State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

BEHAVIORAL HEALTH SERVICES

INTERAGENCY COORDINATION OF SERVICES

Report to the Arizona Legislature
By Debra K. Davenport
Auditor General

February 2000
Report No. 00-2

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DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

February 15, 2000

Members of the Legislature

The Honorable Jane Dee Hull, Governor

Dr. James L. Schamadan, Acting Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, a performance audit of the coordination and provision of behavioral health services among selected state agencies, in response to an October 6, 1998, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by A.R.S. §41-1279.

This report addresses why people referred from other state agencies to the state behavioral health system do not always receive services. Several factors appear to contribute to such service denials. First, we found that disputes over the medical necessity of services and agency roles in serving clients with special needs often contribute to disagreements over needed services. Second, there is some confusion over whether some services, particularly substance abuse services, are available to Medicaid clients. Confusion also exists over whether clients referred by other state agencies are actually enrolled in the Medicaid program. Finally, some services are simply unavailable, especially for disruptive clients or for clients living in rural areas. Several recommendations, ranging from clarifying existing policies to transferring the administration of behavioral health services for developmentally disabled ALTCS clients, are offered to help diminish interagency disagreements and improve access to needed services.

This report also recommends that the Division of Behavioral Health Services play a greater role in providing treatment for Medicaid-eligible juvenile sex offenders on parole or probation, and Medicaid-eligible juveniles who are removed from prison for behavioral

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health treatment. Such a shift in service provision could help the State save money. If BHS provides such services when medically necessary with Medicaid dollars, the State may be able to conserve money since Medicaid dollars are largely financed by the federal government. Currently, such services are paid for by the courts and Juvenile Corrections using state-only dollars.

As outlined in its response, the Department of Health Services agrees with all of the findings and recommendations. In addition, although they were not asked to provide written responses to the report, the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Office of the Courts, the Department of Juvenile Corrections, and the Department of Economic Security reviewed the report. All four agencies also agreed with the recommendations that pertained to them.

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

This report will be released to the public on February 16, 2000.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit of the coordination and provision of behavioral health services among selected state agencies, in response to an October 6, 1998, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by A.R.S. §41-1279. A separate review of the Department of Health Services—Division of Behavioral Health Services (BHS) was issued in July 1999 (Report No. 99-12).

Individuals with behavioral health needs often encounter other agencies first.

Although BHS is responsible for providing publicly funded behavioral health services in Arizona, many individuals with behavioral health needs first encounter another public agency, such as a court or the Department of Economic Security. The agencies often refer these individuals to BHS for services, but are not always able to access all of the care agency officials believe is needed for their clients. Previous studies by legislative committees and private organizations have recommended ways to improve interagency communication and reduce duplicated efforts. In this audit, in-depth case studies were conducted to explore the reasons some individuals do not receive the services requested by the referring agencies. These case studies, along with other audit methods such as interviews and reviews of documentation, uncovered common themes that help to explain interagency disagreements and suggest additional recommendations for ensuring that other agencies' referred clients receive appropriate services.

Managed Care Focus, and Structure That Divides Responsibility, Leads to Interagency Disagreements (See pages 11 through 21)

Arizona's behavioral health system has three characteristics that contribute to interagency disagreements.

- **First**, its managed care focus provides some incentive for limiting services in order to minimize costs. The Regional

Behavioral Health Authorities (RBHAs) that contract with BHS to administer the delivery of behavioral health services may incur financial losses if they spend more than the fixed sum they receive in advance.[1] As a result, RBHAs monitor service utilization, require authorization for service beyond predetermined limits, and deny services when they are not medically necessary.

- **Second**, Medicaid rules require RBHAs to provide only services that are "medically necessary," a standard with an appropriately broad definition that provides ample discretion for allowing or denying services. According to Arizona's definition of medical necessity, services must be expected to benefit the client's mental or physical health, and should be delivered in the least restrictive setting proven or predicted to be effective in meeting the client's behavioral health needs in order to conserve costs.

- **Third**, the fragmented structure of service provision between agencies allows cost-shifting between agencies. Other agencies can sometimes purchase behavioral health services for their clients, making it difficult to determine which agency should pay for such services for a shared client. Distinctions between agency roles are unclear in some cases.

These system characteristics contributed to interagency disagreements regarding two cases auditors examined, Todd and Irene.[2] Todd, a 15-year-old boy referred to BHS by Child Protective Services (CPS), was receiving services in a residential treatment center where staff supervised him 24 hours a day, but these services were terminated by a RBHA psychiatrist who said they were not medically necessary. Although Todd's court-appointed psychiatrist and CPS caseworker believed he needed to stay in the supervised setting, where he did well, the RBHA psychiatrist thought his good progress in the supervised setting indicated his behavioral problems might be caused by family problems at

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[1] The Division may adjust capitation rates or payments to RBHAs if losses are too great. Further, contractual limits on the amount of profit that can be realized by the RBHAs further guard against underservice.

[2] All names cited in the report have been changed to protect privacy.

home. In Todd's case, professionals disagreed about the necessity for providing services in a restrictive live-in setting.

Cost-shifting appeared to be a factor in the case of Irene, a DDD client.

Cost-shifting appeared to be a factor in Irene's situation. Irene, a client of DES' Division of Developmental Disabilities (DDD), has cerebral palsy, which does not create behavioral health problems. However, RBHA staff attempted to shift responsibility for Irene's services to DDD, first by alleging that her behavioral health problems were caused by mental retardation, and later, when they learned she did not have mental retardation, by claiming that her cerebral palsy explained her behavior.

To alleviate these types of disputes, responsibility for some clients such as some DDD clients could be transferred away from the RBHAs. In addition, agencies could make some procedural changes and BHS could improve its oversight of the RBHAs. Specifically:

- DDD could assume responsibility for some of its own clients' behavioral health services. This would be comparatively easy because DDD already has the needed financial and information systems in place for clients enrolled in the Arizona Long Term Care System (ALTCS).

- BHS and other agencies could reduce medical necessity disputes by working with other agencies to develop methods for routinely reviewing and synthesizing all agencies' assessment information, and ensuring that RBHA staff responsible for performing assessments are adequately qualified.

- Finally, to ensure that clients receive adequate and appropriate care, BHS should continue to improve its oversight of RBHAs to help ensure they do not inappropriately limit or deny services.

Confusion Exists Regarding Medicaid Coverage (See pages 23 through 32)

Confusion over which services Medicaid will cover explains why some clients may be denied services. Substance abuse coverage, in particular, sometimes may be misunderstood by RBHA offi-

cials, leading to inappropriate service denial. Medicaid *does pay for* medically necessary substance abuse services, regardless of whether the client has another behavioral health problem in addition to the substance abuse problem. In addition, Medicaid-eligible clients who have other behavioral health problems *do not need to be free of substance abuse problems* before they can receive medically necessary treatment. Finally, the full array of behavioral health services, including respite-like care and residential detoxification (not including room and board), *can be paid for by Medicaid*, as long as the services are medically necessary and provided in a Medicaid-compatible setting. In spite of this, a RBHA denied services to Maria, a pregnant teenager currently in the Child Protective Services (CPS) system. She was seeking residential drug treatment, but was denied because she did not have another behavioral health diagnosis. Similarly, Rachel is a seriously mentally ill woman currently on probation. She is receiving methadone for her heroin addiction, but has been told she must get off methadone before she can receive any other substance abuse services to address her problems with alcohol and other substances.

Maria, a pregnant teenager currently in the CPS system, was denied residential drug treatment.

In addition to RBHA officials and providers being confused about Medicaid coverage for services, the courts and Juvenile Corrections may not always know whether the person they are referring for services is enrolled in Medicaid. This can result in treatment delays or denials, since the behavioral health care system has limited monies to treat people who are not entitled to Medicaid services.

BHS has initiated efforts to ensure that clients with substance abuse as well as other mental health problems receive treatment. Nonetheless, the Division should take further actions to diminish confusion and ensure that clients receive Medicaid-covered services. Specifically, BHS policies governing the services provided by RBHAs should be revised to clearly specify all the services that are covered by Medicaid. In addition, BHS should approach the Arizona Health Care Cost Containment System (AHCCCS) about changing the capitation structure because it appears to contribute to some confusion over whether Medicaid clients can receive substance abuse treatment. Currently, a different capitation rate category exists for "general mental health and substance abuse," which may inappropriately imply that chil-

dren and adults with serious mental illness are not eligible to receive substance abuse services.

To address confusion over enrollment, the courts and the Department of Juvenile Corrections should adopt methods of determining whether probationers or parolees are eligible for and enrolled in Medicaid and KidsCare. These determinations should be made before making referrals to the RBHAs.

Changes Could Enhance Ability to Secure Specialized Services (See pages 33 through 38)

Even when there are no disagreements between agencies, auditors' case studies showed that some referred clients may be unable to access needed services because the services are simply unavailable. For example, Kristine, a young woman from a rural area who has a developmental disability, needed a residential placement upon her discharge from the Arizona State Hospital, but the placements available near her home could not handle her extensive needs. Although such problems appear most prevalent in rural areas, some clients' needs are difficult to meet even in urban areas. For instance, Jake, another DDD client, was placed in a partial care facility but his I.Q. score was too low for him to benefit from that facility's services. Other clients may be rejected by providers due to disruptive behaviors or other issues. For example, Joseph is a homeless man who is currently on probation and who has a serious mental illness. He apparently was rejected by a provider for treatment because of his past felony drunk-driving conviction.

Joseph, a homeless man with a serious mental illness, was rejected by a residential treatment center because of a felony drunk-driving condition.

While gaps in service availability will likely continue, particularly for sex offenders, AHCCCS and BHS could make some changes that would help to increase service availability.

- **First**, BHS can continue its efforts to encourage RBHAs to contract with providers for difficult-to-find services by informing them that provider contract rates are flexible, allowing the RBHAs to pay higher rates when necessary.

- **Second**, BHS could ensure that at least some of the RBHAs' providers accept difficult or disruptive clients as a condition of their contracts, in exchange for higher provider fees or other incentives.

- **Finally**, AHCCCS could request approval from the Health Care Financing Administration to let RBHAs contract with certified substance abuse counselors and master's-level individual providers, such as social workers and therapists, certified through the State's Board of Behavioral Health Examiners. Currently, RBHAs can contract only with physicians, nurse practitioners, physician assistants, psychologists, and licensed provider facilities.

Expanding BHS' Role in Serving Juvenile Offenders Could Save the State Money (See pages 39 through 42)

State dollars could be saved if services for Medicaid-eligible juveniles were provided through BHS and the RBHAs, instead of being provided by the juvenile justice system. Currently, the Department of Juvenile Corrections and the juvenile and adult probation systems pay out of their own state-funded dollars to treat juvenile sex offenders who are on parole or probation. According to Juvenile Corrections and the courts, these agencies use their own funding rather than referring these clients to the behavioral health system, since the RBHAs have refused to provide such services in the past. In addition, Juvenile Corrections currently pays for residential treatment for juveniles who are removed from correctional facilities to receive behavioral health treatment. In both cases, such services for Medicaid-enrolled individuals could be paid for by the behavioral health system with Medicaid dollars, which are provided largely by the federal government. In order to conserve state dollars and effectively leverage federal Medicaid dollars, the Division should ensure that the RBHAs are made responsible for providing medically necessary behavioral health care to juvenile sex offenders and Medicaid-eligible prisoners removed from prison for treatment.

Other Pertinent Information (See pages 43 through 54)

During the audit, other pertinent information was collected regarding previous efforts undertaken to improve service provision for people involved with the behavioral health system and other state agencies. Since 1986, numerous studies and other efforts have been initiated to improve coordination of these services. Studies by legislative committees and private foundations have identified problems with fragmentation, redundancy, and inappropriate service delivery. To resolve these problems, suggested solutions have ranged from an overall redesign of the way services are delivered to more specific procedural improvements, such as changing the amount and type of information collected from shared clients. Specifically, the groups have recommended:

- Streamlining the service delivery system by using a centralized screening process, creating local family assistance service centers, and integrating case management by assigning a single case manager to serve interagency clients;

- Providing a full continuum of specialized services for specific populations;

- Improving communication among agencies by establishing local councils, an interagency cabinet, and multi-agency teams;

- Improving information sharing among agencies by creating a central information system, a common database or data warehouse, developing data-sharing links, and avoiding collecting redundant information;

- Providing more timely, complete, and accurate assessments by incorporating a developmental and long-term view, adopting similar guidelines, and using a common screening process; and

- Using funding more efficiently, by exploring ways to make funding more flexible, expanding an existing joint agreement for the purchase of provider services, establishing a mechanism to ensure sufficient funding, and maximizing the use of federal funds.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the coordination and provision of behavioral health services among selected state agencies, in response to an October 6, 1998, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S) §41-1279. A separate review of the Division of Behavioral Health Services was issued in July 1999 (Report No. 99-12).

The Division of Behavioral Health Services (BHS) within the Department of Health Services is responsible for providing publicly funded behavioral health services in Arizona. BHS provides services to persons with a wide variety of behavioral health problems, ranging from adults with depression, schizophrenia, or substance abuse problems to children with attention-deficit hyperactivity disorder and post-traumatic stress disorder.

History and Evolution of the Audit

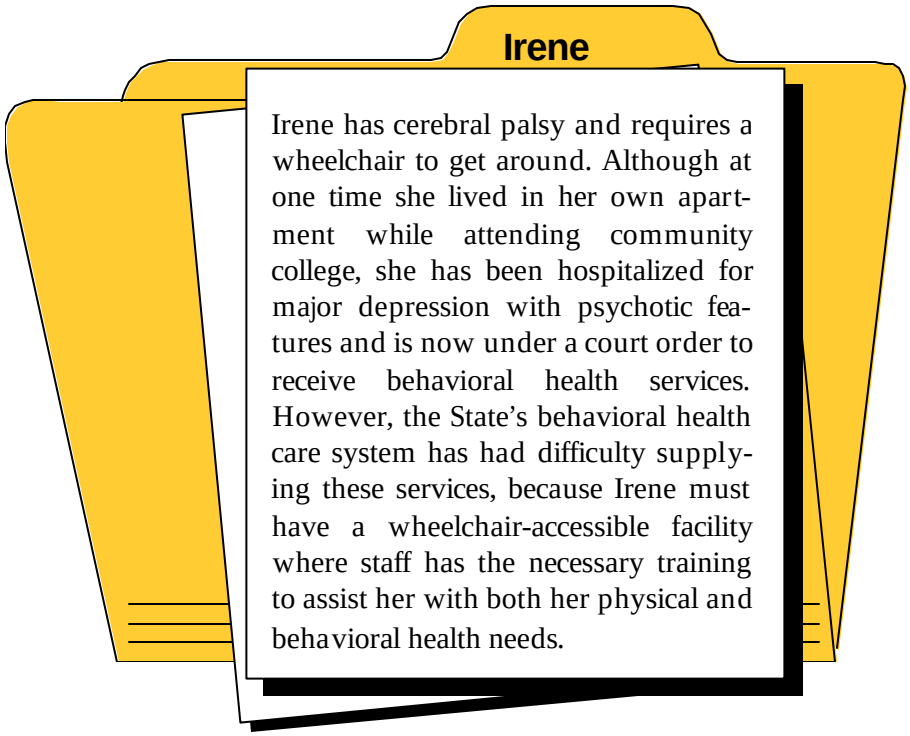
Disputes have revolved around whether clients can access all behavioral health services requested by other agencies.

