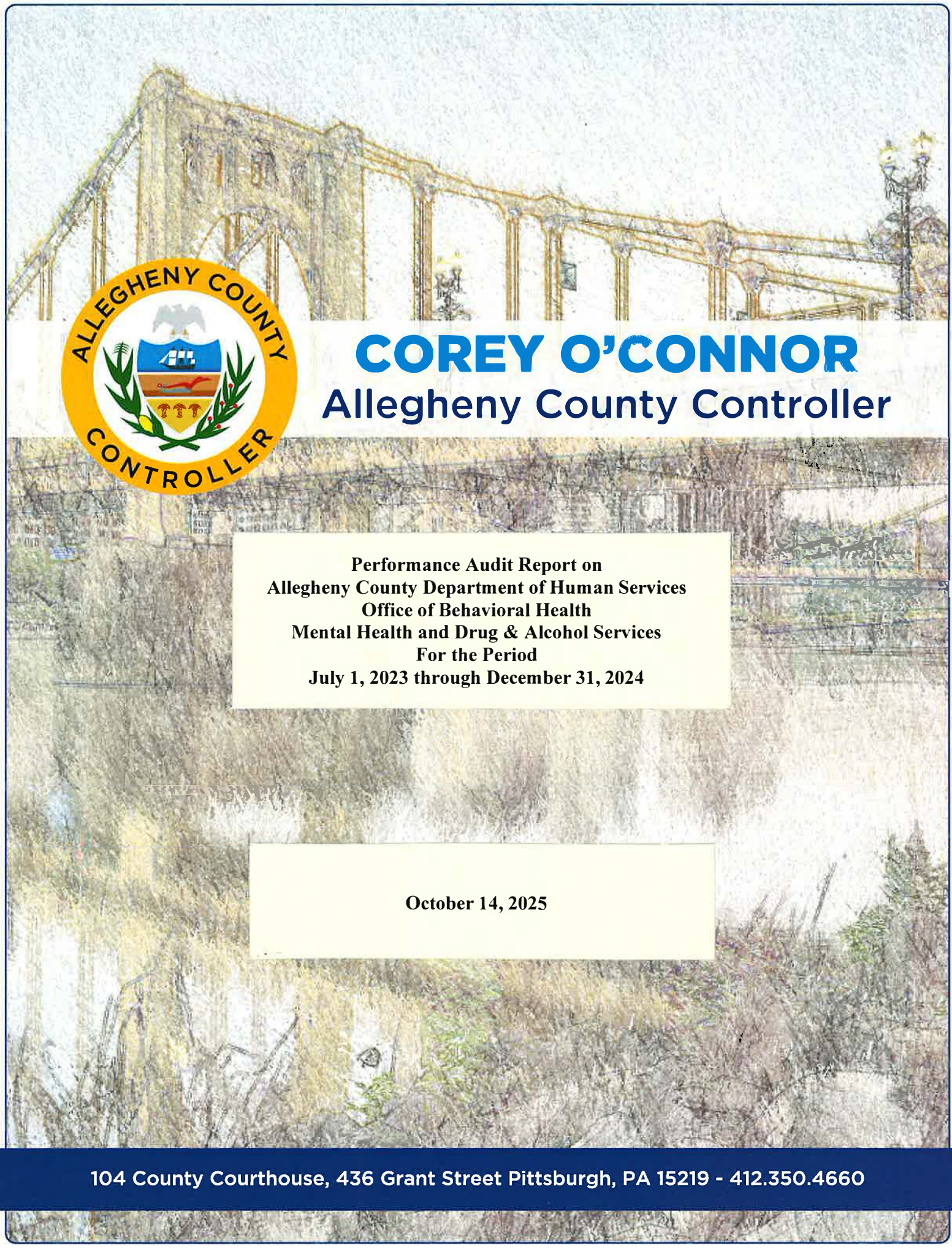

COREY O'CONNOR
Allegheny County Controller

Performance Audit Report on
Allegheny County Department of Human Services
Office of Behavioral Health
Mental Health and Drug & Alcohol Services
For the Period
July 1, 2023 through December 31, 2024

October 14, 2025

104 County Courthouse, 436 Grant Street Pittsburgh, PA 15219 - 412.350.4660

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September 12, 2025

Ms. Erin Dalton
Director
Department of Human Services
One Smithfield Street
Fourth Floor
Pittsburgh, PA 15222

Performance Audit Report on
Allegheny County Department of Human Services
Office of Behavioral Health
Mental Health and Drug & Alcohol Services
For the Period July 1, 2023 through December 31, 2024

Dear Director Dalton:

We conducted a performance audit on the operations of the Office of Behavioral Health (OBH) relating to mental health (MH) and drug & alcohol (D&A) services. Our procedures were applied to the period from July 1, 2023, through December 31, 2024. Our performance audit was performed in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States.

The results of our procedures revealed that DHS pays certain claims for drug and alcohol services at Community Care Behavioral Health (CCBH) rates instead of the provider contract rates, did not provide documentation to support certain provider rates, does not require detailed supporting documentation from program-funded providers, does not maintain waitlist data for certain mental health services, and has experienced staffing vacancies in the Office of Behavioral Health.

We offer recommendations so that the Department of Human Services can better assist the population of individuals accessing mental health and drug & alcohol services. The results of our audit are detailed in the attached report.

Director Dalton
September 12, 2025

We would like to thank the management and staff of the Department of Human Services for their courtesy and cooperation during our audit.

Kind Regards,

Corey O'Connor
Controller

Lori A. Churilla
Assistant Deputy Controller, Auditing

cc: Honorable Patrick Catena, President, County Council
Honorable John F. Palmiere, Vice-President, County Council
Honorable Sara Innamorato, County Executive, Allegheny County
Mr. John Fournier, County Manager, Allegheny County
Mr. Grant Gittlen, Chief of Staff, Allegheny County
Mr. Ken Varhola, Chief of Staff, County Council
Ms. Sarah Roka, Budget Manager, County Council

I. Introduction

Behavioral Health Services include mental health (MH) as well as substance use/drug & alcohol (D&A) services. The Allegheny County Department of Human Services (DHS) Office of Behavioral Health (OBH) administers publicly funded mental health and drug & alcohol services for Allegheny County residents and provides support for county residents in need of these services. DHS utilizes several funding sources including Medicaid funds, an allocation from the Pennsylvania Human Services Block Grant (HSBG) for mental health and substance use services, funding through the Pennsylvania Department of Drug and Alcohol Programs (DDAP), as well as other special funds such as the Opioid Settlement funds, American Rescue Act Plan funding, and other grant funds.

Funding

DHS oversees the Behavioral HealthChoices program which is funded through Medicaid. Medicaid, also referred to as Medical Assistance, is jointly funded through federal and state programs and provides coverage to eligible groups, including low-income individuals. Although DHS is the primary contractor for the program, it contracts with Community Care Behavioral Health Organization (CCBH), which is a Behavioral Health Managed Care Organization (BH-MCO) to deliver the program in Allegheny County. CCBH manages the day-to-day functions of the program including care management, the provider network, and provider payments. According to DHS, of the more than 220,000 Allegheny County residents enrolled in Medicaid, more than 50,000 utilize behavioral health services under the program. The Pennsylvania Department of Human Services (PA DHS) provides payment to DHS using established capitation rates. DHS receives a specified amount for each eligible member enrolled in Medicaid during the month, regardless of the individual's use or non-use of services. Since CCBH contracts with the providers for the Behavioral HealthChoices program, our testing primarily focused on the base-funded providers contracted through Allegheny County.

The HSBG and DDAP funds are collectively referred to as base funds, which are used to cover mental health and drug & alcohol services for the uninsured and underinsured (individuals whose primary insurance does not cover the specified service), as well as programs not currently covered by Medicaid or private insurance (e.g. prevention programs and crisis services). If an individual is insured, and their insurance covers the service, the cost is paid by that insurance. If they do not have insurance, providers can help determine their eligibility for Medicaid and assist in enrolling them. DHS base funds are used, when necessary, as the payor of last resort. According to DHS, base funds are used to provide mental health services to more than 20,000 individuals and drug and alcohol services to more than 2,500 individuals.

The table below summarizes the expenditures for the Fiscal Year July 1, 2023 through June 30, 2024 (FY 23/24). Schedule I, beginning on page 27, shows the amount paid to each base-funded provider.

I. Introduction

Funding Source	FY 23/24 Expenditures
Human Services Block Grant (Mental Health)	$ 86,198,175
Human Services Block Grant (Drug & Alcohol)	1,588,455
PA Department of Drug & Alcohol Programs	19,799,413
Subtotal (Base Funds)	$ 107,586,043
Behavioral HealthChoices (Medicaid)	$ 499,146,519
Office of Mental Health and Substance Abuse Services	828,549
Other Funding and Grants	9,029,357
Total	$ 616,590,468

Source: DHS and the Allegheny County JDE Accounting System

Access to Services

All mental health and drug and alcohol services are delivered through contracted providers. DHS does not perform any assessments or directly provide any services. Behavioral health services typically require documentation indicating the individual's clinical need for the identified service prior to its delivery to ensure the appropriate service is being delivered for the person's needs. Behavioral health providers also complete screenings and assessments at service intake to identify if an individual has any other health-related social needs. Service coordination may also occur as a function of the specific behavioral health service. According to DHS, an individual's or a family's participation in mental health or drug and alcohol services is voluntary, and DHS promotes the client's choice in their service and the service provider.

DHS provided information on the various options available for individuals to access mental health or drug and alcohol services. Service information is available at the local, state, and national level. For example, a client can contact DHS's Bureau of Mental Health Services/Bureau of Drug and Alcohol Services, CCBH member services (Medicaid members), PA Get Help Now (for drug & alcohol services), a Certified Assessment Center in Allegheny County, the National Alliance on Mental Illness (NAMI) helpline, or a provider directly (text messaging and online chat may also be available through PA Get Help Now and NAMI). Providers direct contact information is available through various platforms, including the DHS *'Where to Call'* directory, the CCBH online provider directory (Medicaid members), and on the pa211.org website. DHS said that entry points are not necessarily tied to an individual's type of insurance. The type of service best suited for an individual is determined based on an assessment conducted by providers, and then the client's insurance is reviewed to determine which funding source will apply.

Mental health and drug and alcohol crisis services are available through resolve Crisis Services via phone (1-888-7-YOU-Can) or the walk-in center. Other resources are also available to assist individuals experiencing a crisis including the national 988 Suicide & Crisis Lifeline, the PA Crisis

Text Line (text HOME to 741741 or chat at www.crisistextline.org), and the emergency department at local hospitals. Pathway to Care and Recovery is also available (call or walk in) for a drug and alcohol crisis.

Drug & Alcohol Services

According to DHS, access to drug & alcohol services begins with a standard assessment tool referred to as a Level of Care Assessment (LOCA), along with a formal clinical assessment/evaluation, which is completed through one of four (there were five during our audit period) Certified Assessment Centers (CAC) or through any drug & alcohol provider. This assessment determines the best type of treatment for the client. The best way for an individual to get immediate help is to contact Pathway to Care and Recovery (Pathway), which is a CAC that is open 24/7/365. Pathway is available in-person or over the phone and staff can assist in drug and alcohol crisis situations, complete the LOCA, and locate a provider. If a client walks into the DHS office asking for help, DHS will have a brief meeting with the client and call Pathway, who may come to DHS to take the client over to the Pathway to Recovery Center that is located nearby.

