

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

Report to the Arizona Legislature
By the Auditor General
November 1989
89-10

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November 8, 1989

Members of the Arizona Legislature
The Honorable Rose Mofford, Governor
Mr. Ted Williams, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Health Services, Division of Behavioral Health. This report is in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. The performance audit was conducted as a part of the Sunset Review set forth in Arizona Revised Statutes §§41-2351 through 41-2379.

The report addresses the fragmentation between State and county behavioral health programs and the need for an integrated, statewide system. The report also identifies deficiencies in the division's contract monitoring and also suggests improvements in contracts and allocation of funds.

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

Sincerely,



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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379. This is the seventh in a series of reports issued on the Department of Health Services.

The Division of Behavioral Health Services is comprised of three program service units: the Office of Community Behavioral Health Services, the Arizona State Hospital, and the Southern Arizona Mental Health Center. The Office of Community Behavioral Health Services (OCBHS) is responsible for overseeing the delivery of community-based behavioral health services, and overseeing contract funds, and contract development and monitoring. The Arizona State Hospital (ASH) located in Phoenix is responsible for providing inpatient treatment services, and the Southern Arizona Mental Health Center (SAMHC) located in Tucson provides mental health services including outpatient and residential treatment, and prevention programs. This audit focuses on the Office of Community Behavioral Health Services and the delivery of community-based behavioral health services. (See report #89-9 for a performance audit report on the Arizona State Hospital.)

Integration of State and County Behavioral Health Programs Is Needed (see pages 7 through 15)

The State and counties of Arizona operate separate community-based behavioral health programs, which may result in costly duplication and, in some cases, poor client service. In total, counties spent approximately \$24 million on community-based behavioral health services in FY 1988. Four counties - Maricopa, Pima, Yuma, and La Paz - accounted for 90 percent of total county expenditures and they play a major role in the delivery of community-based services. For example, Maricopa County spent \$12.2 million for services in FY 1988. The county operates a 66-bed psychiatric facility at its health center and dedicates 120 beds for mental healthcare in its correctional health program. Pima County spent \$8.7 million for behavioral health services in FY 1988. It

maintains a 36-bed psychiatric unit in the county hospital, a 16-bed residential care facility, and a 47-bed psychiatric unit in the county jail. By contrast, DHS spent \$35.5 million statewide on community-based services in FY 1988.

Although substantial in size, county programs are poorly coordinated with the State system. DHS contracts for service delivery and oversight with private, nonprofit organizations called administrative entities. Entities have not consistently involved counties in assessing needs, planning programs, or delivering services, and only two counties are represented on entity boards. This lack of coordination has resulted in a fragmentation of services which can impact clients adversely. For example, one client suffering from depression was shuffled back and forth multiple times between a state-funded provider and the county, and did not get the needed treatment from either system.

An integrated State system with a single authority and funding stream is needed. Rather than operate a county-based system as done in some other states, Arizona may wish to consider developing a state-run behavioral health program as it did with indigent medical care. A single state-run system would benefit the counties and eliminate the costly overlap and duplication which now exist.

DHS Is Not Adequately Monitoring the Performance of Administrative Entities (see pages 17 through 23)

Because DHS has not monitored administrative entity performance effectively, significant deficiencies have not been identified and problems have not been fully addressed. For example, allegations that an entity official used staff, clients, and materials to repair his home, and that clients were being overcharged and poorly treated were only superficially investigated. In a previous review by DHS, the same administrative entity was unable to show that it had provided more than \$150,000 worth of services for which the State had paid. However, DHS never pursued recovery of the \$150,000 it claimed the administrative entity owed the State.

We found that DHS is not following its own established monitoring procedures. In fiscal year 1988 the department did not conduct annual

site visits of each administrative entity as required, and in fiscal years 1988 and 1989 it did not complete site visit reports in a timely manner. Most site visit reports, moreover, do not address important contract requirements. In addition, DHS is not checking sufficient numbers of client records to verify that services have been provided.

Changes in Contracts Could Result in Improved Services (see pages 25 through 30)

DHS could strengthen contract provisions to more effectively ensure delivery of quality services. Entity contracts currently do not target services to those most in need. The contracts contain few specific definitions of persons qualified to receive behavioral health services. Instead, contracts spell out the types and number of units of services to be provided. This can result in two problems. First, services may be provided to those who present themselves for services, not necessarily those most in need. Second, since payment is based on contractually established units of service (e.g., alcohol treatment), an administrative entity may direct its efforts toward filling those units to avoid losing payments. Yet those services may not be the most needed.

In contrast, Colorado, which has developed a nationally recognized performance contracting system, defines the target population which provider agencies must serve. For FY 1990, Colorado's target population consists of the most seriously mentally ill, children, elderly, and minorities. Specific definitions of each target population are spelled out in the contracts.

DHS' contract provisions could also be improved in two other areas. First, administrative entity contracts do not contain penalty provisions to enable the State to effectively enforce contractual requirements. Second, contracts currently do not require entities to establish quality assurance programs. Quality assurance is needed to make certain that clients receive appropriate services and that services are not over- or underutilized. Again in contrast, Colorado has specific penalty provisions in its contracts as well as requirements that funded agencies perform quality assurance.

DHS Could Improve Its Methods of Allocating Funds by Basing Funding More on Needs Assessments (see pages 31 through 37)

DHS should consider modifying its methods of allocating funds to ensure that limited resources are dedicated to those most in need of behavioral health services. To address disparities in regional funding which existed at the time the administrative entity system was created, DHS has used a formula (for alcohol and drug treatment, and general mental health services) and a comprehensive plan (principally for chronically mentally ill services) to allocate funds and achieve parity. Both methods of allocating funds rely heavily on population, and less on social indicators of need.

Greater use could be made of both direct and indirect measurements of need. For example, DHS could use such factors as income levels, employment, ethnicity, gender, age, divorce rates, and other social indicators to estimate the need for services within each region. The National Institute of Mental Health (NIMH) reports that such indirect indicators provide a valid, reliable, and comparatively low-cost way to estimate service requirements. At least two states, New Jersey and Minnesota, are currently using indirect measures to allocate portions or all of their behavioral health funding.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379. This is the seventh in a series of reports issued on the Arizona Department of Health Services (DHS).

The Division of Behavioral Health Services is comprised of three program service units: the Office of Community Behavioral Health Services (OCBHS), which is responsible for overseeing the delivery of community-based behavioral health services, and overseeing contract funds, and contract development and monitoring; the Arizona State Hospital (ASH) located in Phoenix, which is responsible for providing inpatient treatment services; and the Southern Arizona Mental Health Center (SAMHC) located in Tucson, which provides behavioral health services including outpatient and residential treatment, and prevention programs. This audit will not address the operations of ASH or SAMHC but rather will focus on the Office of Community Behavioral Health Services and the delivery of community-based behavioral health services. (See report #89-9 for a performance audit report of the State Hospital.)

Community-Based Care

The concept of community-based mental health programs grew nationally in the 1960s. The development of psychotropic medicines and court decisions affirming individual freedom and the right to treatment in the least restrictive setting contributed to the trend of deinstitutionalizing patients of state mental hospitals.⁽¹⁾ Rather than isolating persons with mental illness in state institutions, the goal was to meet their needs in the community. Arizona responded with legislation in 1980 with the intent of establishing "a statewide system of residential services and adequate treatment for the chronically mentally ill in the least restrictive alternative available."

(1) Psychotropic drugs such as mood stabilizers, antipsychotics, antidepressants, and anti-anxiety medications help to control some of the symptoms of mental illness.

Deinstitutionalization has succeeded in releasing large numbers of patients from state mental hospitals. The Arizona State Hospital has seen a decrease in population from an average daily census of 1,684 patients in 1965 to an average daily population of 515 in 1988. However, the development of an adequate service system in the community has not been achieved.

In Arizona the Division of Behavioral Health Services (BHS) in DHS has responsibility for providing care to those needing behavioral health services. It does this through provisions for service delivery, planning, needs assessment, and evaluation for several service areas. These areas include mental health, chronic mental illness, domestic violence, alcohol and drug abuse, and children's behavioral health.

Administrative Entity History

DHS currently provides community-based services through the administrative entity system and through SAMHC. According to the department, in late 1983 it began looking at the delivery service system because of the concern about fragmentation and lack of coordination among 125 nonprofit organizations that received State funding through more than 20 umbrella agencies. Historical funding patterns from both State and federal governments had created this patchwork delivery system in which umbrella agencies competed with each other for funds. Many felt that the administrative structures of the agencies were duplicative, thus burdening the system with unnecessary cost.

In 1984, with the Legislature and Governor's approval and funding, DHS developed the administrative entity (AE) system. This system established nine administrative entities, organized by geographic areas, responsible for administering, coordinating, and monitoring community-based behavioral health services for each region.⁽¹⁾

DHS contracts with each entity to perform the necessary functions, and

(1) One administrative entity has been closed by DHS for administrative inefficiencies. In fiscal year 1989 DHS contracted directly with six provider agencies in this region. In addition, the department contracts directly with some Indian tribes throughout the state.

the administrative entities contract with nonprofit agencies to provide the direct services. However, this varies by entity. Some AEs, particularly in rural Arizona, also serve as direct providers in addition to their administrative responsibilities.

Division History and Organizational Structure

In 1986 the Legislature passed legislation which reestablished the Division of Behavioral Health Services.⁽¹⁾ The legislation gave the division responsibility for administering unified mental health programs, including ASH, community mental health programs, and substance abuse programs. The Office of Community Behavioral Health Services, ASH, and SAMHC were placed in the division. In addition, several administrative support units were also established within the division and are described below.

- **Office of Planning, Rules and Grants** - This office is responsible for developing the five-year plan, forecasting service needs, coordinating the budget process, and overseeing the grants process.

- **Office of Management Information Systems, Research, and Evaluation**
This office is responsible for establishing a behavioral health management information system, operating current information programs, maintaining federal reporting systems, and determining appropriate and needed research and evaluation functions.

- **Office of Behavioral Health Licensure** - This office is responsible for inspecting and licensing behavioral healthcare treatment facilities.

