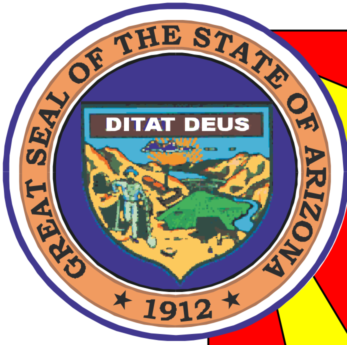


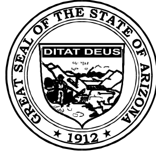
State of Arizona
Office
of the
Auditor General

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

Report to the Arizona Legislature
By Debra K. Davenport
Acting Auditor General
July 1999
Report No. 99-12



DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
DEPUTY AUDITOR GENERAL

July 22, 1999,

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. James Allen, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Health Services, Division of Behavioral Health Services. This report is in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957.

This is our fifth audit of the behavioral health system in the past ten years. Although our previous audits have generally been critical of the Division's ability to manage the State's behavioral health system, we found the Division has made significant improvements in its oversight efforts since our last audit in 1996 (see Auditor General Report No. 96-19). The Division has added qualified staff and improved its procedures for monitoring behavioral health services. However, the Division still needs to focus more on measuring the appropriateness of care that clients receive. It also needs to improve its monitoring of the accessibility of services.

We also found the Division is not obtaining complete and accurate data on the numbers of services being provided by the Regional Behavioral Health Authorities (RHBAs), or complete data on the types of illnesses being treated and the outcomes of treatments. The Division should consider sanctioning the RHBAs if data reporting is not complete.

Finally, we noted the demand for services paid for by non-Medicaid monies far exceeds the available funding and the demand is growing. We recommend that the Legislature establish priorities for the use of the non-Medicaid monies to ensure that they are spent on the highest priority needs.

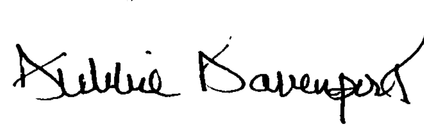
2910 NORTH 44th STREET • SUITE 410 • PHOENIX, ARIZONA 85018 • (602) 553-0333 • FAX (602) 553-0051

As outlined in its response, the Department of Health Services agrees with all findings and recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on July 23, 1999.

Sincerely,



Debbie Davenport
Acting Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review as set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957, and is the fourth in a series of six reports on the Department. A separate review of the Arizona State Hospital, which the Division oversees, was issued in May 1999 (Report No. 99-9).

The Department of Health Services' Division of Behavioral Health Services (Division) is responsible for providing publicly funded mental health and substance abuse treatment and prevention services. The Division oversees a managed behavioral health care system administered by five organizations called Regional Behavioral Health Authorities (RBHAs), which function like health maintenance organizations. The Division contracts with the RBHAs to offer services in specific geographic service areas throughout the State, and the RBHAs subcontract with service providers to deliver services and/or deliver services directly.

Improved Oversight of the Behavioral Health Care System Can Be Further Strengthened by Additional Actions
(See pages 11 through 18)

In the two-and-a-half years since the Auditor General's previous report (Report No. 96-19), the Division improved its ability to oversee the financial performance of the RBHAs and the quality of services they deliver to clients through their subcontractors. For example, the Division added qualified staff to review RBHA financial operations and conduct clinical research. The Division also upgraded its instruments for monitoring the RBHAs and for monitoring service quality, and developed more specific standards to assess RBHA performance.

Additional changes could further enhance the Division's oversight efforts. First, the Division should change case file review activities so that they focus more on measuring the appropriateness of care that clients receive. Second, the Division should focus more on ways to assess service accessibility. This includes monitoring the geographic availability of services, as well as monitoring waiting times. Finally, the Division needs to ensure that its oversight activities result in improved RBHA performance by monitoring the RBHAs' progress in implementing corrective actions.

The Division Continues to Have Problems Collecting Critical Data (See pages 19 through 24)

Although oversight has improved, the Division has only partly addressed problems with collecting complete data since the Auditor General's last report. Accurate and complete information on service use and clients' diagnoses and clinical progress is critical to justify funding requests, fulfill reporting requirements, conduct quality management, and measure client outcomes. Additional changes in automated systems, improved data submission guidelines, and additional data policies are needed to enhance data collection. The Division also needs to receive adequate staff support and more timely information from other divisions within the Department of Health Services to ensure that data collection and reporting are complete.

The State Needs to Better Ensure that Non-Medicaid Behavioral Health Monies Are Allocated Equitably and Spent Effectively (See pages 25 through 30)

The State needs to better ensure that non-Medicaid monies are expended equitably and effectively. These monies provide services for persons who do not qualify for Medicaid or KidsCare or whose need for services exceeds Medicaid's or KidsCare's benefits. While the full extent of Arizona residents who need such services is unknown, demand for these monies greatly surpasses available revenues and continues to increase.

The Division's current approach for distributing these monies is based largely on historic funding levels, not on demonstrated health care needs, and guidelines for using the funds are vague. The Division does not have a system for defining who should receive services or what kinds of services should be provided. As a result, funding and services vary across regions of the State. For example, two RBHAs provide in-patient hospitalization services for children as a general benefit, while others do not. Though a difficult task, the Legislature should consider defining priorities and statewide goals to enable the Division to implement a more structured system for the use of these monies.

Other Pertinent Information (See pages 31 through 34)

The Department appears to be far from meeting the settlement agreement established to end *Arnold v. Sarn*, a class action lawsuit filed against the Department and Maricopa County for failing to provide a sufficient level of mental health services to adults with serious mental illness residing in Maricopa County, as promised by state law. The court monitor, who is

responsible for overseeing compliance with the agreement, has found that persons covered by the lawsuit are still not receiving sufficient community-living arrangement or support services, such as vocational programs. Substantial increases in state dollars may be needed to meet the terms of the agreement. Alternative approaches include changing the statute on which the lawsuit is based, or renegotiating the agreement, which would probably also require additional funding. The fiscal year 2000-2001 budget supports only modest increases in appropriations for non-Medicaid-funded services. The future of the case may lie with a committee that will soon be looking at ways to settle the lawsuit.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review as set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957, and is the fourth in a series of six reports on the Department. A separate review of the Arizona State Hospital, which the Division oversees, was issued in May 1999 (Report No. 99-9).

The Behavioral Health System

The Department of Health Services' Division of Behavioral Health Services (Division) is responsible for providing publicly funded mental health and substance abuse treatment and prevention services in Arizona. The Division's mission is "to serve the people of Arizona by continually improving the effectiveness and efficiency of behavioral health services."

The Division does not directly provide services. Instead, the Division oversees a managed behavioral health care system administered by organizations called Regional Behavioral Health Authorities (RBHAs). Currently, there are five RBHAs under contract with the Division (see Figure 1, page 2):

- **Value Options**, which serves Maricopa County. Value Options, the only for-profit RBHA in the State, was awarded the contract in August 1998. Previously, ComCare served as the Maricopa County RBHA.

- **Community Partnership of Southern Arizona (CPSA)**, which serves two geographic regions in the southeastern part of the State, including Pima, Santa Cruz, Graham, Greenlee, and Cochise Counties;

- **Northern Arizona Regional Behavioral Health Authority (NARBHA)**, which serves the northern part of the State, including Coconino, Mohave, Navajo, Apache, and Yavapai Counties;

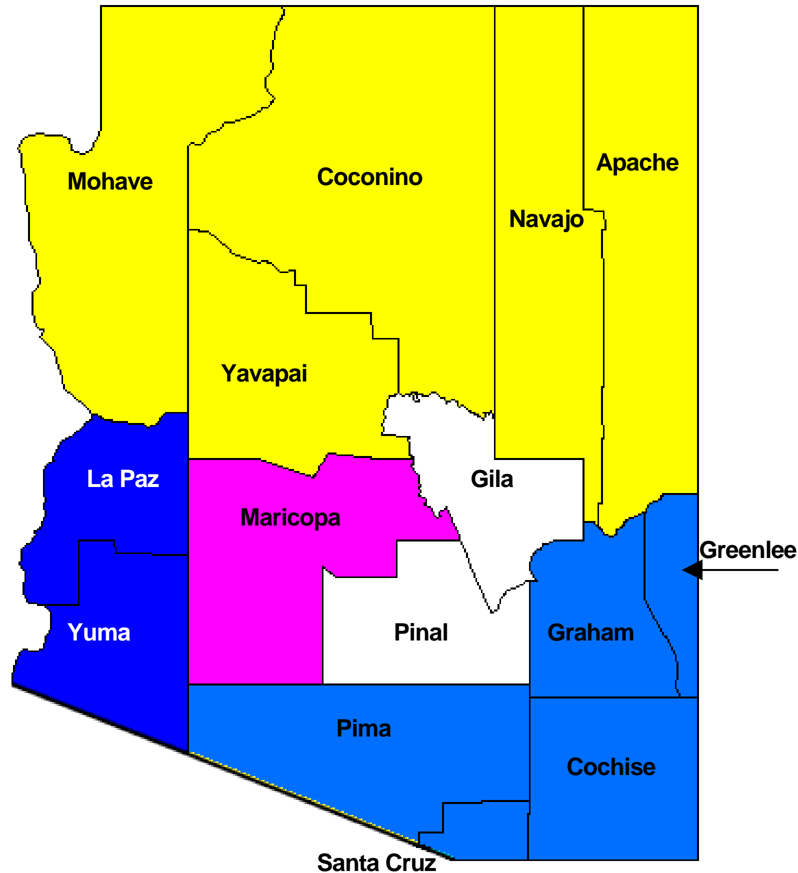
- **Pinal Gila Behavioral Health Association (PGBHA)**, which serves both Pinal and Gila Counties; and

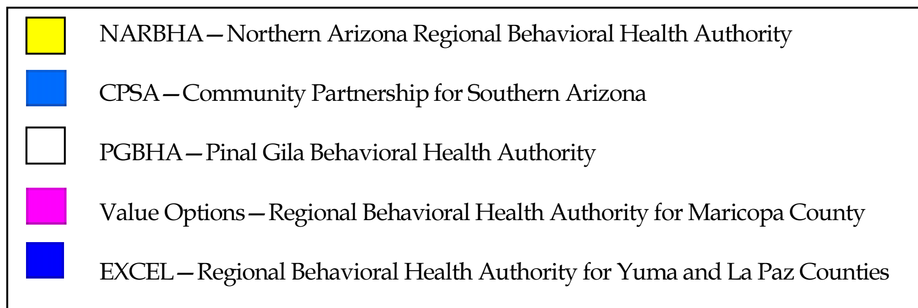
- **The EXCEL Group**, which serves La Paz and Yuma Counties.

The RBHAs function in a fashion similar to health maintenance organizations. For example, the Division pays them capitated rates (that is, a fixed dollar amount per eligible person per

Figure 1

Department of Health Services
Division of Behavioral Health Services
Regional Behavioral Health Authorities by Geographic Service Area
As of August 1998





Source: 1998 Annual Report for Division of Behavioral Health Services.

month) to serve each Medicaid-eligible person in a geographic region, instead of paying them on a fee-for-service basis. The RBHAs then subcontract with more than 350 service providers statewide, although the EXCEL group, which serves a predominantly rural community, provides most services directly instead of through subcontractors.

