. Unfortunately, this situation can create a scenario where there may be winners and losers - even within programs that are otherwise complimentary in nature.

However, the political process is designed to allow policy makers to choose among options after heanng the best arguments from all sides. Only in very limited cases is the law used to restrict actually making the argument.

Federal and state tax law in no way restrict the ability of an appropriately authorized "501(c)(6)" entity from engaging in lobbying activities that are consistent with that entity's organizational purposes.

UBHN, as an association of service providers, is accountable to its members. Those members are accountable to the counties or other political subdivisions with whom they contract.

Obviously, state law has imposed requirements governing the bid process, the nature of contracts and other operational components. However, within the realm of policy debates, counties are independent entities free to express and advocate their own positions. They are also free to choose the means and methods associated with this advocacy. Candidly, this issue appears much less about the propriety of UBHN's lobbying activities and much more about the fact that UBHN apparently did a better job than others did.

RESPONSE TO THE EXPOSURE DRAFT OF A PERFORMANCE AUDIT OF UTAH'S LOCAL MENTAL HEALTH SYSTEM (REPORT NO. 2003-05) JUNE 10, 2003

First, I would like to commend the Auditors on the level of understanding that was achieved in a very complex system. My comments are being offered as the CEO and President of Bear River Mental Health Services, Inc. We did provide data to the Auditors since some of the conclusions drawn could impact Bear River Mental Health Services, Inc.

Digest of Performance Audit of Utah's Local Mental Health System
Page 1:
Paragraph 1:

The $132 Million Dollars mentioned in the first paragraph appears to be a combination of both public and private funds and all are being lumped together as public funds. In fact not all funds received by mental health centers or expended by mental health centers across the system are public funds, via the statutory definition. Other fees, insurance, interest, etc. are revenue sources, for example, that are not meeting the statutory definition of public funds. I don't believe there is a definition in statute to support a deductive leap of co-mingling of funds converts all funds to public funds.

State and County Oversight of MHCs Needs to Improve

- **LMHAs need to improve oversight of the MHCs:**

This is a conclusion that is drawn on a visit to a sub-set of mental health centers and is generalizing to the entire system. The Local Mental Health Authority Oversight of Bear River Mental Health and the three counties that Bear River Mental Health is responsible for, is extremely efficient and effective and was not assessed in drawing this conclusion.

Chapter I, Page 2, 1st Paragraph, last sentence:
MHCs that operate as private nonprofit corporations, however, are primarily under the control of an appointed Board of Directors; county authority oversight is more indirect in these cases, though the responsibility is still there.

At Bear River Mental Health Services the County Authority Oversight occurs routinely with an Oversight Committee that attends all board meetings. There are three representatives appointed by each of the three counties, Rich, Box Elder, and Cache. These three county officials have an in-depth understanding of their responsibility and carry it out quite appropriately.

Page 4, Paragraph at top of page, last sentence:
Thus, in many ways, even though they are private entities, the four nonprofit MHCs can be viewed as extensions of government, especially in terms of the need for accountability.

Legally and statutorily, this is not the case. Nonprofit, private corporations are not extensions of government, but are simply contractual providers for government. Of course, accountability for the use of public funds still applies. Utah has only recently begun to follow the national trend and certainly the regional trend of mental health centers moving into private nonprofit status. One hundred percent of the centers, for example, in Wyoming and Colorado are now nonprofit and all of those used to have some relationship directly to or as extensions of county government. Moving into the nonprofit sector allows for substantial revenue production from the private sector with declining governmental dollars being available to maintain quality mental health services in the public sector.

Chapter II, State and County Oversight of MHCs Needs to Improve
Page 13, first paragraph:
While overall mental health center (MHC) expenditures appear to be appropriate, the lack of detailed information on some mental health center activities warrants more oversight by county authorities and state funding agencies. Effective Local Mental Health authority (LMHA) oversight is hampered by misperceptions among some county officials as to their responsibility and authority over the MHCs.

There are no misperceptions at Bear River Mental Health Services, or with the three Oversight County Representatives. Again, this is a general conclusion that is not true on a state-wide basis since these elected officials have a very in-depth understanding of' the Local Mental Health Authority responsibility and carry it out thoroughly.

Page 13, Paragraph 2, 2nd sentence:
MHCs, particularly the private non-profits, need to provide more information to their authorities on administrative costs, service provision, and activities in other fields.

I believe this already occurs at Bear River Mental Health Services which is a nonprofit, private corporation. There is not any additional data that is provided by other mental health centers that I am aware of under other governing structures, county or non-county that are not provided to Bear River Mental Health Services' Board of Directors

and Oversight Committee (Local Mental Health Authorities) on a routine basis or upon request.

Local Authorities Need to Improve Contractor Oversight.
Pages 13 and 14. Second sentence:
As a result, oversight is insufficient, more often with the private nonprofit than the publicly affiliated MHCs.

Again, for the reasons listed above since the Local Mental Health Authorities receive the same information as the Board of Directors, at the same time, in the same depth.