- **Office of Support Services** - This office provides administrative support for the division but principally for the central office units.

(1) The division had been abolished in 1984, and the major functions were transferred to the director's office.

In addition to OCBHS and the support units, the division is also responsible for direct, community-based service delivery through SAMHC. SAMHC is located in Tucson and provides crisis and brief treatment, day treatment, youth and family programs, residential treatment, outpatient treatment, and aftercare programs. SAMHC is the division's only direct service provider for community-based services.

Funding

In recent years Arizona has been criticized for low funding of behavioral health programs. A 1988 study of services for the chronically mentally ill cited Arizona with the lowest per capita funding of the fifty states and the District of Columbia. However, in the past two years the Legislature has responded by increasing its appropriations for behavioral health services. For fiscal year 1989 the division was appropriated \$83,757,100 which represented a 33 percent increase in funding from the previous year. Of this increase, \$16.6 million was appropriated specifically for behavioral health programs (\$14.8 million for community-based programs) in a bill separate from the general appropriations bill. In fiscal year 1990 the Legislature continued to increase funding for such services by appropriating an additional \$16.7 million to expand services.

According to DHS, the majority of all funds the division uses to provide behavioral health services are State appropriations. In addition to State appropriated funds, federal block grants, fines, and other types of grants comprise the total funds provided the division.⁽¹⁾ The division's total budget for fiscal year 1990 (excluding ASH) is \$89,358,900.

Although not included in the department's budget, matching funds are also a source of behavioral health monies. Organizations contracting with the

(1) DHS receives monies from the fines of DWI offenses to be used for alcohol abuse treatment programs.

administrative entities are required to provide matching funds. ⁽¹⁾ Matching funds generated by the administrative entities are comprised of other federal, State, and local government funds, client fees, contributions, donations, and grants. DHS estimates the contractor match to be 23 percent of total dollars expended for services.

Scope of Audit

This audit contains findings in four areas:

- The need for the State to integrate State and county behavioral healthcare programs;
- The need for DHS to improve its monitoring of administrative entity contracts;
- The need for DHS to strengthen its contract provisions to ensure delivery of quality service;
- The need for DHS to improve its method of distributing funds to better reflect and address needs in the community.

The report also contains Other Pertinent Information (pages 39 through 45) which discusses concerns with the administrative entity system and the status of the Behavioral Health Management Information System. It also discusses other State agencies providing behavioral health programs and the impact of multiple agencies and their requirements on service providers.

The audit was conducted in accordance with generally accepted governmental auditing standards.

(1) DHS may waive the match requirement based on hardship and may not require it in all circumstances.

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

FINDING I

INTEGRATION OF STATE AND COUNTY BEHAVIORAL HEALTH PROGRAMS IS NEEDED

Integration of State and county programs is necessary to achieve an efficient system of community-based behavioral health services. The State and some counties operate relatively independent, poorly coordinated behavioral health programs. The lack of integration and coordination between these programs results in costly duplication and has left some clients poorly served. Arizona should consider developing an integrated system with the State as the administrative authority.

State and Counties Operate Independent Programs

The State and counties operate separate delivery systems for community-based services. Although some counties are a key provider of mental and other behavioral health services, their programs are not integrated or coordinated with State programs. Unclear legislation, poor relations between the State and counties, and establishment of the administrative entity system have contributed to fragmented and uncoordinated services.

Counties operate major programs - Counties play a sizeable role in providing behavioral health services. In fiscal year 1988, the counties spent approximately \$24 million for such services.⁽¹⁾ In that same year, DHS spent \$35.5 million in State funds (plus \$9.5 million in federal grants) for community-based services delivered through the administrative entities and SAMHC.⁽²⁾

(1) Because many counties are not able to separate behavioral health expenditures from overall human services budgets, the total county figure is an estimated figure.

(2) In addition to community-based services, DHS expended \$28.1 million in fiscal year 1988 for treatment of patients in ASH.

The State has also significantly increased its appropriations for community-based behavioral healthcare for fiscal years 1989 and 1990, an additional \$14.8 million for fiscal year 1989, and \$16.7 million for fiscal year 1990 for community-based services.

Four counties in fiscal year 1988 accounted for over 90 percent of total county behavioral health expenditures. These four counties were Maricopa, Pima, Yuma, and La Paz.⁽¹⁾ Maricopa County has the largest county behavioral health program. In fiscal year 1988 it spent \$12.2 million for services. Of that amount, it spent \$3 million for the chronically mentally ill (CMI) and \$2.2 million for alcohol abuse treatment. The county also maintains a 66-bed psychiatric facility at its medical center.

Maricopa County also operates a large correctional mental health services program with the majority of services for CMIs. As part of its fiscal year 1988 expenditures, the county devoted \$2.4 million for these services. According to the county correctional health director, the bulk of correctional services goes to CMIs who have not received needed services elsewhere. The program has 120 beds dedicated primarily to CMI care at two of its jails. Consequently, the difficult and costly care of CMIs was for Maricopa County, and for some other counties, its major expense.

Other counties have proportionately large programs. Although Pima County has a population one third the size of Maricopa County, Pima County spent \$8.7 million for behavioral health services. It maintains a 36-bed psychiatric facility in the county hospital, a 16-bed residential care facility, and a 47-bed psychiatric unit in its county jail. In addition, Yuma County proportionately spent more than twice as much as Maricopa County with expenditures of \$1.3 million and La Paz County spent proportionately 50 percent more than Maricopa County.

(1) With the passage of the Arizona Health Care Cost Containment System legislation, counties were only required to maintain their respective service levels (not increase them) for indigent healthcare, including mental health, as of January 1, 1981. Because most counties at that time only provided for court ordered evaluations, the majority of counties have limited mental health services today.

Independent programs result in a fragmented system - Although substantial in size, these county programs are not coordinated with the State system. DHS operates the State program through its administrative entity system, and the administrative entities have not consistently involved the counties in assessing needs, planning activities, or delivering services. A survey of county health authorities indicated only two counties had representation on entity boards. Only one county has coordinated its services in any substantial manner with those of the administrative entity for its area. In fact, many of the county officials contacted were uninformed about specific entity programs or activities in their area.

The department concurs that the counties and the State operate uncoordinated programs. The 1989 DHS State plan reported that the delivery system in Arizona is "a non-system that is both complex and fragmented." The report states, "One of the greatest problems facing those concerned with behavioral health in Arizona is lack of coordination." The report concludes that coordination is needed at the community and state level among providers, administrative entities and state, and county agencies. Further, this same report also states that "efforts are needed to coordinate existing limited funding in such a way as to avoid unnecessary duplication and maximize the benefits."

Factors hindering integration - Unclear statutes, poor State and county relations, and the decision to establish the administrative entity system are all factors which have hindered integration and coordination of State and county systems. Statutes require both the State and counties to provide behavioral health services and have consistently called for coordination of services between the two levels of government. However, State and county officials do not believe statutes confer authority to ensure services are coordinated or define which jurisdiction is responsible for particular services. Consequently, there is overlap between systems and disagreement over responsibility for services.

Poor State and county relations also impede integration. According to State and county authorities familiar with DHS' early efforts to establish a community-based system, relations between responsible parties

were very poor. Difficulties encountered in establishing the Arizona Health Care Cost Containment System (AHCCCS) further deteriorated relations, and they continue to be strained. According to the assistant Maricopa county manager for health services, there is a "non-relationship" between the State and the county regarding mental health resources.

The third area which has hindered integration of systems is the administrative entity system. Until 1984 when DHS developed the entity system, county officials believed that the counties would, if they wished, assume responsibility for DHS funded community services. However, with the entity system, DHS developed a system of overseeing service delivery and distributing state funds without going through the counties. DHS did not provide the administrative entities with direction or guidance for integrating counties into needs assessment and activity planning or for coordinating county and state-funded services. DHS has still not provided such direction.

Fragmentation Adversely Affects Service Delivery

Failure to integrate State and county community-based services into a unified system adversely affects the delivery of services. Availability and efficient delivery of services is reduced.

Experts and practitioners agree that uncoordinated programs reduce efficient service delivery. They state that lack of coordination, coupled with a lack of clear roles and responsibilities for the agencies involved, results in costly duplication and repetition of services for some clients and the inability of others to find or receive appropriate services. The following case examples provided by an advocate group for the chronically mentally ill illustrate the continuing difficulty of some clients to receive prompt and appropriate treatment.

Case Example One

A client suffering from depression was referred by the county to a local service provider on contract with the administrative entity. The client was seen by a doctor, put on medication, and scheduled for another appointment. The client was unable to make the appointment

and due to poor communication with the service provider the client was not notified of the rescheduled appointment. Consequently, the client again failed to appear and was dropped by the service provider. He was told he had to go back to the county for services. However, when he returned to the county he was told that the state-funded service provider would have to continue care. Also, the county would not refill the client's prescription because it was written by the service provider doctor. The client ultimately filed a grievance to resolve the situation and to receive treatment.

Case Example Two

A long-time schizophrenic client was released from the county hospital on high dosages of lithium. He was placed in a state-run outpatient treatment program. Although a doctor with the state operation prescribed medication, the client actually received the medication from the county. A county outreach worker delivered the medication to the client. Both the county and the state-run program thought the other was monitoring the client's lithium blood level. After about six months it was discovered that neither was doing the monitoring. By that time the lithium level had become toxic and had damaged the client's kidneys.

Meantime, this patient, whose schizophrenia had long been resistant to all available schizophrenia medication, was being scheduled for a clinical trial at the county hospital on a promising new drug not yet federally licensed for general use. However, due to the kidney damage the client was not able to try the new drug.

A recent Arizona Supreme Court decision also concluded that uncoordinated programs have adverse results. In the Arnold vs. Sarn case (775 P.2d 521 [1989]) the court noted the effects of fragmentation and lack of cooperation. It found that as a result of the independent operations, the present level of care provided "to the CMI is tragically low." The court also found that many CMIs received no mental health services at all.

A State-Directed System Should Be Established

A statewide system with a single authority and funding stream should be developed. A single authority and funding stream are necessary for the efficient delivery of behavioral health services. Arizona may wish to consider establishing a consolidated behavioral health system.

