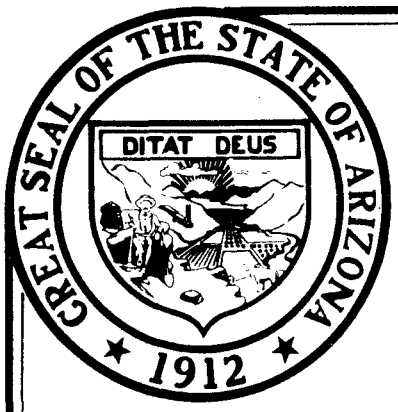


SPECIAL STUDY

DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

ADMINISTRATIVE ENTITY SYSTEM

Report to the Arizona Legislature
By the Auditor General
January 1992
92-1

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

January 27, 1992

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Ms. Alethea Caldwell, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Special Study of the Department of Health Services, Behavioral Health Administrative Entity System. This report is in response to a May 8, 1991, resolution of the Joint Legislative Oversight Committee.

The report contains a limited financial review of three administrative entities, plus a review of the adequacy of the Department's contracts with the entities. The report also contains information on a number of program issues including accessibility of services, services for special populations and case management. In addition, the report addresses the eight questions specifically posed in the Joint Legislative Oversight Committee resolution.

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

This report will be released to the public on Tuesday, January 28, 1992.

Sincerely,

Douglas R. Norton
Auditor General

DRN:lmn

2700 NORTH CENTRAL AVENUE • SUITE 700 • PHOENIX, ARIZONA 85004 • (602) 255-4385 • FAX (602) 255-1251

SUMMARY

The Office of the Auditor General has completed a special study of the behavioral health administrative entity system within the Department of Health Services (DHS). This study was conducted in response to a May 8, 1991, resolution of the Joint Legislative Oversight Committee.

In directing this study, the Committee identified eight areas of interest, including the use of State behavioral health funds by the entities and provider agencies, the accessibility of services to the seriously mentally ill (SMI), the cost efficiency of the entity system, and the adequacy of management systems. Due to the complexity of the questions and time limitations, we were unable to thoroughly address all eight areas of interest. Therefore, the scope of the study was limited to those issues of greatest concern.

Financial Review Of Administrative Entities (see pages 11 through 19)

We conducted a limited review of three administrative entities' expenditures for adult SMI services for fiscal year 1990-91. These three entities received approximately $35 million in State funding, or 62 percent of all adult SMI funds received by the entities from the Department of Health Services.

While the entities contracted most of the funds they received to provider agencies, all three entities have accumulated significant balances of unexpended funds that are unrestricted. Unrestricted fund balances for the three entities we reviewed totaled over $10 million as of June 30, 1991. While some unrestricted funds were expended on behavioral health programs in fiscal year 1990-91, these funds were also expended on goods or services, such as employee bonuses, and food and entertainment, that are not directly related to the provision of behavioral health services.

In addition, we attempted to estimate entity administrative costs. These costs are difficult to determine because reporting formats differ and a uniform method of classifying administrative costs has not been developed by DHS. Nonetheless, entity administrative costs ranged from 10 to 12

percent of the funds expended in fiscal year 1990-91. We estimate that, at most, 72 to 79 percent of the funds were expended on direct services when both entity and provider administrative costs are considered.

Contract Monitoring And Provisions (see pages 21 through 26)

We reviewed the Department's efforts to address deficiencies in contract monitoring and the contract provisions identified in our previous performance audit of the Department of Health Services, Division of Behavioral Health (Report No. 89-10). The Department's recovery of monies owed the State by entities continues to be weak, ineffective, and untimely. In addition, the Department is performing very little fiscal monitoring of the entities at this time.

We also found that the Department's entity contracts for fiscal year 1991-92 contain many of the same problems we identified in our previous report. For example, contracts do not specify target populations, and they lack enforcement provisions. In addition, contracts do not address other concerns, such as ownership of real property and equipment and the disposition of interest earnings.

The Behavioral Health Management Information System (BHMIS) Has Failed To Meet The Needs Of DHS, The Administrative Entities, And Service Providers (see pages 27 through 34)

Since fiscal year 1987-88, DHS has expended over $4 million designing, developing, maintaining, and supporting the Behavioral Health Management Information System (BHMIS). We found that despite this substantial commitment of resources, BHMIS has failed to meet the needs of the Department and its users. The Department intends to use BHMIS in the future only for program informational purposes. A separate system will be developed to handle contract payments.

Accessibility And Availability Of Entity Services (see pages 45 through 56)

We attempted to determine the length of time required for seriously mentally ill adults to access the entity system and begin receiving services. Due to the lack of adequate data, we were able to determine

the length of time for only three of the five entities subject to our study. Although the length of time varies significantly among and within the three entities, on average clients waited from 21 to 52 days to receive psychiatric services.

Our analysis of the clients most in need of services indicates that the entities are improving delivery of services to these clients. For example, our analysis of SMI adults discharged from the Maricopa County Jail system revealed that most are either already enrolled or are successfully accessing community-based services through the entity system. However, the jail population appears especially vulnerable to becoming "lost" in the referral process and not obtaining the services they need.

Lack of community services impacts institutional discharges in some areas of the State. We found that many patients at the Arizona State Hospital cannot be released when they are clinically ready for discharge because there is no place for them to go.

Our review also found that there are few services specifically targeted to meet the needs of the homeless SMI population. Outreach services are limited. Some entities have no outreach programs, and funding for these programs has declined over the past several years. However, DHS and other community organizations have recently begun to focus planning efforts on the problems of homeless SMI adults.

Case Management
(see pages 59 through 68)

The Arizona community-based mental health system focuses on case management as the mechanism for ensuring clients receive the services they need, and that services are coordinated and appropriate to the client's changing needs over time. We found that although caseload size varies, overall, caseloads are large, which reduces the case manager's ability to provide adequate individual attention to clients. For the five entities we reviewed, caseloads averaged 43 clients per case manager; one case manager had 83 clients. Large caseloads prohibit case

managers from spending adequate time with clients. Additional case managers and funding will be needed to reduce caseloads to the levels that will be required by a court-ordered plan, which DHS is attempting to implement.

Other needs of the SMI population that are not being adequately met include a lack of available residential services, dental care, and other services. Under the court-ordered plan, DHS will have to increase accessibility of all needed services.

Other States' Programs
(see pages 71 through 75)

We were asked to compare Arizona's administrative entity system with mental health service delivery systems in other states. We found that Arizona's administrative entity system is unique among the states we surveyed, and that structures for delivering and paying for services for the seriously mentally ill vary widely from state to state. In addition, each state is unique in the way it provides case management services, targets populations with special needs, and controls the expenditure of state funds.

TABLE OF CONTENTS

TABLE OF CONTENTS (Con't)

TABLE OF CONTENTS (Con't)

ILLUSTRATIONS

ILLUSTRATIONS (Con't)

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a special review of the Department of Health Services (DHS), Division of Behavioral Health, and the administrative entity system. This study was conducted in response to a May 8, 1991, resolution of the Joint Legislative Oversight Committee and under the authority vested in the Auditor General by Arizona Revised Statutes §41-2353.

Structure And Funding Of The Mental Health Services Delivery System

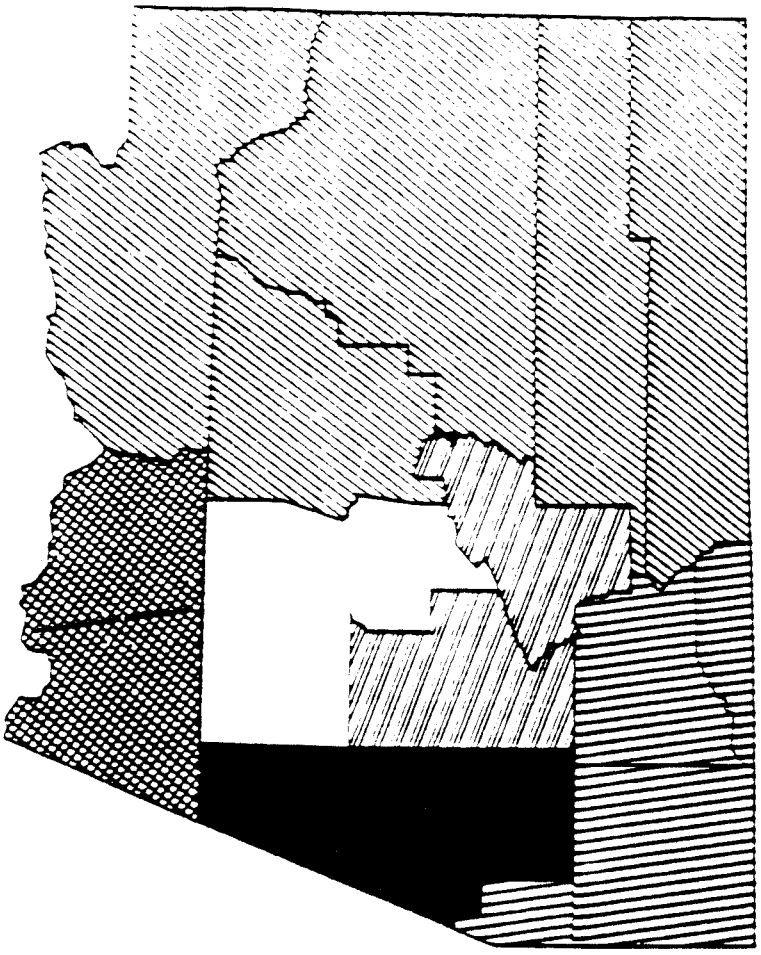
DHS currently provides community-based mental health services through the administrative entity system. The Division of Behavioral Health is responsible for providing behavioral health services to those most in need. To fulfill this mandate, DHS contracts with private, nonprofit organizations called administrative entities. There are presently eight administrative entities. Each entity is responsible for administering, coordinating, and monitoring community-based behavioral health services in a specific region of the State. (See Figure 1, page 2 for a map of the administrative entities and the region served by each entity.) In turn, the administrative entities contract with other agencies to provide direct services. Further, each entity is responsible for the ongoing development and implementation of a case management system.[1]

---

(1) A case management system consists of a clinical team of psychiatrists, social workers, case managers, and other professionals. This team is responsible for developing an individual treatment plan for each client in the administrative entity system and ensuring continuous client treatment and care.

FIGURE 1

DIVISION OF BEHAVIORAL HEALTH ADMINISTRATIVE ENTITIES' SERVICE AREAS



Service Areas

- Community Organization for Drug Abuse, Mental Health and Alcoholism Services, Inc./Community Care Network/East Valley Behavioral Health Association (Maricopa County)
- ADAPT, Inc. (Pima County)
- Behavioral Health Services of Yuma (La Paz and Yuma Counties)
- Northern Arizona Comprehensive Guidance Center (Apache, Coconino, Mohave, Navajo, and Yavapai Counties)
- Pinal Gila Behavioral Health Association, Inc. (Gila and Pinal Counties)
- Southeastern Arizona Behavioral Health Services, Inc. (Cochise, Graham, Greenlee, and Santa Cruz Counties)

Administrative entities are responsible for five general program areas: serious mental illness, substance abuse, childrens' services, domestic violence, and general mental health. This report focuses exclusively on services for the seriously mentally ill.

In recent years the court has participated in the development and oversight of the delivery system for the seriously mentally ill (SMI). In 1981, the Arizona Center for Law in the Public Interest filed suit (Arnold vs. Sarn) on behalf of five chronically mentally ill people. The center sued the Department of Health Services, the Arizona State Hospital (ASH), and the Maricopa County Board of Supervisors alleging that the State and County failed to provide these people with adequate community mental health services. The court ruled in favor of the plaintiffs and the decision was appealed to the Arizona Supreme Court. The Arizona Supreme Court upheld the ruling, stating that both the State and Maricopa County have mandatory duties to provide the full continuum of services to all seriously mentally ill people who could reasonably benefit from them.

In the spring of 1991, the parties reached an agreement to fulfill the requirements of the court orders. The implementation provisions of this agreement are contained in The Blueprint: Implementing Services to the Seriously Mentally Ill. The purpose of the blueprint is to ensure that by September 30, 1995, a comprehensive community mental health system for the SMI population is established. The blueprint specifies the types and number of services that should be made available to comply with the court order and, therefore, directs the establishment as well as the continuation of services. The blueprint also calls for a court monitor to oversee and act as mediator in implementing the terms of the court order.

Services for the seriously mentally ill population are largely State funded. Most of the funding appropriated for behavioral health services for the seriously mentally ill is passed through to the administrative entities to contract for community-based services. In fiscal year 1990-91, the Legislature appropriated approximately $49 million for services to the SMI population. In addition, DHS received another $8 million from other sources. Table 1, page 4 shows the Department's

revenues and expenditures for services for the seriously mentally ill during fiscal year 1990-91.

TABLE 1

DEPARTMENT OF HEALTH SERVICES
Schedule Of Revenues And Expenditures For The
Seriously Mentally Ill
Fiscal Year 1990-91
(unaudited)

Revenues for SMI		
Total appropriations for SMI	$49,173,400(a)	
Pima County funds	3,918,000	
Other funds for SMI	4,369,587	
Total funds for SMI		$57,460,987
Expenditures for outside organizations		
ADAPT, Inc.	14,071,885	
Community Organization for Drug Abuse, Mental Health, and Alcoholism	10,898,956	
Community Care Network	9,829,416	
Northern Arizona Community Guidance Center	6,061,133	
East Valley Behavioral Health Association	3,911,937	
South Eastern Arizona Behavioral Health Association	2,376,097	
Pinal Gila Behavioral Health Association	1,926,528	
Behavioral Health Services of Yuma	1,880,942	
Other organizations	5,469,261	
Total expenditures for outside organizations		56,426,155
Administrative costs		459,498
Total expenditures		56,885,653
Excess of revenues over expenditures		$ 575,334

(a) Excludes appropriation for operation of the Arizona State Hospital.

Source: Department of Health Services, Financial On-Line System reports for the fiscal year ended June 30, 1991.

General Conclusions And Recommendations Of The Study

The Joint Legislative Oversight Committee (JLOC) authorized the Auditor General to perform a review of the administrative entity structure, including related contract mechanisms and information systems. In its resolution authorizing the study, JLOC outlined eight questions to be addressed and limited the review to five of the eight entities.[1] (See Chapter X for a brief response to the eight questions.) To answer as many of the questions or portions of the questions as possible, audit work was organized into four general topic areas. The information compiled in these four areas is included in this report in ten chapters. Presented below are the general conclusions and recommendations, if applicable.

Chapters I through III: Financial And DHS Operations

Audit work in these chapters focused on three areas: a limited review of three administrative entities' expenditures for adult SMI services for fiscal year 1990-91; DHS' efforts to address deficiencies in contract monitoring and contract provisions; and the Behavioral Health Management Information System (BHMIS).

We found that the Department has insufficient control over the use of contracted monies and the delivery of services. Continued weaknesses in contract provisions allow the entities to accumulate unexpended funds and fail to restrict how these funds and the interest earned on them are to be used. As of June 30, 1991, collectively, ADAPT, CODAMA, and CCN had over $10 million in unexpended funds. Also, the Department does not define administrative costs and how these costs should be classified. Consequently, reported administrative costs may understate actual costs. We estimate less than 80 percent of State SMI monies received by entities are expended on direct services.

The Department's contract monitoring continues to be weak and ineffective. In addition, problems with BHMIS limit the use of this information to assist in monitoring contracts and reconciling payments.

To address these concerns, the Department must strengthen and clarify contract provisions to address the use of unexpended funds and define administrative costs. In addition, DHS needs to strengthen its monitoring of administrative entities. Finally, the purpose of BHMIS needs to be determined and efforts made to ensure the quality and timeliness of data on the system.

---

(1) The five entities included in the review are ADAPT, CCN, CODAMA, EVBHA, and SEABHS.

Chapters IV through VI: Accessibility Of Services To SMIs And Subpopulations

An analysis of services for the SMI population in general and specific subpopulations indicates that most clients are able to access services. However, the length of time it takes for each client varies by entity and the severity of the client's illness. Some clients must wait over a month to receive initial services. In addition, some SMI persons are lost in the referral process and do not obtain the services they need.

For the homeless SMI population, it appears services are particularly lacking. The present number of residential programs falls far short of the number needed and the number required by the blueprint. In addition, funding for outreach services has decreased in recent years.

Efforts are currently underway to improve the availability and accessibility of services. Coordination among DHS, the entities, jails, and hospitals is improving and is helping SMI persons to make a timely transition into community-based services. DHS and community service groups have also focused on the needs of homeless SMI people. However, increased services will likely mean additional funding.

Chapters VII and VIII: Needed Services

Millions of dollars will be needed to meet the blueprint requirements for case management and residential services. Currently, case managers carry an average caseload of 43 clients. The blueprint limits caseloads to 25 clients or less per caseworker. Funding for case management salaries in Maricopa County alone would have to increase almost $8 million annually to provide the estimated number of case managers needed by 1995.

To meet the blueprint requirements for residential services, several thousand additional beds will be needed. In addition, several other types of services, such as day treatment programs, vocational and supported work programs, and mobile crisis stabilization teams, will need to be expanded to meet blueprint projections.