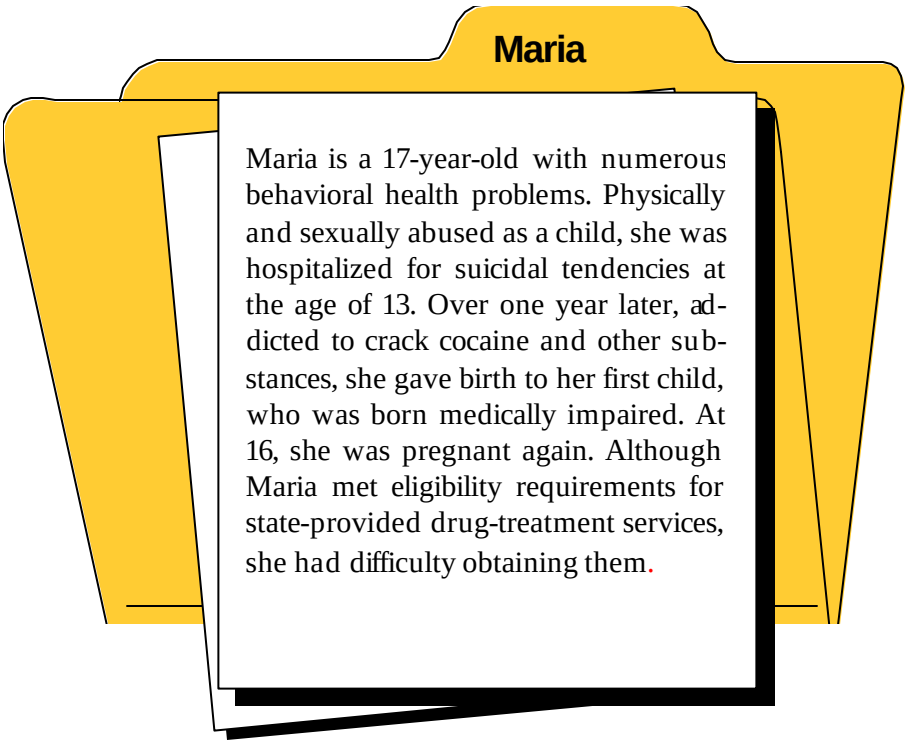
Although BHS is responsible for providing publicly funded behavioral health services in Arizona, long-standing disputes have revolved around whether clients served by other public agencies, such as the courts and the Department of Economic Security, can access all behavioral health services requested by the other agencies, and whether such services are appropriate for clients' needs. During the 1990s, many different efforts, mostly focused on children's services, were launched to examine various aspects of the coordination between the State's behavioral health care system and other state agencies. Several efforts were outgrowths of a 1991 Arizona Federal District Court case (*JK* v. *Griffith, No. Civ 91-261)* alleging that Medicaid-eligible children were not receiving adequate or appropriate behavioral health care.

These previous efforts addressed a wide variety of issues related to coordination of services among state agencies. Recommendations were made to address problems such as duplication of efforts and poor communication among agencies. (Other Pertinent Information, pages 43 through 54, describes the efforts and recommendations more fully.) While some of these efforts showed that clients referred from other state agencies do not always receive appropriate or adequate services, these other efforts did not focus on *why* clients referred to the behavioral health system may not always receive the services other state agencies believe they need.

This audit attempts to develop explanations for why people referred for behavioral health services cannot always access requested services, or receive more limited treatment than other agencies believe to be necessary. It makes recommendations pertaining to how the State might improve service accessibility for people referred to the behavioral health system, and ensure that the duration and level of care provided are appropriate.

To identify common themes explaining why clients from other agencies cannot always access requested services, auditors examined the problems encountered in providing services to people such as the following:





Behavioral Health Services in Arizona

This introduction describes how the study was conducted and how its findings are presented. It also provides an overview of how the State's behavioral health services delivery system is organized.

Division of Behavioral Health Services provides services through Regional Behavioral Health Authorities—Arizona Revised Statutes (A.R.S.) §36-3403 requires the Division of Behavioral Health Services to administer a unified mental health program, including the state hospital and community mental health. To carry out this charge, BHS oversees a managed care system administered by five contracted organizations called Regional Behavioral Health Authorities (RBHAs). The RBHAs are similar to health maintenance organizations in that they do not receive fees for services. Instead, they receive a fixed dollar amount per eligible person per month (a capitated rate) for Medicaid and KidsCare clients,

RBHAs—Do not receive fees for services, instead they receive a fixed dollar amount per eligible person per month.

and a fixed amount for serving clients who do not quality for these two programs. RBHAs in turn contract with more than 350 service providers to provide the actual services.

The Division of Behavioral Health Services, through its RBHAs, is responsible for providing services to several categories of entitled clients.

- The Division is responsible for supplying medically necessary behavioral health services to Medicaid clients in the State through a contract the Division has with the Arizona Health Care Cost Containment System (AHCCCS).

- BHS is also responsible for providing services to developmentally disabled Arizona Long Term Care System (ALTCS) recipients through a contract it has with the Department of Economic Security's Division of Developmental Disabilities (DDD).

- Furthermore, the Division of Behavioral Health Services is responsible for providing all needed behavioral health services and additional services, such as vocational services and housing, to adults with serious mental illness (SMI), regardless of their Medicaid status. This latter requirement is outlined in A.R.S. §36-3407, and is currently enforced under a court order for persons living in Maricopa County, based on the *Arnold* v. *Sarn* lawsuit.

The Division of Behavioral Health Services is also responsible for providing care to KidsCare recipients. Under this program, eligible children can receive a total of 30 days of inpatient and 30 units of outpatient behavioral health services. Finally, the Division also provides services to other persons who do not qualify for Medicaid, ALTCS, or KidsCare, as funding allows.

Other agencies' involvement with the Division—Many of the clients involved in the behavioral health system have multi-agency involvement. These mutual clients are often referred to the RBHAs for services by the other state agencies serving them. These other state agencies include:

- **Division of Developmental Disabilities (DDD)**—A unit of the Department of Economic Security, this agency is respon-

sible for about 17,000 persons with developmental disabilities such as mental retardation, cerebral palsy, and epilepsy. Of these clients, over 10,000 are ALTCS enrollees.

- **Child Protective Services (CPS)—**Also a unit within the Department of Economic Security, this agency served approximately 33,000 families and provided out-of-home care to approximately 6,700 children and youth in fiscal year 1998. CPS investigates allegations of child abuse and neglect, provides in-home family support and preservation services, and provides foster care and other services for children removed from their families.

- **Department of Juvenile Corrections—**Juvenile Corrections supervises 700 youth offenders. Each year, the Department also supervises 2,500 youth on parole, and transitions these youth back into the community once they are released from one of the Department's seven secure facilities.

- **Administrative Office of the Courts—**The Supreme Court's Administrative Office of the Courts administers statewide adult and juvenile probation services, which are operated at the individual county level. In 1998, adult probation offices supervised approximately 35,000 probationers. During that same year, juvenile probation offices supervised 9,000 probationers.

Sometimes other state agencies pay for behavioral services.

Additional agencies also refer clients to the RBHAs for behavioral health treatment. These agencies include AHCCCS, whose clients may be referred to the RBHAs through contracted medical care providers, and the Department of Education, whose students may be referred to the behavioral health care system by individual school districts.

Although agencies often do refer clients to the behavioral health care system for treatment, this is not always the case. Sometimes, other state agencies pay for behavioral health services themselves. In interviews conducted with other agency officials, they noted that referrals usually are not made if clients are not eligible for Medicaid. In addition, other state agencies often do not refer clients for behavioral health treatment when Medicaid does not cover a service that the agency or a court order deems appropriate for the client. Further, these agencies (particularly Juvenile Corrections) may not refer clients for services if the agency has

had historic difficulties accessing such services. (See Finding IV, pages 39 through 42).

Other state agencies also pay for behavioral health services for clients who are referred but not able to access services deemed necessary by the referring agency. In still other cases, the RBHAs and other state agencies share the costs of providing services. For example, the Department of Economic Security's Child Protective Services may pay for room and board costs associated with a child residing in a therapeutic group home, while BHS pays for the behavioral health services provided at the facility. According to agency officials at the Department of Economic Security, the Department of Juvenile Corrections, and BHS, the use of such cost-sharing agreements has increased dramatically over the past two years. BHS and other state agencies regard such agreements as holding great promise for reducing interagency disputes.

The use of cost-sharing agreements has increased dramatically.

Other state agencies' spending on behavioral health services appears to vary in magnitude. For example, the Department of Economic Security's Division for Children, Youth, and Families expended approximately $11 million and the Department of Juvenile Corrections over $2 million for behavioral health services in fiscal year 1999. DDD spent approximately $100,000 in non-ALTCS monies. BHS spent approximately $308 million in Medicaid, KidsCare, and all other monies on behavioral health services during that same period.

Audit Scope and Methodology

To assess the coordination of behavioral health services among state agencies, the audit focused on determining reasons why clients referred by other state agencies for services do not always receive services through the RBHAs. To do so, a combination of audit methods was used. However, the central method of this audit was conducting in-depth case studies.

Case study method—A case study is a method for learning about a complex instance, based on a comprehensive understanding of that instance obtained by extensive description and analysis of

that instance taken as a whole and in its context.[1] Recently, case studies have gained increased attention for the value they have in exploring the reasons behind problems common to complex organizations. A congressional committee, for example, used a case study approach in 1991 to study fraud and abuse in the insurance industry in order to determine causes of insurance company failures. In this audit, case studies were used to discover explanations for disagreements between agencies regarding services for referred clients, and to determine what appropriate actions can be taken.

Case studies can be used for a variety of purposes. They have been used primarily to isolate complex causal elements, as they were used in this audit. They can also be useful to compare across various sites, such as the various agencies making referrals to the RBHAs. The benefits of case studies include their ability to encompass the context in which events occur, as well as the small but significant differences that can be obscured in large-scale statistical analysis. Thus the case study was an ideal method to provide information and explanation for some of the problems identified in the many previous studies of Arizona's behavioral health system.

For the audit, ten individuals in the behavioral health care system were selected as case studies. The group of ten, which includes both adults and children, all met three basic criteria:

- They were clients who entered the behavioral health care delivery system through agencies other than BHS.
- They either were eligible for Medicaid or were thought to be eligible for Medicaid when they entered the system.
- They had difficulty in obtaining needed services.

[1] United States General Accounting Office, *Case Study Evaluations*, GAO/PEMB-91-10.1.9, November 1990 (page 15).

Clients selected for the case-study review came from DDD, CPS, Juvenile Corrections, and the Administrative Office of the Courts.[1]

After identifying and selecting cases, auditors used a structured protocol to review documentation from numerous sources, including referring agency files, RBHA files, and records regarding Medicaid eligibility. To ensure they had a clear picture of the treatment histories, auditors also interviewed multiple people who were familiar with each case, including RBHA case managers, officials from referring agencies, and service providers to determine why clients were not able to receive needed services.

Supplementary methods—To supplement this case-study approach with a broader review that would help set the findings in context, auditors also conducted the following work:

- Reviewing reports by legislative committees, multi-agency councils, nonprofits, and experts on coordination problems between state agencies and BHS;
- Interviewing Health Care Financing Administration and AHCCCS officials;
- Attending work groups on coordination problems between agencies;
- Examining intergovernmental agreements, protocols, established guidelines, policies, rules, and statutes related to behavioral health service delivery;
- Examining entitlement requirements for behavioral health services;
- Reviewing the State's Medicaid plan and BHS' strategic plan for substance abuse provision;

[1] Time constraints and limited audit resources did not permit drawing cases from all possible referring agencies or from every RBHA. Also, time constraints limited the review of probationers from the Administrative Office of the Courts to adult probationers, although some Juvenile Corrections cases reviewed also contained information on clients' experiences in the juvenile probation system.

- Interviewing representatives and conducting focus groups to solicit the views of mental health advocates, providers, and agency representatives;

- Reviewing literature on medical necessity definitions, rural behavioral health care, and behavioral health treatment and diagnosis;

- Examining BHS service matrixes and service authorization codes; and

- Reviewing information provided by the Department of Health Services' Division of Assurance and Licensure on changes in licensed providers.

The audit contains three findings on reasons why clients referred by other agencies cannot always access services from the behavioral health system, and recommendations on changes needed to make the system more accessible. Specifically, the findings discuss:

- Issues related to the behavioral health system's design that affect the ability of referred clients to access some services (see Finding I, pages 11 through 21);

- Uncertainty about who is eligible to receive Medicaid-provided services and about which services Medicaid will provide (see Finding II, pages 23 through 32); and

- Lack of provider services for some clients (see Finding III, pages 33 through 38).

The report also contains a fourth finding, pertaining to possible savings of state dollars if BHS takes a greater role in providing services to juvenile offenders, parolees, and probationers (see Finding IV, pages 39 through 42). Finally, the report contains Other Pertinent Information on the numerous studies and work groups formed in recent years to review issues related to the coordination of behavioral health services across agencies, and common recommendations from these work groups. (See Other Pertinent Information, pages 43 through 54.)

Audit Limitations

While this audit focused on why clients referred by other state agencies are not always able to access services from the behavioral health system, it could not determine how *frequently* clients cannot receive requested services. At the time of the audit, the Division of Developmental Disabilities, Juvenile Corrections, county adult probation offices, and Child Protective Services did not track cases referred to the behavioral health system for services. As a result, auditors could not estimate the frequency at which such denials occur. Nonetheless, previous independent evaluations of the care that behavioral health clients receive have noted instances where clients with multiple agency involvement did not receive adequate services.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Acting Director of the Department of Health Services, the Assistant Director of the Division of Behavioral Health Services, and officials at the Department of Juvenile Corrections, the Department of Economic Security, the Administrative Office of the Courts, and county probation offices for their cooperation and assistance throughout the audit.