National authorities agree - National studies recommend a behavioral healthcare system with a single authority and funding stream. The National Conference of State Legislatures, the National Institute of Mental Health, and a leading advocacy group have performed independent studies. Their respective reports concluded that state or county systems

with a single authority and funding stream offer the greatest promise for effective service delivery. Although state mental health systems are in transition and none have been fully implemented or evaluated, the studies agree that the structure of the system may be as important for service delivery as the amount of money expended.

Other state programs - Wisconsin and Ohio, frequently cited as having leading behavioral health programs, both have programs with a single management authority and a single funding stream. (In both cases, the authority has been placed at the community level.) In 1974 Wisconsin transferred state funds and full responsibility for providing services to the counties. From the funds they receive, the counties are responsible for all appropriate services, including payment for inpatient services from state mental hospitals.

Ohio has community boards which serve as the management authority. In 1988 the state transferred responsibility and funds to community mental health boards. Fifty-three boards serve 88 counties. Fiscal and administrative responsibility for community-based and inpatient services will be gradually consolidated and given to the local boards. Ultimately, the State's role will be that of policymaker, provider of funds, monitor, and evaluator.

Arizona's experience - Although many states have developed county-run behavioral health systems, Arizona may wish to consider a state-administered program for the following reasons. First, most counties may not have sufficient resources to support a county-run system. Second, by establishing the administrative entity system, the State has indicated its preference for and established a structure to administer a state-run program rather than a county-run system.

Most counties may not have the resources to operate a county behavioral health system. The assistant director of BHS claims that most counties do not have the expertise, taxing power, or desire to support a county mental health system. As previously stated, most rural counties currently provide only court ordered evaluations, and in many counties the jail serves as the only county facility to hold those needing care.

The current system allows each county to operate differently making it difficult to create a cohesive statewide policy integrating fifteen county systems.

The urban counties also feel that the present delivery system causes them to absorb the most costly clients and services. For example, the chairman of the Department of Psychiatry at Kino Community Hospital (who oversees behavioral health services in Pima County) noted that the county cannot legally turn someone down in an emergency situation. Consequently, the county absorbs the most costly component of the services continuum, crisis intervention. He believes that the State should be made the single authority and counties should no longer be responsible for service delivery.

Officials over the behavioral health programs in Maricopa, Pima, Yuma and La Paz counties concur that there needs to be a single administrator for behavioral health services. However, the county representatives expressed some concerns regarding specific aspects of how a state-administered system might be structured. A primary concern is the funding mechanism and the amount counties would have to contribute. The counties also fear that the State would not involve them in the development of a state-run system. In addition, while the assistant Maricopa County manager for health services agrees there should be a state-run system, he has a specific concern about how it should be structured in Maricopa County. He believes the county should oversee service delivery instead of using the current system of three administrative entities which results in the county being divided into three service areas.

The State has also shown its preference for a state-run behavioral health program by establishing the administrative entity system. DHS has elected to provide services, distribute funds, and oversee programs through private, nonprofit organizations. In fact, in some instances DHS selected newly established agencies to serve as administrative entities instead of counties already providing behavioral health services. DHS has continued to provide community-based services through the

administrative entities. While we recognize the entity system has experienced some problems (see Other Pertinent Information, page 39), according to the assistant director, DHS is still committed to that system.

Finally, precedence exists for establishing a state-operated system in the State's creation of its indigent healthcare system. In providing indigent healthcare, the State developed a state-operated system rather than a county system. AHCCCS integrates state and county healthcare services under a single, state level authority. While the State is responsible for administering the program, county and State funds, in addition to federal monies, are combined to pay for services.⁽¹⁾

On a small scale, DHS has recently attempted to take a similar approach in behavioral health by consolidating funds and establishing a single authority for its children's program in Pima County. This program could serve as a model for integration for other behavioral health programs. In January 1989, the Comprehensive Child and Adolescent Treatment Services (CCATS) program began providing a full continuum of care for children and adolescents. By voluntary agreement the State and Pima County have consolidated funds at the DHS level. County monies were redirected to the State and via the entity combined with DHS funds. The entity contracts with SAMHC for clinical management of the program. SAMHC also provides intake, crisis intervention, and case management services. All other long-term treatment is contracted for with other service providers.

Because CCATS has been in operation only since January 1989, it cannot yet be fully evaluated. Nevertheless, SAMHC and entity administrators state the program is working well. In fact, they consider it to be very cost-effective, and discussions are underway to expand it to other State agencies.

(1) The level of a county's financial contribution was capped by statute at 50 percent of its fiscal year 1980-81 healthcare budget or expenditures, whichever was less.

RECOMMENDATION

The State should develop a long-range plan to establish a state-run, behavioral health program that integrates State and county behavioral health programs. A single management authority and funding stream should be key elements of the integrated system.

FINDING 11

DHS IS NOT ADEQUATELY MONITORING THE PERFORMANCE OF ADMINISTRATIVE ENTITIES

DHS' monitoring of entity performance and compliance with contract provisions has been lax. Important deficiencies and problems have gone undiscovered or uncorrected because DHS is not conducting adequate site visits, verifying services, or following up when problems are discovered. Monitoring has not been a management priority, and staff responsible for monitoring administrative entities have not received clear direction.

Importance of Monitoring

Since most community-based behavioral health services funded through DHS are provided by nonprofit agencies under contract with DHS, contract monitoring is an important DHS responsibility. Monitoring ensures that services the State is paying for are being provided as required. Monitoring also is important to ensure that clients are being properly treated and that both clients and the State are properly charged for services. When done effectively, monitoring should result in the timely discovery and correction of problems.

DHS has assigned seven staff members the responsibility of monitoring the performance of administrative entities. DHS procedures require that monitoring be done through regular site visits to the administrative entities, verification of services reported and billed to the state, and preparation of reports on entity compliance with contract provisions.

Problems and Deficiencies Are Not Identified and Corrected

DHS monitoring of entity performance has been limited and follow-up on problems has been weak and superficial. As a result, significant deficiencies have not been identified and problems have not been fully addressed and corrected. Our analysis found that site visits,

verification of services, and reporting are not being done consistently and in accordance with established policies and procedures.

Examples of poor monitoring - In some cases, DHS has not identified significant deficiencies and noncompliance with entity contract provisions. In other cases, problems identified or brought to the department's attention have not been fully and adequately followed up and resolved. The following examples illustrate this problem.

- **Example 1** - In April 1989, a clergyman alleged impropriety at an administrative entity. Allegations included misuse of staff, clients and materials used to repair the executive director's home, overmedication of clients, poor client service, inappropriate sexual relations between CMI clients and staff, and other problems. The DHS staff person responsible for overseeing the entity met with the executive director who denied all of the allegations. However, no effort was made to investigate. Client records were not reviewed, interviews were not conducted, and no report was prepared.

Previously, DHS had conducted a review of client service records at the same entity and found that it may have overcharged the State more than \$150,000. In August and September 1987, DHS could find no documentation to verify that the entity had provided any of the 759 "semi-supervised" units of service for CMI clients for which it had charged the State. DHS could verify only 208 (19 percent) of the 1087 units of residential service for which it had been billed, and only 40 (27 percent) of the 146 units of case management. Seven months later, DHS conducted a 100 percent review of some entity records. The review revealed that the agency may have been miscoding service units. For example, semi-supervised days were reported as long-term residential days, while outpatient visits were reported as semi-supervised days. DHS requested that the agency return over \$150,000 to the State. The agency filed a written response disputing most of DHS findings and has not repaid any funds. Over one year later, DHS has taken no further action to recover monies owed or to correct deficiencies at the entity.

Comment - In this case, DHS was aware of serious potential problems at an administrative entity but has failed twice to take adequate follow-up action. These problems involve improperly charging clients and the State, poor client treatment, and potential fraud. When asked why he did not take further action on the more than \$150,000 DHS claimed was owed to the State, the DHS staff person responsible stated that other duties took precedence and neither the former nor the current OCBHS Administrator requested further follow-up.

- **Example 2** - DHS is not checking to ensure that clients are being properly charged for services. State law requires DHS to establish fee schedules for chronically mentally ill (CMI) residential clients and clients receiving alcohol treatment services. Entity contract

provisions further require that DHS approve client fee collection policies. DHS has adopted a fee policy which essentially establishes a sliding scale fee based on income and family size. We found, however, that 55 of the 61 agencies we randomly sampled are not following approved fee schedules. Nineteen of the providers (who the administrative entities are responsible for overseeing) had no fee schedule whatsoever. One agency even charges clients twice as much for an initial visit as DHS policy allows, and requires that clients pay for services when they are rendered, unless other arrangements are made beforehand.

Comment - DHS is not adequately monitoring fee schedules. DHS management acknowledges that many provider agencies are not following the DHS fee schedule and that agencies' fee policies may differ substantially. Therefore, some clients are not being properly charged. This can result in three problems. First, the State may be paying for some services that some clients can afford to pay for themselves, consuming State resources that could be allocated to more needy clients. Second, clients may themselves be overcharged for some services that, according to DHS policy, should be paid by the State. In addition, inequity results when different providers charge comparable clients different fees for similar services. For example, we found that one agency charges certain clients \$5 for outpatient alcohol services while another agency charges comparable clients \$32. Neither agency's fee policy complies with DHS policy.

- **Example 3** - Over the last three years, DHS and the responsible administrative entity have received several complaints about the practices of a provider agency. Allegations include improper charging of clients and not treating crisis clients. A DHS site visit team also discovered that the agency may have been involved in a questionable practice called "creaming." This latter allegation involves a practice in which clients with ample financial resources are placed in for-profit programs that provide better quality and a wider range of services than nonprofit programs.

During the fiscal year 1987-88 annual visit DHS staff found evidence suggesting that the agency's for-profit program was providing better drug abuse treatment services to its paying, insured clients than it was to those served in the agency's nonprofit (DHS-supported) division. DHS referred the matter for follow-up to the administrative entity. However, DHS never monitored the entity's follow-up actions, and did not address the matter in its most recent site visit to the entity.