Clients in the System

Arizona's behavioral health system served more than 65,000 individuals in fiscal year 1998. As Figure 2 (see page 4) shows, these clients fall into four categories:

- **Children with mental health problems**—Children suffer from a variety of behavioral health problems, such as Oppositional Defiant Disorder, characterized by argumentative or defiant behavior, and Attention Deficit Hyperactivity Disorder, characterized by a short attention span and restlessness. About 18,600 children, or 28 percent of all clients, were served in fiscal year 1998, and of these, 78 percent were eligible for Medicaid. In fiscal year 1998, approximately 32 percent of the Division's client service monies were spent on them.

- **Adults with serious mental illness**—These adults have severe, chronic mental illness (such as schizophrenia) that interferes with their ability to function in society. About 19,000 such adults, or 29 percent of all clients, were served in fiscal year 1998, with 52 percent of them eligible for Medicaid. Approximately 43 percent of the Division's client service monies were spent on them.

- **Adults with general mental health disorders or substance abuse problems**—This is the largest of the categories, comprising over 38 percent of the clients served (over 25,000) of which 26 percent were Medicaid eligible. Approximately 23 percent of the Division's client service monies were spent on this population.

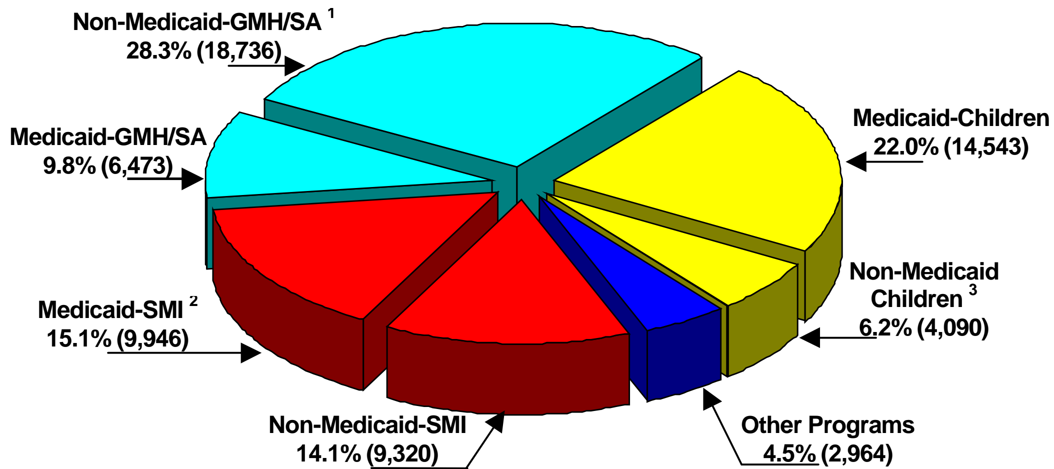
- **Other**—Approximately 5 percent of all people served in fiscal year 1998 received other services, such as prevention services, that are not funded with Medicaid revenues. These services include prevention programs for at-risk youth and other groups, and substance abuse prevention programs. About 2 percent of the Division's client service monies were spent on this group.

Funding Arizona's System

The Division receives monies from several sources, as illustrated in Figure 3 (see page 5). The Division receives federal dollars through AHCCCS, the state agency designated by the federal government as the sole recipient of Medicaid (Title XIX) and Title XXI monies. Title XXI monies are for the State Children's Health Insurance Program, known in Arizona as the

Figure 2

**Department of Health Services
Division of Behavioral Health Services
Number of Clients Served by Program
Fiscal Year 1997-98
(Unaudited)**



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[1] GMH/SA represents adults with general mental health disorders and substance abuse problems.

[2] SMI represents adults with a serious mental illness.

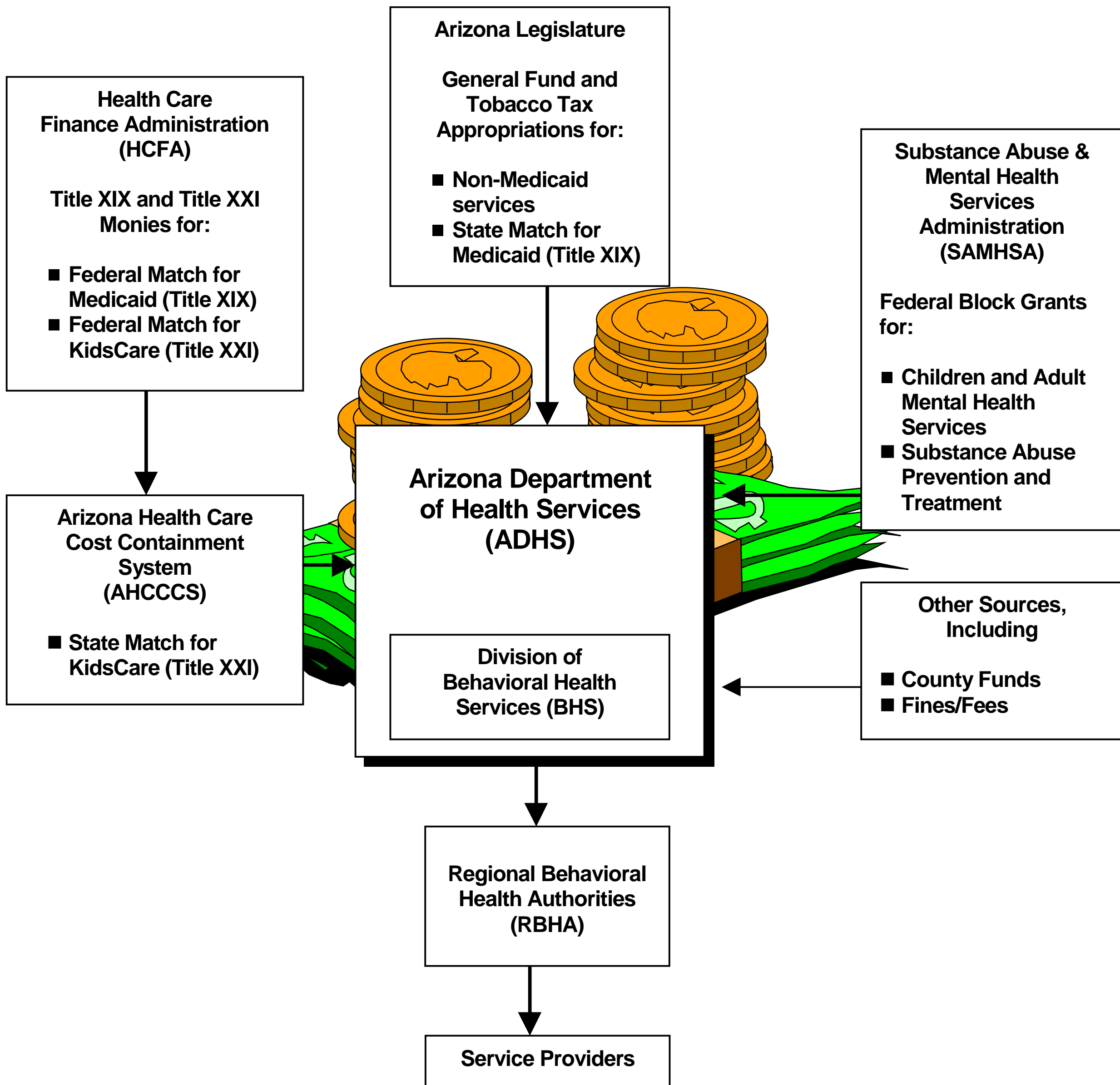
[3] Children represents individuals younger than 18 with behavioral health problems.

Source: 1998 Annual Report for Division of Behavioral Health Services.

KidsCare program. The State provides matching monies for these federal dollars. Currently, the State finances about one-third of Medicaid clients' services, and one-fourth of KidsCare services. The Division also receives federal general mental health and substance abuse block grants from the federal Substance Abuse and Mental Health Services Administration. The Division allocates these block grant funds, together with revenues from the State General Fund and the tobacco tax, to serve persons whose incomes are too high to qualify for

Figure 3

Department of Health Services
Division of Behavioral Health Services
Sources of Funding for Behavioral Health Services



Source: Auditor General staff analysis of the Division of Behavioral Health Services' *Overview of Managed Behavioral Health in Arizona* and information about KidsCare, obtained from the Division of Behavioral Health Services and the Arizona Health Care Cost Containment System.

Medicaid or KidsCare but who lack insurance or are otherwise unable to pay for their own services. Also, some of this money is used to provide non-Medicaid covered services to persons who are eligible for Medicaid and KidsCare benefits.

As illustrated in Table 1 (see page 7), the Division received a total funding of approximately $300 million in fiscal year 1998. Estimated revenues for fiscal year 1999 are approximately $321 million. The Division disburses most of the revenue it receives as Aid to Individuals and Organizations, which includes the RBHAs. In 1998, the Division disbursed approximately $285 million in aid, with RBHAs receiving approximately $275.5 million. In turn, the RBHAs spent approximately $253 million on program services, and $21 million on general administration in fiscal year 1998, as illustrated in Table 2 (see page 8).

The Division disburses behavioral health dollars to RBHAs in two ways:

- **Medicaid and KidsCare monies** are disbursed in the form of monthly capitation payments, meaning that each RBHA receives a fixed rate each month for every person who is enrolled in Medicaid or KidsCare and lives in its geographic service area. The RBHAs, the Division, and AHCCCS negotiate these rates when necessary based on estimated forecasts of how many services AHCCCS members will use, the cost of those services, and the number of Medicaid or KidsCare enrollees. The Health Care Financing Administration, which administers the Medicaid and KidsCare programs at the federal level, must also approve the capitation rates.

- **Non-Medicaid monies** are disbursed in monthly payments that are based on the availability of these monies and historical funding patterns. RBHAs do not have to serve non-Medicaid clients in their regions if such monies are not sufficient, with the exception of adults who are or could be deemed seriously mentally ill, as stipulated in the *Arnold v. Sarn* lawsuit. (This lawsuit is explained in Other Pertinent Information, pages 31 through 34).

Scope and Methodology

This audit builds on previous Auditor General audits of the Division issued in 1992, 1994, and 1996. These previous audits focused on such issues as the Division's oversight role in behavioral health care, problems with information systems, the impact of the *Arnold v. Sarn* lawsuit on the behavioral health system, and the adequacy of services children receive. This audit included a review of the Division's oversight methods, its effectiveness in collecting critical data, and its distribution of and policy for non-Medicaid monies. The audit also included a review of the status of the *Arnold v. Sarn* lawsuit.