FINDING I

MANAGED CARE FOCUS, AND STRUCTURE THAT DIVIDES RESPONSIBILITY, LEADS TO INTERAGENCY DISAGREEMENTS

The managed-care focus and multi-agency structure of Arizona's behavioral health care system is inherently vague and leads to conflict over whether clients referred by other agencies should receive care from the Division of Behavioral Health Services (BHS). The managed-care system provides some incentive for limiting care and mandates that services be provided only when "medically necessary," a concept that is vague and open to dispute. Blurred roles among agencies and the potential for other agencies to pay for services that BHS does not provide also lead to disputes over which agency should provide services to clients. Auditor General staff identified three options that could help mitigate some of these sources of dispute:

- Eliminating some of the divided responsibility among agencies;
- Improving and standardizing assessments of behavioral health clients' conditions; and
- Improving oversight of services provided by Regional Behavioral Health Authorities (RBHAs).

System's Inherent Vagueness Leads to Disagreements

After examining the case studies in depth, interviewing agency officials and other interested parties, and examining the results of other recent study efforts, three primary factors emerged as contributing to interagency disagreements. The first is the system's managed-care focus, which provides some incentive to limit care and control costs. The second factor, which naturally follows the first, is that the behavioral health system is focused on providing only "medically necessary" services, which is a requirement for coverage under the federal Medicaid program. The concept of

"medical necessity" is inherently vague and open to conflict. Finally, divided responsibilities and funding create incentives for cost-shifting between agencies.

Managed care system creates some incentive to limit care—Arizona's managed behavioral health care system creates some incentive for the RBHAs and/or their providers to limit care, thus contributing to conflict between agencies.[1] Officials and case managers from other agencies and providers often stated in interviews that services provided by the RBHAs were too limited in duration or intensity to meet clients' needs. It was alleged that efforts by the RBHAs to continually review and authorize services would sometimes cut off services prematurely or inappropriately. Also, representatives from another agency said that the RBHAs provide only a limited scope of services, when a fuller array of services would appear to be justified.

RBHAs are required to ensure that services are provided in the least restrictive setting.

The State's behavioral health care system does indeed limit the duration and scope of services. State law has established a system of health care in Arizona designed to control costs. [2] Accordingly, BHS/RBHA contracts require the RBHAs to ensure that services are provided in the least restrictive settings possible. For example, a client should not be confined in a psychiatric hospital if he or she can be treated equally well as an outpatient. In addition, the system for funding behavioral health services in this State creates some incentive to limit care. The RBHAs are paid a fixed sum of money in advance for serving Medicaid-eligible people in their geographic region, and incur a loss if they spend more than they receive. As a result, RBHAs protect their limited funds by monitoring service utilization, requiring authorization for services beyond pre-defined limits, and denying services when the need for

[1] In some cases, the RBHAs share the risk of providing services with their contracted providers. The Community Partnership of Southern Arizona and the Northern Arizona Regional Behavioral Health Authority each pay their contracted providers in advance for providing all services to a defined number of clients.

[2] See A.R.S. §§36-2903, 36-2907, and 36-2989.

services is unclear or when it appears that another agency could provide the service. [1]

While the State's behavioral health care system is designed to control costs, it is questionable whether it is limiting services so much that the care delivered is sometimes inappropriate in type or duration. Because auditors reviewed a limited number of cases referred for services by other agencies, it was impossible to conclusively answer this question. However, other studies performed recently do suggest that care may sometimes be inappropriately limited for clients referred from other agencies to the State's behavioral health care system. An in-depth independent review of Maricopa County's behavioral health system for Medicaid children performed in 1998 as part of the *JK* v. *Griffith* lawsuit noted:

"(The) current service pattern is to under-serve children by delivering episodic treatment and crisis services even though…a more comprehensive and continuous intervention strategy is required to prevent harm and achieve satisfactory results."

The study also found that underservice was especially pronounced for children involved with the juvenile justice, developmental disability, and child welfare systems. Children with developmental disabilities received the least acceptable services of these groups.

Medical Necessity—How Is It Defined?

In BHS' most recent RBHA contract, medically necessary covered services are defined as services that are:

- Provided by the practitioners within the scope of their practice to prevent disease, disability, and/or other adverse health conditions or their progression;
- Promoting progress toward the highest possible level of health and self-sufficiency;
- Reasonably expected to benefit the eligible person's mental or physical health;
- Necessary and appropriate to the eligible person's present condition;
- Designed to assist eligible and enrolled persons to manage their illness to the extent possible and to live, learn, and work in their own communities.

The contract further states that a "covered service is medically necessary if there is no equally effective service that is less restrictive or substantially less costly. Services shall not be denied based on 'medical necessity' solely because the enrolled person has a poor prognosis or has not shown improvement if the covered services are necessary to prevent regression or maintain their present condition."

[1] Some of the incentive to limit care is mitigated by BHS/RBHA contractual clauses that allow the Division to adjust capitation rates or payments to the RBHAs if losses are too great. Further, contractual limits on the amount of profit that can be realized by the RBHAs further guard against underservice.

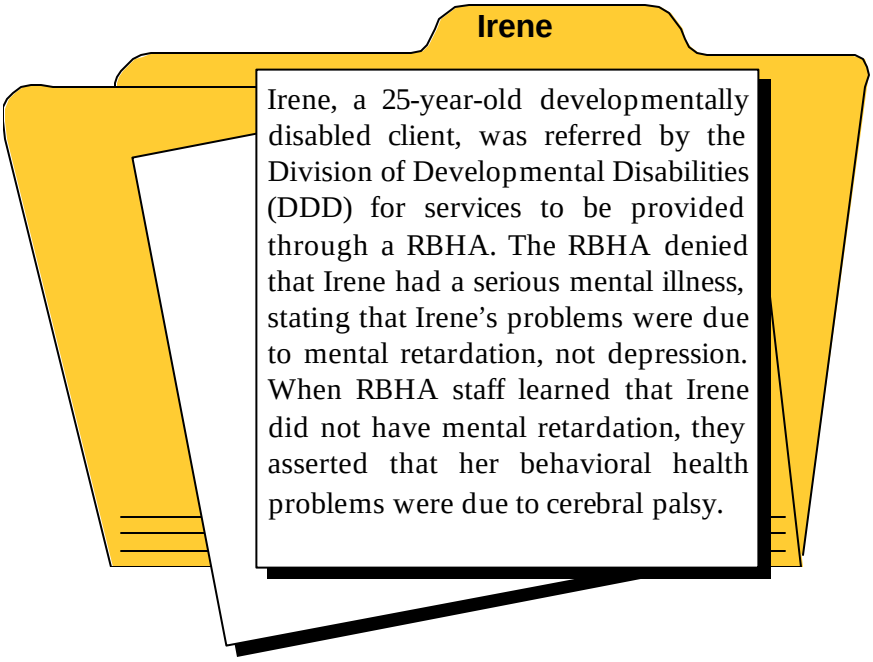
Medical necessity often the source of denials, disputes—To help control costs, each RBHA is required by contract with BHS and by Medicaid rules to deliver only those services that are "medically necessary," meaning that services must be expected to benefit the client's mental or physical health, and should be delivered in the least restrictive setting proven or predicted to be effective in meeting the clients' behavioral health needs in order to conserve costs. The different opinions among RBHAs, the courts, and state agencies over which services are medically necessary appear to be a common reason for disputes over services received by clients who have been referred by other agencies. "Medical necessity" is defined quite broadly in this State (see highlighted information on page 13), allowing the RBHAs much discretion in interpreting the medical necessity of individual services. While this broad definition may result in differences of opinion regarding whether services are medically needed, it also appropriately allows an array of services to be covered under Medicaid reimbursement.

In many of the reviewed cases, disagreements centered on a RBHA's decision to terminate or refuse to approve behavioral health treatment because the service was not deemed "medically necessary." These disputes frequently occur regarding continued placements in costly residential treatment settings. Representatives from other state agencies often disagreed with the RBHA's interpretation. For example:

Todd

Todd, a 15-year-old client with aggressive, hyperactive behaviors, had his services terminated at a residential treatment center after eight weeks. The RBHA stated that out-of-home treatment was no longer medically necessary. Todd's court-appointed psychiatrist and his CPS caseworker believed he needed intense treatment in a confined setting, such as the residential treatment center, because he was in danger of fleeing and because of his conflicts with staff at group homes where he had stayed in the past. They said it was inappropriate for him to receive care at home due to problems with his family. The psychiatrist assigned to Todd by the RBHA disagreed, saying that because he did well when removed from his family and placed in a confined setting, problems with his parents and inappropriate foster care placements may explain his behavior. In the RBHA psychiatrist's opinion, treatment was needed, but placing Todd in the residential treatment center did not meet "medical necessity."

Multiple funding streams create opportunities for cost-shifting—Although the Division is the primary agency responsible for providing publicly funded behavioral health services, other agencies sometimes purchase behavioral health services for their Medicaid-eligible clients, raising questions about who should pay for a particular service.[1] RBHAs can reduce their spending if they transfer payment responsibility to another agency. In one of the ten cases auditors reviewed in detail, the RBHA appeared to inappropriately be attempting to shift the costs of behavioral health treatment to another agency:



Interviews with behavioral health professionals confirm that cost-shifting sometimes occurs. For example, a RBHA psychiatrist indicated that children who have conduct disorders or who have committed sexual offenses and are referred to the RBHA for possible Medicaid-provided care are traditionally shifted to other agencies because the other agencies have money to pay for treatment.

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[1] The Division currently receives federal- and state-appropriated dollars to provide behavioral health services to Medicaid-eligible members of AHCCCS health plans. Medicaid dollars are received through the Division's contract with AHCCCS, Arizona's designated Medicaid agency. Arizona Long Term Care System dollars for ALTCS-eligible Developmental Disabilities clients are also received directly from AHCCCS. BHS provides services for DDD ALTCS clients through an interagency agreement between DDD and BHS.

In some cases, disputes over who should pay may also be attributed to narrow and unclear distinctions between agencies' roles. For example, one high-level DDD administrator explained that DDD provides habilitative treatment for its clients, while RBHAs are responsible for providing rehabilitative treatment. The administrator admitted that it can be very difficult to distinguish the difference between a client's needs for habilitative versus rehabilitative services. Interviews, case studies, and literature also suggest that the distinction between a developmental disability and a behavioral health problem can be difficult to distinguish.

Habilitative Treatment—care that brings clients to a new, higher level of functioning.

Rehabilitative Treatment—care that restores clients to their former level of functioning.

Changes Could Diminish Some Disagreement

Changes in the current behavioral health delivery system could eliminate some of the disputes between agencies and result in more accessible, appropriate, and integrated treatment for individuals. Specifically, improvements may occur by:

- Transferring responsibility for some clients' behavioral health services from BHS to DDD.
- Revising RBHA and other agencies' assessment practices.
- Enhancing BHS' oversight of the RBHAs to help ensure that treatment for interagency clients is appropriate in type and duration.

Transferring responsibility could eliminate some conflict— By allowing some other agencies to contract directly with providers for the behavioral health treatment for their Medicaid clients, interagency conflict could be diminished. Although other groups of clients with multi-agency involvement might also benefit from carving out treatment, this could most easily occur for DDD clients in the Arizona Long Term Care System (ALTCS). Currently, DDD has an intergovernmental agreement

with BHS to provide behavioral health services for such clients through the RBHAs. Because of this separate capitation rate set by AHCCCS and an existing information system for reporting DDD/ALTCS services to AHCCCS, DDD would need to make fewer changes in its administration and contract monitoring practices than other agencies might need to make.

"Carving out" DDD/ALTCS clients from the behavioral health system may make sense for other reasons, too. Differences between problems associated with a client's developmental disability versus any diagnosed behavioral health problems can be difficult to determine. Indeed, an independent study of Medicaid service provided to children in Maricopa County for the *JK v. Griffith* lawsuit stated:

> *"A developmental disability is a life-long condition while a mental illness may be episodic and controllable with medications. Each diagnosis requires supports, services and treatments that are appropriate and effective for each condition—the first using a developmental, supportive approach and the other using an interventive, therapeutic approach. These dual requirements are difficult to manage across the boundaries of different state agencies."*

Finally, transferring responsibility for the provision of behavioral health care back to DDD for its ALTCS clients makes sense for these more than other agencies' clients for another reason. The independent study noted above pointed out that DDD children eligible for Medicaid are the least likely among groups of children with multi-agency involvement to receive appropriate treatment from the behavioral health system.

Transferring responsibility was discussed seriously in 1994-1995 by BHS, DDD, and AHCCCS. A joint task force met several times to develop a plan for transferring DDD clients who were eligible for ALTCS from BHS to DDD for their behavioral health services. An internal study by DDD had found that its ALTCS clients were more likely to be denied services by the RBHAs than other DDD clients. However, a pilot project scheduled to begin on October 1, 1995, was never implemented.

Because such a transfer could make behavioral health services more available to DDD ALTCS clients, the transfer could result

in increased costs to the State. Currently, DDD estimates that almost 18 percent of its ALTCS clients receive behavioral health services. In the 1995 study, DDD estimated that if it provided behavioral health services to its ALTCS clients, 30 percent of its ALTCS clients would utilize services. Although costs might increase if service use grows, accurately projecting the increased cost to the State would require an actuarial study similar to those conducted to prepare for Medicaid capitation rate negotiations with the Health Care Financing Administration. If the Legislature favors the transfer of responsibility in principle, it could authorize DDD, BHS, and/or AHCCCS to contract with an actuarial firm for such a study.

Assessments are performed in different ways depending on the agency completing them.

Changing assessments—By changing the way that clients' conditions are assessed by other state agencies and BHS, disputes over whether a client is suffering from a behavioral health problem could be diminished. Other agencies sometimes perform their own assessments of clients' behavioral health problems and needs. However, these assessments are performed in different ways depending on the agency completing them, potentially resulting in diverging opinions of clients' conditions and treatment needs. This often occurs with individuals who are involved with the courts, and are court-ordered for a psychiatric evaluation. While the courts and their contracted psychiatrists may determine that an individual suffers from a particular behavioral health problem and needs certain types of treatment, the RBHAs are under no obligation to provide such treatment and may reach different conclusions regarding the referred client's condition and needs.

A group established out of the *JK v. Griffith* litigation is proposing that children's agencies cover a core set of assessment elements and screening for other service needs when conducting initial assessments. The group is recommending that this information be available to all agencies. Such a procedure could also be modified and used by agencies conducting adult assessments.

The RBHAs' use of more qualified medical health professionals could also increase confidence in the RBHAs' determinations of whether clients referred for services have behavioral health problems and whether services are medically necessary. Independent studies performed in the past have found that RBHAs do not always perform adequate assessments of clients' condi-

tions, resulting in inaccurate diagnoses and incomplete treatment plans. For example, in 1995, independent psychiatrists found in their review of treatments delivered to Medicaid recipients that there was "room for improvement in diagnostic accuracy." The same group formed out of the *JK* v. *Griffith* lawsuit, which is recommending common assessment tools, also recommends that more qualified people perform assessments.

