PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

BEHAVIORAL HEALTH SERVICES

Report to the Arizona Legislature
By the Auditor General
October 1994
Report 94-8

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October 24, 1994

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Jack Dillenberg, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Department of Health Services, Division of Behavioral Health Services. This report is in response to a May 5, 1993 resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957.

We found little need in this audit to identify additional problems with the behavioral health system. Problems with the system are numerous and widely known. In fact, in the past five years, there have been 15 different studies identifying the system's problems. However, while problems clearly exist, recent changes indicate progress is gradually being made in addressing them.

What appears now to be needed is for the Department of Health Services to have: 1) the time to further implement ongoing and proposed changes, and 2) control of the system removed from the courts and returned to the Department. We recommend giving the Department three years to make the needed changes to the system. During this period, the Department should provide the Legislature with quarterly reports on its progress. We further recommend that the Legislature consider revising the statutes to end the Arnold vs. Sarn lawsuit which has effectively placed much of the decision-making for the system under the control of the courts.

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

This report will be released to the public on October 25, 1994

Sincerely,

Debra K. Davenport

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Deputy Auditor General

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a May 5, 1993, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review as set forth in Arizona Revised Statutes §§41-2951 through 41-2957.

The Division of Behavioral Health Services (BHS) is the state authority responsible for administering behavioral health programs, including a community-based service system. BHS provides behavioral health care to children and seriously mentally ill adults, as well as providing general mental health and substance abuse programs. BHS contracts with six Regional Behavioral Health Authorities (RBHAs), who in turn contract with local providers to deliver community-based behavioral health services.

BHS Should Be Given A Final Opportunity To Develop An Effective And Accountable Behavioral Health System (see pages 6 through 15)

Arizona's behavioral health system does not require additional study to identify problems and develop recommendations. The system has been "studied to death." We identified 15 studies completed within the last 5 years that indicate BHS continues to experience the same problems. Historically, BHS has been unable to account for the provision of quality, cost-effective services. The persistence of program deficiencies is due to the large number and magnitude of the problems, past management inaction, insufficient internal expertise and staff, and problems which arose from the advent of Title XIX funding and managed care.

Despite ongoing problems, recent developments suggest improvements may be forthcoming. Important new legislation is aimed at stabilizing the RBHA structure and increasing system accountability. Effective implementation of the legislation is a critical cornerstone in building an effective program. In addition, BHS management plans to renegotiate those provisions governing federal Title XIX monies which establish minimum service requirements. The current minimum service requirements appear to be inappropriate for treating the Seriously Mentally Ill (SMI) population and have negatively impacted Title XIX funding. Management is also attempting to create incentives for the RBHAs to better manage costs and account for services. Such incentives could help attract other organizations, such as AHCCCS health plans, to bid for RBHA contracts. This would inject greater competition into the system and provide BHS alternatives should a RBHA fail.

The Legislature should give BHS staffing resources, and three years to develop a responsive, accountable behavioral health system. Three years will allow BHS time to implement the new legislative mandates, make needed changes to the Title XIX provisions, continue other important efforts, and evaluate the results. However, during this three year period, the Legislature should regularly monitor BHS progress in developing a sound management system. If sufficient progress has not been made by BHS, the Legislature should consider moving system administration responsibilities out of DHS, as was considered during the 1994 legislative session.

The Legislature Should Consider Changing The Statutes To Return Control Of The Behavioral Health System To DHS (see pages 16 through 21)

The Arnold vs. Sarn lawsuit (a class action suit filed in 1981 on behalf of the seriously mentally ill), once necessary to improve the state's mental health system, now hinders effective system management. The Legislature should consider amending state laws to end the lawsuit for a number of reasons. First, state resource restrictions prevent full implementation of the lawsuit's provisions, which would require additional state appropriations of almost $100 million annually for seriously mentally ill (SMI) adult services. Second, extensive court and plaintiffs' counsel involvement in day-to-day operations undermines DHS control over the behavioral health program. Finally, the court and attorney fees (potentially exceeding $1.1 million in fiscal year 1994-95) could be better spent on services for the mentally ill.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services in response to a May 5, 1993, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review as set forth in Arizona Revised Statutes §§41-2951 through 41-2957.

The Division of Behavioral Health Services (BHS) is the state authority responsible for administering mental health programs, including a community-based service system. BHS also oversees the operations of the Arizona State Hospital in Phoenix (ASH), and the Southern Arizona Mental Health Center in Tucson. BHS is the largest division of the Arizona Department of Health Services (DHS), constituting approximately 75 percent of DHS' total budget.

Service Delivery System

Prior to 1984, BHS delivered mental health services through more than 20 umbrella agencies, which competed for state and federal funds, and then passed these funds through to more than 125 providers. In 1984, DHS restructured the delivery system, intending to reduce administrative costs and increase accountability. The State was divided into nine geographic regions, each with its own administrative entity to plan and oversee service provision in the region. In 1992, the delivery system underwent further change. The number of administrative entities was reduced to six and entities were renamed Regional Behavioral Health Authorities (RBHAs).

The six RBHAs are responsible for providing mental health services to children and seriously mentally ill (SMI) adults, as well as providing general mental health and substance abuse services. The RBHAs contract with direct service providers (e.g., psychiatrists, counselors, and residential treatment centers) to deliver the majority of these services. The RBHAs also perform case management functions for the seriously mentally ill and children, conduct needs assessments, and implement prevention programs.

Most of the behavioral health funds flow from BHS to the RBHAs.[1] While BHS' role is to monitor the performance of the RBHAs, the RBHAs are accountable for the quality and cost-effectiveness of the services provided to clients in their region. The RHBAs are not governmental agencies but rather are private, nonprofit organizations. However, some aspects of RBHA expenditures are limited by BHS contract provisions. The RBHAs receive a certain percentage of a total contract dollars for administration and currently are not able to keep as profits dollars not spent on services or administration.

Title XIX Funding and Managed Care

The behavioral health system has undergone significant changes in recent years. Between 1990 and 1992, Arizona became one of the last states in the nation to phase in federal Title XIX Medicaid funding for children's and SMI adult's behavioral health services. Prior to this time, other than federal grant money, Arizona's behavioral health system was primarily funded by state monies (see Table 1, page 5). As of October 1994, approximately 24 percent of BHS's enrolled clients are Title XIX eligible. Also in 1992, DHS implemented a capitated, managed care mental health system to control health care expenditures. In this new system, the RBHAs receive a capitated rate (specified amount per client per month) for all Title XIX eligible clients. More important, the managed care component emphasizes providing appropriate services to clients in the least restrictive setting. The utilization review function (ongoing review of individual cases), a responsibility of each RBHA, is designed to ensure clients are not over- or underserved.

