

**BUDGET REVIEW AND ANALYSIS
OF THE
MENTAL RETARDATION AND
MENTAL HEALTH PROGRAMS**

A Report to the Legislature of the State of Hawaii

**Submitted by the
Legislative Auditor of the State of Hawaii**

**Report No. 84-9
January 1984**

FOREWORD

Pursuant to legislative direction, the Office of the Legislative Auditor has undertaken a budget review and analysis program aimed at providing the Legislature with additional assistance and perspectives in its consideration of program and budget requests coming before it for action.

In this second year of the program, we have focused attention upon selective aspects of the two major program areas of health and social services in addition to following up on the two program areas reviewed last year (lower education and higher education).

Presented in this report are the results of our examination of the mental retardation and mental health programs under the Department of Health.

We wish to acknowledge the cooperation and assistance extended to our staff by officials and staff members of the Department of Health and the Department of Social Services and Housing.

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January 1984

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Chapter 1

INTRODUCTION

Purpose and Focus of Budget Review and Analysis

This budget review and analysis effort was undertaken in response to provisions contained in the legislative appropriation acts of 1981 and 1982, which directed the Legislative Auditor to initiate a program of budget review and analysis. The overall purpose of this effort is to assist the Legislature in gaining a better understanding of the program and budget requests coming before it for consideration.

More specifically, the objectives of budget review and analysis are:

1. To assess the processes by which budgets are developed and executed, with emphasis on quality of review and analysis at key decision points.
2. To identify and assess significant internal and external factors which influence or constrain budget preparation and execution.
3. To identify areas where the Legislature has expressed specific interest or concern and determine and assess the adequacy of the executive's responses.
4. To identify significant budget changes and evaluate the justifications or explanations provided to support those changes.
5. To examine and evaluate the content and presentation of existing budget information, provide additional or supplemental information, or suggest alternative means of presentation.

Attention was directed in our current budget review cycle to the major program areas of health and social services. Within the health program, mental health and mental retardation were selected for analysis in this report.

Budget processes in the Department of Health (DOH) are not basically different from those anywhere else. There have been complications during the current biennium arising from strict ceilings and restrictions on expenditures, but these have not raised any problems unique to the department.

In one respect, financing the DOH is somewhat different. The department has a number of revenue-producing facilities and programs. Revenue administration has given rise to problems in a number of areas, but as each is somewhat different from the others, they are discussed in the context of the programs involved.

Organization of the Report

This report consists of three chapters. Chapter 1 is this introduction; Chapter 2 discusses in some detail mental health services; and Chapter 3 does the same for services for the mentally retarded.

Glossary

In this report we use numerous acronyms in discussions of the subject programs. To facilitate understanding of these terms, we list them here:

1. B&F—Department of Budget and Finance.
2. CIP—capital improvements program.
3. DAGS—Department of Accounting and General Services.
4. DOH—Department of Health.
5. DSSH/Medicaid or Medicaid—Department of Social Services and Housing as administrator of the State of Hawaii's medicaid program.
6. FB—Fiscal Biennium.
7. FY—Fiscal Year.
8. HMSA—Hawaii Medical Services Association.
9. HSH—Hawaii State Hospital.
10. IC; ICF; ICF/MR—intermediate care; intermediate care facility; intermediate care facility for the mentally retarded.
11. JCAH—Joint Commission on the Accreditation of Hospitals.
12. MH—mental health.
13. MHD—Mental Health Division of the Department of Health.

14. MR—mental retardation.
15. PDR—project development report prepared by consultants to the State on the modernization project of Hawaii State Hospital.
16. PFP—program and financial plan.
17. SN; SNF—skilled nursing; skilled nursing facility.
18. WTSH or Waimano—Waimano Training School and Hospital, a division of the Department of Health.

Chapter 2

PROBLEMS IN BUDGETING FOR THE MENTAL HEALTH PROGRAM

There are two principal components of the mental health program: community based services and the Hawaii State Hospital (HSH). Community based services furnish non-institutional mental health services through eight centers, while HSH treats and cares for institutionalized mental patients in its 220-bed facility.