Table 1

Department of Health Services
Division of Behavioral Health Services
Statement of Revenues, Expenditures, and Other Financing Sources and Uses [1]
Years Ended June 30, 1997, 1998, and 1999
(Unaudited)

	1997 (Actual)	1998 (Actual)	1999 (Estimated)
Revenues:			
State General Fund appropriations	$141,505,200	$150,390,600	$159,489,300
Intergovernmental [2]	125,632,965	141,770,386	154,002,300
Tobacco tax [3]	5,500,000	5,500,000	5,500,000
Fines and forfeits	1,598,281	1,749,377	1,550,000
Sales and charges for services	124,485	269,191	100,000
Other	72,588	209,557	200,000
Total revenues	274,433,519	299,889,111	320,841,600
Expenditures: [4]			
Personal services	2,772,940	2,692,610	3,060,300
Employee related	634,073	625,427	765,100
Professional and outside services	5,094,877	5,021,405	3,804,000 [5]
Travel, in-state	99,924	70,884	68,000
Travel, out-of-state	44,410	35,238	56,000
Aid to individuals and organizations [6]	262,138,047	284,795,620	308,350,000
Other operating	3,385,548	1,686,087	2,232,000
Capital outlay	172,377	625,534	439,000
Indirect costs	614,055	384,201	620,000
Total expenditures	274,956,251	295,937,006	319,394,400
Excess of revenues over (under) expenditures	(522,732)	3,962,105	1,447,200
Other financing sources (uses):			
Net operating transfers in (out)	(61,049)		104,000
Remittances to the State General Fund	(924,484)	(296,699)	
Reversions to the State General Fund [7]	(3,535,324)	(1,747,695)	(1,225,000)
Total other financing sources	(4,520,857)	(2,044,394)	(1,121,000)
Excess of revenues and other sources over (under) expenditures and other uses [8]	$ (5,043,589)	$ 1,917,711	$ 326,200

1 Excludes Arizona State Hospital financial activity.

2 Includes approximately $96.3, $110.1, and $121.4 million of federal revenue in 1997, 1998, and 1999, respectively.

3 Includes $5.5 million of tobacco taxes allocated to the Public Health Division, but expended in the Behavioral Health Division.

4 Each year includes the prior year's administrative adjustments.

5 In 1999, the processing of medical claims and encounters was transferred from a private corporation to the regional behavioral health authorities. Consequently, approximately $1.8 million of expenditures was incurred for aid to organizations instead of professional and outside services.

6 Includes approximately $250.4, $275.5, and $299.2 million of federal and state monies disbursed to the regional behavioral health authorities in 1997, 1998, and 1999, respectively.

7 The amount reverted is based on the prior year State General Fund appropriation.

8 Amounts fluctuate because sometimes expenditures were made before receiving related revenues and reversions were based on prior year General Fund appropriations.

Source: The Arizona Financial Information System (AFIS) *Accounting Event Extract File* and *Status of Appropriations and Expenditures* reports and financial information provided by the Department of Health Services for the years ended June 30, 1997 and 1998; and Division-prepared estimates of financial activity for the year ended June 30, 1999 (actual amounts were not available at the time of this report).

Table 2

Department of Health Services
Division of Behavioral Health Services
Regional Behavioral Health Authorities
Statement of Activities and Changes in Net Assets
Year Ended June 30, 1998

	ComCare [1]	CPSA	Excel	NARBHA	PGBHA	Total
Revenues						
State	$109,985,450	$43,101,983	$ 5,455,703	$17,882,780	$ 8,126,546	$184,552,462
Federal	54,365,357	28,258,033	3,014,500	10,361,939	5,496,647	101,496,476
Local	7,869,011	192,018	2,579,687			10,640,716
Other	522,522	4,756,604	220,663	618,310	402,116	6,520,215
Total revenues	172,742,340	76,308,638	11,270,553	28,863,029	14,025,309	$303,209,869
Expenses						
Program service	142,654,555	63,127,285	9,708,505	25,714,788	11,711,314	252,916,447
General and administration	10,899,830	5,365,631	1,227,811	2,598,643	1,094,139	21,186,054
Total expenses	153,554,385	68,492,916	10,936,316	28,313,431	12,805,453	274,102,501
Increase in net assets	19,187,955	7,815,722	334,237	549,598	1,219,856	29,107,368
Net assets, beginning of year	6,144,790	8,010,994	4,066,229	6,283,869	3,904,499	28,410,381
Net assets transferred [2]	(9,065,923)					(9,065,923)
Net assets, end of year	$ 16,266,822	$15,826,716	$ 4,400,466	$ 6,833,467	$ 5,124,355	$ 48,451,826

[1] The Department's contract with ComCare to serve Maricopa County expired September 18, 1998. The Department awarded ValueOptions the contract, and ValueOptions subcontracted with ComCare to continue providing services through February 8, 1999.

[2] The Department transferred a portion of ComCare's net assets to a separate organization operated by ComCare's former management to provide behavioral health services similar to those provided by ComCare.

Source: Audited financial statements of the regional behavioral health authorities for the year ended June 30, 1998. Various contracted audit firms performed the audits.

Methods used to conduct the audit included the following:

- Interviews with representatives from the Division, AHCCCS, the RBHAs, providers, the Legislature, the Office of the Court Monitor (who is responsible for overseeing the Division's compliance with the *Arnold v. Sarn* settlement agreement), and mental health advocacy groups.

- A review of literature about managed behavioral health care to identify best practices in the oversight of health care organizations. Literature regarding the collection and use of data and the rationing of health care services was also reviewed.

- Review of Division requests-for-proposals, contracts, and reporting guidelines for the RBHAs; AHCCCS requirements for its contractors; and Division and AHCCCS policies and procedures. As part of this review, auditors compared the current Maricopa County RBHA contract to previous RBHA contracts, and behavioral health contracts from other states, including Oregon, Massachusetts, and Colorado.

- Review of current and past oversight tools used by the Division including operational and financial reviews, quarterly quality management reports, customer satisfaction surveys, performance indicators, case file reviews, and RBHA financial statements.

- Review of AHCCCS' 1997 and 1998 service data validation studies and reports generated from the Division's information system on clients who entered the behavioral health system during fiscal year 1998. Such information was used to determine the completeness of both service and clinical data.

This audit contains findings in three areas: (1) the Division's oversight of the behavioral health care system; (2) the Division's collection and use of service data and clinical assessment data; and (3) the need to better ensure that non-Medicaid monies are allocated equitably and spent effectively. This report also contains Other Pertinent Information (see pages 31 through 34) that discusses the Department's status in meeting the settlement agreement in the *Arnold v. Sarn* case, the lawsuit that has obligated the Department of Health Services to provide a level of mental health services to persons with serious mental illnesses, as promised by state law.

This audit was conducted in accordance with government auditing standards.

The Auditor General and his staff express appreciation to the Director of the Department of Health Services, the Assistant Director of the Division of Behavioral Health Services, the RBHAs, and their staffs for their cooperation and assistance throughout the audit.

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FINDING I

IMPROVED OVERSIGHT OF THE BEHAVIORAL HEALTH CARE SYSTEM CAN BE FURTHER STRENGTHENED BY ADDITIONAL ACTIONS

In the face of past problems with its system for overseeing the Regional Behavioral Health Authorities (RBHAs), the Division of Behavioral Health Services has made substantial improvements. Improving this system is critical because it represents an important effort to ensure that RBHAs are providing needed services and that state, county, and federal dollars are being spent effectively. The Division has added more staff with specific expertise in financial management and other skills necessary for oversight, improved its instruments for assessing RBHA performance, and developed more specific contractor standards against which performance can be assessed. To take full advantage of these improvements, however, the Division needs to take additional steps for monitoring whether clients receive appropriate services. The Division also needs to continue its efforts to ensure that RBHAs implement the corrective actions they promise in response to problems found during the Division's reviews.

The Division Had Difficulty Meeting Critical Oversight Role

Because RBHAs are paid in *advance* for the services that they are to deliver, rather than being paid for services that they *actually* deliver, oversight of the services they provide is critical. While this approach to paying for services can help control costs, it may also give RBHAs an incentive to keep their own costs down by denying services or delivering too few or inappropriate services. While provisions in RBHA contracts limit the amount of profit the RBHAs can earn, Division review of RBHAs is still essential for ensuring that RBHAs are not limiting services in order to earn a profit.[1]

Past audits by the Auditor General have found the Division's oversight to be lacking. The 1996 report (Report No. 96-19) found that the Division had difficulty answering questions about the accessibility, effectiveness, and appropriateness of services. The report also noted that the Division had not developed standards defining what services clients should typi-

[1] The RBHAs, by contract, are allowed to retain no more than 4 percent of non-Medicaid monies as profit. In addition, BHS has the right to renegotiate RBHA Medicaid and KidsCare capitation rates if RBHA profits exceed the predetermined limits of 10 percent and 5 percent, respectively.

cally receive based on their illness, thus making it difficult to assess the appropriateness of client services. The report also found that the RBHA contracts contained inadequacies in defining service expectations. The Auditor General's 1994 report (Report No. 94-8) also found that the Division lacked key staff positions in the financial review area.

The Division Has Made Substantial Efforts to Improve Oversight

The Division has been making changes in the past two years that are helping it perform its oversight role better. It has added staff with the needed expertise to better review RBHA financial management and operations, upgraded its reviews and other diagnostic tools, and made performance standards for RBHAs more specific.

Qualified staff have been added—The Division has added qualified staff to both its financial review and quality management areas. In 1994, the Division had only two persons monitoring the financial operations of RBHAs, and neither was a Certified Public Accountant (CPA). CPA-type expertise is needed to adequately monitor RBHAs' use of the prepayments they receive. The Division now has five people conducting financial oversight, including three CPAs with prior work experience monitoring health plans for AHCCCS.

The Division has made similar changes in staff positions that oversee the services provided to mental health clients, a responsibility referred to as quality management. Three new manager positions (two of which have been filled) have been added in this area, including positions responsible for research and evaluating clinical information. The Division is also attempting to add, albeit slowly, five programmers and analysts; positions that, once filled, will allow the Division to perform data analyses of service and client information to help monitor the delivery of care. The Division also now employs an epidemiologist, allowing it to perform analyses of the prevalence of behavioral health problems so that the need for various services can be better defined and accessibility can be better monitored. The person in charge of quality management has come to this position with prior experience overseeing quality management at one of the RBHAs.

Instruments for measuring quality have improved—The Division has changed and added to the monitoring tools it uses, helping it to better assess RBHA performance. For example:

- **Operational and financial reviews** have been standardized to allow easier reporting and comparability. These reviews look at the sufficiency of processes in place at the RBHAs, and their compliance with contractual and policy requirements. The effect of the change can be seen in the dramatic increases in the number of areas noted for corrective action. In 1997, reviews at four RBHAs disclosed a need for corrective action in four broad areas at the EXCEL in Yuma, two areas at the Northern Arizona Regional Behavioral Health Authority, one area at the Community Partnership of Southern Arizona,

and none at the Pinal Gila Behavioral Health Association. Under the more standardized approach used the following year, the Division found a need for improvement in 83, 65, 38, and 58 specific areas, respectively.

- **Client satisfaction surveys**, which have been used for years, have been changed to better ensure reliability and validity. The Division has adopted a nationally tested instrument that will enable it to compare results with other states. The results of the client satisfaction surveys help the Division to monitor the accessibility, effectiveness, and appropriateness of services.

- **Quarterly quality management indicators** have been revised to develop a better indication of the accessibility and appropriateness of services. Measures found to be of little use have been removed, and other measures, such as the timeliness of services, have been revised so that reporting is more standardized, allowing comparability between RBHAs. Finally, measures reflecting the effectiveness of services have been added, such as the average change in the severity of clients' conditions since enrollment.

- **Performance indicators** have been developed to give the Division a broader view of the accessibility, effectiveness, and adequacy of services and the RBHAs' financial health. Compared to the quarterly quality management indicators, these indicators include a broader array of outcome measures, such as percentage of children with maintained or improved school attendance, to help the Division monitor service effectiveness. The set of 58 performance measures includes many being used by other states as part of a project to determine the best performance measures for behavioral health services. By using such indicators, the Division will eventually be able to compare Arizona's performance to other states.