Budget and Personnel

Funding for behavioral health services has increased dramatically in recent years due to large increases in state appropriations and the influx of federal Title XIX monies for the adult SMI population and children. State appropriations have increased from $84.4 million in fiscal year 1988-89 to $159.3 million in fiscal year 1993-94. Additionally, BHS expected to receive approximately $84.7 million in federal funds (including approximately $22.6 million in grants and $61.7 million in Title XIX monies) in fiscal year 1993-94. Table 1 on page 5 depicts the magnitude of funding increases that have occurred over the past six years.

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[1] For federal Title XIX funds, AHCCCS is the single state Medicaid agency and thus has oversight responsibilities for funds passed through to BHS for Medicaid-eligible behavioral health services. AHCCCS' contract with BHS defines the program requirements for the provision of behavioral health services. The contract requires BHS to provide specific client and financial data to AHCCCS.

The majority of funds pass through BHS to the RBHAs, who in turn authorize payment to direct service providers. RBHA contracts for the year ending June 30, 1994, totaled over $207 million, with the largest RBHA, ComCare, contracting for $122 million and the smallest, BHS Yuma, contracting for approximately $5 million. Table 2 (see page 5) reports the fiscal year 1993-94 RBHA contract fund amounts for each program area. As shown, adult SMI services receive the most funding.

BHS has 170.4 approved FTE positions for fiscal year 1994-95. Of these, 88.6 are authorized to manage the behavioral health system and 81.8 are employees of the Southern Arizona Mental Health Center. However, BHS reports that only 63 of the 88.6 FTEs are filled positions.

Scope and Methodology

Arizona's behavioral health system has been the subject of numerous studies and reports in recent years. These reports have cited many of the same problems. Rather than duplicating previous studies, this audit sought instead to identify ***why*** DHS has repeatedly failed to resolve problems. Various reasons, including the number and magnitude of the problems faced, management inaction, insufficient internal expertise, and the advent of Title XIX funding and managed care have impacted BHS's ability to act on previous recommendations. Additionally, DHS is involved in a court case that interferes with its ability to assume responsibility for system improvements. This audit contains findings which address DHS' ability to improve an ailing mental health system.

This audit contains findings in two areas:

- DHS needs to act on previous studies' recommendations and develop an effective, accountable behavioral health system by December 31, 1997.
- The Arnold vs. Sarn lawsuit impedes DHS' ability to effectively and efficiently manage the behavioral health system.

This report also contains Other Pertinent Information (see pages 22 through 26) which discusses the poor financial condition of the Arizona Center for Clinical Management (ACCM), the RBHA in Pima County.

This audit was conducted in accordance with government auditing standards.

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

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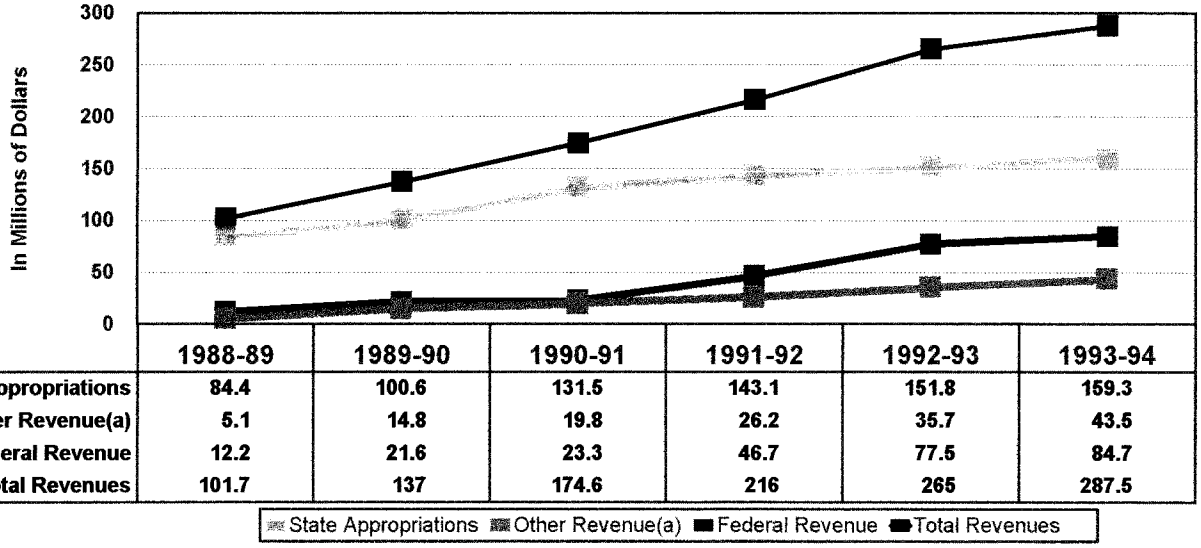
Table 1

Department of Health Services - Division of Behavioral Health Services
State and Federal Revenues
Fiscal Years 1988-89 Through 1993-94
(Unaudited)



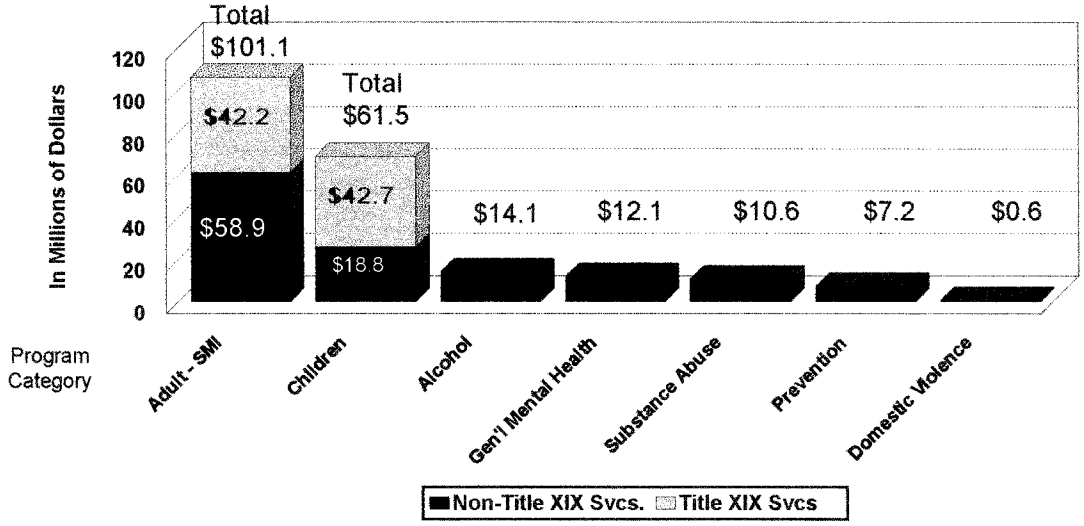
	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94
State Appropriations	84.4	100.6	131.5	143.1	151.8	159.3
Other Revenue(a)	5.1	14.8	19.8	26.2	35.7	43.5
Federal Revenue	12.2	21.6	23.3	46.7	77.5	84.7
Total Revenues	101.7	137	174.6	216	265	287.5

(a) Includes a variety of nonappropriated monies, such as revenue from intergovernmental agreements, other contracts, donations, fines, etc.