Summary of Findings

With respect to the community based services for the mental health program, we find as follows:

1. Action under the 1983-85 budget to shift funds from personal services ("A" funds) to other current expenses ("B" funds) represents an inappropriate use of budgeting because: (a) it was done without adequate planning and preparation, and (b) it forces the program to conform to the budget rather than have the budget support the program.

2. The imposition and collection of fees by the mental health centers are subject to vaguely defined statutory authority, and, as administered, are chaotic, ineffective, and probably illegal. As a result, the fees are inequitable and are non-productive in generating revenue.

With respect to the Hawaii State Hospital, a multi-million dollar project for capital improvements is being proposed in the face of the following handicaps and deficiencies affecting the planning of the project:

1. A lack of a data gathering and analysis capability to determine the reasons for and trends affecting admissions to and population of the hospital.

2. A lack of information concerning the kinds and costs of community programs which might be utilized to prevent or reduce the need to hospitalize for mental illness.

3. A failure to develop sufficiently detailed information whereby the costs of correcting deficiencies in standards might be distinguished from the costs of program enhancements.

4. A failure to assess adequately the institution's revenue situation to determine whether there are ways to improve its collection of revenues.

Program Budget

The total budget for mental health amounts to well over \$21 million per year. Of this total, somewhat over half is appropriated to community based services, about 40 percent to HSH, and the remainder to general support. Table 2.1 summarizes the operating budget for FB 1983-85.

Inspection of the table reveals that appropriations for the two fiscal years are generally about the same, except for some predicted declines in federal support. Small increases were made in state support, but not enough to make up the difference.

Reduced federal aid for community based services. There has been a significant longer-term trend in financing the community based and general support programs. Table 2.2 presents a comparison of FY 1979-80 appropriations versus FY 1984-85 appropriations, and the most noticeable change is the decline in federal funding.

Increasing budgets for HSH. Operating appropriations for HSH exceed \$8.7 million for each year of the 1983-85 biennium. These amounts represent an increase of more than 50 percent over FY 1979-80. Over the same period, authorized positions have increased from 348 to 404—a 16 percent increase.

The hospital's population has been increasing quite steadily in the past few years, and the increased budget and staff would appear to be reasonable. In the future, however, there are likely to be continuing pressures for increased budgets to correct deficiencies in program, staffing, and operations; and possibly to accommodate more patients. There is also the possibility that revenues from the hospital could change materially, thus increasing or decreasing the amount of offsetting revenues derived by the general fund.

Table 2.1
Mental Health Appropriations
Fiscal Biennium 1983–85

<i>Program</i>	<i>FY 1983–84</i>	<i>FY 1984–85</i>
HTH 401—Community Based Services		
General Funds	\$10,056,354	\$10,151,199
Federal Funds	1,943,796	1,569,293
Total	\$12,000,150 ^a	\$11,720,492
HTH 430—Hawaii State Hospital		
General Funds	\$ 8,722,771	\$ 8,778,258
Federal Funds	—0—	—0—
Total	\$ 8,722,771	\$ 8,778,258
HTH 495—General Support		
General Funds	\$ 964,495	\$ 978,487
Federal Funds	163,984	148,845
Total	\$ 1,128,479	\$ 1,127,332
Total Operating Budget ^b		
General Funds	\$19,743,620	\$19,907,944
Federal Funds	2,107,780	1,718,138
TOTAL	\$21,851,400	\$21,626,082

^aDoes not include \$846,459 in grants-in-aid to designated private agencies or \$1,608,963 in lump sum grant-in-aid to Community Based Services for Mental Health, as provided for in Part IV of Act 301.

^b\$1,271,000 for Capital Improvements Program expenses were also appropriated for HTH 430 for FY 1984–85.

Source: Act 301, SLH 1983.