Chapters IX and X: Miscellaneous Issues

These chapters present a comparison of other states' programs, and the answers to the eight questions outlined by the resolution.

Audit Scope And Limitations

Based on time limitations and legislative interest, the study focuses on the delivery of services to the seriously mentally ill population. The fragile nature of this population makes it particularly sensitive to

problems with the availability and accessibility of services. Persons with serious mental illnesses are often unstable; many are low-functioning and have difficulty locating services. This population is defined by statute as those who, as the result of a mental disorder, exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. Serious mental illnesses include schizophrenia, mood disorders, and organic and personality disorders.

As noted previously, the scope of our study was established by the May 8, 1991, resolution of the Joint Legislative Oversight Committee. This resolution directed us to address eight specific questions. However, due to the breadth and complexity of the questions, we informed the Committee at the time of the resolution that we would not be able to thoroughly address all eight questions within the time frame provided. Therefore, we agreed to perform as much work as possible in the time allowed.

In addition to the scope limitations imposed by the short time frame and the breadth and complexity of the questions, persistent problems with data also restricted our audit work.

- Concerns regarding BHMIS data precluded us from relying on it as a primary source for service data. (See Chapter III, page 27 regarding BHMIS data.)

- Data from client files proved difficult to use for analysis. Client files are not kept in a standard format, nor is all client service information stored in one central location. Furthermore, some files lacked adequate documentation of services.

- Data is not recorded or maintained in a consistent manner among entities. Of the five entities from which we requested basic service information, only two were able to fully comply with our request. A third provided partial information, and the remaining two were unable to provide adequate information. (See Chapter IV, page 37.)

Given the time frame and data problems, we were able to compile information describing the system; however, we did not have time to obtain sufficient information to assess the relative performance of the

system vis-á-vis the eight questions. Therefore, because we did not form detailed conclusions and provide the recommendations normally associated with a performance audit, we are presenting the results of our work as a special study.

This study was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Director and staff of the Department of Health Services, the Division of Behavioral Health, and the staff of the administrative entities for their cooperation and assistance during this study.

SECTION ONE

Chapter I	Financial Review Of Administrative Entities
Chapter II	Contract Monitoring And Provisions
Chapter III	Behavioral Health Management Information System (BHMIS)

CHAPTER I

FINANCIAL REVIEW OF ADMINISTRATIVE ENTITIES

We estimate less than 80 percent of SMI monies received from DHS by entities are expended on direct services. While most funds for fiscal year 1990-91 were contracted to provider agencies, all three entities have accumulated significant balances of State-appropriated behavioral health funds. Some of these funds, which are considered unrestricted, were expended on goods or services not directly related to the provision of behavioral health services. In addition, administrative costs captured and reported by the entities' financial accounting systems may underestimate total administrative costs.

Methodology

To determine the proportion of funds expended providing direct services in relation to administrative costs, we selected the three entities that received the most State funding for adult SMI services for fiscal year 1990-91. The entities were ADAPT, Inc.; Community Organization for Drug Abuse, Mental Health and Alcoholism Services, Inc. (CODAMA Services); and Community Care Network, Inc. (CCN). Combined funding to these three entities represented 62 percent of all adult SMI funds received from the Department of Health Services in fiscal year 1990-91. At each of the three entities, we reviewed financial records documenting how adult SMI funds were expended. In addition, we reviewed financial records at the two largest provider agencies under contract with each entity to further determine how funds were expended at the provider level.

Results Of Financial Review

In fiscal year 1990-91, DHS expended $56,885,653 for adult SMI services. Of this amount, $56,426,155 was contracted to outside organizations. The three entities we reviewed received $34,800,257 of this amount; the remainder went to the five other entities and to other organizations.

ADAPT, Inc.

As shown in Table 2, ADAPT. received $14,071,885 from DHS for adult SMI services in fiscal year 1990-91. Almost $13 million of this amount was paid to provider agencies. The Arizona Center for Clinical

TABLE 2

ADAPT, INC.
Schedule Of Revenues And Expenditures
For The Seriously Mentally Ill
Year Ended June 30, 1991
(unaudited)

SMI revenue from DHS		$14,071,885
Expenditures		
To providers:		
Arizona Center for Clinical Management	$7,235,048	
La Frontera Center	3,009,196	
Southern Arizona Mental Health Center	892,960	
Kino Hospital (overflow providers)	798,747	
Community Organization for Personal Enrichment	171,987	
Intermountain Centers	127,200	
Primavera Foundation	57,300	
Other providers	628,841	
Total to providers		12,921,279
Direct services (Arizona Hotel)		187,802
Medication		264,000
Administrative		523,009
Total Expenditures		13,896,090
Excess of revenue over expenditures		$ 175,795

Management (ACCM) received the largest share of ADAPT's contracted funds. Fifty-one percent of ADAPT's funding was contracted to ACCM to provide case management services for all SMI clients in ADAPT's service area, and to contract with provider agencies for other direct services. ACCM's financial records indicate that approximately $3.5 million was expended by the agency on case management, and $2.7 million was contracted to other providers. ADAPT is the only entity currently contracting the case management function with another agency.

ADAPT reports spending $523,009 on administrative costs in fiscal year 1990-91. This represents 3.8 percent of its total expenditures, which is low when compared to the other administrative entities that do not contract for case management services. However, if ACCM's administrative costs for case management of $869,187 are included, the percentage of administrative costs rises to 10 percent. Approximately $176,000 of the SMI funds received remained unexpended at the end of the fiscal year.

CODAMA Services

As indicated in Table 3, page 14, CODAMA expended almost $9.5 million of its adult SMI funding in fiscal year 1990-91. Of this amount, $5.8 million was contracted to other providers. Unlike ADAPT, CODAMA provides case management services directly rather than contracting this function to another agency. CODAMA's financial records indicate that approximately $2.3 million was spent on case management.

CODAMA reports spending $962,664 on administrative costs in fiscal year 1990-91. This represents over 10 percent of its total expenditures. Approximately $1.4 million of the SMI funds CODAMA received remained unexpended at the end of the fiscal year.

TABLE 3

CODAMA Services
Schedule Of Revenues And Expenditures
For The Seriously Mentally Ill
Year Ended June 30, 1991
(unaudited)

SMI revenue from DHS		$10,898,956
Expenditures		
To providers:		
Phoenix South Community Mental Health Center	$2,314,861	
Triple R Foundation	1,079,720	
Maricopa County Health Services	966,758	
Toby House	770,743	
New Arizona Family	348,202	
AHCCCS	122,887	
Project Arts	113,792	
Survivors on Our Own	109,381	
Behavioral Health Services	20,434	
Total to providers		5,846,778
Case management		2,341,745
Administrative		962,664
Medication		305,624
Other operating		4,943
Total expenditures		9,461,754
Excess of revenue over expenditures		$1,437,202

Community Care Network, Inc.

Community Care Network contracted with providers for almost $5.2 million of the $9.6 million it expended on adult SMI services in fiscal year 1990-91. As indicated in Table 4, page 15, CCN spent $844,115 on case management. In addition, CCN contracted $959,871 to providers for case management services.

TABLE 4

COMMUNITY CARE NETWORK, Inc.
Schedule Of Revenues And Expenditures
For The Seriously Mentally Ill
Year Ended June 30, 1991
(unaudited)

SMI revenue from DHS		$9,829,415
Expenditures		
To providers:		
Terros	$1,156,400	
Wayland Family Centers	1,115,548	
Toby House II	723,878	
Good Samaritan Regional Medical Center	616,060	
Community Behavioral Health	508,624	
Presbyterian Service Agency	493,027	
Phoenix Interfaith Counseling Service	375,228	
Survivors United	118,000	
Jewish Family and Child Services	56,749	
Other organizations	14,775	
Total to providers		5,178,289
Pilot program		970,042
Case management		844,115
Medical supplies		420,140
Payments to psychiatrists		1,028,501
Administrative		1,162,979
Total expenditures		9,604,066
Excess of revenue over expenditures		$ 225,349

Of the three entities, CCN reported the highest administrative costs. However, $528,727 of the administrative costs CCN reported were for the pilot program[1], costs that were not incurred at ADAPT or CODAMA. CCN reports spending $1,162,979 on administrative costs in fiscal year 1990-91. This represents almost 12 percent of its SMI expenditures. Approximately $225,000 of the SMI funds received remained unexpended at the end of the fiscal year.

Questionable Expenditures From Unrestricted Funds

Our review raised some concerns about the entities' use of unrestricted funds, a portion of which are SMI funds received by the entities. There

(1) Pilot programs were established in 1986 to test alternative delivery systems such as capitated systems.

are no restrictions in the contracts between DHS and the administrative entities regarding the use of unexpended funds or the interest earned on these funds. Therefore, these monies can be expended by the entities at their discretion. All three entities have accumulated significant balances of unrestricted funds. Based on our review of expenditures from these unrestricted funds, we noted some unrestricted funds were expended on behavioral health programs. However we also identified some expenditures that were not directly related to providing behavioral health services.

Fund balances - We found that the three entities' fund balances, consisting of cash and other assets, totaled over $10 million at June 30, 1991. These fund balances were not only from SMI funds. However, ADAPT, CODAMA, and CCN received 95, 96, and 100 percent, respectively, of their revenue from State funds. Accordingly, these cumulative fund balances consisted mainly of State funds that remained unexpended at the end of each fiscal year, and interest earnings on these monies. The interest earned on these funds was approximately $690,000 for fiscal year 1990-91. Periodically the entities had large receivable balances from DHS and AHCCCS which required them to use part of the fund balances to pay providers. Because DHS contract provisions do not specify how these monies are to be used or disposed of, the entities may retain these funds or their interest earnings and expend them at their discretion (see Chapter II, page 25).

Table 5 reports the June 30, 1991, unaudited fund balances for the administrative entities we reviewed.

TABLE 5

Fund Balances Of Administrative Entities
June 30, 1991
(unaudited)

Administrative Entity	Fund Balance
ADAPT, Inc.	$ 2,194,641
CODAMA Services	5,574,685
CCN	3,197,236
TOTAL	$10,966,562

There are no restrictions in the DHS contracts regarding the use of these funds. However, both the Legislature and the Department of Health Services originally intended that these monies be used to provide behavioral health services. They were not intended to provide the entities with discretionary funds. Left unrestricted, these funds may not be used for the purpose intended or in the best interest of the State.

Questionable expenditures - As part of our review, we examined check registers, vendor files, and a limited number of specific expenditures for each entity to determine whether entity expenditures appeared appropriate and reasonable. We identified a number of expenditures from the unrestricted and SMI funds that demonstrate how unexpended behavioral health monies can be spent in subsequent fiscal years if they remain unrestricted.

We found that entities spent these funds on employee bonuses, food and entertainment, retreats and conferences, and other items. For example:

- ADAPT distributed $102,960 in bonuses, primarily to executive staff between fiscal years 1990-91 and 1991-92. One-half of the bonus pool was distributed in January 1991, and one-half in July 1991. Twelve employees received bonuses ranging from $1,560 to $26,154.
- ADAPT spent over $1,800 for food and accommodations for meetings, and $800 for flowers for various occasions.
- Community Care Network spent $5,300 on a retreat for directors of provider agencies, $5,200 for its annual board meetings, $4,600 for an annual board retreat, and $1,200 for a provider picnic.
- CODAMA spent $2,500 for its annual board retreat, $700 for its Christmas party, and almost $500 for flowers.

To prevent behavioral health monies from being expended for unintended purposes, DHS should restrict the use of State monies and disallow costs and expenditures that are not related to contract provisions. Unlike the bidding process for most State contracts, entities have experienced no competition in obtaining behavioral health contracts. DHS received only one proposal for each of the administrative entity areas. Consequently, all applicants for the contract were awarded the designation of administrative entity. Due to the circumstances of this award process, the administrative entities should be treated as if they were grantees

rather than vendors. Accordingly, DHS and the administrative entities should work together to ensure that fund balances and related interest earnings are expended in the best interest of the State, as was originally intended. DHS should negotiate the disposition and use of the unrestricted fund balances accumulated from prior-year contracts. In future SMI contracts, DHS should restrict the use of unexpended funds and interest earnings to ensure they are spent only for the purpose originally intended.

Administrative Costs May Be Understated

While entity administrative costs are difficult to determine accurately due to inadequate and inconsistent DHS reporting requirements, our review of expenditures suggests administrative costs reported may understate actual costs. For example, some administrative costs, such as those associated with case management, are categorized as direct services.

Entity costs - Because DHS has not defined administrative costs and specifically directed how costs should be classified (see Chapter II, page 25), we were unable to determine or compare the administrative costs of the entities. The entity tables shown earlier present administrative costs as reported to DHS. These costs were calculated based on methodology provided by DHS; however, this methodology determines direct and indirect costs, not administrative costs.

Further, the reporting formats required by DHS and used by the administrative entities and the providers were inadequate to determine amounts for administrative or direct service expenditures. However, our review of the entities' and providers' expenditures indicated that the administrative expenditures reported in Tables 2, 3, and 4 are low. DHS allows the entities to treat case management as a direct service for purposes of determining administrative costs. At the administrative entities we reviewed, many costs were combined under the heading of case management. For example, CODAMA recorded all of the operational costs of the mental health clinics as case management costs. Also included in the case management costs were expenditures for employee benefits, travel, advertising, telephones, and supplies. We consider these expenditures administrative.

Provider costs - Entity administrative costs did not include provider administrative costs, which can be significant. As part of our review, we examined the expenditures of the two providers that received the most funding from each entity. Providers examined included the Arizona Center for Clinical Management and the La Frontera Center funded by ADAPT, Phoenix South Community Mental Health Center and the Triple R Foundation funded by CODAMA, and Terros and Wayland Family Centers funded by Community Care Network.

To determine the percentage of total SMI funding spent on direct services, we considered both entity and provider administrative costs. We estimated the percentage of total SMI funding expended on direct services for fiscal year 1990-91 by combining entity and provider administrative costs, and then deducting these amounts and unexpended funds from the total revenues received. For the providers examined in the calculation, we used the administrative expenditures they reported. These expenditures ranged from 7 to 17 percent of total SMI expenditures. For the providers not examined, we assumed administrative costs of 10 percent.

Our calculations estimate that 72 to 79 percent of revenues received are being expended on direct services. This estimate may be high since no adjustments were made for administrative costs that may have been classified by the entities or providers as direct services.

DHS should develop uniform accounting and reporting guidelines that would require more detailed reporting of program expenditures. This would also ensure consistent reporting of expenditures between the entities and providers, and assist DHS in monitoring SMI expenditures.

RECOMMENDATIONS

1. DHS and the administrative entities should work together to ensure the expenditure of fund balances is in the best interest of the State, as was originally intended. In future SMI contracts, DHS should restrict the use of expended funds to ensure they are spent for the purpose originally intended.

2. DHS should develop uniform accounting and reporting guidelines that would require more detailed reporting of program expenditures. This would also ensure consistent reporting of expenditures between the entities and providers and aid DHS in monitoring the SMI expenditures.

CHAPTER II

CONTRACT MONITORING AND PROVISIONS

The Department continues to have deficiencies in contract monitoring and contract provisions that we identified in our previous audit. We found that weak and ineffective contract monitoring persists. In addition, contract provisions continue to exhibit the same weaknesses previously identified, although the Department plans to overhaul its entity contracts for fiscal year 1992-93.

Previous Audit Findings

In our previous audit report dated November 1989 (Performance Audit Report No. 89-10), we noted several deficiencies in the Department's monitoring of administrative entity contracts and contract provisions:

- Limited and inconsistent monitoring of entity performance, and weak and superficial follow up on problems resulted in the failure to fully address or correct problems.
- Staff lacked definite direction from management on monitoring duties and responsibilities.
- The DHS Policies and Procedures manual for behavioral health was outdated.

In addition to monitoring deficiencies, we also identified the following weaknesses with the Department's contract provisions:

- The Department's contract contained few specific definitions of who was to receive behavioral health services, and did not contractually establish target populations to be serviced by the administrative entities and providers. Because the Department based contract compliance on units of service provided, the administrative entities may not have been providing services to those most in need.
- Contracts did not contain provisions establishing penalties for failure to perform, or for failure to submit timely financial reports.
- Contracts did not have provisions requiring the administrative entities to conduct quality assurance.

An examination of the steps taken by the Department to implement the recommendations made in our November 1989 audit follows.

Monitoring Continues To Be Weak

The Department has made little improvement in its monitoring of the administrative entities' performance. The Department's recovery of unallowable costs is weak, and the discontinuation of fiscal monitoring by program representatives raises concerns. In addition, little progress has been made in addressing other deficiencies noted previously.

Ineffective recovery of funds - The Department's recovery of unallowable costs continues to be weak, ineffective, and untimely. In the 1989 audit, we reported that a Department review of an entity's client service records revealed that the entity may have overcharged the State more than $150,000. At the time of the previous audit, the entity had not repaid these funds and, as of this review, the Department still has not collected these monies. Instead, the Department appears to have let the issue lapse before finally submitting it to the Audit Disposition Committee (ADC),[1] on September 10, 1991, for resolution. The entity has since requested a formal administrative hearing, which was scheduled for December 6, 1991 -- more than two years after we originally reported the issue.