***Standards are more specific*—**The Division has also made progress in defining the standards against which RBHA performance can be assessed. This progress can be seen in the Request for Proposal (RFP) developed for awarding the RBHA contract for Maricopa County, which was much more specific in terms of performance expectations than previous RFPs. A national study of states' managed care contracts suggests the Division is mirroring other states in the development of more detailed specifications in RFPs. Accordingly, the Division will be able to better ensure that the RBHA's performance meets expectations, and sanction the RBHA if its performance does not meet contract standards. New provisions that were previously absent in the Maricopa County RFP include requirements that:

- Data pertaining to a client's assessed condition be entered into the Division's information system within a specified time frame and updated;

- Clinical assessments be made by credentialed professionals;

- Certain types of crisis services, such as face-to-face interventions, occur within specified time periods. Also, the new contract contains specifics about crisis phone lines that help to ensure these services are readily available and effective;

- The RBHA inform the Division of additions and deletions to its provider network;

- The RBHA document all verbal, telephone, and written requests for services. Previously, agencies making referrals had to document requests.

- The RBHA follow up with people who do not show up for appointments; notify people whose services are being terminated; and ensure that people who no longer receive services withdraw from their medications gradually;

- The RBHA present proof of higher capitalization than previously required. Also, the RBHA is required to ensure a specified amount of equity for each client. Both provisions help to ensure that the RBHA remains financially stable.

The Division has also created service guidelines on what types and amounts of services clients with specified illnesses should typically receive. Such guidelines can be compared against treatment actually delivered, thus requiring service providers to explain treatment decisions that deviate from the standard. While the Division has yet to incorporate these service guidelines into its actual quality management activities, its Medical Director states that they may be used as part of the future focus studies that the Division performs of RBHA clients.

Additional Changes Could Further Enhance Oversight

The changes detailed above go a long way toward resolving past oversight problems. During this audit, Auditor General staff identified two additional areas that also need strengthening in order to take full advantage of these improvements:

- **First**, the Division's case file reviews, which look in detail at clinical assessments, treatment planning, and services provided, are currently locked into examining certain procedural requirements and are not being devoted to their primary purpose, which is ensuring the appropriateness of care.

- **Second**, the Division's efforts at improving oversight need to include focusing more attention on ways to assess service accessibility.

Case file reviews need to be changed—The Division needs to improve its case file review process. Several times a year, the Division selects and reviews a sample of case files to re-

view, among other things, the assessments, treatment planning, and services clients receive. A review of relevant literature about these reviews suggests that the Division should be performing them to ensure that clients receive appropriate care. However, the Division is attempting to satisfy other reporting requirements as well as its own information needs, thus diminishing its ability to serve this basic purpose. These other requirements include:

- **Reporting requirements of the *Arnold v. Sarn* decision**—The current review process attempts to satisfy the reporting requirements of the *Arnold v. Sarn* decision (explained more fully in Other Pertinent Information, pages 31 through 34). Until 1994, the court-appointed monitor conducted a review to evaluate the Division's compliance with the terms of the court settlement, but now the Division conducts its own reviews using questions approved by the court monitor.[1] In performing these reviews, the Division has focused its case file reviews more on compliance issues than on the appropriateness of care. Further, the large number of compliance questions (over 60 per case file) required by the monitor limits the number of files reviewed. For example, the Division looks at only 20 case files of children and 20 case files of adults with serious mental illnesses every quarter. Accordingly, the results of the reviews are not as reliable and as valid as they could be. Also, the large number of questions limits the time the reviewer can spend teaching providers how more appropriate services could have been delivered.

- **Determining if Medicaid clients receive appropriate assessment and service planning**—The Division has been using case file reviews to meet this requirement, which AHCCCS has established on a quarterly basis. To meet the AHCCCS requirement of a quarterly review, the Division is performing a case file review each quarter, using the lengthy court monitor-approved questionnaire. The Division could satisfy AHCCCS' requirements by performing a much more narrow review three quarters of each year, and in addition, incorporating the fourth (or final) quarterly review into a more comprehensive annual case file review performed for its own and the court monitor's purposes.

By separating the AHCCCS, Division, and court monitor reviews, the Division's own review can be performed annually rather than quarterly, and the Division can focus more on its own information needs while increasing its sample size and the reliability of results. While separating the reviews may increase the Division's workload, it appears to be critical, given the importance of determining the appropriateness of care. In order to diminish its workload, the Division could consider having the court monitor perform the review as part of her independent review. Since the court monitor retains the right to negate the Division's case file review findings, and has done so in the past, there appears to be little benefit to the Division performing such reviews.

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[1] The court monitor's office conducted an independent review again in 1998, after questioning the results of the Division's case file reviews. As outlined in the supplemental agreement reached between the Department of Health and the plaintiffs in the *Arnold v. Sarn* case in 1998, the court monitor will continue to conduct such independent reviews until the results of the case file reviews and court monitor reviews approximate each other.

Additional monitoring and standards needed to ensure service accessibility—Greater attention is also needed to monitor the accessibility of services. Currently, the Division oversees the accessibility of services by tracking the time it takes clients to receive a service from the time they are first referred by someone for a service. What the Division has not yet begun to measure is whether eligible people who need services are facing barriers that prevent their enrollment in the behavioral health system, whether through referrals or on their own. The Division will begin to grapple with this issue through a performance measure that looks at the number of clients with different illnesses and compares it to rates of illnesses that would be expected in the population. While this gives the Division a better understanding of whether people are getting into the behavioral health system, other steps could also be taken to ensure the accessibility of services. These include:

- **Monitoring the geographic accessibility of services**. The Division could determine where clients and available services are located to determine if gaps in the service network limit the accessibility of services. AHCCCS has requested such a geographical analysis for over three years in order to address AHCCCS' concern about how the Division evaluates the sufficiency of RBHAs' provider networks. The Division owns software allowing it to perform such analysis, yet it appears that the Division has not made this analysis a priority. By performing such analyses, the Division could also set standards regarding how far clients should be expected to travel to the nearest provider, a determination AHCCCS has made for clients in the acute care system and that is common in managed care contracting.

- **Refining minimum network standards**. The Division could better define in its RFPs what types and levels of services should be available to better ensure service availability for clients. In the 1998 RFP for the Maricopa County RBHA, the Division developed such standards. However, the standards used were based primarily on the previous RBHA's provider network, a network that was often criticized for being inadequate. While the Division also bolstered its analysis of network standards by reviewing behavioral health licensure information, the Division still could go further to ensure that true need is captured in these standards. The Division could use research it is currently conducting on gaps in its service delivery system for seriously mentally ill persons in Maricopa County, and it could expand upon this research to define what services are needed for all clients throughout the State. It could then use this information in future RFPs and contracts.

- **Monitoring waiting lists**. The Division could survey providers to determine the accessibility of services. Providers are not allowed to put Medicaid clients on waiting lists, but non-Medicaid clients may be placed on such lists. By surveying providers to determine how many days clients have to wait for appointments and to determine if some services are not available to people who are not eligible for Medicaid, the Division and the RBHAs could better monitor service shortages and better manage the demand for services.

The Division Needs to Ensure That Monitoring Efforts Lead to Improved Results

While improvements to the Division's quality management activities are important, such improvements will be of little value unless problems identified at the RBHAs and promised corrective actions are monitored. In the past, the Division had no organized system of overseeing corrective action plans or monitoring whether improvements were occurring in identified problems. As a result, corrective action plans developed by the RBHAs were not always monitored to determine whether actions promised by the RBHAs occurred. Currently, the Division is developing a method for assigning specific staff the responsibility for monitoring corrective actions. The Division needs to continue these efforts and management should monitor and assess their impact once they have been in place for a year.

Recommendations

1. The Division should continue its efforts to add or modify existing positions as needed and hire staff for its quality management area. In particular, the Division should ensure that it adds the programmers and analysts needed to retrieve and analyze data from the Division's information system.

2. The Division should incorporate and use the recently developed service guidelines to gauge the appropriateness of care as part of its quality management activities.

3. The Division should revise its case file review to create an annual review that measures the appropriateness of care clients receive. To satisfy AHCCCS' requirement that the Division assess the appropriateness of assessment and service planning quarterly, the Division could perform a much more narrow review, incorporating one quarterly review into a more comprehensive annual review performed for the Division's and the court monitor's needs. The Division may also wish to consider having the court monitor conduct her own reviews of the Division's compliance with the exit criteria as part of her annual independent reviews, rather than incorporating such compliance reviews into the Division's case file reviews.

4. The Division should use software that it currently owns to monitor where service providers are located versus where clients live. The Division should then consider adding geographical accessibility standards to future RFPs.

5. The Division should incorporate findings from its analyses of service gaps in its provider network into future RFPs and contracts.

6. The Division should monitor waiting lists and availability of services. To do so, the Division could also survey providers to determine the accessibility of services.

7. The Division should monitor the RBHAs' progress in implementing corrective actions.

FINDING II

THE DIVISION CONTINUES TO HAVE PROBLEMS COLLECTING CRITICAL DATA

The Division's ability to improve its oversight of the State's mental health delivery system is threatened by continued problems it experiences in collecting accurate and complete information about clients. The Division has two major information systems to collect client data: one to track services that clients receive, the other to record clients' illnesses and track the progress they are making. The Division needs accurate and complete information from these systems to justify funding requests, conduct quality management, and measure client outcomes. Although some progress has been made, more needs to be done to improve the accuracy and completeness of both types of information.

The Division Experiences Deficiencies Collecting and Correcting Service Data

The Division has only partly managed to address long-standing problems in collecting data on the types and costs of services received by clients in the behavioral health system. For example, a 1998 study by AHCCCS, the State's Medicaid agency, found that there was an omission error rate of almost 21 percent in the submission of fiscal year 1996 outpatient services data reported to AHCCCS. Lack of better information limits the Division's ability to set capitation rates and monitor the adequacy of services that clients receive, and it also leaves the agency open to fines levied by AHCCCS for substandard reporting of services provided to Medicaid clients. Problems that continue to need attention include resolving a backlog of 116,000 records caused partly by the lack of an automated system to correct service records that AHCCCS has rejected because of inaccuracies during data transfer.

Division has experienced significant and ongoing service data reporting problems—The Division has had long-standing problems with the accuracy and completeness of its client services data. This information is important not only for the Division, but also for AHCCCS and the Health Care Financing Administration, the state and federal agencies responsible for monitoring services funded by Medicaid, a major source of funding for the mental health program. The Division receives the data from RBHAs, who collect it from the service providers they manage, and subsequently transfers Medicaid service records to AHCCCS. Problems with the data were identified as early as 1995, when three studies done by an actuarial consulting firm the Division hired found that service data was often incomplete. For example, a common type of counseling session was underreported by 25 percent. Similarly,

a subsequent study AHCCCS performed in 1998 found that there was an omission error rate of almost 21 percent in the submission of outpatient services data reported to AHCCCS during fiscal year 1996.

*Service information is critical to Arizona's capitated health care system—*A capitated behavioral health care system such as Arizona's needs complete service data for several reasons:

- **First**, service records are necessary for developing capitation rates, which are based, in part, on historical service delivery patterns. If services are underreported, capitation rates may be set too low and the State may receive too few Medicaid dollars to cover the Medicaid population's service needs.