Source: Data compiled by BHS from the ADHS Financial Online System.

Table 2

Department of Health Services - Division of Behavioral Health Services
Projected Contract Amounts to RBHAs by Program Category (a)
Fiscal Year 1993-94
(Unaudited)



(a) All categories and subcategories may include state, federal, and other fund sources. For example, the $42.2 million in Adult SMI Title XIX Services includes both the federal funds and the state match.

Source: RBHA Payment Report provided by BHS.

FINDING I

BHS SHOULD BE GIVEN A FINAL OPPORTUNITY TO DEVELOP AN EFFECTIVE AND ACCOUNTABLE BEHAVIORAL HEALTH SYSTEM

Despite a long history of problems, recent changes warrant giving BHS a final opportunity to develop an effective behavioral health system by December 31, 1997. In the interim, the Legislature can hold BHS accountable by monitoring its progress in several key areas. Study after study has found that BHS continues to experience the same financial and programmatic weaknesses. Weaknesses have persisted due to past management inaction, inadequacies in internal expertise and staffing, the advent of Title XIX funding and managed care, and the sheer magnitude of the problems facing the system. However, because current BHS management has taken some promising steps and the Legislature is mandating system changes, BHS should be given limited time and the necessary resources to improve. If sufficient progress is not made in three years, the Legislature should consider moving the behavioral health program out of DHS.

Numerous Studies Identify Same Problems

Arizona's behavioral health system does not require additional study to identify problems and develop recommendations. The system has been "studied to death." We identified 15 reports completed in the past 5 years, which offer detailed analysis of and recommendations to address, problems that exist within the behavioral health system. Rather than identifying problems anew, our review focused on the analysis and results presented by these studies. We conducted a systematic review, identifying and categorizing all problems and recommendations presented in 11 of the most important reports. We reviewed:

- Two reports by the Health Care Financing Administration (HCFA) (HCFA is an administration within the U.S. Department of Health and Human Services.),
- Four reports by Mercer and Associates (private consultant),
- The report of the Joint Legislative Ad Hoc Committee on Mental Health Services,
- A report prepared the Office for Excellence in Government,
- A report by Clegg and Associates, Inc. (a private consultant commissioned by the Legislature), and

- Two reports by the State of Arizona, Office of the Auditor General.

These reports, which were prepared at a cost of more than $1 million, indicate that over time, the same problems remain prevalent in the behavioral health system. The following report excerpts offer a sample of the types and similarity of problems identified.

Financial

- ***March and July 1994, HCFA reports*** – HCFA found that DHS did not meet deadlines for reporting financial information to AHCCCS because it could not obtain this information from the RBHAs. HCFA's follow-up review disclosed that DHS still had not provided AHCCCS with timely financial information.

- ***July 1994, HCFA report*** – HCFA will require AHCCCS to return federal monies until the underlying problem with the RBHAS' accounting and management information system is corrected.

- ***March 1994, Mercer reports*** – Information on expenditures by category of services or client characteristics is not presently available.

Quality

- ***March 1993, HCFA report*** – Programmatic, administrative, and evaluation systems have not been implemented. As a result, AHCCCS was unable to effectively monitor, review, and maintain accountability for the statewide network of mental health services.

- ***December 1993 report of the Joint Legislative Ad Hoc Committee on Mental Health Services*** – Currently, there is little, if any, indication as to the effectiveness of behavioral health expenditures. Citizens of Arizona are entitled to know what benefit they are receiving for their tax dollars.

- ***November 1989, Auditor General report*** – DHS monitoring of entity performance has been limited and follow-up on problems had been weak and superficial. As a result, significant deficiencies have not been identified

  January 1992, Auditor General report – DHS has made little improvement in its monitoring of the administrative entities' performance.

Management Information Systems

- ***December 1993 report of the Joint Legislative Ad Hoc Committee on Mental Health Services*** – BHS has continually had difficulty in producing accurate data on clients and expenditures and spent large amounts trying to improve first the Behavioral Health Management Information System (BHMIS) and now the Client Information System (CIS).

- ***March 1994, Mercer report*** – The RBHAs consistently raised concerns about the limited information available from the EDS and CIS systems.

- ***Both the 1989 Auditor General report and the 1991 Clegg and Associates, Inc.*** report found BHS has historically experienced problems developing and implementing management information systems.

Additionally, some reports indicated that the current behavioral health system is severely fragmented and cumbersome, with too many administrative layers. According to HCFA, each layer of administration creates delays, redundancy, and inefficiency. Intake, case management, treatment authorization, provider contracting, and data processing are so disparate and uncoordinated that there is inefficiency and inadequate accountability throughout the program.

Problems effectively reduce service dollars – BHS' inability to resolve problems in accountability and data reporting reduces the dollars available to provide mental health services. BHS was unable to provide data or documentation verifying the provision of $9.5 million in services to eligible clients during November 1992 through March 1993. As a result, HCFA recovered the federal portion of Title XIX dollars, amounting to $6.28 million of the $9.5 million. HCFA recovered this money because BHS and the RBHAs could not document: (1) client eligibility, (2) the provision of client services, or (3) the provision of the required number of services. This process, known as recoupment, effectively reduces the amount of service dollars currently available for Non-Title XIX clients and services. Since the State is mandated to continue to provide services to Title XIX-eligible clients from a reduced pool of federal dollars, due to HCFA recoveries, state dollars are substituted.

Although DHS is in the process of obtaining changes in the capitation agreement (see page 13) the State has just started to see the impact of the recoupment process. The $6.28 million recently recovered represents only the first five months that capitation payments and the minimum service levels were in effect. There is a 15-month lag time between the disbursement of federal Title XIX monies and eventual recovery of monies for which BHS and the RBHAs cannot provide supporting documentation. While BHS has seen a decrease in recovery amounts, millions in service expenditures have yet to be reviewed for recovery. (For recoupment amount by RBHA, refer to Table 3, page 23.)