Table 2.2
**Appropriations for
 Community Based Services and General Support
 FY 1979–80 and FY 1984–85**

	<i>Appropriations</i>		<i>Amount of Change</i>	<i>% of Change</i>
	<i>FY 1979–80</i>	<i>FY 1984–85</i>		
HTH 401—Community Based Services				
General Funds	\$ 6,541,159	\$10,151,199	\$ 3,610,040	55.2
Federal Funds	3,883,124	1,569,293	(2,313,831)	(59.6)
Total	<u>\$10,424,283</u>	<u>\$11,720,492</u>	<u>\$ 1,296,209</u>	<u>12.4</u>
HTH 495—General Support				
General Funds	\$ 829,976	\$ 978,487	\$ 148,511	17.9
Federal Funds	184,821	148,845	(35,976)	(19.5)
Total	<u>\$ 1,014,797</u>	<u>\$ 1,127,332</u>	<u>\$ 112,535</u>	<u>11.1</u>
Total Operating Budget				
General Funds	\$ 7,371,135	\$11,129,686	\$ 3,758,551	51.0
Federal Funds	4,067,945	1,718,138	(2,349,807)	(57.8)
TOTAL	<u>\$11,439,080</u>	<u>\$12,847,824</u>	<u>\$ 1,408,744</u>	<u>12.3</u>

Sources: Act 214, SLH 1979, and Act 301, SLH 1983.

Budget Issues in Community Based Services

Budget issues in the community based mental health services arise largely from developing programmatic changes connected with planned redefinition of the role of such services. These issues, together with revenue problems at the mental health centers, are discussed in this section.

Abrupt shift away from personal services requests at mental health centers. The major budgetary action to redefine community based services was to require all branches to reduce their personal services costs by 10 percent in FY 1983-84, and by another 5 percent in FY 1984-85. This was accomplished by abolishing 30 positions in all professional and subprofessional classifications the first year and 15 more the second. The amount of the savings so effected was offset by increases in other current services budgets, to be used for expanded purchases of service.

At the same time, the centers were also given primary responsibility for contracting and budgeting, duties with which they were unfamiliar. The timing of such changes, under the pressure of budget deadlines, resulted actually in budgets leading program definition, rather than the other way around. The ultimate objective may well be meritorious, but the method used was bound to create major transitional problems.

Although increase in contracting for purchases of service was said to promote cost-effectiveness in the program, the division did not have and still does not have data or analyses to support that contention. It may be observed, however, that combined "A" and "B" appropriations for fiscal year 1982 were some \$2 million less than budget requests for the same items in subsequent years. Thus, initially at least, this change represents a significant proposed *increase* in overall costs of the program.

Inadequate administration of fees at mental health centers. Section 334-6(a) of the Hawaii Revised Statutes makes provision for fees to be charged for outpatient professional and other personal services rendered to mental health patients. The provision is, however, phrased in such a manner that whereas the establishment of fees by the director is mandatory, collection of them is not. The statute reads: "The director *shall* establish reasonable charges . . . and *may* make

collections on such charges.” [Emphasis added.] It then goes on to say that in making collections the financial circumstances of the patient and his family are to be considered and that no collections are to be made “where, in the judgment of the director, [they] would tend to make the patient or his family a public charge or deprive [them] of necessary support.”

A fee schedule adopted July 1, 1965 established weekly fees, depending upon monthly income and number of persons in the family. The original schedule provided for income intervals of \$100 per month, from \$201 through \$699, and fees ranging from zero to \$7 per week. It is still in use in one Oahu center, but the other three Oahu centers have made more or less extensive changes in the basic schedule.

Among the results of these changes is that no two centers have identical schedules, that some charge three times as much as others to similarly situated clients, and that maximum fees range from \$7 to \$19 per week. Further, two schedules provide for fees for incomes only up to \$900 a month, while one other goes to \$1,121, and the fourth to “over \$2,000.”

This somewhat chaotic condition might be expected from the fact that the Department of Health (DOH) has not even taken steps to adopt policies or fee schedules by rule, in accordance with Chapter 91, HRS. Such adoption would appear to be a prerequisite to making them either legal or effective, and they probably have no standing otherwise.