Once the LOCA is completed, a provider is found for the client who can deliver the recommended level of care from the assessment. As mentioned above, the client chooses the service and the provider from which they receive service. According to DHS management, they never force a client to choose a specific provider. In some cases, clients have previous experience with a certain provider, so a CAC or other provider may look there first for availability. If the client does not have a preference, the provider will suggest the best option for the client.

Mental Health Services

DHS indicated that the mental health treatment system does not have an equivalent universal level of care assessment as the substance use treatment system. For mental health, this assessment is conducted by a mental health professional, however, the level of care assessments in the mental health system vary by provider. The level of care determination is based on the clinical information provided as part of the assessment. Based on the information gathered in the assessment, the assessing clinician may determine that a person has needs that would not be best treated by the level of care their program or organization provides and can direct the person to or directly connect them with another program or organization. This approach in mental health emphasizes coordination between providers and programs, aims to ensure that individuals receive appropriate services no matter where they initially sought help, and tries to empower individuals to make decisions about their care.

Monitoring and Evaluation

According to DHS, multiple entities are involved with monitoring the mental health and drug & alcohol services administered by DHS. The regional office of the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) conducts a quarterly oversight monitoring visit with DHS OBH and CCBH. The PA DDAP completes annual monitoring to assess programmatic

and fiscal compliance with the grant. Staff in the County DHS Bureau of Mental Health Services (BMHS), Bureau of Drug and Alcohol Services (BDAS), and the Office of Analytics, Technology, and Planning (ATP) also perform monitoring and review activities. For example, the BMHS attends annual licensing visits with OMHSAS and reviews provider spending during quarterly budget meetings, and the BDAS completes annual monitoring using standardized tools to ensure providers' contract compliance. In addition, DHS management stated that they perform general monitoring activities. For example, staff will review and respond to incidents and Director's Action Line complaints, monitor client progress, and review complex cases. DHS also utilizes a variety of analyses, reports, and dashboards to evaluate providers' effectiveness and review program outcomes such as the number of people served, lengths of stay, and transitions in care.

DHS Base-Funded Services

As mentioned above, our procedures focused on the base-funded services since CCBH, not DHS, contracts with the providers for Medicaid-funded services under the HealthChoices Behavioral Health Program. DHS provided information on the base-funded services it administers, as well as data on the number of clients served by service name and provider. Based on the data provided by DHS, clients are directly served through 17 general mental health services and 12 general drug & alcohol services. Schedule II, beginning on page 29, shows the number of unique mental health and drug & alcohol base-funded clients served by general service and provider for FY 23/24 and for the period July 1, 2024 through December 31, 2024. Schedule III, beginning on page 36, provides a brief description of these services. These broad categories may include numerous sub-services (due to an extensive number of sub-services, these descriptions were not included in the Schedule).

II. Objectives, Scope, and Methodology

Objectives

Our objectives were to:

- Ensure that DHS is adhering to key regulations as well as internal policies and procedures related to mental health and drug and alcohol services.
- Evaluate DHS's practices surrounding mental health and drug & alcohol providers.
- Evaluate key staffing vacancies and provider monitoring.
- Review outcome measures and analyze performance data to assess program effectiveness.

Scope

Our audit procedures covered the period July 1, 2023 through December 31, 2024. We conducted our audit in accordance with *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Methodology

Methodologies used to accomplish our objectives included, but were not limited to, the following:

- Interviewed personnel from DHS to gain an understanding of the processes involved in providing mental health and drug & alcohol services in Allegheny County, including internal controls deemed significant within the context of our objectives. Any significant findings related to internal control are included in the findings and recommendations section of the report.
- Reviewed and evaluated policies, procedures, reports, regulations, best practices, studies, and other relevant documents associated with mental health and drug & alcohol services.
- Obtained information regarding the types of data maintained by DHS related to mental health and drug & alcohol services.
- Analyzed data and statistics related to individuals served through mental health and drug & alcohol programs as well as the amount paid for those services.

II. Objectives, Scope, and Methodology

- Reviewed and evaluated policies and procedures as well as provider contracts related to provider billings for client services.

- Tested a sample of provider invoices to verify the fee-for-service rates paid on the invoice agreed to the provider's contract rate or verified the amount paid for program-funded services agreed to supporting documentation. The sample invoices were haphazardly selected from the JDE accounting records.

- Reviewed and evaluated information provided by DHS relating to waitlists for mental health and drug & alcohol services.

- Analyzed waitlist data and statistics managed by DHS for base-funded clients.

- Examined OBH staffing vacancies related to mental health and drug & alcohol offices.

- Reviewed processes, procedures, and reports surrounding provider monitoring.

- Tested monitoring records maintained by DHS for a judgmentally selected sample of providers services.

- Examined outcomes used by DHS to evaluate mental health and drug & alcohol providers.

III. Findings and Recommendations

Finding #1
DHS Pays Certain Claims at the Community Care Behavioral Health Rate Instead of the Contract Rate

Criteria: According to DHS's Provider Payment Provisions, DHS is to pay service providers according to the rate schedule included in the allocation statement of the contract. Fee-for-service reimbursements include a rate and a unit component.

Condition: We tested 15 fee-for-service vouchers, consisting of 99 provider sub-service rates. For 75 (76%) of these 99 rates, the invoiced rate agreed to the contract rate. However, for the remaining 24 (24%) rates, the invoice rate did not agree to the DHS contract rate.

We were told by DHS management that the claims data for these entries was submitted though CCBH. If a provider submits a claim to CCBH, but it is not approved, CCBH may send that claim to DHS instead of sending it back to the provider. When this occurs, the claims data includes CCBH's rate, which can be different than the County contract rate. DHS opted to pay these invoices using the CCBH rate. However, the providers' contracts do not include a provision that DHS may pay certain claims at the prevailing CCBH rates.

A total of six drug and alcohol providers were paid for 24 sub-services based on rates that were not included in the contract. DHS provided documentation that the rate paid was a CCBH rate. The table below summarizes the rate differences identified for each provider, including the American Society for Addiction Medicine (ASAM) service and the contract sub-service.

III. Findings and Recommendations

Summary of Providers Paid CCBH Rates Instead of Contract Rates

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #1 ASAM Level 1.0 Outpatient Service					
Individual Psychotherapy (16-37 minutes)	$54.58	$51.98	$2.60	133	$345.80
Individual Psychotherapy (16-37 minutes)	$45.00	$51.98	($6.98)	1	($6.98)
Individual Psychotherapy (38-52 minutes)	$90.96	$86.63	$4.33	10	$43.30
Individual Psychotherapy (53-74 minutes)	$128.73	$122.60	$6.13	52	$318.76
Individual Psychotherapy (75+ minutes)	$144.07	$137.21	$6.86	1	$6.86
Methadone Maintenance-Clinic Visit	$13.65	$13.00	$ .65	1,323	$859.95
Methadone Maintenance-Comprehensive Services	$141.75	$135.00	$6.75	585	$3,948.75
Methadone Maintenance-Take Home	$13.65	$13.00	$ .65	1,280	$832.00
Total Variance					**$6,348.44**

III. Findings and Recommendations

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #2 ASAM Level 1.0 Outpatient Service					
Individual Psychotherapy (16-37 Minutes)	$54.58	$51.98	$2.60	7	$18.20
Individual Psychotherapy (38-52 Minutes)	$90.96	$86.63	$4.33	6	$25.98
Individual Psychotherapy (53-74 Minutes)	$128.73	$122.60	$6.13	13	$79.69
Ambulatory Detox	$27.50	$51.50	($24.00)	2	($48.00)
Methadone Maintenance-Clinic Visit	$13.65	$13.00	$ .65	175	$113.75
Methadone Maintenance-Comprehensive Services	$141.75	$135.00	$6.75	94	$634.50
Methadone Maintenance-Take Home	$13.65	$13.00	$ .65	176	$114.40
Total Variance					**$938.52**

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #3 ASAM Level 2.1 Intensive Outpatient Service					
Buprenorphine Maintenance	$161.22	$146.56	$14.66	10	$146.60
Individual Psychotherapy (53-74 minutes)	$128.73	$122.60	$6.13	2	$12.26
Intensive Outpatient	$11.00	$10.00	$1.00	461	$461.00
Total Variance					**$619.86**

III. Findings and Recommendations

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #4 ASAM Level 2.1 Intensive Outpatient Service					
Buprenorphine Induction	$375.72	$341.56	$34.16	2	$68.32
Individual Psychotherapy (16-37 Minutes)	$54.58	$51.98	$2.60	1	$2.60
Individual Psychotherapy (53-74 Minutes)	$128.73	$122.60	$6.13	4	$24.52
Total Variance					**$95.44**

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #5 ASAM Level 3.5 Clinically Managed Residential Services					
Clinically Managed Residential Services Adult (ID: H2036)	$224.83	$245.04	($20.21)	6	($121.26)
Clinically Managed Residential Services Adult (ID: H2036U8)	$224.83	$234.00	($9.17)	66	($605.22)
Total Variance					**($726.48)**

III. Findings and Recommendations

Sub-Service Provided	Invoice Rate Paid	Contract Rate	Rate Difference	Number of Units	Total Variance
Provider #6 ASAM Level 3.5 Clinically Managed Residential Services					
Clinically Managed Residential Services Adult (ID: H2036U3)	$268.77	$306.00	($37.23)	109	($4,058.07)
Total Variance					**($4,058.07)**

Source: Provider invoices and contracts

Overall, of the 24 provider services listed above, 19 were paid more than the contract rate by $8,057.24 and five were paid less than the contract rate by $4,839.53, resulting in a net variance of $3,217.71 between the amount paid and the contract rate.

Cause: According to DHS, management made a business decision to pay these claims at the CCBH rates instead of the DHS contract rate. However, DHS is unable to provide documentation to support when this decision was made, who authorized this change, or why the provider contracts were not amended to reflect the change.

Effect: The current practice leads to payment variances based on the way the claims data is submitted to DHS. These variances could result in disputes between DHS and the providers or create incentives for providers to improperly file payment claims through CCBH instead of directly filing them through DHS.

Recommendations: We recommend that DHS implement the following recommendations:

- Evaluate the current practice of processing and paying certain claims at CCBH rates versus contract rates to determine if this practice should be continued.
- If the current practice is continued,
    - DHS should amend provider contracts to include all rates that can be paid to the provider. If DHS intends to pay a provider various rates for the same service, the contract should explicitly identify the circumstances surrounding the use of each rate.

- DHS should also maintain records to support the rationalization of a variable-rate system and document the authorization of the above decision.

Management's Response: The response from the Director of Human Services begins on page 42.

III. Findings and Recommendations

Finding #2
DHS Did Not Provide Documentation to Support Certain Provider Rates

Criteria: Good financial management and procurement practices require that payments for the same services be consistent unless differences are supported by documented factors such as provider qualifications, service location costs, or other approved criteria.

Condition: Our review of provider contracts found that DHS pays different rates to various providers for the same behavioral health sub-services.

Various Rates Paid to Providers for the Same Sub-Service

We requested documentation from DHS management for how they determined the contract rates for 121 provider sub-services among eight providers (a rate is counted multiple times if it appears under more than one provider, or if a provider has more than one rate for the sub-service). DHS provided documentation to show that 14 of the 121 contract rates were properly set according to a federal agency requirement, leaving 107 provider sub-service contract rates that required further explanation.