- **Second**, complete service data is needed to help the Division monitor the adequacy of service delivery. In fact, such data is used to develop quarterly quality reviews for AHCCCS, and is also a key component of the Division's new performance indicators.

Failure to report complete or accurate Medicaid service data has also resulted in costly sanctions, and could result in more sanctions in the future. In 1998, AHCCCS fined the Division nearly $100,000 for its failure to meet HCFA's standards on data completeness for fiscal year 1996 data. Although AHCCCS has not imposed additional sanctions, it could do so in the future. AHCCCS has the contractual authority to sanction the Division $5 per month for every service record that stays uncorrected on its database for over 100 days. As of January 1999, almost 20,000 records have been uncorrected for more than 100 days. More than 8,000 have been uncorrected for 180 days or more. While the Division could pass future sanctions onto the RBHAs (and has done so in the past), addressing the causes of data incompleteness and untimely data correction is also necessary.

*Division has only partly addressed causes of incomplete data—*One reason for the incomplete data has been that RBHAs or providers have not been submitting it. Recent changes may help address this problem. A new Division policy, which penalizes RBHAs for incomplete data submission, should encourage compliance with submission requirements. Since February 1998, the Division has performed quarterly checks of service data, and imposed financial penalties on RBHAs failing to meet specified service record reporting thresholds. In fact, the Division recently withheld $1.4 million from CPSA and NARBHA for not meeting such thresholds. (Such amounts are eventually withheld permanently if data submission requirements are not met within specified time frames.) The Division has also completed a major project to change the way the RBHAs and the Division exchange service records, which led to backlogs when some RBHAs experienced difficulties conforming their systems to the Division's new data submission requirements.

A second reason for incomplete or inaccurate data is that providers may be misclassifying data. For example, Division staff note that long-standing omissions in laboratory services may be attributed to providers reporting these services as pharmacy or other types of serv-

ices. The Division and RBHA staff contend that AHCCCS' and the Division's respective data reporting requirements are sometimes unclear.

A third reason for not providing AHCCCS with better data, and a reason not yet fully addressed, is that one computer system does not accept service information received from another system. Some records get rejected (pending correction) because they lack essential information, or contain errors that make them look invalid. Further, the Division has experienced difficulties correcting service records that AHCCCS has not initially accepted. Several factors have contributed to this:

- **Problems identifying Medicaid service providers**—Many records submitted to the Division are rejected (pending correction) because they do not meet a critical requirement, which states that providers can report only those services they are licensed to provide. As of October 1998, the Division had 102,971 records that it had not submitted to AHCCCS since the Division's information system showed the providers were either not licensed to provide the service or not currently registered as AHCCCS providers. The cause of this problem is unknown, since another division within the Department of Health Services (the Division of Assurance and Licensure, Office of Behavioral Health Licensure) determines provider eligibility. It appears that the two divisions need to work together to ensure that the Division of Behavioral Health Services and the RBHAs receive updates on providers' licensure status in a timely manner.

- **The inability to identify Medicare-eligible clients**—Some AHCCCS clients who receive Medicaid assistance are also eligible for Medicare, the federal program that provides health care for the elderly. The Health Care Financing Administration requires Medicare to be billed before Medicaid when clients have dual coverage. However, AHCCCS' information system has been rejecting a large number of service records because the records do not indicate whether service providers billed Medicare for dual-coverage clients. The Division and the RBHAs have not been complying with this requirement because they have not been receiving lists of Medicare enrollees from AHCCCS. Neither Division nor AHCCCS staff realized that the Division was not receiving such lists until a recently hired information technology manager dedicated to behavioral health services discovered the problem. Since the discovery, the Division and AHCCCS have resumed discussions on how this information can be supplied to the Division. In November 1998, over 11,000 service data records were being held in an AHCCCS pending file until the problem could be corrected.

- **Lack of automated system to correct data**—The Division has lacked an effective automated system to correct service records that AHCCCS rejects during data transfer. As of January 1999, over 116,000 records were being held in a pending file at AHCCCS awaiting correction by Division staff. Rather than using an automated system to make changes to problem records sent over from AHCCCS, the Division has had to delete the

records, and later re-submit corrected records. The Division is currently working to develop an automated system for correcting records, which is expected to be in place by July 1, 1999.

- **Lack of technical support staff**—The lack of information technology support from ADHS' Division of Information Technology Services (ITS) has contributed to problems transferring data. When problems with the Division of Behavioral Health's information system have been identified in the past, programming changes were not made for long periods. For example, it took over two years for ITS to make programming changes that allow the Division's information system to accept multiple transportation services provided to clients on the same day.

The Division Also Lacks Complete Clinical Data

In addition to its problems with service data, the Division lacks complete clinical data regarding the types of illnesses that clients experience and their clinical progress. Such information is necessary to evaluate client outcomes and identify service gaps. Two factors have contributed to the Division's deficiencies collecting clinical data, including the lack of incentives to submit such data.

Clinical information is incomplete—The Division continues to have problems collecting complete clinical information on behavioral health clients from the RBHAs. For example, during fiscal year 1998, 56,000 adults and children entered the behavioral health system, but Division records for approximately 27,000 of them (48 percent) lacked information on the client's diagnosis, the client's ability to function, or both. While clinical data submission overall is poor, results vary dramatically by RBHA. For example, in 1998, NARBHA did not submit information for any of its clients on their ability to function. In contrast, auditors' review of the Maricopa County RBHA's records for children who entered the system during fiscal year 1998 found that only 13 percent lacked information on the child's ability to function. Such problems collecting complete data are not new. In fact, the 1996 Auditor General report noted that clinical records were incomplete.

Clinical records are important for studying service needs and client outcomes—The absence of clinical data undermines the Division's ability to assess client outcomes and evaluate service gaps. Information on clients' ability to function is key to evaluating the success of the behavioral health system. For example, several of the Division's new performance indicators (see Finding I, pages 11 through 18) depend on information regarding changes in clients' ability to function.

Similarly, information about client diagnoses is essential for system oversight. Without complete diagnostic information, the Division cannot compare the number of clients who

have different types of illnesses and are being served to the numbers and types that research would suggest the system should be serving. Also, the Division cannot easily determine whether service gaps exist in the provision of behavioral health services if they do not know what types of illnesses need to be treated. Likewise, if the Division fails to use and report such data, the RBHAs cannot compare themselves with each other in order to identify opportunities to improve their own practices.

Transition to new computer system and vague contract language have contributed to incomplete clinical data— Incomplete clinical data can be attributed to at least two factors. First, a 1998 change to the Division's information system affected the RBHAs' submission of clinical data, in part because the RBHAs had to change their own information system reports to conform to the new system's needs but also because at least two RBHAs, in anticipation of the change, temporarily stopped submitting clinical data. That problem is being resolved since the new BHS system has been implemented. A second problem, namely the failure of the Division to sanction the RBHAs for not submitting clinical data, has also affected clinical data submission. According to Division staff, they believed it was unfair to impose such sanctions in the past because the Division was not routinely producing reports using the data and was requiring the RBHAs to adapt to changes in the information system. Further, the RBHA contracts contained unclear language about clinical data submission requirements and penalties. Recent completion of information system changes and changes in contract language now leave the Division in a better position to impose such penalties. The Division should enforce its new contract language, sanctioning RBHAs when data submission is incomplete.

Recommendations

1. The Division should work with AHCCCS to clarify data submission requirements for Medicaid service information, and ensure that all RBHAs and service providers receive clear information regarding Medicaid data submission requirements.

2. The Division should take the following actions to clear up the backlog of records that it has not processed because of uncertainty about whether providers are authorized to provide Medicaid services:

   a. Correct the records currently being held for resolution, and

   b. Work with the DHS Division of Assurance and Licensure and the RBHAs to ensure that the Division of Behavioral Health Services and the RBHAs receive timely, accurate information regarding what Medicaid-funded services providers are licensed to provide.

3. The Department of Health Services and the Division should continue to work with AHCCCS to develop an automated system for correcting behavioral health service records.

4. The Department of Health Services should ensure that the Division of Information Technology Services provides adequate support in the future to the Division of Behavioral Health Services.

5. The Division should enforce contract language regarding clinical data submission requirements and penalties, sanctioning the RBHAs when data submissions are incomplete.

FINDING III

THE STATE NEEDS TO BETTER ENSURE THAT NON-MEDICAID BEHAVIORAL HEALTH MONIES ARE ALLOCATED EQUITABLY AND SPENT EFFECTIVELY

The State needs to better ensure that non-Medicaid monies are spent equitably and effectively. These monies provide services for persons who do not qualify for Medicaid or KidsCare or whose need for services exceeds Medicaid or KidsCare benefits. Demand for these monies greatly surpasses available revenues and continues to increase. The Division's current approach for distributing these monies is based largely on historic funding levels, not on demonstrated health care needs, and guidelines for using the monies are vague. Further, the Division does not have a system for defining who should receive services and what kinds of services should be provided. As a result, funding and services vary across regions of the State, and the Division cannot determine if limited monies are being spent as effectively as possible. The Division should consider implementing a more structured system for the use of these monies based on defined priorities and statewide goals as defined by state policymakers.

Non-Medicaid funds are a significant part of the Division's budget. In fiscal year 1998, non-Medicaid state-appropriated revenues totaled approximately $101 million. The Legislature appropriates approximately 60 percent of these monies for services for the non-Medicaid-eligible SMI population. This funding has remained fairly static, increasing by less than an average of 1 percent annually since fiscal year 1995.

High Demand Exists for Limited Non-Medicaid Monies

More Arizona residents need services than the State is currently able to fund with non-Medicaid monies. Further, the increasing costs of care and the implementation of new mental health programs place even greater demands on these limited monies.

Existing demand exceeds available funding—Currently, a high demand exists for non-Medicaid monies. Many Arizona residents who do not qualify for Medicaid-paid services require assistance to meet their mental health care needs because they are uninsured or underinsured. For example, it has been estimated that as many as 40 million Americans are without any health care coverage. Further, for those non-Medicaid eligible people who are

insured, mental health care benefits provided by insurers are usually restricted and limited[1], meaning that mental health care treatment can result in substantial out-of-pocket expenses. This issue is particularly significant since it is estimated that approximately 29 percent of adult Americans suffer from a behavioral health problem in any given year.[2]

While the full extent of Arizona residents who need such services is unknown, the high unmet demand for non-Medicaid monies became clear in 1997 when ComCare, the previous Maricopa County RBHA, initiated an aggressive outreach program to identify and provide increased services to the non-Medicaid population. As a result of these efforts, ComCare experienced a 68 percent increase in the number of non-Medicaid children receiving services and a 63 percent increase in the number of adults receiving general mental health and substance abuse services. Owing to this tremendous response, ComCare was unable to meet the demand and had to eliminate services to approximately 13,000 non-Medicaid clients.

Maricopa County is not alone in this regard. Statewide, other RBHAs report that the demand for services paid by non-Medicaid monies greatly surpasses the available resources. As a result, RBHAs often must place non-Medicaid clients on informal waiting lists for services. For example, the number of non-Medicaid clients on a statewide waiting list for substance abuse services has averaged about 1,000 persons.

