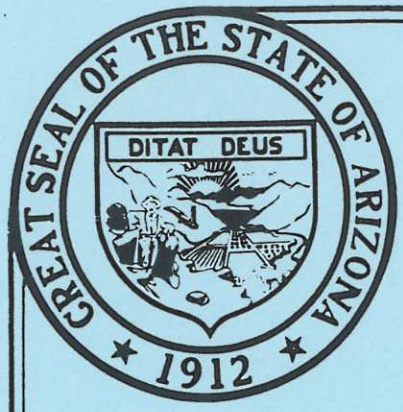

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF FAMILY HEALTH SERVICES

Report to the Arizona Legislature
By the Auditor General
April 1989
89-1

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
DEPUTY AUDITOR GENERAL

April 24, 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 Family Health Services. 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.

This is the third is a series of reports to be issued on the Department of Health Services. The report addresses issues in three areas. We found the Women, Infants and Children (WIC) food program is generally well managed but could be expanded to serve additional people by negotiating rebates on infant formula sold to program participants. We also found the division needs to continue to improve its handling of complaints filed against hearing aid dispensers and midwives by establishing consistent investigation procedures and seeking statutory authority for intermediate sanctions. Finally, the Children's Rehabilitative Services program should be reviewed to ensure that the conditions eligible for coverage are the most effective use of the limited funds available.

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

Sincerely,

Douglas R. Norton
Auditor General

DRN:BT:lmn

Staff: William Thomson
Mark Fleming
Martha B. Dorsey
Kurt L. Schulte
Shan D. Hays

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

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Family 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 third in a series of reports to be issued on the Arizona Department of Health Services (DHS). Overall, our audit work identified few major problems with the Division of Family Health Services (FHS) programs. This report focuses on three areas. These include the need for the Women, Infants, and Children (WIC) program to expand its service capabilities through the implementation of cost saving techniques, the adequacy of DHS' management of complaints against hearing aid dispensers and midwife licensing programs, and the need for continued evaluation of DHS' Children's Rehabilitative Services (CRS) program.

WIC Program Is Adequately Managed, But Could Serve Additional People by Negotiating Rebates with Infant Formula Manufacturers **(see pages 5-10)**

The Arizona nutrition program for women, infants, and children appears to be well managed, but the use of infant formula rebates could increase the number of people served. Comparison of Arizona's WIC program with those in other western states suggests that DHS management is adequate, when measured by service levels and program costs. However, Arizona could save as much as $310,000 per month, which would allow serving up to 6,900 additional people, by implementing an infant formula rebate program similar to those used in other states. Although research by Arizona WIC staff concluded that rebates would allow Arizona to expand services, DHS management was reluctant to implement a rebate program because of possible price increases after the rebates are established. However, DHS could include provisions in its rebate agreements to protect against such increases.

The state WIC office could also improve relations with local agencies by

providing more information about fund allocation decisions. These agencies feel that DHS has allocated funds for its own administrative purposes to the detriment of the local programs, and has also unfairly limited the agencies' ability to negotiate for available WIC monies. These concerns appear misplaced since federal requirements limit DHS' negotiating potential. However, DHS could improve communication with local agencies about funding decisions.

The Division of Family Health Services Has Not Adequately Managed Hearing Aid Dispenser and Midwife Licensing Complaints **(see pages 11-17)**

FHS' management of complaints against hearing aid dispensers and midwives has not been adequate. Previous complaint tracking and logging efforts for each program have been limited. Prior to our audit neither program had a complaint log, and staff were unaware of the scope, content, and status of the complaint population. Formal complaint investigation procedures were also lacking, which has resulted in inconsistent and poorly documented investigations. Each program now logs and tracks all complaints received, and investigation procedures have also been developed, but not formalized.

Both programs have also been hindered by inadequate enforcement options. Neither program has the ability to impose intermediate sanctions such as civil penalties. The only enforcement options are extreme, license suspension or revocation. Also, DHS cannot require hearing aid dispenser licensees to make restitution to customers, even though this is the request of most of the complaints we reviewed. Nor does DHS have the authority to access all records necessary for midwife complaint investigations.

DHS Should Continue Efforts To Reevaluate CRS Program **(see pages 19-23)**

The present structure of the Children's Rehabilitative Services section may be inappropriate due to changing needs and medical advances. The program only covers certain medical conditions of chronically ill children. However, the list of conditions covered developed incrementally as medical technology advanced and funding became

available. As a result, some serious illnesses such as hemophilia, bronchopulmonary displasia, severe asthma, and diabetes are not covered while other illnesses which are now more easily treated, such as ear infections, are still covered.

There has been national debate over which conditions should be covered and how treatment should be provided by such programs. Most states cover a list of specified conditions much like Arizona's. However, research is currently underway to develop other methods of coverage. For example, one state covers any condition, but only for families with a very low income ($9,000/year for a family of four). FHS is attempting to develop the ability to determine coverage based on the condition's impact on the child and family. Arizona should continue to evaluate the role of the CRS program, specifically the conditions covered and the level of financial assistance available.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Family 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 third in a series of reports to be issued on the Arizona Department of Health Services.

The Division of Family Health Services (FHS) administers a variety of food, medical, educational, and social services programs. FHS is divided into five offices: Nutrition Services, Maternal and Child Health, Children's Rehabilitative Services, Dental Health, and Assistant Director/Administration. These offices are responsible for managing a total of 34 separate programs.