According to DHS, it considers whether base funds are available to increase contract rates to match CCBH's rates for mental health treatment services. Recently, DHS has not had Block Grant funding to match rates across the board, so many rates remain the same as a prior year CCBH rate. Increases to match CCBH rates are typically directed at priority services and providers. For example, DHS said it increased rates for Family-Based Mental Health Services providers who participated in a DHS program to attract new employees. For drug & alcohol services, DHS indicated that during our audit period, their practice was to pay base-funded provider treatment claims at the CCBH rate (less any third-party insurer contributions). DHS management stated that after the audit period, they have begun to develop new policies and procedures related to the OBH rate setting process for base-funded drug & alcohol services.

According to CCBH's Provider Rate Setting Policy provided by DHS, CCBH publishes base fee schedules for most services, but may individually negotiate rates with providers for certain services. DHS provided us with Excel files listing the CCBH Base Fee Schedule and the CCBH Negotiated Rates as support for the determination of the contract rates. For mental health, we received the Base Fee Schedule for January 2023 and June 2023,

and the Negotiated Rates for January 2022, January 2023, and June 2023. For drug & alcohol, we received the Base Fee Schedule and the Negotiated Rates for June 2023.

We compared the provider sub-service contract rates to the CCBH Base Fee Schedule and to the Negotiated Rate files provided by DHS for the 107 provider sub-service rates. Overall, we agreed 57 (53%) contract rates to a CCBH rate, but could not agree the other 50 rates (47%). Specifically, 41 contract rates did not agree with any of the CCBH rates provided by DHS, and we could not find nine provider sub-services contract rates in any of the CCBH rate files provided by DHS. The table below details the results of our comparison.

Provider Sub-Service Contract Rates Compared to CCBH Base Fee and Negotiated Rates

	Number of Provider Sub-Service Contract Rates:			
	Tested	Agree to CCBH Rate	Does Not Agree to CCBH Rate	Not Found in CCBH Rate Files
Mental Health Providers	88	54	27	7
Drug & Alcohol Providers	19	3	14	2
Total	107	57	41	9

Source: Provider contacts and CCBH Base and Negotiated Rates provided by DHS

Provider Sub-Service Contract Rates with Significant Differences

We also selected three sub-services with a significant difference between the providers' contract rates. We compared the providers' sub-service contract rates to the CCBH Base Fee Schedule and to the Negotiated Rate provided by DHS. Our analysis found the following:

For the MH Outpatient sub-service Long-Term Structured Residential Adult Outpatient, there are eight provider contract rates. All eight rates are different and range from $260.37 to $428.72 (a difference of $168.35). The CCBH Base Fee Schedule shows that this is a negotiated rate.

- Seven of the contract rates agreed to the CCBH Negotiated Rate, and
- One of the contract rates did not agree to the CCBH Negotiated Rate.

For the D&A Medically Monitored Short Term Residential Treatment Services sub-service ID T2048, there are seven provider contract rates. Of these seven rates, six of these rates are different and range from $170.50 to $297.43 (a difference of $126.93). The CCBH Base Fee Schedule shows this is a negotiated rate.

- Two of the contract rates agreed to the CCBH Negotiated Rate,
- Three of the contract rates did not agree to the CCBH Negotiated Rate, and
- Two contract rates were not included in the CCBH Negotiated Rates.

For the D&A Medically Monitored Short Term Residential Treatment Services sub-service ID H2036U3, there are three provider contract rates. Of these three rates, two of the rates are different and range from $234.00 to $306.00 (a difference of $72.00). The Base Fee Schedule shows this is a negotiated rate.

- None of the three contract rates agree to the CCBH Negotiated Rate.

Although DHS provided the CCBH rates utilized in its rate-setting process, we could not agree all the sampled provider sub-service contract rates back to the CCBH rates. DHS did not provide documentation to show if the rate was an older rate, or if there is another reason for the difference.

Cause: DHS uses CCBH base and negotiated rates as part of its rate-setting process, however, other factors affect the sub-service contract rates set by DHS for base-funded providers as noted in the condition.

Effect: Paying different rates for identical services without thoroughly documenting the rationale for each rate reduces transparency in the process, increases the risk of inequitable treatment of providers, and may give the appearance that the process is not impartial.

Recommendations: We recommend that DHS formally document its rate-setting policy for all mental health and drug & alcohol services. The policy documentation requirements should include a comprehensive list of all provider rates, the source of these rates, the reason for increasing (or not increasing) to the CCBH rate, the reason for any variation from the standard rate, as well as support for any variations should be consistently documented.

Management's Response: The response from the Director of Human Services begins on page 42.

III. Findings and Recommendations

Finding #3
DHS Does Not Require Detailed Supporting Documentation for Invoices from Program-Funded Providers

Criteria: According to DHS's Payment Provisions for contracted service providers, program-funded providers are reimbursed by DHS for all or a portion of the cost to operate the service provided. The provider is required to submit a budget for each service and maintain accounting records to permit comparison between budgeted and actual activity. Providers are also required to enter billings into DHS's MPER system and submit a report of costs and revenues by service category for each service provided to DHS. The reimbursement shall be the audited, actual costs for the services actually provided. If the audited actual costs are less than the amount already reimbursed, DHS will recoup the difference.

Condition: According to DHS management, the policy requiring providers to submit financial reports to support the amount billed was not consistently enforced during our audit period. We tested 12 program-funded service vouchers paid to 10 different providers and requested documentation from DHS to support the amount paid to the provider. For five of the 12 (42%) vouchers tested, the support did not clearly identify the amount paid. When we inquired with DHS management about the support, they had to perform additional research or follow up with the providers. DHS was ultimately able to provide records supporting the amount paid for all 12 vouchers.

During our review of the program-funded service vouchers, it was noted that providers only submit an internal financial report (e.g. income statement, trial balance) as supporting documentation for the amount to be paid. These internal reports did not include detailed transaction-level records or adequate evidence of provider costs for the services rendered. DHS does not universally require providers to submit any source documents with the monthly billing, such as utility bills, rent payment, or other receipts, to substantiate the amounts on the internal financial reports (if specific grant provisions require this documentation, DHS will obtain the records from the provider).

Alternatively, DHS performs compliance reviews that include testing source documents. However, according to management, this division does not have the resources to annually review every provider, so there may be several years between reviews for certain providers. DHS indicated that compliance reviews were completed in either 2024 or 2025 for seven of the

10 (70%) providers. Due to staffing constraints, the remaining three providers (30%) have not been reviewed since either 2018, 2019, or 2022.

Cause: DHS's Payment Provisions do not require providers to submit detailed support for the amounts, such as receipts to match line items, identified in the provider's internal financial reports. Instead, DHS accepts these internal reports as sufficient supporting documentation.

Effect: Without adequate supporting documentation, DHS cannot verify that invoiced costs are accurate and in compliance with contract terms and program requirements. This also increases the risk of paying unallowable costs and reduces the ability to detect and prevent fraud, waste and abuse.

Recommendations: We recommend that DHS implement the following recommendations:

- Consistently require program-funded providers to submit financial reports with every invoice. The reports should clearly identify the amounts that agree to the invoice total.

- Develop and implement a policy requiring program-funded providers to submit source documents or receipts for all expenses on their monthly invoice for a specified number of sample months during the fiscal year.

Management's Response: The response from the Director of Human Services begins on page 42.

III. Findings and Recommendations

Finding #4
DHS Does Not Request Waitlists for Certain Mental Health Services

Criteria: Best practices in case management and administrative oversight require that client service waitlists be kept up-to-date, accurate, and regularly reviewed to ensure timely access to care. The SAMHSA (Substance Abuse and Mental Health Services Administration) also emphasizes prompt access to services and the elimination of administrative barriers.

Condition: During the audit, we requested a list of individuals on the waitlist for each mental health service. However, DHS does not have policies and procedures requiring providers to maintain and report waitlist data for each mental health service it provides.

Waitlist Management

According to DHS, centralized referral list and waitlist management only occurs for certain mental health services, all other mental health services' referral lists and wait times are managed directly by the providers. DHS identified 17 base-funded mental health services for fiscal year July 2023 through June 2024 (FY 23/24), where data on the specific clients utilizing the service is maintained (see Schedule II). Of these 17 services, DHS could only provide waitlist information for four services (24%):

- DHS manages the waitlist for one service (6%), Community Residential Services (CRS).
- CCBH manages waitlists and provides detailed information (including client ID number, referral date, and placement date) to DHS for two services (12%), Assertive Community Treatment/Community Treatment Team and Targeted Case Management.
- DHS receives client waitlist information from individual service providers for one service (6%), Family-Based Mental Health Services.

DHS did not provide us with waitlist information for the remaining 13 services (76%). This includes Administrative Management, Community Employment & Employment-related Services, Consumer Driven Services, Family Support Services, Housing Support Services, Mental Health Crisis

Intervention, Outpatient, Partial Hospitalization, Peer Support Services, Psychiatric Inpatient Hospital, Psychiatric Rehabilitation, and Social Rehabilitation Services. DHS management told us that if they are made aware of any issues accessing services, they can request information from providers, but there are no standardized reporting requirements.

We asked DHS management if they could obtain the number of individuals on the waitlist as of December 31, 2024, for three mental health services: Housing Support, Outpatient, and Transitional & Community Integration Services. DHS did not provide this information. We also asked DHS management how they ensure that they have enough providers to meet clients' needs if they do not have waitlist data. They stated that they manage and assess system capacity in other ways depending on the type of service (e.g. review of contract allocation increase requests and contact with providers through monitoring activities, reviews, technical assistance, and incident reports). DHS management also indicated that waitlists may not be the most relevant tool to assess system capacity. For example, certain expenses under Transitional & Community Integration Services are for staffing-related services, and some of the services under Housing Support Services relate to the CRS waitlists identified above. Additionally, DHS also said the majority of County outpatient services are covered through the Behavioral HealthChoices program, and base funding is the last resort. Based on the client data provided by DHS, more than 1,700 base-funded clients received MH outpatient services during FY 23/24. In general, there is a shortage of outpatient service providers across the country. DHS management said they don't expect to be able to cover service costs for all uninsured or underinsured clients, but they will consider requests for additional funding for providers that offer outpatient services.

Although factors outside of wait times may be reviewed to assess capacity, for certain services, particularly outpatient services, a centralized waitlist system could be valuable when there are known capacity shortages and potentially long wait times for services. The lack of a centralized waitlist system requires patients to navigate waitlists across different providers on their own, which can lead to frustration or a reduction in motivation to receive treatment. Patients may also sign up with multiple providers in an attempt to reduce their wait time, which can lead to a higher 'no-show' rate, wasting resources that could be used by other patients.

Community Residential Services (Adult) Waitlist

We analyzed the details of the CRS waitlist managed by DHS. The file provided by DHS contained information on all the individuals on the waitlist as of specific dates. This included the referral date, which reflects the date the referral was initiated in the system by the referral source.

However, the individual is not included on the actual waitlist until the referral source completes any required documentation, submits the referral, and the referral is approved. The delays identified below are based on the referral date, not the approval date. As of:

- June 30, 2023, there were approximately 111 people awaiting services, with records indicating delays exceeding 800 days.
- June 30, 2024, there were approximately 81 people awaiting services, with records indicating delays exceeding over 1,900 days.
- December 31, 2024, there were 58 people awaiting services, with records indicating delays exceeding over 2,100 days.