Not only are the fees themselves inconsistent, the administration of them is essentially a matter of self-assessment and payment on the honor system. Center personnel are instructed to reduce or eliminate charges if the client says he or she cannot afford to pay, and payment is seldom pressed even if agreement is reached. Third party carriers, such as HMSA, refuse to pay altogether. As a result, practically the only revenue actually realized in the centers derives from Medicaid, which has contracted to pay \$10 per visit for persons eligible under its program, and from a few clients.

Budget Issues at Hawaii State Hospital

Budget issues at HSH also proceed from prospective program changes, but here the changes are dependent upon a planned capital improvements modernization

project. The project not only involves an estimated \$37 million in construction costs, it also will largely define the State's mental health program for years to come. Commitments to financing both the capital and operational requirements of that program should be made only after determining that the program itself will indeed best serve the mental health needs of Hawaii.

The capital improvements project is set forth at length in a Project Development Report (PDR) prepared by a consulting team in 1982 and 1983.¹ The plan is predicated on perceived needs to correct certification and licensure deficiencies while also increasing capacity to accommodate an increased patient population. The report also examines tradeoffs in increased revenues derivable from removal of deficiencies.

We believe that the evidence cited to substantiate these perceptions and their corollaries is uncertain at best and warrants further examination, and that correction of physical problems might be achieved by a considerably less ambitious effort than that described in the PDR.

Questionable census projections. Future hospital population is a primary factor in cost projections for HSH. Thus, it is of the utmost importance that census projections be as firmly based as possible, but the consultants did not have an adequate data base to start from. They noted numerous shortcomings and concluded: "The lack of specific unit use data and statistics *requires that some basic assumptions regarding patient flow and treatment unit use be made on which to project future treatment unit needs.*"² It is on this somewhat tentative basis that the PDR presents projections for future growth.

There are four major assumptions presented in the PDR to support a prediction that census figures will continue to increase. These are: (1) that a swing back towards institutionalized care will occur, to a point of balance or equilibrium between deinstitutionalization and hospitalization; (2) that resources for community mental health services will be cut back, thus reducing community placement opportunities and precluding their growth; (3) that chronic patients will

1. Planning and Design Team: Anbe, Aruga, Ishizu Architects, Inc., H. Mogi Planning and Research, Inc., *Complex Development Report for the Hawaii State Hospital, Part I, Project Development Report, July 1982*, Department of Accounting and General Services Job Number: 02-20-2521, revised draft dated July 6, 1983.

2. *Ibid.*, p. 89 (original emphasis).

continue to return to HSH under criminal commitments; and (4) that future increases will occur partially as a result of population increases. The report further states: "No significant influences have been identified which are expected to reduce patient census."³

The reinstitutionalization trend forecast by the first assumption is at variance with past history. The philosophy implicit in it is by no means universally held by professionals in the field nor is it necessarily that which will prevail during the life of the new facilities. Without other support this assumption is questionable.

The second assumption, that community placement opportunities will be reduced, is even more tenuous. True, if the objective is reinstitutionalization, other options will tend to disappear, but a commitment to deinstitutionalization, together with judicious use of funds could produce more, not fewer, opportunities. Such a program will not be free, but it could be a better use of fewer dollars than what would occur if the hospital project is pursued.

The third assumption, that chronic patients will continue to return under criminal commitments overlooks the nature of the problem. Forensic admissions have indeed increased a great deal, but 75 percent of them are misdemeanants, while 90 percent were felons just 10 years ago. It is the opinion of hospital administrators that many of the petty offenders are charged and committed merely to procure care at HSH for want of any other place to go. They believe many are hospitalized inappropriately. If true, appropriate alternatives should be sought.

Alternatives indeed exist, at least potentially. A Crisis Response System Project, started in May 1983, reports identification and diversion of 44 inappropriate admission candidates in only two months of operations. Further, in response to House Resolution No. 473, the DOH is preparing a plan on community alternatives to hospitalization for the Legislature. This report, also, may shed more light on the propriety and necessity of a new facility.

Another new factor is Kahi Mohala, a psychiatric hospital that opened September 28, 1983 with 88 beds. It is expected to relieve the shortage of acute care beds which now contributes so much to HSH's patient load.

3. *Ibid.*, p. 96.