Comment - DHS did not monitor the entity to ensure that appropriate follow-up investigation and action was taken in response to potential problems identified. These problems involved potential mischarging of clients and inequitable treatment of clients based on ability to pay. Without follow-up monitoring, DHS may not know if potentially improper practices have been corrected.

Monitoring procedures not followed - Problems identified above are occurring because DHS is not consistently monitoring administrative entities and is not following established procedures for monitoring.

Site visits and verification of services are inconsistent and are not always performed in accordance with prescribed policies.

DHS staff are required to make an annual site visit to each administrative entity and to report on the site visit results within 21-working days of the site visit. In fiscal year 1987-88, DHS did not conduct an annual site visit at two of the eight administrative entities. In fiscal year 1988-89 DHS conducted an annual site visit at each entity, but only two of the site visit reports were completed within the policy timeline. In fact, as of July 1989, DHS had still not completed two of the eight reports even though the site visits had been conducted in March 1989.

When DHS has completed site visit reports, the reports have lacked uniformity and completeness. A review of the six completed annual site visit reports for fiscal year 1988-89 revealed that staff reviewed different aspects of entity performance and used different methods to report their findings. Most reports also fail to sufficiently address the quality of service that clients receive. Most of the reports are, however, consistent in one respect: they do not address most of the administrative entities' contract requirements. The annual site visit section of one recently completed report was just over four pages long and, therefore, could not possibly cover the contract requirements (the work statement itself is 14 pages long), let alone provide a comprehensive analysis of the entity.

DHS is also not sufficiently checking client records to ensure that services billed to the State were, in fact, properly categorized and provided. The DHS service verification policy requires that at least 20 client records be reviewed annually at each provider agency.⁽¹⁾ A review of DHS files revealed that service verifications were conducted at

(1) Aside from the DHS service verification, administrative entities usually conduct quarterly service verifications of subcontracting agencies. However, the DHS policy predates the administrative entity system, which could create some question as to whether DHS should reverify records reviewed by the entity or draw a separate sample of client reports submitted to DHS by subcontractors. Although the OCBHS Administrator stated that both methods are used, he also stated that service verification should be conducted by DHS at each agency at least biennially.

only two of the administrative entities in fiscal year 1987-88 and at only five administrative entities in fiscal year 1988-89. In fiscal year 1987-88, DHS reviewed records at only 10 of some 234 contracting facilities. However, DHS reviewed the minimum 20 records at only two of those facilities. In fiscal year 1988-89, DHS reviewed records at 27 of some 260 facilities, but reviewed 20 or more records at only eight of them.

Contract Monitoring Has Not Been a Priority

OCBHS has not made the monitoring of entity performance and contract compliance a priority. Monitoring has not received adequate attention, and many standards and policies needed for effective monitoring have not been updated since the entity system was implemented. Furthermore, DHS staff responsible for monitoring have not received clear direction from management.

Inadequate attention - According to the OCBHS Administrator, the monitoring of entity contracts has not received adequate attention. The Administrator attributes the lack of attention to OCBHS management's failure to ensure staff were properly monitoring entity performance and service delivery. In addition, staff time has been devoted to reviewing financial reporting of the administrative entities and to numerous contract amendments resulting from additional funding and the creation of new services. ⁽¹⁾

Neglect of program standards and policies used for monitoring is further indication of monitoring's low priority. The Program Approval Standards contain criteria against which DHS is to monitor any behavioral health service provider that contracts or subcontracts with DHS. The standards have been used as a major monitoring tool and address several important program areas including planning for service needs, personnel management, facility environment, confidentiality of records, and program

(1) According to the OCBHS Administrator, beginning in fiscal year 1989-90, the monitoring of entity financial reporting will no longer be the responsibility of program staff. Instead, the deputy administrator and her staff will have this responsibility.

evaluation. However, the standards were originally drafted by DHS over 10 years ago and have never been updated. They were first used to evaluate the performance of the provider agencies. However, since the introduction of the administrative entity system, DHS continues to use the same standards. Therefore, it is not clear whether DHS should apply the standards to the administrative entities or to the provider agencies. Some sections would probably be more appropriate as licensing standards. For example, the standards require that the dining area be "light, airy, and suitably decorated," windows have proper screening, the facility be free of insects and rodents, and burned out light bulbs be fixed or replaced. While DHS has initiated revisions to the standards, the revisions will be relatively minor.

The Policies and Procedures Manual used by OCBHS is also outdated. The manual provides guidelines to be used by OCBHS in administering behavioral health contracts. The policies range from methods to be used in receiving contract proposals to guidelines to be used in contract negotiation, preparation, and processing. Several policies address contract monitoring and evaluation. Some, like the verification of services policy, have not been updated since 1985 when the administrative entity system was developed and, therefore, address OCBHS' administration of provider agencies rather than administration of the administrative entities.

Staff lack clear direction - While present DHS management has established monitoring as a priority, more direction needs to be given to staff on the procedures to be used. For example, program representatives use different standards in monitoring the administrative entities. One program representative said he always uses the Policies and Procedures Manual as a guide. In contrast, several other program representatives stated they were not sure to what degree the manual is to be used. One representative claimed a documents monitoring report is used widely but none of the other representatives stated they use it. Because of this confusion, program representatives agreed that there is little consistency in the methodology used in monitoring or report writing. Staff members said they had received very little direction since November 1988 when they received a brief, two-page memorandum listing their job

duties. However, the memo does not contain specific details on how monitoring should be performed by the staff. Staff members said few staff meetings are held, and little communication is received regarding how they should complete their duties. One staff member stated that an "underground" communication network had developed among program monitoring staff to share information and develop a common direction.

RECOMMENDATIONS

1. DHS' annual site visits and reports should:
 - Focus on contract requirements;
 - Be more comprehensive, uniform, and timely;
 - Include follow-up visits to determine whether recommended changes have been implemented.
2. DHS should conduct a greater number of service verification reviews. These reviews should also be more thorough.
3. DHS should immediately follow up on allegations of agency misconduct and should provide to the administrative entities written reports of its findings. Site visits should be used to determine whether administrative entities have corrected the problem.
4. DHS management should make monitoring of administrative entity performance a priority and should provide clear direction to staff as to how monitoring is to be accomplished.
5. The OCBHS Program Approval Standards, and Policies and Procedures Manual should be updated in order to be used as effective monitoring devices of administrative entities.

FINDING III

CHANGES IN CONTRACTS COULD RESULT IN IMPROVED SERVICES

Changes in the manner and form of contracting between DHS and the administrative entities could result in improved behavioral health services. Contracting methods used by Colorado could address shortcomings in DHS contracts involving the provision and quality of services.

Colorado has developed a progressive contracting system to purchase mental health services from providers and is considered a national leader in this area. This system, referred to as performance contracting, establishes target populations to be served by providers and incorporates provisions to ensure performance as well as quality of services provided. Because of the system's unique approach, as well as its reported adaptation by several other state mental health authorities, Auditor General staff visited the Colorado Department of Institutions, Division of Mental Health, to obtain a firsthand perspective on the performance contract system and its potential benefits to Arizona.

Contractual Problems Involving the Provision and Quality of Services

DHS' contracts with the administrative entities fail to direct services to specific populations and lack necessary provisions to ensure the quality of services provided. Entity contracts contain few specific definitions of who is to receive services. Furthermore, the contracts do not contain provisions allowing the assessment of penalties for nonperformance. Finally, the contracts do not contain specific requirements for administrative entities to conduct quality assurance of services.

Few definitions of who is to receive services - Entity contracts contain few specific definitions of who is to receive behavioral health services. Without contractually defined populations to be served, the administrative entities determine who will receive available services.

However, because DHS bases contract compliance on units of service provided, the administrative entities may not be providing services to those most in need. In contrast, Colorado contractually establishes target populations to be served by providers.

Those receiving most contracted services are not defined specifically. For fiscal year 1989-90, DHS contracted with the administrative entities to provide a particular number of units of service at a specific price per unit for several behavioral health programs, including drug, alcohol, and mental health, as well as services to the chronically mentally ill (CMI) and to seriously emotionally disturbed children (SEDC). However, while a statutory definition for services to CMIs exists, DHS has not defined who should receive services from the other behavioral health programs.⁽¹⁾ Current contract language indicates only that those individuals who are at risk of or suffering from a particular behavioral health disorder can be served. Furthermore, client intake criteria broadly defines serviceable problems.⁽²⁾

Since populations to be served are not defined in the entity contracts, the administrative entities determine who will receive available services. This can, in turn, result in two problems. First, services may be directed to those who present themselves for treatment rather than those with the greatest need for services. As such, the "worried well" may be receiving services rather than those individuals suffering from more serious mental illnesses. Second, according to several entity and DHS officials, this system results in the units of service driving the provision of services rather than a targeted population. For example, if an entity has an abundance of units of a particular service (e.g. alcohol

(1) Chronic mental illness is defined by A.R.S §36-550 and must be documented by the Checklist for Chronic Mental Illness Determination.

(2) Client intake criteria, as defined in the DHS Behavioral Health Management Information System (BHMIS) client assessment form, broadly defines serviceable problems to include such factors as anxiety, stress or tension, depression or mood disorder, thought disorder, medical or physical problems, marital or family problem, social or interpersonal problem, role performance (i.e. job, school, homemaker), involvement with criminal justice system, and other significant problems.

treatment), it may direct its efforts to filling those units to avoid losing payments. However, these services may not be the services the entity most needs to provide.⁽¹⁾

Rather than basing successful performance on the completion of agreed upon units of service, the Colorado performance contract targets particular populations for which service providers contractually agree to provide treatment. For fiscal year 1989-90, the Colorado target population is comprised of the most seriously mentally ill, children, elderly, and minorities, with specific definitions for each. Unlike the Arizona system, service provision and contract compliance is based on who is served, rather than on how many units of service are provided. For example, while Arizona might purchase 100 units of CMI residential care from an entity and allow the entity to determine how many CMIs should receive the services, Colorado would establish the minimum number of CMIs to receive services from a provider and allow the provider to determine the appropriate mix of services to meet each client's needs. Establishing the target population ensures that the state, rather than the providers, determines who will receive services while allowing the providers to determine the types of services needed. According to Colorado officials, this requires outreach by service providers to ensure that targeted populations are served, not just those persons who present themselves for service. Finally, Colorado pays providers monthly based on the units of service provided.