According to data provided by DHS, a total of 329 unique clients were served through Community Residential Services during June 2024. As of June 30, 2024, there were 81 people waiting for a residential bed, or 25% of the number of clients served during the month. According to DHS, some of these individuals may have chosen to remain on the wait list. For instance, they were offered a bed, but preferred to wait for a different provider, location, or accommodation. Although there may be a reason why some individuals have remained on the waitlist, there are not enough CRS providers to accommodate all individuals waiting for service. DHS is in the process of redesigning the assessment process for these residential services to ensure the scarce resources are allocated to the most vulnerable clients. DHS management also said that while an individual is waiting for a bed, they are typically receiving other treatment, and DHS works to connect them with other services to support their behavioral health needs.

Further review of the CRS waitlist documentation identified 86 individuals that were removed from the waitlist but were not placed with a service provider. According to DHS, there are several reasons the referral is closed without placement. For example, the individual found other housing, withdrew or is no longer interested, is not ready, cannot be located, or the required level of care changed.

In addition, we found that the referral date can be changed for various reasons including if the required level of care changes or if a new case manager is assigned to the client. We identified five clients where the referral date was changed. One changed because the level of care changed. However, for the other four clients, DHS indicated that the 'case management system user' changed the date, but did not provide a reason why the date was changed.

Cause: DHS has not implemented policies or procedures requiring providers to maintain and report detailed waitlist information. As a result, DHS does

not require a routine internal review of provider-maintained waitlist data for all mental health services.

Effect: De-centralized waitlist management can result in clients experiencing delays in accessing necessary mental health care, which can potentially worsen their condition. In addition, delayed treatment could result in the need for more acute care, resulting in higher long-term costs. When waitlist information is only maintained at the individual provider level, waitlists may contain duplicate or outdated data, inflating the need for services and further increasing service delays. Furthermore, resource planning and funding decisions may be made based on unreliable or incomplete data.

Recommendations: We recommend that DHS develop and implement policies and procedures requiring routine, consistent reporting of waitlist data for all mental health services. Provider waitlist data should be submitted using standardized templates, should be verified and analyzed, and inactive or ineligible clients should be removed to ensure waitlists are accurate.

Management's Response: The response from the Director of Human Services begins on page 42.

III. Findings and Recommendations

Finding #5
DHS's Office of Behavioral Health is Not Fully Staffed

Criteria: Best practices for public behavioral health agencies recommend adequate staffing levels to ensure timely services delivery, effective oversight of contracted providers, and compliance with regulatory requirements.

Condition: Our review of OBH mental health, drug & alcohol, and general/program operation staff positions (excluding staff in the MATP group) totaled 87 positions as of December 31, 2024. Of these 87 positions, 61 (70%) positions were filled and 26 (30%) remained unfilled. Of the 61 filled positions, 40 were County hires and the remaining 21 positions were filled through a contracted agency. The 26 vacant positions included:

County Positions
- Administrative Assistant 1 and 2,
- MH Program Specialist 1 and 2,
- Caseworker 1 and 2,
- Clerk 3,
- Clerk Typist 2 and 3, and
- Single County Authority D&A Program Representative.

Contracted Agency Positions
- BH Monitoring & Evaluation Analyst,
- Office Assistant,
- Pharmacy/Benefit Program Specialist,
- Program Development Coordinator,
- Program Fiscal Specialist,
- Program Specialist, and
- Senior Manager BH Planning.

DHS's Office of Behavioral Health is operating with staffing levels significantly below the number of available positions. Several key positions remain vacant for extended periods (one year or longer). For example, only three of the nine Program Specialist positions were filled at December 31, 2024. By the end of January 2025, only one of the nine positions was filled. This is an important job that is responsible for monitoring and providing technical assistance for assigned adult mental health programs. This role ensures services are delivered in accordance with state regulations, county policies, and established contracts. This position also plays a role in policy development and problem solving related to behavioral health services. In

addition, the Director of OBH position has been vacant for eight months now, and the position is still unfilled.

We requested an update as of August 25, 2025, and there are still 25 unfilled positions.

Cause: Staffing shortages could be the result of challenges in recruiting qualified candidates and budgetary constraints limiting the ability to offer competitive salaries.

Effect: When staffing shortages occur, it can create increased workloads for existing staff. Understaffing could also result in delayed program monitoring and slower response times for client requests which could negatively impact services for individuals in need of behavioral health services.

Recommendations: DHS should prioritize filling vacant positions with the Office of Behavioral Health by reviewing the recruitment process and compensation structures to remain competitive.

Management's Response: The response from the Director of Human Services begins on page 42.

IV. Conclusion

Overall, the results of our audit suggest that the Department of Human Services' (DHS) Office of Behavioral Health (OBH) operations relating to mental health and drug & alcohol services need improvement. The audit identified several concerns within DHS. First, DHS paid certain claims at the Community Care Behavioral Health (CCBH) rate rather than the established contract rate. This current practice leads to payment variances which can result in disputes between DHS and providers.

Additionally, DHS was unable to provide sufficient documentation to support certain provider rates. This reduces transparency and increases the risk of inequitable treatment of providers.

It was also noted that DHS does not require detailed supporting documentation for invoices submitted by program-funded providers. Without adequate supporting documentation, DHS cannot verify that invoiced costs are accurate and in compliance with contract terms and program requirements.

Furthermore, DHS does not request or maintain waitlists for certain mental health services, which limits oversight of service demand. It can also result in clients experiencing delays in accessing necessary mental health care, which can potentially worsen their condition.

Lastly, OBH is not fully staffed, potentially affecting both staff workloads and program oversight.

If DHS addresses the conditions that we have identified, which can be accomplished by implementing the recommendations we have offered, it will likely improve the various program operations.

Schedule I

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Base-Funded Expenditures by Provider for Fiscal Year July 1, 2023 through June 30, 2024

	Provider	FY 23/24 MH Block Grant	FY 23/24 D&A Block Grant	FY 23/24 D&A Activities	Total FY 23/24 Base-Funded Expenditures
1	AHEDD	$ 35,109.00		$ -	$ 35,109.00
2	Allegheny Children's Initiative	$ 256,398.81		$ 159,659.39	$ 416,058.20
3	Allegheny Family Network	$ 615,475.48			$ 615,475.48
4	Alliance For Infants And Toddlers	$ 75,000.00			$ 75,000.00
5	Alpha House Incorporation			$ 28,571.24	$ 28,571.24
6	Auberle Home	$ -		$ 33,861.00	$ 33,861.00
7	Bethlehem Haven	$ 348,841.00			$ 348,841.00
8	Case Western Reserve University	$ 15,900.00			$ 15,900.00
9	Community Care Behavioral Health Organization	$ 55,000.00		$ 810,000.00	$ 865,000.00
10	Center For Hearing And Deaf Services	$ 2,725.00			$ 2,725.00
11	Center For Victims	$ 36,000.00			$ 36,000.00
12	Central Outreach Resource And Referral Center			$ 242,187.59	$ 242,187.59
13	Chartiers MH/MR Center	$ 2,979,749.49		$ 1,148.73	$ 2,980,898.22
14	Children's Institute Of Pittsburgh			$ 25,679.59	$ 25,679.59
15	Community Human Services Corp	$ 2,105,542.08		$ 1,609,059.88	$ 3,714,601.96
16	Deloitte Consulting	$ 133,072.16			$ 133,072.16
17	Diversified Care Management LLC	$ 1,275,347.59			$ 1,275,347.59
18	East End Co-Op Ministry			$ 874,526.00	$ 874,526.00
19	Every Child Incorporation	$ 2,739.72			$ 2,739.72
20	Family Links Incorporation	$ 882,225.31		$ 133,080.00	$ 1,015,305.31
21	Fayette Resources Incorporation	$ 2,000,000.00			$ 2,000,000.00
22	First Choice Answering Service	$ 15,400.00			$ 15,400.00
23	Gaiser Addiction Center		$ 7,267.05	$ 27,614.79	$ 34,881.84
24	Gateway Rehabilitation Center			$ 1,221,673.43	$ 1,221,673.43
25	Heuer House			$ 142,380.00	$ 142,380.00
26	Highland House			$ 2,750.80	$ 2,750.80
27	Human Services Admin Organization	$ 6,275,962.47		$ 2,223,348.04	$ 8,499,310.51
28	Jade Wellness Center			$ 148,786.19	$ 148,786.19
29	Jewish Family & Children's Services Of Pittsburgh	$ 260,915.95			$ 260,915.95
30	Jewish Residential Services Incorporation	$ 351,474.42			$ 351,474.42
31	Keystone Human Services North	$ 1,180,000.00			$ 1,180,000.00
32	Light of Life (L2) Community Support	$ 110,000.00			$ 110,000.00
33	Merakey Pennsylvania	$ 1,782,169.58			$ 1,782,169.58
34	Mercy Life Center Corp DBA Mercy Behavioral Health	$ 18,856,391.90	$ 4,520.84	$ 75,567.66	$ 18,936,480.40
35	Milestone Centers Incorporation	$ 2,491,546.71			$ 2,491,546.71
36	Mon Yough Community Services Incorporation	$ 4,397,999.76	$ 957.85	$ 153,037.70	$ 4,551,995.31
37	Nami Keystone Pennsylvania	$ 1,113,000.00			$ 1,113,000.00
38	Onala Recovery Center Incorporation			$ 315,000.00	$ 315,000.00
39	Optum Rx PBM Of Maryland Incorporation	$ 215,821.56			$ 215,821.56
40	Pa Organization Women In Early			$ 571,947.76	$ 571,947.76
41	Passages To Recovery Incorporation			$ 699,908.94	$ 699,908.94
42	Passavant Memorial Homes	$ 481,000.00			$ 481,000.00
43	Peer Support And Advocacy Network	$ 1,177,004.06			$ 1,177,004.06
44	Peoples Oakland	$ 525,000.00			$ 525,000.00
45	Persad Center Incorporation	$ 80,000.00			$ 80,000.00
46	PLEA	$ 173,000.00			$ 173,000.00
47	Pressley Ridge	$ 80,756.63			$ 80,756.63
48	Prevention Point Pittsburgh			$ 799,581.02	$ 799,581.02

Schedule I

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Base-Funded Expenditures by Provider for Fiscal Year July 1, 2023 through June 30, 2024