The Department appears to continue to be lax in recovering funds. For example, we reviewed a May 6, 1991, finding for another entity that identified $7,932 in unallowable costs and requested a response from the entity by June 6, 1991. When no response was received, Department audit staff submitted the finding to the ADC for resolution. According to Department audit staff, the committee decided at their September 10, 1991, meeting to return the finding to the entity for a response before making a decision.

Discontinuation of fiscal monitoring - In addition to the Department's weak cost recovery efforts, the discontinuation of fiscal monitoring by program representatives raises concerns. At the time of our last audit,

---

(1) The Audit Disposition Committee was established by the Department to serve as the first step for resolving Department audit finding and recommendation conflicts between the Department audit staff and the administrative entities.

program representatives were responsible for fiscal reviews of entities to ensure that the entities had actually provided the services for which they were paid. However, due to a reorganization of OCBH, program representatives no longer perform this function.

As a result of this change and fragmentation of responsibilities, it appears the Department is doing very little fiscal monitoring. Personnel from Provider Services, the office responsible for receiving the entities' invoices and authorizing payment for services, indicate that they rely on the program representatives to ensure that the services the entities claim they are providing have actually been provided. However, as previously noted, program representatives are not performing this function. In addition, Department audit staff say that they rely on the annual independent audits of the entities to verify that the services the entities are reporting and being paid for have actually been provided. However, when we interviewed an audit firm, we found that although this firm claimed to verify services, they did not conduct a sampling or review any client files. Instead, they sent a letter to the Department asking DHS to verify if the service units their client claimed agreed with units the Department had purchased.

Lack of progress in other areas - We found the Department has made little progress in addressing three other deficiencies: a lack of consistency in monitoring, a lack of timeliness, and policies and procedures that have not been updated. A review of the six "draft" site visit reports we received revealed that staff focused on different aspects of entity performance and used different methods to report their findings.

In addition, while we found site visits for all eight administrative entities were conducted by the Division for fiscal year 1990-91, timely completion of reports and annual verification of data continue to be problems. Site visits for fiscal year 1990-91 were conducted during April, May, and June 1991; however, as of October 7, 1991, all six reports we had received were still in "draft" form, which is contrary to Division policy. Furthermore, the site visit report for CODAMA notes that data verification, which was last performed in April/May 1990, will be conducted again in September 1991. However, as of November 1991, this

verification had not been done. In addition, ADAPT's site visit report states that a complete data verification will be performed in the future, when sufficient data is available.

Finally, the Department has not made significant and necessary changes to the OCBH Policies and Procedures manual. The manual provides guidelines to be used by OCBH staff in administering behavio[illegible]health contracts. A majority of the outdated policies we found duri[illegible]our previous audit remain in effect.

Contract Provisions Not Substantially Changed

Behavioral health services contracts have not changed substantially since our last audit, and the problems previously identified continue. Some additional concerns have also been identified since our previous audit. However, the Department anticipates making changes to the entity contracts in the future.

Previous problems remain - We reviewed contract provisions for fiscal year 1991-92 contracts, as well as providing copies of these contracts to the State Purchasing Office for their review. We found that fiscal year 1991-92 contracts still contain few specific definitions of who is to receive behavioral health services. Contracts also lack penalties for noncompliance. Furthermore, the Department's standard contract is still based on a unit of service approach rather than performance contracting.

As mentioned in the previous audit, without contractually defined populations to be served, the entities determine who will receive available service, and because the Department bases contract compliance on units of service provided, the entities may not be providing services to those most in need. This system results in providing services based on the units of service rather than based on the needs of a targeted population. In Chapter IX, we found some other states' contracts are more specific regarding the population to be served.

Additional concer[illegible] identified - Several additional concerns with the Department's contract provisions have been identified since our previous audit. First, the fiscal year 1991-92 contract fails to address real

property and equipment ownership or interest earnings. In February 1991, our Office conducted a special financial review of ADAPT's purchase of a building. Our review revealed that the contracts are not specific as to whether administrative entities may purchase fixed assets. The lack of contract language that delineates the purchase with State funds and the ownership of real property and equipment is a matter that needs to be addressed. Although contract provisions restrict the spending of certain Federal funds (e.g., they cannot be used for inpatient services, the purchase of land, buildings, or major medical equipment), there are no such restrictions on State funds. Interest earnings present another concern. We identified an entity that had accumulated large amounts of interest on State funds; however, the Department's contract fails to address this issue.

In addition, entity contracts may not provide, either directly or by reference to Department policy, a sufficient and appropriate definition of administrative costs. While the fiscal year 1991-92 contract stipulates an administrative cost limit up to 8 percent of the total contract amount, it does not specify which costs can be included as administrative costs. Without a definition of administrative costs, entities may misinterpret and inconsistently classify these costs. In addition, contract language is unclear whether the 8 percent administrative cost ceiling includes administrative costs at the provider level. Consequently, this lack of clarity in the contract language does not enable accurate calculation of the percentage of administrative costs allowed by the entities and their providers. This concern is addressed in greater detail in Chapter I, the financial review of administrative entities.

Contract changes planned - The newly appointed Director of the Department of Health Services has indicated that changes are planned for DHS contracts and the 1992-93 Request for Proposals. These changes will include developing performance contracts, requesting a service plan and a quality assurance plan from the entities, as well as requesting reimbursement from entities if services are not provided as planned. The Department will use Florida's behavioral health contracts, which are based on performance contracting, as a reference point for improvements in the new DHS contracts.

RECOMMENDATIONS

1. DHS should recover unallowable costs in a more timely manner.

2. DHS should strengthen fiscal monitoring of administrative entity contracts.

3. DHS should improve the consistency and timeliness of its program monitoring efforts.

4. In revising entity contracts, DHS should consider adding provisions to target service populations, clarify the definition of administrative costs, address ownership of real property and equipment purchased with State funds, and provide for the disposition of interest earnings.

CHAPTER III

THE BEHAVIORAL HEALTH MANAGEMENT INFORMATION SYSTEM (BHMIS) HAS FAILED TO MEET THE NEEDS OF DHS, THE ADMINISTRATIVE ENTITIES, AND SERVICE PROVIDERS

Although DHS has committed over $4 million to the Behavioral Health Management Information System (BHMIS) since fiscal year 1986-87, BHMIS fails to adequately meet the needs of DHS, the administrative entities (AEs), and service providers. BHMIS has been plagued by operational and data problems since it was brought on-line. Although the Department is currently in the process of upgrading the system in an attempt to better address users' needs, some problems remain and fundamental decisions need to be made.

Background

In 1986, the Legislature required the Division of Behavioral Health to "contract for the design and development of a computer system to track and monitor chronically mentally ill clients and to provide the division with information on all behavioral health programs." The Legislature ultimately required that the system be on-line by January 1, 1990.[1] Consequently, DHS designed and implemented BHMIS, which went on-line in July 1989.

The Department designed BHMIS to provide the information and management tools necessary to plan, operate, monitor, and evaluate behavioral health services throughout Arizona. Specifically, BHMIS was to provide information for activities such as case management; client tracking; contract compliance; program monitoring; and client, program, and resource assessment.

Prior report identified BHMIS problems - In our 1989 report on the Division of Behavioral Health (Performance Audit Report No. 89-10), we identified problems with BHMIS. We observed that the selection of the hardware and software for BHMIS may have been premature, given that the

---

(1) Legislation called for the system to be implemented on a Statewide basis no later than July 1, 1987. The Legislature extended the deadline to July 1, 1988, and then to January 1, 1990.

final systems design was not completed until after those components were purchased. We also reported that DHS was having serious problems with system performance, and identified weaknesses in the evaluation component of BHMIS. We warned that if improvements were not made, DHS would have to consider various options, including reduced data collection, restricted access to on-line reporting, and changes or reductions in information reporting.

DHS responded to these suggested options by saying that BHMIS was on-line and operating according to expectations. They also said that any start-up problems had been identified and were being resolved. The Department claimed that the program evaluation concerns expressed in our 1989 report were unfounded. However, our current review indicates that the BHMIS problems identified in our 1989 report have not been resolved and have affected the ability of the system to adequately meet the needs of the Department.

Despite Commitment Of Over $4 Million BHMIS Does Not Meet The Needs Of The Behavioral Health System

Since fiscal year 1986-87, DHS has expended over $4 million in designing, developing, maintaining, and supporting BHMIS. Despite this huge commitment, BHMIS has failed to adequately meet the needs of the Division of Behavioral Health, the administrative entities, and direct service providers.

User survey indicates BHMIS is not meeting the needs of the administrative entities and service providers - A survey of BHMIS users conducted by our Office found that BHMIS is not meeting the needs for which it was designed. We surveyed administrative entity and service provider management staff to try to determine the extent to which BHMIS meets their needs.[1]

---

(1) We mailed 225 surveys to administrative entity and service provider agencies, which were identified in DHS reports, by administrative entity staff, and in other lists. Thirteen surveys that we were unable to find a forwarding address for were returned as undeliverable. Thirteen survey respondents indicated that they were no longer funded by DHS or did not have a current contract with an administrative entity. Six respondents indicated that they were responding for more than one subcontractor. For the remaining 193 surveys, we received 118 responses (61.1 percent). Some of those who did not respond indicated that they did not feel that the survey was relevant to their agency and declined to respond.

According to our survey, BHMIS has failed to meet the needs of and provide information useful to administrative entity and service provider staff. For example:

- Less than 17 percent of the respondents felt that BHMIS was successful in meeting the needs of their organization. When asked to rate the extent to which BHMIS assists them in the functions for which it was designed, users overwhelmingly indicated that BHMIS was not very useful.

- Only 36 percent of the respondents indicated that they use BHMIS reports on a regular (at least monthly) basis. Only 26 percent of respondents felt that it was easy to obtain information from BHMIS. Some users claimed they get nothing from BHMIS.

- Finally, a majority of BHMIS users felt that BHMIS data was not timely or reliable. One-half of those who responded to a question asking them to rank the timeliness of BHMIS data indicated that it was not timely. Less than one-half felt that BHMIS data was accurate (i.e., reliable, correct), and only 36 percent felt that it was complete (i.e., all records that should be in BHMIS are in the system).

BHMIS also does not meet the needs of DHS - BHMIS has also not successfully met the needs of DHS. Although much effort has been expended on the system, little use is being made of BHMIS data for operational concerns. For example:

- DHS SMI program representatives responsible for monitoring compliance with behavioral health contracts indicated that, due to limitations with BHMIS data, it is of little use to them. Several program representatives also indicated that if they need information, instead of going to BHMIS, they will often request it from the administrative entities.

- BHMIS data has not been useful in contract reconciliations performed by the Department. Provider Services within the Division of Behavioral Health is responsible for authorizing payments to administrative entities for services provided as part of their contract with DHS. One auditor in Provider Services presented us with work sheets he had prepared when reviewing administrative entity contracts. He found that information presented by the administrative entity and information in BHMIS varied considerably in some instances. As a result, he determined that BHMIS information could not be reliably used for performing his review and had to rely on information prepared by the administrative entities.

- Additionally, the BHMIS evaluation component also appears to be of limited use. A recent series of studies performed for the Legislature by Clegg and Associates cited limitations due to BHMIS data problems. Among other problems, Clegg found discrepancies between service data reports produced by administrative entities and those produced by BHMIS.

Several Factors Have Contributed To BHMIS' Failure To Meet Its Users Needs

A number of factors have contributed to BHMIS' failure to adequately meet the needs of its users. BHMIS has been plagued by operational and data problems since it was brought on-line. The computer hardware and software used by BHMIS proved inadequate for managing the volume and type of work. Changes in DHS operations have also affected BHMIS. In addition, BHMIS data quality and timeliness have been susceptible to problems with systems maintained by other organizations.

Hardware and software problems - DHS purchased the original computer hardware and software based on recommendations made by a consulting firm hired by the Department. However, this equipment was purchased prior to the completion of the full BHMIS design. This violates standard principles of systems development. Consequently, inadequate hardware and software have severely impacted BHMIS' effectiveness.[1] For example, at the time of our audit:

- Software limitations restricted the number of users that could access BHMIS data at one time. Although 31 work stations are tied into BHMIS, the system could accommodate only four users on-line at one time. If a fifth user attempted to obtain access, system performance and response time were severely affected. DHS had to "bump" the fifth user off the system.

- Due to the length of time it takes to process some reports, most report production had to be done during off-peak hours when users were not on the system. This limits the availability of timely reports.

- BHMIS users could not access information on-line about all services received by clients. Instead, users had to request reports to obtain this information.

Changes in DHS operations - Operational changes within the Division of Behavioral Health have also affected BHMIS' effectiveness. For example, DHS has changed the way it contracts for behavioral health services. In

---

(1) DHS claims that limitations placed on them by the Department of Administration in regard to the kind of machine and operating system they could obtain has also been a factor.

the past, administrative entities were required to adhere to the service units negotiated in the contracts. Currently, administrative entities are allowed more flexibility in the way they meet their contract requirements. Changes like these have an affect on BHMIS. Changes in contract information must be incorporated into BHMIS to keep data current and meaningful for contract compliance and program monitoring. At the present time, there is no mechanism in place to ensure that such changes are transmitted to BHMIS staff.

Administrative entity impact on timeliness and data quality - The method by which information is transmitted to BHMIS also affects the system's ability to meet the needs of its users. Most data (90 percent or more) is transmitted to DHS from the administrative entities' computer systems. This reporting arrangement makes BHMIS susceptible to problems with the systems maintained by other organizations. For example, our survey revealed that six administrative entities have backlogs of one month or longer. One administrative entity with internal system problems did not report data to BHMIS for approximately nine months. As of October 1991, BHMIS still did not contain all the data for services provided in fiscal year 1990-91.

There are also problems with data accuracy. Our own data testing showed problems with missing and potentially inaccurate data.(1) We tested a sample of services to registered clients for the five administrative entities included in the scope of this audit. We compared hard-copy records for a six-month period to data in BHMIS files. We found that over one-fourth of the records we reviewed were not in BHMIS data files. In addition, we found discrepancies between the information on the hard-copy forms and the information in the BHMIS data files for almost 11 percent of the records we reviewed. Table 6 (see page 32) presents a summary of our findings.

---

(1) For the entities selected, we collected Services to Registered Client forms from 13 subcontractors for February 1991 through July 1991. We checked records against BHMIS files containing service data from January 1991 to mid-September 1991. Although we did not attempt to draw a statistically significant sample, we did review over 1,800 records.

We chose the Services to Registered Client form for testing because it was reasonably consistent among all subcontractors, was feasible in the audit time frame, and would still allow us to identify timeliness and potential accuracy problems with the data.

TABLE 6

Comparison Of Services On Registered Client Forms
And BHMIS Data Files
February 1991 - July 1991

Month	Percent Matched	Percent Did Not Match	Percent Unable to Locate
February	62.7%	16.0%	21.3%
March	68.4	11.5	20.1
April	80.8	8.1	11.1
May	72.1	12.1	15.8
June	61.7	15.6	22.7
July	20.8	0.4	78.8
Overall	62.3%	10.9%	26.8%

Source: Office of the Auditor General, staff analysis of a sample of Services to Registered Client forms compared against BHMIS data files.

We also found additional problems with BHMIS data. For example:

- one administrative entity consistently entered "dummy" dates for client records into the BHMIS database, and
- some administrative entities used inconsistent codes to designate certain functions (e.g., intake screenings were coded as 23 by one administrative entity and 03 by another administrative entity.)

Lack of accurate and timely data affects BHMIS' ability to perform any of the functions for which it was designed. Under the current reporting arrangement, these problems are not likely to be totally resolved.

DHS Is In the Process Of Upgrading BHMIS; However, Fundamental Questions Concerning The System Still Need To Be Addressed

Although DHS is endeavoring to upgrade BHMIS, problems will remain, and fundamental questions concerning the system will still need to be addressed.

DHS is currently upgrading BHMIS - DHS is in the process of upgrading BHMIS. The Department recently replaced the original computer with an

upgraded model and, at the time of our study, was in the process of converting the operating system and database software on which BHMIS is based. This conversion is expected to be fully completed in early 1992. The new hardware and software should increase system performance and allow more users to access the system on-line at the same time. DHS obtained nearly $600,000 in third-party financing[1] for this new computer hardware and software.

Some fundamental problems with BHMIS still need to be addressed

Although the Department's efforts to upgrade BHMIS may address some of the problems with the system, other problems remain and the following fundamental problems with BHMIS still need to be addressed:

- Controls over data reporting should be established. As presently constituted, BHMIS is highly dependent on systems maintained by other organizations, and DHS does not have a procedure for enforcing its reporting requirements. BHMIS data will continue to be only as accurate and timely as the systems from which it receives data. Questions related to what, to whom, and how information should be reported need to be considered.

- There has been some confusion as to what information should be collected. Although most survey respondents indicated that they attempt to report to BHMIS all the behavioral health services they provide, over 20 percent said that they did not. Many providers explained they report only services funded by DHS. Others appear to report all services, regardless of whether the service is funded by DHS or another source.