High demand for limited non-Medicaid dollars is increasing—The problem with the inability of non-Medicaid monies to meet current needs is exacerbated by the fact that the demand for these monies is increasing. For example:

- **Rising costs of treatment**—Costs of medications used for treatments of behavioral health ailments have increased dramatically in the past few years. For example, newer, more effective drugs used to treat such illnesses as schizophrenia cost more than older types of drugs used. The Division estimates that the need for non-Medicaid revenues for such drugs will be approximately $15 million in fiscal year 2000. The Division's budget includes approximately $13 million for these drugs for fiscal year 2000.

- **Limited levels of care provided by existing programs**—Programs implemented to provide greater assistance to the non-Medicaid population may ultimately place greater demands on non-Medicaid dollars. For example, the federal State Child Health Care Insurance Program (known in Arizona as the KidsCare Program), implemented in November 1998, provides monies for mental health services to children who are not eligible

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[1] For example, a 1998 study conducted by the Goldwater Institute found that insurance coverage for mental health and substance abuse was not equivalent to that for physical health care. Eighty-six percent of insurers examined had more restrictive coverage for inpatient mental health care. Ninety-six percent had more restrictive coverage for outpatient mental health care.

[2] Prevalence rate information cited from the *Epidemiological Catchment Area Survey* sponsored by the National Institute of Mental Health and the *National Comorbidity Survey* mandated by the U.S. Congress in 1990.

for Medicaid-paid services. It is estimated that as many as 60,000 children will eventually participate in the program. Since KidsCare limits services to a total of 30 days of inpatient care and 30 outpatient visits per year, the State could find itself with thousands of additional clients who require services above and beyond current funding levels.

The Division's Approach for Expending Non-Medicaid Monies Is Problematic

The Division's current approach for allocating and monitoring the use of limited non-Medicaid monies is problematic. It distributes these monies largely on the basis of historical funding levels that have evolved over time and does not link the funding distribution to behavioral health goals or priorities. Further, the current policy directing the use of these monies is vague and does not provide specific guidance regarding how RBHAs should prioritize and spend these monies.

Funding formula not tied to defined goals and priorities—Unlike the system used for allocating Medicaid monies, the Division's formula for distributing non-Medicaid monies does not attempt to satisfy the mental heath care needs of the various geographic regions based on defined populations and services set at the state level. Currently, the Division allocates non-Medicaid monies to RBHAs based primarily on historical funding levels. These historical funding levels evolved as various RBHAs implemented different behavioral health programs and services over time. Such historical funding amounts have not been linked to statewide behavioral health goals and priorities.

Policy provides limited guidance as to how monies should be used—The Division has developed only general guidelines for the use of these monies, which have been in draft form since October 1998. For example, the policy does not identify any priority populations or provide direction regarding the types and extent of services to be provided with non-Medicaid monies. Further, while the Division's contracts with the RBHAs require that they provide the same standards of care to non-Medicaid-eligible clients as are provided to Medicaid-eligible clients, they must do so only "as funding allows." In effect, the Division allows RBHAs to spend non-Medicaid monies as they see fit.

Lack of a State-Driven Prioritized System for Use of Non-Medicaid Monies Has Several Negative Effects

The Division's current approach for allocating and overseeing the use of non-Medicaid monies results in funding inequities between RBHAs, variances in the types and levels of services offered across the State, and an inability to measure the effectiveness and impact of these monies on the State's behavioral health care needs.

Funding inequities between RBHAs—The Division's process for allocating non-Medicaid monies results in funding inequities between RBHAs. For example, though Maricopa County contains 59 percent of the State's entire population, the RBHA providing services in the region received only 49 percent of the total amount of the State's non-Medicaid monies in fiscal year 1998. Further, this RBHA received only 35 percent of non-Medicaid monies designated for general mental health services (services provided to clients with short-term illnesses who can be treated with limited outside assistance) during that year.

Services can vary by region—Because funding levels vary and RBHAs are allowed to allocate non-Medicaid monies as they choose rather than in accordance with defined statewide priorities, services vary by region. In fact, the Division's policy explicitly states that "service priorities may vary by region, depending on funding availability and community need, as demonstrated through the community planning process." As a result, RBHAs provide different services with these monies. For example, two RBHAs provide in-patient hospitalization services for children as a general benefit while the others do not. Further, differences exist between RBHAs regarding medication and transportation benefits provided for non-Medicaid clients.

Cannot measure effectiveness of dollars—Because no system exists for defining who should receive services and what types of services should be provided, it is difficult for the Division to monitor whether RBHAs are spending monies as effectively as possible, which is a definite limitation compared to the Medicaid program. For Medicaid services, the Division is able to determine how many dollars are spent for each Medicaid-eligible client in a geographic region and then compare it to the capitated rate. Since the rate is based on predictions of how many people will need services and the costs of those services, the Division could determine if service dollars are spent effectively and measure the impact of such expenditures. For non-Medicaid monies, the Division is only able to confirm that the dollars are being spent on services.

The Legislature Needs to Better Define How Non-Medicaid Monies Should Be Distributed and Used

The Legislature needs to take the lead in developing statewide priorities for the use of non-Medicaid monies. The Division recognizes the need to set such priorities, as witnessed by its policy for allocating non-Medicaid monies, which states "a need for a more unified, parity based allocation methodology has become apparent." However, the Division has been cautious to develop a new approach since a comprehensive redistribution of these monies could negatively impact certain RBHAs that have implemented programs based on the current allocation formula. However, not developing a more structured approach limits the State's ability to know if these monies are being used in the most effective manner. Therefore, the Legislature should consider establishing priorities for the use of these monies. Several policy options are available for the Legislature's consideration when setting such pri-

orities. After statewide priorities have been identified, the Division should revise its non-Medicaid funding allocation formula to reflect these statewide funding goals.

Need for clear set of priorities—Establishing defined priorities for the use of non-Medicaid monies is a daunting task, because it means that the State would explicitly exclude certain populations from receiving services paid for by non-Medicaid monies and/or diminish the extent and type of services provided. Such decisions are not only difficult to make but may be controversial and could lead to negative public reaction to such decisions. However, since limited non-Medicaid dollars do not meet the current demand, the Division already rations these monies but does so by default, rather than basing tough funding decisions upon a structured process built on well-defined statewide goals.

Several options exist—A literature review reveals that several policy options exist for establishing general funding priorities for non-Medicaid monies. The Legislature, in consultation with key stakeholders, may want to adopt one approach or develop a hybrid of several.

- **Prioritize based on population types**—The State may want to prioritize non-Medicaid funds based on specific population types. Populations could be prioritized based on a number of different variables. For example, priorities could be based on the income level of non-Medicaid-eligible clients. Under such an approach, the "working poor" who are not eligible for Medicaid could be a priority population for non-Medicaid monies and services. Another possible approach is to prioritize based on clients most at risk. Such an approach would prioritize non-Medicaid services for those clients who are most at risk if they do not receive services. Conversely, the State could prioritize non-Medicaid resources for clients who are most likely to have successful outcomes from treatment.

- **Prioritize based on services**—Another option for rationing non-Medicaid monies is to limit the number and/or types of services available. For example, the State could limit the number of services provided to each client. Under this approach, clients would not receive the full range of treatments prescribed for any given disorder but would instead receive a limited amount of services. Under such a scenario, clients would perhaps receive medications for their illness but would not receive any counseling services. Another method for prioritizing funds would be to offer only those services proven to be highly effective. However, since these services are often costly, the number of clients served would most likely be very restricted. Conversely, since these treatments are often costly, the State could instead opt to use non-Medicaid funds for less expensive types of services that could be provided to a greater number of clients. For example, the State could eliminate funding for costly treatments such in-patient hospitalization in favor of less costly outpatient services.

Regardless of the policy approach adopted by the State, funding priorities should ensure the equitable delivery of non-Medicaid services statewide and should be structured in a manner that ensures the ability to measure the effectiveness of these dollars. While funding priorities should be established based on statewide goals, they should provide RBHAs with some

flexibility regarding how they use non-Medicaid funds to address unique local mental health issues. Further, priorities should be developed using input garnered from key stakeholders and the general public. Oregon gathered extensive public input when it developed mental health spending priorities. For example, Oregon, among other things, held 47 community meetings and extensively surveyed key stakeholders and members of the general public. Oregon's plan provides basic mental health coverage to all of its citizens who do not have medical insurance. Additionally, the plan places high funding priorities on clients with biological illnesses, such as schizophrenia; on illnesses causing a loss of functioning, such as eating disorders; and on illnesses that have a high impact on children.

***Revise funding formula*—** After priorities have been identified, the Division should revise its non-Medicaid funding allocation formula to reflect these statewide funding goals. Any funding formula designed should contain some of the theoretical underpinnings behind the capitated system used for Medicaid monies. Specifically, in addition to aligning allocations to specific funding goals, distribution should be based upon a General Services Area's population and the potential need for services in those areas based on data that reveals prevalence rates of persons needing services.

Recommendations

1. The Legislature should establish funding priorities for the use of non-Medicaid monies. In doing so, the Legislature should solicit input from key stakeholders and the community at-large.

2. After the Legislature sets funding priorities for non-Medicaid monies, the Division should revise its funding allocation formula to reflect these goals.

OTHER PERTINENT INFORMATION

In 1981, the Superior Court of Arizona ruled that the Department of Health Services had not provided the level of mental health services promised in state law. This decision, *Arnold v. Sarn,* led to a 1991 court-ordered plan for delivering increased services to people with serious mental illnesses in Maricopa County. The Department did not meet the conditions of this plan. After missing a court-imposed deadline for implementing the plan in 1995, the Department of Health Services negotiated criteria for ending the lawsuit. However, the Department remains far from meeting these criteria and appears to have little hope of doing so without substantial increases in state funding. The future of the case may lie with a committee that will soon be looking at ways of settling the lawsuit.

***Decision requires Department to increase services*—**In 1981, the Superior Court of Arizona decided in the *Arnold v. Sarn* lawsuit that the Department of Health Services and the Maricopa Board of Supervisors had failed to provide adequate mental health services to people in Maricopa County as promised by state law. A.R.S. Title 36, Chapters 5 and 34 establish the State's mandatory and nondiscretionary duty to provide an extensive array of community mental health services to all seriously mentally ill people regardless of funding availability.

As a result of the decision, a court-ordered plan was developed in 1991, containing 246 requirements the Department was supposed to meet by September 30, 1995, at an estimated cost of $240 million. The plan was considered by many to be an "advocates' dream." It gave clients a voice in their treatment decisions, established a grievance and appeal process for clients, and outlined an extensive system of care for persons with serious mental illnesses.

***Conditions of plan not met*—**In November 1995, after missing the deadline for meeting the terms of the court-ordered plan, the Department and the plaintiffs entered into negotiations to resolve the lawsuit. As a result of the negotiations, "exit criteria" were developed defining the services, supports, and benefits that must be provided to indigent persons with serious mental illnesses in Maricopa County in order to exit the court case. The actions and requirements necessary to meet the criteria include:

- Development of community living arrangements and appropriate supports for individuals discharged from supervisory care homes or the Arizona State Hospital;
- Expansion of the crisis network in Maricopa County;
- Diversion of some seriously mentally ill people from the Maricopa County Jail and the provision of mental health services for the seriously mentally ill at the jail;
- Development of internal quality management systems;

- Compliance with standards and defined degrees of compliance in the exit criteria itself. An example of such a standard is that 80 percent of a group of "priority" persons with serious mental illnesses in Maricopa County were to have their needs met within three years.