The Office of Nutrition Services provides services and funding to promote good health through good nutrition. The office spent $19.5 million during fiscal year 1987-88, of which almost $19 million was allocated to the Women, Infants, and Children (WIC) program. The WIC program is federally funded, and is designed to provide supplemental food and nutrition education to high-risk pregnant women as well as to infants and children to five years of age. Other programs administered by the office provide nutritional consulting to the elderly, developmentally disabled, child daycare centers, and children with special health care needs.

The Office of Maternal and Child Health has the mission of promoting the health of women in childbearing years and children. The office has two sections: maternal health and child health. The maternal health section of the Office of Maternal and Child Health provides a statewide system of consultation and transportation for high-risk pregnant women. Other programs pertain to the promotion of maternal and infant health, family planning, social services consultation, and communications consultation to communities about health programs. This section is also responsible for the licensing and regulation of midwives.

The major child health program is the newborn intensive care program, which accounted for $4.1 million of the office's $7.8 million expenditures during fiscal year (fy) 1987-88. This program will provide transportation, hospital care, physician consultation, and follow-up services for critically ill newborns. Other programs in the child health section include consultation with communities on early childhood issues, case management by nurses of high-risk children and adolescents (five counties), child health planning (five counties), child injury prevention, and technical assistance to school health staff.

The Office of Children's Rehabilitative Services primarily provides for the comprehensive medical care of eligible children under 21 years of age who are chronically ill or physically disabled. The children must meet medical and financial eligibility criteria. Overall office expenditures for fiscal year 1987-88 exceeded $12.7 million. The majority of this money was used to contract services for these children. The office also administers smaller programs pertaining to hearing conservation and vision screening for children, and sickle cell anemia screening and consultation for both adults and children. The hearing conservation program is responsible for the licensing of hearing aid dispensers.

The Office of Dental Health coordinates dental prevention and treatment programs for the homebound, the frail and elderly, and for children from families not eligible for Arizona Health Care Cost Containment System (AHCCCS) reimbursement but who are below federal poverty level. Prevention programs include the use of fluoride mouthrinse and dental sealant to prevent dental problems among school children. Treatment is provided by mobile dental units in the rural areas of the state where the need is greatest.

The office also publishes a newsletter on continuing education for dental professionals. Other office functions include dental consultation for AHCCCS and the state hospital, as well as regulating prepaid dental plans and programs in Arizona health maintenance organizations (HMOs). Total office expenditures for fy 1987-88 were over $1.1 million.

The Assistant Director/Office of Administration is responsible for budget development and control, contract management, word processing, and personnel services. Total fiscal year 1987-88 expenditures exceeded $740,000.

Table 1 summarizes the Division of Family Health Services' financing and staffing.

TABLE 1

DIVISION OF FAMILY HEALTH SERVICES
FISCAL YEAR 1987-88 PROGRAM EXPENDITURES AND FTEs
BY REVENUE SOURCE

	SOURCE				FTEs(a)		
FHS Office	State Funds	IGAs(b)	Federal Grants	Total Expenditures	State	Federal	Total
Nutrition Services	$ 602,239	$ 109,822	$18,813,439	$19,525,500	13.00	13.00	26.00
Children's Rehab.	6,495,724	5,320,466	905,615	12,721,805	40.50	14.75	55.25
Maternal/Child Health	5,319,983	294,354	2,150,801	7,765,138	8.50	26.25	34.75
Dental Health	455,531	95,069	582,126	1,132,726	11.00	1.00	11.00
Asst. Director/ Admin.	737,629	-0-	5,650	743,279	10.50	11.50	22.00
TOTAL	$13,611,106	$5,819,711	$22,457,631	$41,888,448	83.50	65.50	149.00

(a) As of February 1989.
(b) IGAs represent the total dollars DHS received for these programs through intergovernmental agreements with other state agencies. . Figures also include donation amounts of $17,047 for Children's Rehabilitative Services and $80,569 for Dental Health.

Source: Auditor General analysis of DHS expenditure data for fiscal year 1987-88. FTE data provided by FHS Office of Administrative Services.

Audit Scope and Purpose

This audit was conducted to evaluate the effectiveness of operations within the Department of Health Services, Division of Family Health Services, focusing on these specific areas:

- The need for DHS to implement additional cost-saving measures in order to increase service by the WIC program.

- The adequacy of DHS' complaint management for the hearing dispenser and midwife licensing programs.

- The need to reevaluate the CRS program.

The audit scope focused on these three areas only because few problems directly related to FHS programs and activities were identified during the preliminary audit work. Most concerns about FHS centered on the extent to which medical care and services are generally available in Arizona, especially for families lacking health insurance but not eligible for AHCCCS. Addressing the broader questions about availability and financing of medical care would have exceeded the resources available for the audit. Complaint management review was conducted because of problems found in DHS' handling of complaints in other recent Auditor General performance audits. (See reports number 88-5 and 88-12.)

The section entitled Areas for Further Audit Work addresses issues identified during the course of our audit work, but which we were unable to research due to time constraints. (See pages 25-26.)

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

The Auditor General and staff express appreciation to the Director of the Department of Health Services and the staff of the Division of Family Health Services for their cooperation and assistance during the course of our audit.

