



A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Special Audit

Department of Health Services—

Behavioral Health Services for Adults
With Serious Mental Illness in
Maricopa County

SEPTEMBER • 2006
REPORT NO. 06 – 09



Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

WILLIAM THOMSON
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September 28, 2006

Members of the Arizona Legislature

The Honorable Janet Napolitano, Governor

Ms. Susan Gerard, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Special Audit of the Department of Health Services—Behavioral Health Services for Adults with Serious Mental Illness in Maricopa County. This report is in response to Laws 2005, Chapter 256, Section 1 and was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1279.03. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

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

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

This report will be released to the public on September 29, 2006.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a special audit of the delivery of behavioral health services to adults with serious mental illness (SMI) in Maricopa County, pursuant to Laws 2005, Chapter 256, Section 1. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

Serious mental illness (SMI) is not a specific mental disorder, but a designation for a group of mental health conditions. To obtain SMI designation in Arizona, a person must be at least 18 years old and have a qualifying psychiatric diagnosis and a resulting functional impairment.¹ As of fiscal year 2005, more than 18,000 adults with SMI were enrolled to receive services in Maricopa County, according to the Arizona Department of Health Services, Division of Behavioral Health Services (Division). The number of adults with SMI in Maricopa County has risen by approximately 50 percent since 2000. Arizona, once near the bottom in state mental health spending, is now tenth among the states.

The Division's funding to administer the system includes Medicaid and KidsCare monies—a blend of federal funding and state matching monies—from the Arizona Health Care Cost Containment System (AHCCCS), additional monies from the State's General Fund, and other government funding, including federal grants, county funds, and other legislative appropriations. The growth in Arizona's mental health funding is due, in part, to population growth and the expansion of Arizona's Medicaid program that occurred following voter approval of Proposition 204 in 2000, which expanded Medicaid eligibility up to 100 percent of the federal poverty guidelines.

The State of Arizona contracts with managed-care organizations called "Regional Behavioral Health Authorities," or RBHAs, to administer behavioral health services in specific geographic service areas of the State. The Division contracts with a private company, VO of Arizona, Inc. (ValueOptions), to administer Maricopa County's behavioral health system.^{2, 3}

¹ Psychiatric diagnoses are standardized and published in *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), published by the American Psychiatric Association. It is the official reference guide that psychiatrists and other clinicians use to identify psychiatric diagnoses.

² This audit focused on that portion of the system that provides services to adults with SMI. Other parts of the system administered by ValueOptions cover children's mental health services, general mental health, and substance abuse.

³ The State contracts with VO of Arizona, Inc., an Arizona-based subsidiary of ValueOptions, Inc., a wholly owned subsidiary of Virginia-based FHC Health Systems. In addition to VO of Arizona, Inc., ValueOptions, Inc. has affiliates that manage behavioral health systems in several states, including Colorado, Florida, Massachusetts, New Jersey, New Mexico, North Carolina, and Texas.

This audit focused on the following main topics:

- How the money for adult SMI services is being spent in Maricopa County.
- Whether there is an adequate focus on the outcomes achieved by the services.
- The use of SMI monies and how effectively the Division conducts financial oversight.
- How effectively the Division reviews the levels and costs of services reported by ValueOptions and its subcontractors.

SMI monies fund a diverse range of services in Maricopa County (see pages 13 through 17)

In fiscal year 2005, program expenses for adults with SMI in Maricopa County totaled approximately \$243 million. These monies were spent primarily on a diverse range of services shown in Table 1 (see page iii). Specifically, support, including case management services such as helping consumers obtain services and monitoring service delivery, accounted for about 42 percent of the amount spent on services.¹ The rest went to such services as medication, inpatient and residential care, rehabilitation, and crisis intervention. ValueOptions provided most of the case management and other support services, while subcontractors provided nearly all of the other services.

Division should strengthen focus on outcomes (see pages 19 through 29)

Research shows that adults with SMI can recover and that outcome goals should determine the services provided. To date, however, the focus on what expenditures are accomplishing has been limited as the Division continues to implement basic system requirements brought on by a 1981 lawsuit, *Arnold v. Sarn*. The *Arnold v. Sarn* lawsuit was filed on behalf of people with SMI in Maricopa County and alleged that the State and Maricopa County failed to provide them adequate community health services as required by law.

The Division is attempting to move its behavioral health program in a results-oriented direction, in part by adopting a recovery-based model aimed at helping people make progress toward recovery from SMI. However, the Division may experience difficulty

¹ The Division and the RBHAs refer to people receiving services as consumers.

Table 1: ValueOptions' SMI Expenses
By Type of Service Delivered
Fiscal Year 2005
(Unaudited)

Expenses (in millions)	Service Category	Description
\$101.0	Support	To plan clinical treatment, help consumers obtain services and resources (such as housing or food preparation), and monitor service delivery.
41.1	Medication	To provide prescription drugs intended to prevent, stabilize, or improve symptoms.
26.5	Inpatient services	To provide inpatient detoxification and psychiatric services delivered in hospitals and other inpatient facilities.
17.8	Residential services	To provide 24-hour residential services, including structured treatment and room and board.
13.9	Rehabilitation services	To provide education, coaching, training, and other services, including securing and maintaining employment.
13.7	Treatment services	To provide counseling, therapy, assessment, evaluation, screening, and other services to reduce symptoms and promote functioning.
12.7	Medical services	To provide services to reduce symptoms and improve or maintain functioning, including laboratory, radiology, and medical imaging. Also includes medication management.
9.9	Crisis intervention services	To provide telephone crisis lines, mobile crisis intervention units, and crisis services delivered at two psychiatric rehabilitation centers.
6.1	Day programs	To provide skills training and development, behavioral health prevention/promotion, medication training and support, support to maintain employment, and self-help/peer services to improve consumers' ability to function in the community.
0.5	Other	To provide other services, including some housing, vocational, screening, and evaluation services.
<u>\$243.2</u>	Total	

Source: Auditor General staff analysis of financial information provided by ValueOptions for fiscal year 2005 from its financial accounting system and ValueOptions' audited financial statements for fiscal year 2005.

in moving further in this direction, in large part because it must continue to comply with the *Arnold v. Sarn* lawsuit and other federal and state process requirements. Compliance with lawsuit requirements is measured through a court-ordered review that is not designed to measure consumers' progress toward recovery over time, but rather focuses on the consumer's status on the day of the review. Experts and clinical advisers who provided input to auditors noted that the emphasis in Maricopa County is focused on the process of service delivery rather than the level of progress

consumers achieve, and they attributed the Division's lack of focus on consumer outcomes to the rigidity of process measurements in the lawsuit agreements.

To make further progress in moving to a results-oriented approach, the Division should take action on two main fronts:

- **Incorporating outcome measures into oversight mechanisms.** The Division should continue to develop outcome measures, such as employment and number of crises, into its oversight of the behavioral health system and its contract with the RBHA. The Division should continue to allow the RBHA to earn a portion of its profits through the achievement of specified performance outcomes.
- **Reducing process-oriented measures that do not contribute to results.** The Division should consider renegotiating measures of improvement in the court orders arising from the lawsuit. Specifically, the Division should determine which court mandates focus on process rather than outcomes and inhibit full implementation of an outcome-oriented model, discuss this with the plaintiffs, and work to modify the provisions.

Division can improve financial oversight and limit use of SMI monies (see pages 31 through 39)

Many of the Division's tools for monitoring the solvency and expenses of ValueOptions and other RBHAs appear to be working reasonably, but some can be improved. Financial solvency is key to ensuring that RBHAs can continue to deliver services without interruption, and the Division has several mechanisms that appear to be adequately monitoring ValueOptions' solvency. Similarly, many steps for controlling expenses, such as contractual restrictions on service profits and administration, are in place. However, auditors identified two areas in which processes can be strengthened:

- **Tailoring financial audits to ensure that monies are spent appropriately.** The financial audits that ValueOptions is required to undergo provide some assurance regarding ValueOptions' financial reporting and use of program monies, but do not sufficiently enable the Division to ensure that monies are spent appropriately. The Division could improve spending oversight by requiring a compliance audit that would determine if ValueOptions used monies in accordance with contractual requirements. For example, it should consider requiring a compliance audit in line with the American Institute of Certified Public Accountants' professional standards for determining compliance with defined requirements.

- Limiting the use of SMI monies for other programs.** The Division allows ValueOptions to use monies allocated for adults with SMI for other programs. By contract, starting in fiscal year 2005, the Division allows ValueOptions to earn up to 4 percent profit on service revenue within each major program—Medicaid, KidsCare, and other contract monies.¹ Within each of these major programs, though, ValueOptions can use SMI monies for other categories within the same program. For example, it can use SMI Medicaid funds for other Medicaid funding categories, as allowed by contract, such as children’s programs or adult substance abuse programs.² Specifically, in fiscal years 2002 through 2004, ValueOptions used a total of \$21.4 million of Medicaid and KidsCare SMI revenues for other Medicaid and KidsCare programs.³ However, the Legislature appropriated these monies for use in SMI programs, with annual increases from fiscal years 2002 through 2004 intended to address requirements of the *Arnold v. Sarn* lawsuit.

In addition to using SMI monies to offset other program losses, ValueOptions has used these monies disproportionately to earn its allowed profits. For example, as allowed by contract, during fiscal years 2002 through 2004, ValueOptions used net income it earned from SMI Medicaid monies to offset losses in other Medicaid programs. The most significant offset occurred in fiscal year 2004, when it used \$15.8 million from SMI Medicaid monies to offset \$9.7 million in other Medicaid programs’ losses. ValueOptions had losses totaling \$6 million in its children’s Medicaid programs and \$3.7 million in non-SMI adult Medicaid programs that year. Still, it earned approximately \$6.1 million in total Medicaid profits entirely from Medicaid SMI monies, including service profits of \$6 million, which represented 2.17 percent of Medicaid service revenue. This was below the fiscal year 2004 contractually allowed profit of 5 percent. In fiscal year 2005, ValueOptions did not use SMI Medicaid monies to offset losses in other Medicaid programs, and it again complied with contractual limits on service profits.

Given that the Legislature has increased funding to provide more SMI services and meet lawsuit requirements, the Division should consider including a provision in its RBHA contract that would limit the use of excess SMI revenues to make up for losses in other programs. If the Legislature wants to ensure that its SMI appropriations are used to provide services only to adults with SMI, it may wish to consider statutorily limiting the use of these monies similar to the statutory limits it has placed on appropriations for children’s behavioral health programs.

¹ Service revenues represent total contract revenues less 7.5 percent allowed for administrative expenses, or 92.5 percent of each program fund’s total contract revenues. Starting in fiscal year 2005, allowable service profits equal 4 percent of total service revenues. Before fiscal year 2005, the profit limit was 5 percent of these revenues.

² This report uses the term “program” throughout the report when referring to the three major funding categories into which behavioral health services monies are categorized—Medicaid, KidsCare, and Other Contract Monies. The use of the term “program” represents the same thing as the term “funding category.”

³ Auditors’ analysis of division profit/risk corridor analysis reports for fiscal years 2002, 2003, and 2004 showed SMI Medicaid and KidsCare profits of \$7.5 million, \$6.9 million, and \$7 million, respectively, were used for other Medicaid and KidsCare programs. Division reports are based on ValueOptions’ audited financial statements and reflect accounting adjustments for timing and other factors.

Better oversight needed of service level provided (see pages 41 through 46)

The Division should take steps to strengthen its contractual requirements in order to better ensure that ValueOptions delivers sufficient services to adults with SMI. Under the State's RBHA contract, ValueOptions is required to submit electronic records showing that it delivered services that equal at least 85 percent of the service revenues ValueOptions received under its contract.¹ ValueOptions establishes service values in its contracts with its subcontractors and reports these values for the services the subcontractors deliver. However, the Division's contract with ValueOptions allows ValueOptions to assign its own value for each of the services it delivers. Because the Division does not approve the reasonableness of these service values, the contractual requirement does not achieve its intended purpose. As of July 1, 2006, the Division has drafted revisions to its *Financial Reporting Guide* that would make its monitoring more meaningful. For example, the revisions state that the Division will use an AHCCCS-approved fee schedule to value encounters in order to determine if the 85 percent requirement has been met. Division management reports it is considering further revisions, such as adding a fixed percentage to the fee schedule for purposes of valuing encounters.

Auditors compared the values that ValueOptions reported to the Division for services it delivered itself with values ValueOptions reported it paid to its subcontractors for the same types of services, and also with the amounts allowed in an AHCCCS-approved fee schedule the State uses when it pays providers directly on a fee-for-service basis. ValueOptions often assigned much higher values to its services. Auditors' analysis of the Division's fiscal year 2005 encounter data concluded that ValueOptions valued its services at approximately 99 percent higher than what it would have if it had been using the State's fee-for-service schedule.² ValueOptions officials have explained that its costs are high due to contractual and *Arnold v. Sarn* lawsuit requirements, and therefore the values for the services it provided are higher than the values it has established for the same services provided by its subcontractors and the fee-for-service schedule. However, because the Division's contract with ValueOptions does not require ValueOptions to support its service values with a fiscally sound analysis, the Division cannot determine whether the service values are reasonable in light of ValueOptions' costs. To make the service level requirement effective, the Division should continue its efforts to establish a process for assigning appropriate values to services.

1 This same requirement is included in the Division's contracts with the RBHAs that serve other areas of the State.

2 Auditors' analysis included encounters for services delivered during fiscal year 2005 that were submitted to the Division as of November 2005. In addition, auditors only analyzed encounters approved by the Division, with fees that were updated and approved by AHCCCS for fiscal year 2006.

Other Pertinent Information (see pages 47 through 48)

As part of the audit, auditors gathered other pertinent information regarding the administrative expenses associated with ValueOptions' Arizona operations. ValueOptions' overall administrative expenses totaled approximately \$37.2 million in fiscal year 2005, and substantially complied with the Division's requirement limiting administrative expenses to 7.5 percent of each type of contract revenue.



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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a special audit of the delivery of behavioral health services to adults with serious mental illness (SMI) in Maricopa County pursuant to Laws 2005, Chapter 256, Section 1. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

Serious mental illness as defined in Arizona

Serious mental illness (SMI) is not a specific mental disorder, but a designation used by states and the federal government. In Arizona, state laws and the Department of Health Services' Division of Behavioral Health Service's (Division) policy define who

Division's SMI Eligibility Determination Policy

Eligibility determination for SMI status in Arizona requires having a qualifying psychiatric diagnosis and a functional impairment as a result of the qualifying diagnosis, as described below:

Qualifying Mental Disorders and Diagnoses

More than 70 standardized psychiatric diagnoses are considered "qualifying SMI diagnoses" in Arizona. Division policy categorizes them into seven disorders, specifically:

- Psychotic disorders
- Obsessive-compulsive disorder
- Other mood disorders
- Personality disorders
- Bipolar disorders
- Major depression
- Anxiety disorders

Not all standardized diagnoses are considered "qualifying diagnoses" for SMI determination. For example, antisocial personality disorder, which is one of several specific personality disorder diagnoses, does not qualify for SMI status in Arizona.

Functional Impairment Categories

In addition to a qualifying diagnosis, a person must have a functional impairment as a result of the diagnosis. Dysfunction should be present for at least 12 months, or at least 6 months with expected continuation for another 6 months. Impairment must be present in one or more of four impairment categories, as follows:

- Inability to live in an independent or family setting without supervision
- Risk of deterioration
- Risk of serious harm to self or others
- Inability to perform in specific roles, for example, in school or work

can obtain legal status as an adult with SMI and thereby be entitled to a wide range of services paid for by the State using Medicaid, KidsCare, State General Fund monies, and federal grants, and other revenue sources. To obtain SMI designation in Arizona, a person must be at least 18 years old and have a qualifying psychiatric diagnosis and resulting functional impairment as determined by a licensed psychiatrist, psychologist, or nurse practitioner (see text box, page 1). The Division's SMI determination policy identifies more than 70 standardized psychiatric diagnoses from *The Diagnostic and Statistical Manual of Mental Disorders* as "qualifying SMI diagnoses."¹ Arizona's SMI definition is very similar to the federal definition used by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

SMI enrollment in Maricopa County exceeds 18,000

As of fiscal year 2005, the Division reported that more than 18,000 adults with SMI were enrolled to receive services in Maricopa County, out of a state-wide enrollment of nearly 31,500 adults. Figure 1 (see page 3) presents state-wide and Maricopa County's SMI enrollment trends from fiscal years 2001 through 2005. As shown in Figure 1, Maricopa County's total enrollment increased from approximately 13,000 to approximately 18,000 from fiscal years 2001 to 2005. During all 5 fiscal years, Maricopa County accounted for the majority of state-wide enrollment.