Finally, it may be observed that the construction of a new larger hospital effectively locks the State into a pattern of mental health care for the indefinite future. The existence of beds may foster their use, thus making larger censuses self-fulfilling prophecies while at the same time discouraging development of alternatives. Operating costs will rise and may be expended for the wrong purpose. Less ambitious alternatives should be exhaustively explored before accepting the permanent solution of a new mental hospital.

Doubtful revenue projections. The PDR projected annual revenues of about \$2.3 million for the HSH if the standards of Medicare and the Joint Commission on the Accreditation of Hospitals (JCAH) are met. This would represent an increase of about \$1.5 million over current revenues and was cited as partial justification for the new facility.

It is not clear today, however, whence these increases would derive. Better standards would not increase the number of patients now paid for by the present revenue sources—Veterans Administration, Medicare, and private sources. JCAH accreditation could make Medicaid and HMSA possible sources, but before any actual money came in the State would have to expand its Medicaid program to include psychiatric hospitals and HMSA would have to change its policy of denying payment to institutions that adjust charges for needy patients. Neither step seems even remotely likely. In view of these facts, DOH now agrees that the PDR revenue estimates were overly optimistic.

Unclear level of capital costs. A primary reason given for the project is that HSH today does not meet the physical building standards set by state, federal, and professional bodies. This contention is correct.

Improvements should be made, but the PDR and DOH's cost presentation in present form are inadequate for pricing the necessary steps. Improvements specifically for the correction of cited deficiencies are not clearly distinguishable from other program enhancements that are included for the recommended new facility. The Legislature therefore is at a disadvantage in distinguishing between what is necessary and what would be desirable.

Recommendations

With respect to budgeting for community based mental health services, we recommend:

1. In the future, the Mental Health Division should plan and implement programmatic changes on their own merits, reflecting such changes in the budget, rather than making budgetary changes to force subsequent changes in program.

2. The Department of Health should establish by rule equitable fees for services at mental health centers and have fair procedures to determine who should pay and who should not.

With respect to the Hawaii State Hospital, we recommend:

1. That HSH improve its data gathering and analysis capability in order to determine more clearly the reasons for and trends affecting admissions to and population of the hospital; and that it specifically:

- a. monitor and assess the reasons for repeated admissions and short-term stays;*
- b. determine the numbers of inappropriate hospitalizations;*
- c. determine the community alternatives needed to prevent inappropriate hospitalizations and the costs of such alternatives; and*

d. assess the long-term population of the hospital to determine the future need for and costs of community alternatives that would allow for continued deinstitutionalization of HSH patients.

2. That HSH develop cost proposals that concisely list the new construction, renovation, and demolition proposed for HSH; and that it specify the costs that are needed to correct deficiencies in standards, separate from those associated with other recommended program enhancements.

3. That HSH comprehensively assess its revenue situation to determine whether there are viable ways to improve its collection of revenues.

Chapter 3

PROBLEMS IN BUDGETING FOR THE MENTAL RETARDATION PROGRAM

The mental retardation (MR) program is organized similarly to mental health (MH). There are community activities (known as services for the developmentally disabled) and a large institutional program at Waimano Training School and Hospital (WTSH). There is, however, a considerable difference in balance between the programs. While the institutional program for mental health at the Hawaii State Hospital takes only about 40 percent of the total MH expenditures, WTSH accounts for over 70 percent of the MR budget. Our review deals primarily with the larger component of the mental retardation budget: Waimano.