Once DHS has determined what the primary purpose of BHMIS should be, the Department should then consider whether the current system can be adapted to meet those needs. The new DHS director has indicated that the Department plans to limit the use of BHMIS in the future to program informational purposes and will develop a separate system to handle contract payments. If the role of BHMIS goes beyond that, the current software used to support BHMIS might need to be replaced. Often, when systems in other states or agencies are determined to be effective, they

---

(1) DHS obtained this funding through Chrysler First Financial Services Corporation and makes quarterly payments on the loan from their general appropriations. According to a DOA official, it is not uncommon for state agencies to seek third party financing arrangements.

can be adapted to meet other needs. For example, the Department of Economic Security (DES) obtained a system from the State of Utah that allows DES to do client tracking for their developmentally disabled clients. Utah's system has a mental health component that DES did not convert. DHS should attempt to identify other systems that might meet their needs and consider whether it would be more efficient and effective to adapt another system or modify the current system with the resources at hand.

RECOMMENDATIONS

1. DHS should establish controls over data reporting. These controls should address questions related to what, to whom, and how information should be reported to BHMIS.

2. DHS should determine what the primary purpose of BHMIS should be, and then consider whether the current system can be adapted to meet those needs.

3. DHS should attempt to identify other systems that might meet their needs and consider whether it would be more efficient and effective to adapt another system or modify the current system with the resources at hand.

SECTION TWO

Chapter IV	Accessibility Of Services
Chapter V	Accessibility Of Services To Special Populations
Chapter VI	Services For The Homeless SMI Population

CHAPTER IV

ACCESSIBILITY OF SERVICES

The length of time required for an adult SMI client to access the community behavioral health entity system varies greatly. We reviewed the extent to which behavioral health entity services were accessible; however, our efforts were hindered due to the inadequacy of data provided by two of the five entities. Analysis of service data from the three remaining entities revealed some clients obtained services the day of referral while others waited two months or longer.

To address the question of service accessibility, our analysis focused on identifying how quickly clients receive initial services. Specifically, we compared the following:

- referral date to psychiatric evaluation date, and
- referral date to first service date other than meeting with a case manager.(1)

We requested the entities to provide basic service information on all new referrals received in the last quarter of fiscal year 1990-91. Of the five entities within the audit scope, only two, CODAMA and SEABHS, were able to fully comply with our request for information; a third, CCN, provided adequate information about psychiatric evaluations but not about first services. ADAPT and EVBHA were unable to identify the basic information needed to document the length of time new clients waited for service.

In evaluating the data, it should be noted that the entities are not always responsible for the delays clients experience. For instance,

---

(1) The analysis focused on accessibility at the initial psychiatric evaluation and first service other than case management because professionals working in the system identified these areas as bottlenecks for new referrals entering the system. In addition, case management services may have been provided prior to the service dates analyzed.

although clients in the county jail and inpatients at both the Maricopa Medical Center and Arizona State Hospital can be referred to the entity and case managed prior to discharge, clients cannot be evaluated and services cannot be provided until they are released. Also, some delays are caused by client behavior. According to one intake specialist, unstable clients are prone to reschedule or postpone appointments.

Results By Entity

We found accessibility of service varies among entities. CODAMA clients in crisis appear to access services quickly; however, clients not in crisis may wait. Although CCN did not provide the data necessary to determine the length of time clients waited for services, it did provide enough information about psychiatric evaluations to indicate that CCN clients appear to wait longer for evaluation than CODAMA clients. SEABHS is generally able to serve clients more quickly than urban entities because the intake process is streamlined in its rural communities.

CODAMA Services

CODAMA reported receipt of 245 referrals for the last quarter of fiscal year 1990-91, but not all of the referrals were included in this analysis. For example, clients who refused services or failed to show up for appointments, or for whom data was unavailable, were eliminated from the population.[1] The average length of time clients waited for psychiatric evaluation was determined for 127 referrals. First service times were determined for 115 referrals. Analysis of these referrals revealed that many clients wait over one month to receive a psychiatric evaluation and services other than case management.

---

(1) In the psychiatric evaluation analysis, certain referrals had to be dropped for the following reasons: some refused services (34); some were referred to another agency (25); some were determined not to be SMI (4); some had an illogical date sequence of service prior to referral (4); and for others, no date of service or evaluation was reported (39). The latter might happen for several reasons. Service might not yet have been received or possibly service was provided but not yet logged. Twelve additional new clients were known to have been in jail or the Arizona State Hospital, which would limit their receipt of service. While not exactly the same distribution, referrals were dropped from the service date analysis for similar reasons.

Psychiatric evaluation - Our review of the timeliness of psychiatric evaluations revealed the following:

- Twenty-five percent of the clients were evaluated by a psychiatrist within one week of referral.
- Fifty percent of the clients waited longer than one month for an evaluation.
- Some evaluations were performed the day of the referral; however, one client waited 119 days for a psychiatric evaluation.
- The average delay between referral and psychiatric evaluation was 35 days.

The results of our analysis appear to reflect CODAMA's intake policy. CODAMA prioritizes clients and tries to provide services most quickly for those in crisis or running out of medication. Those clients that appear stable and have sufficient medication wait significantly longer. This philosophy may explain why a large number of clients were seen within the first week after referral, although one-half waited more than a month.

First service - Our analysis of the time between the referral date and the date of first service revealed the following:

- Thirty-one percent of CODAMA's clients received services within one week of referral.
- Forty-five percent waited more than one month to receive services.
- Some clients received services on the day of referral; however, one client in the study group did not receive services until 135 days after referral.
- The average delay between referral and first service was 32 days.

The average time to obtain initial service was slightly less than the average time to obtain evaluation. The lower average wait for service may result from clients receiving medication or crisis services prior to their scheduled evaluation.

Community Care Network, Inc.

CCN reported receipt of 323 referrals for the last quarter of fiscal year 1990-91; however, not all of the referrals were included in this analysis.[1] The average length of time clients waited for psychiatric evaluation was determined for 187 referrals. Analysis of these referrals revealed that most clients wait over one month to receive a psychiatric evaluation. CCN did not provide the data necessary to determine the average length of time clients waited for services other than case management.

Psychiatric evaluation - Our review of the timeliness of psychiatric evaluation revealed the following:

- Two percent of the clients were evaluated by a psychiatrist within one week of referral.
- Seventy percent of the clients waited longer than one month for an evaluation.
- One evaluation was performed the day of the referral, but one client waited 167 days for an evaluation.
- The average delay between referral and psychiatric evaluation was 52 days.

During the period of our review, on average, CCN clients waited at least two weeks longer than CODAMA clients to receive a psychiatric evaluation. According to CCN officials, several factors may account for

---

(1) Again, certain referrals had to be dropped for the following reasons: some refused services or did not keep their appointments (39); some were referred to another agency (3); two were determined not to be SMI; some reported an illogical date sequence of psychiatric evaluation prior to referral (4); some were in ASH or in jail (4); and for others, no date of evaluation was reported (91). As with CODAMA clients, the CCN client evaluation dates may not have been reported for several reasons.

the longer wait. For example, although CCN now has responsibility for conducting psychiatric evaluations, during the three-month period of our review, providers performed this function. Thus, CCN had little control over the process. CCN staff also attribute some of the delay to large caseloads. According to one CCN official, large caseloads impact the amount of time case managers can devote to proactive activities, such as scheduling a client for a psychiatric evaluation.

First service - CCN did not provide the information needed to determine the average length of time clients waited before receiving initial services.

SEABHS

Thirty of the thirty-five new SEABHS referrals reported for the quarter were used in our analysis. Four clients were dropped from the analysis because no date of service was provided, and one client refused service. The review indicates that many clients were evaluated and received service within a week of referral.

Psychiatric evaluation - We noted the following about the timeliness of SEABHS evaluations:

- Forty-three percent of the evaluations were performed within one week of referral.
- Twenty-three percent of the clients waited longer than one month for evaluation.
- While several clients were evaluated the day of referral, one client waited 77 days.
- On average, referred clients waited 21 days for a psychiatric evaluation.

First service - Our review of the time between the referral date and the date of first service revealed the following:

- Sixty-three percent of SEABHS clients received a service within one week of referral.

- Thirteen percent of SEABHS clients waited longer than one month.
- The longest wait for service was 58 days.
- On average, SEABHS clients waited 10 days before receiving their first service.

In general, SEABHS is able to serve clients sooner than CODAMA or CCN. SEABHS' shorter time frames are not surprising because SEABHS' intake process differs from the metropolitan entities in that those seeking assistance can visit SEABHS service providers (which have a high profile in their smaller communities) directly. SEABHS' providers are also able to initiate services for the individual clients through SEABHS without the client needing to visit SEABHS.

EVBHA

We were unable to analyze EVBHA's performance because of problems with EVBHA's data. EVBHA did not provide us with data on crisis clients, who are handled more quickly than other cases. Consequently, any analysis would be skewed. We also found other problems with EVBHA's data. For example:

- EVBHA could not provide a list of all new clients referred to it during the review period.
- For those clients EVBHA did identify, the information was inadequate. For some clients, EVBHA often provided only the date of the client's first service with a referring agency prior to referral to EVBHA. Because that date is not indicative of EVBHA's response, the length of time before receiving initial service could not be determined.[1] For others, no date of service was provided.

ADAPT, Inc.

Due to lack of appropriate data, we were unable to analyze services to clients in Pima County. Although ADAPT did make several attempts to provide us with information, there were several problems with the data that prevented us from conducting any meaningful analysis.

---

(1) Although EVBHA subsequently offered to provide the first service date after referral to EVBHA, sufficient time was not available to conduct the analysis.

- ADAPT could not provide a list of all new clients referred to it during the review period.
- Of the 80 new clients that were identified, evaluation dates were provided for only 32, and service dates were provided for only 23. Therefore, no meaningful analysis was possible.

Some of the problems with ADAPT data were the result of organizational changes taking place in Pima County at that time. During our study period, an ADAPT assessment team was reevaluating all SMI adults enrolled with ADAPT, in addition to processing new referrals and then passing both groups on to the newly created case management contractor, Arizona Center for Clinical Management. Thus, separating clients actually new to the ADAPT system and those being reassigned was problematic.

RECOMMENDATIONS

This chapter provides information only, therefore no recommendations are presented.

CHAPTER V

ACCESSIBILITY OF SERVICES TO SPECIAL POPULATIONS

Our analysis indicates that most people with serious mental illness who are released from jail or discharged from the Arizona State Hospital (ASH) or the Maricopa County Psychiatric Annex do enroll in the entity system and receive community-based services. In fact, many appear to have already been enrolled in the system before their arrest or hospitalization. However, some of these people, especially those in the jail population, are lost in the referral process and do not get the services they need. Coordination is improving between the entities and the jails and hospitals.

Methodology

We were directed by the Joint Legislative Oversight Committee to examine the extent to which behavioral health services are accessible to populations of the greatest need, including the jail population. We expanded the scope of our review to include patients at the Arizona State Hospital (ASH) and the Maricopa County Psychiatric Annex, because they too are among those with the greatest need for mental health services when they are discharged into the community.

To determine whether those in these special populations made a successful and timely transition into the entity system, we asked the jails, ASH, and the Maricopa County Psychiatric Annex to provide lists of persons they referred to the entities during April, May, and June 1991. At the same time, we asked the entities to provide lists of the referrals they received during the same period. We then compared the lists, and attempted to resolve any discrepancies by reviewing BHMIS data and interviewing staff at the entities and institutions.

Our analysis was limited to institutions in Maricopa County because we were unable to obtain reliable information about referrals in Pima County. Pima County Jail staff directed our inquiries to ADAPT, which, as discussed in Chapter IV, could not provide the information.

The Jail SMI Population And The Entity System

Our review indicates that most people with serious mental illness who are released from jail make a transition into the entities' community-based care system. Some do not, partly due to factors outside the control of the entities. The entities have taken steps to ensure that fewer people are lost through the cracks of the system. According to jail officials, these efforts are making a positive impact.

Most of the SMI releases we reviewed were enrolled by the entities - We attempted to determine whether 74 SMI persons released from Maricopa County jails during April, May, and June 1991 received entity services. Most are now enrolled in the entity system. However, some refused services, or their service histories could not be determined.

Service histories for most of the SMI releases could be determined using records provided by the jails and the entities.

- Forty-six people (roughly 60 percent of the seventy-four releases) were enrolled in the entity system. Twenty-seven were already enrolled in the entity system before arrest; twelve more enrolled during their incarceration or upon release; and seven were referred to service providers where they could obtain services.
- Thirteen people (about 18 percent) refused services.
- Five people (or 7 percent) including two known only as Jane and John Doe, could not be tracked because the jails could not provide enough information.
- Ten people (about 14 percent) appear to have "fallen through the cracks." Three were not referred because they were in jail for only a short time. The other seven were referred to the entities, according to jail staff; however, the entities and the BHMIS system have no record of them and entity staff have no knowledge of these individuals. The current whereabouts and mental health status of these people is unknown.

Factors outside the entities' control may contribute to the problem of getting released SMI individuals enrolled in entity services. According to Maricopa County officials, some SMI inmates are released from jail too quickly for the entity to enroll them in the system. About one-half of those jailed are released in 24 hours, and the jail cannot hold anyone if the person is released by the court. Even if someone is identified as SMI, these hurried releases can lead to failure to notify the entities.

Coordination is improving - According to jail officials, coordination between the entities and the jails is improving. Some entities have a structure to identify and offer services to the SMI jail population. For example, one Maricopa County entity has designated a case manager to act as jail coordinator and visit both county jails one day a week to establish contact with prospective clients and maintain contact with ongoing clients. Another entity has designated three case managers to handle referrals from the jails. In Pima County, one case manager has an office at the jail. Jail officials report that these efforts, which have been in development for as long as seven years in some places, are beginning to have an effect on improving the transition from jail to community services.

In addition to the entities' efforts, DHS has taken action. DHS staff have been meeting with jail officials for over a year, weekly at first and now monthly, to learn which inmates are in psychiatric units and determine how and where to place them in the community-based system. DHS has assigned a program representative to work with each county jail and the entities to develop a coordinated process for connecting those in jail with the entities. To comply with blueprint requirements for a written plan, due February 1, 1992, which will ensure that each SMI person in the jail population receives appropriate services, the Department has assigned a staff member to work with jail and Department of Corrections personnel in developing a draft. Finally, DHS plans to use all of the available new funding for fiscal year 1991-92 to develop alternative housing for specified groups, including clients released from jail.

The ASH Population And The Entity System

Our analysis indicates that most patients discharged from ASH make a successful transition into the entity system. However, although 137 patients discharged during a recent three-month period were either already enrolled in the entity system or had made the transition into it, the status of 16 other patients could not be determined. In addition, some patients do not make the transition into the entity system successfully. ASH identified several patients with poor outcomes, including readmission to ASH. The hospital also has several patients who are clinically ready for discharge but cannot be discharged because there are no suitable beds available for them in community-based facilities.

Many ASH patients are difficult to place in other programs. Some have a history of mental illness spanning 10 years or more, and have received most of their treatment as inpatients. These patients are extremely dependent on the hospital and consider it their home. Elderly patients who, in addition to psychiatric care, need medical care face an additional problem because nursing homes are reluctant to accept psychiatric patients and other SMI residential facilities are unable to care for their medical needs.

Most of the patients we reviewed make a transition - ASH staff identified a total of 153 adult SMI clients discharged during April, May, and June 1991 with referrals to the entities in the audit study group. As in the jail population, we were able to determine the outcome of most of these patients.

- One hundred thirty-seven patients (almost 90 percent) are enrolled in the entity system. One hundred twenty were already enrolled, thirteen new clients enrolled upon referral from ASH, and four more were enrolled with the entity system after their discharge.
- Sixteen patients (a little over 10 percent) could not be found in entity records. ASH reported these people were referred to the entities, but the entities and the BHMIS system have no record of receiving the referrals. The current status of these people is unknown.

Some patients had to be rehospitalized - Of the 153 patients discharged between April and June, 35 were readmitted to ASH by mid-September.

According to ASH's Director, this 23 percent readmission rate is acceptable for this type of patient. However, ASH staff provided a synopsis of the reasons for readmission in each case, and in 7 of the 35 cases, there were problems with case management, coordination, and service provision. For example, one patient was placed in a supervisory care home where the amount of supervision was inadequate for the patient's needs. Another patient was in an entity's pilot program until his court-ordered treatment expired; however, when the pilot program stopped treating him, the entity did not transfer him to its regular case managers.

Availability of services is a problem - Another side to the accessibility issue is the number of patients who cannot be discharged when they are clinically ready because there is no place for them to go. Availability of appropriate residential services is an especially difficult problem for ASH patients because most of them require residential facilities upon discharge. Such facilities are limited in some areas of the State. At any given time, ASH may have dozens of patients who have reached the maximum benefit from their hospitalization but must wait for an available bed. Some patients can wait years for an appropriate bed. For example, ASH has an 81-year-old patient who has been clinically ready for discharge for about six years. However, because she is periodically disruptive (she screams), nursing homes are unwilling to take her, and SMI facilities are not set up to take care of a person her age.

The Department of Health Services is attempting to increase the number of available beds by developing alternative housing for special groups. The Department has also opened new re-entry facilities (REFs) in the 1990-91 fiscal year to provide a residential transition for persons recently discharged from ASH. Despite these steps forward, creating the needed number of residential beds in Arizona will be challenging (see Chapter VIII of this report).