Contractor administers system

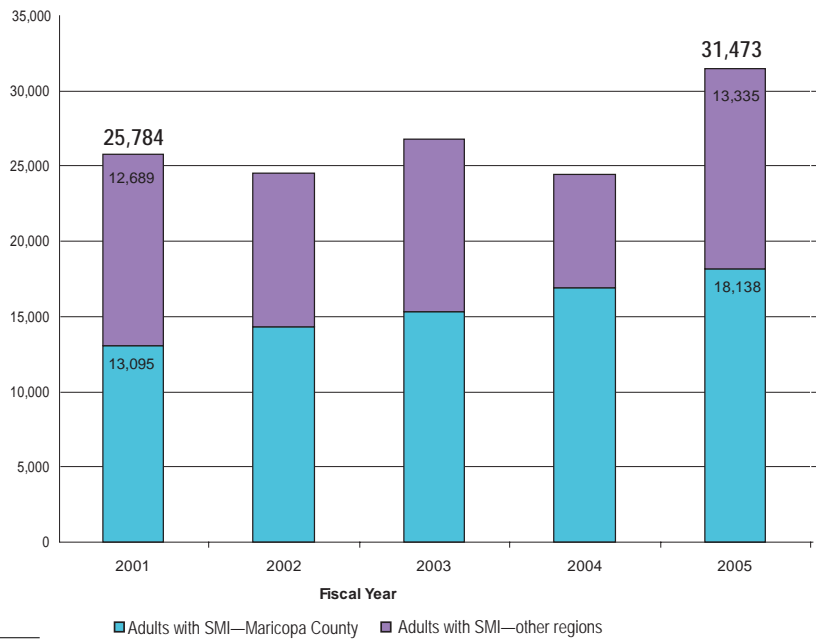
The Department of Health Services contracts with a private company, VO of Arizona, Inc. (ValueOptions), to administer a behavioral health system in Maricopa County for adults with SMI, as well as for several other population groups.² The Division's duties include ensuring that ValueOptions complies with its contractual requirements and overseeing the service system. ValueOptions delivers case management and some other services directly, and also subcontracts with other service providers.

Division of Behavioral Health Services oversees the contracted system—The Division does not provide any direct services except at Arizona State Hospital, but instead contracts with Regional Behavioral Health Authorities (RBHAs) to administer services in specific geographic service areas within the State. Arizona established the RBHA system in 1992. RBHAs are managed-care

¹ Psychiatric diagnoses are standardized and published in *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), published by the American Psychiatric Association. It is the official reference guide that psychiatrists and other qualified clinicians use to identify mental disorders and psychiatric diagnoses.

² The State contracts with VO of Arizona, Inc., an Arizona-based subsidiary of ValueOptions, Inc., a wholly owned subsidiary of Virginia-based FHC Health Systems. In addition to VO of Arizona, Inc., ValueOptions, Inc. has affiliates that manage behavioral health systems in several states, including Colorado, Florida, Massachusetts, New Jersey, New Mexico, North Carolina, and Texas.

Figure 1: SMI Enrollment
In Maricopa County and Other Regions in Arizona
Fiscal Years 2001 through 2005¹



¹ Due to division information system changes in fiscal years 2003 and 2004, the state-wide totals for those years may be incomplete.

Source: Auditor General staff analysis of number of consumers served as presented in the annual reports for the Arizona Department of Health Services/Division of Behavioral Health Services and the Arizona State Hospital for fiscal years 2001 through 2005, and enrollment data reported by ValueOptions for the end of the month of June for 2001 through 2005.

organizations that the State pays in advance through capitated payment arrangements.¹

The Division is primarily an oversight agency. Many of the Division's oversight obligations stem from federal Medicaid requirements reflected in its contract with the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. Other requirements derive from state statutes and administrative rules. In Maricopa County, the Division's oversight also emphasizes compliance with *Arnold v. Sarn* lawsuit requirements. The class action lawsuit was filed in 1981 on behalf of people with serious mental illness in Maricopa County alleging that the State and the County had not established a comprehensive community mental health system consistent with Arizona state law. The Superior Court and Arizona Supreme Court found in favor of the plaintiffs in 1986 and 1989, respectively, and in 1991, the Court approved *The Blueprint: Implementing Services to the Seriously Mentally Ill* (Blueprint) that set forth required system changes. The court approved an exit stipulation in 1995, and then a supplemental agreement in 1998, that set forth additional terms for the State to meet. (See Appendix A for summary of *Arnold v. Sarn* activities.)

¹ The Department of Health Services contracts with four RBHAs to serve the State's six regions. In addition to ValueOptions in the Maricopa County region, the Northern Arizona Regional Behavioral Health Authority (NARBHA) serves the northern region, Cenpatico Behavioral Health serves the Pinal-Gila and Yuma-La Paz regions, and Community Partnership of Southern Arizona (CPSA) serves the Pima County and southeast regions. In addition, the Department contracts with four tribal contractors to serve the Gila River, Colorado River, Navajo Nation, and Pascua Yaqui communities.

The Division monitors RBHA contract compliance and financial performance; conducts quality assurance activities, such as performance improvement, research, and data dissemination; and handles grievances and appeals. In addition, a clinical services division that consists of several bureaus provides technical assistance and guidance for RBHAs and service providers related to best practices in clinical care for adults, children, and substance abusers. In fiscal year 2006, the Arizona Legislature appropriated a total of 122 FTE positions to the Department of Health Services to oversee Arizona's public behavioral health system. The number of FTE has not significantly changed since fiscal year 2004, when the number dropped to 120 FTE from 130 FTE in fiscal year 2003.

ValueOptions serves Maricopa County—ValueOptions has operated as Maricopa County's RBHA since 1998. ValueOptions, a subsidiary of a Virginia-based company, is the second RBHA to serve Maricopa County, and it was the first for-profit company to receive a state RBHA contract. The Department entered into its most recent 3-year contract with ValueOptions on July 1, 2004. As of March 2006, ValueOptions reported having approximately 2,000 full- and part-time positions consisting of 473 administrative and 1,525 clinical operations positions in Arizona.

ValueOptions' Maricopa County operations include a corporate office, an intake/evaluation center, intake/assessment and crisis hotline call centers located in Phoenix, and 23 direct care clinics located throughout the County. ValueOptions delivers SMI services through a combination of its intake, assessment, and crisis services, its direct care clinics, and subcontracted service providers. (See text box for types of services, and Finding 1, pages 13 through 17, for specific definitions.)

SMI Service Examples

- Case management
- Therapy and counseling
- Peer support
- Crisis intervention
- Inpatient services
- Medication
- Rehabilitation
- Day programs
- Housing and housing support
- Residential services

- **ValueOptions direct care clinics:** ValueOptions operates 23 direct care sites located throughout Maricopa County. ValueOptions enrolls each SMI consumer in one of these direct care clinics. Every clinic has clinical teams composed of physicians, nurses, certified clinicians, case managers, and other mental health support staff. (See Finding 2, pages 19 through 29, for description of a clinical team.) ValueOptions' case management strategic plan, which was developed to meet court requirements, states that the most common clinical team (supportive treatment) should have a caseload no greater than 30 consumers per case manager. Some teams, called assertive case management teams, should have caseloads no greater than 12 consumers per case manager in order to provide more intensive services.
- **Subcontracted services:** ValueOptions contracts with more than 100 service providers who provide both inpatient and outpatient services for adults with SMI. For example, ValueOptions contracts with hospitals for inpatient services and human service agencies for treatment services such as counseling and therapy. ValueOptions' officials report that they also co-locate some subcontractor employees at its clinics to improve access for its consumers.

Under its contract with the Division, ValueOptions must comply with requirements associated with the *Arnold v. Sam* lawsuit. For example, *Arnold v. Sam's* 1991 Blueprint requires that for Maricopa County, only one entity provides case management services for adults with SMI. Currently,

ValueOptions delivers adult case management directly through its clinics. However, the Division is examining the court order that requires case management through a single entity to determine whether the current structure is the most effective way to serve adults with SMI. According to ValueOptions officials, ValueOptions would support a change to a contract with a network of contractors for these services, similar to the way case management is provided in Pima County. (See Appendix A for summary of *Arnold v. Sam* activities.)

As indicated in Table 2, the largest source of ValueOptions' SMI service revenues is contract revenue. In addition to state contract revenue, ValueOptions receives other revenues not related to its contract with the Division, including revenues from third parties such as Medicare and other insurers. SMI revenues increased by \$4 million

Table 2: ValueOptions' Schedule of SMI Service Revenues and Expenses
Fiscal Years 2004 through 2006

	2004 (Actual)	2005 (Actual)	2006 (Estimate)
Revenues:			
Contract Division of Behavioral Health Services revenues	\$260,476,899	\$264,279,151	\$300,992,213
Medicare recoveries	443,125	582,704	595,556
Other insurance recoveries	58,340	48,531	93,362
Patient fees (copayments)	7,818	5,057	5,478
Total revenues	<u>260,986,182</u>	<u>264,915,443</u>	<u>301,686,609</u>
Expenses:			
Program Services—			
Treatment	12,518,043	13,749,414	17,013,324
Rehabilitation	12,479,494	13,910,474	19,493,083
Medical ¹	8,956,964	12,703,965	17,993,360
Support (including case management) ²	89,815,497	101,032,099	121,537,114
Crisis intervention	6,666,818	9,872,859	9,999,689
Inpatient	25,663,299	26,454,083	29,036,144
Residential	17,134,361	17,795,122	16,948,380
Behavioral health day program	3,899,870	6,125,640	4,280,221
Medication	40,216,229	41,080,986	38,738,082
Other	4,833,541	478,255	50,227
Total program services expenses	<u>222,184,116</u>	<u>243,202,897</u>	<u>275,089,624</u>
Administrative Expenses—			
Salaries and employee benefits	5,162,391	7,234,547	8,032,378
Professional and outside services	1,417,647	3,803,185	1,976,050
Travel and other	12,318,930	7,895,288	9,897,180
Depreciation	507,360	958,783	1,566,863
Total administrative expenses	<u>19,406,328</u>	<u>19,891,803</u>	<u>21,472,471</u>
Income tax provisions	<u>7,682,557</u>	<u>723,670</u>	<u>2,037,225</u>
Total expenses	<u>249,272,390</u>	<u>263,818,370</u>	<u>298,599,320</u>
Net income	<u>\$ 11,713,181</u>	<u>\$ 1,097,073</u>	<u>\$ 3,087,289</u>

¹ According to ValueOptions, medical expenses have increased significantly since fiscal year 2004 due to an increased utilization of services. These services include medication services, medical management, laboratory, radiology/medical imaging, and electro-convulsive therapy services.

² Support (including case management) is expected to increase from the fiscal year 2005 total of \$101 million to \$121.5 million in fiscal year 2006. In fiscal year 2005, when these expenses increased from fiscal year 2004, VO of Arizona, Inc. reported adding more than 400 new case manager and other positions in its clinics. According to VO of Arizona, Inc. personnel, this staff was added primarily in response to deficiencies identified in the 2004 Independent Review by the Office of the Monitor.

Source: Auditor General staff analysis of the Arizona Division of ValueOptions, Inc.'s *Financial Statements and Supplemental Schedules* for fiscal year 2004 and VO of Arizona, Inc.'s *Financial Statements and Supplemental Schedules* for fiscal year 2005, audited by an independent CPA firm, and ValueOptions-prepared estimates for fiscal year 2006.

Annual Service-Related Costs
Per SMI Enrollee in Maricopa County

2004	\$13,137
2005	\$13,408

between fiscal years 2004 and 2005, while SMI expenses increased more significantly, which resulted in ValueOptions earning less net income from the SMI program in fiscal year 2005. Annual service-related costs per SMI enrollee in Maricopa County increased by approximately \$300 between 2004 and 2005 (see text box). ValueOptions expected total SMI revenues and expenses to increase in fiscal year 2006. See Finding 1 (see pages 13 through 17) for more information on the Division's distribution of behavioral health monies to ValueOptions, and how much of ValueOptions' SMI revenues were spent in its direct care clinics (in-house expenses) compared to its subcontracted service providers.

Arizona has well-funded mental health system

Arizona, once considered at the bottom rung of the ladder in state mental health spending, has now risen to within the top ten among the states. Specifically, in November 2005, the National Association of State Mental Health Directors Research Institute ranked Arizona as tenth in overall mental health expenditures, and seventh in per-capita mental health expenditures (based on 2003 expenditure data).¹ Arizona's behavioral health system is funded through a combination of federal, state, and other government funding sources. Specifically:

- **Medicaid:** Medicaid monies consist of a blend of federal and state monies. The Department of Health Services receives these monies from AHCCCS. The states appropriate monies for their Medicaid programs and the federal government matches those monies. The Arizona Legislature appropriates one-third of Arizona's Medicaid funding and the federal match accounts for the remaining two-thirds.
- **KidsCare:** The Department of Health Services also receives KidsCare monies from AHCCCS. Like Medicaid, KidsCare monies also consist of a blend of federal and state monies. The Arizona Legislature appropriates state funding, and the federal government matches the state monies. In general, KidsCare pays for medical and behavioral health services for youths up to age 19, as well as for the parents of the youths enrolled in KidsCare (called "KidsCare Parents") who do not qualify for Medicaid. Some 18-year-olds, and adults enrolled in the KidsCare Parents program who are determined to have a serious mental illness, can have their behavioral health services paid with KidsCare monies.
- **State General Fund appropriations:** In addition to appropriations for the state match portion of Medicaid and KidsCare monies, the Arizona Legislature appropriates General Fund monies to pay for services not covered by Medicaid. For example, these monies can be used to pay for room and board for Medicaid

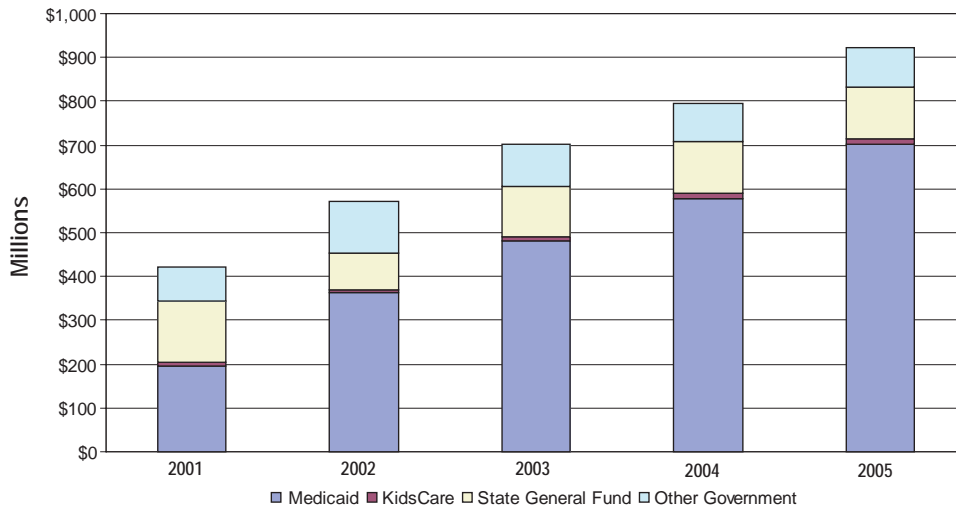
¹ The Institute did not compare how the states ranked with regard to funding for only adults with SMI.

enrollees, or to pay for services for people who do not qualify for Medicaid or KidsCare, but who otherwise qualify for behavioral health services.¹

- Other government funding:** Other government funding consists of revenues from federal block grants, county funds, and other local government monies, and non-General Fund state appropriations. For example, in 2000 the Legislature appropriated more than \$40 million in one-time monies from the State’s tobacco litigation settlement monies to pay for housing, vocational rehabilitation, and other recovery support services for adults with SMI.² Other sources of funding include federal block grants, intergovernmental agreements, and monies from local governments.

As shown in Figure 2, Arizona’s total behavioral health funding—including funding for children’s services, general mental health, substance abuse, and division administration as well as funding for adults with SMI—has more than doubled between fiscal years 2001 and 2005, with much of the increase being paid for by increased Medicaid revenues. Two factors help explain this increase. First, in 2000, Arizona voters approved Proposition 204, expanding eligibility for Medicaid starting

Figure 2: Arizona Behavioral Health Services Funding (All Populations)
Fiscal Years 2001 through 2005
(Unaudited)



Source: Auditor General staff analysis of state-wide behavioral health services funding for fiscal years 2001 through 2005 as presented in the annual reports for the Arizona Department of Health Services Division of Behavioral Health Services and Arizona State Hospital for fiscal years 2001 through 2005.