FINDING I

THE WOMEN, INFANTS, AND CHILDREN FOOD PROGRAM IS ADEQUATELY MANAGED, BUT COULD SERVE ADDITIONAL PEOPLE BY NEGOTIATING REBATES WITH INFANT FORMULA MANUFACTURERS

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is generally well run but its service could be expanded by using rebates on infant formula. Rebates similar to those used by other states could provide approximately $310,000 per month in food and administrative funds to serve an estimated 6,900 more individuals.

The Women, Infants, and Children Program Is A Food Supplement Program

WIC is a program funded by the U.S Department of Agriculture (USDA) to improve the nutrition of low income pregnant and postpartum women and children under the age of five through the use of food supplements. WIC is entirely funded by federal grants. The federal government allocated approximately $19.8 million to Arizona for fiscal year 1988-89.

The Department of Health Services administers the WIC program at the state level through its Division of Family Health Services (FHS). FHS contracts with county health departments, Indian tribes, and other local health agencies to administer WIC services. Participants first visit local clinics for screening, education, and referral to other health services. They next obtain vouchers listing foods which will meet their special nutritional needs. The participants take the vouchers to authorized retail stores and exchange them for the foods listed.

Family Health Services Seems to Adequately Manage Program

Comparisons of Arizona's WIC program with those in other western states suggest that DHS manages the program adequately. The few criticisms of program management came from local agencies. However, those criticisms appear to stem from poor communication rather than actual problems.

Program management appears adequate - Arizona WIC program management appears to be adequate compared with other western states when measured by service levels and program costs. WIC service levels in Arizona are comparable to other western states. Approximately 41,000 Arizonans will receive WIC benefits each month in fiscal year 1988-89. This represents about 32 percent of the estimated potentially eligible population. The average service level in the Western Region - 34 percent - is only slightly higher. USDA statistics summarized in Table 2 (see page 7) show Arizona's WIC program compared with other states in USDA's Western Region. Arizona ranks near the middle in percent of eligible population served, percent of administrative money passed through to local agencies, and food cost per client. The administrative cost per client last year was lower in Arizona than in any other state in the Western Region.

However, communication with WIC contractors can be improved - The state WIC office could improve relations with local agencies by providing more information about WIC fund allocation decisions. When auditors visited local agencies, some health administrators reported dissatisfaction with WIC. They felt that DHS allocated funds for its own administrative purposes to the detriment of local programs. Local administrators also felt that DHS unfairly limited their ability to negotiate for available WIC monies. This concern appears misplaced since federal requirements limit the negotiating potential in WIC contracts. However, DHS could improve communication with local agencies about funding decisions. DHS is currently working with local program administrators to revise the method for distributing funds to counties. This may improve the local agencies' understanding of the federal and financial constraints on the WIC program and reduce some of the local concerns.

TABLE 2

WIC STATISTICS FOR
WESTERN STATES REGION

State	Percent Served	Monthly Administrative Cost per Client(a)	Monthly Food Cost Per Client(b)	Percent Passed Through(c)
Alaska	31.1%	$15.81	$42.02	(d)
Arizona	31.7	8.63	33.49	73%
California	32.2	8.74	37.81	76
Hawaii	24.4	11.30	44.53	72
Idaho	29.4	9.02	32.69	82
Nevada	53.9	9.84	32.05	72
Oregon	37.4	9.30	28.42	73
Washington	32.4	8.79	34.23	67
Average	34.0%	$10.18	$35.66	74%
Arizona's rank	5th	8th	4th	3rd

(a) Administrative funds are used for client service (health evaluation, enrollment, and education) as well as for program administration expenses such as data processing and other overhead.

(b) Food cost per client is the state's total food expenditures divided by the state's total number of participants.

(c) Percent passed through refers to the portion of total administrative funds provided to local health agencies for operating the program. The remainder is spent at the state level.

(d) Data not available.

Note: Cost figures are for fiscal year 1987-88. Percent of funds passed through and percent of target population served are for fiscal year 1986-87. These are the most recent figures available from USDA.

Source: Information provided by USDA's Western Region Office

Rebates on Infant Formula Would Provide Funds to Increase Coverage

Arizona could save as much as $310,000 per month, which would allow serving up to 6,900 additional people, by implementing an infant formula rebate program like those used in other states. Several states have adopted rebates to comply with a 1988 federal law requiring implementation of cost containment measures in order to serve more

people. Although research by Arizona WIC staff concluded that rebates would allow Arizona to expand services, DHS management was reluctant to implement a rebate program until recently.

Several states use rebates - Federal law now requires states to implement WIC cost containment measures, and a number of states have selected an infant formula rebate program to satisfy that requirement. A 1987 federal law encourages states to introduce cost savings by allowing them to retain some of the savings for administrative purposes. The remainder must be used to provide additional WIC services. The most recent federal appropriations bill requires states to initiate cost containment systems by August 30, 1989. Several states have chosen to focus their cost containment efforts on infant formula, possibly because many WIC participants are infants, and infant formula averages about 36 percent of total WIC food costs. These states contract with one or more manufacturers to provide a WIC approved formula, and the manufacturers send monthly rebate checks to the administering state agency for a portion of the price of the formula sold to WIC clients. A September 1988 USDA memorandum indicates nineteen states were either in the process of implementing rebate programs or had already started the program. Savings have been substantial, as illustrated by the following examples.