Department appears to be far from meeting exit criteria—Even though ADHS' former director projected the criteria would be met by the end of 1998, ADHS does not appear close to meeting it. In general, the court monitor (who is responsible for overseeing compliance with the court-ordered agreement) noted a lack of both residential and nonresidential treatment for substance-abusing persons with serious mental illness. The court monitor said there is a lack of housing and vocational and day programs for these priority clients and that the agency is having difficulty transitioning persons with serious mental illness from supervisory care homes to community living arrangements.

The court monitor's comments mirror the findings of an August 1998 independent review performed for her office. Overall, the study found that ADHS had not made available community living arrangements and supports necessary to meet individual needs and to ensure the appropriate discharge of people from the Arizona State Hospital. Also, the study found that most of the specific standards described in the exit criteria were not met for the vast majority of clients whose cases were reviewed.

Supplemental agreements negotiated—As a result of the court monitor's 1998 review, plaintiffs and the Department entered into a supplemental agreement in December so that the Department could avoid going back to court for noncompliance with the exit criteria. In the supplemental agreement, the Department promised to conduct a study of gaps in the current delivery system for persons with serious mental illness in Maricopa County. It also promised to develop strategic plans to address housing, vocational, and substance abuse treatment needs for seriously mentally ill people in Maricopa County. Furthermore, the Department agreed to submit an amended fiscal year 2001 budget and fiscal year 2002 budget to the Governor to fully implement the strategic plans.

Additional state dollars appear to be needed—The supplemental agreement implies that additional dollars will be needed if the Department is to meet the exit criteria. Legal counsel for the Department confirmed this in a March 1999 letter to the court monitor, which stated:

> *"ADHS does not believe it can effectively meet the needs of the seriously mentally ill in this state without additional funds. This is the real issue. The legal proceedings, the Judgment, the Exit Stipulation, and the Supplemental Agreements are the results of these unmet needs relative to statutory requirements regarding the provision of services."*

In its fiscal year 2000-2001 budget request, the Department also recognized the need for additional dollars to meet the exit criteria. It requested approximately $32.2 million to complete the terms of the exit criteria. Similar amounts would be required in subsequent years.

The money requested was to be used for purposes such as:

- **More services**—"To comply with removing patients from placements in supervisory care homes, providing agreed upon levels of case management and quality control, developing additional community alternatives and other stipulations in the agreement."

- **Drugs and new programs**—In addition, the funds were to be used for "the purchase of atypical psychotropic medications. . .(and for) a jail diversions program, dual diagnosis programs. . .and (the) expansion of psychiatric rehabilitative services."

- **Community living arrangements**—Part of the money was to be used to establish community living arrangements for seriously mentally ill clients ready to be discharged from the Arizona State Hospital.

In addition to dollars being needed to augment services to meet exit criteria standards, additional state dollars may be needed to prevent a *decline* in existing services for the mentally ill. The Department recently projected that federal funding for at least 300 Housing and Urban Development (HUD) housing units would not be renewed beginning in April 1999.

Budget calls for smaller increases than needed to meet exit criteria—While significant increases in dollars may be needed for the Department to meet the exit criteria, the fiscal year 2000-2001 budget provides only $10 million in the first year and $6 million in the second year in appropriations for non-Medicaid services. Both budget increases are targeted for antipsychotic medication for seriously mentally ill people. The lack of legislative and gubernatorial support for the Department's budget request has resulted in the Department being called back to court several times in recent months. The plaintiffs in the *Arnold v. Sarn* case have argued that the Department did not fulfill its obligation to use its "best efforts" to ensure that the Governor and Legislature adopt the Department's fiscal year 2000-2001 budget request. The Department contends that it did use its "best efforts," and that nothing in the supplemental agreement commits the Governor to proposing additional funding. In lieu of a more formal compliance hearing, the Department has agreed to work with the plaintiffs in the future when developing their budget request so that the plaintiffs are satisfied that the Department is making adequate efforts.

Task force faces several options for ending the lawsuit—A seven-member task force was created during the 1999 legislative session to review and make recommendations regarding the current mental health system. According to legislative staff, this committee will be looking at how the State can finally end the *Arnold v. Sarn* lawsuit. The committee is comprised of two people appointed by the Speaker of the Arizona House of Representatives, two people appointed by the President of the Arizona State Senate, two people appointed by the Governor, and a chairperson chosen jointly by the Speaker, the Senate President, and the Governor.

It currently appears that this committee will have three options available to it to end the lawsuit. The first would be to change the statute on which the lawsuit is based, thus removing the State's obligation to provide an extensive array of services for those people who have serious mental illnesses, regardless of funding availability. The second option would be to increase funding in hopes of improving the provision of services to the seriously mentally ill and meeting the exit criteria. The final option would be to renegotiate the exit criteria, which would probably still require additional levels of funding. The 1994 Auditor General's report (Report No. 94-8) recommended that the Legislature change statute to limit the Department's nondiscretionary duty to provide services to the seriously mentally ill in order to end the lawsuit.

SUNSET FACTORS

In accordance with A.R.S. §41-2954, the Legislature should consider the following 12 factors in determining whether the Department of Health Services, Division of Behavioral Health Services should be continued or terminated.

1. Objective and purpose in establishing the agency.

State law does not outline overall, specific objectives for the Division. However, the Division's own strategic plan states:

> "*the mission of BHS is to serve the people of Arizona by continually improving the effectiveness and efficiency of behavioral health services.*"

The Division describes its vision as ensuring :

> " *an accountable and accessible behavioral health system. This system provides for responsive, comprehensive, community-based services tailored to the individual, family, community, and culture. It does this to promote healthy development and to provide effective prevention, evaluation, treatment and rehabilitation for people in need who would otherwise go unserved so that people are empowered and can lead responsible, productive and meaningful lives. It reduces the costs to society from behavioral health problems and improves the quality of life for the people (it) serves and for society.*"

2. The effectiveness with which the agency has met its objective and purpose and the efficiency with which the agency has operated.

While the Division has been criticized in the past for its failure to adequately oversee the State's behavioral health care system, it does appear that these oversight efforts are improving. In the last several years, the Division has created more defined standards in the Maricopa County RBHA contract, and revised many of the methods it uses to oversee the RBHAs, allowing the Division to better ensure the accessibility, appropriateness, and effectiveness of behavioral health services. However, the Division needs to make further improvements in its oversight efforts, including changing its case file review practices, measuring service availability, and monitoring RBHA corrective action plans. (See Finding I, pages 11 through 18.) In addition, the Division continues to have problems collecting the service and clinical data that it needs to adequately perform oversight. (See Finding II, pages 19 through 24.) The division could also improve its approach to distributing monies for non-Medicaid-eligible clients and services. (See Finding III, pages 25 through 30.)

3. The extent to which the agency has operated within the public interest.

The Division oversees a managed behavioral health care system that serves over 65,000 people. Through its managed care contractors, the Division ensures that behavioral health services are provided to adults with serious mental illnesses; children with behavioral health problems; adults with short-term mental health problems; and adults with substance abuse problems. The Division also provides inpatient psychiatric services at the Arizona State Hospital.

Even though the State's publicly funded behavioral health care system does serve tens of thousands of people, evidence suggests that many people are not able to receive non-Medicaid funded services since the demand for such services exceeds the state dollars appropriated for them. People seeking such services include the working poor whose incomes are too high to allow them to qualify for Medicaid, and other Arizonans who are uninsured or underinsured. (See Finding III, pages 25 through 30.)

4. The extent to which rules and regulations promulgated by the agency are consistent with the legislative mandate.

According to the Governor's Regulatory Review Council, the Division has promulgated all rules mandated by the Legislature.

5. The extent to which the agency has encouraged input from the public before promulgating its rules and regulations and the extent to which it has informed the public as to its actions and their expected impact on the public.

In the past, the agency was exempt from soliciting public input before promulgating rules. Nonetheless, it did solicit informal public input before establishing its rules. Currently, the Division is conducting a five-year review of its rules, as is required periodically of state agencies. The Division is planning to gather formal input from the public when reviewing those rules. It has already been soliciting comments from the RBHAs regarding proposed rule changes.

The Division also encourages public input in a number of other ways. For example, it holds public forums around the State to gather public input for its planning processes. The Division also coordinates several planning and advisory councils comprised of community members and consumers of behavioral health services.

6. The extent to which the agency has been able to investigate and resolve complaints that are within its jurisdiction.

Complaints regarding such things as a client's eligibility for a service are termed as "appeals" in the behavioral health system. Such appeals are required to be filed with the RBHA, and can be appealed to the Division after the RBHA appeals process has been exhausted. Complaints regarding violations of rights, such as allegations of

physical and sexual abuse, are known as "grievances." Like appeals, grievances generally are first filed with RBHAs, only to be appealed by the client after no satisfactory resolution occurs at the RBHA level. The Division investigates and resolves both types of complaints. However, it appears that the State's complicated and confusing system for filing grievances and appeals may preclude some people from ever filing appeals in the first place. Indeed, a 1998 study by behavioral health care experts found that many consumers cannot easily use the process. The study pointed out that the grievance and appeals process for children in Maricopa county was difficult for families to understand. The experts assert that simpler language could be used to make the complex appeals process more comprehensible.

The Division does not systematically collect information regarding other types of complaints. Currently, it tracks informal complaints sporadically, without a formal system. The Division is currently working on developing a complaint-tracking system that will help it to track informal complaints and identify systematic problems with RBHA performance.

7. The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under enabling legislation.

The Division is not a regulatory agency and does not "prosecute actions." However, the agency does have provisions in its contracts with the RBHAs, required by statute, that require the imposition of penalties for contract violations and for the failure to pay service providers. The penalties are prescribed by statute and the imposition of a penalty must result in an administrative hearing at which the Attorney General represents the agency.

8. The extent to which the agency has addressed deficiencies in the enabling statutes that prevent it from fulfilling its statutory mandate.

No apparent deficiencies exist in the agency's enabling statutes.

9. The extent to which changes are necessary in the laws of the agency to adequately comply with the factors listed in the Sunset Laws.

No apparent changes are needed.

10. The extent to which the termination of the agency would significantly harm the public health, safety, or welfare.

Terminating the Division would likely have an impact on the public's health, safety, and welfare. The Division currently oversees a managed behavioral health system

that provides services to over 65,000 people. Terminating the agency would likely lead to a major disruption in the State's current managed behavioral health care system. However, it has been proposed in the past that the Division's oversight could be performed by the Arizona Health Care Cost Containment System, which oversees acute, Medicaid-funded services for the indigent. AHCCCS currently oversees the Division's performance for the Health Care Financing Administration, the federal agency that distributes Medicaid monies to the states.

11. The extent to which the level of regulation exercised by the agency is appropriate and whether less or more stringent levels of regulation would be appropriate.

This factor is not applicable.

12. The extent to which the agency has used private contractors in the performance of its duties and how effective use of private contractors could be accomplished.

The Division uses private contractors called Regional Behavioral Health Authorities (RBHAs) to deliver publicly funded behavioral health services in Arizona. In fiscal year 1998, these five RBHAs received $275.5 million to provide behavioral health care to over 65,000 Arizonans.