Currently, BHS requires the Maricopa County RBHA to have master's-level behavioral health professionals perform assessments and BHS is considering requiring other RBHAs to meet such a requirement. However, interviews with officials from that RBHA and others suggest that the RBHAs may find it difficult to fulfill this requirement due to the expense and problems in recruiting master's-level caseworkers. BHS should assist the RBHAs in developing a plan for fulfilling the current master's-level caseworker requirements, or develop alternative methods of ensuring that those people who perform assessments are adequately qualified.

Adequate time is needed to submit medical records.

BHS may also need to make changes to ensure that adults referred for services in the behavioral health system have adequate time to submit medical records before medical professionals determine whether the person is to be designated "seriously mentally ill." Currently, Arizona Administrative Code Title 9, Chapter 21 states that persons seeking seriously mentally ill status have seven days to submit medical records before a determination is to be made. Such a narrow time frame may not be long enough for people to obtain necessary medical records, thereby limiting the RBHAs' ability to review clients' medical histories and other psychiatrists' opinions before making determinations about whether an individual's status can be classified as "seriously mentally ill."

Enhanced oversight of RBHAs—Greater oversight of RBHAs by BHS could help ensure that services are not inappropriately denied or limited. BHS has developed service guidelines outlining care that clients should typically receive. Literature suggests that such guidelines may be useful to prescribe typical client care and to ensure that clients receive appropriate and sufficient services. While individual care may differ from such guidelines, they could be used to ensure that the majority of clients with specific types of illnesses receive the treatment deemed appropriate by

BHS. Maricopa County's new RBHA contract actually requires that services be delivered according to guidelines. However, it appears from an interview with a Maricopa County RBHA treatment team member that service guidelines are not consulted. Also, the Division needs to carry out its plans to monitor whether the care that people receive from the RBHAs mirrors these service guidelines.

Also, BHS should better monitor whether RBHAs are making appropriate decisions as to whether behavioral health clients should be receiving inpatient hospital and other inpatient services such as those provided in residential treatment centers. BHS has developed level-of-care criteria outlining when clients should receive intensive, costly inpatient and residential treatment. Nonetheless, while such criteria have been developed, the Division has not yet begun monitoring whether clients seeking such care are receiving or being denied such services based on the criteria.

Recommendations

1. The Legislature should consider directing DDD, BHS, and/or AHCCCS to contract with an actuarial firm to determine the cost of having DDD contract directly with providers for its ALTCS clients' behavioral health services, instead of relying on the RBHAs to deliver such services. If the Legislature finds the projected cost to be acceptable, DDD should begin directly contracting for such services for its ALTCS clients.

2. BHS should continue to work with other agencies to develop methods for streamlining and coordinating assessment of children, as is currently occurring under the *JK* v. *Griffith* litigation. BHS should also work with agencies that conduct adult screening and assessments to ensure that the agency's assessment information is routinely available and incorporated into the RBHA's assessment process.

3. BHS should assist the RBHAs in developing a plan for fulfilling the current master's-level assessment requirements, or develop alternative methods of ensuring that people who perform behavioral health assessments are adequately qualified.

4. BHS should make changes to Title 9, Chapter 21 of the Administrative Code, allowing people applying for Seriously Mentally Ill (SMI) status more time to submit medical records so that past medical histories and other psychiatrists' opinions can be adequately considered.

5. BHS should monitor whether care delivered by the RBHAs reflects the Division's service planning guidelines.

6. The Division should monitor whether the RBHAs are currently using BHS level-of-care criteria when making determinations as to whether clients qualify for inpatient and residential treatment.

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FINDING II

CONFUSION EXISTS REGARDING MEDICAID COVERAGE

A second reason why some clients referred from other agencies may not receive some services, apart from the systemic problems described in Finding I (see pages 11 through 21), is that some basic confusion exists about which services are available for Medicaid recipients and who is covered by Medicaid. RBHAs are denying some services, particularly for substance abuse, because it is not clear if Medicaid covers services in certain circumstances. Also, some clients referred by the courts and Juvenile Corrections may not be receiving services because the referring agency assumes the client is enrolled in Medicaid when that is not the case. This lack of clarity limits the degree to which Medicaid recipients can obtain mental health treatment, and it also shifts expenditures from Medicaid, which is largely funded by the federal government, to programs funded entirely by the State. To resolve the situation, BHS should clarify its policy about which services Medicaid will cover. Changes in the capitation rate structure could also help diminish confusion regarding who is eligible to receive substance abuse services. The courts and Juvenile Corrections should also take steps to ensure that their personnel can identify people who are eligible for and enrolled in Medicaid.

Medicaid Covers a Wide Range of Services

In Arizona, Medicaid can pay for a wide range of services in a variety of settings as long as these services are deemed "medically necessary." These services range from inpatient hospital services to professional services such as therapy and counseling, to rehabilitation services such as assistance with daily living activities and household services (see Exhibit 1, page 24). These services are available to both children and adults. Further, these services are available for people suffering from any type of behavioral health problems in which a person could benefit from treatment, including substance abuse problems.

Exhibit 1

AHCCCS and ADHS Division of Behavioral Health Services
Behavioral Health Services Covered by Medicaid

INPATIENT SERVICES

- **Hospital Services:** Treatment of acute episodes, generally of a short duration, in an acute general hospital.
- **Psychiatric Facility Services:** The facility may be an inpatient residential treatment center or an inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Health Care Organizations under inpatient standards. Services in these facilities are covered only for persons under 21 years of age.
- **Institution for Mental Disease (IMD) Services:** Treatment includes medical attention, nursing care, and related services. The facility may be a hospital, nursing facility, or other institution with more than 16 beds engaged in diagnosing and treating persons with mental diseases, including substance abuse/dependence. An institution for the mentally retarded is not an institution for mental disease. IMD services are covered only for persons under 21 years old or 65 years and older.

PROFESSIONAL SERVICES

- **Therapy and counseling:** Individual therapy and group and/or family therapy and counseling provided by behavioral health professionals or behavioral health technicians.
- **Psychotropic medication adjustment and monitoring:** Review of effects and side effects of medication and adjustment of dosages overseen by licensed medical professionals.

REHABILITATION SERVICES

- **Basic Partial Care Services:** A regularly scheduled therapeutic services program provided in a group. Services include psychosocial rehabilitation, supportive counseling and other activities to promote coping, problem solving, and independent living and socialization skills to prevent placement in more restrictive settings.
- **Intensive Partial Care Services:** A regularly scheduled treatment program including individual, group and/or family therapy, psychiatric services, and other therapeutic activities provided in a group setting under the direction of a psychiatrist or psychologist to address acute or episodic behavioral health problems or to prevent placement in more restrictive settings.
- **Behavior Management Services:** Therapeutic supervision and direction provided to prevent placement in a more restrictive setting. May include assistance with activities of daily living and household services.
- **Psychosocial Rehabilitation:** Treatment to develop community and daily living skills. Skill areas include attention and concentration, interpersonal relations, socialization, understanding and use of medication, symptom management, use of leisure time, and ability to use community resources.
- **Emergency/crisis behavioral health services:** Immediate and intensive, time-limited, community-based, face-to-face crisis intervention services available on a 24-hour basis in situations where a person is a danger to self or others.

OTHER SERVICES

- Screening and Evaluation Services
- Case Management Services
- Emergency and non-emergency transportation services
- Psychotropic medications
- Methadone administration
- Laboratory and radiology services

RESTRICTIONS ON TREATMENT SETTINGS

- **Other non-hospital residential settings:** Medicaid pays only for behavioral health services, not room and board in non-hospital residential settings which are not IMDs when used to treat eligible persons age 21 through 64. Examples of non-hospital residential settings include: residential treatment centers; therapeutic group homes; intensive adult residential; 24-hour supervised adult residential, semi-supervised independent living; 8-hour and 16-hour facilities; substance abuse residential treatment centers; supported community living centers. Medicaid does pay for room and board charges for children in residential treatment centers.

Source: Auditor General staff analysis of Arizona Administrative Code, Title 9, Chapter 22, Article 12. AHCCCS Behavioral Health Rules; ADHS/DBHS Service Matrix, July 1999; and Value Options' Integrated Behavioral Health Services RFP, July 1999.

Coverage for Substance Abuse, Other Services Misunderstood

While Arizona's Medicaid program offers a wide range of services to clients enrolled in Medicaid, actual delivery of such services may be limited by confusion and lack of clarity over what services are covered. In particular, confusion exists in four specific circumstances described below.

- **Medicaid clients, such as seriously mentally ill adults, adults with general mental health disorders who do not meet SMI eligibility criteria, and children, are entitled to receive substance abuse services**—All Medicaid-eligible clients are entitled to receive all medically necessary services, including substance abuse treatment. However, according to BHS' medical director, confusion exists as to whether adults who are enrolled as SMI clients can receive substance abuse treatment, and whether children can receive substance abuse treatment. Other high-level BHS officials also corroborated this confusion.

  BHS' medical director suggested that at least two factors contribute to the confusion:

  - ✓ **Method of capitating Medicaid payments to the RBHAs**—Currently, different capitation funding categories exist for children, seriously mentally ill adults, and adults suffering from general mental health or substance abuse problems. According to the medical director, this split may incorrectly imply that children or seriously mentally ill adults are not eligible for substance abuse services.

  - ✓ **Structure of the provider network**—Particularly in Maricopa County, the structure of the provider network may also contribute to confusion over whether seriously mentally ill adult clients can receive substance abuse services. Especially in Maricopa County, providers have typically been identified as either providers for SMI adults or substance-abusing adults. Little integration or coordination occurs between substance abuse providers and the providers of behavioral health treatment for the seriously mentally ill. Therefore, people who have his-

torically been referred to a provider serving seriously mentally ill adults may have been told that there was no substance abuse treatment available for them. BHS and the new RBHA in Maricopa County are planning to create integrated networks of substance abuse and mental health treatment providers, so that clients referred for one type of treatment will be more easily referred to other types of treatment. This is a part of a larger initiative the Division has been undertaking over the past year to ensure the appropriate treatment of persons with substance abuse and mental health problems.

- **Substance abuse services alone can be provided to clients without an additional mental health diagnosis**—It appears that some RBHA staff **incorrectly** believe that Medicaid clients must be diagnosed with a mental health problem, such as depression, to qualify for substance abuse services. A senior-level community liaison at one RBHA stated that Medicaid-eligible clients can receive mental health treatment only if there is some evidence that a person's mental health problem exists aside from their substance abuse issues.

Some RBHA officials incorrectly believe Medicaid clients must be diagnosed with a mental health problem to qualify for substance abuse services.

One of the audit's case studies provides an example of this situation:

Maria

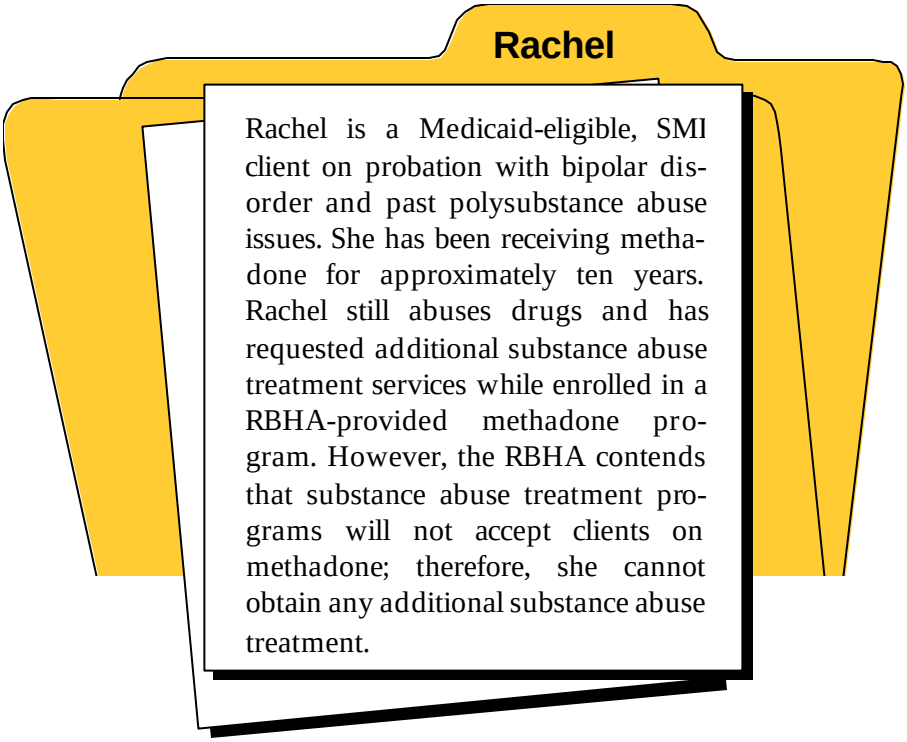
Maria, a pregnant teenager who already had one child, sought residential drug treatment in December 1998. CPS initiated the service request after taking custody of Maria's first child, who had medical problems including seizures and blindness. The RBHA denied her treatment, even though Maria was enrolled in Medicaid, because they were under the impression that the RBHA is not required to provide residential substance abuse to anyone under the age of 21 who does not present any other mental health diagnosis. Although the RBHA eventually agreed to pay for residential treatment for substance abuse, the caseworker told Auditor General staff in August 1999 that she still did not know if Medicaid funds cover treatment for children who suffer only from substance abuse and not other types of behavioral health problems.

- **Clients need not be free from substance abuse problems before being eligible for other treatment**—While some RBHA staff incorrectly believe that substance abuse services are not covered unless someone has another diagnosed behavioral health problem, others incorrectly believe that behavioral health treatment is not available for Medicaid-covered clients unless the client is free from drug impairment. In two Division-sponsored workshops on substance abuse and mental illness in 1998, substance abuse providers noted that mental health providers refuse services to clients who are not "clean and sober."

Some RBHA officials incorrectly believe that behavioral health treatment is not available unless Medicaid clients are "clean and sober."

According to AHCCCS behavioral health rules, Medicaid-eligible clients are entitled to receive any needed behavioral health service. No requirement exists in Medicaid or AHCCCS rules requiring clients to be drug-free to qualify for behavioral health treatment. Providers may be confused about whether clients need to be drug-free because *non*-Medicaid-eligible adults, who may need to be designated as SMI in order to receive state-funded services, may not be able to obtain an SMI determination when their substance abuse interferes with the RBHA's ability to diagnose their mental illness.

In addition to some believing that clients must be "clean and sober" before being eligible to receive behavioral health services, some RBHA providers and staff may incorrectly believe that clients who receive methadone treatment are not eligible for other treatment. A representative from BHS' Bureau of Substance Abuse and General Mental Health noted that some staff from provider agencies incorrectly believed that people receiving methadone are not eligible for other substance abuse treatment. The RBHA made such an incorrect assertion in Rachel's case (see page 28).