According to ASH, 76 patients were ready for discharge as of October 9, 1991.[1] Analysis of the barriers to discharge shows that 26 patients (over one-third of those ready for discharge) were waiting because no appropriate bed was available for them. Some of these patients had special needs as a result of conditions such as pregnancy or incontinence, or required a facility for dually diagnosed clients (such as those with mental illness and chemical dependency), which made them harder to place. Five more patients remained at ASH due to administrative problems such as delays in the referral process. For the remaining 45 patients, there was either no reason for not discharging them or they were not discharged for reasons that were unrelated to the entities or the availability of services.

The problem with a lack of community services for former ASH patients will become more crucial in the future. According to the blueprint, only those with documented medical necessity may be admitted to ASH, and they must be discharged as soon as hospitalization is no longer necessary. The blueprint requires an evaluation of all long-term ASH patients, and sets time limits for evaluating new clients. These evaluations were being conducted during our study. A placement schedule must be established for patients who, according to the evaluation, no longer need hospitalization. ASH already meets to plan placements for patients ready for discharge, but a lack of available facilities hampers its ability to schedule placements.

County Annex Patients And The Entity System

In the past, some patients who received services at the County Annex have had problems making the transition into the entity system. However, Annex staff report that coordination of services between the Annex and the entities is improving.

---

(1) This is a comprehensive list for ASH, so some patients may not be SMI. However, the list indicates the barriers to discharge that SMI patients can encounter.

The Annex has 82 inpatient beds and provides crisis services for about 800 patients at a time in Maricopa County. Many patients under court order for psychiatric treatment receive it at the Annex. The more serious involuntary cases transfer to ASH for long-term care, but most Annex patients are referred out to the administrative entities for community-based services. During April, May, and June 1991, the Annex provided services for a total of 1,756 patients.[1]

Annex patients have had problems; however, services are improving

Delays in connecting patients with entity services have been a persistent problem according to Annex staff. This is particularly true for patients whose court-ordered treatment is expiring. Annex staff attribute much of this problem to Arizona's lack of sufficient residential beds. Annex staff also expressed concern about the large caseloads of entity case managers (see Chapter VII, page 59). Annex staff said they sometimes delay referring patients from their own case managers, who have much smaller caseloads, because some patients need more intensive case management than entity staff may be able to provide.

According to Annex staff, the entities and the Annex work together to coordinate the transition for Annex patients. A CODAMA staff member visits the Annex regularly to facilitate patient transitions, and CODAMA staff cooperate with the Annex in expediting referrals for patients with special needs. In July 1991, the Annex set up a box for each entity, and the entities now stop in to collect referral documents in their box. In addition to these steps, the Annex tries to refer patients before they are ready for discharge, to allow the entities enough lead time to pick up the referral.

RECOMMENDATIONS

This chapter provides information only, therefore no recommendations are presented.

---

(1) We were unable to evaluate Annex referrals by the same method used for the jail and ASH populations. Annex records are not computerized, and a manual search of the high volume of patient files was not practical. Annex staff used a random sampling method to create a representative list of referrals for the purpose of testing entity records for validity and completeness; however, the small number of referrals listed was insufficient for drawing conclusions about the Annex population.

CHAPTER VI

SERVICES FOR THE HOMELESS SMI POPULATION

Services currently available to homeless SMI adults are limited. However, in the last year, DHS and community organizations have begun to focus planning efforts on the problems facing homeless SMI people in order to increase services.

No substantive data about the number of homeless SMI people in Arizona is available, and estimates vary significantly. There is no consensus about the size of the homeless population in general or what percentage of the homeless are seriously mentally ill. Estimates of the homeless SMI population in Maricopa County range from 2,400 to 4,400.[1] One service provider in Pima County estimates that there are 750 to 1,500 SMI homeless persons in that county. Although homeless SMI people are not strictly an urban problem, there are fewer homeless persons with serious mental illness in the State's more rural counties; therefore, our audit work focused primarily on Maricopa and Pima counties.

Services For The Homeless SMI Population Are Limited

There are few services targeted specifically for the homeless SMI population. Outreach services for homeless SMI people are limited and vary by entity. In addition, the need for residential facilities greatly exceeds the availability.

Outreach services - Currently, outreach services for the homeless SMI population are limited and vary by entity. There are only a few outreach programs that serve a small segment of this population. Because homeless SMI persons are typically the most treatment-resistant, outreach programs

---

(1) Based on research for the Maricopa Association of Governments (MAG) Homeless Task Force, June 1991 report on the homeless, a task force spokesperson estimates the homeless population in the county to be 7,251 to 13,415. Of that group she also estimates approximately 33 percent are SMI.

are vital in serving this group. Outreach workers must locate these people by visiting places where they congregate, such as shelters, soup kitchens, or beneath bridges at river bottoms. Outreach workers typically contact homeless SMI persons repeatedly and attempt to gain their confidence by providing them with minor necessities. For example, workers in one program we contacted give out water during the summer. With repeated contact over time, outreach workers may be able to convince a homeless SMI person to accept treatment.

Funding for outreach programs serving the homeless SMI population has decreased over the past several years.[1] DHS has targeted over $470,000 to serve homeless SMI individuals in fiscal year 1991-92 compared to over $540,000 in fiscal year 1988-89. Although funding for these programs is largely Federal money, some State funds are allocated for these services. Our review of services indicates the extent of outreach activities varies considerably among the five entities we reviewed.

- **CODAMA Services** - For fiscal year 1991-92, CODAMA is receiving $207,297 for homeless-related outreach programs through a State contract. Seventy-five percent of this figure is Federally funded with the other twenty-five percent coming from the State. CODAMA contracts with Phoenix South Mental Health Center to provide outreach services for homeless SMI people.[2] In the prior fiscal year, the Phoenix South Psychiatric Outreach Project was the only homeless SMI outreach program funded by DHS in Maricopa County. The program served 881 homeless SMI persons -- 20 to 30 percent of those estimated to need services.

- **EVBHA's** outreach services for homeless SMI persons have fluctuated over the last several years. Outreach services were provided by two subcontractor agencies in fiscal years 1988-89 and 1989-90. Funds for contracted service were not available in fiscal year 1990-91 because EVBHA lost this Federal funding. Consequently, EVBHA assigned several case managers to provide limited outreach services in fiscal year 1990-91. However, these case managers stopped providing outreach services in April 1991 due to large caseloads. The State has funded an EVBHA in-house team to provide

---

(1) Projects for Assistance in Transition for Homelessness (PATH) grants provide most of the funding for DHS's homeless SMI programs. However, this funding has been decreasing.

(2) Maricopa County also has a "drop-in" center (CHAPS) that provides case management and psychiatric services to homeless SMI people. However, this program is not an outreach program because it does not attempt to locate clients and is not supported by funding for the SMI homeless.

outreach services in fiscal year 1991-92. Again, 75 percent of the State's $81,440 contract is Federally funded. EVBHA is in the process of filling the two positions slotted to provide this service.

- **ADAPT, Inc.** - For fiscal year 1991-92, ADAPT is receiving $181,077 through a State contract. Again, 75 percent is Federally funded, and 25 percent is State funded. ADAPT has contracted with La Frontera for the Readily Accessible People Program to provide homeless SMI outreach for the past several years. This program served 384 clients in fiscal year 1990-91, only about one-quarter to one-half of the population estimated to be in need.

- **CCN** - CCN does not receive monies specifically designated for homeless SMI outreach programs and has no programs specifically targeted for such services. According to a DHS official, CCN did not request funding to provide homeless SMI services during fiscal year 1991-92.

- **SEABHS** does not have a homeless SMI outreach program either; however, according to the entity director, this is not an area of real need in southeastern Arizona. He estimates 90 percent of all homeless SMI people in the four SEABHS counties are identified through contacts with other local agencies.

Residential services - Upon consenting to treatment, homeless SMI people are in particular need of residential services. According to outreach program staff, homeless SMI people need residential services tailored to meet their specific needs. Many SMI residential facilities are unequipped to deal with this group. SMI individuals are often difficult clients, and homeless shelters are often forced to turn these people away because they "act out" in the shelter and become disruptive. Furthermore, some homeless SMI persons coming off the street are unable to conform to the structure required by many SMI facilities. According to one program manager, some seriously mentally ill people are unable to deal with treatment programming because for them just getting out of bed each day is an achievement.

There are only a few specialized residential services, although many are needed. The June 1991 Maricopa Association of Governments' (MAG) study identified only 49 beds to serve between 2,400 and 4,400 homeless SMI people in Maricopa County. Recently, an 18 bed facility was opened in Maricopa County to serve the homeless SMI. Currently, Pima County has no beds specifically earmarked to serve its roughly 750 to 1,500 homeless SMI population.

Steps Are Being Taken To Increase Services

In the last year, DHS and community service groups have focused on the needs of the homeless SMI population. A recently established DHS Homeless SMI Task Force is currently working on a plan required by the Arnold v. Sarns court order blueprint.(1) The blueprint requires that the plan consider the number and types of services that need to be developed, including specialized services for homeless SMI persons. After review by the lawsuit's plaintiffs and the court monitor, a final plan will be developed. All parties must agree on the plan and it must be implemented by September 30, 1995. However, additional funding will probably be needed to implement the plan.

Although the blueprint has stimulated action to address the needs of the homeless SMI population, its restrictions have also hindered the development of services. For example, recent efforts to obtain additional beds for homeless SMI people have encountered problems. MAG's Homeless Task Force and the City of Phoenix have been working together to provide additional beds for the homeless SMI population in Maricopa County. HUD money was obtained to fund three new residential facilities to house 52 beds.(2) However, only 24 beds could be developed due to the court-imposed restriction of 8 beds per facility. Thus, 28 of the 52 planned beds could not be developed, and some of the HUD funding had to be returned. According to a staff person for MAG's Homeless Task Force, HUD expressed disappointment at the loss of the 28 beds, given the need for the beds and the availability of funding to provide them.

RECOMMENDATIONS

This chapter provides information only, therefore no recommendations are presented.

---

(1) The court order called for the homeless plan to be completed by October 1, 1991; however, an extension until January 1, 1992, has been given. As of January 10, a plan had not been finalized.

(2) Two of the facilities were to house 20 beds each, and one was to house 12 beds.

SECTION THREE

Chapter VII Case Management

Chapter VIII Other Needed Services

CHAPTER VII

CASE MANAGEMENT

The Arizona community-based mental health system relies on case management to ensure that clients receive the services they need, and that services are coordinated and appropriate. Although we found that caseloads vary greatly among case managers, overall, caseloads are large. As a result, case managers cannot devote adequate time to individual clients. Limiting caseloads to comply with recently mandated standards will require many additional case managers and millions of dollars.

Case Management Is An Essential Part Of The System

Case management is an essential part of Arizona's community-based mental health system. Case management services in Arizona are provided by administrative entities through clinical teams.[1] These clinical teams are responsible for developing an individual treatment plan (ITP) for each client.[2] As part of the clinical team, the case manager has primary responsibility for identifying and obtaining services in the client's ITP. In addition, the case manager has the ongoing responsibility of monitoring the services provided to the client and assessing the client's progress in achieving his or her goals.

To understand the case management function and workloads, we collected caseload data from the five entities. We also observed ten case managers performing a variety of functions, including visiting clients in various

---

(1) The clinical team may consist of a nurse, social worker, vocational therapist, psychiatrist, and case mangers.

(2) The Individual Treatment Plan (ITP) is a written document describing services to assist the client in meeting identified needs, and the objectives and long term goals to be achieved.

settings, such as the county jail, Arizona State Hospital, treatment programs, private homes, supervisory care homes, etc. In addition to visiting clients, we also observed case managers speaking with clients by telephone, providing them with transportation to appointments, consulting with other professionals about their cases, assisting clients in securing basic needs, such as food stamps and lodging, and helping them in times of crisis.

Large Caseloads Restrict Time With Clients

Although caseload size varies, overall, caseloads appear large, which reduces the case manager's ability to provide clients with adequate attention. For the five entities we reviewed, caseload size averaged 43 clients per case manager; one case manager had a caseload of 83 clients. Our observations confirmed case manager's comments that the large number of cases prohibits them from spending adequate time with each client.

Caseload size - Using information provided by the four administrative entities and the Arizona Center for Clinical Management (ACCM)[1] for September 1991, we found that 187 case managers handled 8,053 clients, an average of 43 clients per case manager. Caseloads ranged from 10 to 83 clients. Table 7, page 61 shows case manager to client ratio by agency.[2]

---

(1) The administrative entity in Tucson, ADAPT, Inc., contracts with the Arizona Center for Clinical Management (ACCM) to provide case management.

(2) These numbers are not static; they change as new clients enter the system and others leave, and as a result of case manager vacancies.

TABLE 7

Case Manager To Client Ratio
By Agency As Of September 1991

Agency	Number Of Case Managers(a)	Total Number Of Clients(b)	Caseload Ratio(c)	Range Of Caseloads
ACCM	61	1,984	1:33	14-61
EVBHA	22	867	1:39	23-57
CODAMA	34	1,593	1:47	35-54
CCN	59	3,037	1:51	10-83(d)
SEABHS	11	572	1:52	47-56

(a) Number does not include supervisors who may have caseloads, or new case managers with limited caseloads.
(b) Number excludes 202 clients served by supervisors and new case managers.
(c) Numbers are rounded.
(d) Includes pilot project case managers. When these case managers are excluded, case manager to client ratios average 1:58.

Source: Office of the Auditor General, staff review of data provided by ACCM, EVBHA, CODAMA, CCN, and SEABHS.

There are several reasons for the wide range in caseload size. For example, CCN has a pilot project that funds smaller caseloads. CCN caseloads ranged from 10 to 28 clients for the 11 case managers in the pilot program during September 1991. In addition, ACCM has several case managers with smaller caseloads because they are assigned clients who are more difficult to manage or because clients live in rural areas.

Case managers are likely to continue to carry large caseloads. In fact, their caseloads may increase. Currently, only about one-half of the estimated SMI population in Maricopa County is receiving case management services through the entity system. Once all other clients are brought into the system, they will require case management services. In addition, the "checklist" of eligibility was recently broadened to include personality and organic brain disorders. Thus, an even greater number of people will qualify for case management services. However, no additional funding has been designated for case management services in fiscal year 1991-92. Consequently, the client to case manager ratio may increase.

Large caseloads limit time available for clients - Large caseloads, as well as the wide range of services case managers are expected to provide impact the amount of time case managers have to spend with their clients. In addition to identifying and obtaining services for each client and monitoring the services provided, case managers are responsible for evaluating each client every 90 days. Therefore, they need to spend enough time with each client to adequately assess the client's level of functioning. However, all of the case managers we observed indicated their caseloads are too large and they are unable to spend enough time with their clients. Some case managers complained that they must spend at least 30 percent of their time on paperwork. Two of the ten case managers we observed stated that they have not been able to meet some of their clients because they have not had the time. One of these case managers (with a caseload of 71 clients) told us that he is only able to process new intakes and provide services for those who "make enough noise to get his attention." The following case example illustrates the variety of functions case managers perform during the course of a day and the limited amount of time they have to spend with their clients.

- We spent the day with one case manager who had a caseload of 50 clients. The pace all day was frantic even though the case manager had scheduled and planned the day efficiently. He began the day early by transporting a client to an appointment and then rushing to attend a training session on housing for the seriously mentally ill. Back in the office, the case manager fielded phone calls and did paperwork simultaneously. One of the calls was from a client who wanted to see a doctor because she was very depressed. The case manager immediately discussed the client with a psychiatrist and was able to schedule an appointment for this client later in the day. He then transported another client to an appointment, and went back to the office where he returned three phone calls from other clients who had called about their medications while he was out. The case manager also spent about five minutes each with two additional clients. The case manager explained that he normally tries to spend about 30 minutes with each client; however, on this particular day, he was already running behind schedule and could not spare the time. In fact, the case manager did not break for lunch.

  In the afternoon the case manager visited several clients. One of them lives in an apartment with only mattresses on a concrete floor. The case manager wanted to talk with the landlord about this client's living conditions; however, the client feared being evicted if he criticized the situation. After visiting with this client for about

20 minutes, the case manager drove to visit another client to ensure this client was taking his medication. This client is still paranoid and believes his medication is killing him. The client does not want to participate in a treatment program.

The case manager next attended a meeting at a treatment facility. One client involved in the program had been living in a supervisory care home, and the discussion focused on whether this client was ready for independent living and what problems this client might face in an independent living situation. Following the meeting, the case manager returned briefly to his office and attempted to call two more clients; however, he was unable to reach either of them. He then went to visit another client who is living independently and has a job. The case manager spent about 10 minutes talking with the client about how he was doing and whether he was having any problems. The client appeared to be doing well. After this visit, the case manager planned to pick up a prescription for a client and visit another client at home.

The case manager told us that this was a typical day for him. He had a number of unplanned calls to which he had to respond and more work than he could realistically handle. He also noted that he still had to complete paperwork about the day's activities, and this most likely would be done after hours.