System Improvements Not Realized

DHS management has yet to address the full range of problems confronting the system. Insufficient staff and inadequate monitoring and review tools have impeded BHS efforts to resolve problems. Also, the advent of managed care, capitation, and continuous BHS management attention focused on RBHA operational problems have further hampered efforts to resolve systemic problems.

History of management inaction — The continued prevalence of fiscal and programmatic problems within the system points to management's inability to address them. While numerous studies have detailed these problems and presented recommendations for their resolution, BHS has yet to address the full range of problems discovered by these studies. Constant turnover in leadership may have impacted BHS efforts to improve the system. For example, DHS has had five different directors (two interim) within the past three years, and BHS has had three associate directors during the same time.

Insufficient staff resources — A shortage of professional-level staff also affects BHS's ability to resolve systemic problems. A core of professional staff is necessary to monitor RBHA performance and provide oversight and technical assistance. However, because BHS lacks such a core, it has relied on consulting firms to conduct RBHA operational and financial reviews and to develop internal policies and procedures. Two examples of how this shortage of high-level staff has critically affected the system are the financial review and quality assurance functions at BHS.

- **Financial review** — BHS does not have adequate staff resources to provide financial oversight and technical assistance to RBHAs. The BHS financial review function, which monitors RBHA financial and operational performance, employs a fiscal specialist and an administrative officer to monitor six RBHAs. While the administrative officer position requires a college degree and four years of work experience, the specialist position requires limited experience and no college degree. In essence, BHS employs a person who may not have sufficient experience or education to oversee financial operations of organizations with annual revenues of over $40 million.

  In contrast to BHS, AHCCCS employs more highly experienced and more highly qualified staff to monitor its health plans' financial status and to provide technical assistance. AHCCCS employs a manager, four financial consultants, two staff assistants, and three compliance auditors. The consultant positions require a college degree, two to three years health care work experience, and CPA status or candidacy. The auditor positions require a college degree in accounting, finance, or business, and one to two years professional experience.

- **Quality assurance** – Although conditions have improved, inadequate professional level staff has also impacted the BHS quality assurance function. For several months, this function operated with only a manager, hardly sufficient to ensure the delivery of quality services to approximately 62,000 clients across the state. Only recently have additional professional staff and clerks been hired.

Higher-level, more experienced staff are needed to monitor the RBHA delivery system. Similar to the AHCCCS financial management function, BHS should have the necessary professional-level staff to regulate RBHA financial solvency. This would involve active monitoring of RBHA assets, liabilities, and expenses for direct services versus expenses for administration. Changes in a RBHA's financial status could be detected early and potential problems identified. As is the case in AHCCCS' financial management, BHS should employ financial experts, preferably with several years' experience in health care or a closely related industry, who could detect RBHA problems, offer solutions, and provide technical assistance. Such professional-level staff could have detected ACCM's worsening financial condition and offered immediate assistance to uncover and solve problems. However, BHS did not have these resources and ACCM's condition deteriorated to its current status. (See Other Pertinent Information, page 22.)

Additionally, the absence of sufficient professional staff has affected the development and use of reporting and monitoring tools. While a draft RBHA reporting guide has been developed, the reporting requirements and accounting guidelines detailed in the guide have not been implemented. Also, the development of ratios for RBHA financial analysis, as required in the AHCCCS mental health policy manual, has not been performed.

Major system changes compounded problems – Major health care delivery changes have further complicated and disrupted a troubled behavioral health system. Prior to 1990, Arizona did not participate in the federal Medicaid program covering mental health services. However, Arizona's federal waiver expired in 1990 and it began offering services to Medicaid-eligible children. Medicaid-eligible SMI adults began receiving services in 1992[1]. Prior to October 1990, the State received no Medicaid funding for behavioral health services, except for 72 hours of emergency psychiatric inpatient care for Title XIX clients. Just four years later (fiscal year 1993-94), BHS received over $93.6 million in federal and state funds to serve Medicaid clients. However, the systems to account for these dollars have not kept pace.

Even more disruptive to the system was the advent of managed care and capitation. In November 1992, Arizona's behavioral health system was changed from a fee-for-service delivery model to a managed care, capitated service delivery model. According to the capitation agreement with HCFA, Arizona receives $590 and $583 per

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[1] Because both Medicaid-eligible children and SMI adult populations were phased in, the majority of funding for each group came in 1991 and 1993, respectively.

month for each enrolled Title XIX SMI adult and child, respectively. The intent behind the change to managed care and capitation was to closely manage client services and their costs, and to better account for the dollars paying for those services.

However, the implementation of managed care and capitation brought new problems that still affect the system today. Because DHS lacked data to support the establishment of viable capitation rates, questionable rates were established. Minimum service requirements for clients have also been imposed, but may not be appropriate and workable for mentally ill clients. For example, Arizona agreed to provide Title XIX SMI adults at least two services per month, but some clients may require no Title XIX services for several months at a time, or they may require numerous services during any given month when they experience crises. Additionally, due to the rapid implementation of managed care and capitation, BHS and RBHA managements indicated that they were unprepared and ill-trained to implement and adopt this new delivery model.

RBHA financial problems – Finally, serious operational and financial crises experienced by RBHAs have consumed considerable BHS attention and diverted resources from addressing internal problems. ComCare presented the first crisis as it experienced severe financial problems in July 1993. Due to inadequate organizational infrastructure (ComCare lacked a management information system, a solid accounting system, and good financial management) and uncoordinated management direction, BHS management became involved in ComCare's day-to-day operations. BHS management assistance with ComCare accounted for approximately 25 percent of BHS' top two managers' time between August 1993 and early February 1994. While actively managing the operations of ComCare, BHS became aware of financial problems at ACCM, eventually forcing BHS to become involved in efforts to improve ACCM's financial condition. For more information on ACCM's financial crisis, see page 22.

The crises experienced by the state's two largest RBHAs, Comcare and ACCM, provide examples of a delivery system that requires BHS intervention when problems arise. Because the RBHAs represent the sole administrative authority and service system in their geographic areas, no service alternatives exist for clients nor service delivery options for BHS. Therefore, BHS cannot afford to let a RBHA fail. For this reason, and to ensure continuity of service, BHS has continually provided managerial and financial assistance to problematic RBHAs to keep them operational.