- In Texas, the WIC program chief anticipates serving more participants by saving $35 million per year due to contracting with a single manufacturer who will provide all WIC infant formula at a 99.6 cents per can rebate.

- California expects to serve 135,000 additional clients each month with total savings of $57 million per year by contracting with one manufacturer who has agreed to provide a rebate of $1.45 per can.

- Colorado and New Mexico both contract with two manufacturers instead of a single source, but were still able to obtain agreements at a rebate of 87 cents per can from each manufacturer.

Arizona could increase service by using rebates - The Arizona WIC program could expand services by implementing an infant formula rebate program. The Arizona WIC director conducted research on the rebate program and obtained offers from the two largest manufacturers to provide rebates. Figures developed in late 1987 indicated potential savings of $179,025 (or 3,892 individuals) per month at a rebate of 55 cents per can. One manufacturer recently offered Arizona a minimum rebate of 87 cents per can for liquid iron fortified concentrate (other types of formula would yield higher rebates). The 87 cent rebate would provide Arizona with approximately $310,000 per month, which would enable the program to serve an estimated additional 6,900 participants each month.[1]

DHS recently approved the rebate plan - Although the department is now in the process of negotiating for rebates, DHS management was reluctant to implement the rebate program until recently. The acting assistant director of Family Health Services was concerned that manufacturers might raise prices after the WIC rebate is implemented. A price increase would reduce the program's ability to serve clients and may force the state to drop clients who depend on the program. Other states, however, have written protective clauses into their contracts so that rebates increase to offset most price increases.[2] In addition, the existence of at least three major infant formula manufacturers should assure enough competition in the marketplace to protect against any future price manipulation, barring collusion among the manufacturers.

---

(1) Savings and service levels are calculated as follows:

Current infant enrollment/month	11,500
Average cans of formula/month	X 31
Total cans/month	356,500
Rebate/can	X $.87
Total monthly savings	$310,155.00
Less 25% (estimated) administrative costs	-$77,538.75
Available food funds	$232,616.25
Divided by average food cost/participant	$33.49
Additional participants/month	6,946

(2) USDA determines an acceptable inflation rate for WIC foods annually, and protective clauses allow manufacturers to retain enough of any price increase to cover the USDA approved inflation rate.

Even if future price increases limit the number of persons served, reducing program enrollment can be accomplished by attrition. The federal regulation requiring recertification at six-month intervals provides a mechanism for adjusting caseload. Local agencies already use this method to accommodate funding changes and population shifts. When they need to reduce caseload, they simply stop accepting and recertifying applicants in the lower priority groups.[1] Thus, the WIC program could adjust to price increases by the same method already used to respond to funding changes.

According to DHS officials, the department has completed preliminary steps toward establishing a rebate program and expects to implement the program in July 1989.

Recommendations

1. DHS should negotiate contracts with infant formula manufacturers to provide rebates on WIC approved formula. The contracts should include provisions to increase rebates to meet price increases and to ensure open competition for each year's contract.

2. Prior to annual WIC contract negotiation meetings, DHS should inform local health agencies about available funding levels, distribution of funds, and requirements imposed by federal or state laws and regulations.

---

(1) WIC participation is restricted to people with nutritional risk factors. The factors are classified into six groups and prioritized by federal regulation. Therefore, people who already have a medical condition such as anemia are a higher priority than people whose diet is inadequate which might lead to anemia.

FINDING II

THE DIVISION OF FAMILY HEALTH SERVICES HAS NOT ADEQUATELY MANAGED HEARING AID DISPENSER AND MIDWIFE LICENSING COMPLAINTS

The Department of Health Services (DHS) management of hearing aid dispenser and midwife licensing program complaints has been poor. Previous efforts to track and log complaints for each program have been limited. In addition, both programs lack sufficient enforcement authority to effectively investigate complaints. However, program staff have made progress recently towards improving complaint administration.

Arizona law gives DHS authority to enforce complaint actions against hearing aid dispensers (HADs) and midwives. A.R.S. §36-1934 gives the DHS director authority to suspend or revoke a HAD's license for reasons such as unethical conduct, and gross inefficiency or ignorance in the conduct of practice. A.R.S. §36-756 gives DHS the authority to deny, suspend, or revoke the license of any midwife engaging in conduct or practice detrimental to the health or safety of the mother or child, or allowing or abetting the commission of an unlawful act. The Division of Family Health Services (FHS) is responsible for managing these two licensing functions.

Hearing Aid Dispenser Complaint Management Has Been Poor

The HAD program has had a history of poor complaint management. Complaints have not been tracked or logged, and no formal investigation procedures existed until recently. In at least one instance, this has hindered DHS' ability to take action against an incompetent licensee. Options for enforcement action have also been limited.

Complaint management - Although DHS has had the responsibility for HAD licensing and enforcement since at least 1970, it did not have a complaint tracking system or formalized investigative procedures until 1989. As a result, HAD program personnel were initially unable to provide a listing of complaints against HADs when requested by audit

staff. Program staff did demonstrate a general knowledge of which licensees had complaints, but did not know the total number of complaints, their content, or status. Program staff were also unsure of the location of all of the complaint information. Informal policy had been to keep them in the licensee's regular license file. Several days after our request for complaint data, HAD program staff found a box of complaints filed prior to 1985 that had been kept separately from the license files.