- **Many respite-like services and residential detoxification are covered services—**In addition to the more general confusion over coverage for substance abuse services, interviews revealed two other examples of confusion about services covered. First, confusion exists regarding respite services, which provide relief to care givers in order to enable clients to remain in their homes and communities. One advocate for the disabled contended that Arizona's Medicaid program does not cover respite services for Medicaid-enrolled clients. BHS' medical director confirmed that misunderstandings may exist regarding coverage for these services. BHS' medical director asserts that Medicaid can be used to cover respite-like services for Medicaid-eligible clients if the service is billed under the category "behavior management."

  Second, residential detoxification, which is treatment provided in a 24-hour facility to manage withdrawal from abuse substances, may not be clearly understood to be a covered service, according to a BHS Bureau of Substance Abuse and General Mental Health representative. Although it is a covered service, it is not listed in some information identifying services that can be billed to Medicaid.

Enrollment Another Source of Confusion

In addition to confusion over which services are covered by Medicaid, confusion also exists on behalf of some agencies referring clients for services as to whether clients are enrolled in Medicaid. During this audit, several of the cases provided to auditors by the Administrative Office of the Courts and Juvenile Corrections as examples of Medicaid clients who were referred but unable to receive services were found by auditors to be clients who were ***not*** actually enrolled in Medicaid. Interviews with the courts and Juvenile Corrections suggest that both agencies are not always aware of whether their probationers or parolees are enrolled in the Medicaid program, and have not always been screening clients for Medicaid eligibility or systematically referring them to the Department of Economic Security for enrollment. According to representatives from the Administrative Office of the Courts, lack of access to information pertaining to who is enrolled in AHCCCS or the RBHAs contributes to the Office's inability to identify Medicaid-eligible clients.

Lack of Clarity Has Several Effects

These system-wide points of confusion have negative effects on both delivery of services and state funding.

- **Limitations on service effectiveness**—By inappropriately requiring clients to be "clean and sober" prior to receiving treatment, some clients may be shut out of mental health treatment. This is especially significant since people with mental health disorders often have problems with substance abuse. In fact, a 1998 study by the Center for the Study of Issues in Public Mental Health performed in New York found that 57 percent of individuals with a diagnosis of severe mental illness also have a diagnosis of substance abuse. Clients may also be shut out of services if the referring agency fails to ensure that clients are enrolled in Medicaid or KidsCare before referring the client to

> Literature suggests that failing to treat substance abuse problems along with mental health problems limits treatment effectiveness.

the behavioral health system for services. BHS and the RBHAs receive limited dollars to provide services to people who do not qualify for these programs. Failure to ensure clients are enrolled can result in service delays or denials.

- **Shift of funding from Medicaid to state-supplied monies**—The current confusion over Medicaid eligibility and covered services results in the unnecessary expenditure of state dollars. If a RBHA inappropriately denies a Medicaid-eligible client services that Medicaid can cover, or when an agency fails to ensure that a client is enrolled in Medicaid, state monies may be spent by other agencies for behavioral health services. By paying for services with state dollars rather than Medicaid dollars, the State bears the full brunt of the cost for service, rather than about only one-third of the cost that it would pay for Medicaid-covered services. Agency monies expended for behavioral health services come from funds that the agencies could otherwise use for different purposes, thereby reducing agencies' ability to perform other functions. Furthermore, in instances where the referring agency is unaware as to whether the client is enrolled in Medicaid, the potential exists for the referring agency to pay for services out of state-only dollars even though the client's care is already covered through the Medicaid capitated rate. Indeed, such double payment for services has occurred in some instances in the past.

Several Changes Should Be Made to Ensure That Clients Receive Entitled Services

Several changes should be made to help clarify Medicaid coverage for services and individuals. BHS should create a policy that clearly identifies Medicaid-covered services. BHS and AHCCCS may also wish to consider changing the current capitation method to further diminish confusion regarding Medicaid's coverage of substance abuse services. Finally, the courts and Juvenile Corrections should identify screening methods.

Clarify policy—BHS can help dispel uncertainty regarding Medicaid coverage by clearly describing such services in policy. Currently, BHS' policy regarding Medicaid-covered services is

BHS' matrix describing services does not include some Medicaid-covered services.

incomplete and, in some instances, unclear. It states that covered services are those described on a matrix of different codes used by the RBHAs for billing services. However, the matrix itself does not list residential detoxification services as a Medicaid-covered service. In addition, it is not clear from either the policy or the matrix that services such as respite or personal care can be billed under the category "behavior management," which is covered by Medicaid. BHS and AHCCCS are currently proposing to clarify the policy.

Consider changing capitation structure—To make it clearer that substance abuse services are available for all types of Medicaid clients, AHCCCS and BHS should consider changing the way that capitation rates are set. As noted above, Arizona currently sets different capitation rates for children, SMI adults, and adults with general mental illness/substance abuse problems. This capitation method does not appear to have been consciously chosen by the State. Rather, it evolved over time as different groups of individuals became covered under Medicaid, with the last group being adults with general mental health disorders who are not seriously mentally ill. This may lead people to believe that Medicaid-eligible children or adults with serious mental illnesses cannot receive substance abuse treatment. Arizona could move toward developing rates along only demographic lines (for example, children, adults) instead. According to the Urban Institute, most states' managed care capitation rates are simply divided along demographic lines rather than by diagnosis, although methods vary.

Develop methods to identify Medicaid and KidsCare eligible and enrolled clients—In order to ensure that clients referred by the courts and Juvenile Corrections are enrolled in Medicaid and KidsCare before being referred to the behavioral health system, these two agencies should develop additional screening methods to identify Medicaid- and KidsCare-eligible clients and better train probation and parole officers on eligibility requirements for these programs. In addition, both the courts and Juvenile Corrections should investigate ways of determining which of their clients are enrolled in these two programs, since actual enrollment is performed by the Department of Economic Security. BHS and AHCCCS should explore the possibility of giving the courts access to the names of their enrollees to ensure that Medicaid is used to pay for services when clients are enrolled in the

program. If BHS and AHCCCS do provide the courts such access, efforts should be made to ensure that client confidentiality is maintained.

Recommendations

1. BHS and AHCCCS should develop a policy for RBHAs that clearly specifies the types of services that are reimbursable by Medicaid. As part of this, the AHCCCS/ADHS billing codes (service matrix) should be updated.

2. AHCCCS and BHS should consider altering capitation rates, in order to make it clearer that children and adults with serious mental illnesses are entitled to substance abuse services. Further, the two agencies should work with RBHAs and providers to educate them about entitlement to such services.

3. The Administrative Office of the Courts and Juvenile Corrections should develop methods to screen clients for Medicaid and KidsCare eligibility.

4. The Administrative Office of the Courts and Juvenile Corrections should further train probation and parole officers on Medicaid and KidsCare eligibility requirements.

5. The Administrative Office of the Courts and Juvenile Corrections should investigate methods of identifying whether their clients are enrolled in KidsCare or Medicaid.

6. BHS and AHCCCS should explore the possibility of giving the courts access to the names of their enrollees to ensure that Medicaid is used to pay for services when clients are enrolled in the program. If BHS and AHCCCS do provide the courts such access, efforts should be made to ensure that client confidentiality is maintained.

FINDING III

CHANGES COULD ENHANCE ABILITY TO SECURE SPECIALIZED SERVICES

Even when there is no dispute about whether a client is eligible or which agency should pay for the service, certain services are simply unavailable. Clients in rural areas, for example, may not have appropriate services nearby. While it may not be possible to address all of these gaps in services, Auditor General staff identified three options that could enhance the RBHA's ability to secure specialized provider services:

Certain services are simply unavailable.

- Increasing rates for certain services to attract more providers for services that are not now sufficiently available;
- Ensuring that some or all provider contracts contain provisions requiring them to provide services for more difficult or disruptive clients; and
- Exploring ways to expand the pool of providers to include behavioral health therapists, social workers, and others currently not part of the approved provider group.

Services Not Always Available to Entitled Clients

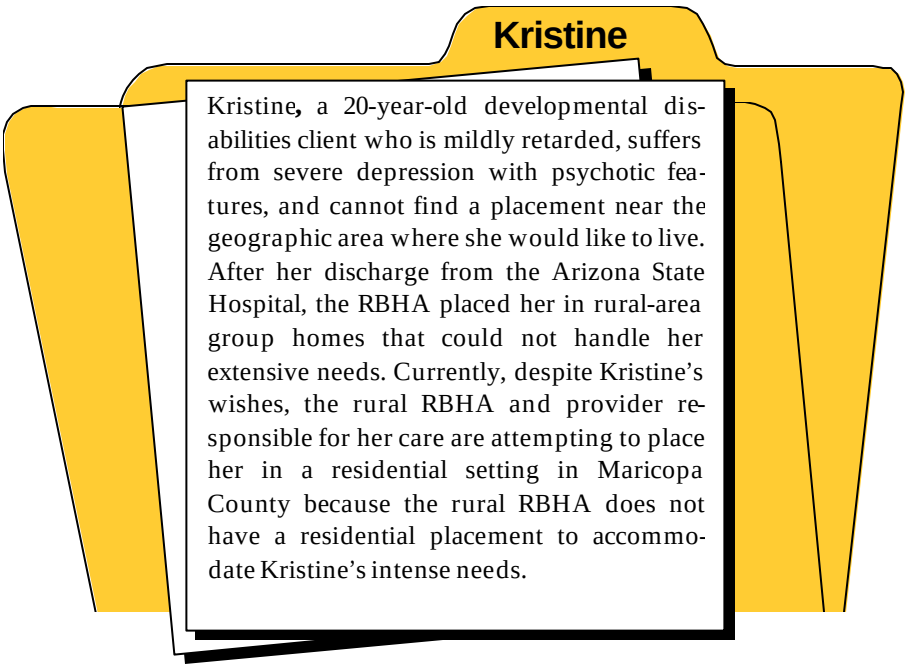
Services required by clients with complex needs may not be available in some cases. Some clients require very intense, specialized services that may be difficult to provide, especially in rural areas. In addition, providers may not always accept clients who are difficult or disruptive or who have felony convictions.

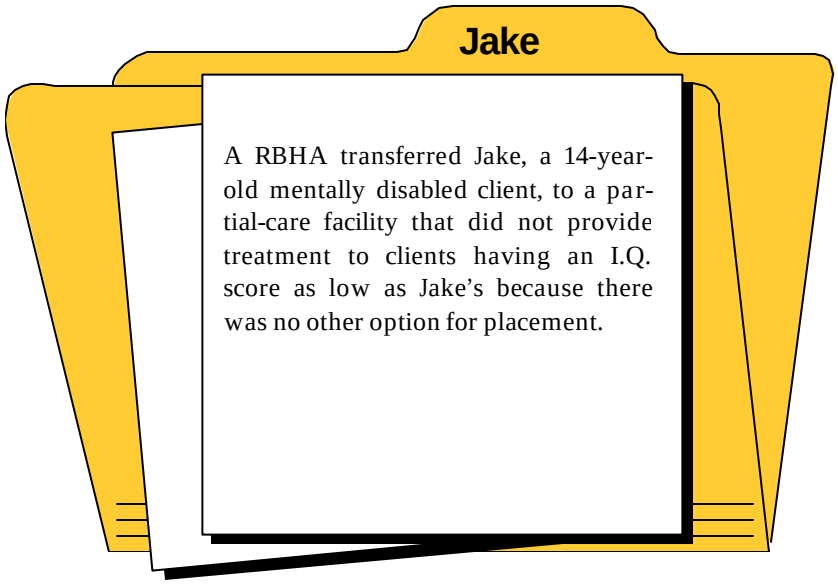
Specialized services for some clients difficult to meet—Work done for this audit, as well as studies already conducted of the behavioral health service delivery system, indicate that provider services may be lacking in some cases for clients with special needs. For example, the studies performed by Human Systems

Services are lacking for the treatment of sexual abuse and youth sex offenders.

and Outcomes for the *JK* v. *Griffith* lawsuit found that provider services tailored to fit children's special needs were sometimes lacking, especially in rural areas. In both northern and southeastern Arizona, the studies noted that services are lacking for the treatment of sexual abuse, youth sex offenders, and bonding or attachment disorders. In addition, interviews with DDD staff suggest that services for developmentally disabled clients may not always be tailored to their needs.

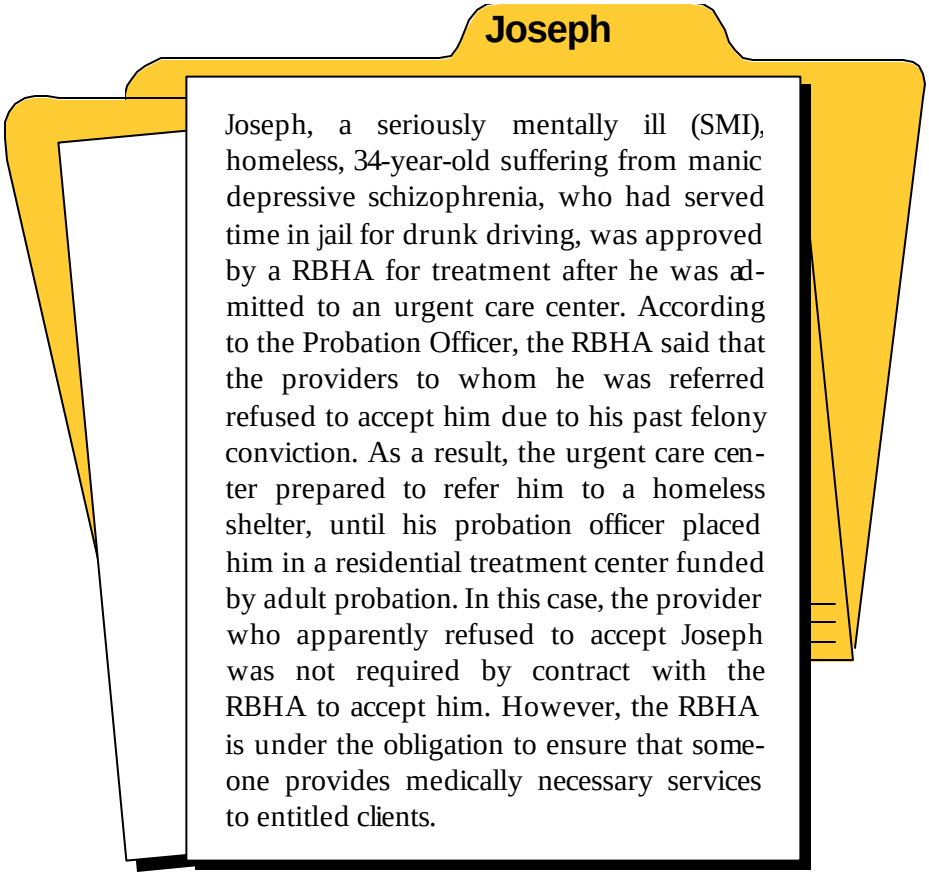
Two of the cases reviewed by the audit team provide examples of service availability problems for clients with special needs:





In Kristine's and Jake's cases, the lack of appropriate services appeared to affect the quality of the clients' treatment. For example, the case coordinator at the partial-care setting in which Jake was placed stated that he was not benefiting from the partial-care program because he could not keep up with the other children. The case coordinator believed that he required one-on-one attention.