Legislature Should Give BHS Three Years To Improve System

The Legislature should give BHS three years to develop a responsive, accountable behavioral health system, but closely monitor BHS for assurance of adequate progress. Important new legislative mandates, if fully and effectively implemented, should provide greater financial stability and accountability with the RBHA system. Additionally, BHS has taken some promising steps to improve the system. The Legislature can assess BHS progress periodically by examining key areas for improvement.

Legislative mandates – Effective implementation of recently passed legislation will lessen financial risk to the State and contribute to a more stable RBHA system. Specifically, House Bill 2067, passed during the 1994 legislative session, mandated the following:

- RBHAs must meet minimum capitalization requirements in order to be considered for a contract award. The capitalization requirements will be determined by the DHS Director and specified in the department's Request For Proposal (RFP).

- The department's contracts with RBHAs will include terms necessary to ensure a RBHA's financial stability and adequate performance. Contract terms will include the maintenance of deposits, performance bonds, financial reserves, or other financial security.

- The department must more intensely monitor the financial management of the RBHAs.

The Legislature should require BHS to report on the implementation status of HB 2067 provisions. Currently, BHS has developed preliminary capitalization and performance bond requirements. These and other proposed financial standards requirements have been sent to current RBHAs for their review. BHS' proposal requires that RBHAs maintain $100 per Title XIX-eligible client in reserves. Based on July 1, 1994, Title XIX client counts, reserve requirements per RBHA will range from approximately $33,700 to $938,700. BHS has also proposed that RBHAs maintain a performance bond equal to one month's capitation payment. Again, based on July 1, 1994, Title XIX client counts and current capitation rates, RBHA performance bond requirements will range from approximately $200,000 to $5.5 million. The Legislature should require BHS to report to them: 1) the final capitalization requirements, 2) whether those awarded contracts in 1995 meet requirements, and 3) whether each RBHA is meeting contract terms during the contract period.

In addition to these requirements, which should improve financial stability, BHS may be able to strengthen the system by attracting new, financially strong organizations to serve as RBHAs. BHS hopes to create incentives within the system to manage costs and account for services by introducing a profit motive. Beginning in fiscal year 1995, BHS will restructure current RBHA contracts, allowing the RBHAs to realize profits by managing their costs. While the opportunity to realize profits will be attractive to current RBHAs, profit incentives may also attract other organizations including AHCCCS health plans who have expressed an interest in providing behavioral health

care.[1] The entrance of AHCCCS health plans and other organizations could be extremely significant as it would inject greater competition into the system and provide BHS with alternatives should a RBHA fail. However, BHS leadership indicated that the opportunity to realize profits will exist only if certain financial requirements are met. These requirements include minimum cash on hand and equity per enrollee.

Legislature should give BHS a limited time to improve system – Even though BHS has been severely criticized for its management of behavioral health care in the state, progress has been made. For example, in its July 1994 report, HCFA acknowledged the "significant progress" made in the behavioral health accounting and management information systems. We also identified several BHS accomplishments:

- **Changes to capitation agreement** — Many of the problems in moving to a capitated system were related to the capitation agreement. DHS recently submitted a proposal to AHCCCS which would remove the current minimum service requirements and possibly bring more federal dollars to the state for behavioral health care. Both DHS and AHCCCS are optimistic that a more appropriate capitation agreement can be negotiated with HCFA and retroactively implemented as of October 1, 1994.

- **ComCare stabilization** – Since its organization to act as the Maricopa County RBHA in July 1992, ComCare continually experienced critical problems that led to its nearly ceasing operations in July 1993. To avert the potential displacement of thousands of clients, BHS management became involved in ComCare's operations. Through the establishment of a steering committee, BHS worked to improve the financial and operating status of ComCare. BHS management participated in the recruitment of a nationally regarded mental health care professional to head ComCare. As a result of these efforts, ComCare's financial and operational condition has significantly improved.

- **Claims payment process** – BHS has long struggled with the claims payment function. In early 1993, over $460,000 in outstanding claims had either been held for clarification or denied. BHS undertook an intensive effort to review the claims and make payments. BHS has also contracted with a third-party payer to process claims, and providers now receive payment for a claim within a week to ten days.

- **Administrative rules** – BHS promulgated administrative rules establishing a system of care for the SMI population in September 1993. These rules provide guidelines incorporating client rights, individual service plan development, and a grievance and appeals process. One mental health professional remarked that these rules are the best he has seen in the country regarding the treatment of mentally ill clients.

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[1] Health plans have expressed interest in providing behavioral health care and believe it is an important part of total health care. AHCCCS began discussions with several health plans to prepare for a possible transfer of BHS functions under legislation proposed, but not enacted, during the 1994 legislative session.

In addition, BHS has recently developed an action plan which begins to address many of the key issues facing the system. This plan lists general steps for such actions as issuing the RFP for new RHBA contracts, developing a comprehensive set of financial reports, measuring quality of care, and developing a profile of service utilization for each RHBA. However BHS management will need time to accomplish further changes including implementing the provisions of HB 2067, acquiring staff resources to administer the program effectively, and developing financial and operational monitoring and review tools. To a certain extent, this "tooling up" would have to take place regardless of whether the program was moved from, or remained with, BHS. BHS will also need time to evaluate these efforts, and make changes where necessary. As long as progress is demonstrated, BHS should be allowed a maximum of three years to improve the system. Additionally, three years will provide BHS additional time to accommodate changes (i.e., utilization review, quality assurance, and progress toward developing valid capitation rates) required by the move to a capitated, managed-care delivery system.

However, if operating efficiencies have not been realized and sound fiscal management principals implemented at the end of three years, the Legislature should consider moving the system out of DHS. Such a move was proposed in HB 2500 which was introduced during the 1994 legislative session, but did not pass. The proposal to move administrative responsibility for behavioral health care from DHS to AHCCCS evolved from work conducted by the Joint Legislative Ad Hoc Committee on Mental Health Service convened in 1993. The committee concluded that DHS' inability to develop an accountable, responsive behavioral health system warranted transfer of the system to AHCCCS. The committee viewed AHCCCS as an appropriate location for the program because it has demonstrated accountability and considerable success providing medical care within a managed care, capitated service delivery environment.

Legislature can look to key areas to gauge BHS performance – The Legislature should frequently monitor BHS during the next three years. To determine if there has been sufficient improvement in the behavioral health system, the Legislature should evaluate the department in key areas. Examples of such areas include:

- **Recoupment** – Are recoupment figures continuously and substantially improving, eventually approaching zero? This would indicate that eligibility decisions are correct, services are being provided, and the appropriate data have been collected.