Penalties for nonperformance - Entity contracts do not contain provisions establishing penalties for failure to perform. Under current contract language, if an entity does not produce at least 80 percent of the agreed upon units of service for the CMI and mental health programs, all that is required is a payback of advanced monies that exceed the amount of units produced.⁽²⁾ While DHS allows and pays for up to

(1) DHS' procedure of paying for the units of service in advance may create additional pressure for the administrative entities to provide service regardless of need in order to avoid paying back monies that may have been spent already.

(2) Although the CMI and mental health programs represent a majority of behavioral health funding, contract provisions for other behavioral health programs, including drug, alcohol, and children's treatment and prevention, require administrative entities to pay back monies in the event 100 percent of the agreed upon units of service are not produced.

20 percent nonperformance, there is no penalty for those administrative entities that exceed this provision.

Under terms of the Colorado performance contract, penalties are assessed if providers do not serve at least 93 percent of the agreed upon target population. Unlike Arizona, these penalties are not merely simple paybacks for services not provided, but rather actual penalties based on the number of clients not served and then subtracted from the following year's contract.⁽¹⁾ However, to ensure that providers are not penalized due to circumstances outside of their control, the contract allows the providers two opportunities during the term of the contract to renegotiate the number of clients to be served.

The Colorado contract also includes specific penalty provisions (\$5,000) in the event a provider does not submit timely financial reports.⁽²⁾ Arizona contracts do not contain penalty provisions for untimely financial reporting.

Requirements for quality assurance - Current contracts do not contain provisions requiring the administrative entities to conduct quality assurance. Quality assurance programs are used throughout healthcare systems to ensure that:

- patients receive quality services,
- patients receive appropriate services, and
- certain types of services are not over- or underutilized.

In an acceptable quality assurance program, the appropriateness of patient care and clinical performance are monitored and evaluated through

(1) The penalty is determined by establishing the providers cost per client served that year (total program costs divided by number of clients served) and multiplying this by the number of clients not provided service.

(2) The \$5,000 is returned to the provider if the report is received within 30 days. If the report is between 30 and 60 days late, half of the penalty is returned. However, if the report is more than 60 days late, the entire \$5,000 is withheld.

an ongoing review of patient records, observations of patient care, and a review of special treatments, medications, and incidents involving patients.

According to an official with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), quality assurance programs are essential for quality healthcare because they require providers to openly display their accountability to those parties interested in their performance (i.e. clients, clients' families, and funding organizations).

Quality assurance is particularly important given Arizona's system of delivering services through contracts. In this system, the contractors determine who will receive service, the type of service that will be provided, and the amount of service. Lacking direct control over these key decisions, the State needs a means of ensuring that its funds are being used appropriately. Thus, quality assurance programs can perform a dual function: they can protect the interests of both the patients and the State.

While quality assurance is clearly important and needed, the FY 1989-90 DHS contract with the administrative entities does not contain specific language requiring the administrative entities to maintain quality assurance programs. Furthermore, DHS officials are apparently aware of the importance of quality assurance since an internal policy and procedure to monitor entity quality assurance programs exists, although there is no contractual provision upon which to base its enforcement.

Again, unlike Arizona, the Colorado contracts require each provider to develop and maintain a quality assurance program in order to ensure high quality patient care. Colorado has formalized this requirement through an administrative rule and regulation, and further clarified the requirement by establishing clinical guidelines for the providers to follow. The clinical guidelines include steps needed to perform quality of treatment as well as service utilization reviews. Furthermore, the guidelines specify the frequency of reviews, the number or percentage of

cases to be reviewed, criteria for identifying unnecessary or inappropriate utilization, and procedures for implementing corrective action.

RECOMMENDATION

The Department of Health Services should evaluate the performance contract system as developed by Colorado and consider adopting those provisions dealing with the development of service provision to targeted populations, assessment of penalties for nonperformance, and quality assurance.

FINDING IV

DHS COULD IMPROVE ITS METHODS OF ALLOCATING FUNDS BY BASING FUNDING MORE ON NEEDS ASSESSMENTS

DHS should consider allocating funds for behavioral health services based more on needs in order to target limited resources to those who most need services. Currently, DHS' focus is on achieving funding equity based on population. However, this focus fails to recognize differences in the particular behavioral health needs of each geographic area in the State and address these needs through funding.

DHS Is Attempting to Equalize Funding on a Per Capita Basis

As mental health funding has increased in the State, DHS has increasingly used per capita formulas to allocate the funds. DHS' goal is to reduce the disparities in funding which originated when the administrative entity system was developed. DHS uses two funding models, both of which are strongly based on a per capita formula, to distribute new funds.

Initial funding distribution - The initial distribution of funding to the administrative entities created a perception of funding disparity. According to DHS officials, when the administrative entity system was established in 1985, initial funding to the administrative entities was determined based upon how much funding had been provided in the previous year to the direct service providers located within each of the newly created administrative entities' geographic area. Under this plan, for fiscal year 1985-86, those administrative entities with numerous providers received a large share of the funding, while those areas with few established providers received little funding, regardless of the population served by each entity.⁽¹⁾ This resulted in the perception

(1) According to DHS officials, the decision to distribute initial funding in this manner was a determination that redistribution of funding based on need would result in reduced funding to existing programs and hence cutbacks in service to those already receiving services. Conversely, it was easier to deny funding to less developed administrative entities who did not have clients already receiving DHS funded services, regardless of the need for such services.

that disparity exists between the administrative entities since some received significantly more funding per capita than others. Table 1 compares the original distribution of funding among the administrative entities and the distribution as of this fiscal year. The table reveals that significant per capita funding disparities continue to exist (e.g., CODAMA versus EVBHA).

TABLE 1
COMPARISON OF TOTAL BEHAVIORAL HEALTH FUNDING
FISCAL YEAR 1985-86 AND FISCAL YEAR 1989-90

<u>Entity</u>	<u>Percentage of State Population^(a)</u>	<u>FY 1985-86 Funding</u>	<u>Percentage of Total Funding</u>	<u>FY 1989-90 Funding</u>	<u>Percentage of Total Funding</u>
ADAPT	19.0	\$ 5,625,653	17.44	\$12,350,271	18.75
BHACA	2.4	1,767,004	5.48	3,212,202	4.88
BHS	3.0	906,681	2.81	2,353,162	3.57
CCN	27.1	5,030,248	15.59	11,595,004	17.60
CODAMA	14.4	9,274,063	28.74	16,684,799	25.33
EVBHA	15.9	1,981,444	6.14	6,173,038	9.37
NACGC	9.2	3,784,417	11.73	7,855,645	11.93
SEABHS	4.7	1,770,902	5.49	3,268,108	4.96
IMBHA/Direct					
Contractors	1.9	1,206,614	3.74	1,563,954	2.37
Indian Res.	2.4	530,054	1.64	715,183	1.09
Other					
Contractors		387,930	1.20	97,000	0.15
TOTAL	<u>100.00</u>	<u>\$32,265,010</u>	<u>100.00</u>	<u>\$65,868,366</u>	<u>100.00</u>

(a) Population figures are based on 1986 estimates from the Arizona Department of Economic Security and are figures currently used by DHS in its funding distribution models.

Source: Auditor General analysis of DHS Director Approved Funding for Fiscal Years 1985-86 through 1989-90 obtained from DHS Budget Office.

Per capita funding equity - To address the per capita funding disparity between administrative entities, DHS utilizes two different models to distribute new behavioral health funding. These models are designed to gradually equalize per capita funding among the administrative entities.

For the distribution of new monies for drug, alcohol, and general mental health programs, DHS uses a funding formula developed in 1988. This

formula distributes all new monies by program plus an equal amount of the prior year funding to the administrative entities as follows:

- Fifty percent to be distributed based on each administrative entities' population
- Forty percent to be distributed based on each administrative entities' population living in poverty (as determined by three poverty indicators)
- Ten percent to be distributed based on each administrative entities' population which is considered youth (ages 5-17) and elderly (age 65 and over)

The second method used by DHS to distribute new behavioral health funding is the Comprehensive Mental Health Plan, completed by DHS in January 1989. In the plan, DHS estimated the total number of chronically mentally ill and seriously emotionally disturbed children for the entire State, and then divided this total into the 15 counties based upon each counties' percentage of the total population.⁽¹⁾ According to the Office of Community Behavioral Health Services' Administrator, all new state monies appropriated for fiscal year 1989-90 to CMI and Children's Treatment and Prevention programs were distributed using the plan.

Both methods used to distribute new funding are primarily intended to achieve equal per capita funding between the administrative entities. Although the formula for drug, alcohol, and general mental health funding incorporates social indicators of need (poverty and age), fifty percent of the formula is based on population. Further, most of the total new funding is distributed based on population. For example, with the exception of some "administrative adjustments," in fiscal year 1989-90, approximately \$12.6 million of the nearly \$16.7 million in new general fund monies to behavioral health was distributed using per capita formulas.⁽²⁾ According to DHS officials, the goal behind the new funding distribution method is to reach parity, whereby each entity's funding is commensurate with its percentage of the State's population.

(1) For example, because 19 percent of the State's population resides in Pima County, DHS assumed that 19 percent of all CMIs in the State reside in Pima County.

(2) "Administrative adjustments" are made by DHS officials in order to fund new programs or to address special needs of some administrative entities.

DHS Should Consider Allocating Funds Based More on Needs

The funding system developed by DHS does not focus on the differences in behavioral health needs of the geographic areas represented by the administrative entities. These differences can be measured either directly, or indirectly, and used to make funding decisions. At least two other states now tie funding more directly to need.

Differences among entities - Behavioral health needs may vary significantly among different geographic service areas. According to the National Institute of Mental Health (NIMH), current literature suggests significant relationships between the occurrences of mental disorder and such social indicators as low median family income and high family disorganization (few husband and wife family households).⁽¹⁾ As illustrated in Table 2 (page 35), a comparison of one variable (poverty) shows the intense differences that can exist among areas. (e.g., Only 2.4% of the State's population reside on the Navajo reservation, while 9.3% of all Arizonans living in poverty reside there. This means that 39.3% of the reservation population live in poverty.)