Lower Caseload Ratios Will Require A Substantial Increase In Funding

By 1995, additional case managers as well as additional funding will be needed to reduce the size of caseloads to the levels required by the blueprint. By September 1995, most caseloads will be limited to 25 clients or fewer. Caseloads with intensive clients, (those more difficult to treat), will be limited to 10 clients. However, as illustrated in Table 7, page 61, none of the five agencies we reviewed are close to achieving these caseload ratios. We found caseloads average almost double the number specified by the blueprint, and almost 90 percent of the case managers have caseloads of more than 25 clients. Consequently, many additional case managers will be needed. For example, according to the blueprint, Maricopa County will need approximately 459 case managers to serve an estimated population of 11,589 SMI people in 1995. As of September 1991, there were only 115 case managers in Maricopa County. As a result, funding for case management salaries

in Maricopa County alone would have to increase almost $8 million annually to provide the estimated number of case managers needed by 1995.[1] DHS believes that some efficiencies in case management may be possible through better interagency coordination or other means. If efficiencies are possible, the cost of meeting the blueprint caseloads standards may be significantly less.

RECOMMENDATIONS

DHS should study whether efficiencies can be realized in case management through interagency coordination.

---

(1) The current average mid-point salary of a Maricopa County case manager ($23,022, excluding employee-related expenses) was multiplied by 344 (the estimated number of additional case managers needed by 1995) to arrive at the $8 million amount.

CHAPTER VIII

ARIZONA LACKS SOME NEEDED SERVICES FOR THE SERIOUSLY MENTALLY ILL

In addition to the need for more case management services described in Chapter VII, we also identified other services that seem to be lacking in Arizona. Residential beds appear to be the area of greatest need. Other services, including dental care, are also needed.

Residential Services Are Lacking In Arizona

The lack of residential services was a recurring theme throughout the review. Case managers and other professionals reiterated the need for more residential services. The blueprint requires that a variety of housing and residential options be provided for SMI persons. The State does not have a sufficient number of residential beds for the number of clients who need them, and some clients are currently living in settings that will not be available in the future due to blueprint restrictions.

Blueprint requires residential services - The blueprint requires DHS to plan for, develop, and maintain a variety of housing and residential options. By 1995, all clients are to be receiving the housing and residential services that can reasonably benefit them. Clients are to be integrated into the community in residential programs of no more than eight people, or in apartment settings where no more than 25 percent of the apartments are occupied by clients. Clients currently living in supervisory care or boarding homes are to be evaluated and moved to alternative housing if appropriate.[1] The blueprint defines several

---

(1) The blueprint limits each residential facility to eight or fewer clients, and almost all supervisory care homes currently have more than eight residents. According to the blueprint, approximately 900 SMI people live in supervisory care settings in Maricopa County. To comply with the blueprint, alternative housing will have to be found for many of these clients by 1995.

different types of residential programs. For example, intensive residential programs are staffed on a 24-hour basis with a high staff to client ratio, and provide vocational and other support services; semi-supervised group living arrangements are minimally staffed, and allow clients to function as part of a household and develop their independence; and supported living provides support services to clients who live on their own. The blueprint directs DHS to develop housing that will be flexible enough to meet each client's needs as those needs change.

Residential facilities are limited - Arizona has an insufficient number of residential beds. The blueprint contains estimates of available beds at the end of fiscal year 1990-91 and projected needs for each type of bed. According to the blueprint, at the present time, Arizona has only 235 intensive 24-hour beds, although it will need 1,145 beds Statewide by 1995. Similarly, the State has only 350 semi-supervised beds, compared to a need for 4,905 semi-supervised beds by 1995. In addition, the State has no supported-living beds, and 2,943 will be needed.

Case managers reported their frustrations - Our discussions with case managers and other professionals revealed frustrations in connecting SMI persons with residential services. We met with case managers and other entity staff, State hospital and County Annex psychiatric staff, and patient advocates. The insufficient number of residential beds compared to the number of patients who need them was mentioned repeatedly in these interviews. They told us that some residential programs are unwilling to accept clients with special needs. These programs refuse clients who might be disruptive, such as those coming out of inpatient hospitalization and those with substance-abuse problems. Also, some clients are placed in less restrictive environments than are clinically recommended because not enough 24-hour supervised beds are available in some areas.

Case managers and others also cited the following specific problems related to residential placements.

- Facilities for the dually diagnosed SMI/substance abuser are in short supply. In Maricopa County, the only option available for

detoxification is LARC, the Local Ambulatory Reception Center, which is not appropriate for some SMI clients.

- The Department of Economic Security's program for the mentally retarded has a statutory provision that it can accept people only to the limits of its resources. Thus, some SMI individuals who are also mentally retarded may wait as long as four years to transfer from ASH to a facility for the dually diagnosed mentally ill/mentally retarded.

DHS is taking steps to increase the number of residential beds - DHS plans to use new funding in fiscal year 1991-92 to develop alternative housing. The Department obtained $5 million in new funding and intends to use most of it for this purpose.(1) The alternative housing will be for clients who are homeless, in jail, in ASH, or in supervisory care homes, with the supervisory care home residents being the lowest priority. The Department is currently getting proposals from the entities on how they will develop this housing, and is also working on developing a method to verify that the new beds are going to these targeted populations.

Other Services Are Also Lacking

In addition to residential services, some other needs of the SMI population are not being adequately met, including dental care and other services. Under the blueprint requirements, DHS will have to work to increase the accessibility of all needed services.

Improved dental care for this population is one area of dire need cited by case managers. For most SMI people their only medical or dental coverage is through AHCCCS, and the only dental procedure AHCCCS will cover is tooth extraction. One case manager cited a client with an abscess who had no dental treatment option other than extraction. Additionally, for those clients who have lost all of their teeth, AHCCCS will not provide dentures. Under these limitations, case managers cannot ensure basic physical care for their clients.

---

(1) $1.2 million of the $5 million will be required to pay the court monitor's administrative costs.

According to case managers and blueprint projections, several other types of service are not available in sufficient quantity to meet the needs of all SMI clients:

- educational services, such as teaching clients to manage their budgets and teaching families about mental illness;
- day treatment programs;
- drug treatment programs;
- vocational, supported work, and work adjustment programs;
- mobile crisis stabilization teams; and
- programs tailored to the needs of elderly clients.

The blueprint requires DHS to work diligently to increase the accessibility of needed services. The blueprint further directs that client treatment plans identify unmet needs for services and that these needs be communicated to DHS. DHS will then be able to address these unmet needs in planning for future services.

RECOMMENDATIONS

This chapter provides information only, therefore no recommendations are presented.

SECTION FOUR

CHAPTER IX

OTHER STATES' PROGRAMS FOR THE SERIOUSLY MENTALLY ILL

Structures for delivering and paying for services for the seriously mentally ill vary widely from state to state. Furthermore, each state is unique in the way it provides case management services, targets populations with special needs, and controls the expenditure of state funds. Although Arizona's system is similar to systems in some other states in some areas, the administrative entity system is unique to Arizona. No other state has this system.

Methodology

The May 8, 1991, resolution directed us to compare Arizona's administrative entity system with the mental health service delivery systems in other states. We conducted a telephone survey of ten mental health service systems in other states and reviewed contracts and other documentation pertaining to those systems. We selected Colorado, Utah, Washington, Oregon, Ohio, Vermont, New Hampshire, Rhode Island, and Orange County, California, because their systems were highly regarded by one or more of the experts we interviewed.[1] We selected the tenth system, Monroe County, New York, because it was described as the country's largest experiment with a capitated system. A national study[2], which rated care of the seriously mentally ill in all 50 states, ranks all of the states we surveyed among the top 16, and

---

(1) Mental health systems were selected for the survey through interviews with the National Council of Community Mental Health Centers, the National Alliance for the Mentally Ill, Arizona's court-appointed monitor for the Arnold vs. Sarn decision, and the Director of the Arizona Department of Health Services.

(2) E. Fuller Torrey, M.D., et al., Care of the Seriously Mentally Ill: A Rating of State Programs, 3rd ed. (joint publication of Public Citizen Health Research Group and National Alliance for the Mentally Ill, 1990). The report ranks states based on hospital services, outpatient and community support services, vocational rehabilitation, housing, and services to seriously emotionally disturbed children.

ranks New York among the top 10.[1] The study ranks Arizona in a tie for 38th place. Even though the states we surveyed were highly ranked, the national study reports that no state is even close to achieving the ideal system of services overall.

SMI program budgets, staffing, and the number of clients served could not be compared reliably based on our survey. We asked each state or county to provide these figures for their SMI programs. However, some reported budget figures that included state hospitals or programs that serve other populations in addition to the seriously mentally ill. Some could eliminate duplications from their figures for the number of clients served; others could not. As a result, the figures reported could not be compared.

Structure Of State Systems

Arizona's administrative entity system is unique among the states we surveyed. One-half of the states we surveyed provide services through county-based systems, and the others contract directly with private service providers. However, one county we surveyed, like Arizona, contracts with a private organization that in turn contracts for all services.

Four states (Oregon, Washington, Utah, and Ohio) and Orange County reported that the state provides funds to counties, which are responsible for either providing services directly or contracting with private organizations for service delivery. In Washington, the state contracts with multi-county coalitions called Regional Service Networks, which are not permitted to provide direct services unless they are the only or the most cost-effective provider available.

The other four states (Colorado, New Hampshire, Rhode Island, and Vermont) and Monroe County have systems that rely on contracts with

---

(1) California, where Orange County is located, ranked 31st in the study. However, Orange County was highly recommended by one of the experts we interviewed.

private companies. All four of these states contract directly with the community mental health centers that provide services to the mentally ill. In Monroe County, a private organization called Integrated Mental Health (IMH) was established to coordinate mental health services for Monroe and another county. Like Arizona's administrative entities, IMH does not provide services directly, but contracts with other companies for services.

Case Management

Arizona assigns a case manager to every SMI client. Some other states also do this but most do not. Although case managers in every system perform functions similar to Arizona case managers, we did not identify any other systems like Arizona that place case managers with an entity that contracts for services but does not provide direct service.

In six of the systems we surveyed (New Hampshire, Washington, Rhode Island, Utah, Orange County, and Monroe County) case managers are generally assigned only to clients who need them. Need is determined by clinical teams or by criteria such as enrollment in Monroe County's capitated system. Vermont, like Arizona, assigns a case manager to every SMI client. Ohio intends to do this, but does not yet have 100 percent assignment. In Colorado and Oregon, every client has someone assigned to perform the case management function, but this may be handled by the client's therapist rather than by a specialized case manager.

In all the systems we surveyed, case managers are responsible for helping clients obtain access to the services they need. In addition, case managers in three states (New Hampshire, Vermont, and Ohio) provide some direct services such as psychotherapy and skills training. Arizona case managers are also responsible for helping clients access needed services, and provide what appear to be direct services, including moving clients' belongings to new homes, helping clients set goals, and taking clients on social and recreational outings.

In all but one of the other systems we surveyed, case managers are employed by the service providers. However, Orange County's case

managers are employees of the county. According to the Orange County Mental Health Director, this arrangement helps the county monitor services and strengthens the system.

Contracting Practices

The basic form of Arizona's contracts with the administrative entities is not unusual among the systems we reviewed. Other states use a variety of methods for determining contract totals and making payments, including variations of Arizona's fee-for-service arrangement. However, some other states' contracts contain provisions that Arizona's contracts lack. These provisions target the clients to be served and define the expenditures that may be funded. The contract provisions of other states may also give these states more control than Arizona over the use of state funds.

Contract form and price determination - Arizona's contracts specify a number of units for a variety of services as well as a unit price determined by negotiation. The entities may provide any combination of services that adds up to the total amount of the contract. Other states use similar contracts, although each system we reviewed had different criteria for determining the total contract amount. The two counties we surveyed have different types of contracts: Monroe County serves some of its most severely ill clients under a capitated system, paying a defined amount per client per year for all services the enrolled client requires; and Orange County has some cost reimbursement contracts under which it reimburses the contractor for allowable expenditures up to a maximum allowable cost per unit of service.

Although negotiating prices and contract totals is not uncommon, some systems have more formal methods for determining contract amounts. In Colorado, unit prices for services are based on a statistical formula that determines the average actual cost of services statewide. Other systems base the contract total on a variety of factors, including the population of a geographic area, prevalence of the seriously mentally ill, prior-year funding, and operating costs of the contractor. In some systems, the contract total can be increased by rewards for reducing the use of state hospital beds or for high performance, or decreased by penalties for overuse of hospitalization.

Targeting clients to be served - Arizona's contracts with the administrative entities do not specify the number of clients to be served, although they do define the number of services to be provided. Because some other states' contracts are more specific, they may provide more opportunity to ensure that clients with the most need are served.

In two states, contracts identify several categories of clients and specify the number to be served in each category. New Hampshire specifies the number of clients and what percentage of the overall caseload each category will be. New Hampshire's categories are based on the nature and severity of the clients' mental illness. Washington specifies the number of clients and service hours to be provided to each of several underserved groups, including the disabled, elderly, and minority populations. Vermont's contracts include a space for the name of each client.

In some states, contractors are penalized for failure to meet target numbers of clients served. For example, Colorado can penalize contractors if they do not meet 93 percent of the target number. However, contracts with these provisions generally provide contractors with an opportunity to renegotiate the target numbers during the term of the contract.

Controlling expenditures - Arizona's contracts with the administrative entities broadly require funds to be used for performing the contracted services; however, they do not specify which expenditures are acceptable or require repayment of unexpended funds. Other states have more restrictive contract provisions.

Five of the systems we surveyed do more to limit the expenditure of State funds. Colorado specifies the number of staff hours and dollar amounts that can be spent on consultation, education, vocational and homebuilder's programs, and case management. Three states (New Hampshire, Rhode Island, and Vermont) approve line-item budgets and permit shifting of funds only in limited amounts or with state approval.

New Hampshire's contracts also limit the amount of individual funded salaries to $120,000 per year. In Orange County, cost reimbursement contracts provide funds only for allowable expenditures as defined by state and Federal standards.

RECOMMENDATIONS

This chapter provides information only, therefore no recommendations are presented.

CHAPTER X

ANSWERS TO LEGISLATIVE QUESTIONS

In directing this study, the Joint Legislative Oversight Committee identified eight issues of concern. Due to time limitations and the complexity of these issues, we were not able to address each issue and, therefore, prioritized our work to focus on those issues of greatest concern. The study focused on the delivery of services to the seriously mentally ill population rather than all behavioral health services. A brief response to the eight issues follows and, where possible, references to related chapters in the report are presented.

1. The degree to which services provided through the behavioral health entity system are planned, targeted for, and accessible to populations of greatest need including populations of the Maricopa and Pima County Mental Health jail units and homeless shelters.

   We conducted work to determine the accessibility of services to the seriously mentally ill. We found most SMI clients are able to access services; however, some are lost in the referral process and do not obtain the services they need. The length of time it takes those who do connect with the entity system to obtain initial services varies from one day to several weeks. For additional information on the extent of our analysis, see Chapter IV, page 37.

   We also reviewed the accessibility and availability of services to specific subpopulations of the seriously mentally ill including those who are homeless, in jail, or in ASH. We found that services for homeless SMI persons are particularly lacking although increased attention is being focused on this population.

Most people with serious mental illness who are released from jail or discharged from the Arizona State Hospital do enroll in the entity system and receive community-based services. However, some SMI people, especially those in jail, are lost in the referral process. Coordination among DHS, the entities, the jails and the hospitals is improving and helping SMI individuals make a timely transition into community-based services. For additional information on these subgroups, see Chapters V and VI.

In recent years, efforts to plan and target services for those most in need have increased considerably. However, many services remain limited, including case management and residential services. Chapters VII and VIII address these areas in greater detail.

2. <u>The efficiency and cost-effectiveness of the administrative entity system relative to other existing mental health service delivery systems.</u>

We conducted a financial review of how three of the entities expend their SMI monies. Our review (discussed in detail in Chapter I, page 11) raised concerns in two specific areas:

a. restricting the use of "earned but unexpended funds"; and

b. adequately defining administrative costs to ensure all appropriate administrative costs are readily identifiable and comparable among entities.

We also conducted a limited survey of several states noted as having good behavioral health programs. However, we found it difficult to make comparisons among other systems because each system is different and unique in the way it provides services for each program. Consequently, the information gathered is insufficient to make a determination on the efficiency and cost-effectiveness of Arizona's administrative entity system relative to other state's mental health systems. The information about other states' systems is presented in Chapter IX.

3. The extent to which competitive bidding procedures are employed in the process of contracting with administrative entities and of subcontracting with direct service providers.

According to the Office of SMI Manager, DHS follows the procurement code when contracting with administrative entities. In 1987, the last time contracts were awarded, there was no competition for entity contracts. DHS' contracts with the entities have been in place almost five years and will expire June 30, 1992. The newly appointed DHS Director has indicated that she plans to work toward making the system more competitive in the upcoming contract cycle.

Currently, the entities are not required to comply with the procurement code when contracting with provider agencies. However, it is the Department's intention that the entities comply with the procurement code. To determine the extent to which competitive bidding procedures are followed by the entities when contracting with direct service providers, we requested the entities to provide us with documentation of their contracting process. Based on the information submitted by entities, it appears they have established procedures to allow for competitive bidding. For example, most entities advertise for proposals, detail the qualifications required, specify proposal evaluation factors, and the relative importance of each factor. However, due to lack of time, we could not review any of the bids received by the entities to determine whether they are complying with the procedures they have established.

4. The fiscal and managerial implications, emphasizing accountability, and the relative merits of providing direct services through each of the following providers:

   a. administrative entities;

   b. subcontractors; and

   c. purchase service pools.

Lack of time and resources prevented us from addressing this question.