- **Capitation rates** – Is BHS able to renegotiate the capitation rates to achieve more appropriate rates? Have the minimum service level requirements been renegotiated?

- **RFP** – Is the RFP for fiscal year 1995 issued on schedule (November 1994) and are winning bidders operational on July 1, 1995? Has BHS awarded contracts to organizations meeting the capitalization and performance bond requirements?

- **Increased health plan interest** — Has BHS implemented changes to the system that increase health plan or other organizations' interest in the business? Did health plans or other organizations bid in any region?

- **Reporting** — Is BHS able to meet the reporting requirements established by the Legislature? Are the reports timely and do they include all required client and funding data?

- **Professional staffing** — Has BHS reclassified key staff positions in the financial review area to attract more highly qualified and experienced staff?

- **Supplemental appropriation requests** — Has the Legislature seen a reduction in the amount of dollars requested through supplemental appropriations? In the past, BHS has regularly approached the Legislature for supplemental appropriations. Recognizing that some supplemental requests are appropriate (e.g., if unanticipated increases occur in the Title XIX population), a reduction in the dollars requested through this process may indicate an improvement in BHS fiscal management.

The Legislature can use these outcomes to gauge BHS improvement without conducting further studies or audits. Most of these questions can be answered easily and definitively. Weighing these and other critical performance achievements, the Legislature can then determine if progress warrants continued DHS management of the behavioral health system; and if not, the Legislature should reconsider moving the system out of DHS.

RECOMMENDATIONS

1. The Legislature should give BHS three years (by December 31, 1997) to develop an effective and accountable behavioral health care system. The Legislature should require quarterly reports from BHS during this time period. To gauge DHS performance, the Legislature can examine key areas for improvements, which will indicate BHS progress toward an effective system. If significant system improvements have not been realized within three years, they should consider moving the system out of DHS.

2. BHS should take steps to develop a core of professional staff, especially in the areas of RBHA financial review and monitoring and quality assurance.

FINDING II

THE LEGISLATURE SHOULD CONSIDER CHANGING THE STATUTES TO RETURN CONTROL OF THE BEHAVIORAL HEALTH SYSTEM TO DHS

While the Arnold vs. Sarn lawsuit initially did much to improve state mental health services, its value today is questionable. Full compliance with all lawsuit requirements appears unlikely due to the high costs required to comply. With no end in sight, the lawsuit presents several drawbacks. First, extensive court monitor and plaintiffs' counsel involvement in DHS policy setting and day-to-day administration undermines DHS control over the behavioral health program. The lawsuit also creates a heavy financial burden. Attorney and court costs alone could exceed $1.1 million in fiscal year 1994-95. To enable DHS to regain control of the program, the Legislature should consider amending state law to end the lawsuit.

In 1981, Charles Arnold, a public fiduciary, sued the Department of Health Services and its Director, James Sarn, M.D., the Arizona State Hospital, and the Maricopa County Board of Supervisors, on behalf of five seriously mentally ill (SMI) people. He alleged the State and County failed to provide these people with adequate community mental health services as promised by state law. The court ruled in favor of the plaintiffs, reaffirming the State's and County's statutory duty. The decision was appealed to the Arizona Supreme Court, which upheld the trial court's decision. *The Blueprint: Implementing Services to the Seriously Mentally Ill* is the court-ordered plan redesigning Arizona's system of care for the SMI population.

Lawsuit spurs system advancements – The lawsuit, and resulting Blueprint, forced Arizona to improve an ailing mental health system through philosophical, administrative, and funding advances. Not only did the lawsuit focus attention on the needs of the mentally ill, it changed the way mentally ill clients are perceived. Clients now have a voice in their treatment decisions. Additionally, BHS adopted administrative rules outlining the SMI system of care which address most issues in the Blueprint. These rules also establish a grievance and appeal process for clients, giving them an even greater voice.

Furthermore, funding has increased dramatically for SMI services. While Arizona was once ranked 50th in the nation in per-capita mental health spending, according to the Joint Legislative Budget Committee it had risen to 17th place in 1993. In fiscal year

1981, when the lawsuit was filed, $637,500 was appropriated for SMI services. In contrast, the Legislature recently appropriated $67.2 million for SMI services in fiscal year 1995. Additionally, the State recently implemented a Title XIX federal program, from which it expects to receive an additional $30 million for SMI-related services in fiscal year 1995.

DHS Unlikely to Meet Blueprint Requirements

The Blueprint outlines an extensive system of care requiring such vast funding increases that compliance with all of its provisions is unlikely. Competing priorities for limited state funds will prevent the level of future funding increases for SMI services needed to meet Blueprint requirements.

Difficulty of full implementation – Unique in the nation, the Blueprint calls for the establishment of a 'cadillac' system of care for the seriously mentally ill. A former DHS Director defined the Blueprint as an "advocate's dream." However, the court may be imposing a standard in Arizona far exceeding that in other states. In upholding the lower court's decisions, the Supreme Court noted that Arnold vs. Sarn was the first case in the nation in which a trial court ordered "broad and all-encompassing relief for the [SMI] under a comprehensive state statutory design." One attorney involved with the lawsuit also agreed that no other state has such an all-encompassing order.

System experts are not optimistic about the likelihood of full compliance with Blueprint mandates. We interviewed officials from key organizations involved with the lawsuit, including the Office of the Monitor and The Arizona Center for Law in the Public Interest (representing the plaintiffs). Not one person believed DHS is likely to meet the September 30, 1995, Blueprint deadline. In fact, some former DHS and BHS employees believe DHS may never be able to comply with all 246 Blueprint requirements.

Requirements are too costly – The financial estimates for full compliance are even more discouraging. Implementation estimates in the Blueprint indicate $163 million for SMI appropriations is needed in fiscal year 1995 to meet all the requirements (federal and other sources will also need to contribute an additional $77 million). Therefore, the State will still need to appropriate almost an additional $100 million annually for SMI services to fully comply with the Blueprint.

Some of the Blueprint's key mandates, currently unmet, would require extensive funding increases. For example:

- By September 30, 1995, all clients in supervisory care homes or board and care homes should be placed in alternate housing settings that provide a treatment component, such as a residential treatment center or in independent living

situations. ComCare reported in March 1994 that 670 people remain in 19 of these homes. According to BHS, an estimated $36 million for housing supplements and community services is needed to place these people in more appropriate housing. Additional funds are needed to divert new clients from entering supervisory care homes.