(1) "Needs Assessment; Its Future," U.S. Department of Health and Human Services, National Institute of Mental Health, 1988.

TABLE 2

COMPARISON OF POVERTY RATES AMONG
BEHAVIORAL HEALTH SERVICE AREAS

<u>Entity or Geographic Area</u>	<u>Population</u>	<u>Percentage of State Population</u>	<u>Population In Poverty</u>	<u>Entity Percentage of Total State Populations In Poverty</u>	<u>Percentage of Each Entity's Population In Poverty</u>
Navajo Reservation	83,256	2.4	32,677	9.3	39.3
Gila/E. Pinal	65,911	1.9	9,838	2.8	14.9
BHACA	83,256	2.4	12,298	3.5	14.8
CODAMA	499,536	14.4	70,624	20.1	14.1
BHS	104,070	3.0	14,055	4.0	13.5
SEABHS	163,043	4.7	21,082	6.0	12.9
NACGC	319,148	9.2	36,893	10.5	11.6
ADAPT	659,110	19.0	67,813	19.3	10.3
EVVHA	551,571	15.9	35,839	10.2	6.5
CCN	940,099	27.1	50,245	14.3	5.3
TOTAL	<u>3,469,000</u>	<u>100.0</u>	<u>351,364</u>	<u>100.0</u>	

Source: DHS Funding formula for fiscal year 1989-90

Specific measures for determining needs are available - Specific measurements to establish and fund behavioral health needs are available to DHS. Need driven funding distribution models are currently used by other states.

Both direct and indirect measurement of needs for behavioral health services are available to DHS. The direct measurement of needs for services involves field surveys in which information about current or past mental health problems is obtained from a sample of community residents. While such surveys are considered to be the best measurement of need, they are difficult and expensive to conduct. According to an NIMH official, these surveys can cost \$150 to \$300 per interview conducted.

Indirect measurements of need involve estimating need for services from already available data such as social indicators (demographic data) or from records of clients already receiving treatment. According to a NIMH official, such subpopulation social indicators as income levels, employment levels, ethnicity, gender, age, marital status, divorce rates, and suicide rates can be used to determine the relative behavioral health needs of an area. In fact, in its recent reports on needs assessment, NIMH concluded that with appropriate validity and reliability, indirect measures provide a comparatively low-cost, easy-to-use, quick, and objective procedure for estimating service requirements. Additionally, while not as accurate as direct measurements, they are clearly better than other procedures currently in use.

Other states - At least two other state mental health authorities are using indirect measurements of need to determine all or a portion of their behavioral health funding.⁽¹⁾ Through an analysis of admissions to mental health facilities within the state, New Jersey has

(1) Based on the results of a NIMH funding distribution study, these were the only two states we were able to identify as using measurements of need to determine behavioral health funding. According to NIMH officials, political pressures to distribute behavioral health monies based on such factors as population and historical funding patterns have discouraged most state mental health authorities from using measurements of need to determine the distribution of funding.

developed over 85 social indicators such as poverty, broken homes, and ethnicity upon which to determine the distribution of funding. Under this system, each social indicator is given a score based upon its established association to particular behavioral health needs. These weighted indicators are then applied to each area's population to establish funding. According to a New Jersey official, weighting the indicators based upon their association to particular needs allows the formula to more accurately determine and fund specific needs. (For example, reported occurrences of child abuse would receive significant weighting when distributing funding for behavioral health services to children.) Through statutory requirements, Minnesota distributes two-thirds of all new mental health funding through poverty indicators related to the number of individuals receiving Aid to Families with Dependent Children (AFDC) benefits.

RECOMMENDATION

The Department of Health Services should identify specific measurements of behavioral health needs and make greater use of them in the funding distribution process.

OTHER PERTINENT INFORMATION

During the audit we developed other pertinent information regarding concerns with the administrative entity system, the Behavioral Health Management Information System (BHMISS), and the delivery of behavioral health services by other State agencies.

Concerns about the Administrative Entity System

During our audit we identified concerns regarding the administrative entity system. The department has not been able to establish a statewide entity system because there are few organizations which are able to perform as an entity.

The administrative entity system was designed to administer and provide for behavioral health services within geographic areas statewide. DHS contracts with one organization in each area to perform administrative functions such as contracting with direct service providers, monitoring contracts, and developing local needs assessments. According to DHS, the advantages of the system are that local involvement and decisions better address local behavioral health needs which may vary by area. Further, the department felt that contracting with administrative entities to administer services would result in administrative efficiencies and flexibility.

Difficulties implementing the entity system - The department has had difficulty establishing a statewide entity system. For the past three years the geographic area consisting of Gila and East Pinal counties has operated without an administrative entity. Initially DHS contracted with an organization named the Intermountain Behavioral Health Association. However, administrative inefficiencies and financial problems resulted in DHS rescinding its contract. DHS contracts directly with the six service providers in the area.

The division has not been successful in returning this area to the entity system. The division has encouraged at least one entity to expand its service area and include these counties. However, the entity chose not to expand. In addition, no other agency has come forward in the area to compete for a contract. Currently, efforts are being made to organize interested direct service providers and others to develop an organization capable of serving as an entity.

DHS has also had difficulty in some rural areas establishing administrative entities which perform strictly entity functions. Two administrative entities in rural Arizona also provide direct services. Before the entity system was created the two administrative entities were direct service providers. The organizations were selected to become administrative entities but were also given a waiver to continue to provide services because few service providers are available in those rural areas. DHS is currently trying to have the two administrative entities move away from providing direct services and have the administrative entities serve solely in an administrative capacity.

Being a direct service provider conflicts with the entity's role as an administrator and monitor of services delivered. The entity cannot serve as an independent oversight agency when reviewing its own records of services. This is a major problem with one of the administrative entities which in fiscal year 1988-89 provided 81 percent of the services in its area.⁽¹⁾

Furthermore, an entity's objectivity in funding decisions may be weakened when it is also a provider. Entities are responsible for contracting for services and allocating resources. According to one entity director, allocation decisions offer the greatest potential for charges of conflict of interest. Because resources are limited, there is the potential for an entity to favor its own programs when contracting for services and

(1) The 81 percent figure is based on the allocation of contract monies to service providers within the entity and not the actual number of service units provided.

allocating funds. One service provider contends that one entity contracts with itself for all the direct services it offers and then approaches independent providers on a "take it or leave it" basis for the remaining services needed.

The State may be at risk because the number of organizations competing for DHS entity contracts is limited. For the current administrative entity contract, only the existing eight administrative entity organizations responded to DHS' request for proposal. Consequently, the State may be at risk if an entity fails to perform its responsibilities. As occurred in the Gila/East Pinal county area, there may be no other organizations capable of performing as an administrative entity if an existing entity fails to perform its contracted duties or discontinues operations. DHS, likewise, may have difficulty assuming the responsibility, especially in the urban areas where administrative entities have numerous contracts and programs to oversee.

Behavioral Health Management Information System

BHMIS may not meet legislative goals. The computer hardware and software may not be adequate to meet the demands of BHMIS because of poor processing times. In addition, the department is unable to use BHMIS data for evaluating programs at this time and complete tracking may not be possible without county and other agencies' data.

In 1986 the Legislature required the Division of Behavioral Health Services to "contract for the design and develop a computer system to track and monitor chronically mentally ill clients and to provide the division with information on all behavioral health programs." Legislation called for the system to be implemented on a statewide basis by no later than July 1, 1987. The Legislature extended the deadline to July 1, 1988, and then to January 1, 1990. The system went on-line June 1989.

Inadequate hardware system - Because DHS purchased the computer and software systems before BHMIS was fully designed, the existing hardware may not be capable of handling BHMIS requirements. Initially, DHS

contracted for a general system design. The study recommended computer hardware and DHS subsequently bought a system for BHMIS. However, the general system design was not a detailed design for BHMIS, and consequently, DHS staff had to develop the detailed design. The selection of the hardware and software for BHMIS may have been premature, given that the final systems design was not done until after those resources were purchased.

The current computer system may be inadequate for BHMIS requirements. At present, batch transaction times and on-line processing are extremely slow. According to the program administrator, during system testing initial transaction times for 5,000 records in batch reporting mode took approximately eleven hours or 7.9 seconds per transaction. Transaction time has reportedly been reduced to 2.8 seconds per transaction, but the goal is less than one second. DHS expects that about 80 percent of all transactions will be processed through batch reporting. Because the system has only begun operation, it is too early to tell how batch transaction times will affect system processing and contractor payments.

On-line processing response time also appears to be very poor. Reportedly, during the testing phase on-line processing was originally taking ten to twelve minutes per transaction. Later during the testing phase, DHS reduced on-line processing time to a range of eight seconds to one minute per transaction. The goal is ten seconds or less per transaction. Follow-up interviews after implementation revealed that on-line processing time is still a problem. One entity staff person said that they have experienced automatic log-offs while waiting for transactions to process completely. The terminal is automatically logged off if the enter key is not pressed within approximately 10 minutes. Because some transactions are not completed within 10 minutes, terminal operators are not able to enter more data and consequently are logged off. As the database grows and the number of users on the system increases, the problems associated with poor on-line processing times are likely to increase.

The program administrator attributes much of the problem to the inadequacy of the hardware and the computer requirements of the

software. He questions whether the current hardware will be adequate beyond a year of operation. According to the department, staff has actively sought ways to overcome the limitations of the hardware and software. They have worked with the vendors to develop solutions to problems they have encountered. In addition, they have recently completed an extensive series of tests using an upgraded computer. DHS reports that significant improvements may be possible with upgraded equipment. However, if the improvements are not attained, DHS will then have to consider various options including reduced data collection, restricted access to on-line reporting, and changes or reduction in information reporting.

Evaluation component - Although an important use of BHMIS is to evaluate client progress and program effectiveness, the program administrator estimates it will be at least twelve months before valid research can begin. DHS must first establish and fill staff positions and develop quality assurance plans to ensure the integrity of the client assessment data.