The current program staff were aware of this problem and were developing a computerized system to track complaints but had not entered data prior to the audit. Eventually, program staff compiled a computerized list of 172[1] complaints filed against the 409[2] current active licensees. We reviewed the 21 complaints filed since July 1, 1987, and found that 16 were filed by consumers and pertained to HAD product and service problems. The other 5 complaints were about advertising. Thirteen of the consumer complaints specifically requested refunds for unsatisfactory product and service. Investigation and resolution of these complaints is important for consumer protection, particularly since DHS officials believe the HAD statutes address unfair business practices.

Investigation procedures - The HAD program also lacks formal complaint investigation procedures. Our review of HAD complaint files showed inconsistent use of investigation procedures. For example, some files contained summary sheets documenting all investigative activities, while others did not. Also, analysis of the newly created computerized complaint log identified 14 complaint records[3] (out of 172 total) of unknown status due to insufficient information in the file. The program staff has drafted policies and rules for complaint investigations although they have not yet been formalized.

---

(1) This figure includes all records since 1970.

(2) There are also approximately 600 inactive licensees for which comprehensive complaint information is not available. According to the HAD manager, these licensees have few complaints.

(3) All 14 of these complaints were filed prior to 1986.

Enforcement actions - The HAD manager is aware of at least four enforcement actions since 1984. One licensee received a two-month license suspension for numerous statutory violations.[1] Another licensee went to hearing for illegal business practice, but received no disciplinary action. Another recent case involves unlicensed activity, for which DHS and the Attorney General are seeking an injunction. One licensee has had numerous complaints since 1982, but DHS did not deny his license renewal until December 1988. The circumstances pertaining to this case are described below.

Case Example

Fifty-two complaints have been filed against one licensee since 1983. According to analysis by HAD staff, these complaints contained over 90 specific allegations. The HAD manager stated that at least 13 of these allegations could be considered violations of statute and rule, such as refusing to honor 30-day trial period agreements, charging for repairs while the hearing aid was under warranty, and medical problems related to improperly fitted hearing aids. There were also 8 complaints about the licensee verbally harassing customers, 1 instance of the licensee physically harming a customer, and 2 complaints of sexual advances to employees and customers. Most of the remaining complaints involved unsatisfactory merchandise.

HAD program management has unsuccessfully attempted to take disciplinary action since at least 1983. They were aware of the licensee's complaint history, but poor complaint tracking and investigative procedures prevented them from developing a case that the Attorney General would take to hearing. They were lacking a comprehensive and detailed summary of the scope and magnitude of these complaints. They also had not developed evidence or witnesses that could be used in a hearing. Attempts to impose a license suspension pending an investigation were unsuccessful, as the Attorney General stated this could not be done legally.

---

(1) After a disciplinary hearing, this licensee also paid a $500 penalty as the result of a settlement agreement negotiated with the Attorney General. DHS does not have the statutory authority to impose administrative penalties, and would have been unable to impose this penalty in the absence of the agreement.

By May of 1987, DHS still did not have a sufficiently strong case against this licensee, and so renewed his license. However, by this time, a full-scale investigation was underway by DHS and the Attorney General. A detailed review was done of the complaints and charges against this licensee, and by December 1988, DHS and the Attorney General were able to deny renewal of his license. The licensee voluntarily relinquished his license just prior to this action.

According to the HAD manager, the Attorney General is continuing its investigation of possible criminal charges relating to these complaints, and this licensee has recently been investigated by the DHS Office of Special Investigations for unlicensed activity.

Enforcement authority - The HAD program presently lacks the authority to order restitution by licensees, although this is the reason for the majority of complaints reviewed. According to DHS officials, the department policy for handling these cases is to refer the complainant to the Attorney General-Consumer Fraud Division, the Better Business Bureau, or the Small Claims Court. According to these same officials, DHS does not have the resources to adjudicate these cases and feels sufficient alternatives for restitution are available for the consumer. However, DHS has received only 13 restitution cases since July 1, 1987, and only 9 were not resolved with the licensee providing a full refund. Thus, resolving these few cases does not appear to be beyond DHS' existing resources.

In contrast to DHS, other Arizona medical licensing boards have the authority to order restitution. A.R.S. §32-1693 gives the Board of Dispensing Opticians this authority through a decree of censure. The Board of Medical Examiners has this authority through A.R.S. §32-1451 F.(4).

No intermediate sanctions - HAD program staff want the ability to take action against a licensee without having to suspend or revoke the license. Currently, suspension or revocation are the only options available for disciplinary action. At least six Arizona health regulatory boards have the statutory provision for administrative penalties. These include the statutes governing Arizona optometrists, nurses, chiropractors, osteopaths, pharmacists, and medical doctors.

Midwife Licensing Program Also Has Poor Complaint Management

DHS has also poorly managed the midwife complaint function. Despite receiving complaints involving death and other significant harm from actions by licensees, midwife licensing program personnel have only recently begun formally tracking and logging complaints. Complaint investigations have also been hindered by inadequate enforcement authority.

Complaint management - The midwife licensing program has lacked formal complaint tracking and investigation procedures. The program manager was only aware of nine complaints. Also, the lack of formal procedures lead to nonuniform and poorly documented investigations.

Proper management and investigation of these complaints is important because the potential for public harm is great. Although there are only nine complaints which the manager is aware of, three of these pertained to infant death. For example, one complaint alleged that an infant was stillborn because the midwife did not obtain medical consultation when the patient exhibited abnormal symptoms. A second complaint involved a stillborn infant delivered after the normal 42 weeks. The third instance involved an infant born with severe complications who died after three days.