- The Blueprint requires each case manager be assigned no more than 25 clients. However, the average case manager-to-client ratio in Maricopa County is 1 to 48. To lower the ratio to 1 to 25, over 205 case managers and 27 team leaders need to be hired. Salaries and benefits alone for an additional 232 employees total over $5 million. Space, equipment, and the cost to hire the employees could significantly raise this amount.

- The Blueprint requires development of many services for SMIs. A recent focus has been on crisis services. Eleven mobile crisis teams and 216 short-term crisis residential beds are needed in Maricopa County by September 1995.[1] Currently, there are only 7 mobile crisis teams and 28 short-term crisis residential beds. BHS expects crisis service development to be very costly.

Arizona has many service priorities – Given other competing critical service needs, the funds for full Blueprint implementation may never be available. Limited state funds must be divided among many state programs and special populations in need of increased services. For example, hiring more child protective services workers to investigate cases of child abuse, building more prisons and jails to handle convicted felons, and fully funding the K-12 formula are also important priorities in Arizona. The needs of SMIs must be weighed against those of other populations also dependent upon state aid. It is the Legislature's responsibility to prioritize programs and make these policy decisions.

The needs of other populations served by DHS must also be considered. Within DHS, behavioral health services have been given the largest share of funding increases over the last decade, while funding for public health programs such as child immunization, prenatal care, emergency medical services, and AIDS prevention services has remained stagnant.[2] Similarly, within BHS, SMI programs have received most of the funding increases in recent years, while substance abuse and general mental health program funding has remained relatively constant.

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(1) The Maricopa County Planning Office estimated Maricopa County's 1995 population to be 2,399,600 people. This figure was used to calculate Blueprint crisis system requirements.

(2) In fiscal year 1982-83, public health programs received $32.6 million and behavioral health programs $31.2 million. In fiscal year 1992-93, public health programs received $55 million while behavioral health received $157 million. Most of the public health program increase was for children's rehabilitative services.

Lawsuit Has Many Drawbacks

While the lawsuit has forced overdue attention on the system, it currently prevents DHS ownership and responsibility for the direction of the mental health system. The lawsuit restricts DHS and BHS management control by giving considerable power and authority to the court monitor and plaintiffs' counsel. Additionally, the money spent each year to fund the lawsuit and the staff time diverted to work on lawsuit activities are resources that are not focusing on clients.

DHS, rather than the court, should direct the system – DHS, not the courts, is responsible for administering the behavioral health system, yet the court is assuming this role. One former DHS Director expressed frustration over this lack of control. This Director had difficulty establishing needed system infrastructure, (i.e., developing information systems and hiring experienced staff to implement managed care) because the court monitor and plaintiffs wanted funds spent on client services. Other DHS Directors have been unable to fully explore valid policy discussions or make realistic budget proposals because the court views this as contradictory to working toward meeting Blueprint requirements. For example, the court harshly reprimanded one director for suggesting that BHS be moved to AHCCCS to improve the system's accountability. Another director was found in contempt of court for not requesting sufficient funds for services.

Several people we interviewed who work with DHS also believe the court has too much control over the system. We found many management decisions must either be approved or reviewed by the court monitor and plaintiff's counsel. The monitor must agree with DHS's budget requests and is involved in expenditure decisions. The monitor and plaintiff's counsel also review BHS administrative rules, written plans to provide services, and its design for system monitoring, evaluating, and quality assurance.

The Court Monitor's Office has an extensive, high level administrative staff that enables the office to get involved in BHS policy and administrative matters. The monitor, executive director, and program director for the Office of the Monitor are all paid more than the top manager for the Office of the Seriously Mentally Ill in BHS. The manager of the BHS office is paid $51,500 a year while the Court Monitor, paid an hourly rate, received over $115,000 in fiscal year 1993-94. The executive director and program director for the Office of the Monitor make $64,800 and $54,000 a year, respectively.

Lawsuit expenses very high and may be adding little value – In addition to the lawsuit's intrusiveness, court and attorney costs may exceed $1.1 million in fiscal year 1994-95. Case costs include:

- The Office of the Monitor has an approximate annual budget of $588,000. In addition to paying for the Court Monitor and other consultants as needed, the

Office employs a full-time executive director, project director, staff assistant, and a part-time clerk. Since it was established in 1991, the Office of the Monitor has received over $1.6 million.

- The plaintiffs are represented by the Arizona Center for Law in the Public Interest. The defendants are responsible for paying plaintiffs' attorneys fees. The Center has received over $1 million from the State and County for its work on Arnold vs. Sarn.

- An outside law firm represents DHS in addition to an Attorney General Representative. Fiscal year 1995 costs are estimated to be $350,000 to $400,000.

Some of this taxpayer money may not be well spent. BHS management, the court monitor, and the judge assigned to this case are frustrated with excessive lawyer involvement, yet the attorneys appear to be adding little value to the process. Additionally, we attended three Arnold vs. Sarn meetings in which the litigiousness of the case impeded decision making. Fifteen people, including four attorneys representing DHS, two attorneys for the plaintiffs, and an attorney representing the Office of the Court Monitor, attended one two-hour meeting to discuss communication among the parties and to decide when DHS lawyers would attend lawsuit meetings. No agreement was reached regarding communication at this meeting. In fact, none of the lawsuit meetings we attended appeared to result in substantive decisions being made to move the system forward.

Resources diverted from system management — In addition to the legal costs, the lawsuit diverts DHS and BHS staff resources from managing the system. DHS and BHS managers and staff spend significant amounts of time on tasks associated solely with the lawsuit. Eleven managers and staff identified the amount of time spent on lawsuit activities.[1] The estimates for these 11 people range as high as 36 hours per week, with an average of over 26 percent of their time consumed by these tasks. For example, one manager spends 15 hours a week researching and responding to lawsuit correspondence, attending case status meetings, and reviewing reports provided to the court and plaintiffs. The amount of staff time spent responding to plaintiffs' concerns tends to keep BHS in a crisis mode.

Options for Ending the Lawsuit

The Legislature needs to take action to end the lawsuit, allowing DHS to assume responsibility for the mental health system. The best option would be for the Legislature to change the statutes that provide a basis for the lawsuit. An alternative

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[1] During the audit we asked 19 people involved in the lawsuit were asked to estimate their time spent on lawsuit activities, and 18 responded. Of these, 11 were able to provide a weekly time estimate. A 40-hour workweek was assumed for all calculations.

solution would involve developing exit criteria outlining specific tasks to be completed by DHS to end the lawsuit.