Valid research is dependent on accurate and timely data. Providers must complete a client assessment for each registered client seen. The assessment determines the client's functional ability considering psychological, social, and occupational categories. This assessment must be completed at the time of intake, every 90 days thereafter, and when the client is discharged. This data is reported to BHMIS. However, in many instances paraprofessionals will be completing the assessment forms due to the nature of the service provider's program. They may not have the qualifications to accurately assess the clients. For this reason, DHS will have to provide appropriate training. DHS has offered limited training to date but has plans to provide additional training in the future. In addition, professional staff must also be able and willing to accurately complete the assessment form. Ensuring accurate and timely data will require an intense quality assurance effort by DHS including auditing provider records.

Aside from client assessment data, DHS has made considerable effort to ensure data integrity. They have developed a quality users manual, have conducted several training sessions on BHMIS and have developed extensive data edits that prevent many errors from getting into the data base.

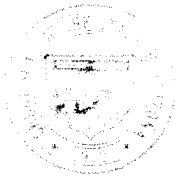
Although legislation calls for BHMIS to track chronically mentally ill clients, BHMIS may not be able to completely track some individuals who receive county services instead of or in addition to State services. BHMIS data is collected from service providers under contract with DHS or administrative entities. However, some chronically mentally ill may also receive services from the counties and other state agencies. These services are not reported to BHMIS, and therefore, tracking of services may be incomplete. DHS feels that to collect such information from other agencies exceeds its legislative mandate and would require further legislative authority. The problem could be addressed in part by integrating State and county systems as recommended in Finding I (see pages 7 through 15).

Service Providers Must Contend With Multiple State Agencies

In addition to DHS, other State agencies provide behavioral health services. These agencies include the Department of Economic Security (DES), the Department of Corrections (DOC), the Department of Education (DOE), and the Supreme Court as administrator of juvenile probation programs. Many of these agencies expend substantial monies on behavioral health services. Although these agencies have large programs with similar or related services, there is little coordination between agencies.

Multiple agencies contracting for services adversely affects service providers and clients. Service providers we interviewed reported that they have contracts with two or more state agencies, as well as with counties. One service provider has contracts with the administrative entity, DES, the Supreme Court, and DOC. Another provider has contracts with two counties, DES, and the administrative entity. Service providers noted that each agency has its own record-keeping requirements and conducts its own financial audits, program evaluations, and licensing

reviews. One service provider reported that as a result of the various requirements, his operation was subject to 24 audits per year by two administrative entities in addition to 20 other audits and licensing reviews. The provider has one full-time employee to assist entity and agency personnel. Consequently, service providers reported that professional time with clients is reduced because of time they must devote to records and reports that vary from agency to agency. They claim the cost of services is increased due to multiple agency involvement.



ARIZONA DEPARTMENT OF HEALTH SERVICES

Division of Behavioral Health Services

ROSE MOFFORD, GOVERNOR
TED WILLIAMS, DIRECTOR

November 6, 1989

Douglas R. Norton
Auditor General
2700 N. Central Ave.
Suite 700
Phoenix, AZ 85004

Dear Mr. Norton:

The ADHS/Division of Behavioral Health Services has reviewed the revised preliminary draft of the performance audit report dated October 25, 1989. Our written response to that report is attached and reflects commentary by Boyd Dover, Assistant Director, Division of Behavioral Health Services, the Division management and myself.

Thank you for the opportunity to review and to respond to the preliminary draft.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ted Williams".

Ted Williams, Director
Arizona Department of Health Services

TW:bp

The Department of Health Services is An Equal Opportunity Affirmative Action Employer. All qualified men and women, including the handicapped, are encouraged to participate.

FINDING I

INTEGRATION OF STATE AND COUNTY BEHAVIORAL HEALTH PROGRAMS IS NEEDED.

RECOMMENDATION

THE STATE SHOULD DEVELOP A LONG RANGE PLAN TO ESTABLISH A STATE RUN, BEHAVIORAL HEALTH PROGRAM THAT INTEGRATES STATE AND COUNTY BEHAVIORAL HEALTH PROGRAMS. A SINGLE MANAGEMENT AUTHORITY AND FUNDING STREAM SHOULD BE KEY ELEMENTS OF THE INTEGRATED SYSTEM.

Discussion

Finding One and the resultant recommendation is based on several observations discussed in the audit report. They are as follows:

- 1) The existence of separate State and County behavioral health delivery systems has resulted in fragmented and uncoordinated services, thereby creating an inequitable distribution of available resources to individuals with similar needs.
- 2) The existence of separate delivery systems has resulted in poor County-State relations prompting poor communications, unmet expectations, disproportionate financial burden to the counties and lack of clear state direction to the State established Entity System.
- 3) Separate systems have led to fragmented services which, in turn, have reduced the quality and efficiency of those services.
- 4) The creation of a single management authority and a single funding stream are considered critical to establishing an integrated delivery system approach. Such can be accomplished at either the State or County level. Wisconsin and Ohio are referenced by the report as good examples of county operated systems. Given the lack of county resources in Arizona, the report concludes that for Arizona, a state administered system is appropriate. AHCCCS, the state indigent health care program is cited as the Arizona precedent for integrating state and county services.

RESPONSE

The Division of Behavioral Health Services (DBHS) management concurs with the report's assessment that the existing service delivery system is fragmented and that "like" services are not always well coordinated between State and County programs. However, some of the information presented as substantiation for that assessment is in error. For example, County expenditures for behavioral health services are cited as being nearly equal to total DBHS expenditures for community based services delivered statewide through the administrative entities and SAMHC. Specifically, the report states on page seven that in FY 1988 Counties spent approximately \$24 million dollars for behavioral health services while DBHS spent \$20.9 million in State funds and \$4.9 million in federal funds that same year. In actuality, DBHS for FY 1988, spent \$50.4 million dollars for the

* Auditor's Note: The report has been revised to reflect the correct amount of \$35.5 million for DBHS' FY 1988 expenditures.

provision of community based services. Furthermore, the referenced county expenditures for behavioral health services includes institutional services provided at Maricopa Medical Center and Kino Community Hospital. Consequently, one could legitimately argue that the total State expenditure should include the approximately 30 million dollars expended to operate the Arizona State Hospital during FY 1988 thus bringing total DBHS expenditures to \$80 plus million dollars.

The information presented as a justification for Finding One is subjective and/or lacking in verifiable data references. For example, county officials are quoted as professing total lack of knowledge regarding the entity system or its activities. How this information was gathered and whether the information reflects one officials opinion or that of several is not indicated. Commentary by the authors of this report on the negative experiences by two clients seeking behavioral health services from the State administered system, implies that these occurrences indicate the norm rather than the exception. Yet the report does not reference the thousands of clients who repeatedly have received adequate care through the existing delivery system. In neither of these two examples is the number of individuals reviewed or interviewed identified.

The Division of Behavioral Health Services, ADHS, is very interested in aggressively moving toward a statewide system with a single authority and funding stream, as suggested by this report. The September 1989 Arizona Comprehensive Mental Health Services Plan, prepared by DBHS and the Governor appointed Mental Health Planning Council, supports this concept as a means for establishing a more efficient and consolidated service delivery approach. Many of the goals contained in this Plan reflect that direction and address specific strategies for achieving such a systems approach. The Division is also giving serious consideration to the introduction of legislation in the upcoming session supporting such an approach and has raised the issue with the Governors Task Force on the Serious Mentally Ill for consideration and recommendation.

FINDING II

DHS IS NOT ADEQUATELY MONITORING THE PERFORMANCE OF ADMINISTRATIVE ENTITIES

RECOMMENDATION

DHS' ANNUAL SITE VISITS AND REPORTS SHOULD:

- * FOCUS ON CONTRACT REQUIREMENTS;
- * BE MORE COMPREHENSIVE, UNIFORM, AND TIMELY;
- * INCLUDE FOLLOW-UP VISITS TO DETERMINE WHETHER RECOMMENDED CHANGES HAVE BEEN IMPLEMENTED.

RESPONSE

The DBHS, since its inception, has been conducting annual site visits of Community Behavioral Health programs which focus on adherence to contract requirements. An existing requirement checklist is employed which measures contractor performance based on agreed to stipulated requirements and timelines on a contract by contract basis. The checklist states each contract requirement, date the requirement is due, the date submitted and any approval notation.

All DBHS annual site visits are performed in accordance with OCBHS established procedures. Doing so ensures comprehensiveness, uniformity and timeliness. The due date for FY 89-90 site visits reports was established as October 1, 1989. Site visits for FY 1989 have been completed, reports have been finalized and follow-up meetings have been scheduled for the remainder of this year. These follow-up visits will be documented and submitted as part of agency final trip reports.

RECOMMENDATION

DHS SHOULD CONDUCT A GREATER NUMBER OF SERVICE VERIFICATION REVIEWS. THESE REVIEWS SHOULD ALSO BE MORE THOROUGH.

RESPONSE

DBHS will continue to conduct service verification reviews at the time of site visits in accordance with established procedures. Agencies that are experiencing problems in data recording are reviewed again at follow up visits for the purpose of verifying corrective actions. Additional visits may be scheduled to verify compliance on an as needed basis. A final audit is also completed by the DHS auditors and where overpayments or undocumented payments are found, reimbursement is requested. A hearing or other legal action follows, if the reimbursement is challenged.

RECOMMENDATION

DHS SHOULD IMMEDIATELY FOLLOW-UP ON ALLEGATIONS OF AGENCY MISCONDUCT AND SHOULD PROVIDE TO THE ADMINISTRATIVE ENTITIES WRITTEN REPORTS OF ITS FINDINGS. SITE VISITS SHOULD BE USED TO DETERMINE WHETHER ADMINISTRATIVE ENTITIES HAVE CORRECTED THE PROBLEM.