	Provider	FY 23/24 MH Block Grant	FY 23/24 D&A Block Grant	FY 23/24 D&A Activities	Total FY 23/24 Base-Funded Expenditures
49	Pyramid Healthcare Incorporation			$ 679,279.20	$ 679,279.20
50	Renewal Incorporation			$ 400,000.00	$ 400,000.00
51	Residential Care Services Incorporation	$ 4,843,000.00			$ 4,843,000.00
52	Resources For Human	$ 1,560,355.51		$ 62,278.20	$ 1,622,633.71
53	Salvation Army			$ 169,554.11	$ 169,554.11
54	Social Data Analytics LLC	$ 77,300.00			$ 77,300.00
55	Sojourner House			$ 15,560.00	$ 15,560.00
56	Sojourner House Moms			$ 180,000.00	$ 180,000.00
57	Tadiso Incorporation			$ 1,262,983.56	$ 1,262,983.56
58	Three Rivers Youth	$ 125,000.00		$ 337,508.96	$ 462,508.96
59	Transitional Services	$ 3,733,000.00			$ 3,733,000.00
60	Travelers Aid Society Of Pittsburgh			$ 117,237.66	$ 117,237.66
61	Treasurer Of Allegheny County (County Jail)	$ 3,668,837.70		$ 250,000.00	$ 3,918,837.70
62	Turtle Creek Valley MH/MR	$ 2,400,029.18		$ 485,978.54	$ 2,886,007.72
63	University Of Pittsburgh			$ 310,479.54	$ 310,479.54
64	UPMC McKeesport			$ 7,232.00	$ 7,232.00
65	UPMC Mercy			$ 65,521.17	$ 65,521.17
66	UPMC Presbyterian Shadyside	$ 7,459,709.57	$ 5,831.50	$ 895,462.99	$ 8,361,004.06
67	University Of Pittsburgh Physicians			$ 55,800.00	$ 55,800.00
68	Valley Medical Facilities Incorporation	$ 932,364.04			$ 932,364.04
69	Vataha, John DBA Actuarial Solutions LLC	$ 27,600.00			$ 27,600.00
70	Wesley Family Services	$ 1,701,859.37			$ 1,701,859.37
71	White Deer Run			$ 717,936.25	$ 717,936.25
72	YMCA Of Pittsburgh	$ 60,049.00			$ 60,049.00
73	Zakiyah House Housing			$ 199,860.00	$ 199,860.00
	Shared Admin Home Cost Center (Note)	$ 221,004.63			$ 221,004.63
	Behavioral Health Home Cost Center Allocation (Note)	$ 9,464,676.32		$ 4,857,248.66	$ 14,321,924.98
	Redistributions	$ (463,179.22)			$ (463,179.22)
	Reclass Entry		$ 1,569,878.00	$ (1,569,878.00)	$ -
	Totals:	**$ 86,198,174.78**	**$ 1,588,455.24**	**$ 19,799,412.59**	**$ 107,586,042.61**

Note: Home Cost Center (HCC) allocations are DHS administrative costs that get fairly allocated to the different accounting job numbers.

Source: DHS and the Allegheny County JDE Accounting System

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
	Mental Health (MH) Services and Providers		
1	**Administrative Management**		
	AHEDD Inc.	151	66
	Allegheny Children's Initiative	178	189
	Chartiers MH MR Center Inc.	577	367
	Family Links	184	152
	Human Services Administrative Organization	879	291
	Mercy Life Center Corporation	1,170	790
	Milestone Centers Inc.	350	100
	Mon Yough Community Services Inc.	695	328
	Pressley Ridge	179	69
	Turtle Creek Valley MH MR Inc.	402	158
	UPMC Western Psychiatric Hospital	920	789
	Valley Medical Facilities Inc.	1,079	745
	Wesley Family Services	313	108
	Total	**7,077**	**4,152**
2	**Assertive Community Treatment (ACT) and Community Treatment Team (CTT)**		
	Mercy Life Center Corporation	84	58
	UPMC Western Psychiatric Hospital	38	27
	Total	**122**	**85**
3	**Community Employment and Employment-Related Services**		
	Mercy Life Center Corporation	171	104
	Mon Yough Community Services Inc.	223	130
	Peoples Oakland Inc.	65	48
	Turtle Creek Valley MH MR Inc.	23	0
	Total	**482**	**282**
4	**Community Residential Services (CRS)**		
	Chartiers MH MR Center Inc.	26	22
	Family Links	1	0
	Keystone Service Systems	9	9
	Merakey	32	33
	Mercy Life Center Corporation	182	147
	Milestone Centers Inc.	48	40
	Mon Yough Community Services Inc.	65	56

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
	Passavant Memorial Homes Inc.	10	8
	Residential Care Services Inc.	110	68
	Resources For Human Development	23	13
	Turtle Creek Valley MH MR Inc.	33	12
	UPMC Western Psychiatric Hospital	22	25
	Wesley Family Services	10	5
	Total	**571**	**438**
5	**Consumer Driven Services**		
	Mercy Life Center Corporation	3	0
	Turtle Creek Valley MH MR Inc.	53	26
	Total	**56**	**26**
6	**Family Support Services**		
	Allegheny Children's Initiative	29	10
	Chartiers MH MR Center Inc.	0	12
	Human Services Administrative Organization	981	634
	Milestone Centers Inc.	13	11
	Mon Yough Community Services Inc.	32	0
	PLEA	15	12
	Pressley Ridge	8	1
	Turtle Creek Valley MH MR Inc.	34	13
	UPMC Western Psychiatric Hospital	154	95
	Total	**1,266**	**788**
7	**Family-Based Mental Health Services**		
	Allegheny Children's Initiative	20	13
	Every Child Inc.	2	2
	Family Links	12	9
	Pressley Ridge	9	2
	UPMC Western Psychiatric Hospital	33	13
	Wesley Family Services	19	6
	Total	**95**	**45**
8	**Housing Support Services**		
	Jewish Residential Services (JRS)	27	19
	Light of Life (L2) Community Support	8	3
	Mercy Life Center Corporation	129	99

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
	Milestone Centers Inc.	15	13
	Mon Yough Community Services Inc.	34	30
	Residential Care Services Inc.	42	28
	Turtle Creek Valley MH MR Inc.	48	40
	UPMC Western Psychiatric Hospital	51	7
	Wesley Family Services	81	58
	Total	**435**	**297**
9	**Mental Health Crisis Intervention**		
	Mercy Life Center Corporation	46	46
	UPMC Western Psychiatric Hospital	3,730	1,715
	Total	**3,776**	**1,761**
10	**Outpatient**		
	Chartiers MH MR Center Inc.	20	6
	Family Links	1	4
	Merakey	5	4
	Mercy Life Center Corporation	909	190
	Milestone Centers Inc.	51	11
	Mon Yough Community Services Inc.	382	184
	Pressley Ridge	1	0
	Resources For Human Development	4	4
	Turtle Creek Valley MH MR Inc.	21	17
	UPMC Western Psychiatric Hospital	302	151
	Wesley Family Services	20	13
	Total	**1,716**	**584**
11	**Partial Hospitalization**		
	Chartiers MH MR Center Inc.	2	1
	Milestone Centers Inc.	2	0
	Turtle Creek Valley MH MR Inc.	4	6
	UPMC Western Psychiatric Hospital	1	0
	Total	**9**	**7**
12	**Peer Support Services**		
	Mercy Life Center Corporation	6	12
	Milestone Centers Inc.	14	0
	Peer Support & Advocacy Network	37	15

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
	Total	**57**	**27**
13	**Psychiatric Inpatient Hospital**		
	UPMC Western Psychiatric Hospital	25	10
	Total	**25**	**10**
14	**Psychiatric Rehabilitation**		
	Chartiers MH MR Center Inc.	4	1
	Jewish Residential Services (JRS)	82	64
	Mercy Life Center Corporation	14	10
	UPMC Western Psychiatric Hospital	25	22
	Wesley Family Services	6	7
	Total	**131**	**104**
15	**Social Rehabilitation Services**		
	Chartiers MH MR Center Inc.	62	48
	Jewish Family And Children's Services Of Pittsburgh	41	37
	Jewish Residential Services (JRS)	124	85
	Mercy Life Center Corporation	673	234
	Milestone Centers Inc.	30	24
	Mon Yough Community Services Inc.	36	30
	Peoples Oakland Inc.	191	166
	PLEA	27	21
	Residential Care Services Inc.	112	102
	Turtle Creek Valley MH MR Inc.	62	32
	Wesley Family Services	41	33
	Total	**1,399**	**812**
16	**Targeted Case Management**		
	Allegheny Children's Initiative	12	10
	Chartiers MH MR Center Inc.	37	25
	Human Services Administrative Organization	29	7
	Mercy Life Center Corporation	336	238
	Milestone Centers Inc.	32	27
	Mon Yough Community Services Inc.	49	0
	Pressley Ridge	16	6
	Turtle Creek Valley MH MR Inc.	35	36
	UPMC Western Psychiatric Hospital	279	174

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served: July 2023 - June 2024	Unique Clients Served: July 2024 - Dec. 2024
	Valley Medical Facilities Inc.	81	52
	Wesley Family Services	44	31
	Total	**950**	**606**
17	**Transitional and Community Integration Services**		
	Diversified Care Management	204	90
	Human Services Administrative Organization	1,602	1,012
	Mercy Life Center Corporation	49	0
	Three Rivers Youth	1,065	542
	Total	**2,920**	**1,644**
	Drug & Alcohol (D&A) Services and Providers		
1	**Halfway House**		
	Gateway Rehabilitation Center	8	4
	Highland House Inc.	1	0
	Pennsylvania Organization For Women In Early Recovery	0	1
	Pyramid Healthcare Inc.	0	4
	Total	**9**	**9**
2	**Intensive Outpatient (IOP)**		
	Gateway Rehabilitation Center	87	57
	Jade Wellness Center	34	18
	Mon Yough Community Services Inc.	11	7
	Pyramid Healthcare Inc.	18	11
	Three Rivers Youth	0	1
	Turtle Creek Valley MH MR Inc.	2	0
	UPMC Western Psychiatric Institute	2	6
	Total	**154**	**100**
3	**Medically Managed Inpatient (IP) Detox**		
	UPMC McKeesport	3	5
	UPMC Mercy	22	12
	Total	**25**	**17**
4	**Medically Managed IP Residential**		
	UPMC McKeesport	0	2

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
	Total	**0**	**2**
5	**Medically Monitored IP Detox**		
	Gateway Rehabilitation Center	151	108
	Pennsylvania Organization For Women In Early Recovery	4	0
	Pyramid Healthcare Inc.	80	62
	White Deer Run LLC	68	47
	Total	**303**	**217**
6	**Medically Monitored Long-Term Residential Treatment**		
	Gateway Rehabilitation Center	9	4
	Total	**9**	**4**
7	**Medically Monitored Short-Term Residential Treatment**		
	Alpha House Inc.	8	8
	Ellen O'Brien Gaiser Addiction Center Inc.	19	9
	Gateway Rehabilitation Center	130	144
	Passages To Recovery Inc.	67	24
	Pennsylvania Organization For Women In Early Recovery	12	0
	Pyramid Healthcare Inc.	100	86
	Resources For Human Development	5	0
	Salvation Army	14	12
	Sojourner Moms	3	0
	White Deer Run LLC	123	105
	Total	**481**	**388**
8	**Outpatient (OP) Drug Free**		
	Chartiers MH MR Center Inc.	1	0
	Gateway Rehabilitation Center	44	47
	Jade Wellness Center	40	31
	Mon Yough Community Services Inc.	42	36
	Pennsylvania Organization For Women In Early Recovery	0	1
	Pyramid Healthcare Inc.	25	21
	Tadiso Inc.	376	306
	Three Rivers Youth	2	1
	Turtle Creek Valley MH MR Inc.	2	0
	UPMC Western Psychiatric Institute	101	89
	Total	**633**	**532**

Schedule II

Allegheny County Department of Human Services
Office of Behavioral Health - Mental Health and Drug Alcohol Services
Number of Base-Funded Clients Served by Service and Provider

Service	Provider Name	Unique Clients Served July 2023 - June 2024	Unique Clients Served July 2024 - Dec. 2024
9	**Other Intervention Services**		
	Mercy Behavioral Health	87	42
	Total	**87**	**42**
10	**Partial D&A / Partial Hospitalization**		
	Gateway Rehabilitation Center	3	0
	Pyramid Healthcare Inc.	3	1
	White Deer Run LLC	6	9
	Total	**12**	**10**
11	**Recovery Housing**		
	East End Cooperative Ministry Inc.	174	81
	Heuer House	46	0
	Jade Wellness Center	22	43
	Zakiyah House Housing	59	37
	Total	**301**	**161**
12	**Service Coordination**		
	Chartiers MH MR Center Inc.	50	14
	Gateway Rehabilitation Center	118	86
	Jade Wellness Center	28	20
	Mon Yough Community Services Inc.	294	211
	Pennsylvania Organization For Women In Early Recovery	57	22
	Pyramid Healthcare Inc.	72	60
	Tadiso Inc.	19	7
	Turtle Creek Valley MH MR Inc.	2	0
	UPMC Western Psychiatric Institute	13	9
	White Deer Run LLC	3	0
	Total	**656**	**429**

Source: Allegheny County Department of Human Services Data

Allegheny County Department of Human Services
Office of Behavioral Health
Mental Health and Drug & Alcohol Client Service Descriptions

Mental Health (MH) Base-Funded Client Services

The Allegheny County mental health base-funded client services include the following:

1. Administrative Management

   This includes activities and administrative functions undertaken by staff to facilitate intake into the county mental health system and ensure the appropriate and timely use of available resources and specialized services to best address the needs of individuals seeking assistance. The purpose is to facilitate and monitor a person's access to mental health services and community resources.