Disruptive and difficult clients not always accepted—Services may also be limited for some clients because the clients are difficult to manage. Interviews with foster care and Developmental Disabilities caseworkers suggest that clients referred for services are sometimes screened to determine if the client's behavior is too difficult to handle, or rejected from facilities if they "act up." Joseph is a probationer in need of services who was denied placement because of his criminal background:



Changes Could Make Services for Special-Needs Clients More Available

Although it probably will not be possible to provide services in every instance, changes can be made to better ensure that clients receive the specialized care that they need.

- Changes affecting provider rates could make it easier for RBHAs to pay some providers more money in order to attract specialized providers.

- In addition, changes in contracting practices could ensure that some providers are available to care for disruptive or difficult clients.

- Finally, altering the State's Medicaid plan could allow RBHAs to contract with individual certified master's-level practitioners, thus allowing RBHAs to fill some service gaps when provider services are lacking.

The number of behavioral health providers is declining.

Some service availability problems will probably continue—In some cases, there may be no easy solutions to finding providers who can meet clients' specialized needs. In several interviews with DHS, RBHA, and provider representatives it was noted that the number of behavioral health providers is declining. According to the Division of Licensure, many providers have been going out of business in recent years, although the exact number is unknown. Provider shortages may be especially pronounced among providers who handle sex offenders. Indeed, Juvenile Corrections officials noted that they are sending some probationers out of state to receive treatment because of provider shortages in Arizona. In addition, limitations in the supply of providers may be occurring in rural areas. A 1999 study by the National Rural Health Association found that there is "substantial evidence that the number of mental health providers in rural America is inadequate."

RBHAs could increase provider rate flexibility to help attract some providers—Paying providers higher rates to serve more difficult clients could have an effect on securing such services. RBHAs are allowed to pay providers any rate necessary to obtain needed services. Nonetheless, according to a memo from

RBHAs are allowed to pay providers any rate necessary to obtain needed services.

BHS to the RBHAs, some RBHA officials apparently believe that provider contractor rates can be no higher than rates included on a list BHS distributes to RBHAs to report services delivered. This misperception may have affected the ability of RBHAs to contract for a sufficient number of providers since they may not have believed they were allowed to pay rates higher than those listed. Currently, BHS is attempting to resolve this misperception by informing the RBHAs that provider contract rates are flexible.

Ensuring that some providers take difficult clients—BHS could also help ensure that the clients who are difficult or disruptive receive specialized care by ensuring that a sufficient number of the RBHAs' contracts require providers to accept and serve clients referred to them. Currently, only one RBHA's contract contains such a clause. BHS, who oversees RBHA/provider contracting, should ensure that at least a sufficient number of RBHA/provider contracts contain such provisions, in exchange for higher provider rates or other incentives.

Amending the State's Medicaid plan could allow the RBHAs to directly contract with individual therapists certified by the State Board of Behavioral Health Examiners.

Allowing RBHAs to contract with individual therapists— AHCCCS and BHS could also help ensure that services are available to clients with specialized needs by expanding the pool of potential service providers. Currently, RBHAs are prohibited from contracting directly with many non-physician behavioral health professionals for service delivery. All services provided by non-physicians must be delivered through licensed provider facilities, with the exception of individual services performed by licensed psychologists, physician assistants, and nurse practitioners. Such a prohibition is included in contracts between BHS and its RBHAs and in AHCCCS behavioral health rules and reflects a limitation currently contained in the State's Medicaid plan that is submitted to the federal Health Care Financing Administration.

Although contracts currently do not allow the pool of providers to be expanded in this way, it is possible to change the current limitation. According to an AHCCCS official, the current requirement exists because behavioral health therapists in Arizona are not licensed. However, it is possible for AHCCCS to request that the Health Care Financing Administration amend its Medicaid plan to allow services to be provided by approximately

5,200 substance abuse counselors and master's-level social workers and therapists, certified through the State's Board of Behavioral Health Examiners. Such a change could potentially make professional and outpatient services more readily available. For example, one official at a rural RBHA noted that the RBHA wished to contract with a certified practitioner who specialized in therapy for those who have been sexually abused, but may have been prohibited from doing so due to this restriction.

Recommendations

1. BHS should re-examine listed provider rates to help ensure that RBHAs are not artificially constrained in paying providers higher rates to obtain needed services for clients.

2. BHS should ensure that a sufficient number of RBHA/provider contracts contain language requiring the provider to accept and serve clients who are difficult or disruptive, in exchange for higher provider rates or other incentives.

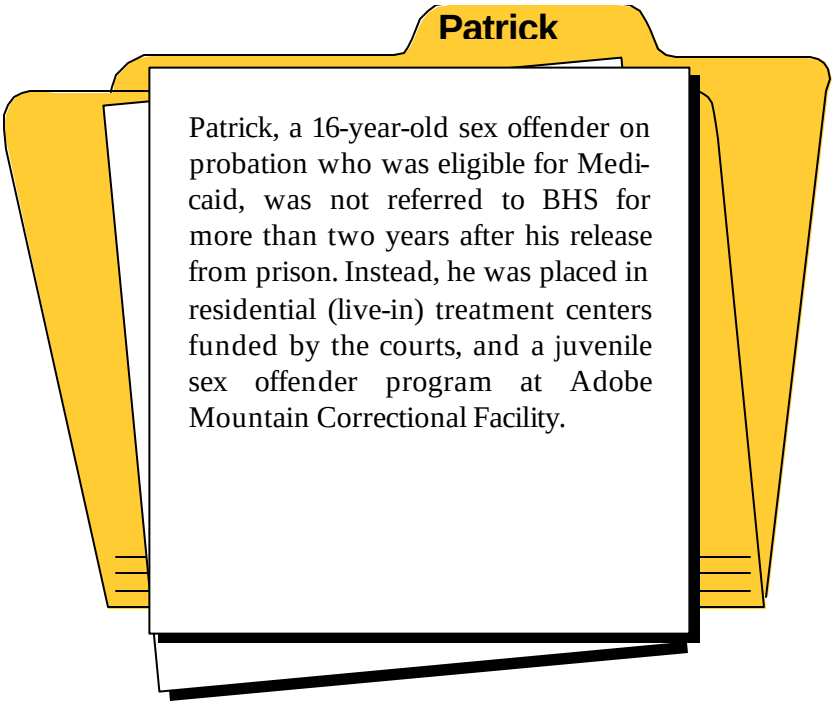
3. AHCCCS should consider requesting a change in the State's Medicaid plan, allowing professionals certified by the Board of Behavioral Health Examiners to also be eligible for providing services.

FINDING IV EXPANDING BHS' ROLE IN SERVING JUVENILE OFFENDERS COULD SAVE THE STATE MONEY

The limited role that BHS plays in providing behavioral health services to juvenile offenders should be examined. Currently, juvenile offenders who are taken out of prison for behavioral health treatment receive services that are paid for with state-appropriated Juvenile Corrections dollars. In addition, juvenile sex offenders on probation or parole are not always referred to the behavioral health system for possible services, even if they are eligible for Medicaid-provided services. Providing such care through Medicaid whenever possible could lower the State's cost of providing services, because the federal government pays the majority of the cost under Medicaid. Under the current arrangement, the State may not effectively leverage these federal dollars. Making such a change would require BHS to take greater responsibility for providing the behavioral health component of such care. In order to conserve state dollars and effectively leverage federal Medicaid dollars, the Division should ensure that the RBHAs are made responsible for providing behavioral health care to juvenile sex offenders and Medicaid-eligible prisoners removed from prison for treatment. Also, the Division should work with Juvenile Corrections to ensure that Medicaid is spent whenever possible for such behavioral health services.

BHS Plays Limited Role in Providing Services for Juvenile Offenders

Juvenile justice agencies sometimes pay for behavioral health treatment for juveniles who could receive Medicaid-funded treatment through the behavioral health system. The courts and Juvenile Corrections often pay for behavioral health treatment for sex offenders on probation or parole. Officials noted that these people are not referred to the behavioral health care system for services because the RBHAs will not treat these clients. This situation occurred in one of the cases auditors reviewed (see Patrick, page 40).



It appears that juvenile justice agency officials' belief that the behavioral health care system may not accept sex offenders for treatment may be well-founded. One interview with a RBHA psychiatrist seemed to corroborate that RBHAs may indeed reject such clients. This psychiatrist noted that children who are sex offenders are traditionally shifted to other agencies for treatment.

Sex offenders on probation and parole are not the only ones who receive services through the juvenile justice system when such services could be provided by BHS. Currently, juvenile offenders who are removed from prison to receive behavioral health treatment in secure residential treatment settings receive their treatment in facilities funded by Juvenile Corrections. According to Juvenile Corrections officials, they have been told in the past by the RBHAs that Medicaid will not pay for treatment for prisoners, even when they are removed from prison to receive needed treatment. However, Medicaid will pay for services (except, in some cases, room and board) as long as the juvenile is enrolled, the services are medically necessary, and the juvenile is not an inmate in a public institution.

Shifting Medicaid-Eligible Juveniles to Behavioral Health Services System Could Help Stretch State Dollars

By not referring Medicaid-eligible juvenile offenders more readily to BHS and its network of RBHAs, the State is losing an opportunity to leverage federal Medicaid dollars and stretch its own appropriations for behavioral health services. If juvenile offenders who have been released from prison (or removed for medical care), qualify for Medicaid, their care could potentially be paid for by Medicaid dollars. Medicaid cannot pay for services delivered to inmates of public institutions. However, an official at the Health Care Financing Administration (the federal agency that oversees Medicaid) stated that although the administration has no written policy on the subject, it will allow Medicaid to pay for some or all medically necessary services for patients who are removed from prison for medical care. Any limitations on the use of Medicaid dollars in such instances (such as Medicaid not being available to pay for room and board in many residential settings) are the same limitations that apply to the delivery of any Medicaid service.

State dollars could be saved if services for unincarcerated Medicaid-eligible juveniles were provided through BHS and the RBHAs instead of being paid for by Juvenile Corrections. In this part of the system, the State pays approximately one-third of Medicaid-provided services and the federal government pays the remaining two-thirds. By ensuring that Medicaid paid for the services provided to juveniles who were eligible for such support, the State could stretch those dollars that are appropriated to provide care for people who must be supported solely by state dollars.

Making Such a Change Would Require a Shift in Responsibility

While Medicaid dollars could be used to deliver behavioral health services to incarcerated persons removed from prison for medical care, BHS staff have not believed Medicaid will pay for such care. According to the Department's Assistant Director for Behavioral Health Services, the Division has understood that such services are not reimbursable under Medicaid. Nonetheless,

according to a HCFA official, the State does have the ability to use Medicaid dollars to provide such services, although it is under no obligation to do so. The HCFA official also noted, however, that a finalized policy statement in this area had not yet been developed. An AHCCCS official confirmed that Medicaid could potentially pay for medically necessary services for Medicaid-eligible prisoners who were removed from prison for treatment. This official stated that AHCCCS had recently received a memo from HCFA on the subject.

In order to conserve state dollars and effectively leverage federal Medicaid dollars, the Division should ensure that the RBHAs are made responsible for providing medically necessary behavioral health care to juvenile sex offenders and Medicaid-eligible prisoners removed from prison for treatment. Also, the Division should work with Juvenile Corrections to ensure that Medicaid is utilized whenever possible for such medically necessary behavioral health services.

Recommendations

1. In order to conserve state dollars and effectively leverage federal Medicaid dollars, the Division should ensure that the RBHAs are made responsible for providing medically necessary behavioral health care to juvenile sex offenders and Medicaid-eligible prisoners removed from prison for treatment.

2. The Division should work with Juvenile Corrections to ensure that Medicaid is utilized whenever possible for juvenile sex offenders and for persons removed from prison for medically necessary behavioral health treatment.

OTHER PERTINENT INFORMATION

During this audit, other pertinent information was obtained regarding numerous efforts undertaken to improve service provision for people involved with the behavioral health system and other state agencies, such as the Department of Economic Security, the Arizona Department of Juvenile Corrections, and the Administrative Office of the Courts. Table 1 on pages 52 through 54 summarizes the groups and projects auditors reviewed.

Coordination Problems Among Agencies Identified

Since 1986, numerous efforts have been initiated to improve coordination of behavioral health services between state agencies. Multi-agency projects and legislative committees have published studies on how to improve services for people (primarily children) who are involved with more than one agency. In addition, numerous efforts have ensued to improve interagency coordination. While some efforts are initiatives stemming from the federal government and the Governor, others have actually evolved out of the recommendations made by other groups trying to improve coordination. Furthermore, recent efforts have been initiated as a result of litigation (*JK* v. *Griffith*) contending that Medicaid-enrolled children receive inadequate mental health services in Arizona.

These studies and efforts identify and attempt to solve a number of problems that confront clients involved with multiple agencies. Such problems are more broad in scope than the one identified in this report: namely, the ability of clients referred to the behavioral health system to receive services (which this report attempts to delve into more deeply). Instead, these studies and efforts identify and attempt to provide solutions to three central problems:

✓ **Fragmentation in service delivery—**Numerous studies identify Arizona's fragmented service delivery as a barrier

to people receiving appropriate services. For example, the nonprofit group Partnership for Children wrote in a 1991 project report that "Children and families [in Arizona] receive services from multiple agencies with limited institutional willingness to cooperate or communicate." It further stated that "current services target specific problems with fragmented services driven by funding sources rather than meeting the needs of the whole family." The same report adds that different agencies each treat a small part of the problem, often in different buildings and using their own eligibility standards. Efforts such as Governor Hull's No Wrong Door Initiative, which is striving to ensure that people needing services can go to any agency to begin the process of receiving treatment, is aimed at resolving fragmentation problems.

- ✓ **Inappropriate service delivery—**A number of studies have noted that children involved with multiple state agencies often receive services that are inappropriate or too limited to fit their needs. For example, studies by the Partnership for Children and the Joint Legislative Children and Families Reorganization Study Committee both note that service delivery to children in this State is crisis-oriented, thus resulting in more costly and less effective services. The 1998 studies performed as a result of the *JK* v. *Griffith* lawsuit noted that Medicaid-eligible children with multiple agency involvement receive treatment that may be too brief and limited to meet their needs.