¹ General Fund and other government monies are limited and are not considered entitlement monies like Medicaid and KidsCare monies. The Division requires the RBHAs and tribal contractors to set priorities for how these limited monies will be spent within their respective service regions.

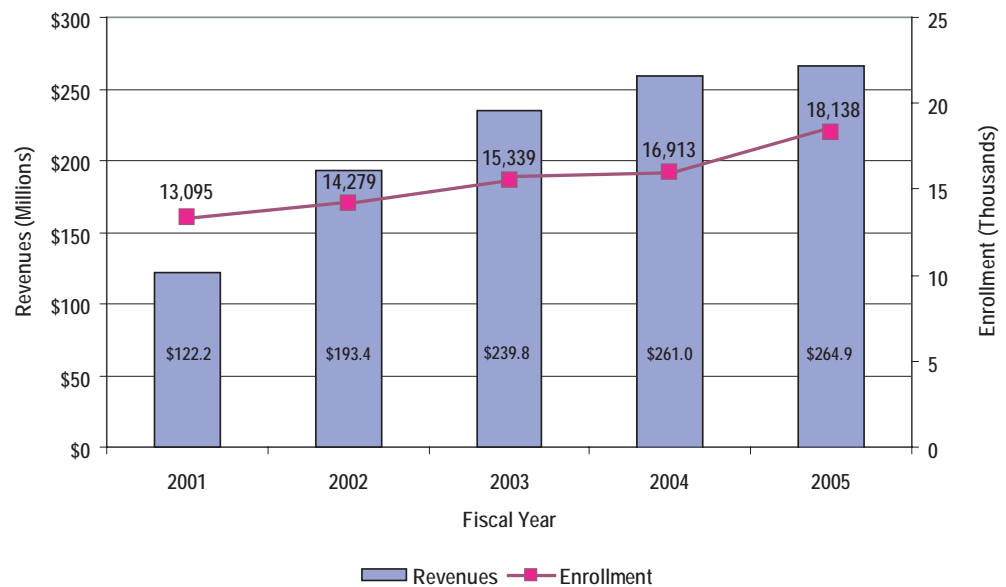
² The program was more commonly known as the HB2003 program for the original legislation that authorized the one-time funding. See Auditor General Report No. 04-03 for additional information on the HB2003 program and the SMI programs and services developed with one-time funding from tobacco litigation settlement monies.

in 2001. The proposition expanded income eligibility requirements up to 100 percent of the federal poverty level, greatly increasing Arizona's Medicaid enrollment. This change expanded Medicaid spending significantly. Starting in fiscal year 2002, the Division received additional Medicaid monies (both state and federal matching monies) to provide services to people made eligible by the Proposition 204 expansion. Population growth in Arizona also played a factor as it also helped increase the number of people eligible for Medicaid-funded services in Arizona. At the same time the eligibility expansion took effect, Arizona began covering a broader array of behavioral health services in its Medicaid program. All of these changes contributed to increased uses of Medicaid monies to pay for behavioral health services.

ValueOptions' SMI revenues compared to adults served

Similar to state-wide mental health funding, ValueOptions also received more funding to serve adults with SMI between fiscal years 2001 through 2005. Figure 3 compares the growth in ValueOptions' SMI service revenues to SMI enrollment for fiscal years 2001 through 2005. SMI revenues increased significantly between 2001 and 2003, primarily due to the effects of increased Medicaid funding. Figure 3 shows that although ValueOptions was receiving more revenues to serve adults with SMI between fiscal years 2001 through 2004, it was serving more people during these

Figure 3: ValueOptions' SMI Revenues and Enrollment
Fiscal Years 2001 through 2005



Source: Auditor General staff analysis of the Arizona Division of ValueOptions, Inc.'s *Financial Statements and Supplemental Schedules* for fiscal years 2001 through 2004, VO of Arizona, Inc.'s *Financial Statements and Supplemental Schedules* for fiscal year 2005, audited by an independent CPA firm, and the number of consumers served as reported by ValueOptions in its monthly enrollment reports.

years, with annual increases of over 1,000 people. According to ValueOptions reports, ValueOptions served more than 18,000 adults with SMI in fiscal year 2005, and it did so with approximately the same amount of revenues as it received in fiscal year 2004.

Scope and methodology

Laws 2005, Chapter 256, Section 1, requires the Office of the Auditor General to assess the Department's delivery of behavioral health services to adults with serious mental illness in Maricopa County. This audit focuses on the following main topics:

- How the money for adults with SMI is being spent in Maricopa County.
- Whether there is an adequate focus on the services' outcomes.
- The use of SMI monies and how effectively the Division conducts financial oversight.
- How effectively the Division reviews the levels and costs of services reported by ValueOptions and its subcontractors.

The audit contains four findings and associated recommendations:

- In fiscal year 2005, ValueOptions spent the vast majority of SMI funding on a wide variety of services, with approximately 40 percent spent on support services including case management.
- The Division should strengthen its focus on consumer outcomes to better account for what its expenditures accomplish.
- Although many of the Division's approaches for monitoring solvency and expenditures are working reasonably, the Division can strengthen its requirements to provide greater assurance that monies are being spent appropriately.
- Requirements designed to ensure that SMI funding is being spent on providing services to consumers need to be strengthened.

In addition, this report contains Other Pertinent Information regarding ValueOptions' overall fiscal year 2005 administrative expenses (see pages 47 through 48).

Various methods were used to study the issues addressed in this audit. General methods included interviews with division officials and staff, and ValueOptions' executive management team members and other staff. Auditors also reviewed Arizona Revised Statutes, Administrative Rules, and the Division's policies and

procedures as well as information about its goals, objectives, and performance measures. In addition, auditors reviewed provisions in the State's contract with the Maricopa County Regional Behavioral Health Authority and various court documents associated with *Arnold v. Sarn* such as the 1986 judgment, 1989 Supreme Court opinion, 1991 Blueprint, 1995 exit stipulation, 1998 supplemental agreement, the 2004 and 2005 independent review reports, and more recent related documentation. Auditors also used specific methods to develop each finding:

- **Determining how service dollars for adults with SMI were spent in fiscal year 2005**—To establish service categories, auditors reviewed the Division's *Covered Services Guide*, which describes the various types of covered behavioral health services. To understand how monies flow in the system and how monies were spent, auditors reviewed, collected, and analyzed information from a number of sources, including AHCCCS' contract with the Division; financial schedules the Division reported in its Annual Report for fiscal year 2005; audited financial statements of VO of Arizona, Inc., for fiscal year 2005; and an electronic download of the data that external auditors PricewaterhouseCoopers used in the fiscal year 2005 audit of VO of Arizona, Inc.'s financial statements.¹
- **Determining what services are accomplishing among adults with SMI who receive them**—To understand the reasons for service provision problems experienced by some adults with SMI in Maricopa County, auditors conducted ten case studies of consumers whose needs were deemed as "not met" by the *Arnold v. Sarn* Court Monitor in 2005. The case studies consisted of client file reviews, including reviews of client progress notes, interviews with case managers, reviews of client demographic and service data (encounters), and several interviews with the court monitor.

To understand issues that affect service delivery in Maricopa County, auditors obtained the input of behavioral health experts and others who are familiar with service planning and provision through a number of activities, including:

- Two focus groups consisting of division and ValueOptions clinical advisors who are experts in behavioral health services assigned to clinics to provide guidance to staff;
- An online Web-based discussion with 14 behavioral health experts, and interviews with an additional 5 behavioral health experts with questions similar to those posed to the Web-based discussion participants. Seventeen of the experts' expertise is based on local experience/perspective, and two of them have expertise based on a national perspective/experience; and
- Observation of a Boston University Recovery Training overview given by a behavioral health expert, and attendance at division oversight meetings

¹ Although it is more commonly known as ValueOptions, VO of Arizona, Inc. is the legal name of the Maricopa County RBHA. VO of Arizona, Inc. is an Arizona-based subsidiary of ValueOptions, Inc., a wholly owned subsidiary of Virginia-based FHC Health Systems.

with ValueOptions and parties involved with the *Arnold v. Sarn* lawsuit, community advocate briefing meetings led by the ValueOptions' administrators, and ValueOptions' clinical team meetings.

Finally, to identify best practices in measuring behavioral health outcomes and recovery in managed care systems, and to understand the Division's quality management activities and requirements, auditors reviewed literature and reports such as journal articles and literature related to measuring recovery outcomes and incorporating outcome measurement into government oversight of managed care entities; provisions in the Division's contracts with AHCCCS and ValueOptions related to performance measures and financial incentives; Boston University reports on Individual Service Plan (ISP) production and training methods; the 2003 and 2004 Arizona Department of Health Services Independent Case Reviews conducted by an independent third party; and the Division's 2003 ADHS Consumer Survey State Report, which is its most recent.

- **Assessing the Division's effectiveness in providing financial oversight of funding for adults with SMI in Maricopa County**—To assess the adequacy of the Division's financial oversight activities, auditors reviewed the requirements set forth in AHCCCS' contract with the Division, as well as the Division's contract with VO of Arizona, Inc; obtained and reviewed AHCCCS standards related to financial oversight in a managed behavioral healthcare system; obtained and reviewed the Division's analysis of ValueOptions' compliance with financial standards; and reviewed ValueOptions' audited financial reports and the findings of the external auditors' fiscal year 2005 OMB A-133 audits of VO of Arizona, Inc.
- **Assessing the adequacy of the Division's oversight of service data (encounters) and service utilization**—To assess the adequacy of the Division's oversight of level of services delivered through encounter data, auditors obtained an electronic download of fiscal year 2005 data that VO of Arizona, Inc. reported to the Division. Auditors analyzed a subset of this data comprising more than 814,000 electronic service records reported to be valued at \$21.1 million associated with ValueOptions' in-house clinical and subcontracted services. The analysis included service records where the service was delivered in fiscal year 2005, the service was delivered to a consumer designated as SMI, the Division's computer system had received the record by November 2005 and marked the record approved, and the type of service was listed on AHCCCS' fee schedule with a rate that was updated as of July 15, 2005. Auditors analyzed the encounter data to compare the cost values of services provided by ValueOptions in-house to the cost values of the services provided by ValueOptions' subcontractors and the State's fee-for-service schedule.
- **Other Pertinent Information**—To gather information on ValueOptions' fiscal year 2005 administrative expenses, auditors reviewed VO of Arizona, Inc.'s audited

financial statements for fiscal year 2005, and an electronic download of the data that external auditors PricewaterhouseCoopers used in its fiscal year 2005 audit of VO of Arizona, Inc.'s financial statements.

- **Introduction and Background and Appendix A**—To document the definition of serious mental illness and trend information on the number of adults being served in Maricopa County, auditors documented definitions set forth in federal and state laws and the Division's SMI determination policy, and information on the number of clients served as reported in the Division's annual reports for fiscal years 2000 through 2005 and ValueOptions' enrollment data for the same timeframe. To document the Division's responsibilities and the responsibilities of its contractor, VO of Arizona, Inc., auditors reviewed several sources, including the Division's annual reports; unaudited information from the Division's Web site and other agency-prepared documents; unaudited information from AHCCCS' Web site and the AHCCCS contract with the Department of Health Services; and VO of Arizona, Inc.'s unaudited company-prepared information, including information published on VO of Arizona, Inc. and ValueOptions, Inc.'s Web sites. To understand how SMI monies were spent in fiscal years 2004 and 2005, and projected 2006 expenses, auditors reviewed audited financial statements of the Arizona Division of ValueOptions, Inc. for fiscal year 2004, and VO of Arizona, Inc.'s audited financial statements for fiscal year 2005, and its 2006 estimates.¹

To document mental health expenditure trends in Arizona, auditors analyzed information reported in the Division's annual reports for fiscal years 2001 through 2005, and information reported in a November 2005 report published by the National Association of State Mental Health Program Directors Research Institute. To compare the growth in ValueOptions' SMI service revenues to SMI enrollment for fiscal years 2001 through 2005, auditors analyzed information reported in audited financial statements for the Arizona Division of ValueOptions, Inc. (for fiscal years 2001 through 2004) and VO of Arizona, Inc.'s financial statements for fiscal year 2005, and compared this information to the number of SMI enrollees served, as reported by ValueOptions for fiscal years 2001 through 2005.

To develop Appendix A, auditors reviewed and analyzed *Arnold v. Sarn* court documents previously mentioned.

The audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the director of the Department of Health Services, her staff at the Division of Behavioral Health Services, and ValueOptions for their cooperation and assistance throughout the audit.

¹ VO of Arizona, Inc. was officially incorporated as an Arizona-based corporation in July 2004 after the start of fiscal year 2005, which began July 1, 2004 and ended June 30, 2005.

FINDING 1

SMI monies fund a diverse range of services in Maricopa County

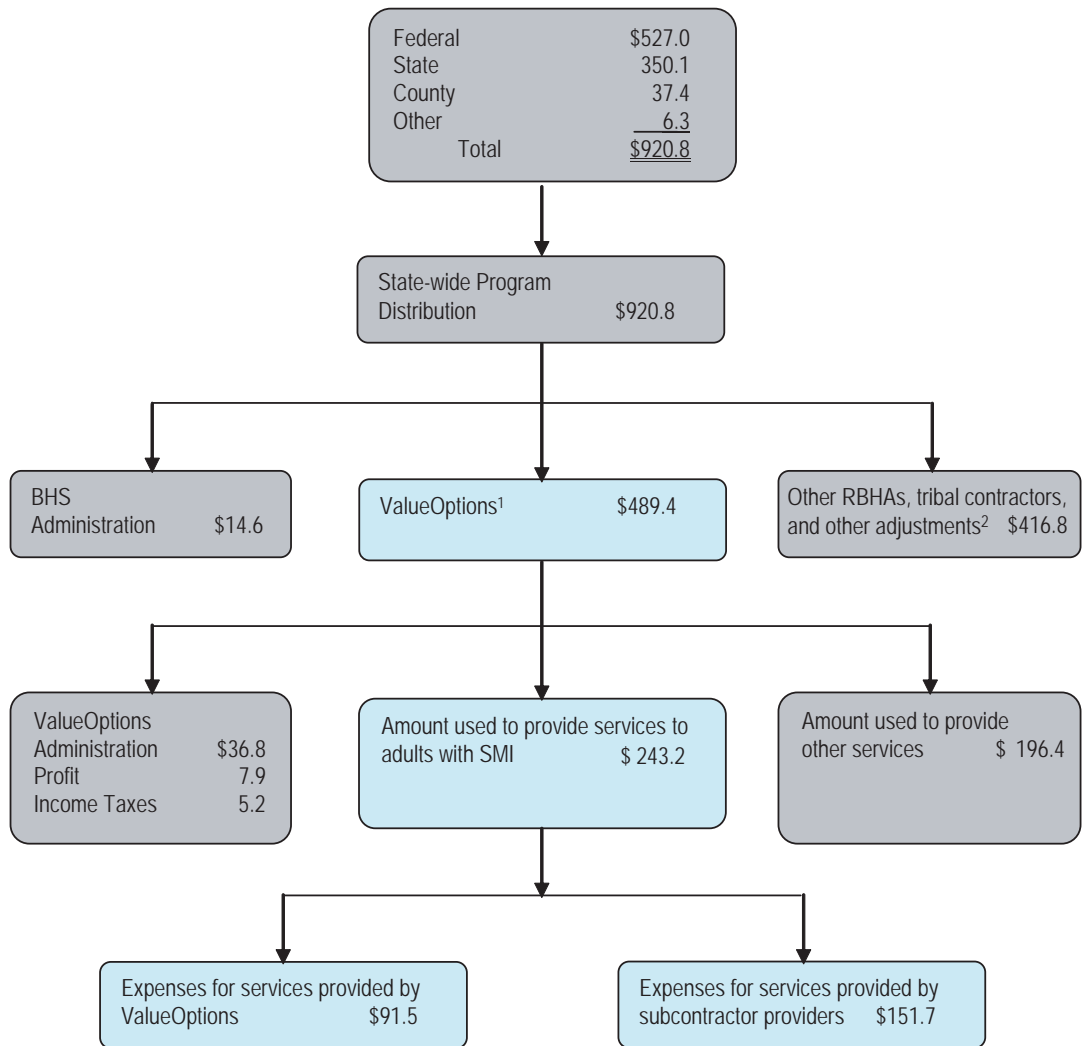
In Maricopa County, most monies appropriated for SMI are spent primarily on a diverse range of services. Of the total revenues ValueOptions received during fiscal year 2005, nearly 50 percent went to provide services for adults with SMI, 40 percent went to provide services to children and other adults, and slightly more than 10 percent went for ValueOptions' administrative costs, taxes, and profit. Among services for adults with SMI—the primary focus of this audit—support (which includes case management services such as helping identify needed resources and monitoring delivery of other services) accounted for about two-fifths of the expenditures. The rest went to such services as medication, inpatient and residential care, rehabilitation, and crisis intervention. ValueOptions personnel provided most of the case management, other support, and crisis intervention services, while subcontractors provided nearly all of the other services.