Oversight by LMHAs is Often Insufficient.
Page 16, first paragraph, 2nd sentence:
Oversight also varies between public and private MHCs with the private, nonprofit MHCs undergoing less complete oversight review by counties or the state.

This is not factual at Bear River Mental Health Services, Inc. Again, the Oversight Committee representing the three counties is extremely active in their roles and attend every board meeting and review all data that the board members receive. The information that they work with is far beyond external financial audits.

Last paragraph:
MHCs' Boards Are Relied Upon for Oversight.

This paragraph appears to apply to one specific mental health center and has been generalized on a state-wide basis. The conclusions are not accurate when this is not a description of other nonprofit mental health centers in the state.

Page 17:
Oversight is More Direct with Public MHCs.
Last sentence in paragraph:
Thus, the board and the LMHA are essentially the same entity **so that the oversight authority has full and instant access to all information given to the center's board.**

As noted previously, at Bear River Mental Health Services, there is no differentiation between the information or the timeliness of the information given to the governing board and the oversight authority. Therefore, again, this is not a reasonable conclusion on a state-wide basis. Additionally, not all county commissioners from every county sit on all county-governed boards on a state-wide basis. It is often a representative model even in the county-affiliated organizations.

Page 18:
MHC Information and LMHA Review Can Improve
First Paragraph, 4th sentence:

Staff in one county also reported difficulties in obtaining requested information from their MHC.

Clearly that is not the case, as noted in the above comments, at Bear River Mental Health Services.

Page 17:
Second Paragraph, last sentence:
It should be noted that the boards of the private, nonprofit MHCs typically review monthly expenditures in some detail, and because of this review, they often have more information provided to them than the LMHAs have.

This is not an accurate statement on a state-wide basis. As noted above, the Local Mental Health Authorities have the same detailed monthly expenditure reports provided to them in the same time frame, and at the same meeting as the governing board of the nonprofit corporation. Therefore, this conclusion should be modified.

Pages 17 and 18:
Regarding closed meetings:

The only closed meetings that happen with the Board of Directors at Bear River Mental Health Services would be an appropriate executive session for the legally required reasons, and the Local Mental Health Authority representatives are invited to attend those meetings and participate in them.

Page 24:
Third Paragraph, third sentence:
It is **of concern, however, that the state board initially chose to bypass the options presented by division staff as well as the advice implicit in a letter from the department's attorney which stated that the UBHN option did not appear to meet statutory requirements:**

It would be helpful to have a more complete picture presented on this issue. The funding formula had not been followed out as statutorily required by the Department and the Division for many years. Due to this not being implemented for several years, the consequences of a sudden implementation would have been devastating to the mental health system as a whole injuring client treatment. The UBHN recommendation was an attempt to not devastate services in some segments of the state due to the lack of the implementation of the required formula by the state itself for several years, and rather have a planned resolution over time that would not have a negative impact on the clients who are the true beneficiaries of these services. So although the conclusion is accurate, the state itself had not taken the state statutes into account for several years prior, setting the stage for this potential disaster.

Page 25:
Second Paragraph, first sentence:
To illustrate, the MHCs have indicated that as they use more state funds to match federal Medicaid dollars, fewer state funds are left to serve non-Medicaid clients.

An issue that was not addressed here is that eligibility growth match should be automatically included in the state's budget process so that a crisis does not occur with Medicaid funding.

Page 58:
Item No. 4:
We recommend that the LMHAs clarify to their service providers their expectations related to conflicts of interest and dual employment issues with the goal of minimizing these occurrences.

The Division of Substance Abuse and Mental Health has required this for a substantial period of time. All of the employees at Bear River Mental Health Services, and all board members, and all oversight committee members from the Local Mental Health Authority sign Conflict of Interest and Dual Employment forms, exposing any potential problem in these areas and educating all staff, board and oversight Local Mental Health Authority representatives on these issues. Therefore, this process is already in place at Bear River Mental Health Services, Inc.

Respectfully submitted by:

Dr. Mick Pattinson
President/CEO

FCCBH, Inc. Exposure Draft Response
Report No. 2003-05
A Performance Audit of Utah's Local Mental Health System

Digest

The Audit is seriously flawed. A lack of understanding of the role of private nonprofit providers in Utah's state/local system leads to unwarranted conclusions and recommendations.

The report seems to contradict itself, stating that "a review of service provision was beyond the scope of the audit. . ." and that ". . . Utah has received recognition for its mental health services..."[1] The report repeatedly asserts that ". . . MHC expenditures appear to be appropriate. . ." The conclusion that "Current level of available data is insufficient to allow an accurate assessment of system efficiency." is erroneous. A review of DSAMH, DHCF and UBHN data collection would have led to a very different conclusion. The DSAMH currently has data including all services provided by the MHCs. Efficiency is assessed by calculating both penetration of mental health services in target populations and cost per unit service. The joint UBHN/DSAMH/DHCF Performance Development project was undertaken to compile just the sort of data needed to allow an assessment of system efficiency.

The report repeatedly minimizes the work of the nonprofit MHC boards and the knowledge and commitment of county commissioners. It assumes that because the nonprofit MHCs operate differently then county and state agencies that something is wrong. It assumes that if nonprofit MHC boards of trustees make business decisions that take the MHC beyond "tradition", that adequate oversight was not provided.