- ✓ **Redundancy in service delivery—**Many studies and efforts focus on redundancies that exist in the current service delivery system. For example, the Joint Legislative Children and Families Reorganization Study Committee notes redundancy in data gathering between agencies. Efforts such as the Interagency Case Management Project, a joint partnership between state agencies that serve children, such as DHS and the Department of Economic Security, are attempting to address redundancy problems.

Similar Recommendations Made to Improve Service Coordination

The recommendations proposed and/or implemented by the committees, task forces, and others cover a broad spectrum. Suggested solutions for resolving the problems described above range from redesigning the way services are delivered to procedural improvements, such as changing the amount and type of information collected from shared clients.

Streamline the service delivery system—In order to address the problem of a fragmented service delivery system, some groups advocate a change to one streamlined process for clients receiving services from multiple agencies. Groups propose having one centralized location or case manager capable of seeking services from more than one agency, to minimize the number of agencies the client interacted with.

- ✓ **Centralized screening process—**The Partnership for Children recommended a system involving a uniform path by which children and families receive services from multiple agencies. It proposed a centralized screening process so clients could be made aware of all services available to them. Services would then be coordinated through a service plan developed to address all of the client's needs.

- ✓ **Local service centers—**The Joint Legislative Children and Families Reorganization Study Committee reported that current services require families with multiple problems to exit and re-enter multiple systems at multiple locations. This committee advocated an integrated process for service delivery, as did the Partnership for Children. To do so, it proposed the creation of family assistance centers. Case managers located at these centers would be trained to access services from multiple agencies.

- ✓ **Integrated case management—**Similarly, the Interagency Case Management Project (ICMP), currently implemented as a pilot project in limited areas, assigns a single case manager to serve its clients. The project involves children and their families who have multiple problems and are involved with multiple agencies. Rather than have multiple case managers from each agency, the family interacts with one

ICMP case manager who is cross-trained to provide services through multiple state agencies.

Provide full continuum for specialized services—Addressing the concern that services are too limited or inappropriate, various efforts have recommended that a full range of services be available to specific populations. The types of services addressed include treatment for juvenile sex offenders and substance abusers, as well as transitional services between agencies.

- ✓ **Specialty services for children and adolescents—**In its 1997 Annual Report, the Children's Behavioral Health Council stated that a continuum is lacking in specialty services, such as treatment for juvenile sex offenders and substance abuse services for children and adolescents. Their recommendation was to "develop easier access to services." In its 1998 Annual Report, the Council states that it will continue to advocate for expanded substance abuse services specific to children and for a more comprehensive service system.

- ✓ **Services for released mentally impaired offenders—**According to the Council on Offenders with Mental Impairments, it is important to establish services that incarcerated juveniles need and programs that offer a continuum of care after juveniles leave incarceration. In its 1998 Annual Report, the Council recommends that a continuum of services be available for released mentally impaired offenders. Often, developmentally disabled adults and juveniles are excluded from a range of transitional services because of their illness and/or offenses. The Council recommends that interagency cooperation be sought for providing a continuum of housing and other transitional services for mentally impaired offenders released from custody.

Improve communication among agencies—To diminish fragmentation and facilitate common strategies to care for mutual clients, groups have proposed and implemented ways to solve communication problems among the agencies and better serve the clients' needs.

- ✓ **Local councils—**In its 1998 Annual Report, the Council on Offenders with Mental Impairments calls for an increased flow of communication between correctional facilities and community mental health providers. The council also recommends establishment of local councils to increase the networking between correctional facilities, criminal justice agencies, and behavioral health agencies.

- ✓ **Interagency cabinet—**The Joint Legislative Children and Families Reorganization Study Committee recommends establishing an Interagency Coordination Cabinet comprised of agency directors, local advisory boards, and local assistance centers. Through its membership, the cabinet would facilitate communication regarding the coordination of agency procedures and the fostering of integrated service delivery.

- ✓ **Multi-agency teams and coordinating councils—**Improved communication has taken place in Arizona, according to the Independent Reviews being conducted as part of the *JK* v. *Griffith* lawsuit. The reports cite examples of Multi-Agency Teams and Care Coordinating Councils that have been developed to resolve problems experienced by clients involved with multiple agencies.

Improve information-sharing among agencies—In order to address the problem of collecting redundant client information, many groups recommend the creation of centralized data systems. Agencies collect similar client information, and oftentimes agencies are unaware of the services a client may be receiving through another agency. A central system used to store information would alleviate the problem of collecting redundant information, as well as providing useful information to agencies for treatment-planning purposes.

- ✓ **Create central information system—**The Joint Legislative Children and Families Reorganization Committee Study examined changing the information management architecture, noting that 20 different informational systems are used to support children and family services. The recommendations involve creating a central, multi-agency information system

to collect client information from one location that would allow a case manager to access the information from multiple locations and / or agencies.

- ✓ **Create common database, allow interfaces between agency computer systems—**The Partnership for Children effort recommends the creation of a database to gather common data needed to support the necessary service delivery functions. It also advocates allowing the agencies' systems to interface with each other.

- ✓ **Exchange assessment and case-planning data through a data warehouse—**The Assessment and Evaluation Work Group sees a need to expand informational linkages beyond demographic data to allow the exchange of assessment and case-planning data. The group advocates developing a common data warehouse.

- ✓ **Develop information-sharing links between criminal justice and behavioral health system—**As part of the goals developed for its 1997 Annual Report, the Council on Offenders with Mental Impairments sought to develop information-sharing links among the stakeholders for mentally impaired offenders. In its 1998 Annual Report, the Council notes progress in improving data sharing between the criminal justice and behavioral health system. Various counties have established methods in order to increase identification of RBHA-enrolled seriously mentally ill clients who are incarcerated. One example is the development of computer linkages between the RBHA and Maricopa County Sheriff's Office. Pima County has also agreed to share information on the booking and release of mentally impaired offenders with the RBHA in Pima County.

- ✓ **Avoid collecting redundant information—**Governor Hull's No Wrong Door Initiative**,** after assessing the existing services provided by the state agencies and the service delivery processes used across multiple agencies, found that common information should not be collected from the client redundantly. The effort notes that agencies should have access to commonly needed information once it is collected, regardless of the source. The effort also advocates the crea-

tion of service lists to identify all family and child resources available for successful referral to a service provider.

Provide more timely, complete, and accurate assessments— Problems with inadequate service delivery have been noted to stem from incomplete and inaccurate assessments. An adequate assessment is essential to understanding the client's needs and planning for appropriate services. Groups have focused on this important aspect and have suggested similar recommendations in that common information should be shared across agencies.

- ✓ **Incorporate developmental and long-term view—**The agencies involved with the *JK* v. *Griffith* lawsuit developed a document called "JK Practices to Achieve Success for Children." The Practices call for assessments that are sufficient and incorporate a developmental and long-term view. There must also be a shared understanding of the child and family as a result of the assessment process so that an appropriate intervention plan can be developed.

- ✓ **Adopt similar guidelines—**The Assessment and Evaluation Work Group recommends that all agencies need to adopt similar guidelines for assessments. Further, it advocates the formation of collaborative special teams for those served by multiple agencies to help identify the most effective service plan.

- ✓ **Common screening process—**Governor Hull's No Wrong Door Initiative also recognizes that the focus should be on integrating the processes for accessing services, such as screening and referrals. The strategic plan for this project recommends developing a common screening process that could be performed at any point of the client's entry into the service system. Again, it advocates having common data elements to better coordinate and share information for determining the best way to meet the client's needs.

***Use funding more efficiently*—**It has been noted that agencies sometimes provide limited services because of constraints on their resources. Many groups recommend identifying funding barriers to enable efficient and effective use of resources so that services can be provided to those in need.

- ✓ **Explore ways to make funding more flexible—**In its review of funding issues, the Partnership for Children identifies current funding streams, which support services to children and families. Often, the review discovers, funding could be more effectively and efficiently spent if the State has more flexibility in its use. The Partnership makes a few recommendations for exploring funding options. One recommendation calls for designating a state-level entity charged with developing a plan to maximize flexible funding. They call for the lead responsibility to be established within the Governor's Office, not within an existing agency.

- ✓ **Expand joint purchase agreement—**In its 1997 Annual Report, the Children's Behavioral Health Council advocates expanding the existing Single Purchase of Care contract (a contract between state agencies and DHS, DES, and other agencies aimed at simplifying provider contracting) to obtain more services for children and families. The Council also recommends that government agencies become more involved in sharing the responsibility for children. According to the Council, this would involve cost-sharing agreements among the agencies. In its 1998 annual report, the Council says it supports DHS in obtaining grants to fund innovative children's behavioral health programs. The Council also advocates finding additional non-Medicaid revenue (i.e., state appropriations and federal block grants).

- ✓ **Establish mechanism to ensure sufficient funding—**The Council on Offenders with Mental Impairments advocates establishing a funding mechanism to ensure that services are supported for non-incarcerated mentally disturbed youth. They call for reviewing innovative programs to fund services for mentally ill juveniles. This includes programs that are funded by grants for additional services.

- ✓ **Maximize use of federal funds—**In its 1999 Progress Report, the Behavioral Health Subcommittee also recommends that funding support the needs of children in the State's care. The Subcommittee emphasizes that special attention be taken to ensure providers/placements are not changed based on how a service is funded. They also advocate the use of Medicaid and KidsCare funding to its fullest extent to conserve state monies.

Table 1

Behavioral Health Services Coordination Audit
Efforts to Improve Coordination of Behavioral Health Services

Group/Project	Authorization	Participants	Responsibility	Status
Behavioral Health Planning Council	Laws 99-660 (U.S. Congress 1986)	ADHS, AHCCCS, DES, criminal justice representatives, providers, consumers, and families	Determines whether behavioral health services are sufficiently provided across the State	Meets quarterly
Children's Behavioral Health Council	A.R.S §§36-3421 and 3422 (1988)	ADE, ADHS, ADJC, AHCCCS, AOC, DES, Governor's Office, legislators, and community representatives	Provides recommendations on improving behavioral health issues facing Arizona's children. Oversees development of a single, coordinated continuum of services for children. Reviews intergovernmental agreements entered into by agencies serving children.	Meets monthly and issues an annual report to the Governor and Legislature. Council to be sunset December 1999.
Partnership for Children	Arizona Community Foundation and Tucson Community Foundation (1991)	ADE, ADHS, ADJC, AHCCCS, AOC, DES, Governor's Office, legislators, providers, and community representatives	Created a comprehensive, integrated, and responsive service delivery model.	Developed model for a coordinated system of care. Proposals made to Legislature for funding pilot programs, but model has never been implemented.
Council on Offenders with Mental Impairments	Laws 1992, Chapter 234	ADHS, ADJC, AOC, DES, DOC, RBHAs, a representative from the Behavioral Health Planning Council, and law enforcement and community representatives	Addresses issues concerning the welfare of offenders with mental impairments. Identifies needed services for offenders, develops plan to meet their treatment needs, and makes recommendations to improve service coordination.	Meets monthly and issues an annual report to the Governor and Legislature.

Table 1 (Cont'd)

Behavioral Health Services Coordination Audit
Efforts to Improve Coordination of Behavioral Health Services

Group/Project	Authorization	Participants	Purpose	Status
Governor's Action Committee	Governor (1993)	ADE, ADHS, ADJC, AOC, DES, service providers, consumers, and advocates	Developed an intergovernmental agreement (known as the Children's IGA) between state agencies that serve children.	Recommendations provided to Governor in 1993.
Children's IGA Executive Committee	Governor's Action Committee (1993)	ADE, ADHS, ADJC, AHCCCS, AOC, DES, parent advocates, and a representative from the Children's Behavioral Health Council	Oversees efforts resulting from the Children's IGA, specifically the Integrated Case Management Project and the Single Purchase of Care agreement.	Meets as needed.
Interagency Case Management Project (ICMP)	Children's IGA Executive Committee (1993)	ADE, ADHS, ADJC, AHCCCS, AOC, DES, county courts, and children and families involved with multiple agencies	Provides an efficient, coordinated service delivery system. Children and their families served by one case manager trained to acquire services from multiple agencies.	Five-year pilot project, the Maricopa ICMP, began in 1995. Statewide ICMP Work group meets monthly.
Single Purchase of Care (SPOC)	Children's IGA Executive Committee (1993)	ADHS, ADJC, AOC, DES, RBHAs, and service providers	Provides children's behavioral health services for all agencies under a single contract.	Currently under revision. Instead of a single contract for all agencies, each agency will have its own contract. State SPOC Work Group meets at least quarterly.
Court Improvement Project	Congressional Omnibus Budget Reconciliation Act, Public Law 103-66 (1993)	ADHS, AOC, DES, and county courts	Improve court system's handling of child maltreatment cases. Processes cases more timely, including expediting the delivery of behavioral health services to children and their families.	In 1997, Pima County Model Court Project was created to test court process. HB 2645, requiring process to be implemented statewide, passed in 1998.

Continued

Table 1 (Concl'd)

Behavioral Health Services Coordination
Efforts to Improve Coordination of Behavioral Health Services

Group/Project	Authorization	Participants	Responsibility	Status
Independent Quality Reviews	Ordered through lawsuit , *JK* v. *Griffith* lawsuit (1997) [a]	Independent expert panel, Human Systems Outcomes, Inc.	Examined whether Title XIX children are receiving adequate behavioral health services and offer feedback for improving practices.	All six RBHAs were evaluated. ADHS and AHCCCS contracted evaluators who will provide technical assistance to RBHAs in developing practice guidelines.
Joint Legislative Children and Families Reorganization Study Committee	HB 2537 (1997)	Legislators	Reviewed issues regarding Arizona's service delivery system for children and families. Recommended a long-range plan for an integrated service delivery system.	Issued final report. Committee's recommendations, proposed in 1998 legislation, failed to pass.
Assessment and Evaluation Workgroup	Parties involved with *JK* v. *Griffith* lawsuit (1998)	ADE, ADHS, ADJC, AHCCCS, AOC, DES, RBHAs, community representatives, and service providers	Examine the assessment process for children entering behavioral health services from various agencies.	Issued recommendations in May 1999. Work group meets regularly.
"No Wrong Door" Committee	Executive Order 98-8	ADHS, ADJC, AHCCCS, GITA, DOA, Arizona Supreme Court, DES, and community leaders	Examines how services can be made available to all eligible children and their families, regardless of which state agency or "door" they enter to seek services.	Draft of strategic plan completed May 1999.

[a] *JK* v. *Griffith* is a class action lawsuit filed in 1991 on behalf of Medicaid children who have not received necessary mental health services. Defendants include ADHS and AHCCCS. The lawsuit is currently in a stay of litigation.