ValueOptions received about half of State's behavioral health funding

In fiscal year 2005, ValueOptions received about half of the State's behavioral health monies and used about half of these revenues to provide services to adults with SMI. The overall flow of monies through the system is shown in Figure 4 (see page 14). As the figure shows, a combination of federal, state, and county monies fund the behavioral health system in Arizona. For fiscal year 2005, the Division received a total of \$920.8 million to oversee and contract for behavioral health services in Arizona. ValueOptions received \$489.4 million for programs in Maricopa County.¹ Of this amount, ValueOptions used \$243.2 million for programs for adults with SMI and \$196.4 million to provide other services, of which 53 percent were for children.

Nearly all ValueOptions' Arizona revenues come from its contract with the Division. In fiscal year 2005, ValueOptions received \$2 million of revenues from other sources, including interest and recoveries from Medicare and other insurers. In total,

Figure 4: Flow of Sources and Distributions of Behavioral Health Services Monies in Arizona Fiscal Year 2005
In Millions
(Unaudited)



¹ ValueOptions received an additional \$2 million from other sources, including interest and recoveries from Medicare and other insurers. All these monies were used for administration, profit, and income taxes.

² The Department contracts with three other RBHAs and four tribal contractors. In addition, an insignificant adjustment was made to account for the difference between the Division's cash basis and ValueOptions' accrued amounts.

Source: Auditor General staff analysis of *Arizona Department of Health Services Division of Behavioral Health Services and Arizona State Hospital Annual Report Fiscal Year 2005*, an electronic file obtained from ValueOptions containing financial statement data for fiscal year 2005, and *VO of Arizona, Inc. Statement of Activities Year Ended June 30, 2005*.

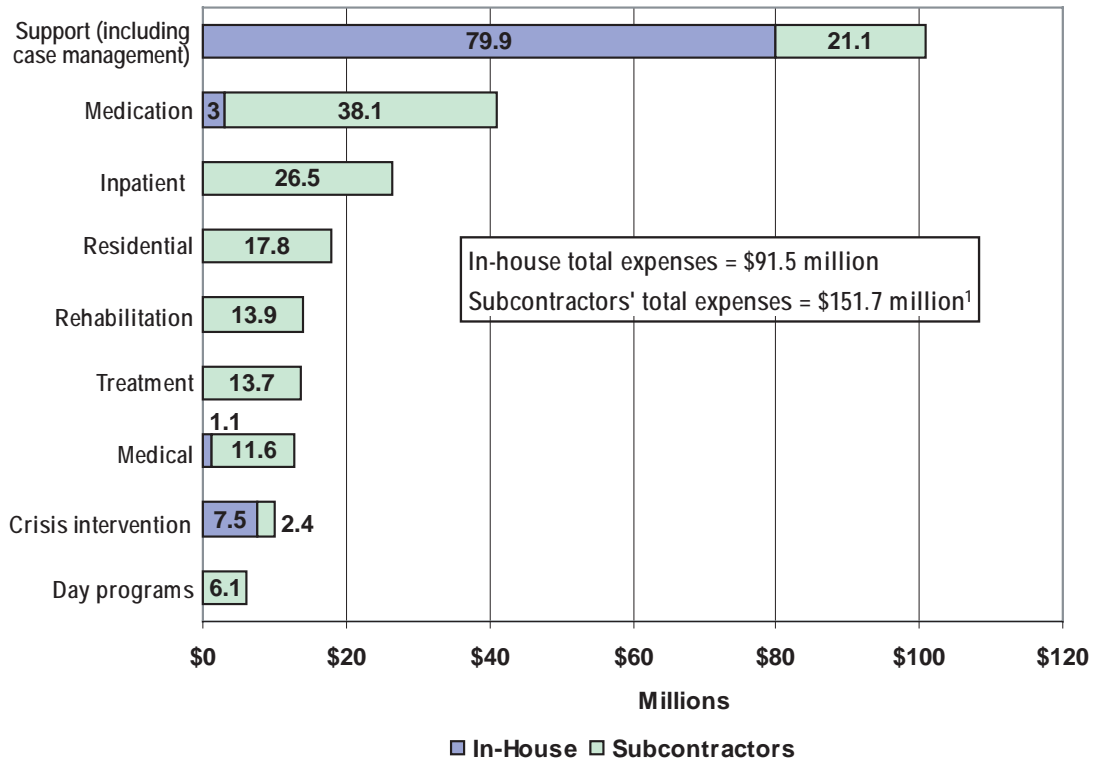
ValueOptions received \$491.4 million from all sources. From all of its revenue sources, ValueOptions earned \$8.8 million in profits (1.79 percent of revenues), used \$37.2 million to pay for administrative expenses (7.57 percent), and incurred \$5.8 million in income taxes associated with its Arizona operations (1.18 percent). Administrative expenses associated with the division contract totaled \$36.8 million, which is substantially in compliance with the contractual requirement limiting administrative expenses to 7.5 percent of each type of contract revenue. See Other Pertinent Information (pages 47 through 48) for more information on ValueOptions' administrative expenses.

Largest category of adult SMI services is support, including case management

The \$243.2 million for services to adults with SMI was used for many different kinds of services. As Figure 5 (see page 16) shows, support services, which includes case management, was by far the largest category, representing about 42 percent of total service expenditures. ValueOptions provided most of the support services. Nearly all of the other categories of services were provided primarily by subcontractors. The types of services were as follows:

- **Support services (\$101 million)**—Mainly case management services that help consumers obtain behavioral health services via ValueOptions direct care sites or through subcontractors. Specifically, case managers help consumers obtain services and monitor service delivery. Other support services include respite care, peer support, home care training, transportation, helping consumers find resources such as housing and carrying out daily tasks such as assisting with food preparation, and ensuring that medications are taken as prescribed.
- **Medication (\$41.1 million)**—Prescription drugs intended to prevent, stabilize, or improve symptoms due to a behavioral health condition or its treatment.
- **Inpatient services (\$26.5 million)**—Inpatient detoxification and psychiatric services delivered in hospitals and other inpatient facilities, including residential treatment centers that provide a structured treatment setting with 24-hour supervision, an intensive treatment program, and on-site medical services.
- **Residential services (\$17.8 million)**—Twenty-four-hour residential services, including structured treatment, which includes room and board, delivered in residential facilities or supported independent living settings.

Figure 5: ValueOptions' SMI Expenses by Types of Services Delivered
Fiscal Year 2005
(Unaudited)



¹ Includes an additional \$500,000 of miscellaneous behavioral health services delivered by subcontractors.

Source: Auditor General staff analysis of an electronic file obtained from ValueOptions containing financial statement data for fiscal year 2005, and VO of Arizona, Inc. Statement of Activities Year Ended June 30, 2005.

- **Rehabilitation services (\$13.9 million)**—Education, coaching, training, and other services, including securing and maintaining employment. Services include living skills training, cognitive rehabilitation, health promotion, and ongoing support to help maintain employment.
- **Treatment services (\$13.7 million)**—Counseling, therapy, assessment, evaluation, screening, and other professional services to reduce symptoms and promote consumer functioning.

- **Medical services (\$12.7 million)**—Services to reduce a person’s symptoms and improve or maintain functioning, including laboratory, radiology, and medical imaging. Medical services also include medication management, which is the review of medication effects and side effects, and adjusting the type and dosage of prescribed medications.
- **Crisis intervention services (\$9.9 million)**—Telephone crisis lines, mobile crisis intervention units, and crisis services delivered at two psychiatric recovery centers (PRCs) managed by ValueOptions.
- **Day programs (\$6.1 million)**—Skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, and self-help/peer services to improve consumers’ ability to function in the community.
- **Other (\$478,000)**—Other behavioral health services include some community housing, vocational, screening, and evaluation services. This amount includes approximately \$400,000 in Tobacco Litigation Settlement Fund monies that the Division allocated to ValueOptions in fiscal year 2005. (See Auditor General Report No. 04-03 for additional information on SMI community housing developed with one-time funding from tobacco settlement monies.)

FINDING 2

Division should strengthen focus on outcomes

The Division should strengthen its focus on consumer outcomes to better account for what expenditures on services for adults with SMI accomplish. To date, the focus on what expenditures are accomplishing has been limited as the Division continues to implement basic system requirements. The Division is attempting to move its program in a results-oriented direction, in part by adopting a recovery-based model aimed at helping people make progress. However, the Division may experience difficulty in moving further in this direction, in large part because it must measure numerous process requirements in order to comply with federal, state, and *Arnold v. Sarn* lawsuit requirements. To strengthen its focus on consumer outcomes, the Division should continue implementing outcome-based training, continue developing outcome goals and measures in its quality management system and RBHA contract, and ensure that the data it collects to measure outcomes is accurate. In addition, the Division should consider working with *Arnold v. Sarn* plaintiffs to renegotiate criteria for exiting the lawsuit.

Limited focus to date on what system expenditures accomplish

The Division has had limited focus on whether its expenditures are helping consumers make progress in their recovery. Research shows that many adults with SMI can recover, or make progress, and live personally meaningful and fulfilling lives. Experts believe that a public mental health system's service planning and clinical practices should be recovery-based (see text box). To date, there has been limited focus on what is being accomplished through case management and support services, including service planning by clinical teams, or what consumer outcomes are as a result of the services they receive. However, the Division and ValueOptions are beginning to focus on consumer outcomes.

What Recovery Means^{1,2}

To consumers—Being able to participate in meaningful activities, assume responsibilities, and/or overcome disadvantages such as discrimination after being categorized mentally ill.

To the Division—Ensuring that the RBHAs provide services that facilitate a consumer's progress, and focusing its oversight on measuring consumer recovery as a result of those services.

¹ Anthony, William A. A Recovery-Oriented Service System: Setting Some System-Level Standards. *Psychiatric Rehabilitation Journal*, Fall 2000. 159-168, Vol. 24, No. 2.

² Anthony, William A. Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990's. *Psychosocial Rehabilitation Journal*, 1993. 11-23, Vol. 16 No. 4.

Service planning focuses on process—Behavioral health experts believe outcome goals should determine the services provided by considering consumer improvement when developing long-term objectives, making assessments, and identifying needs. However, several experts and clinical advisers who participated in auditors’ focus groups believe that the Division and ValueOptions focus on the process of service delivery rather than the level of progress that consumers achieve.¹

One example of the emphasis on process is the recent effort to meet quotas, which according to ValueOptions’ management, requires staff at the various clinics to meet site-specific, monthly goals for developing individual service plans (ISPs), which are written plans showing consumers’ needed services. To comply with *Arnold v. Sarn* court agreements, consumers must have ISPs. Case reviews by the court monitor in 2004 and 2005 found a high rate of consumers without adequate ISPs, and since then the Division and ValueOptions have emphasized the need to develop ISPs for consumers.

The increased emphasis on meeting ISP quotas may help clinical teams develop the required number of ISPs, but available evidence indicates that teams may not always create meaningful plans appropriate for consumer needs (see text box for a listing of these needs). Boston University mental health system experts observed ValueOptions’ clinical teams in May 2005. The Boston University experts conducted a review at six clinics and reported that the teams had difficulty setting personalized ISP goals and lacked the ability to identify consumer needs and develop appropriate objectives to help consumers make progress in their recovery. Clinical advisers in auditors’ focus groups confirmed Boston University experts’ report that the clinical teams did not view the ISP as a planning tool to help link consumers to needed services for long-term progress. Auditors’ review of case files showed an example of the problem:²

- Lisa, a 58-year-old woman with a psychotic disorder, received services valued at approximately \$4,800 in fiscal year 2005. She expressed to her case manager that she has financial problems. However, she is not ready to work, but would like to move to a more affordable apartment. Although her ISP reflects this goal, her case manager believes that her living situation is adequate, and there has been little effort to help Lisa find a less expensive place to live. According to agency rules, if the goal is appropriate, the team should help Lisa work toward achieving it.

Clinical team efforts not adequately coordinated—Effective supervision and clinical team practices are important to implementing policies focused on consumer progress, according to behavioral health experts. These experts believe

¹ Behavioral health experts participated in a Web-based discussion and clinical advisers participated in two focus groups as part of audit methods (see Introduction and Background, pages 9 through 12). Clinical advisers are experts in behavioral health services, employed by the Division or ValueOptions, and assigned to several clinics to provide guidance to staff during calendar years 2004 and 2005.

² To identify causes for problems with service delivery, auditors conducted ten case studies on consumers who were identified in the *Arnold v. Sarn* court monitor’s 2005 review as having unmet needs according to their ISPs. All consumer names have been changed. These cases are used for illustrative purposes and are not meant to tell the whole story.

Clinical teams may not always create meaningful plans appropriate for consumer needs.

Consumer needs to address in service plan goals¹

- Safety and other basic needs (food and shelter)
- Access to resources
- Symptom relief
- Assumption of responsibilities
- Health
- Empowerment
- Equal opportunity

¹ Anthony, William A. A Recovery-Oriented Service System: Setting Some System-Level Standards. *Psychiatric Rehabilitation Journal*, Fall, 2000. 159-168, Vol 24, No.2.

that the team should engage the consumer in creating his or her ISP and use team member expertise to implement it (see text box).

In contrast, experts and clinical advisers identified lack of effective coordination both within the ValueOptions team and between the team and other providers. In the May 2005 Boston University review, experts found that in general, clinical teams in Maricopa County were not prepared to use resources and supports from the clinical team to implement the ISP. Clinical advisers also observed this lack of collaboration among clinical teams. Specifically, advisers in one focus group noted that members of clinical teams do not coordinate their efforts or follow up with one another. Further, advisers in the other focus group said teams lack the ability to use team resources to match services to consumer needs. An auditor case study shows that the problem persists:

- Tammy, a 37-year-old woman with bipolar disorder, received services valued at approximately \$14,850 in fiscal year 2005. According to her clinical team, she has not made progress in her substance abuse treatment. She experienced staff turnover within the team with four new case managers over an 18-month period, and it appears that the team did not communicate effectively during times of transition. Each time she had a new case manager, the team would start over with treatment options. For example, Tammy attended a substance abuse program for which she expressed dislike, and later, when a new case manager joined the team, that person referred her to the program that she did not want to attend. To ensure that Tammy received consistent guidance to help her progress in her substance abuse treatment, her clinical team should have communicated and followed up with one another when someone new joined the team.

In addition to inadequate coordination within the clinical team, ValueOptions' teams do not always coordinate with others outside the teams. For example, clinical advisers in one focus group stated that the teams do not consistently communicate with service providers or follow up with them while consumers are receiving services. One expert who participated in auditors' Web-based discussion also stated that there is a lack of collaborative planning with providers and another expert commented that there is a lack of interaction between clinical teams and consumers' primary care physicians. In addition, auditors found evidence of clinical teams' lacking integration of consumers' legal obligations into their service planning, such as court-ordered treatment, including a lack of communication with consumers' parole officers. Here is an example of a lack of coordination with providers outside the team, taken from the cases the auditors examined:

- Jeff is a 55-year-old man with schizophrenia who received services valued at approximately \$13,330 in fiscal year 2005. His clinical team arranged for a provider to assist him with medication management to ensure that he takes his medications as prescribed. While his clinical team coordinated their efforts internally, the team did not verify that the provider observed Jeff taking his

Typical clinical team members¹

- Case manager
- Clinical liaison (supervisor)
- Psychiatrist
- Nurse
- Rehabilitation specialist
- Other professionals as needed

¹ A.A.C. R9-21-101(B)14.

Clinical teams do not consistently coordinate efforts with service providers.

medication to ensure that he took the proper dosages. The case manager later discovered that the consumer was over-medicating himself and that the provider was not delivering services according to their agreement. To assist Jeff in effectively managing his medication and reducing the symptoms of his mental illness, the clinical team should have followed up more effectively with the service provider to ensure close management of Jeff's medication.

Boston University Training Plan for Maricopa County

- Teaches how to facilitate consumer recovery.
- Certified participants will be able to use the model and coach others.
- Core group will be certified in July 2006.