In addition, two of the nine complaints are alleged violations of Rule 9-16-205 C. which requires the midwife to make formal arrangements with a licensed physician for back-up medical care during the delivery. The remaining four complaints dealt primarily with advertising, business practice, and falsifying an application. All were closed with no action taken against the licensee.

Enforcement authority - The midwife licensing program also lacks adequate enforcement authority to effectively carry out complaint investigations. There presently is no statutory or rule provision which would allow midwife licensing program staff to access patient records from the admitting hospital without family consent. According to the program manager, lack of this authority has hindered a current investigation of infant death. Other Arizona licensing boards have this authority.

A.R.S. §32-1451.01 A. gives the Board of Medical Examiners the authority to access any records needed for an investigation. The Board of Nursing is granted similar authority through A.R.S. §32-1664.I.

Also, according to both the midwife licensing program manager and the DHS legal counsel, the physician back-up and consultation (R9-16-205 A. and C.) requirements need clarification. The consultation requirement is weak as it does not specify that the physician be an obstetrician. Also, midwives have difficulty complying with the physician back-up requirement because of mistrust by the medical community. Some midwives in Yuma have established back-up agreements with physicians in Phoenix, which may not be adequate should complications arise during delivery.

The program manager also expressed the need for intermediate sanctions such as administrative penalties. Currently, the only enforcement options available are either license suspension or revocation. As mentioned earlier, numerous state medical licensing boards have the statutory authority to impose administrative penalties.

Progress Has Been Made

Complaint management has recently improved at both the program and department level. Each program now has a complaint tracking system. Also, DHS is moving towards developing legislation which would standardize the use of civil penalties for all its enforcement functions.

Both the HAD and midwife licensing programs now log and track all complaints filed. The HAD program now has complaint population information that was previously unavailable. The midwife licensing program has had far fewer complaints, and the manager has been aware of all complaints filed since taking over responsibility for the licensing program. A complaint log has also been established for the midwife licensing program. Each program has also developed complaint investigation procedures, though these have yet to be formalized or written into rule.

DHS has initiated an effort to develop legislation which would standardize civil penalties for all licensing programs. The legislation would also give the authority to invoke these penalties to programs which currently do not have that power. According to DHS management, this legislation will probably not be introduced until the next legislative session.

Recommendations

1. Both the HAD and midwife licensing programs should formalize complaint investigative procedures by writing them into their rules and regulations.

2. DHS should continue its effort to develop civil penalty legislation, and include the hearing aid dispenser and midwife licensing programs in this effort. The legislature should consider amending:

   - A.R.S. §§36-1901 through 36-1938 to give DHS the authority to order HAD licensees to make restitution to complainants.

   - A.R.S. §§36-751 through 36-757 to give midwife licensing program personnel the authority to access patient records from the admitting hospital.

3. DHS and the Attorney General should evaluate and clarify Rule 9-16-205 A. and C. relating to requirements for physician back-up and consultation.

FINDING III

DHS SHOULD CONTINUE EFFORTS TO REEVALUATE CHILDREN'S REHABILITATIVE SERVICES PROGRAM

Because of changing needs and medical advances, the present structure of the Office of Children's Rehabilitative Services (CRS) may be inappropriate. CRS provides services to children who are chronically ill or who have disabling conditions which can be improved with treatment. However, only certain conditions are covered. DHS and an Arizona advocacy group have joined the national debate over which conditions should be covered and how treatment should be provided. Since the program has limited funds, planning for the most effective use of funds is essential.

CRS is a program that provides medical and other services to children with special health-care needs. CRS clinics treat children free or at a reduced charge if their families meet financial eligibility criteria. However, for some conditions, such as spina bifida, CRS is the only source of the required multidisciplinary care. Because CRS is the only source of care in these cases, children who would normally be financially ineligible for such care can receive treatment if their families pay full price for it. The department contracts for clinic services in Phoenix, Tucson, Flagstaff, and Yuma.

Children's Rehabilitative Services Program Treats Children With Certain Medical Conditions

CRS treats only specified conditions. The present CRS program descended from the Crippled Children's Service, a federal program begun in the 1930s when orthopedic problems such as polio were the most common handicapping conditions. According to the program's current director, doctors who volunteered time to the program added their specialties to the conditions covered. More conditions were added incrementally as medical technology advanced and funding became available. Thus, the program's scope appears to be more the result of circumstance than any conscious design.

In addition, funding limits the program's coverage. Until 1980, according to CRS' director, Arizona's legislature granted supplemental appropriations each year when the program ran out of funds, so CRS was able to cover new conditions as children requested treatment. Since 1980, CRS has had to stay within its original budget. It cannot add new conditions and may even curtail coverage of approved conditions. For example, the department does not publicize its coverage of arthritis, since the program manager feels the large number of cases[1] could use up funds the department needs for treating children with more serious conditions.

Although CRS receives a larger state allocation than any other FHS program, its funding falls far short of the estimated need. In fiscal year 1987-88, CRS' state allocation was $6.2 million, and the program actually controlled a total of $12.7 million including federal funds and payments from AHCCCS. This represents about $850 for each of CRS' 15,000 patients, far below the cost of treating many chronic conditions.[2] DHS believes that an actual 36,000 to 60,000 Arizona children may fall within the broad category of "children with special health-care needs." Serving only 36,000 at the current average cost would require over $30 million - a 136 percent increase.