Summary of Findings

With respect to Waimano Training School and Hospital, we find that:

1. After a decade of rather dramatic change—which has produced a sharp drop in patient population and a significant upgrading in staffing—the Waimano Training School and Hospital program has now reached the point where there is uncertainty as to what should be its future direction.
2. As a result of this general situation, there are some important budget related misconceptions and problems which need to be addressed but are presently receiving little or no attention. These include the following:
 - a. The method of presenting the budget (involving interprogram transfers of federal funds) is causing the apparent costs of WTSH to be easily misunderstood and seriously distorted.
 - b. Dropping of Medicaid funding for WTSH patients, which has been considered by DSSH and DOH, would have resulted in an annual net loss to the State of almost \$6 million in federal funds.

c. The ongoing reclassification of services at WTSH represents a potential annual revenue loss to the State resulting from decreased federal Medicaid payments, but also might reduce expenditures by DSSH/Medicaid.

d. Despite financial as well as program advantages to deinstitutionalization, there continues to be a backlog of patients of WTSH who are reported to be ready for out-placement.

e. Reductions in patient population of WTSH resulting from deinstitutionalization and reclassification of beds are not being reflected in the size or classification of staff.

f. Although WTSH occupies a large and valuable facility (including 240 acres of land) and although it is undergoing program changes, there are no comprehensive and long range program or facility plans for the institution.

Program Budget

The program for the mentally retarded is of substantial size. Most of the budget is devoted to the institutional part of the program, as the community services programs jointly account for only 27 percent of the budget and 16 percent of the staff. Table 3.1 displays the appropriations provided for the mental retardation program in Act 301, SLH 1983.

The table indicates that community services (HTH 500 and 501) are supported 95 percent by the State's general fund. This has not always been the case, however. In fiscal year 1979, 58 percent of their support came from the federal government. Since then, federal support has been reduced by \$2.2 million, which has thrown a very considerable burden on the State. In terms of money, the State has made up the decrease with some \$200,000 to spare, but there has been a net decline of 56 positions.

The budget for Waimano Training School and Hospital amounts to over \$11 million per year. Practically all of these funds come from the general fund, although there are substantial offsetting revenues received from Medicaid as discussed below.

Inconsistent staff trends at WTSH. One of the more important elements in budgeting for WTSH in recent years has been trends in staff positions. The drastic reductions in patient populations have not been reflected in staff changes. Table 3.2 shows the changes in population and staff over the past 10 years.

Table 3.1

Mental Retardation Appropriations
Fiscal Biennium 1983-85

<i>Program</i>	<i>FY 1983-84</i>	<i>FY 1984-85</i>
HTH 500—Identification, Evaluation and Treatment		
General Funds	\$ 2,137,884	\$ 2,203,909
Federal Funds	246,902	249,424
Total	\$ 2,384,786	\$ 2,453,333
HTH 501—Community Based Services		
General Funds	\$ 1,864,513	\$ 1,925,894
Federal Funds	-0-	-0-
Total	\$ 1,864,513	\$ 1,925,894
HTH 511—Waimano Training School and Hospital*		
General Funds	\$11,391,040	\$11,481,679
Federal Funds	78,189	85,226
Total	\$11,469,229	\$11,566,905
Total Operating Budget		
General Funds	\$15,393,437	\$15,611,482
Federal Funds	325,091	334,650
TOTAL	\$15,718,528	\$15,946,132

*Excludes transfer amounts (See text).

Source: Act 301, SLH 1983.

Table 3.2

Waimano Training School and Hospital
Numbers of Patients and Staff Positions
FYs 1973-74, 1978-79, and 1983-84

<i>Year</i>	<i>No. of Patients</i>	<i>Percent Change</i>	<i>No. of Staff</i>	<i>Percent Change</i>	<i>Staff/Patient Ratio</i>
FY 1973-74	705		383		1:1.84
FY 1978-79	482	(32)	590	54	1:0.82
FY 1983-84	367	(24)	566	(4)	1:0.65

Sources: Department of Health, *Statistical Report*, 1980, appropriation acts for respective years, and departmental records.

The changes from fiscal year 1974 to fiscal year 1979 reflect a massive redefinition of program, and a major increase in staff-patient ratios during that period was to be expected.

By 1979, however, WTSH was fully certified as meeting minimum standards and thus presumably possessed a staffing ratio that was adequate. Continuing decline in population could then be expected to be reflected in staffing, but instead the ratio has continued to rise, without apparent justification.

Need for clarification of WTSH transfer moneys. Expenditure information for Waimano in the PFP includes so-called transfer moneys within operating costs. (These moneys are excluded from our exhibits). This is misleading and confusing, as actual program expenditures are far less than the amount shown. For example, for FY 1984-85 over \$8 million in transfer funds was included, although only \$2 million was actually proposed for expenditure by WTSH.