2. Assertive Community Treatment (ACT) Teams / Community Treatment Teams (CTT)

   ACT is a Substance Abuse and Mental Health Services Administration (SAMHSA) recognized Evidence Based Practice (EBP). A multidisciplinary team provides an array of comprehensive services to individuals with a serious mental illness who meet certain eligibility criteria. CTT Services merge clinical treatment, rehabilitation, and varying levels of support based on an individual's need.

3. Community Employment and Employment-Related Services

   This category includes two different types of employment services. First, employment in a community or employment setting combines vocational evaluation, vocational training, and employment in a non-specialized setting such as a business or industry. Second, supported employment is a SAMHSA-recognized EBP which is competitive employment that involves community-based job placements other than sheltered workshops and includes rapid job search and follow-along supports.

4. Community Residential Services (CRS)

   CRS are structured, community-based living arrangements that provide housing and 24-hour support to eligible individuals with mental health needs. The room and board costs associated with the residence are included in this service, however, the individuals may also receive care, treatment, rehabilitation, or other services. This general service category includes: Long-Term Structured Residence (LTSR), Comprehensive Personal Care Home (PCH), 24/7 Supported Housing, Specialized Residences, Community Residential Rehabilitation (CRR) Group Home and Individual Apartment, and Domiciliary Care.

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5. Consumer Driven Services
   This category includes a variety of services that extend beyond social rehabilitation services but do not meet the licensure requirements for psychiatric rehabilitation services. The services are driven by the consumer and prioritize the active involvement of individuals receiving care in the planning, delivery and evaluation of those services.

6. Family Support Services

   These are intensive, team-delivered services provided in the home to families with children at risk of out-of-home placement due to severe emotional or behavioral issues.

7. Family-Based Mental Health Services (FBMHS)

   FBMHS are comprehensive, team delivered in-home services to assist families in caring for their children or adolescents with emotional disturbances. Services are available 24/7 for up to 32 weeks (or longer if medically necessary) and can include mental health treatment, casework services, and family support. This is an Office of Mental Health and Substance Abuse Services (OMHSAS) licensed program.

8. Housing Support Services

   These support services are provided to mental health consumers which enable the recipient to access and retain permanent, decent, affordable housing.

9. Mental Health Crisis Intervention

   These are immediate, crisis-oriented services designed to stabilize adults or children and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations, which threaten the well-being of the individual or others and include intervention, assessment, counseling, screening and disposition services.

10. Outpatient (OP) Mental Health Services

    Outpatient mental health treatment services are delivered by a clinic or a practitioner, in a clinic, in the community (mobile), or by telehealth, to an individual who is not admitted to a hospital, institution, or facility. These services provide assessment/evaluation, diagnosis, and treatment for behavioral health conditions by providing therapy, medication management, and coordinating care plans.

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11. Partial Hospitalization

    These are structured, intensive services provided during the day that do not require overnight hospitalization for individuals with moderate to severe mental illness and children and adolescents with serious emotional disturbance who require more support than outpatient treatment but do not require 24-hour continuous care.

12. Peer Support Services

    Services that provide support to individuals with mental illness from those who have life experience with mental illness (peers) by sharing that experience and by helping them develop coping skills, build their own support network and learn about community resources.

13. Psychiatric Inpatient Hospital (Inpatient Mental Health Services)

    These services involve care in a licensed psychiatric inpatient facility and apply to treatment or services provided to an individual in need of 24-hour a day continuous psychiatric hospitalization.

14. Psychiatric Rehabilitation

    These services assist individuals with long-term psychiatric disabilities in developing, enhancing, and/or retaining psychiatric stability, social competencies, personal and emotional adjustment and/or independent living competencies. The goal is for them to experience more success and satisfaction in the environment of their choice, and function as independently as possible.

15. Social Rehabilitation Services

    This refers to programs or activities designed to teach or improve self-care, personal behavior, and social adjustment for adults with mental illness. The aim is to increase the person's level of social competency and decrease the need for structured supervision in order to make community or independent living possible.

16. Targeted Case Management

    Services are designed to help individual with serious mental illness and children diagnosed with or at risk of serious emotional disturbance gain access to needed medical, social, educational, and other services through natural supports, generic community resources and specialized mental health treatment, rehabilitation and support services. Targeted Case

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Management services are expected to help consumers achieve specific outcomes of independent living, vocational/educational participation, adequate social supports, and reduced hospitalization.

17. Transitional and Community Integration Services

    These services are provided to individuals who reside in a facility or institution as well as individuals who are incarcerated. It can also include diversion programs (for consumers at risk of incarceration or institutionalization), adult outreach services, and homeless outreach services. Services aim to help the individual reintegrate into the community or assist underserved or atypical populations.

Drug & Alcohol (D&A) Base-Funded Client Services

The American Society of Addiction Medicine (ASAM) provide a framework for classifying levels of care. The ASAM levels are included in the descriptions below.

1. Level 1.0 Outpatient (OP Drug Free)

   These are non-residential treatment services provided in regularly scheduled treatment sessions. Adults attend less than 9 hours per week and adolescents attend less than 6 hours per week. This program may be beneficial for individuals with less severe substance use disorders, those in the early stages of recovery, or those stepping down from more intensive programs.

2. Level 2.1 Intensive Outpatient (IOP)

   Includes organized non-residential treatment according to a planned regime of regularly scheduled treatment sessions. Adult participants attend 9-19 hours of structured programming per week, and adolescents attend 6-19 hours of service per week.

3. Level 2.5 Partial Hospitalization (Partial D&A)

   This service is designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment programs, but who do not require 24-hour care. This environment provides multi-modal and multi-disciplinary programming facilitated by an interdisciplinary team.

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4. Level 3.1 Clinically Managed Low-Intensity Residential Services (Halfway House)

   Programs that offer a supportive living environment with 24-hour staff and integrated clinical services (at least five hour per week of low-intensity treatment). These services assist with recovery skills, relapse prevention and emotional coping strategies.

5. Level 3.5 Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium Intensity Residential Services (Adolescent) (Medically Monitored Short-Term Residential Treatment)

   These programs serve individuals who need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress and who need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills.

6. Level 3.7 Medically Monitored Intensive Inpatient Services (Medically Monitored Long-Term or Short-Term Residential Treatment)

   These services are for individuals that require inpatient treatment but who do not need an acute care general hospital or a medically managed inpatient treatment program. These services provide a structured regime of 24-hour professionally directed evaluation and observation, medical monitoring, and addiction treatment in an inpatient setting.

7. Level 3.7 WM Medically Monitored Inpatient Withdrawal Management (Medically Monitored IP Detox)

   An organized service delivered in a permanent facility with inpatient beds by medical and nursing professionals that provides 24-hour a day evaluation and withdrawal management (detoxification).

8. Level 4.0 Medically Managed Intensive Inpatient Services (Medically Managed IP Residential)

   An organized service delivered in an acute care inpatient setting. It is appropriate for patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Treatment is provided 24 hours a day in a permanent facility with inpatient beds.

9. Level 4.0 WM Medically Managed Intensive Inpatient Withdrawal Management (Medically Managed IP Detox)

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An organized service delivered in an acute care inpatient setting by medical and nursing professionals that provides 24-hour a day, medically directed evaluation and withdrawal management (detoxification). Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

The following are other services that do not have an ASAM level associated with them.

10. Other Intervention Services

    This category includes intervention activities initiated by DHS that are not readily captured under other prevention activities.

11. Recovery Housing

    This housing provides a safe and supportive drug and alcohol-free environment for individuals recovering from addiction, which may include peer support and other recovery support services. Many recovery houses are licensed by the Pennsylvania Department of Drug and Alcohol Programs (DDAP).

12. Service Coordination / Case Management

    Case management determines the treatment and non-treatment needs of the individual and ensures that arrangements are made to meet the needs identified. This includes screening and assessment to determine the appropriate level of care for referral to treatment as well as ongoing planning, advocacy, and linking/coordination of services.

Source: Information provided by the Allegheny County Department of Human Services

COUNTY OF ALLEGHENY

SARA INNAMORATO
COUNTY EXECUTIVE

September 22, 2025

Allegheny County Controller
104 Courthouse
436 Grant Street
Pittsburgh, PA 15219

RE: Performance Audit Report on Allegheny County Department of Human Services, Office of Behavioral Health, Mental Health and Drug & Alcohol Services

Controller O'Connor,

Allegheny County Department of Human Services (AC DHS) values your Office's interest in improving behavioral health services for our community. This document serves as a response to your Office's report following a performance audit of some Office of Behavioral Health (OBH), Mental Health and Drug & Alcohol Services for the time period of July 1, 2023 through December 31, 2024.

In summary,

- In response to your Office's recommendations for **rate setting and payment policies**: AC DHS is actively working toward enhancing its behavioral health rate setting and payment processes, recognizing these processes as more than budgeting exercises—they are strategic levers to drive better health outcomes, reduce disparities, and ensure long-term system viability. In alignment with this view, AC DHS recently enacted changes to rates for mental health housing – normalizing the per bed cost of these programs between providers and producing millions in savings that is being reinvested to support people with unmet behavioral health needs. AC DHS continues to focus on improvements in this area and will implement the audit report recommendations as detailed later in our response.
- In response to your Office's recommendations for **waitlist reporting**: AC DHS views its role as inclusive of managing and monitoring system capacity and access to services. As noted in the audit report, AC DHS already manages waitlist data for some services. While AC DHS is open to the recommendation to implement

additional waitlist reporting, it must be one tool among many for managing capacity and access. To truly manage capacity and access, behavioral health systems need a mix of strategies that are dynamic, equitable, and client centered. AC DHS already invests in many of these strategies, including centralized referral management for oversubscribed, high acuity services; stepped care models; client navigation; and workforce initiatives. AC DHS will evaluate the feasibility and impact of additional waitlist reporting and implement the audit report recommendations in light of this evaluation. Please see additional detail later in this response.

- In response to your Office's recommendations related to **OBH staff recruitment**: While staff recruitment and retention are widely shared challenges in our sector, AC DHS agrees with the importance of a highly skilled OBH workforce and is already taking steps in alignment with the report's recommendations to improve its ability to attract and retain staff. At the County-level, this includes new policies aimed at enhancing benefits. Within AC DHS, this includes the implementation of a new compensation plan and targeted recruitment efforts for key OBH roles. Please see additional detail later in this response.