---

(1) A 1988 National Center for Health Statistics report estimated the incidence of arthritis as 2.3 per 1,000 persons under 18. DES projects Arizona has 1,027,000 children under 18, so about 2,362 may have arthritis.

(2) Data on Arizona's average cost per child for each condition is not available, but in fiscal year 1982-83 average billings per child in California ranged from $500 (ear and mastoid process) to $8,000 (leukemia). The annual cost of treating one condition, hemophilia, is expected to increase from $5,500 per child to as much as $50,000 per child because of precautions needed to protect against transmitting AIDS.

Debate Centers on Extent of Coverage and Delivery Method

Advocates for children with special health-care needs disagree on the best way to determine medical eligibility for and how to provide treatment. We encountered different points of view, none of which favored retaining Arizona's current system. Parents and public health officials agree, however, that changes should be made in the way care is delivered to these children. Arizona's program, like others across the nation, is in transition.

Advocates debate on conditions to cover - The Arizona Consortium for Children with Chronic Illness (ACCCI) would like to see more conditions covered. They suggest reevaluating the current list. ACCCI criticizes CRS for covering some common and easily treated conditions such as ear infections but not covering children with hemophilia, bronchopulmonary displasia, severe asthma, or diabetes. Some other states, including Michigan and California,[1] cover more conditions than Arizona. Both cover hemophilia and severe asthma, among many other conditions.

Some researchers suggest covering all conditions. Florida has adopted this method, and uses income as a basis to limit expenditures. Proponents of this idea believe that excluding children based on diagnosis is not ethically or legally defensible. However, income limits may be very restrictive under this method unless funding is increased. Florida limits eligibility to those with family incomes (net of medical expenses) below $9,000/year for a family of four.

Arizona's CRS director advocates changing to a functional definition instead of the current "laundry list" approach. This means that the condition's potential impact on the child's life would determine whether CRS would provide treatment. If this proposal is adopted, CRS would be

---

(1) We interviewed state agencies using various approaches in providing child rehabilitative services. The states contacted were recommended by a representative of the National Maternal and Child Health Resource Center.

able to cover the conditions mentioned most often by children's advocates: hemophilia, bronchopulmonary displasia, severe asthma, and severe diabetes. The director says he is working on developing a "severity index" to provide an objective basis for treatment decisions. However, one researcher indicates that severity is hard to define and even harder to measure objectively.

Treatment methods could be changed - ACCCI also suggests a change in how CRS provides service. The group wants CRS to provide coordinated care in each child's community instead of treating children at centralized clinics. This reflects a national movement towards community based, family centered programs focused on coordinated case management. A 1987 Surgeon General's report recommended encouraging normal patterns of living and focusing on the needs of families.

CRS has already taken steps in this direction. It recently opened clinics in Yuma and Flagstaff to make treatment available closer to home for many children. CRS' multidisciplinary clinics provide the services of social workers, educators, nutritionists, and others to help meet the multiple needs of children and their families. This approaches the goal of community based care without sacrificing comprehensive care.

Changes Involve Difficult Choices

Program changes must incorporate planning in order to make effective use of limited funds. This includes decisions concerning which children or which conditions will be covered, as well as a determination of the role Arizona's program will play.

Criteria must be established to determine which children will remain in the program, and whether some conditions among the many chronic illnesses and handicapping conditions will be excluded. Because funding is restricted, changing the program will probably require turning some currently eligible children away. This decision is made more difficult by the lack of reliable data on the number of children with chronic illnesses and handicapping conditions, and on the actual costs of care for each condition.

Program changes will also depend on the desired role of Arizona's program. Traditionally, the program here and in other states has had two roles: providing financial assistance to the group not eligible for AHCCCS but unable to obtain private insurance, and providing services not otherwise available. Financial assistance is essential for many families, as insurance is impossible to obtain for children with some conditions and treatment costs quickly reach benefit ceilings for others. The service aspect is also important, as many conditions need the multidisciplinary approach which may only be available at CRS clinics. Other conditions are rare, and treatment may not be readily available outside CRS. Determining the most effective use of Arizona's limited funds will require a compromise between these roles.

RECOMMENDATION

DHS should continue to evaluate its CRS program, and make recommendations to the legislature for needed changes.

AREAS FOR FURTHER AUDIT WORK

During the course of our audit we identified potential issues that we were unable to pursue due to time constraints.

- Have fund transfers to AHCCCS reduced the family health services available in Arizona?

The Division of Family Health Services traditionally provided health care services through county clinics. Recently, however, some FHS programs have been transferred to the Arizona Health Care Cost Containment System (AHCCCS). Eligibility requirements for AHCCCS are more difficult to meet than county requirements, and AHCCCS may not provide the range of services previously offered by the counties. For example, AHCCCS is now apparently the only state source of prenatal care for low income women. State and local health professionals report that the number of births with no prenatal care is rising, and they are concerned that some pregnant women are unable to obtain care. In addition, related services that were part of the county programs - such as social services, nutrition education, counseling, and family planning referral - may not be offered by AHCCCS.

There may be other areas where the roles of the Division of Family Health Service and AHCCCS should be reexamined. Further study is needed to evaluate whether services are lacking and to determine the cost of providing care.