The apparent overstatement of costs arises from the manner in which federal matching funds for care of Medicaid patients at Waimano are accounted for. The DOH receives the funds, as provider of the services, and (after a number of other accounting transactions) they are deposited in the general fund where they become an offsetting revenue to part of the Waimano appropriations. The federal

reimbursements are not spent by WTSH, but nevertheless are considered as non-operational program costs for accounting purposes. Without further clarification, this makes it easy to misunderstand the budget, and appears to inflate the program size by 40 percent or more.

Budget Issues—Waimano

There are two principal areas of budget problems at Waimano. These areas are: (1) matters relating to Medicaid certification; and (2) matters relating to out placements, level of service, and staffing. A third area, planning, has impact largely on capital improvement budgets and development.

Medicaid-related problems. WTSH was certified to participate in the Medicaid program in 1979 and Medicaid has been the principal stimulus to changes in the kind, level, and amount of service at the institution. Today, 95 percent of the residents of WTSH are paid for through the Medicaid program, and the State "earns" nearly \$6 million a year in federal funds. There are, however, some problems associated with this plan of financing.

The question of Medicaid support. In 1982, DSSH/Medicaid, with support from WTSH, proposed to drop intermediate care for the mentally retarded (IC/MR) from its program. This would, in effect, remove WTSH from any Medicaid support and mean a loss of some \$6 million. The proposal did not survive the 1983 legislative session, and some of the reasons for the proposal remain somewhat obscure. One reason given, however, is clearly invalid.

This reason offered was that, if Hawaii exceeded federal cost targets for Medicaid, the resulting penalty would be smaller if the \$6 million WTSH payment was not included. This is true, but once the target level is exceeded (and Hawaii has been exceeding the target), the effect of going higher is to penalize the State 4-1/2 percent of the additional amount or, because of Waimano, about \$270,000 in additional penalty. To forego \$6 million in revenue to save \$270,000 in penalty hardly seems prudent financial management.

In the worst possible case, if the federal share without Waimano exactly equalled the target (\$74 million in FY 1984), Waimano's \$6 million would cause a penalty to be exacted where none would have been otherwise. The penalty would be

4-1/2 percent of \$80 million or \$3.6 million. This would be a not inconsiderable increase in cost to DSSH/Medicaid, but \$6 million in revenue would still yield a net gain of \$2.4 million to the State.

Bed designation. For several years, DSSH/Medicaid has been pressing to refine the service levels at WTSH. Until very recently, all beds were classified as ICF/MR, even though services rendered to some patients were more accurately described as less expensive skilled nursing (SN) or general intermediate care (IC).

The long-standing controversy came to a head when the move to drop IC/MR services was not accepted in the last legislative session. Medicaid then pursued its demand that WTSH repay \$590,000 alleged overpayments that arose from retroactive reclassification of some beds, improper placement of some patients, and inadequate treatment given to patients paid for at ICF/MR rates.

Reductions in Medicaid payments will continue as Waimano completes its conversion of patients to the appropriate levels of care. Regular care rates are about \$32 per day less than mental retardation care rates. Already 64 beds have been converted, and it is planned to convert 58 more. If this is done, a revenue loss of nearly \$1.5 million would be experienced by the treasury, assuming 100 percent occupancy. This loss might be partially offset, however, if Waimano is able to effectuate savings through reduction and reclassification of staff consistent with this patient reclassification plan and with the reduction of overall patient load noted below. A small saving to Medicaid would result also, as there would be some reduction in target overrun penalties.

Placement, service, and staffing problems. The problems arising in this area are those that derive directly from the changed and changing role of Waimano.

Placement backlog. The principal determining factor on operating budgets at Waimano is population and the principal influence on population is placement. There are said to be 100 residents ready for placement outside Waimano and there are plans to place some 28 per year in the new home and community-based services program as well as continuing the present placement program.