BACKGROUND

AC DHS is responsible for administering publicly funded mental health and substance use/drug and alcohol services to Allegheny County residents – this includes 80 different types of behavioral health services delivered by nearly 2,000 contracted providers (roughly 300 facilities and 1,600 practitioners) at more than 1,800 locations to more than 50,000 Allegheny County residents. Services range from the least to most restrictive/intensive and include:

- Prevention services
- Intervention services
- Community-based support/treatment-related services
- Community-based treatment services
- Crisis intervention services
- Residential treatment services and supported housing
- Inpatient/hospital treatment services

The largest portion of funding for behavioral health services comes from Medicaid ($499 million in SFY 2023-24). AC DHS is the Primary Contractor for the Behavioral HealthChoices (i.e., Medicaid or Medical Assistance) program delivered in Allegheny County. AC DHS contracts with a Behavioral Health Managed Care Organization (BH-MCO), Community Care Behavioral Health Organization, to deliver the program under its

oversight. Together, AC DHS and Community Care ensure the accessibility, continuity, and quality of services for Allegheny County's Medicaid behavioral health population while managing program costs for over 220,000 Allegheny County Medicaid enrollees (over 50,000 of whom use behavioral health services). These include children who are eligible for coverage of their behavioral health services via the Children's Health Insurance Program (CHIP) and adults who are dually enrolled in Medicare and Medicaid for whom Medicare as the primary payer will not pay for the behavioral health services.

In addition, AC DHS receives mental health and substance use funding that is allocated through its Human Services Block Grant (which supported approximately $88 million in mental health and drug and alcohol expenditures in SFY 2023-24). This funding covers treatment services for the un-insured and under-insured (e.g., individuals for whom their primary insurance(s) will not cover identified behavioral health services), and programs not currently reimbursable via Medicaid or private insurance such as housing for people with serious mental illness.

AC DHS is also the designated Single County Authority (SCA) for substance use services and receives state and federal dollars through its contract with the Pennsylvania Department of Drug and Alcohol Programs (DDAP; approximately $20 million in SFY2023-24) to plan, coordinate, manage, and implement the delivery of drug and alcohol prevention, intervention and treatment services to respond to local needs. Similar to HSBG, this funding covers treatment services for the un-insured and under-insured, and programs not currently reimbursable via Medicaid or private insurance such as recovery housing.

Finally, AC DHS leverages competitive and other special funds. Examples include Opioid Settlement funding and competitive grants from federal and state agencies to implement innovative and evidence-based practices and services in the behavioral health system.

The audit report from the Controller's Office utilizes sampling performed on HSBG and DDAP-funded services, which represented approximately 17% of overall system expenditures during the audit period. AC DHS is also audited annually on the largest component of its behavioral health system, the Behavioral Health Choices Program.

RESPONSE TO AUDIT FINDINGS & RECOMMENDATIONS

Finding #1: DHS Pays Certain Claims at the Community Care Behavioral Health Rate Instead of the Contract Rate

Recommendation from the Controller's Office

We recommend that the Department of Human Services implement the following recommendations:

- *Evaluate the current practice of processing and paying certain claims at CCBH rates versus contract rates to determine if this practice should be continued.*
- *If the current practice is continued,*
    - *DHS should amend provider contracts to include all rates that can be paid to the provider. If DHS intends to pay a provider various rates for the same service, the contract should explicitly identify the circumstances surrounding the use of each rate.*
    - *DHS should also maintain records to support the rationalization of a variable-rate system and document the authorization of the above decision.*

AC DHS response

AC DHS acknowledges that provider claims for drug and alcohol treatment services were paid at rates set by Community Care Behavioral Health during the audit period and these rates were not updated on the allocation statements that are part of AC DHS-provider contracts. Further, AC DHS agrees to implement the recommendations offered by the County Controller's Office. As context related to this finding:

- AC DHS contracts with Community Care to subsequently contract with, manage and reimburse more than 1,890 providers for the delivery of behavioral health treatment and support/treatment-related services to HealthChoices (e.g., Medicaid)-enrolled County residents.
- AC DHS separately contracts with a subset (currently 33) of the Community Care provider network to reimburse those same providers for services delivered to un-insured or under-insured County residents.
- The claims reviewed throughout the course of the audit were submitted by the same providers and for the same services as those for which the Community Care rates were set. Therefore, by electing to pay these claims at rates set by Community Care, AC DHS paid providers the same rate for serving clients who are un/under-insured as they are already paid for HealthChoices enrolled clients.
- This practice has a small financial impact for AC DHS and its providers (the sample tested by the audit team resulted in a $3,218 net variance, or approximately .05% of AC DHS's total behavioral health spending. We have since expanded this analysis to all impacted providers and the result is still less than 1% of total spending).

In alignment with the recommendations, AC DHS is reviewing its payment processes and evaluating its rate setting methodology with plans to document the resultant processes and procedures in a formalized policy or manual. This includes development of tools to

enable ongoing review and monitoring of CCBH rates compared to County contracted rates.

Finding #2: DHS Did Not Provide Documentation to Support Certain Provider Rates

Recommendation from the Controller's Office

We recommend that the Department of Human Services formally document its rate-setting policy for all mental health and drug & alcohol services. The policy documentation requirements should include a comprehensive list of all provider rates, the source of these rates, the reason for increasing (or not increasing) to the CCBH rate, the reason for any variation from the standard rate, as well as support for any variations should be consistently documented.

AC DHS response

In alignment with the recommendation, AC DHS is evaluating its rate setting methodology with plans to document the resultant processes and procedures in a formalized policy or manual. Beyond documentation, this effort aims to modernize and improve rate setting practices by integrating considerations for financial sustainability, care quality, and equitable access into a unified framework. Our approach recognizes that rate setting is not merely a budgeting exercise—it's a strategic lever to drive better health outcomes, reduce disparities, and ensure long-term system viability. As part of our new rate setting policy, AC DHS expects to use cost benchmarking and analytics to ensure rates reflect actual resource utilization (within the constraints of limited fund availability[1]). Following this initial policy development, AC DHS plans to work toward tying rate structures to performance metrics.

Finding #3: DHS Does Not Require Detailed Supporting Documentation for Invoices from Program-Funded Providers

Recommendation from the Controller's Office

We recommend that the Department of Human Services implement the following recommendations:

[1] All AC DHS behavioral health system funding (e.g., Behavioral Health Choices, Human Services Block Grant (HSBG), and Department of Drug & Alcohol Programs (DDAP)) is significantly constrained. For example, Allegheny County experienced a Behavioral HealthChoices program deficit in 2024 due to inadequate state capitation rates. In 2025, the state's capitation rates again fall short of projected medical expenses – by an estimated $20 million. Similarly, after state cuts in 2013, HSBG funding remained flat for more than a decade, despite increased needs and costs. Fortunately, AC DHS's HSBG allocation in SFY 2025 increased by $2.8M over SFY 2023. While this increase is helpful, it is equivalent to less than 4% AC DHS's HSBG spending on mental health in each of the last three SFYs and does not provide the support needed to correct the long-term underinvestment in mental health.

- *Consistently require program-funded providers to submit financial reports with every invoice. The reports should clearly identify the amounts that agree to the invoice total.*
- *Develop and implement a policy requiring program-funded providers to submit source documents or receipts for all expenses on their monthly invoice for a specified number of sample months during the fiscal year.*

AC DHS response

AC DHS agrees that it should require all invoices for program-funded services to contain supporting documentation, and we have already taken steps toward adopting this as policy. Specifically, in SFY 2025-26, AC DHS is requiring all program-funded invoices to include supporting documentation, such as a copy of the organization's general ledger, in order to gain approval and payment. This requirement was announced to all DHS staff and providers through Office of Administration technical assistance sessions and supporting communication prior to the start of the contract year.

As a next step toward adopting the recommendations, AC DHS will consider methods for increasing its review of source documents or receipts and identify a practice that balances volume, administrative burden, and the effective and accurate stewardship of funds.

Finding #4: DHS Does Not Request Waitlists for Certain Mental Health Services

Recommendation from the Controller's Office

We recommend that the Department of Human Services develop and implement policies and procedures requiring routine, consistent reporting of waitlist data for all mental health services. Provider waitlist data should be submitted using standardized templates, should be verified and analyzed, and inactive or ineligible clients should be removed to ensure waitlists are accurate.

AC DHS response

AC DHS views its role as inclusive of managing and monitoring system capacity and access to services. As noted in the audit report, AC DHS already manages waitlist data for some services. This includes management of waitlists for mental health housing (e.g., "community residential services") and monitoring of waitlists for family based mental health, Assertive/ Community Treatment Teams (ACT/CTT), Enhanced Clinical Service Coordination (ECSC), and Integrated Dual Disorders Treatment (IDDT).

AC DHS is open to the recommendation to implement additional waitlist reporting as one tool among many for managing capacity and access, for those services where it is feasible and appropriate. Prior to implementing this reporting requirement, we will undertake an

evaluation of potential impact on each level of care, including potential effects on provider administrative costs, service costs, and service quality.

The use of waitlists for managing behavioral health treatment capacity and access must be carefully considered. When used as a sole strategy for capacity and access management, waitlists are not considered universally effective or feasible. In the worst cases, they can obscure true demand, making it difficult for systems to plan and allocate resources effectively; generate new administrative burdens, as providers develop infrastructure and dedicate staff resources to track information and attempt to re-engage clients who have disengaged, leading to inefficiencies; delay critical care, worsening symptoms and increasing the risk of crisis events resulting in need for more acute, costly care; and erode trust, as individuals seeking help are met with uncertainty and prolonged suffering.[2] Further, there are services, such as Outpatient Mental Health, for which waitlist reporting is not feasible at scale, due to the decentralized nature of the network that delivers this service.

To truly manage capacity and access, behavioral health systems need a mix of strategies that are dynamic, equitable, and client centered. These are strategies that AC DHS is actively pursuing and investing in, and they include:

- *Stepped care models*. AC DHS and Community Care work to connect clients to the least intensive, most effective level of care based on need, and to reserve high-intensity services for those with acute conditions, freeing up capacity.

  For example, when assessing referrals for its mental health housing programs, AC DHS uses administrative data to predict the likelihood of future adverse events, including mental health hospitalizations and four or more emergency department visits, if an individual does not receive short-term supportive housing. This helps AC DHS prioritize who receives limited mental health housing resources. Low-risk individuals are directed to other, lower-intensity supportive services. This triage function is a core characteristic of a stepped care system. Importantly, through application of this process, which was first implemented in early 2023, the size of waitlists for mental health housing programs in Allegheny County has declined. For programs impacted by the new triaging method, the waitlist dropped by nearly half (from 84 to 38), and the median time waiting (for the point-in-time waitlist) dropped from 89 to 50 days. For programs not impacted by the new triaging method, the

[2] Tran, Q.D. Going Beyond Waitlists in Mental Healthcare. *Community Ment Health J* **60**, 629–634 (2024). https://doi.org/10.1007/s10597-024-01233-2

waitlist reduction was closer to a third (27 to 20) and wait times decreased from 128 to 119 days.