Source: Auditor General staff analysis of project reports, council and working group meeting minutes, and interviews with agency personnel.

AGENCY RESPONSE

Office of the Director

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Ms. Debbie Davenport
Auditor General
Office of the Auditor General
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Phoenix, Arizona 85018

Dear Ms. Davenport:

Enclosed is the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) response to the DBHS - Coordination Services Audit. The ADHS agrees in general with the findings and recommendations of the audit team.

The ADHS is pleased to note that DBHS has already identified many of the issues documented in your report and have begun corrective action. Our goal in Year 2000 is to continue the efforts already underway with an emphasis on improving the involvement of consumers, family members and other stakeholders in the process.

We extend our thanks to the audit team for their thoroughness and professionalism throughout the audit. We appreciate their seeking our input and clarification on issues identified in the report.

Sincerely,

James L. Schamadan, M.D.
Acting Director

JLS:CS:lls

Enclosure

AUDITOR GENERAL'S RECOMMENDATIONS
AGENCY'S RESPONSE

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.

As indicated in the Auditor General report, the characteristics of the system contribute to interagency disagreements. The ADHS appreciates the recognition of the Auditor General for the many efforts and initiatives found in the "Other Pertinent Information" section, which have been undertaken to address the areas of disagreement. Our goal in 2000 is to continue the efforts already underway with an emphasis on improving the involvement of consumers, family members and other stakeholders in the process. The findings of this audit report will be incorporated into our discussions with state agencies and other stakeholders to further refine the system for meeting the behavioral health needs of the people living in Arizona.

Finding I: ***Managed Care Focus, and Structure that Divides Responsibility, Leads to Interagency Disagreements***

Recommendation 1. **The Legislature should consider directing DDD, DBHS, and/or AHCCCS to contract with an actuarial firm to determine the cost of having DDD contract directly with providers for its ALTCS clients' behavioral health services, instead of relying on the RBHAs to deliver such services. If the Legislature finds the increased cost to be acceptable, DDD should begin directly contracting for such services for its ALTCS clients.**

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

DBHS agrees with the finding of the Auditor General and will cooperate with DDD and AHCCCS in this effort to implement the audit recommendation if the Legislature so directs.

If the Legislature does not direct the three agencies to explore this avenue, DBHS plans to do the following:

a. Implement two recently completed Service Planning Guidelines for "Autistic Spectrum Disorders"and for "Considerations in the Assessment and Treatment of Persons with Developmental Disorders and Co-Occurring Behavioral Health Disorders."

Implementation includes:

i. development of a training module, case review module and consumer/family information packet for each guideline;

ii. revision of service matrix and codes as needed for implementation of guidelines;

iii. analysis of estimated prevalence for disorders and calculation of current penetration, using DBHS enrollment and total number of DD-ALTCS eligible members;

iv. projection of costs for full implementation of guidelines for estimated population to be served.

b. Approach DES/DDD with the proposal to jointly contract/RFP for service providers for the provision of integrated medical, habilitative and behavioral health care. (Even if DES/DDD resumes responsibility for behavioral health coverage for DD-ALTCS members, it still maintains a fragmented system of habilitative case managers employed by DES, subcontracted medical providers, and separately contracted behavioral health providers.)

Recommendation 2. **DBHS should continue to work with other agencies to develop methods for streamlining and coordinating assessment of children, as is currently occurring under the *JK v. Griffith* litigation. DBHS should also work with agencies that conduct adult screening and assessments to ensure that the agency's assessment information is routinely available and incorporated into the RBHA's assessment process.**

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 issues. A workgroup has convened to examine the children's assessment process and the mechanisms needed to share assessment information among involved agencies. In addition, the Division participates in the Governor's No Wrong Door initiative whose chief goal is to increase service system accessibility for clients through creating data sharing mechanisms, among other efforts. The Division monitors the RBHAs to ensure that procedures exist and are effective for the transfer of children approaching their 18th birthday into behavioral health services appropriate for young adult clients.

Regarding the adult population, the Division is currently in the second year of an Interagency Services Agreement with the Arizona Department of Corrections to provide substance abuse treatment to adult offenders released from prison pursuant to Proposition 200 through the Correctional Officer/Offender Liaison (COOL) program. The COOL program was expanded at ADC request in March 1999 to cover drug/alcohol services for all adults under community supervision in Arizona. Similarly, the Division has partnered with DES/ACYF and the Office of the Attorney General to implement a family-centered addictions treatment program in Maricopa County for Non-Title XIX families involved with Model Court. Both initiatives involve incorporation of collateral information from other state agencies in the assessment process and in development and monitoring of treatment plans. The Division will continue to foster such initiatives and enhance sharing of clinical assessment data for adults receiving services in the RBHA system.

Finally, the current Maricopa County RBHA contract (and all other RBHA contracts as of July 1, 2000) includes the requirement that all assessment and service planning information from other agencies be considered and integrated into the behavioral health assessment and service planning process.

Recommendation 3. **DBHS should assist the RBHAs in developing a plan for fulfilling the current master's-level assessment requirements, or develop alternative methods of ensuring that people who perform behavioral health assessments are adequately qualified.**

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

As of July 1, 2000, all RBHA contracts will contain requirements for performance of initial assessments by certified or master's level behavioral health professionals. By July 1, 2003, all initial assessments must be completed by certified master's level behavioral health professionals. In addition, the RBHAs are required to develop privileging criteria to assess the competency of staff performing initial assessment, based on credentials, education, training, experience, and supervised practice.

The Division does, however, recognize the challenges in meeting the certified master's level behavioral health professional requirement as evidenced by the difficulty Maricopa County has had recruiting this level of practitioner. We will work with the RBHAs in developing a plan and/or

alternative methods of ensuring that people who perform behavioral health assessments are adequately qualified.

Recommendation 4. **DBHS should make changes to Title 9, Chapter 21 of the Administrative Code, allowing people applying for Seriously Mentally Ill (SMI) status more time to submit medical records so that past medical histories and other psychiatrists' opinions can be adequately considered.**

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

DBHS has drafted changes to the current policy on determination of Seriously Mentally Ill (SMI) that would require the RBHA to extend the evaluation for up to 20 days to obtain needed records or evaluation prior to an eligibility determination decision. This is allowable under the current rules. There will also be proposed revisions to the Administrative Rules to address these changes, but the policy changes will improve the process more quickly.

Recommendation 5. **DBHS should monitor whether care delivered by the RBHAs reflects the Division's service planning guidelines.**

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

The Division has drafted a chart review protocol to monitor service planning guideline implementation by the RBHAs for the adult population diagnosed with schizophrenia. The Division expects to complete two more chart review protocols to monitor guideline implementation for children with conduct disorder and for pregnant substance abusing women.

Recommendation 6. **The Division should monitor whether the RBHAs are currently using DBHS level-of-care criteria when making determinations as to whether clients qualify for inpatient and residential treatment.**

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 issues. The Division reviews a 1% sample of inpatient acute and JCAHO residential treatment utilization management records

each year during the Operational and Financial Review in order to determine that the placements were medically necessary as authorized by a qualified physician. In addition, the Division reviews the level of care criteria that each RBHA uses during the annual Operational and Financial Review to ensure that the RBHA criteria references and aligns with the DBHS level of care criteria. In the 1999 cycle, the level of care criteria for all RBHAs both referenced and aligned with the DBHS level of care criteria. In the upcoming 2000 Operational and Financial Review cycle, the Division will review a 1% sample of inpatient acute and JCAHO residential treatment utilization management records to detect whether the medical necessity determination for the given level of care was correct.

Finding II: ***Confusion Exists Regarding Medicaid Coverage***

Recommendation 1. **DBHS and AHCCCS should develop a policy for RBHAs that clearly specifies the types of services that are reimbursable by Medicaid. As part of this, the AHCCCS/ADHS billing codes (service matrix) should be updated.**

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

The Division will revise our Covered Services policy and procedure to clearly specify the types of services that are reimbursable by Medicaid. An updated Service Matrix will be attached to the revised policy and procedure. In addition, the Division will give technical assistance to the RBHAs to ensure that the policy and procedures are explained and ample opportunity is available for dialogue and clarification.

Recommendation 2. **AHCCCS and DBHS should consider altering capitation rates, in order to make it clearer that children and adults with serious mental illnesses are entitled to substance abuse services. Further, the two agencies should work with RBHAs and providers to educate them about entitlement to such services.**

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

ADHS will work with AHCCCS to review the feasibility of altering the capitation rate structure to make it more clear that all Title XIX clients are eligible for substance abuse services. Also, ADHS will work with the

RBHAs and AHCCCS to educate the providers about Title XIX clients' entitlement to such services.

Recommendation 3. **The Administrative Office of the Courts and Juvenile Corrections should develop methods to screen clients for Medicaid and KidsCare eligibility.**

Agency Response: *This finding is directed to the Administrative Office of the Courts and Juvenile Corrections. Therefore, it would not be appropriate for the Division to take a position on this finding. DBHS will cooperate with the Administrative Office of the Courts and Juvenile Corrections, as needed, to implement the audit recommendation.*

Recommendation 4. **The Administrative Office of the Courts and Juvenile Corrections should train probation and parole officers on Medicaid and KidsCare eligibility requirements.**

Agency Response: *This finding is directed to the Administrative Office of the Courts and Juvenile Corrections. Therefore, it would not be appropriate for the Division to take a position on this finding. DBHS will cooperate with the Administrative Office of the Courts and Juvenile Corrections, as needed, to implement the audit recommendation.*

Recommendation 5. **The Administrative Office of the Courts and Juvenile Corrections should investigate methods of identifying whether their clients are enrolled in KidsCare or Medicaid**

Agency Response: *This finding is directed to the Administrative Office of the Courts and Juvenile Corrections. Therefore, it would not be appropriate for the Division to take a position on this finding. DBHS will cooperate with the Administrative Office of the Courts and Juvenile Corrections, as needed, to implement the audit recommendation.*

Recommendation 6. **DBHS and AHCCCS should explore the possibility of giving the courts access to the names of their enrollees to ensure that Medicaid is used to pay for services when clients are enrolled in the program. If DBHS and AHCCCS do provide the courts such access, efforts should be made to ensure that client confidentiality is maintained.**

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

The Division is willing to explore mechanisms for sharing client enrollment data with the courts within the confidentiality requirements specified in 42 CFR.

Finding III: ***Changes Could Enhance Ability to Secure Specialized Services***

Recommendation 1. **DBHS should re-examine listed provider rates to help ensure that RBHAs are not artificially constrained in paying providers higher rates to obtain needed services for clients.**

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 issues. DBHS has changed the name of the document that contains the listed provider rates from the ADHS/DBHS Maxed Capped Fee Schedule to the ADHS/DBHS Service Matrix in an attempt to remove some of the confusion regarding the inability of the RBHAs to pay above those listed rates. Furthermore, ADHS/DBHS has informed the RBHAs that they are not limited to the amounts shown in the ADHS/ DBHS Service Matrix when they are contracting with providers. The Service Matrix definition has been revised to further reinforce this message. The new definition of the ADHS/DBHS Service Matrix is, "the document that lists all covered services and the rates to be paid in the absence of a subcontract for each covered service."

This topic was on the agenda of the January RBHA Directors Meeting for clarification. We will send a follow-up letter to the RBHA CEOs and CFOs in February.

Recommendation 2. **DBHS should ensure that a sufficient number of RBHA/provider contracts contain language requiring the provider to accept and serve clients who are difficult or disruptive, in exchange for higher provider rates or other incentives.**

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 issues. As of July 1, 2000, all RBHA contracts will require subcontracts with providers to contain "no-reject/no-eject" clauses.

Additionally, as each of the Service Planning Guidelines are fully implemented, the projected costs will be stratified by functional level, allowing the possibility of differential case rates for more difficult clients.

Recommendation 3. **AHCCCS should consider requesting a change in the State's Medicaid Plan, allowing professionals certified by the Board of Behavioral Health Examiners to also be eligible for providing services.**

Agency Response: *This finding is directed to the Arizona Health Care Cost Containment System (AHCCCS). Therefore, it would not be appropriate for the Division to take a position on this finding. DBHS will cooperate with AHCCCS, as needed, to implement the audit recommendation.*

Finding IV: ***Expanding DBHS' Role in Serving Juvenile Offenders Could Save the State Money***

Recommendation 1. **In order to conserve state dollars and effectively leverage federal Medicaid dollars, the Division should ensure that the RBHAs are made responsible for providing medically necessary behavioral health care to juvenile sex offenders and Medicaid-eligible prisoners removed from prison for treatment.**

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

In tandem with efforts to improve the assessment and screening process through the *JK* workgroups, DBHS will engage the RBHAs, providers and other State agencies in a re-exploration of the Service Planning Guidelines for juvenile sex offenders and conduct disorders to specifically delineate the responsibilities of each agency, and how to best leverage existing resources. This effort will include AHCCCS to help clarify specific HCFA requirement and definitions regarding inmates of a public institution.

Recommendation 2. **The Division should work with Juvenile Corrections to ensure that Medicaid is utilized whenever possible for juvenile sex offenders and for persons removed from prison for medically necessary behavioral health treatment.**

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

In tandem with efforts to improve the assessment and screening process through the *JK* workgroups, DBHS will engage the RBHAs, providers and other State agencies, including Juvenile Corrections, in a re-exploration of the Service Planning Guidelines for juvenile sex offenders and conduct disorders to specifically delineate the responsibilities of each agency, and how to best leverage existing resources. This effort will include AHCCCS to help clarify specific HCFA requirements and definitions regarding inmates of a public institution.

Other Performance Audit Reports Issued Within the Last 12 Months

99-7	Arizona Drug and Gang Policy Council
99-8	Department of Water Resources
99-9	Department of Health Services—Arizona State Hospital
99-10	Residential Utility Consumer Office / Residential Utility Consumer Board
99-11	Department of Economic Security—Child Support Enforcement
99-12	Department of Health Services—Division of Behavioral Health Services
99-13	Board of Psychologist Examiners
99-14	Arizona Council for the Hearing Impaired
99-15	Arizona Board of Dental Examiners
99-16	Department of Building and Fire Safety
99-17	Department of Health Services' Tobacco Education and Prevention Program
99-18	Department of Health Services—Bureau of Epidemiology and Disease Control Services
99-19	Department of Health Services—Sunset Factors
99-20	Arizona State Board of Accountancy
99-21	Department of Environmental Quality—Aquifer Protection Permit Program, Water Quality Assurance Revolving Fund Program, and Underground Storage Tank Program
99-22	Arizona Department of Transportation A+B Bidding
00-1	Healthy Families Program

Future Performance Audit Reports

Arizona's Family Literacy Program

Family Builders Pilot Program