The State has estimated that community home care would save \$794 per client per year. While this is not a huge amount (equivalent to about \$67,000 per year if all 84 placements are made), it is enough to add a small financial argument to the accepted service-related reasons for non-institutional living.

Questionable staff levels. Much of the large operating cost increases of the late 1970s came from the changed emphasis in service. More and higher-paid employees were required, but declining populations then led to a high and increasing staff-resident ratio. To correct imbalances, 22 position counts were transferred from Waimano to other MR programs in recent years. Since 1982, however, Waimano has not identified any more available positions, although the community programs continue to request more staff.

While there are differences of opinion as to how much more, and at what rate, Waimano's population will decrease, there is agreement that decrease will continue, at least for some years to come. There exists, however, no assessment of the impact of these trends on the staffing of either professional, support, or maintenance positions.

Another factor affecting staff at Waimano is the change in service patterns resulting from the reclassification of beds as described in the preceding section. When all beds were ICF-MR, a high percentage of the staff was required for training, education, and related services. With downgrading of the beds, which may affect up to 30 percent of the population, a good deal more emphasis will be given to the less demanding regular intermediate care. Considering further that reimbursement to the State will be proportionately less, it is apparent that the size, makeup, and assignment of staff at Waimano presents a problem that needs urgently to be addressed. Failure to make staff adjustments to reflect program changes can have significant adverse fiscal impact upon the State.

Inadequacy of program plans. Since 1976, when it developed plans to qualify for Medicaid certification, Waimano has only minimally addressed program planning. Some other agencies in related fields do some planning, but their efforts do not fill Waimano's planning needs. Rather, such plans are to a great extent dependent on pre-existing plans for Waimano. In the absence of the latter, a certain element of unsureness is introduced into program development.

The lack of a program plan has also complicated Waimano's conversion to Medicaid standards. Even though program development has been, for the most part, a reaction to the Medicaid program, it has not always been timely.

For example, Waimano is converting certain facilities and programs to ICF/SNF classifications. The need for Waimano to develop these levels of care was put forth by Medicaid as early as 1978, but even now, the change is unplanned and being implemented in response to Medicaid reimbursement requirements with sometimes expensive results. Another example of Waimano's ad hoc decisionmaking was its hasty concurrence with DSSH/Medicaid's suggestion to drop it for Medicaid, which could have raised major fiscal, legal, and political problems. No alternative program plans were developed as to how the change would be accomplished and what the trade-offs would be. A little foresight might have reconciled differences and produced a plan with less potentially traumatic results.

Need for facility planning. Waimano's facility includes numerous buildings and 240 acres of land. Extensive renovations are under consideration and major improvements are needed for the electric and sewer systems. Also, as expected with deinstitutionalization, a number of buildings are no longer needed or useful for patient care.

Comprehensive facility planning is needed to assure that future renovations and projects are cost-effectively built, that the buildings are appropriately used, and that the use of the extensive land area is maximized. It is hard to reconcile tying up that much valuable land in support of a shrinking institution. If such a reconciliation can be made, well and good, but a careful use analysis should be made to prove it.

Recommendations

With respect to Waimano Training School and Hospital, we recommend the following:

- 1. That it develop plans to facilitate and promote cost-effective placement of persons outside WTSH by identifying the reasons for the present backlog in Waimano of patients suitable for community placement and determining measures to further the timely placement of them outside the institution; and*
- 2. That it undertake a thorough study of the size and characteristics of staff consistent with future needs as determined by program changes and declining population.*

3. *That it develop comprehensive program and facility plans to include:*
 - a. *projections of the scope and size of the program by each level of care; and*
 - b. *projections of need for the facilities and resources of Waimano for its present and future program, identifying those resources that are and will be available for other uses by the State.*
4. *That B&F and DOH develop a format for the revision of the budget to clearly present transfers and other non-operational costs separate from operational costs.*
5. *That DSSH/Medicaid, DOH, and B&F finally reconcile any remaining differences as to the need, propriety and impact of continuing Medicaid at WTSH. The primary objective of this reconciliation should be to sustain a high level of service and assure maximum receipts for the state treasury.*