5. The adequacy of existing mechanisms for accomplishing the following objectives giving special attention to the unique problems where there are multiple administrative entities within one county:

   a. coordination and standardization of services; and

   b. monitoring, evaluation and analysis of delivered services to assure conformity to established standards and priorities.

Maricopa County is the only county that has multiple administrative entities. The Maricopa County Department of Health Services also offers services to those with serious mental illness. In addition, efforts have been made to improve coordination of services among the entities in Maricopa County. For example, according to one entity representative, the three Maricopa County entities developed an inter-entity agreement to facilitate client transfers from one entity to another.

Currently, Arizona's system has few program standards. However, the blueprint calls for the State to ensure the quality of all services for seriously mentally ill people within Maricopa County, and some of the blueprint requirements specifically address standardization of services. For example:

- rules governing the development of individual treatment plans (These rules are to govern the application for services and the development and implementation of ITPs and shall set forth timelines for each step in the ITP process);
- developing standards for residential programs; and
- drafting rules that will govern the standards for all nonresidential programs.

The blueprint also calls for DHS to design a comprehensive system of monitoring, evaluation, and quality assurance that shall include provisions for appropriateness, individualization and effectiveness of services. Once this system is in place, DHS will have a mechanism to measure whether services conform to standards and priorities. However, at present there are no standards for comparison.

6. The extent to which existing management information systems meet the needs of the division, the administrative entities, and direct service providers.

We found the DHS management information system (BHMIS) fails to meet the needs of the Department, the administrative entities, and service providers. For further discussion, see Chapter III, page 27.

7. Whether service development contracts between the administrative entities and the Division are sufficiently delineated and monitored.

In fiscal year 1990-91, the Division awarded over $8 million to administrative entities through service development contracts to develop and provide new and/or expanded SMI program services. We reviewed these contracts and found they lack detailed information. The contracts contain broad and nonspecific information on the services the entities are to provide, sparse budget information, and unclear and nonspecific contract language. In addition, the service development and delivery plan (the document that delineates the services the entity will provide) appears incomplete, lacks specific data on service levels and clients, fails to clearly delineate the responsibilities of the entities, and lacks standard formats.

The Division's fiscal monitoring of service development contracts also appears weak. The limited financial information the entities are required to report is insufficient to identify the actual costs associated with each project. Since the contracts were fixed rate reimbursement contracts, the entities were reimbursed not for actual expenditures, but for submitting the service development and delivery plan and monthly activity reports. Thus, in most cases, DHS does not

know the actual cost of the programs the entities provide. DHS recognizes the weaknesses in the service development contracts and is currently reviewing other options to distribute service development funds for fiscal year 1991-92.

We also examined the steps taken by the Department to implement the recommendations made in our November 1989 report (Performance Audit Report No. 89-10) addressing contract monitoring and provisions, and found the Department continues to have deficiencies. Weak and ineffective contract monitoring persists. In addition, contract provisions continue to exhibit the same weaknesses previously identified, although the Department plans to overhaul its entity contracts for fiscal year 1992-93. For further information on these deficiencies, see Chapter II.

8. Whether taxpayer interests are sufficiently protected including the adequacy of public access to the information concerning how public funds are distributed by the Division to each entity and then either utilized by the entity itself for the provision of direct services or distributed to entity subcontractors.

Public access to information on the entities' use of public funds is limited to the extent that such information is disclosed by DHS or pursuant to a report such as an audit. Although we were able to obtain all the financial information we requested from both DHS and the entities, administrative entities are private, nonprofit agencies and, as such, would not have to provide information to the general public. If the entities were State agencies, information on their use of funds would be public information and, therefore, accessible. However, as private agencies, the entities may take a more proprietary view of their responsibility for public disclosure. An analysis of our review of entity finances is discussed in Chapter I.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Directo

FIFE SYMINGTON, GOVERNOR
ALETHEA O. CALDWELL, DIRECTOR

January 24, 1992

Mr. Douglas R. Norton
Auditor General
2700 North Central, Suite 700
Phoenix, AZ 85004

Dear Mr. Norton:

Thank you for the opportunity to review and respond to the draft of the performance audit of the Behavioral Health Administrative Entity System. We verbally responded to Mr. Bill Thompson and Mr. Pete Francis Monday, January 20th.

Many of our comments were incorporated in your final draft.

General Comments

While the study would have been more balanced had all the entities been reviewed, we believe that you covered the major issues due to your broad selection and samples.

Like the 1988 performance audit, we found the report to be useful as we set about to improve the behavioral health system in Arizona.

The Department has very few disagreements with the findings and comments in the report, as it generally agrees with this administration's findings and our subsequent testimony to the Joint Legislative Oversight Committee on Behavioral Health Services on November 20, 1991. Another major report "Progress and Accountability - Arizona's Service System for Individuals with Serious Mental Illness" (Clegg and Associates, Inc., November 1, 1991) critiques the behavioral health system and recommends improvements.

Chapter 1 - Financial Review

We agree with the analysis, but regret that the total indirect costs including those of subcontractors could not be reflected.

In reality, the amount of unexpended funds may be greatly reduced since the receivables from the state agencies, both ADHS and AHCCCS, are not current, but the entities have had to continue funding their subcontractors.

The audit does not acknowledge or consider the difficulties ADHS experienced in mounting the Title XIX Mental Health Programs for Children or the administrative time consumed responding to the requirements of the Arnold vs. Sarn court suit and subsequent court monitoring requirements. These factors overburdened the Department's administrative capacity and contribute to the continued lack of attention to entity contract and program monitoring activities for both state and federal funds. The Department is developing a performance contracting and monitoring approach that will far exceed the recommendation of the audit report. The Request For Proposal for competitive bids for regional behavioral entities will be issued by February 15, 1992. The audit work wil be completed by January 31, 1992. In the interim, the Department has engaged the audit firm of Ernst & Young to do a focused audit of the largest entities to determine fund balances for all state funds, and to review accounting and internal control practices. They are also assisting the Department in developing financial audit tools, training internal audit staff, and reviewing the claims reconciliation process in the Department.

The Department has further, within the constraints of the current contracts, required the entities to produce the many outstanding financial reports for federal funds within 30 days from January 28, 1992.

The performance contracting system will include:

- Incentives/sanctions;
- Quality assurance plans and reviews;
- Professional credentialing review processes;
- Outcome measures;
- Uniform financial reports;
- Prior approval of cost-based rates;
- Uniform cost reports to justify rates;
- Defined allowable costs for administration;
- A requirement that unused funds be returned to the state;
- A <u>single</u> third party payor claims processing and adjudication system;
- Uniform data reporting to conform to state and fedearl requirements;
- Managed care and capitation principles; and
- The development of a Regional Behavioral Health Plan with identified target populations

Other Comments

Because the system of selection will be a competitive bidding process and because the checks and balances (i.e., the accountability of the system will be clearly defined), we do not believe that the recipient should be treated as grantees. Further, that would not be practical under the Title XIX Medicaid requirements.

Follow up, though belated, is occurring on January 28th to attempt to recover overpayment funds from both entities referenced in the audit.

In summary, the Department has tightened up the existing system but is focusing its resources on contract preparation; systems requirement analyses, followed by the installation of a third party processor; developing outcome evaluation, program evaluation; and compliance audit instruments for the performance contracts; training providers and entities in submitting accurate claims; and developing a "business office" capable of processing and reconciling claims on all sources of funds.

Information Systems

The vast majority of the statements in the review were on target and were known to the Department. There are a few comments to be made regarding the "expectation" of BHMIS and the current status of the system.

- On Page 28, "User survey indicates BHMIS is not meeting the needs of the administrative entities and service providers:

  We do not have, nor are we aware of, any needs analysis done related to BHMIS serving the needs of the administrative entities. As mentioned in the Background section, BHMIS was designed to "track and monitor chronically mentally ill clients and to provide the Division with information on all behavioral health programs." It does that to some degree and should not be held up to a standard that was not in the original legislative intent. It is true that during the original design of BHMIS multiple reports were developed with both the Department's and entities' needs in mind. Those reports are still available but are not utilized by either party.

- It should be mentioned, other than in a footnote (Page 30), that the hardware and software platform selection process was dictated by the Department of Administration (DOA). The criteria under which the Department operated are still in place. It is a

specific declaration of the DOA which could be quoted in the audit, if appropriate.

- There are multiple indications of the lack of "completeness" of the data in BHMIS. While it is a management issue regarding the entities input of the data, the entities complaining about the reliability of the BHMIS data seems misplaced. The data is unreliable due to the fact that the entities have not supplied BHMIS with reliable, complete data. If the entities are paid based upon reliable data being input to BHMIS, then the data would be much more reliable.

- The BHMIS system was converted from the IBM VSE operating system to the IBM VM operating system on January 15, 1992. As part of the conversion effort, a stress test was conducted. Seventeen users have been on-line simultaneously. These users executed pre-defined scripts that attempted to cause table lock-out and on-line contention problems. The results obtained were impressive -- even to the technical personnel involved. All timed responses to the screen were less than three seconds and no lock-out conditions occurred. Since the system has been live, we purposely ran a resource intensive batch reporting process during the time that multiple users were on-line. The users (aware of what we were attempting to find out) reported that there was "no noticeable degradation of response time" with the batch process running. Responses which previously were timed at two to five minutes without a batch process executing simultaneously, were three seconds or less with the batch process executing.

- On Page 33 it mentions a software conversion in October 1992. We know of no conversion scheduled for that time frame. We are planning on new interfaces to a third party claims processing system being on-line in July of 1992 with the bulk of the new data related to Title XIX claims beginning to impact the system in October.

Case Management

The Department will review the inconsistencies and inadequacies of some of the current case management programs. It will seek to determine the populations that need case management and to review both the centralized vs. decentralized approaches to case management and the quality and quantity of the case managers as recommended.

The Department has appointed a new Assistant Director of Behavioral Health Services and is assisting in reorganizing the Division to provide the technical, professional, and managerial leadership and oversight to a statewide regionalized behavioral health system that

will experience significant changes in 1992. It has contracted for technical assistance to develop its business functions, review prevalence rates, review and/or develop service plans for the adult seriously mentally ill (SMI) and children's population; select and implement claims processing and payment systems; and prepare and negotiate new contracts and intergovernmental agreements. The goals are service integration and accountability for 1992. The Department, in conjunction with AHCCCS, is preparing to implement the Title XIX program for the seriously mentally ill adult populations in October of 1992. We believe that should the Auditor General choose or be requested to conduct another performance audit of the Division in 1993 that the results will be positive and demonstrate great progress.

Sincerely,

Alethea O. Caldwell
Director

Description of Behavioral Health Claims Processing System Schematic

Please find attached the most recent copy of the Behavioral Health Claims Processing System schematic. I would like to briefly describe the key business activities and interfaces underlying this system.

1. There are a number of key objectives to be derived by the claims processing system. Among them are:

   a. A more rapid and accurate mechanism to reimburse the direct service provider for services rendered and to track claims in process.

   b. Creating a uniform mechanism of contracting for provider services, establishing service rates, and providing accountability of available fund balances and other financial reporting.

   C. Providing a single system/single point of data entry mechanism to capture not only claims data but also client demographic, evaluation/outcome data and program evaluation and planning data.

2. Capitation The system identifies two levels of capitation:

   a. AHCCCS, for Title XIX funds, and if possible other state agencies currently maintaining budgets for the delivery of behavioral health services, will capitate monies to ADHS based upon formulary as to membership enrollment, program type, etc.

   b. ADHS, for all registered client services, and for all services that lend themselves to fee-for-service billing, will capitate monies to the Regional Behavioral Health Authorities (Administrative Entities) based also on some determined capitated formulas.

3. Intakes and Assessments The entities will identify new clients and provide intake services and information on these clients. In addition, the entities will assess the clients and, where appropriate (e.g. court monitored SMI clients) will perform these assessments on a prescribed frequency.

4. Treatment Plans The entities will have the responsibility of developing each client's Individual Treatment Plan (ITP) and the authority to approve the ITP and authorize services. The service plan detail from each approved ITP will be sent (input) to ADHS. ADHS will

electronically disseminate these approved services to each appropriate service provider in the form of a letter of authorization and to the claims processor (TPP) for future adjudication of provider service claims. In addition, a report will be generated daily for each entity identifying all Letters of Authorization sent the previous day.

*Note here, that it is not the intent of ADHS to review and give final approval of the treatment service plan, only to capture and disseminate the data.

5. Service Rates It is the intent of ADHS that capped maximum service rates be established for specific services. This will be done to insure fiscal responsibility and controls within the claims processing function. In addition, entities may negotiate service rates with individual providers.

   To provide a quality review function and to promote uniformity within the delivery system, the entities will send (input) their negotiated provider service rates to ADHS. ADHS will maintain a data base of current rates and electronically transfer all approved rates to the claims processor for subsequent payment of provider service claims.

6. Claims Submission and Payment Service providers will submit their claims directly to the TPP claims processor using either hard copy or electronic media. Using the information sent to it from ADHS (client, authorized service plan and approved rates), the claims processor will adjudicate and pay the claims. These payments will be made directly from the claims processor to the provider.

   The "going-in" assumption on the timing of claim payments is that all claims received by the TPP through the close of business on each Friday will be adjudicated and paid (i.e. checks written and mailed) within ten working days.

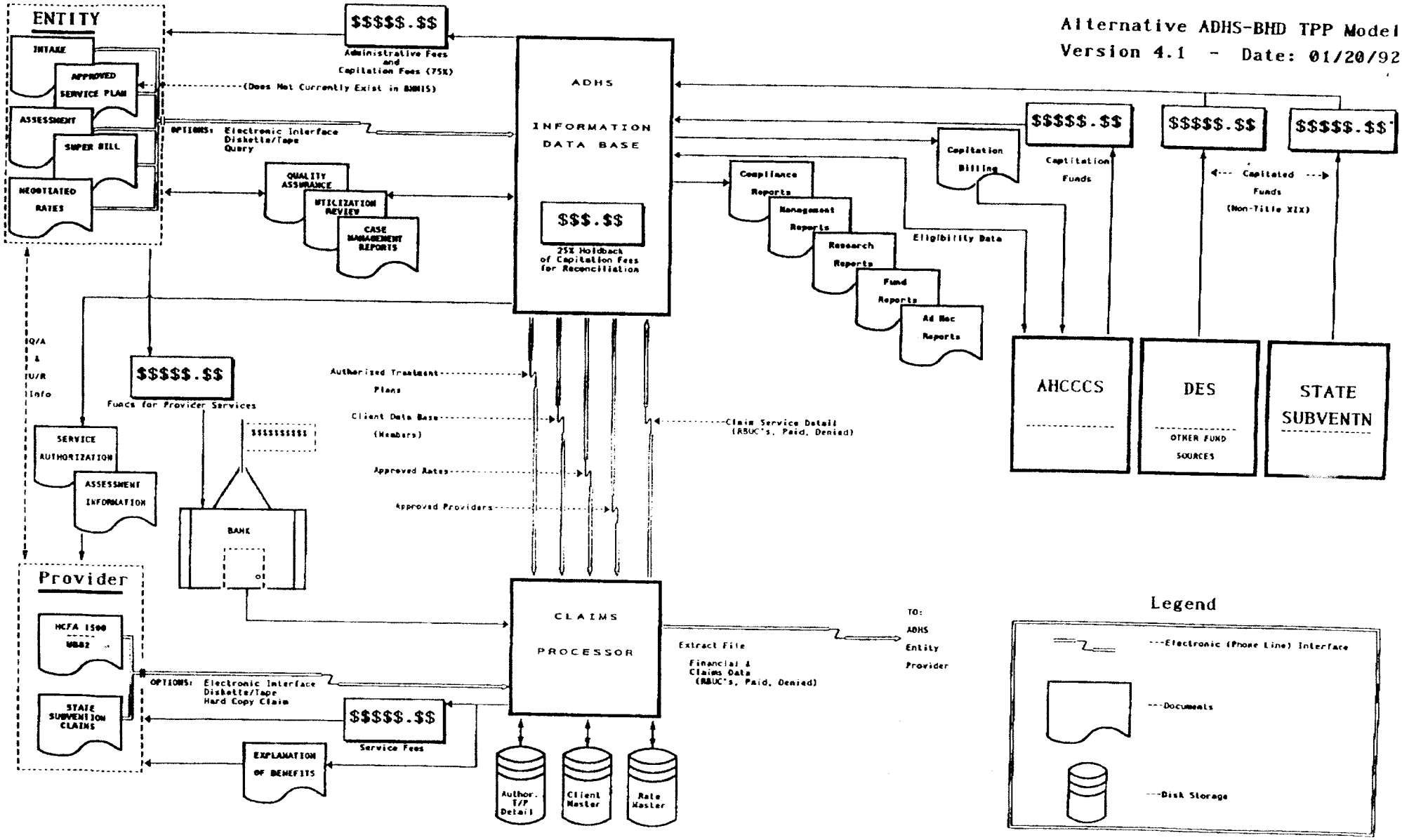
7. Reporting of Encounter Data On a weekly basis, the claims processor will electronically transfer all encounter data to ADHS. This data will include detail services either paid or denied as well as all claims received awaiting payment (RBUC's). This encounter data will contain appropriate information to identify the service plan authorizing the payment as well as the actual cost of the paid service.