Recommendation from experts who participated in auditors' Web-based discussion:

Ensure that clinical teams are properly trained in the recovery model.

Recommendation from clinical advisers:

Implement the Boston University recovery model and maintain and monitor it.

The Division must comply with requirements laid out in court orders associated with the *Arnold v. Sarn* lawsuit.

Division beginning to implement recovery model—To improve service delivery and to comply with *Arnold v. Sarn* court requirements (see Appendix A, page a-iii), the Division and ValueOptions are working with the experts from Boston University who conducted the May 2005 clinical review. These experts have proposed a model for using consumer recovery in service planning for Maricopa County. The model includes specific guidelines for helping consumers set long-term goals and a planning matrix to help the clinical team identify the types of services that will be most helpful to the consumer. In addition, the model includes suggestions for helping clinical teams in Maricopa County improve their understanding of mental illness and their ability to identify client needs and establish client objectives based on recovery.

In its November 2005 joint stipulation with the *Arnold v. Sarn* plaintiffs, the Division agreed to implement Boston University's training program based on the principles of consumer recovery. The purpose of the training is to help clinical teams develop skills to substantively involve consumers in creating recovery and rehabilitation-oriented ISPs.

To allow consumer recovery to drive services and to facilitate effective supervision and clinical team interaction, the Division should continue implementation of the Boston University training program, maintain the recovery model in service planning and clinical practices, ensure that the Maricopa County RBHA continues to train clinical leadership and staff, and monitor RBHA compliance with the recovery model (see text boxes).

Requirements may impede implementation of recovery model

While adoption of the recovery model may help address the underlying concerns of the *Arnold v. Sarn* lawsuit, some aspects of complying with the settlement of the lawsuit may have the effect of limiting the Division's ability to do so. Instead of measuring outcomes, the Division has focused its measurement on compliance with process requirements. In addition to monitoring procedural requirements that are conditions for receiving federal Medicaid funding, the Division must comply with requirements laid out in court orders associated with the *Arnold v. Sarn* lawsuit.

Court requirements drive measurement toward process and

outputs—Court orders associated with the *Arnold v. Sarn* lawsuit establish numerous requirements that the Division must meet (see Appendix A, page a-iii). Agreements between the Division and the plaintiffs prescribe numerous process requirements for service planning, clinical practices, and oversight, which contribute to the Division's lack of focus on consumer outcomes in these areas. For example, the 1991 Blueprint, a plan for fully implementing the Court's judgment, includes specific requirements for clinical team composition, spells out responsibilities and processes that the State must follow in the development and implementation of ISPs, and establishes provisions for a quality assurance system (see text box). The Blueprint stipulated that various requirements be incorporated into the Department's rules, including grievance processes, consumer rights, ISP development and implementation, and standards for residential and nonresidential services.

To measure compliance with *Arnold v. Sarn* requirements, court orders mandate an annual review by a court monitor. The court monitor follows court requirements by reviewing a sample of consumers' cases to measure compliance with standards, including clinical team composition, and whether consumers' ISPs are reviewed every 6 months and consumers participate in their ISP development. However, the court-ordered review is not designed to measure consumers' progress toward recovery outcomes over time, but rather focuses on each consumer's status on the day of the review. For example, the review assesses whether the consumers' needs are met consistent with their ISPs, based on a review of the contents of each consumer's file and interviews with one or more members of the clinical team, consumer, and/or a member of the consumer's family, which are all completed in one day. The court monitor is to determine whether a consumer's needs are met on the day the review takes place in the areas of housing, working or learning, and social activities. If one of these areas is deemed deficient, the consumer is considered to have "unmet needs." The exit stipulation does not require the court monitor to measure whether a consumer had made incremental progress in one of those areas, such as whether a consumer went from living in the Arizona State Hospital, to living in a residential facility, to then living independently in an apartment.

Experts and clinical advisers attribute the Division's lack of focus on consumer outcomes to the rigidity of process measurements in the lawsuit agreements. For example:

Examples of 1991 Blueprint requirements arising from the *Arnold v. Sarn* lawsuit

Clinical team

- Each consumer shall have an assigned case manager.
- Responsible for locating and obtaining services.
- Monitor services and assess continued appropriateness and effectiveness.

Service planning

- ISP to be developed no later than 30 days from the date of consumer application or referral for services.
- Case manager, in conjunction with clinical team, is responsible for locating services identified in ISP and monitoring their delivery.
- ISPs shall be reviewed and revised every 6 months.

Quality assurance

- Division shall design a comprehensive system of monitoring, evaluation, and quality assurance for all areas covered by the Blueprint.
- The system shall evaluate appropriateness, individualization, and effectiveness of services.
- The system shall include consumer and family satisfaction with services.

Experts and clinical advisers attribute the Division's lack of focus on consumer outcomes to the rigidity of process measurements in the lawsuit agreements.

- One expert who participated in auditors' Web-based discussion said the managed behavioral healthcare system in Maricopa County is caught between a paternalistic model and recovery-oriented model because of lawsuit requirements that focus on measuring process instead of outcomes, and another expert commented that the rigidity of the requirements has stymied the system in its efforts to improve.
- Clinical advisers said the lawsuit drives the Division to take actions and use oversight mechanisms based on measuring processes instead of outcomes, causing clinical teams to work to meet administrative requirements rather than consumer needs. They said that what the Division and ValueOptions report as a success is not necessarily based on consumer outcomes, but instead focuses on counting the number of ISPs completed, attributing this to the desire to meet court-ordered, procedural requirements.

Auditors found indications that, while progress is being made in some areas, it is not necessarily recognized by existing review mechanisms. For example, experts who participated in the Web-based discussion commended the Division and RBHA for increasing community-based housing and launching innovative housing projects, which have provided consumers with more and better options for safe, secure living arrangements. In addition, some of the cases auditors reviewed demonstrated that if the Division could better measure outcomes, such as independent living or reduction in substance abuse, it might be able to report consumer progress. For example, two consumers had clearly made progress toward recovery, even though their needs had not been fully met at the time of a July 2005 review by a court monitor who oversees compliance with the *Arnold v. Sam* court requirements:

- Jeff, the 55-year-old man with schizophrenia whose medications were not adequately monitored by a service provider, had lived in the state hospital for 15-18 years and then moved to a supervisory care home, according to the court monitor. In 2005, he moved from the supervisory care home into an apartment by himself. While he had difficulties taking care of his apartment, such as cleaning and operating his air conditioner, he attended social activities and used public transportation. His clinical team was attentive to his needs by helping him with household management, and considered his long-term goals in his ISP appropriately. According to the court monitor, Jeff moved back to a supervisory care home in 2006 because taking care of an apartment was too difficult for him. Although Jeff had unmet or only partially met needs in some areas, his accomplishments in 2005 represent significant progress compared to his prior residence in the state hospital.
- Daniel, a 35-year-old man with bipolar disorder and a substance abuse problem who received services valued at approximately \$14,370 in fiscal year 2005, is making progress in his recovery according to his clinical team. His team focused their efforts on helping him diminish his symptoms and improve his functioning and worked together to get him direct assistance from the

clinic's substance abuse specialist. The team engaged Daniel in his treatment, supported him when he made progress and when he relapsed, and followed up with him when he missed therapy sessions. The clinical team also supports Daniel's musical interests, and Daniel played his guitar at the clinic. Although the court monitor review found that Daniel's needs for housing, working or learning, and social activities were only partially met, the clinical team reported that Daniel made progress in his substance abuse recovery during the year.

To effectively implement recovery model, Division must focus on measuring outcomes

Behavioral health experts believe that measuring consumer progress can help increase accountability of mental health systems and provide a basis for improving consumer outcomes. Thus, while the Division has made some efforts to measure outcomes, it should continue to move to greater incorporation of outcome measures based on consumer progress, such as employment and number of crises, into its quality management system and RBHA contract (see text box). For example, The Village, a Southern California behavioral health program, uses a set of measures that include employment, independent living, symptom distress rated by clients, and level of functioning rated by staff.¹ Other examples of outcome measures include days in jail and days of involuntary hospital care.

Division has made some efforts to measure outcomes—Although to date its oversight has focused mainly on process, the Division has begun focusing on outcomes in its quality management and contractual oversight. In addition, a now-ended program developed with one-time funding illustrates the Division's ability to measure outcomes, and the Division is participating in two national measurement projects:

- **Quality management pilot test**—In an effort to focus more on outcomes, the Division is pilot testing a process to measure outcomes for people with SMI in its quality management plan in the areas of employment, stable-living situation, social support, reduction of the use of in-patient hospitalization, decreased criminal justice involvement, and access to services. The Division is evaluating its data and indicators, and formalized the process in June 2006.
- **Oversight of contractual compliance**—In January 2006, the Division developed new outcome measurement standards for its annual Independent Case Review (ICR) process, which is used to measure compliance with financial incentive performance indicators included in the ValueOptions' contract for fiscal years 2006 and 2007. The new standards provide specific

Outcome measures

Indicators that can be used to assess a consumer's change in status after having received services.

¹ The Village Integrated Service Agency.

guidance for measuring consumers' clinical outcomes, such as a decrease in criminal activity or increased participation in social activities. These standards will be used to determine whether ValueOptions will be eligible to earn a portion of its financial incentive for fiscal years 2006 and 2007.

- **HB2003 program**—The Division measured consumer outcomes associated with a recently concluded program for adults with SMI. The Legislature required the Division to develop performance measures and assess outcomes of new programs established using one-time funding from the State's tobacco litigation settlement.¹ For example, the Division measured the impact of housing, rehabilitation, and intensive case management programs on consumers' level of functioning, use of hospitalization, and substance abuse. The Division developed a system to collect data to measure consumer outcomes from the services they received, but according to the Division, now that the pilot program is over, the Division is no longer collecting some of this outcome data.
- **National measurement projects**—The Division participates in two national projects related to the collection of outcome data. According to the Department, it has incorporated survey questions from the Mental Health Statistics Improvement Program into its state-wide consumer survey, which includes the assessment of the outcomes of services.² In addition, the Division provides outcome data to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), which is working with states to achieve a performance environment with true accountability.³

While the Division uses mechanisms within its contract and quality management system to oversee quality of care of behavioral health services, to date, these measures have been based on process and have not focused on what is accomplished through system expenditures. For example, the contract with ValueOptions includes performance measures for fiscal year 2005 that are passed down from the Division's contract with AHCCCS that measure such things as access to care, coordination of care with primary care physician, and consumer/family involvement in the treatment planning process. In addition, AHCCCS requires the Division to measure ValueOptions' performance in "quality clinical outcomes," but until fiscal year 2006, performance standards in the Division's contract with ValueOptions did not specify what the outcomes should be, such as employment or reduced number of days in jail.

¹ House Bill 2003, Laws 2000, Fifth Special Session, Chapter 2, §§1 and 5. See Auditor General Report No. 04-03 for additional information on the HB2003 program.

² The Mental Health Statistics Improvement Program is a national program that provides uniform, comparable statistical information about mental health services to enable broad-based research on systems of care and models for service delivery. It focuses on the need for and development of data standards for high-quality statistical information on mental health services.

³ The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration collaborated with states to identify ten domains for national outcome measures for substance abuse and mental health services, including employment/education, crime and criminal justice, stability in housing, and social connectedness.

The Division participates in two national projects related to the collection of outcome data.

Division should take further action to measure outcomes—To help increase accountability of the Maricopa County mental health system and provide a basis for improving consumers' outcomes, the Division should continue its current efforts and take some additional steps as follows:

- **Define outcome goals and develop appropriate outcome measures—**Outcome goals should be measurable and capable of being tracked and used to improve treatment. Measures should be based on consumer progress, such as employment and reduced use of crisis services. In February 2006, representatives of the Division, ValueOptions, and the court monitor's office visited The Village in Southern California and learned about their outcome measures. The Division should build on these steps and use the results of its quality management plan pilot test, as well as the measures used in the HB2003 program and by SAMHSA, to define outcome goals, and develop appropriate outcome measures and a system-wide focus on measuring recovery outcomes.
- **Continue to incorporate outcomes and financial incentives into its contract with the RBHA—**The quality of services delivered to adults with SMI depends in large part on the quality of the contracting process. While contracts and financing mechanisms do not ensure quality, they influence the conduct of managed care providers. For instance, Massachusetts has helped ensure quality by tying earnings to performance outcomes in its behavioral health managed care contract. In addition, SAMHSA reports that financial incentives, a flat dollar amount or a percentage of profits, can be used to measure the performance of a managed care provider and they should be large enough to influence the behavior of the managed care provider. Further, a behavioral health expert who has consulted with approximately 40 state governments on their mental health systems recommended allowing ValueOptions to earn a base profit margin of 1-2 percent for accepting the financial risk of delivering services, and an additional maximum allowable profit margin should be established based on compliance with outcome measures. The Division already implemented a profit incentive in fiscal year 2005 by setting a base profit of 4 percent and allowing ValueOptions to earn another 1 percent through complying with certain contract provisions regarding consumer access to care, which ValueOptions earned. Starting in fiscal year 2006, ValueOptions can also earn incentives by meeting performance thresholds related to symptom and functional improvement, satisfaction, coordination of care, cultural competency, and consumer and family involvement.¹ Thus, the Division should continue and build on these efforts to tie a portion of ValueOptions' profits to achieving agreed-upon performance outcomes, such as consumers having a certain number of days in stable housing (see recommendations text box, page 28).

The Division should tie a portion of ValueOptions' profits to achieving agreed-upon performance outcomes.

¹ The current Maricopa County contract is effective for 3 years, starting with fiscal year 2005. The contract stipulates performance incentives of up to 1 percent additional allowed profit for each contract year, with a base profit of 4 percent.

As part of its contractual provisions to collect consumer outcome data, the Division should ensure that an information management system exists to properly collect accurate outcome data that can be used to reliably measure recovery outcomes. The fiscal year 2008 request for proposals should require the vendor to demonstrate that it has an adequate information technology system to collect, report, and validate agreed-upon outcome data (see recommendations text box).

Recommendations from experts:

- Implement outcome measures into the RBHA contract.
- Develop a more effective quality management system that is based on the measure of outcomes to identify areas of improvement and move away from the focus on process.
- Ensure that the data used to measure outcomes and to make improvements in the system is validated.
- Renegotiate with the plaintiffs the objective measures of improvement in the lawsuit exit stipulation.

Recommendations from clinical advisers:

- Provide incentives that are aimed toward desired outcomes.
- Use data collection as a management tool and to supervise cases, including quality management.
- Renegotiate Appendix C of the exit stipulation to focus on outcomes.

The Division should consider renegotiating measures of improvement in the court orders arising from the lawsuit.

As part of its efforts to focus on outcomes, the Division should consider renegotiating criteria in the court orders arising from the lawsuit. While the Division, plaintiffs, and court monitor agreed on steps in January 2006 to improve the reliability and consistency of the annual review methodologies, these enhancements did not address the underlying requirements to focus on process rather than consumer outcomes. The Division should determine which court mandates focus on process rather than outcomes and inhibit full implementation of an outcome-oriented model, discuss this with the plaintiffs, and work to modify the provisions (see recommendations text box). For example, the lawsuit exit stipulation requires a certain portion of the population to have all of their needs met, as identified on their ISP, but does not assess whether the goals listed in the ISP will help the consumer improve his or her functioning and recover, or whether the consumer is making progress based on the services he or she receives.

Recommendations:

1. The Division should continue its implementation of the Boston University training program by monitoring the RBHA's compliance with the recovery model and ensuring that the Maricopa County RBHA:
 - a. Continues to train clinical leadership and staff; and
 - b. Maintains the training principles in service planning and clinical practices.
2. The Division should incorporate measurement of consumer outcomes into its oversight mechanisms by:
 - a. Using the results of its quality management plan pilot test, as well as the measures used in the HB2003 program and by SAMHSA, to define outcome goals and develop appropriate outcome measures;
 - b. Continuing to incorporate these measures into the Division's quality management plan and RBHA contract;
 - c. Continuing to tie a portion of the RBHA's profits to achieving agreed-upon performances outcomes;
 - d. Ensuring that an information management system exists to properly collect accurate outcome data that can be used to reliably measure recovery outcomes; and
 - e. Requiring the RBHA to demonstrate that it has an adequate information technology system to collect, report, and validate agreed-upon outcome data.
3. The Division should consider renegotiating measures of improvement in the court orders arising from the *Arnold v. Sam* lawsuit by:
 - a. Determining which court mandates focus on process rather than outcomes and inhibiting full implementation of an outcome-oriented model; and
 - b. Discussing this with the plaintiffs and working to modify the provisions.