The Division has made considerable progress in its ability to attract bidders for RBHA contracts over the past several years. The 1998 request for proposal for the Maricopa County RFP attracted three bidders, while the agency was able to attract only one bid for the Maricopa contract in 1995. Increased competition for the contract can be attributed in part to improvements made to the RFP. For example, the most recent RFP allowed for-profit companies to bid for the contract.

While improvements were made to the Maricopa County RFP, the Division may need to make additional changes to future RFPs to encourage competition. Some representatives from current RBHAs believe that competition will be limited if provisions in the Maricopa County RFP are replicated in future RFPs for other geographic service areas. For example, several RBHA representatives note that the capitalization requirement in the Maricopa County RFP may be too high for the current nonprofit RBHAs to match. Also, the Division has yet to make other changes to RFPs suggested in the Auditor General's 1996 report (Report No. 96-19). For example, the RFP does not guarantee risk sharing with the contractor. Other states assure potential contractors that they will not face unreasonable losses for providing needed services to Medicaid clients, thus making contracts appear less financially risky.

In addition to using private companies to administer the provision of behavioral health services, the Division also uses private contractors to provide consulting and actuarial services. In fiscal year 1998, the Division spent $2.4 million on such services.

Also, the Division paid ComCare, the former RBHA for Maricopa County, $1 million for Deloitte and Touche's consulting services after the financial failure of ComCare and the State's subsequent takeover of the agency. The RBHA subsequently reimbursed the Division.

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Agency Response

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JANE DEE HULL, GOVERNOR
JAMES R. ALLEN, MD, MPH, DIRECTOR

Debbie Davenport
Acting Auditor General
Office of the Auditor General
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Phoenix, AZ 85018

Dear Ms. Davenport:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) wishes to thank you for soliciting our response to your draft report of the performance audit of the Department's Division of Behavioral Health Services.

The ADHS agrees in general with the findings and recommendations of the audit team. The Department is pleased to note that the Division has already identified many of the issues documented in your report and have already begun corrective action.

I would like to thank you and your staff for the thoroughness, professionalism and consideration shown during this audit. The audit team kept the ADHS management informed regarding their review process and progress and maintained a non-threatening, professional manner.

Sincerely,

James R. Allen, M.D., M.P.H.
Director

JRA:CS:ad

Enclosure (1)

c: Jim Griffith
Ronald Smith

Arizona Department of Health Services
Response to the Performance Audit on the
Division of Behavioral Health Services

Overview:

The Arizona Department of Health Services (ADHS) agrees in general with the findings and recommendations of the audit team and would like to thank the Auditor General's staff for the professional manner in which the audit was performed. The audit team was cooperative and pleasant to work with.

As noted by the audit team, in the two-and-a-half years since the Auditor General's previous report, the Division of Behavioral Health Services (Division) has made many changes and tried to incorporate as many of the recommendations from the previous report as possible. The Division issued an RFP for Maricopa County that was both competitive in nature and specifically outlined the requirements of the new contractor. The Bureaus of Quality Management and Financial Operations have been restructured and staffed to adequately perform the oversight and monitoring roles of the Division. A new RBHA Operational and Financial review process has also been instituted, including a revised tool and a complete process for monitoring and following up on the RBHAs corrective action plans. The Department understands the need for outcome data. The Division has created the CEDAR system which allows for the creation of performance measures. The Division reported on the first set of Performance Measures in the June Quality Management Report for the time period January 1999 - March 1999. Furthermore, with the addition of a new Deputy Assistant Director, who has experience working with the AHCCCS Contracted Health Plans, the Division is more capable to meet the provisions of the AHCCCS/ADHS IGA. The ADHS has hired key staff, including an Assistant Director and Project Manager, in the Information Systems Technology Unit to assist the Division in meeting the data submission and reporting requirements of HCFA and AHCCCS. Lastly, the Division has created a mentor program designed to train staff in the oversight and monitoring process. This will ensure that the progress made over the last two-and-a-half years will not be lost as the staff that facilitated this progress leave the Division.

Finding I: ***Improved Oversight of the Behavioral Health Care System can be Further Strengthened by Additional Actions***

Recommendation 1. The Division should continue its efforts to add or modify existing positions as needed and hire staff for its quality management area. In particular, the Division should ensure that it adds the programmers and analysts needed to retrieve and analyze data from the Division's information system.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented subject to available funding.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Department of Administration approved the positions of Business Information Manager, Applications Programmer, Programmer Analyst II (two positions), and Programmer Analyst III, Researcher/Data Analyst, Program Project Specialist I and Executive Consultant II on July 12, 1999. The Division will immediately begin the hiring process.

Recommendation 2. The Division should incorporate and use the recently developed service guidelines to gauge the appropriateness of care as part of its quality management activities.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Clinical Initiatives Council of the Division has elected to begin with practice guidelines for conduct disordered children/adolescents, pregnant substance abusing women, and schizophrenia. The guidelines will be used to develop focused chart audit modules to assess practice for these targeted groups of clients.

Recommendation 3. The Division should revise its case file review to create an annual review that measures the appropriateness of care clients receive. To satisfy AHCCCS's requirement that the Division assess the appropriateness of assessment and service planning quarterly, the Division could perform a much more narrow review, incorporating one quarterly review into a more comprehensive annual review performed for the Division's and the court monitor's needs. The Division may also wish to consider having the court monitor conduct her own reviews of the Division's compliance with the exit criteria, as part of her annual independent reviews, rather than incorporating such compliance reviews into the Division's case file reviews.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Division is developing a core set of questions which will be employed either quarterly or annually for

case file review purposes. In addition, practice guidelines will be used to develop focused review modules to assess practice for targeted groups of clients. The first three modules we are considering are for schizophrenia, conduct disorder, and pregnant substance abusing women. Finally, the Division will continue its quarterly review of persons with serious mental illness in the interest of continuous system performance improvement. At the same time, the Division continues to work with the court monitor to streamline the Case File Review Protocol and direct its content toward outcomes of care as well as compliance with the Exit Criteria.

Recommendation 4. The Division should use software that it currently owns to monitor where service providers are located versus where clients live. The Division should then consider adding geographical accessibility standards to future RFPs.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Division has sent seven (7) staff to training in the month of June 1999 for the Geographical Information System software, ArcView. Ongoing training will be scheduled to increase the staff expertise, as needed. The GIS software is installed and it is anticipated that the Division's Annual Provider Network Status Report will contain geo-coded maps which show providers' location relative to client population base.

Recommendation 5. The Division should incorporate findings from its analyses of service gaps in its provider network into future RFPs and contracts.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division and its consultants will continue to identify service delivery models for optimally treating individuals served through the RBHAs. Considerable effort will need to be focused on developing a statewide provider network that can sufficiently fill the identified gaps in services. The Division will use the research methodology currently being conducted for service gap analysis for persons with serious mental illness in Maricopa County to expand the development of the statewide provider network for all behavioral health populations served. This analysis will not be completed in time for the RFP currently being written for the

Geographical Services Areas outside of Maricopa County, due to be issued in the Fall of 1999. However, requirements for minimum network standards based on actual need could be reflected in future RFPs and RBHA contracts.

Recommendation 6. **The Division should monitor waiting times and demand for services. To do so, the Division could also survey providers to determine the accessibility of services.**

Agency Response: *The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.*

The Division agrees with the recommendation but will require the RBHAs to survey their providers to determine the accessibility of services for all clients. This then would become another element on which the Division will monitor.

Recommendation 7. **The Division should monitor the RBHA's progress in implementing corrective actions.**

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Division continues to monitor the corrective actions required of the RBHAs. A systematic tracking matrix has been developed which logs and tracks the status of all corrective actions required of the RBHAs. The corrective actions are reviewed, approved, and monitored by the Division's monitoring teams and through the DBHS Quality Management Committee. Executive Management is informed of corrective action plans which have not been completed or are slow in implementation in order for further actions to be considered, up to and including financial sanctions or contract termination.

Finding II: The Division Continues To Have Problems Collecting Critical Data

Recommendation 1. The Division should work with AHCCCS to clarify data submission requirements for Medicaid service information, and ensure that all RBHAs and service providers receive clear information regarding Medicaid data submission requirements.

Agency Response: *The findings of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. As necessary, the Division and AHCCCS have meetings to discuss the data transmission and submission requirements between the Division and AHCCCS. Furthermore, beginning in April, 1999, the Division started conducted monthly information system meetings between the Division and the RBHAs to discuss the data submission requirements of the Division and AHCCCS and to provide technical assistance and updates to the RBHAs.

Recommendation 2. The Division should take the following actions to clear up the backlog of records that it has not processed because of uncertainly about whether providers are authorized to provide Medicaid Services:

a. Correct the records currently being held for resolution, and

b. Work with the DHS Division of Assurance and Licensure and the RBHAs to ensure that the Division of Behavioral Health Services and the RBHAs receive timely, accurate information regarding what Medicaid-funded services providers are licensed to provide.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

a. The Division agrees with the recommendation and has already implemented steps to address the issue. The Division has identified the records that need to be corrected and is in the process of clearing up the backlog of records.

b. The Division and the Division of Assurance and Licensure will work to create a process to ensure timely notification to the Division of changes in providers ability to provide behavioral health services. The Division will subsequently notify the RBHAs

of a change in a provider's status. This timely notification will ensure that only those providers registered to provide behavioral health services will be the providers providing such services.

Recommendation 3. **The Department of Health Services and the Division should continue to work with AHCCCS to develop an automated system for correcting behavioral health service records.**

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. The Division has worked with AHCCCS and the RBHAs to develop an automated system for correcting behavioral health service records. As of June 1999, the Division and the RBHAs started correcting such records.

Recommendation 4. **The Department of Health Services should ensure the Division of Information Technology Services provides adequate support in the future to the Division of Behavioral Health Services.**

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Department agrees with the recommendation and has already implemented steps to address the issue. Through the hiring of a new Assistant Director of ITS, a new Chief of ITS for Behavioral Health Services, and a new ITS Project Manager for Behavioral Health Services, the Department has started to provide adequate support to the Division of Behavioral Health Services.

Recommendation 5. **The Division should enforce contract language regarding clinical data submission requirements and penalties, sanctioning the RBHAs when data submissions are incomplete.**

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Division agrees with the recommendation and has already implemented steps to address the issue. With the new contract amendments, effective July 1, 1999, changes in the requirements for submission of data, and changes in the contract language regarding imposition of sanctions, the Division is now in a better position to enforce data requirements.

Finding III: The State Needs to Better Ensure that Non-Medicaid Behavioral Health Monies Are Allocated Equitably and Spent Effectively

Recommendation 1. The Legislature should establish funding priorities for the use of non-Medicaid monies. In doing so, the Legislature should solicit input from key stakeholders and the community at-large.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented.*

The Department recognizes the efforts of the Auditor General in looking at how non-Medicaid monies are disbursed. The report does point out how difficult it is to distribute limited monies which, as acknowledged by the Auditor General, are insufficient to meet the current demand.

The Department agrees that if priorities are set differently than they are now, which is through a local planning process, then it should be at the direction of the Legislature. The Department will assist the Legislature in determining the pros and cons of legislatively mandated priorities.

Recommendation 2. After the Legislature sets funding priorities for non-Medicaid monies, the Division should revise its funding allocation formula to reflect these goals.

Agency Response: *The finding of the Auditor General is agreed to and the audit recommendation will be implemented consistent with Legislative mandate.*