ADHS will use this data to close the "feed-back" information loop to the client case manager as well as for financial reporting and capitation analysis. Standard production reports will be generated from this information.

In addition to ADHS receiving this information each week, the TPP will also provide diskettes containing the data respective for each entity and possibly the larger providers so that management and ad hoc reporting can be facilitated at the entity/provider locations.

8. Case Management, Q/A and U/R A specific objective of this proposed system is to not impede or disrupt the case management activity and/or rapport developed between the client, the case manager and the service provider. The required quality assurance and utilization review functions between the entity, case manager and service provider will, as is currently the case, continue.

The goal of this system, from a claims processing and encounter reporting perspective, is to return information to the case manager as rapidly and as accurately as possible. This will be accomplished through single source entry, uniform data flows, electronic data transfer and standardized reporting.


Alternative ADHS-BHD TPP Model
Version 4.1 - Date: 01/20/92
ENTITY
INTAKE
APPROVED SERVICE PLAN
ASSESSMENT
SUPER BILL
NEGOTIATED RATES
$$$$$.$$
Administrative Fees and Capitation Fees (75%)
(Does Not Currently Exist in BHMIS)
OPTIONS: Electronic Interface Diskette/Tape Query
QUALITY ASSURANCE
UTILIZATION REVIEW
CASE MANAGEMENT REPORTS
ADHS
INFORMATION DATA BASE
$$$.$$
25% Holdback of Capitation Fees for Reconciliation
$$$$$.$$
Capitation Billing
Capitation Funds
$$$$$.$$
$$$$$.$$
Capitated Funds (Non-Title XIX)
Compliance Reports
Management Reports
Research Reports
Fund Reports
Ad Hoc Reports
Eligibility Data
AHCCCS
DES
OTHER FUND SOURCES
STATE SUBVENTN
Q/A & U/R Info
$$$$$.$$
Funds for Provider Services
$$$$$$$$$
BANK
Authorized Treatment Plans
Client Data Base (Members)
Approved Rates
Approved Providers
Claim Service Detail (RBUC's, Paid, Denied)
SERVICE AUTHORIZATION
ASSESSMENT INFORMATION
Provider
HCFA 1500
UB82
STATE SUBVENTION CLAIMS
OPTIONS: Electronic Interface Diskette/Tape Hard Copy Claim
$$$$$.$$
Service Fees
EXPLANATION OF BENEFITS
CLAIMS PROCESSOR
Extract File
Financial & Claims Data (RBUC's, Paid, Denied)
TO:
ADHS
Entity
Provider
Author. T/P Detail
Client Master
Rate Master
Legend
---Electronic (Phone Line) Interface
---Documents
---Disk Storage

TITLE XIX BEHAVIORAL HEALTH WORK PLAN
ADULT MENTAL HEALTH

In 1991 the Arizona Legislature passed SB 1317, Chapter 265E, which approved funding for the Arizona Health Care Cost Containment System (AHCCCS) to develop a plan to implement an adult mental health program with submission of the plan to the Legislature in December 1991.

The AHCCCS administration is the single state agency for Title XIX funded services with responsibility for the entire Medicaid program. The Arizona Department of Health Services (ADHS) is the designated state agency to plan and administer publicly funded behavioral health services. This mandated responsibility covers all Arizona residents eligible for services from providers in the community behavioral health network.

The required addition of mental health Medicaid coverage for Title XIX eligible seriously mentally ill (SMI) adults has been significantly influenced by a 1981 class action suit against the Arizona Department of Health Services, the Arizona State Hospital and the Maricopa County Health Services on behalf of the SMI. In 1985, the Maricopa County Superior Court ruled on behalf of the plaintiff class. This ruling was upheld by the Arizona Supreme Court, requiring the defendants to set forth a comprehensive system of care for all SMI clients by 1995. This is fully detailed in a negotiated document entitled "Blueprint: Implementing Services to the Seriously Mentally Ill," and signed into order by Judge Bernard Dougherty on May 6, 1991.

The class action stipulates that ADHS seek and obtain all the funds required to fully meet the 1995 target, an amount totaling over $200,000,000. In order to enhance the use of federal Title XIX and other non state dollars, ADHS seeks AHCCCS Administration support to initiate Title XIX coverage one year earlier than October 1993, as stipulated when the present federal waiver expires. By implementing federal Title XIX coverage for SMI adults in October 1992, Arizona will be able to obtain significant new federal dollars a year earlier. In anticipation of these federal dollars, ADHS has negotiated an understanding with the court monitor and the plaintiff that ADHS will only request what it can realistically defend within its budget priorities versus the $65,000,000 in new state support, as presently required by the "Blueprint" for the 1992-1993 budget year. This understanding has been achieved and with it is the ADHS's commitment to further develop services in Maricopa County, as well as the other Arizona Counties, that follow a creative regional prevention driven psychosocial rehabilitative model, based on sound managerial and administrative support systems.

This work plan is based on the general implementation framework that had previously been discussed and agreed upon by AHCCCS, ADHS and the Governor's Office. Within each activity ADHS has responsibilities for the seriously mentally ill (SMI) and AHCCCS has responsibilities for the elderly enrolled under the long term care program (ALTC). The issues related to the nonseriously mentally ill (Non-SMI) and Non-elderly ALTC member will need to be addressed at a later date. For this reason the Non-SMI are included only where activities must be completed within the time frame of this work plan.

This work plan includes a breakdown of proposed consultant use and costs, a chart identifying individual tasks, their responsible agencies, and the end dates on each.

CONSULTANT USE AND ESTIMATED COSTS

Primary responsibility for SMI adults will be under the direct supervision of ADHS staff; responsibility for elderly ALTC rests with AHCCCS. Managed care principles will be an integral component of the SMI program, and a negotiated fee reimbursement used in the first year. After experience rating information is compiled on the first year, a capitated based reimbursement system is planned for October 1993. In all instances, coordination between ADHS and AHCCCS, their administrators or designated consultants, is essential.

AHCCCS and ADHS have identified areas in which they will be utilizing the services of consultants. The consultant activities and estimated costs are as follows:

AHCCCS

DESCRIPTION	ESTIMATED COST
ALTCS service delivery/operations	$ 87,000
Program costs and rate category	80,000
	$ 167,000*

ADHS

DESCRIPTION	ESTIMATED COST
Lewin/ICF	$ 150,000
Prevalence rates	
Review of other states	
Title XIX Design (subject to AHCCCS review)	
Program/Outcome evaluation model	
NTE & Montgomery Ryland, Inc. (Admin.& MIS)	200,000
Req. analysis for claims management system	
Review of current claims systems and "clean up"; New claims processing	
Selection of Third Party Administrator	
Conversion/Implementation	
Financial & Data required for capitation	
Modify BHMIS	
	$ 350,000**
Total Estimated Consultant Costs:	$ 517,000

* $85,000 already expended.

** Does not include cost of third party administrator; to be determined later.

TITLE XIX MENTAL HEALTH PLAN - TIMELINE

Responsible	Completion Date	Activity Description
AHCCCS/ADHS	December 17, 1991	Legislative implementation report by AHCCCS and ADHS.
AHCCCS	December 23, 1991	Estimate ALTC Population to be served. AHCCCS has constructed a computer model to be used for estimating the ALTC population to be served using varying assumptions. AHCCCS will also examine existing records for the ALTCS program to determine the number of elderly who will use long term care services.
Governor's Office	February 3, 1992	Request Legislative Authorization and hold Legislative Briefings (ADHS will develop request for SMI; AHCCCS for ALTCS)
ADHS	February 3, 1992	Review existing Arizona and Federal rules, regulations and statutes that apply to implementing Title XIX funding for adult behavioral health clients with Attorney General.
ADHS	February 3, 1992	Receive the requested definition of "state" indigency from Office of Arizona Attorney General on behalf of Executive Office and Legislature for adults (and children).
ADHS	February 17, 1992	Develop and issue a new Request for Proposal for Regional Preferred Providers that requires the following: Regional needs assessment plans; financial and performance audits by and independent, qualified audit firm; evidence that all ADHS funds are used for specified programs and services; uniform data reporting; centralized intake, case management and assessment functions; provider network development and other performance responsibilities as designed by ADHS.
AHCCCS/ADHS	February 28, 1992	Service Delivery Design - AHCCCS and ADHS must review their existing program service delivery models to accommodate mental health services for SMI adults and ALTC elderly. This should include clear statements of administration and funding structure as well as client identification and flow: (how clients are identified as having mental health problems, what is the appropriate setting for care, who is responsible for coordination of care, and how the individual actually receives care.)
ADHS	March 2, 1992	Develop SMI Provider Network. ADHS must define the provider network requirements for mental health services providers, along with requirements for long term and acute care providers. This includes developing provider network requirements, and developing a provider network evaluation procedure to ensure compliance.
ADHS/AHCCCS	March 15, 1992	Determine the potential array of adult mental health services and funds under the program options of Title XIX based on survey of states with high use of Title XIX for mental health. Design service package for SMI and ALTC elderly.
ADHS	April 1, 1992	Assess current ADHS programs and provider network for SMI adults, including CMI Pilot Projects, to determine readiness for meeting requirements for serving those adults that are projected to be eligible for Title XIX mental health care.
ADHS	April 1, 1992	Confirm the prevalence rates of adults in Arizona who could receive mental health services from each Title XIX program option through careful review of all known sources (and validate prevalence rates of Title XIX already eligible children).
ADHS	April 1, 1992	Complete selection and begin contract negotiation processes for Behavioral Health Preferred Providers in each region.
ADHS	April 10, 1992	Define total SMI population (Title XIX and non Title XIX) by diagnostic and financial classification.

TITLE XIX MENTAL HEALTH PLAN - TIMELINE

Responsible	Completion Date	Activity Description
ADHS/AHCCCS	April 10, 1992	Develop estimate of Title XIX federal funding available under current Title XIX options for SMI and ALTC elderly, along with equivalent estimates from the county match.
ADHS/AHCCCS	April 15, 1992	Finalize SMI/ALTCS Program Costs and service/funding proposal to Governor. ADHS and AHCCCS must develop financial models to estimate the program cost under varying service package and population options. In this task administrative expenses are incorporated into the model and one time start-up costs identified.
ADHS	May 1, 1992	Based on review of various options for obtaining federal and state match funds for Title XIX options for adult mental health services and recommend an option for Arizona that fits state philosophy and the requirements of the "Blueprint". Reconcile "Blueprint" to proposed service package and then review and revise estimate and description of "Blueprint" services against new information.
AHCCCS	May 4, 1992	Draft initial AHCCCS/ADHS IGA which defines roles, responsibilities, and standards for the SMI Program.
AHCCCS	May 15, 1992	Initial HCFA (Possible Waiver) Submittal. In order for the adult mental health program to be implemented HCFA must agree to the program design and capitation rates. Should any specialized waivers be necessary for the implementation of the mental health program, these must be developed and negotiated with HCFA.
ADHS	June 1, 1992	Complete contracts for Behavioral Health Providers in each region.
ADHS	June 1, 1992	Development by ADHS of a statewide, uniform claims processing system that will be used by all Regional Preferred Providers and their subcontractors and managed by a third party claims administrator.
ADHS	June 1, 1992	Complete modifications of the current Behavioral Health management Information and its interface with MIS programs in AHCCCS, the Arizona Department of Economic Security (DES), and the regional Preferred Providers, resulting in a more effective system for client referrals, service provision and network capacity.
ADHS	June 1, 1992	Develop an evaluation design to determine efficiency, efficacy and cost-benefit ratios of Title XIX mental health service delivery to SMI adults.
Governor's Office	June 1, 1992	Authorizing Legislation for SMI/ALTC Programs.
AHCCCS	July 15, 1992	Initiate HCFA Negotiations.
AHCCCS/ADHS	August 1, 1992	Finalize AHCCCS/ADHS IGA.
ADHS	August 3, 1992	Conduct SMI Program Start-Up Activities; Rules Amendments
ADHS	August 3, 1992	Implement all feasible components for improving managerial and financial operating systems in ADHS for client tracking, claims processing, client adjudication, provider relations, and quality assurance.
ADHS	August 3, 1992	Ensure uniform conformance of regional Behavioral Health Preferred Providers ADHS managerial and operating systems.

TITLE XIX MENTAL HEALTH PLAN - TIMELINE

Responsible	Completion Date	Activity Description
ADHS	August 3, 1992	Develop and refine negotiated fee reimbursement system for the SMI Program and review with AHCCCS for methodology and for fiscal impact assessment. Final negotiated fee reimbursement schedule to be implemented October 1, 1992.
AHCCCS	August 17, 1992	Obtain HCFA Authorization.
ADHS	September 1, 1992	Execution of intergovernmental agreements with DES/DD, CMDP, other state agencies, Indian Tribes and/or Indian Health Services, and Arizona Counties.
AHCCCS	October 1, 1992	Develop ALTCS Provider Network. AHCCCS must define the provider network requirements for mental health services providers, along with requirements for long term and acute care providers. This includes developing provider network requirements, and developing a provider network evaluation procedure to ensure compliance.
AHCCCS/ADHS	October 1, 1992	Implement Children's Mental Health capitation payment system.
ADHS	October 1, 1992	Implement SMI Mental Health Program.
AHCCCS	November 1, 1992	Develop ALTC Program Operations and Controls. This task involves the definition and implementation of program operations including case management requirements, utilization requirements such as prior authorization, grievances and any federal requirements for mental health services. Also in this task, AHCCCS develops the internal operations for the program.
AHCCCS	November 1, 1992	Initiate Contractor Requirements (Health Plans/Behavioral Health Preferred Providers/Governments) and Agreements for ALTC Program. Program Contractor requirements are specified in the Comprehensive Services Delivery Plan (CSDP). Annually, Program Contractors receive updated CSDP requirements and must respond to AHCCCS specifying their plans for compliance. A contract is then executed. In addition, AHCCCS will need to amend the IGA's with tribal governments. The incorporation of mental health services into the CSDP and resulting contract occurs in this task.
AHCCCS/ADHS	November 2, 1992	Develop Service Delivery Design; Non SMI and Non Elderly ALTC, Service Delivery Alternatives.
AHCCCS	November 2, 1992	File State Plan Amendment for SMI program with HCFA. In addition, AHCCCS rules may need to be amended.
AHCCCS	December 1, 1992	Financial Management Plan for ALTCS. Financial and utilization reporting by Program Contractors must be revised to accommodate mental health services. Reporting changes are defined and communicated to Program Contractors in this task. Plans for evaluation and monitoring of Program Contractors management of mental health services are also developed here.
AHCCCS	December 1, 1992	Develop ALTCS Capitation Rates. In this task, capitation payment adjustments to Program Contractors necessary to accommodate mental health services are incorporated into the rate-setting process by the AHCCCS actuary.
AHCCCS	December 1, 1992	Develop ALTCS Capped Fee-for-Service Schedule. In this task, the capped fee-for-service schedule needs to be reviewed for payments made to clients who have no Program Contractor. A separate fee is established for each mental health and substance abuse service.

TITLE XIX MENTAL HEALTH PLAN - TIMELINE

Responsible	Completion Date	Activity Description
AHCCCS	**December 1, 1992**	**Complete Contractor Requirements (Health Plans/Behavioral Health Preferred Providers/Tribal Governments) and Agreements for ALTCS members; Complete contracts and amend tribal IGA's.**
AHCCCS	**December 1, 1992**	**Develop ALTC Program Financial Management Features; Evaluation and Monitoring and Program Controls.**
AHCCCS	December 2, 1992	**Define ALTCS Management Information Systems; System Modifications. The addition of mental health services will impact both the long term care management information systems (LEDS/CATS) and the new PMMIS systems. The program will also impact the systems used for encounter reporting by the Program Contractors. Necessary changes to these systems are defined and implemented in this task.**
AHCCCS	January 2, 1993	Conduct ALTCS Program Start-Up Activities.
AHCCCS	January 2, 1993	HCFA ALTCS Capitation Rate Submittal.
Governor's Office	January 4, 1993	Develop Service Delivery Design; Non-SMI and Non Elderly ALTC; Final Service Delivery Model.
AHCCCS	February 1, 1993	Implement Elderly ALTCS Mental Health Program.
AHCCCS	March 1, 1993	File State Plan Amendment for elderly ALTCS program with HCFA and conduct Program Start-Up Activities. At the start of each program clients, providers and the public must be informed of the services to be offered, payment policies and authorization requirements. In addition, AHCCCS rules may need to be amended.
Governor's Office	June 1, 1993	Obtain Legislative Authorization; (Non-SMI)
ADHS/AHCCCS	July 1, 1993	Initiate capitation analysis for SMI Program - Capitation planned for 10-01-93.
AHCCCS/ADHS	July 1, 1993	Define Organizational Responsibilities Between Agencies, Incorporate Non SMI and Non-elderly ALTC in IGA
ADHS	July 1, 1993	The purpose of this activity is to determine the efficacy of selected options which will be implemented as non capitated services, following managed care principles for SMI adults on October 1, 1992. The key element is to test the degree to which the State was successful and provide an objective report card to policy makers. The product from this phase should be an evaluation report that presents key findings and recommendations for improving the system. This phase should lead to an ongoing evaluation process designed to facilitate communication with policy-makers, recipients and other involved groups.