RESPONSE

OCBHS has always investigated allegations of misconduct as they have been identified. The rapidity of the response is based on the seriousness of the complaint. Allegations of agency misconduct are investigated by OCBHS within one week of notification. Allegations involving client abuse or mistreatment are investigated within 24 hours of notifications. All investigations are documented on field trip reports. If program investigations prove misconduct, the matter may be referred to Adult or Child Protective Services, Behavioral Health Licensing, appropriate Law enforcement agencies, or the Department's Special Investigation unit for appropriate follow up. Any findings are shared with Administrative Entities, as appropriate, and corrective action is initiated and verified.

RECOMMENDATION

DHS MANAGEMENT SHOULD MAKE MONITORING OF ADMINISTRATIVE ENTITY PERFORMANCE A PRIORITY AND SHOULD PROVIDE CLEAR DIRECTION TO STAFF AS TO HOW MONITORING IS TO BE ACCOMPLISHED.

RESPONSE

DBHS/ADHS management has always considered monitoring of Administrative Entities as the highest priority for the Office of Community Behavioral Health. Existing OCBH Program staff vacancies will be filled as quickly as possible so that OCBHS staffing will be at full strength. Existing Quality Assurance procedures and program procedures will be strictly adhered to by program staff. Standards and procedures are updated on an as needed basis and periodic staff meetings are utilized for discussion of program direction, clarification of procedures and site visit findings, when appropriate.

RECOMMENDATION

THE OCBHS PROGRAM APPROVAL STANDARDS, AND POLICIES AND PROCEDURES MANUAL SHOULD BE UPDATED IN ORDER TO BE USED AS EFFECTIVE MONITORING DEVICES OF ADMINISTRATIVE ENTITIES.

RESPONSE

OCBHS Program Approval Standards are revised periodically as dictated by changes in programs and services. The OCBHS Policies and Procedures Manual is also continually under revision to reflect changing State and Federal monitoring requirements.

FINDING III

CHANGES IN CONTRACTS COULD RESULT IN IMPROVED SERVICES

RECOMMENDATION

THE DEPARTMENT OF HEALTH SERVICES SHOULD EVALUATE THE PERFORMANCE CONTRACT SYSTEM AS DEVELOPED BY COLORADO AND CONSIDER ADOPTING THOSE PROVISIONS DEALING WITH THE DEVELOPMENT OF SERVICE PROVISION TO TARGETED POPULATIONS, ASSESSMENT OF PENALTIES FOR NON-PERFORMANCE, AND QUALITY ASSURANCE.

RESPONSE

The Report suggests that DBHS evaluate Colorado's contracting approach as a possible remedy for its own contracting process deficiencies. The Report stipulates that the Division's contracting approach is deficient in that contracts do not clearly define who is to receive services, establishes no penalties for non-performance, and does not contain specific requirements for quality assurance.

As a general comment on the audit team's concerns about the contracts, the report seems to ignore that the development of the service levels set forth in the contracts follows an extensive needs assessment at the local levels. Since the service levels are set

forth in the contracts, it is difficult to understand how the audit team concludes that "the administrative entities determine who will receive available services." It is clear that DHS contracts are based on provision of service levels versus target population as defined by the audit team. It is not clear that utilization of target populations would result in better overall service to the population. In either approach, the system must provide treatment to those who present for treatment and the "worried well" have equal opportunities under either system. Finally, the audit team offered no comment on a recommended approach to converting to a target population system nor did they discuss the practical aspects of doing so.

The facts are that contracts do clearly define which target populations are to be served. The Division (DBHS) recently provided each Administrative Entity with a document that provides baseline data (i.e., population projections by age, sex, and target subgroup) to use in developing projections for the various target groups as to who is to receive what services within their primary services area. Entity contract language stipulating that needs assessment must be part of their annual plan of services has been clarified. Collaborative efforts are presently underway between the Office of Planning, Rules and Grants and the Office of MIS Research and Evaluation to refine the baseline database for the purpose of providing additional demographic data for each target group such as income, education, employment status, household size, etc. DBHS anticipates that this data will be available to the Entities for their FY 1991 planning cycle.

The DBHS is committed to implementing an externally administered quality assurance program to assess treatment approaches. The Arizona Comprehensive Mental Health Services Plan calls for the establishment of a Quality Assurance program during FY1990, to be operational in FY 1991 (See Goal S.I., page 86). OCBHS has developed and published a Request for Proposal seeking qualified professionals to assist in this endeavor.

Non-performance on the part of Administrative Entities for contracted services not provided requires the return to DBHS of any dollars allocated for services not provided. Consistent underserving of a target population or consistent non-provision of contracted services will result in OCBHS evaluating alternative methods of providing the applicable services.

The statement that "there is no penalty for those administrative entities that exceed this provision" is not true. The penalty for exceeding the 20 percent provision is nonpayment for those services which exceed the contract provision. Further, the audit team does not recognize that increased payment is not made for overproduction.

The audit team's comment that Arizona contracts do not contain penalty provisions for untimely financial reporting is inaccurate. General Provisions 16 b. and c. provide for withholding of or adjusting payments if reports are not timely and accurate or if compliance problems are discovered. Such penalty provisions are more effective than relatively small "fines."

FINDING IV

DHS COULD IMPROVE ITS METHODS OF ALLOCATING FUNDS BY BASING FUNDING MORE ON NEEDS ASSESSMENTS.

RECOMMENDATION

THE DEPARTMENT OF HEALTH SERVICES SHOULD IDENTIFY SPECIFIC MEASUREMENTS OF BEHAVIORAL HEALTH NEEDS AND MAKE GREATER USE OF THEM IN THE FUNDING DISTRIBUTION PROCESS.

RESPONSE

The Division is currently allocating funds according to population, poverty indicators and by age of the target population. In so doing, historical funding disparities, although still existent, are being minimized. Important to note is that those disparities existed prior to the Entity system-not because of it. The Report, on page 36 advocates the use of social indicators data as a measure of need. As previously stated, efforts are consistently underway to expand the Division's data-base to include such indicators. At this time, the Division continues to rely on the needs assessment data prepared by Peat, Marwick and Main which was based on their extensive national experiences in developing needs assessment data. The Division is continually updating that basedata as is reflected in the needs assessment data contained in the September 1989 Comprehensive Mental Health Services Plan.

It is interesting to note that Arizona was selected as one of the States to participate in the health block grant compliance reviews conducted in FY 1988 by the U.S. Department of Health and Human Services. Regarding Arizona's approach to needs assessment, the finding of the report states "The State of Arizona uses an impressive array of tools in identifying populations in need of behavioral health services. Among these are the needs assessments included in the annual report and budgets submitted by contractors to the identified Administrative Entities. Those Administrative Entities, in turn, prepare annual requests for funding that include assessments of needs in their geographic areas. These requests are submitted to DBHS for use in the planning process."

FINDINGS: OTHER PERTINENT INFORMATION

The Report covers three additional areas of concern: the Administrative Entity System, the Behavioral Health Management Information System (BHMIS), and the delivery of behavioral health services by other State agencies.

RESPONSE

With respect to the Entity System, the Division of Behavioral Health Services continues to support the concept of community based delivery of services, administered by the Entity Network on a regional basis. Gila and Pinal Counties will be combined under one Administrative Entity yet to be selected, thus reducing the statewide total from nine Entities to eight. The Division will continue to provide Entities with technical assistance in the areas of contracting, contract compliance, quality assurance, needs assessment and planning, for the purpose of enhancing the capacity of Entities to support the local provider network.

With respect to multi-state agency provision of behavioral health services, DBHS is addressing this issue, as it affects children with behavioral health problems, by having initiated a centralized intake approach in Pima County whereby children, irrespective of referral source, are screened and referred to appropriate agencies for follow-up treatment. The funds that pay for the services provided to the child are passed through a single agency (ADAPT), irrespective of funding source. In other words, the dollars follow the child. If this approach continues to be successful in Pima County, DBHS will replicate this approach statewide.

Regarding BHMIS, the Report states that BHMIS may not meet legislative goals and cites three areas of concern: computer hardware, program evaluation and client tracking. DBHS MIS management agrees that computer hardware and software problems created difficulties during system implementation. Without detailing all of the corrective action measures involved in overcoming these difficulties, DBHS is satisfied that the integrity of the system has not been compromised and that appropriate steps have been taken with the Departments data administrators and legal counsel to resolve these problems. The System is up and operating according to expectations. Any start up problems have been identified and are being resolved.

Program evaluation concerns expressed in the Report are unfounded. Due diligence dictates that any data generated by a new MIS system must be interpreted cautiously during the first few months of operation. Quality assurance activities such as training programs, procedure manual, system specifications data edits and random "on site" edits are in place. With respect to client tracking, all individuals accessing State provided services will be captured. The legislative mandate required BHMIS to provide DBHS with information on all behavioral health programs funded by the Division. We believe that BHMIS meets that mandate.

CONCLUDING REMARKS

The Auditor General's Report concentrates only on the problems associated with the delivery of behavioral health services. The Report does not contain any language acknowledging the substantial gains in behavioral health services delivery achieved during the last several years.

Some of those gains are: (1) legislative appropriations of 16.6 and 16.7 million in new behavioral health services dollars for FY 1989 and FY 1990, respectively; (2) creation of a Governors Blue Ribbon Task Force charged with developing recommendations for implementing *Arnold vs. Sarn*; and (3) the coalition of mental health advocates, consumers, providers and state agency personnel resulting in a unified public policy strategy for behavioral health in Arizona (4) Beginning development of the States first Comprehensive Children's Mental Health System.

The aggregate impact of these gains is the emergence of a rapidly growing behavioral health system that is experiencing some of the problems typically associated with rapid growth in demand, i.e. shortage of professionals, scarcity of support capacity and inadequacy of follow-up due to staffing shortages, while providing a broader array of services to more individuals than ever before.

Despite these growing pains, public sentiment and statements by the Governors Office and many of the legislators demonstrate that behavioral health is regarded as a top funding priority for the State of Arizona. The Division of Behavioral Health Services, the mental health community at large and those persons impacted by the serious nature of mental illness are committed to achieving a comprehensive behavioral health delivery system. The Department management is committed to implementing and supporting the strategies required and the resources necessary for implementing this system and is working diligently to that end. It will take time and will require the ongoing commitment of the legislature, the mental health community, the provider network and the availability of resources.

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