FINDING 3

Division can improve financial oversight and limit use of SMI monies

Many of the Division's tools for monitoring the solvency and expenses of ValueOptions and other RBHAs appear to be working reasonably, but some can be improved. Financial solvency is important to ensuring that RBHAs can continue to deliver services without interruption, and the Division has several mechanisms that appear to be adequately monitoring ValueOptions' solvency. Similarly, many steps for controlling expenditures, such as contractual restrictions on profits and administration, are in place. However, current audit requirements can be strengthened so that audits become better tools for ensuring compliance with these requirements. Besides strengthening controls in this way, the Division—and if necessary, the Legislature—should consider restrictions that would prohibit using monies appropriated for SMI for other programs. As allowed by contract, over the past several years, ValueOptions has used more than \$21 million in SMI monies for other programs.¹

Monitoring of solvency appears adequate

The Division employs several mechanisms to help ensure and monitor RBHA financial solvency. Monitoring solvency is important to avoid interruptions in service, as illustrated by a past RBHA's financial failure. In 1997, the RBHA for Maricopa County at the time—ComCare—reached a bankruptcy settlement, necessitating state takeover of services until a new contractor could be found. The main mechanisms used by the Division show that ValueOptions is reasonably solvent.

- **Measuring financial solvency**—The Division requires ValueOptions to meet commonly used financial measures to ensure that it remains solvent, such as having sufficient assets to meet short-term obligations. As of June 30, 2005, a division monitoring report showed it was in compliance with these requirements. AHCCCS uses similar measures to check the solvency of acute care (medical) and long-term care providers.

A former RBHA financial failure illustrates the importance of financial oversight.

Financially solvent—Capable of meeting financial obligations.

¹ The Division's contracts with RBHAs that serve other areas of the State also allow use of SMI monies for other programs.

Measures of financial solvency

- **Current ratio** measures ability to pay for short-term obligations (current assets divided by current liabilities). Division requires current ratio of at least 1.
- **Defensive interval** measures the number of days a provider can operate on assets that can be quickly converted into cash. Division requires defensive interval of at least 30 days.

Standards to ensure solvency

- **Equity per enrollee**—Division requires net worth of at least \$300 per enrolled member.
- **Capitalization requirements**—Division requires the RBHA to maintain net assets greater than or equal to 90 percent of monthly revenues but no less than \$10 million, whichever is greater.
- **Performance bond**—Division requires a bond to guarantee payments to providers. As of July 2006, ValueOptions' bond totaled nearly \$50 million.

- **Enforcing other standards to ensure solvency**—The Division requires ValueOptions to meet standards intended to ensure that it remains solvent. In some cases, the Division's requirements are higher than AHCCCS' requirements for acute care and long-term care providers. For example, the Division requires ValueOptions to maintain at least \$300 equity or unobligated assets per enrolled member, while AHCCCS requires no less than \$100 or \$150 for its acute-care providers, depending on the provider's size. As of June 30, 2005, a division monitoring report showed ValueOptions equity per enrolled member was \$698, and division records show ValueOptions also complied with all of the solvency standards such as capitalization requirements and performance bonds (see text box).
- **Placing limits on losses**—To help protect ValueOptions against financial failures, the Division limits the amount the company can lose on the contract. Specifically, the contract between the Division and ValueOptions limits losses to 4 percent of certain revenues. For example, if ValueOptions' losses in its Medicaid program exceed 4 percent, the Division may reimburse the losses subject to available funding.

Division oversees spending in multiple ways

Besides checking for solvency, the Division uses a number of methods to oversee how monies are spent. Monitoring spending is especially important in a capitated system like Arizona's, where the RBHA is paid in advance to deliver behavioral health services instead of receiving payment for services delivered. The Division's methods center on two main approaches: analyzing financial reports and conducting various types of audits. For the most part, these approaches appear to be working reasonably.

Analyzing financial reports—The Division analyzes ValueOptions' monthly, quarterly, and annual financial statements to determine the RBHAs' compliance with financial requirements and spending limitations that help monitor spending. The Division monitors spending through the following:

- **Minimum spending levels for services**—The Division establishes minimum expenditure levels for services to help ensure that an adequate level of services are provided. Specifically, the Division requires ValueOptions to spend at least 88.5 percent of each type of contract revenue—Medicaid, KidsCare, and others—on services. These limits are higher than those

imposed by AHCCCS, which requires its acute care providers to spend at least 80 percent of contract revenues on services and its long-term care contractors to spend at least 85 percent of contract revenue on services. A division monitoring report shows that ValueOptions met this requirement during fiscal year 2005.

ValueOptions met spending standards in fiscal year 2005.

- **Limits on administrative expenses**—The Division limits ValueOptions' administrative expenses. For example, ValueOptions can spend up to 7.5 percent of its Medicaid revenues on administrative expenses related to its Medicaid programs, and up to 7.5 percent of its KidsCare revenues for KidsCare-related administrative expenses. Again, these limits are more stringent than those that AHCCCS imposes, which limits administrative costs for acute care providers to no more than 10 percent of the contract revenue and administrative costs for long-term providers to no more than 8 percent. Placing limits on administrative expenses is also in line with practices that the auditors found in reviewing relevant literature.¹ A division monitoring report shows that ValueOptions substantially met this requirement during fiscal year 2005.²
- **Limits on service profits**—The Division limits ValueOptions' profits on service revenues.³ Specifically, for fiscal year 2005, there is a 4 percent limit on service profits for Medicaid, KidsCare, and other contract monies, respectively. In addition, its children's program service profits are also limited to 4 percent of service revenues in each category.⁴ If ValueOptions has service profits of more than 4 percent in one of these categories, it must return the excess monies to the Division within 12 months of fiscal year-end. The Bazelon Center for Mental Health Law and the federal SAMHSA recommend that public payers, including states and local authorities, consider limiting profits.⁵ Further, SAMHSA reports that public payers such as states consider less than 5 percent to be a reasonable profit margin.⁶ As illustrated in Table 3 (see page 34), a division monitoring report shows that ValueOptions' service profits were

¹ Koyanagi, Chris. *Managing Managed Care for Publicly Financed Mental Health Services*. Washington, D.C.: Judge David L. Bazelon Center for Mental Health Law, 1995; U.S. Department of Health and Human Services. Office of the Inspector General. *Cost-Saver Handbook*. Washington, D.C.: DHHS, 2004.

² ValueOption's KidsCare administrative expenses were 0.05 percent over the limit in fiscal year 2005. A division official explained that administrative expenses in excess of limits decreased ValueOptions' overall profits.

³ Service revenue equals 92.5 percent of total Department of Health Services revenue adjusted for certain payables and receivables.

⁴ Combined administrative expenses and profits for House Bill 2003 programs are limited to 8 percent of these program revenues. The Legislature appropriated one-time funding for these programs in fiscal year 2001, and this program ended on July 1, 2005.

⁵ Koyanagi, Chris. *Managing Managed Care for Publicly Financed Mental Health Services*. Washington, D.C.: Judge David L. Bazelon Center for Mental Health Law, 1995; Moss, Stephen. *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers. Technical Assistance Publication Series #22. DHHS Publication No. (SMA) 98-3173*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Oct. 1998.

⁶ Savelle, Terry, Gail Robinson, Sarah Crow. *Contracting for Public Mental Health Services: Opinions of Managed Care Behavioral Health Care Organizations. DHHS Publication No. (SMA) 00-3438*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2000.

**Table 3: ValueOptions' Compliance with Service Profits Limits
By Program Fund Category
Fiscal Year 2005
(Unaudited)**

	Medicaid	KidsCare	Other Monies
Service revenues ¹	\$332,366,387	\$6,745,651	\$112,944,051
Service and income taxes expenses	<u>326,617,921</u>	<u>6,536,714</u>	<u>110,001,617</u>
Service profits	<u>\$ 5,748,466</u>	<u>\$ 208,937</u>	<u>\$ 2,942,434</u>
Allowable service profits ²	\$ 13,294,655	\$ 269,826	\$ 4,517,762
Contractual service profit limit	4.0%	4.0%	4.0%
Achieved service profit ^{3,4}	1.7%	3.1%	2.6%

¹ Service revenues in this table represent total contract revenues, excluding HB2003 and PASARR (pre-Admission Screening and Resident Review), less 7.5 percent allowed for administrative expenses, or 92.5 percent of each program fund's total contract revenues excluding HB2003 and PASARR.

² Allowable service profits equal 4 percent of total service revenues.

³ Service profit achieved equal service profits divided by service revenues.

⁴ The Division's profits/risk corridor analysis, based on ValueOptions' audited financial statements, reflects accounting adjustments for timing and other factors. ValueOptions' analysis based on its audited financial statements shows service profits for Medicaid, KidsCare, and Other Monies of 1.8 percent, 3.1 percent, and 1.9 percent, respectively.

Source: Auditor General staff analysis of the Division's profits/risk corridor analysis for ValueOptions for fiscal year 2005.

well within its contractual limits during fiscal year 2005, although it was required to return approximately \$1.5 million because it exceeded contract limits in the "other monies" children's funding category.

- **Requiring audits**—In addition to analyzing financial reports, the Division requires ValueOptions to obtain several audits. Most of these audits are conducted to ensure that financial reports accurately reflect ValueOptions' activities. Specifically, the Division requires:
 - **An annual audit of ValueOptions' financial statements**—This audit, conducted by an independent auditor, provides reasonable assurance that the financial statements are free of material misstatements and reliable. In fiscal year 2005, this audit found that ValueOptions' financial statements reasonably represented its financial position.
 - **An opinion on ValueOptions' statements of activities**—Similar to the financial statement audit, this opinion provides reasonable assurance of the accuracy of these statements. The statements of activities present a more detailed description of revenues and expenses than what is found in typical financial statements. Specifically, revenues and expenses are reported by different types of programs, including Medicaid children, Medicaid adult with SMI, and general mental health programs. In addition, expenses are segregated into 13 different

service categories such as treatment, crisis intervention, and residential services. In fiscal year 2005, this audit found that these statements reasonably represented ValueOptions' activities.

- o **An audit to determine compliance with U.S. Office of Management and Budget Circular A-133 (OMB A-133)**—This audit determines compliance with federal requirements for ValueOptions programs funded with federal grants. Typically, an OMB A-133 audit is mandated by the federal government when a state or local government or a not-for-profit entity spends more than \$500,000 of federal grant monies. However, beginning in its fiscal year 2005 contract, the Division required ValueOptions, a for-profit entity, to have an OMB A-133 audit of its federal grants. As part of this review, independent auditors examined internal controls over financial reporting and compliance with laws, regulations, and contract provisions that have a material effect on federal programs (see text box).

Examples of OMB A-133 compliance requirements

- Allowable and unallowable activities
- Allowable and unallowable costs
- Cash management
- Procurement
- Reporting requirements
- Sub-recipient monitoring

Audit results demonstrate need for additional oversight

Although recent efforts to increase monitoring through added audit requirements resulted in the recovery of \$1.5 million, most monies and contractual provisions are not subject to all the current requirements. In the OMB A-133 audit, independent auditors found that ValueOptions had not evaluated by fund source its estimate for claims not yet reported by its providers. After discovering the error when reviewing federal programs, the independent auditors recommended corrections to claims estimates for all programs. They found that because ValueOptions did not evaluate claims by fund source there was an error in the claims estimate for non-Medicaid children's services. This error resulted in overstating expenses and understating ValueOptions' service profit. When the error was corrected, the independent auditors determined that ValueOptions had more service profits in the "other monies" children's funding category than it was allowed to earn under its contract with the Division. ValueOptions returned approximately \$1.5 million in excess service profits to the Division in February 2006.

While valuable, the OMB A-133 audit examined only 4.8 percent of the money the Division provided to ValueOptions in fiscal year 2005. In fiscal year 2005, the Division provided over \$489 million to ValueOptions, including federal grant programs totaling \$23.5 million. OMB A-133 auditors were only required to examine the federal grant programs, which do not include the largest funding source, Medicaid. A compliance audit covering the nearly \$466 million of nonfederal program monies it received from the Division could have resulted in the discovery of other types of problems.

The audit for compliance with federal requirements was limited to a small portion of contract revenues.

Compliance Audits Can Follow AICPA Standards

The American Institute of Certified Public Accountants issues professional standards for compliance audits and attestation engagements.

Further, although audits of financial statements provide reasonable assurance regarding ValueOptions' financial reporting and use of program monies, they do not sufficiently enable the Division to ensure that monies are spent appropriately. Financial statement audits show that ValueOptions recorded its revenues, expenses, assets, and liabilities accurately. However, these audits are not designed to test compliance with all division requirements. For example, these audits may or may not include checking compliance with division contract limits on administrative expenses or minimum requirements for service expenditures.

The Division should continue to strengthen its audit requirements over contractual requirements and nonfederal monies. To better ensure monies are spent appropriately, the Division should consider adding an audit requirement for all non-federal program monies that tests for compliance with requirements important to the Division. These audit requirements for nonfederal monies can include the following:

- Requiring a compliance audit following AICPA's Professional Standards for Attestation Engagements. These standards establish guidelines for conducting an attestation review and determining compliance with a defined requirement. An attestation engagement is similar to an audit; however, it is more flexible in that it would allow the Division to define what topics, requirements, or standards should be covered by the review. By requiring this type of review, the Division would ensure that ValueOptions' independent auditors determine compliance with requirements important to the Division.
- Determining which compliance requirements and standards should be met and how frequently specific requirements should be tested. For example, the Division could require the reviewer to examine a limited number of requirements each year on a rotating basis in order to cover all important standards over a period of several years, while limiting the costs of the reviews. The Division can consider rotating requirements based on prior years' audit results and risk of noncompliance.

After obtaining audit reports, the Division should review the results of the required audits and take action when appropriate.

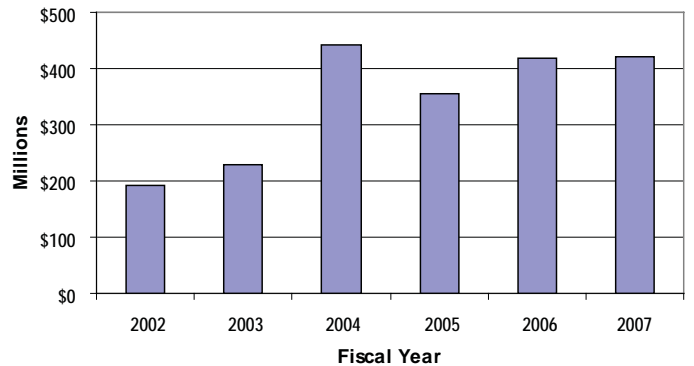
Additional spending restrictions should be considered

Although the Division limits profits to a percentage of each type of service revenue—Medicaid, KidsCare, and other—it allows ValueOptions to use monies allocated for adults with SMI for other programs, including programs for children, adult general mental health, and substance abuse. If the Legislature wants to ensure that its appropriations are used to provide services to adults with SMI, it

may wish to consider limits on the use of these monies similar to the limits established on appropriations for children’s behavioral health programs.

SMI monies have been used to deliver services for other consumers—The Division allows ValueOptions to use revenues allocated for adults with SMI to be used to support or make up for losses in other programs. The Legislature has increased appropriations for services to adults with SMI in the past several years, although appropriations dropped from fiscal year 2004 to fiscal year 2005 (see Figure 6). Specifically, the Legislature increased its appropriations by approximately 119 percent between fiscal years 2002 and 2007. These monies include appropriations intended to address requirements of the *Arnold v. Sam* lawsuit.