- Will the Division of Family Health Services' new computer system meet users' needs?

The Division of Family Health Services is developing a new integrated management information system (FHAMIS) to replace computers currently in use. The cost for development of the new system will be approximately $1.3 million. Some service providers will be connected to FHAMIS through remote terminals, and county health departments will use FHAMIS software on personal computers and submit data by modem. FHAMIS is expected to

provide detailed information for program planning and evaluation, allow the tracking of individuals between all of the Division of Family Health Services programs, and permit counties to print their own WIC vouchers.

Since the system is still under development, we were unable to evaluate it during the audit. However, county administrators said their information needs were neglected in planning, and they may be unable to purchase the necessary computer hardware. Further study is needed to determine whether the system, when in place, satisfies the requirements of all users, including county health departments.

- Is the Division of Family Health Services appropriately staffed?

Two questions arose concerning staffing at FHS. First, according to one office chief, the Division of Family Health Services has a high staff turnover rate, which they attribute to low job classifications in technical positions. Many FHS staff provide expert technical assistance to others. One county health administrator expressed concern that new staff may not have the expertise needed, and staff may leave shortly after gaining enough experience to be really helpful. Second, the division has several vacant staff positions. Since the remaining staff seems to be adequately carrying out the division's duties, some of the vacant positions may not be necessary. Further study is needed to evaluate the cause and effect of staff turnover, and the necessity of filling all vacant positions.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Director

ROSE MOFFORD, GOVERNOR
TED WILLIAMS, DIRECTOR

April 18, 1989

Douglas R. Norton
Auditor General
2700 North Central Avenue
Suite 700
Phoenix, Arizona 85004

Dear Mr. Norton:

Thank you once again for the opportunity to review the draft performance audit for the Division of Family Health Services, Department of Health Services. Our comments are attached.

Sincerely yours,

Glyn G. Caldwell, MD

Glyn G. Caldwell, M.D.
Deputy Director

Attachment

ARIZONA DEPARTMENT OF HEALTH SERVICES
COMMENTS ABOUT SUNSET AUDIT
DIVISION OF FAMILY HEALTH SERVICES

In general we feel the audit was reasonable and for the most part the auditors understood the relevant issues and recognized the complexity of the Division. The following comments from the Division are compiled using the findings listed in the draft report.

FINDING I - OFFICE OF NUTRITION SERVICES

Recommendation 1 - WIC Rebates

The Office of Nutrition Services has already taken the following steps towards the implementation of infant formula rebates:

1. included provisions for an infant formula rebate in the FY 1989 WIC State Plan of Operations (this plan has received federal approval);

2. held, as required by federal regulations, Public Hearings in order to gain an understanding of the preferences of the community in regard to this issue;

3. solicited (and received) Request for Proposal from other states which have implemented infant formula rebate cost containment systems;

4. met with staff from the Procurement Office to establish guidelines for developing the Arizona RFP for infant formula rebates; and

5. met with staff from the Controller's Office to establish procedures for accounting for rebate funds.

The Office of Nutrition Services anticipates publishing an RFP for infant formula rebates by May 1989 with implementation to start in July 1989. It has been useful to proceed cautiously as, in the interim from initial consideration, the State has been able to build community support for this initiative and federal laws have been enacted to protect states from sudden drops in administrative reimbursement rates (which are tied to food package costs). Additionally, Arizona will be able to take advantage of concessions won, by other states, from the formula manufacturers (e.g. an increase in the wholesale price would cause an increase in the rebate rate).

Recommendation 2 - Local Agency Funding

The Office of Nutrition Services formed a committee composed of county health officers, local agency nutritionists and state staff to review and revise, as necessary, the process for distributing WIC administrative funds. The group met on several occasions to discuss the method by which the State allocation is determined by the Federal granting agency and the procedures used at the State for apportioning the grant. The committee decided:
1) not to change the current system until after the current automation initiative (FHAMIS) is completed;
2) to accept a minimum of a two percent inflation increase to the base payment rate.
A report of the committee's work was presented to all Health Officers at one of their quarterly meetings.

FINDING II - HEARING AID DISPENSER AND MIDWIFE LICENSING COMPLAINTS

Recommendation 1 - HAD and Midwife Complaint Investigation Procedures

The Midwife Licensing Program staff is in the process of revising the rules and regulations for the program. The process for complaint investigation will be included.

The current HAD staff are aware of this problem and have set up a computerized system to track complaints and have drafted policies and rules for complaint investigations.

Recommendation 2 - Civil Penalties

There is a half-time staff person working on the HAD program. The staff committment is insufficient for current program demands. Additional responsibility would not be possible without adding another half-time FTE.

Program staff will offer a proposal for statutory changes in A.R.S. § 36-751 through 36-757 which will include authority to access medical records for the Midwife Licensing Program.

Recommendation 3 - Physician Back-up for Midwives

ADHS and the Attorney General's Office are in the process of reviewing and clarifying Rule 9-16-205 A. and C.

FINDING IV - CHILDREN'S REHABILITATIVE SERVICES

Recommendation - Continue Evaluation and Make Recommendations to Legislature

The Office of Children's Rehabilitative Service agrees that the program needs further refinement and expansion. Program staff will continue to work closely with CRS families, physicians and advocacy groups to evaluate the scope and structure of the program. This group will strive to develop a concensus position to present to the Legislature regarding the future of the program.