Nonprofit MHCs are allowed in Utah in part because they can access resources not available to government agencies. Many of the differences between private nonprofit MHCs and government agencies are indications that the nonprofits are succeeding, not that something is wrong. Utah has been in the forefront of replacing the warehouse, state hospital "tradition" of poor services to the mentally ill, with effective, innovative community-based services. In spite of

[1] Page 10

Utah's place among the bottom three states in per capita state mental health funding, we are widely recognized as having one of the more effective and efficient systems of care for citizens with mental illness.

The report repeatedly confuses the part for the whole. The statements of one or two unidentified county commissioners are used to prove wide-spread ignorance on the part of county commissioners concerning their role and authority as LMHAs. Using this flawed logic, it would be easy to "prove" widespread commissioner ignorance on any subject by interviewing a newly elected commissioner on a subject not in his or her portfolio. Sound logic would dictate that each county is different and that an assumption of widespread ignorance does not represent the true picture.

Errors of fact compromise the audit.

The report states that the Division of Mental health was renamed the DSAMH.[2] In fact, the two separate divisions were combined by legislative action as a cost savings measure.

Some of the errors lead to important and misleading conclusions. The report states that a 1988 legal opinion is a barrier to the increased involvement of County Commissioners.[3] However, in addition to the referenced legal opinion, the Director of DHS directed all private nonprofit MHCs to remove County Commissioners from their boards.

The report asserts that "Oversight Is More Direct with Public MHCs."[4] However, of the five examples of this "more direct oversight" cited, four are standard oversight and accountability practices at Four Corners Behavioral Health, Inc., one of the four private nonprofit MHCs in Utah. In fact, the audit goes on to report that the nonprofit boards ". . .typically review monthly expenditures.. ."[5] The assertion that County Commissioners make more conservative administrative decisions and are more scrupulous of the taxpayers' money then the members of Utah's private nonprofit MHC boards is just not supported by the evidence in the audit.

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[2] Page 13

[3] Page 17

[4] Page 17

[5] Page 19

The audit reports that MHCs do not always comply with county information requests and cites UCA 52-4-5, but does not distinguish between public bodies covered by UCA 52-4-5 and the boards of private nonprofits which clearly are not covered.[6]

The three LMHAs that contract with FCCBH, Inc. have combined annual budgets of $25,176,179. Their combined annual allocation for mental health and substance abuse services together is $185,000, or less then 0.8%. This ratio is typical for Utah and sets a limit on the level of oversight that the LMHAs can reasonably be expected to provide without slighting their other responsibilities. Assuming that each county commission meets four hours a week, or 208 hours a year this would suggest that 0.8% of that time, or 1.7 hours a year should be devoted to MHC oversight. In fact, a great deal more time is actually spent on this activity.

The audit's definition of public funds is not supported by law and thus leads to unwarranted conclusions.

Funds transferred by a LMHA to a private provider remain public funds only when they are transferred pursuant to a contract to provide comprehensive mental health services.[7] The audit's unsupported argument would lead to the conclusion that MHCs expenditures for electricity would allow state and county oversight of UP&L.

The level of state oversight of the LMHAs and MHCs envisioned in the audit has been rendered problematical by the combination of the DMH and DSA and accompanying reduction in resources. It would be appropriate for the Legislature to monitor the effectiveness of oversight provided by the newly combined DSAMH as the reorganization is completed.

The audit envisions a substantial and unwarranted increase in state intrusion via administrative policy into the contractual relationships between LMHAs and private nonprofit MHCs.[8] The private nonprofit

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[6] **UCA 52-4-2. Definitions.**
As used in this chapter:
(3) (a) Public body means any administrative, advisory, executive, or legislative body of the state or its political subdivisions

[7] Pages 22 & 23

[8] Page 25

MHCs are not government agencies, and their scope of activity is governed by their by-laws, state law and their contracts with the LMHAs. The state is a signatory to such contacts and initiatives such as those described in the audit would properly occur at contract renewal, not by unilateral action of one party no matter how well intentioned.

Chapter II Recommendations

Training and information dissemination for LMHAs should be designed and conducted collaboratively by the state (DHS & DSAMH), the counties (UAC) and the provider association (UBHN).

Chapter III

Unsupported definition of public funds undermines credibility of analysis of UBHN.[9]

As discussed above, public funds are those appropriated through a contract by a LMHA to a comprehensive provider for mental health services. UBHN does not meet either of these conditions. The UBHN budget is therefore not public funds and thus not appropriate for direct LMHA oversight.

Chapter IV

The issues cited in the audit appear to be stated several times each creating the impression that there were more problems then were actually found. The audit reports that the URS has already reviewed the VMH retention plan and that technical problems were corrected. The audit raises the issue of non-employees being processed through a participating employer's payroll.[10] However, this is an inaccurate characterization as a management services agreement is in place between VMH and UBHN that makes the individuals cited employees of the participating employer.

Respectfully submitted,

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[10] Page 57

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