We want to clarify that the findings in the report that community residential "records indicate delays exceeding" 800, 1900, and 2100 days are referencing *maximum days* for *four unique clients* with special circumstances. Median times have decreased during this period and are currently less than four months for any mental health housing program. Charts in an appendix to this response illustrate waitlist size and median wait times, which we offer as a supplemental indicator to the maximum wait times included in the report.

- *Centralized referral management and scheduling.* Centralized referral management enables triaging (described as key to stepped care models above) and the use of tools and dashboards to track openings across providers and locations. AC DHS already uses centralized referral management for some services, like housing, and is actively pursuing application of centralized referral management and scheduling to high acuity mental health treatment services, including ACT/CTT.

- *Workforce expansion initiatives.* A key factor, and challenge, in behavioral health system capacity is availability of quality staff. AC DHS has implemented workforce initiatives, including the Behavioral Health Fellows program[3], to improve staff recruitment and retention in key areas.

- *Care navigation.* AC DHS provides, and monitors Community Care's provision of, services and supports to help clients navigate care and maintain engagement in needed services – including navigation support during key transitions and for children, youth, and adults at high risk. For example, AC DHS and Community Care coordinate complex case reviews, interagency meetings, and treatment team meetings to help clients overcome system barriers and gain access to services. In addition, AC DHS directly, and through its contract with Community Care, contracts with providers to deliver a range of mental health and/or drug and alcohol service coordination/case management services that connect clients to services and coordinate care across systems, ensuring that different service providers, including therapists, doctors, and other professionals, work together to support client goals.

[3] https://www.alleghenycounty.us/Government/Employment/Job-Opportunities-by-Department/Human-Services-Careers/Professional-Opportunities/BH-Fellows-Program

- *Interim support*. AC DHS, Community Care, and our providers also engage clients in interim support if awaiting services at a level of care where capacity limits prevent immediate access.

Finding #5: DHS's Office of Behavioral Health is Not Fully Staffed

Recommendation from the Controller's Office

DHS should prioritize filling vacant positions with the Office of Behavioral Health by reviewing the recruitment process and compensation structures to remain competitive.

AC DHS response

AC DHS agrees that a 30% vacancy rate is high, even for government human services where recruitment and retention can be especially challenging. Further, AC DHS agrees that it is imperative to recruit and retain high-quality staff in its OBH and is taking actions in alignment with the Controller's Office recommendations related to the recruitment process and compensation structures.

As context for the finding, many of the vacancies on the formal AC DHS personnel roster are intentionally unfilled, as we're focusing effort on recruitment for the OBH Director role and other key positions and otherwise re-evaluating what roles are necessary in OBH. Therefore, the vacancy rate presented here is not a meaningful measure of unfilled positions.

OBH is currently actively recruiting for 11 County and 6 Contract positions, which include:

- Deputy Director (County, Interim in Place)
- Assistant Deputy Director (County, Interim in Place)
- Caseworkers (4) (County)
- Drug and Alcohol Program Specialist (County)
- Medical Assistance Transportation Program Oper Off (County)
- Transportation Worker (2) (County)
- Administrative Officer (County)
- OBH Stand Together Coordinator (Contract)
- Community Wellness & Youth Training Specialist (Contract)
- Training & Technical Assistant Coordinator (Contract)
- OBH Community Support & Youth Training Specialist (Contract)
- Mental Health Program Specialist (Contract)
- Mental Health Quality Improvement Specialist (Contract)

Additionally, DHS anticipates posting or re-posting the following positions imminently:

- Senior Manager BH Planning

The vacancies listed above as in or near active recruitment have the most important impact, and AC DHS has made special efforts to fill them, including:

- Enhanced recruitment efforts for key roles, such as the OBH Director position.
- A new compensation plan for all Non-Union County AC DHS employees, recently approved by the state and in process of being implemented, with the goals of making compensation more competitive, equitable and transparent. The plan includes rules for determining compensation for new hires and for existing employees who are reassigned, promoted, demoted, or return from leave. The compensation plan also provides guidelines for merit pay increases.

Finally, AC DHS expects that recent employment policies enacted by the County Executive, such as the approval of hybrid work schedules and updated paid leave policies, will help improve recruitment outcomes for these roles.

Sincerely,

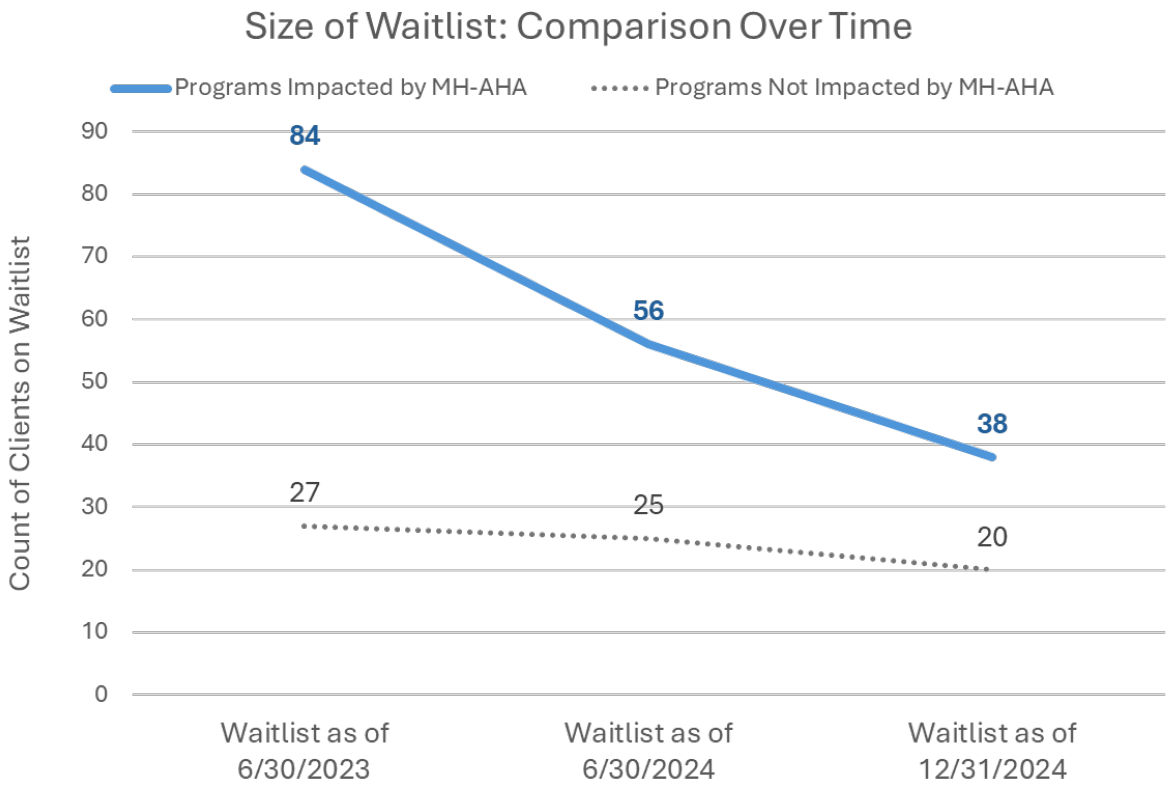
Erin Dalton

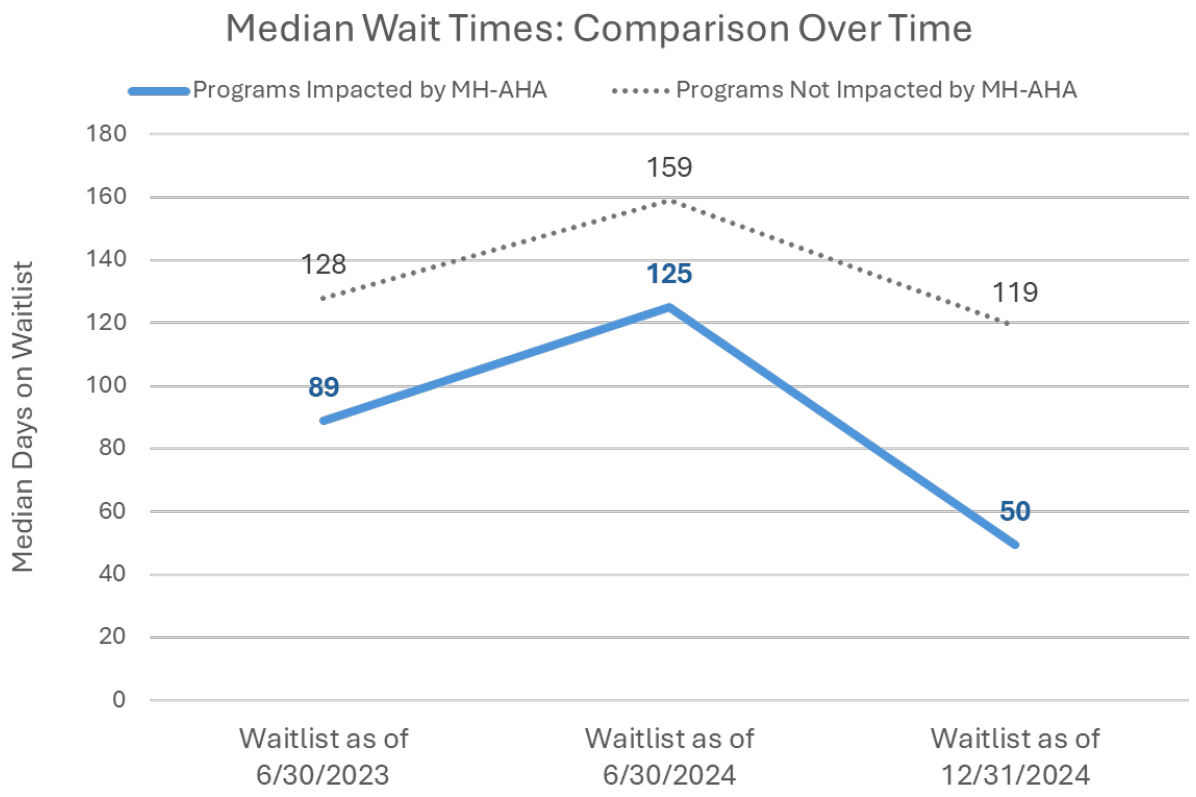
Director

APPENDIX

Mental health housing (e.g., community residential) waitlist supplemental information

The Mental Health – Allegheny Housing Assessment (MH-AHA) launched in February 2023. MH-AHA utilizes administrative data from Allegheny County's data warehouse to predict the likelihood of two potential types of adverse events that may occur in an individual's life if they do not receive adequate support for their condition over the next 12 months: 1) a mental health inpatient stay and 2) frequent use [4 or more visits] of hospital emergency departments. These events serve as indicators of harm and are things we aim to prevent. The MH-AHA assigns a risk score that is used as part of the eligibility determination (which also includes historic and current clinical information). Individuals who are not eligible are connected to other supportive services options instead of waiting a long time on a waiting list for a placement that might not occur. By prioritizing those most in need of MH residential services, the MH-AHA simplifies the referral process, decreases uncertainty and reduces wait times. In addition, it helps AC DHS document unmet mental health residential needs created by the gap between limited residential resources and the number of high-risk eligible individuals.




Median Wait Times: Comparison Over Time
Programs Impacted by MH-AHA
Programs Not Impacted by MH-AHA
Median Days on Waitlist
180
160
140
120
100
80
60
40
20
0
128
159
119
89
125
50
Waitlist as of 6/30/2023
Waitlist as of 6/30/2024
Waitlist as of 12/31/2024