Figure 6: Legislative Appropriations for Behavioral Health Services for Adults with SMI Fiscal Years 2002 through 2007



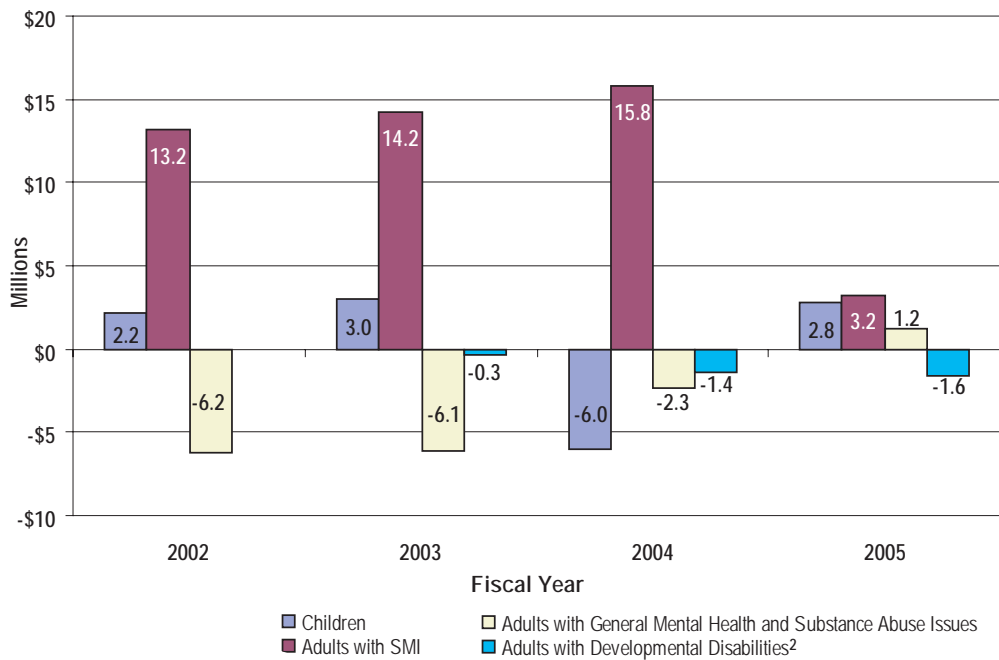
Source: Auditor General staff analysis of appropriations reports for fiscal years 2002 through 2007 prepared by the Joint Legislative Budget Committee.

Because neither statute nor the Division’s contract with ValueOptions restricts the use of monies allocated or appropriated to serve adults with SMI, the monies can be used to fund services for other populations. By contract, starting in fiscal year 2005, the Division allows ValueOptions to earn up to 4 percent profit on service revenue within each major program—Medicaid, KidsCare, and other contract monies. Within each of these major programs, though, ValueOptions can use SMI monies for other categories within the same program. For example, it can use SMI Medicaid funds for other Medicaid funding categories, such as children’s programs or adult substance abuse programs. Auditors reviewed the Division’s analyses of ValueOptions’ profits and losses for fiscal years 2002 to 2005 and found that some revenues the Division allocated to ValueOptions to pay for services for adults with SMI were used to make up losses in other programs, as allowed by contract. Specifically, in fiscal year 2002, ValueOptions used \$7.5 million of Medicaid and KidsCare SMI monies to make up losses in other Medicaid and KidsCare programs, including programs for children, adult general mental health, and substance abuse. Similarly, ValueOptions used \$6.9 million of Medicaid and KidsCare SMI monies in fiscal year 2003 and \$7 million in fiscal year 2004 for these programs. In fiscal year 2005, ValueOptions did not use SMI monies to offset losses in other programs.

Neither statutes nor contract provisions restrict the use of monies appropriated for adults with SMI.

In addition to using adult SMI monies to offset other programs’ losses, ValueOptions has used these monies disproportionately to earn its allowed profits. As illustrated in Figure 7 (see page 38), ValueOptions used net income it earned from its SMI Medicaid program to offset other Medicaid program losses, as allowed by contract. The most significant offset occurred in fiscal year 2004, when it used \$15.8 million

Figure 7: ValueOptions' Medicaid Programs Losses and Profits¹
 In Millions of Dollars
 Fiscal Years 2002 through 2005
 (Unaudited)



1 Figure does not include other funding sources, specifically KidsCare and other contract monies.

2 ValueOptions receives Medicaid monies to provide behavioral health services to adults with developmental disabilities, including adults with SMI. These monies were included in the children and adults with SMI programs in fiscal year 2002.

Source: Auditor General staff analysis of the Division's profits/risk corridor analysis for ValueOptions for fiscal years 2002 through 2005.

from SMI Medicaid monies to offset \$9.7 million in losses in other Medicaid programs. ValueOptions had losses totaling \$6 million in its children's Medicaid programs and \$3.7 million in non-SMI adult Medicaid programs that year. Still, it earned approximately \$6.1 million in total profit from all Medicaid programs, which includes \$6.0 million in service revenue, representing 2.17 percent of Medicaid service revenue. This was below the fiscal year 2004 contractually allowed profit of 5 percent. However, the profit came entirely from Medicaid SMI monies because all other programs incurred losses. In fiscal year 2005, ValueOptions did not use SMI Medicaid monies to offset losses in other Medicaid programs, as it had in previous years.

Given that the Legislature has increased funding to provide more services and meet requirements associated with the *Arnold v. Sarn* lawsuit (see Appendix A), the Division should consider limiting the use of monies allocated for adults with

SMI. Specifically, the Division should consider a contract provision that would limit using monies allocated to fund programs for adults with SMI to make up for losses in other programs. A contractual requirement limiting the use of SMI monies would restrict ValueOptions' ability to manage behavioral health services because it would not be able to transfer money between programs. However, the Division would still maintain the ability to transfer monies among programs to meet unexpected needs or demands.

If the Legislature wants to ensure its adult SMI appropriations are used to provide services only to adults with SMI, it may wish to consider statutorily limiting the use of these monies similar to the limits it has placed on appropriations for children's programs. In 2000, the Legislature enacted A.R.S. §36-3410, which limits the use of appropriated monies for children's behavioral services to be used as intended by their appropriation. Thus, the Division's contract with ValueOptions establishes that any excess profits in children's programs may not be used to offset losses in programs for adults, including adults with SMI. Instead, these excess monies must be returned to the Division within 12 months after the end of the fiscal year. As the Legislature considers whether to similarly restrict adult SMI monies, it should consider the impact this tighter control may have on other programs. Specifically, imposing this statutory limit would reduce ValueOptions' and the Division's flexibility to manage behavioral health services and use available monies to meet unexpected needs.

Recommendations:

1. To better ensure monies are spent appropriately, the Division should consider expanding the current compliance audit requirement to include all program monies. If the Division determines a compliance audit is needed, it should:
 - a. Determine which requirements and standards are most important to it and should be included as part of a contractually required audit;
 - b. Develop contract provisions that would require auditing nonfederal program monies against those requirements; and
 - c. Review the results of these audit reports and take action when appropriate.
2. The Division should consider a contract provision that would limit the Maricopa County RBHA's ability to use SMI monies for other programs. As the Division considers this option, it should consider the impact this contract limit would have on the RBHA's ability to manage other programs.
3. The Legislature may wish to consider statutorily limiting monies appropriated for adults with SMI to be used only for this population. As the Legislature considers this option, it should consider the impact on other behavioral health programs.

FINDING 4

Better oversight needed of service level provided

The Division should take steps to strengthen its contractual requirements in order to better ensure that ValueOptions delivers sufficient services to adults with SMI. The Division's contract with ValueOptions requires ValueOptions to deliver services that equal at least 85 percent of the service revenues it receives from the Division. However, although ValueOptions establishes service values in its contracts with its subcontractors, the Division's contract with ValueOptions allows ValueOptions to assign its own values to the services it delivers. Because the Division does not approve the reasonableness of service values, this requirement does not achieve its intended purpose. Auditors' analysis of the values submitted by ValueOptions shows that these values were often far higher than amounts that subcontractors submitted or amounts allowed in a fee schedule that the State uses when it pays providers on a fee-for-service basis. As of July 1, 2006, the Division has drafted revisions to its *Financial Reporting Guide* that would make its monitoring more meaningful. To ensure that sufficient services are provided, the Division needs to continue its efforts to establish a process for ValueOptions to follow when assigning cost values to services.

Data used to monitor services and determine funding needs

Under managed care, state-level monitoring is based on data submitted by providers.¹ The Division uses service data—also called encounters or encounter data—to help analyze service usage, determine funding needs, and monitor services. For example:

- **Analyzing use of services**—The Division analyzes encounter data to compare service delivery among RBHAs and against state-wide averages.² Through these comparisons, the Division determined that during fiscal year 2005, several

Encounter—Record of a service delivered to a consumer by a provider. Includes specifics about the type and date of service, provider that delivered the service, and dollar value of the service.

¹ Wooldridge, Judith and Sheila D. Hoag. Perils of Pioneering: Monitoring Medicaid Managed Care. *Health Care Financing Review*, Winter 2000. 61-83.

² The Division established a state-wide average based on a study completed by Intelligent Healthcare, LLC, for the California Healthcare Foundation. The average was determined by taking a cumulative state-wide average over fiscal years 2002 to 2004. Also, upper and lower control limits were derived based on six sigma analyses. If the RBHA falls above or below control limits, that particular RBHA is considered to be using particular services more or less than the average.

services delivered to adults with SMI in Maricopa County were used more than state-wide averages. Specifically, support services, including case management, and behavioral health day programs, were used more than the average. In contrast, rehabilitation, medical, residential, inpatient, crises intervention, and treatment services were used less than the average. Pharmacy services were close to but slightly under the state-wide average.

- **Setting payment levels for contractors**—Encounter data helps set future capitation rates. The Department of Health Services hires consultants to develop separate behavioral health capitation rates for the Medicaid-eligible and KidsCare eligible populations that it serves. To determine actuarially sound Medicaid capitation rates for fiscal year 2006, for example, a consultant analyzed encounter data from fiscal year 2002 through the first 6 months of fiscal year 2005.¹
- **Ensuring sufficient services are provided**—The Division’s contracts with the RBHAs require them to submit encounters whose total value equals at least 85 percent of service revenue, which translates to 78.6 percent of the total contract revenues. For example, based on ValueOptions’ contract revenues of \$489.4 million in fiscal year 2005, the Division’s contract with ValueOptions

requires ValueOptions to submit encounters with a total value of at least \$384.8 million (see text box). Because RBHAs are paid in advance on a monthly basis for the services they are to deliver rather than being paid for services after delivery, division oversight of the services they provide is critical. A division official explained that the 85 percent service level requirement helps ensure that services are delivered and that the RBHA submits data regarding the services it provides. If the RBHA does not meet the requirement, the Division can withhold payments.

Example of Division’s encounter value requirement in Maricopa County RBHA Contract (fiscal year 2005)

Contract revenue	\$489.4 Million
7.5% administration	<u>-\$36.7 Million</u>
Service revenue	\$452.7 Million
85% of service revenue	\$384.8 Million

Encounter data is not used to determine compliance with profit limitations or requirements related to total spending on services. Actual costs are used to determine compliance with profit and spending requirements.

Monitoring system does not achieve its intended purpose

The Division’s service level monitoring requirement does not achieve its intended purpose because the Division does not approve the reasonableness of the service values submitted by ValueOptions.² The requirement is met when ValueOptions delivers service units whose values total a percentage of contract revenues.

RBHAs can set their own values for the services provided.

¹ To help ensure the Medicaid capitation rates are reliable, consultants also use financial reports when establishing the basis of capitation rates. They use the lower values of either those reported in service encounter data or expenditures reported in financial reports. After determining a base rate, they adjust it based on various factors such as program changes.

² This same requirement is included in the Division’s contracts with the RBHAs that serve other areas of the State.

However, the contract allows ValueOptions to set its own values for the services provided, and the Division does not approve their reasonableness. Auditors found wide variations in the values assigned by ValueOptions as compared to the values for the same services provided by its subcontractors and the State's fee-for-service schedule. As of July 1, 2006, the Division has drafted revisions to its *Financial Reporting Guide* that would change its method of determining whether the requirement has been met. The Division should continue its efforts to improve its monitoring of service reporting.

Service requirement is not meaningful—Because the contract allows ValueOptions to assign the values to the encounters it submits without the Division's approving the reasonableness of the service values, ValueOptions could meet the minimum service requirement regardless of the amount of services it provides. ValueOptions establishes service values in its contracts with its subcontractors and reports these values for the services the subcontractors deliver. However, the Division's contract with ValueOptions allows ValueOptions to assign its own value for each of the services it delivers. The Division does not establish or approve the value of the services ValueOptions delivers. Auditors compared the values that ValueOptions assigned to several services it provided during fiscal year 2005 (case management, family counseling, group self-help and peer support, and group skills training and development) with the values that ValueOptions established with its subcontractors and the fee schedule approved by AHCCCS for fee-for-service payments for the same services. The AHCCCS-approved schedule is developed through a division contract with a consultant who develops fiscally sound behavioral health service rates.¹ This schedule is used to pay for services of providers that are compensated under a fee-for-services arrangement instead of receiving payments on a capitated basis.

These comparisons showed that ValueOptions often assigned values for its services higher than the values for the same types of services provided to adults with SMI by its subcontractors or the fee-for-service schedule (see Table 4, page 44). For example:

- **In-office case management by behavioral health technicians**—For fiscal year 2005, auditors analyzed a subset of ValueOptions' submitted encounters with approximately 241,411 hours of this service.² Approximately 80 percent of these encounters were valued at \$62. By comparison, a ValueOptions case manager's salary is approximately \$14 per hour, indicating the total cost of delivering the service is likely \$25.40 per hour.³ Further, ValueOptions increased the value of this

¹ ValueOptions officials reported that they have concerns about the methodology used to determine these rates, including concerns about the supervision and productivity assumptions and the overhead rate.

² Auditors analyzed encounters where the service was delivered in fiscal year 2005, the service was delivered to a consumer designated as SMI, the Division's computer system had received the record by November 2005 and marked the record approved, and the type of service was listed on AHCCCS' fee schedule with a rate that was updated as of July 15, 2005.

³ Auditors adjusted the hourly wage to account for factors that affect the cost of delivering case management services, consistent with the assumptions used by AHCCCS consultants when determining fiscal year 2006 case management fees. Specifically, to determine the fee-for-service rate for that service, the Division's consultant started with an hourly wage of \$18.38 and then added employee-related expenses, supervision, time allocated to writing notes, and other costs including 10 percent administration to calculate the recommended rate of \$32.55 per hour, approximately 1.77 times the hourly wage. As shown on Table 4 (see page 44), this is slightly higher than the AHCCCS-adopted rate for fiscal year 2006.

Table 4: Comparison of Selected Hourly Encounter Values Between ValueOptions, ValueOptions' Subcontractors, and AHCCCS Fee-for-Service Schedule Fiscal Year 2005

Service Description and Location				ValueOptions ¹				ValueOptions' Subcontractors				AHCCCS
				Mode ²		High Value		Mode ²		High Value		Hourly Fee ³
	IN OFFICE	OUT OFFICE	HOME	Hourly Rate	Service Hours	Hourly Rate	Service Hours	Hourly Rate	Service Hours	Hourly Rate	Service Hours	Hourly Fee ³
Case Management												
Technician	•			\$ 62.00	196,525	\$150.00	24,883	\$ 62.00	16,266	\$ 77.52	27	\$ 32.00
Technician		•		112.88	42,540	150.00	4,252	70.00	10,866	87.52	32	46.00
Technician			•	112.88	25,196	150.00	3,786	70.00	5,479	87.52	13	46.00
Professional			•	138.00	8,013	150.00	183	92.00	1,264	115.00	19	104.00
Family counseling and therapy without client	•			296.00	606	296.00	606	80.00	57	80.00	57	94.00
Group self-help/peer support			•	13.52	5	13.52	5	9.00	1,594	35.20	445	8.00
Group skills training and development	•			15.00	3,968	32.00	6	12.00	23,193	21.20	3,933	8.00

¹ The values for ValueOptions reflect encounters submitted and are used to determine compliance with the Division's contractual requirement related to delivery of sufficient services. They are not used to determine compliance with profit limitations or requirements related to total spending on services.

² Mode is the most frequent service value.

³ These fees were developed by an independent actuary to be in effect starting July 15, 2005.

Source: Auditor General staff analysis of service data (encounters) submitted by ValueOptions and approved by the Division's Client Information System (CIS) for services delivered to consumers designated as SMI during fiscal year 2005 as of November 2005, and *ADHS/BHS Allowable Procedure Code Matrix* approved by AHCCCS effective September 1, 2005.

service to \$150 per hour near the end of the year and the subset of encounters analyzed included submitted encounters with 24,833 hours showing this higher value. In comparison, the AHCCCS fee schedule, which is used to pay fee-for-service providers like tribal RBHAs for this service, shows a value of \$32 per hour, and ValueOptions' subcontracted service providers valued this service at a maximum of \$77.50 per hour. Most subcontractors valued it at a lower amount.

- **In-home case management by behavioral health technicians**—For fiscal year 2005, auditors analyzed a subset of ValueOptions' submitted encounters with approximately 30,559 hours of this service. More than 82 percent of them were valued at \$112.88 per hour. ValueOptions also increased the value of this service to \$150 per hour later in the year. In comparison, the AHCCCS fee for this service is \$46 per hour, and ValueOptions' subcontracted service providers valued it at \$87.50 per hour or less.

Collectively, these differences have a sizeable effect. Using the AHCCCS fee-for-service schedule, auditors calculated the amount ValueOptions would have been able to report for selected services covered in the analysis.¹ In total, the services would have been valued at \$16.9 million using the AHCCCS schedule, compared to \$33.7 million that ValueOptions submitted. Thus, ValueOptions valued its services approximately 99 percent higher than what the services would have been under the AHCCCS schedule. Results would also change, though not to the same degree, if subcontractors had been limited to the AHCCCS amounts. ValueOptions' subcontractors' encounter values submitted for fiscal year 2005 totaled \$5.6 million, approximately 35.2 percent higher than the \$4.2 million they would have been valued at using the AHCCCS schedule.

ValueOptions officials offered an explanation of why they valued their services at higher amounts, but this explanation may not fully explain the difference. They explained that under a 1998 agreement associated with the *Arnold v. Sam* lawsuit, the Division was required to develop a strategic plan for case management, and the plan specifies ValueOptions' clinical staffing structure. The structure includes case managers with caseloads of 30 consumers, clinical liaisons who each supervise 3 case managers, and other case management team members such as rehabilitation specialists. However, the differences appear too large for the staffing model to explain. Without an analysis of costs, it is impossible to determine if this explanation is valid. Because the Division does not establish or approve the reasonableness of the service values submitted by ValueOptions, the Division does not know whether the service values are reasonable in light of ValueOptions' costs.

Division should continue efforts to improve service data monitoring—

Because ValueOptions, like other RBHAs, is allowed to set the value of its encounters, the 85 percent requirement does not serve its intended purpose. To make the requirement effective, the Division has drafted changes to its *Financial Reporting Guide*. The July 1, 2006, draft states that the Division will use AHCCCS' approved fee schedule to value all encounters submitted by the RBHAs, including the services the RBHAs provided directly as well as those provided by their subcontractors, in order to determine if the 85 percent requirement has been met. Division management reported that they are considering further revisions, such as adding a set percentage to the AHCCCS-approved fee schedule for the purpose of valuing encounters, because the fee schedule may not fully reflect the market dynamics from one region to another. The Division should continue its efforts to improve the effectiveness of monitoring encounter data. Using encounter values based on the AHCCCS-approved fee schedule may be the simplest approach. However, because it is not based on an analysis of ValueOptions' costs, it may not accurately reflect the true value of services. The Division should consider requiring ValueOptions to develop a fiscally sound encounter value schedule and submit it for review and approval, and using this schedule to determine if the requirement has been met.

The Division should continue efforts to improve monitoring effectiveness.

¹ Auditors' analysis included encounters for services delivered during fiscal year 2005 that were submitted to the Division as of November 2005. In addition, auditors analyzed encounters approved by the Division with fees that were updated and approved by AHCCCS for fiscal year 2006.

In addition, the Division should consider increasing the encounter submission requirement to mirror service expenses. As described in Finding 3 (see pages 31 through 40), the Division sets minimum spending levels for services at 88.5 percent of program revenues. This requirement was developed to help ensure that an adequate level of services is provided. The 85 percent requirement for service submission was established several years ago. Current division management explained that some flexibility is necessary to allow ValueOptions to maintain readiness to provide some services, such as crisis transport, that may be rarely used but must be available. However, they could not explain why the requirement was set at 85 percent. To ensure that an adequate percentage of contract revenues are used to deliver services and it receives encounter data, the Division should determine an appropriate level for the minimum encounter submission requirement and modify its *Financial Reporting Guide* accordingly.

Recommendations:

1. The Division should continue its efforts to better ensure that sufficient services are delivered by modifying its *Financial Reporting Guide* to identify a fee schedule to be used in valuing encounters to determine whether the minimum requirement has been met. For example, it could use the AHCCCS-approved fee schedule or an adjusted value based on the AHCCCS-approved schedule, or require ValueOptions to develop a fiscally sound method to develop a schedule of encounter values and submit the schedule for Division approval.
2. The Division should:
 - a. Determine an appropriate level for the minimum encounter submission requirement; and
 - b. Modify its *Financial Reporting Guide* accordingly.

OTHER PERTINENT INFORMATION

As part of the audit, auditors gathered other pertinent information regarding ValueOptions' administrative expenses associated with its Arizona operations. As Table 5 shows, in fiscal year 2005, ValueOptions' overall administrative expenses

Table 5: ValueOptions' Schedule of Administrative Expenses By Category
Fiscal Year 2005
(Unaudited)

Salaries and employee-related		\$12,651,649
Corporate allocations ¹		10,676,768
Professional and outside services:		
Medical malpractice and legal ²	4,063,771	
Other	<u>3,037,114</u>	
		7,100,885
Business meals		170,392
Other operating:		
Depreciation	1,219,418	
Building and equipment rental	1,035,599	
Insurance	738,826	
Penalties	678,273	
Repairs and maintenance	509,768	
Utilities	409,524	
Recruiting	317,337	
Supplies	281,416	
Printing	190,800	
Contributions	154,684	
Conferences and conventions	135,680	
Postage	78,173	
Other	<u>610,236</u>	
		6,359,734
Office equipment		<u>244,225</u>
Total expenses		<u>\$37,203,653³</u>

¹ According to ValueOptions, this amount includes allocated costs for services provided by its parent and affiliated companies, including payroll processing, system support, and accounts payable.

² According to ValueOptions, medical malpractice and legal expense consists of estimated and actual expenditures related to malpractice claims, settlements, their associated legal defense and other legal fees. ValueOptions is self-insured, but purchases stop-loss insurance to mitigate medical malpractice claims exposure.

³ Administrative costs allocated to revenues from ValueOptions' contract with the Division totaled \$36,778,797. This substantially complied with the Division's contractual requirement limiting administrative expenses to 7.5 percent of each type of contract revenue (Medicaid, KidsCare, and Other).

Source: Auditor General staff analysis of an electronic file obtained from ValueOptions containing financial statement data for fiscal year 2005.

totaled approximately \$37.2 million. Its administrative costs associated with its Division contract totaled \$36.8 million, and substantially complied with the Division's contractual requirement limiting administrative expenses to 7.5 percent of each type of contract revenue (Medicaid, KidsCare, and Other). The largest category of ValueOptions' administrative expenses was salaries and employee-related expenses, totaling approximately \$12.7 million. These expenses include salaries, employee-related insurance, incentives and allowances, and temporary staff. The second largest category, corporate allocations, totaled approximately \$10.7 million. ValueOptions reports that these expenses are for services provided by their parent company and other affiliates to ValueOptions, including information system functions, accounts payable, and payroll processing. The third largest category, professional and outside services, totaled over \$7.1 million, and includes legal, consulting, training, accounting, and auditing services. ValueOptions' total administrative expenses included \$19.9 million associated with delivering services for adults with SMI (see Introduction and Background, Table 2, page 5 for a description of ValueOptions' SMI administrative expenses).

APPENDIX A

Appendix A *Arnold v. Sarn* Selected Events

- Prior to 1980** Nation-wide, state hospitals discharge patients with mental illness for whom hospitalization or institutionalization is not appropriate. Arizona state hospital yearly admissions drop from a high of 1,443 in fiscal year 1970 to 552 by 1983.
- 1980** Legislature finds the existing mental health system does not provide sufficient rehabilitation programs to enable these individuals to remain in the community and function at their optimal level, and as a consequence, they often become isolated and neglected. Legislature enacts A.R.S. §36-550 establishing a community mental health residential treatment system.
- 1981** Public fiduciary Charles Arnold files suit on behalf of people with SMI in Maricopa County, alleging that the State and county do not comply with the new law.
- 1986** Superior Court finds on behalf of the plaintiffs.
- 1989** Arizona Supreme Court affirms the finding, saying, "We write today from the bottom rung of the ladder. The record before us demonstrates that Arizona is last among the states of this union in providing care and treatment for its indigent chronically mentally ill. Arizona has imprisoned its CMI in the shadows of public apathy. The Legislature was the first to speak on the issues before us."
- 1991** Superior Court appoints a court monitor to oversee compliance with the court order. The parties stipulate, with court approval, *The Blueprint: Implementing Services to the Seriously Mentally Ill*, a plan for fully implementing the court's judgment by September 30, 1995. The Blueprint declares principles for treatment and consumers' rights; defines service types; mandates an administrative structure, including a single case-management agency for the county; and specifies other requirements such as training, a data system, a quality assurance system, and efforts to seek funding for the comprehensive system of care.
- 1995** Deadline for implementing the Blueprint passes. The parties agree upon a new Exit Stipulation that sets out terms for fully satisfying the lawsuit, including deadlines for achieving specific goals. The Exit Stipulation requires the court monitor to monitor all unsatisfied terms.
- 1998** Plaintiffs allege a pattern of noncompliance, and a Supplemental Agreement is developed, requiring the Department of Health Services to create strategic plans for vocational services, case management, housing, and dual diagnosis (mental illness and substance abuse), and to hire Human Services Research Institute to determine services necessary to meet class member needs. The court monitor is to conduct annual reviews of efforts, activities, and compliance.
- 1999–2003** Department implements requirements of Supplemental Agreement.
- 2004** Court monitor issues report finding substantial noncompliance with requirements of the Exit Stipulation.
- 2005** Court monitor issues report finding some improvement, but continued noncompliance with the requirements. Plaintiffs file Motion for Noncompliance. In November, parties issue a new Joint Stipulation requiring the Department to establish mentor teams at ValueOptions clinics, hire Boston University experts to provide training, and complete a targeted network capacity analysis. In addition, parties agree to an expert review of the court monitor's review process.

AGENCY RESPONSE

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JANET NAPOLITANO, GOVERNOR
SUSAN GERARD, DIRECTOR

September 22, 2006

Debra K. Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85008

Dear Ms. Davenport:

The Arizona Department of Health Services (ADHS) has reviewed the draft of the Behavioral Health Services for Adults with Serious Mental Illness in Maricopa County performance audit report. ADHS appreciates the audit team's thoughtful and thorough evaluation.

ADHS agrees with the audit findings and, in fact, has already begun to make considerable progress on many of the areas described.

The Division of Behavioral Health Services (the Division), within ADHS, will be or has begun implementing the recommendations presented in the report as follows:

Finding 1, SMI monies fund a diverse range of services in Maricopa County

The audit report outlined no recommendations.

Finding 2, Division should strengthen focus on outcomes

Recommendations:

1. The Division should continue its implementation of the Boston University training program by monitoring the RBHA's compliance with the recovery model and ensuring that the Maricopa County RBHA:
 - a. Continues to train clinical leadership and staff; and
 - b. Maintains the training principles in service planning and clinical practices.

Agency Response:

The finding of the Auditor General is agreed to, and the audit recommendation will be implemented in ongoing efforts to ensure that clients not only receive appropriate treatment, but also make progress towards recovery.

2. The Division should incorporate measurement of consumer outcomes into its oversight mechanisms by:
 - a. Using the results of its quality management plan pilot test, as well as the measures used in the HB2003 program and by SAMHSA, to define outcome goals and develop appropriate outcome measures;
 - b. Continuing to incorporate these measures into the Division's quality management plan and RBHA contract;
 - c. Continuing to tie a portion of the RBHA's profit to achieving agreed-upon performance outcomes;
 - d. Ensuring that an information management system exists to properly collect accurate, outcome data that can be used to reliably measure recovery outcomes; and
 - e. Requiring the RBHA to demonstrate that it has an adequate information technology system to collect, report, and validate agreed-upon outcome data.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented in ongoing efforts to effectively utilize outcome measurements in the treatment of individuals with serious mental illness.

3. The Division should consider renegotiating measures of improvement in the court orders arising from the Arnold vs. Sarn lawsuit by:
 - a. Determining which court mandates focus on process rather than outcomes and inhibit full implementation of an outcome-oriented model; and
 - b. Discussing this with the plaintiffs and working to modify the provisions.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented in ongoing efforts to negotiate terms and court orders that are outcome-oriented and designed to measure meaningful progress.

Finding 3, Division can improve financial oversight and limit use of monies

Recommendations:

1. To better ensure monies are spent appropriately, the Division should consider expanding the current compliance audit requirement to include all program monies. If the Division determines a compliance audit is needed, it should:
 - a. Determine which requirements and standards are most important to it and should be included as part of a contractually required audit;
 - b. Develop contract provisions that would require auditing nonfederal program monies against those requirements; and
 - c. Review the results of these audit reports and take action when appropriate.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Division presently exceeds current audit requirements in ongoing efforts to ensure monies are being used properly. The Division requires an A-133 audit of ValueOptions, even though such audits are not required of for-profit organizations. This audit is performed in compliance with OMB Circular A-133, and establishes audit requirements for nonprofit organizations receiving Federal awards. The Division will expand its auditing requirements by requiring stringent audits similar to A-133 for all funding sources.

2. The Division should consider a contract provision that would limit the Maricopa County RBHA's ability to use SMI monies for other programs. As the Division considers this option, it should consider the impact this contract limit would have on the RBHA's ability to manage other programs.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Division will establish criteria requiring agency approval for use of SMI monies for other programs.

3. The Legislature may wish to consider statutorily limiting monies appropriated for adults with SMI to be used only for this population. As the Legislature considers this option, it should consider the impact on other behavioral health programs.

Agency Response:

This recommendation is not directed at ADHS.

Finding 4, Better oversight needed of service level provided

Recommendations:

1. The Division should continue its efforts to better ensure that sufficient services are delivered by modifying its Financial Reporting Guide to identify a fee schedule to be used in valuing encounters to determine whether the minimum requirement has been met. For example, it could use the AHCCCS-approved fee schedule or an adjusted value based on the AHCCCS-approved schedule, or require ValueOptions to develop a fiscally sound method to develop a schedule of encounter values and submit the schedule for Division approval.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. As noted in the report, the Division is already working to improve the effectiveness of monitoring encounter data by issuing a change in the Financial Reporting Guide

for the Regional Behavioral Health Authorities to value encounters beginning July 1, 2006. Additionally, the Division is developing guidelines for the encounter oversight process by establishing controls for reasonableness in the encounter system and will adjust policies, procedures and contracts as needed.

2. The Division should:
 - a. Determine an appropriate level for the minimum encounter submission requirement; and
 - b. Modify its Financial Reporting Guide accordingly.

Agency Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented. The Division continues to work towards improving the effectiveness of monitoring encounter data.

Again, thank you for the comprehensive review. I especially appreciate that the team recognized the commitment that ADHS has already shown in addressing many of these findings. I can assure you that continued implementation of these recommendations is a high priority for my staff and myself.

Sincerely,

Susan Gerard
Director

Performance Audit Division reports issued within the last 24 months

04-08	Department of Environmental Quality—Sunset Factors	05-08	Department of Economic Security—Sunset Factors
04-09	Arizona Department of Transportation, Motor Vehicle Division—State Revenue Collection Functions	05-09	Arizona State Retirement System
04-10	Arizona Department of Transportation, Motor Vehicle Division—Information Security and E-government Services	05-10	Foster Care Review Board
04-11	Arizona Department of Transportation, Motor Vehicle Division—Sunset Factors	05-11	Department of Administration—Information Services Division and Telecommunications Program Office
04-12	Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers	05-12	Department of Administration—Human Resources Division
05-L1	Letter Report—Department of Health Services—Ultrasound Reviews	05-13	Department of Administration—Sunset Factors
05-01	Department of Economic Security—Division of Employment and Rehabilitation Services—Unemployment Insurance Program	05-14	Department of Revenue—Collections Division
05-02	Department of Administration—Financial Services Division	05-15	Department of Revenue—Business Reengineering/Integrated Tax System
05-03	Government Information Technology Agency (GITA) & Information Technology Authorization Committee (ITAC)	05-16	Department of Revenue Sunset Factors
05-04	Department of Economic Security—Information Security	06-01	Governor’s Regulatory Review Council
05-05	Department of Economic Security—Service Integration Initiative	06-02	Arizona Health Care Cost Containment System—Healthcare Group Program
05-06	Department of Revenue—Audit Division	06-03	Pinal County Transportation Excise Tax
05-07	Department of Economic Security—Division of Developmental Disabilities	06-04	Arizona Department of Education—Accountability Programs
		06-05	Arizona Department of Transportation—Aspects of Construction Management
		06-06	Arizona Department of Education—Administration and Allocation of Funds
		06-07	Arizona Department of Education—Information Management
		06-08	Arizona Supreme Court, Administrative Office of the Courts—Information Technology and FARE Program

Future Performance Audit Division reports

Board of Fingerprinting