Change statutes underpinning lawsuit – The Legislature should consider changing the overly broad statutes that form the basis of the lawsuit. A.R.S. §36, Chapters 5 and 34, establish the state's mandatory and nondiscretionary duty to provide an extensive array of community mental health services to all seriously mentally ill people regardless of funding availability.

This statutory right to service is not given to other, equally worthy populations. For example, the child welfare statutes, A.R.S. §8-512, authorize DES to only provide comprehensive medical and dental care for each child in the custody of the probation department and placed in foster care if funds are available. Similarly, A.R.S. §36-551.01 limits the right of developmentally disabled clients to receive appropriate services by making them subject to available appropriations unless mandated by federal law. Finally, A.R.S. §36-2907 gives the Director of AHCCCS the ability to modify client services if funds are insufficient to pay for full contract services. BHS statutes could be amended to resemble statutory provisions governing services to these populations. In fact, such proposed statutory language has been drafted in the past.

Develop exit criteria for the lawsuit – If the Legislature decides not to change the statutes, exit criteria need to be developed. The Blueprint does not include objective measures for determining compliance with all of its provisions. However, DHS and the plaintiffs can develop specific criteria identifying exactly what DHS needs to accomplish for full compliance. Once DHS has met the criteria, the lawsuit would end. DHS recently asked the plaintiffs to enter negotiations to develop criteria; however, negotiations had not yet begun when our audit concluded.

There are several drawbacks to this method of ending the lawsuit. First, developing these criteria require negotiations among the defendants, plaintiffs, the court monitor, and probably consumer advocates. It is unlikely the court or the plaintiffs will agree to criteria that do not include most of the Blueprint's current requirements and will certainly expect that the most important and costly mandates are achieved. Therefore, the time and money needed to meet these new criteria may not be significantly less than the current estimates. Additionally, given the lawsuit's history, negotiating exit criteria may also be a time-consuming and costly process. Already, there is a plan to hire outside consultants to help DHS develop these criteria.

RECOMMENDATION

The Legislature should amend A.R.S. §36, Chapters 5 and 34, to limit DHS's mandatory duty to provide services to the seriously mentally ill, and end the lawsuit, Arnold vs. Sarn.

OTHER PERTINENT INFORMATION

The Financial Condition of ACCM

During our audit, we collected information on the current and projected financial condition of the Arizona Center for Clinical Management (ACCM), the Regional Behavioral Health Authority (RBHA) under contract with BHS to serve Pima County.

In the first two years of its three-year contract term ACCM has lost over $11 million, for much of which the State may be liable. The problems ACCM encountered illustrate the inadequacies in the behavioral health system. As noted in Finding I (see page 6 through 15), BHS cannot let a RBHA fail because there are no alternative administrative bodies to maintain the continuity of care in the regions they serve. Yet BHS does not have the financial infrastructure – experienced staff and resources – to cope with enormous and complex financial problems within the RBHAs. ACCM's situation also illustrates how quickly a seemingly stable organization can deteriorate in a rapidly changing environment. ACCM has not been able to effectively manage the accelerated growth in its revenues and responsibilities, nor the new demands brought on by the advent of Title XIX funding and managed care.

Background

In July 1992, ACCM was awarded the contract to administer behavioral health services in Pima County. Prior to this, ACCM enjoyed a somewhat stable financial position. Its assets exceeded its liabilities, it showed strong financial indicators, and its revenues exceeded its expenditures for fiscal year 1990-91.

Prior to becoming a RBHA, ACCM was an organization solely providing case management services for seriously mentally ill (SMI) adults. ACCM's revenues leaped from approximately $13 million to over $46 million in its first year as a RBHA. Additionally, ACCM greatly expanded its responsibilities to include providing children's services, establishing and maintaining a provider network, initiating a community-wide planning process, and assuming activities related to general mental health and substance abuse.

ACCM's Financial Position Deteriorated Rapidly

Almost immediately after becoming a RBHA, ACCM began to experience heavy losses. As of June 30, 1994, ACCM's accumulated losses exceeded $11.6 million. ACCM's

financial problems stem primarily from inadequate financial management and the overauthorization of services.

ACCM lost over $11 million in two years — ACCM lost almost $4 million in its first year as a RBHA (fiscal year 1992-93). In fiscal year 1993-94, losses totaled over $7.7 million. In general, ACCM's liabilities include debts to providers, unspecified accounts payable, and recoupment amounts owed to the federal government as reimbursement. Since July 1992, ACCM's liabilities increased over 800 percent, from $1.24 million to $11.4 million in April 1994, while its assets remained relatively constant over the same time frame.

Recoupment liabilities present a severe financial problem for ACCM. Recoupments are the monies owed back to the federal government for Title XIX services not appropriately documented, not meeting minimum service requirements, or providing unauthorized services. Recoupments are recognized 15 months in arrears. Thus, ACCM's recoupment liabilities were first recorded in June 1993 for the months of November and December 1992 and averaged $334,000 per month. Recoupment amounts should decline as RBHAs gain experience in Title XIX documentation requirements. However, in the second recoupment period (January through March 1993), ACCM's average monthly recoupments improved by only 2.1 percent. In contrast, the other five RBHAs registered improvements ranging from 21 to 56 percent (see Table 3).

Table 3

Department of Health Services - Division of Behavioral Health Services
Recoupments of Title XIX Monies by RBHA
November 1992 through March 1993
(Unaudited)

Average Monthly Recoupment	ACCM	BHSY	COMCARE	NARBHA	PGBHA	SEABHS
Nov./Dec. '92	334,181	65,489	1,501,331	172,261	103,867	100,603
Jan.-Mar. '93	326,869	45,483	1,061,015	76,400	70,577	78,559
Percent Improvement	**2.19**	30.55	29.33	55.65	32.05	21.91

Source: Auditor General staff analysis of data contained in the Monthly AHCCCS Detailed Capitation Reports.

ACCM's mounting liabilities dramatically impact its solvency. In fact, as of April 1994, ACCM was virtually unable to pay any obligations. If ACCM's sources of revenue

stopped, they could have continued operating for only five days. The average time for the other RBHAs given the same scenario was 139 days.[1]

Inadequate infrastructure and overauthorization of services – ACCM's losses are primarily due to an inadequate financial infrastructure and overauthorization of services. ACCM lacked the necessary financial expertise when making important management decisions. When it became a RBHA, ACCM did not expand its administrative infrastructure and as a result, lacked qualified financial personnel. In fact, ACCM did not employ any CPA's, nor did its financial officers have significant experience in financial management, yet its revenues exceeded $46 million in fiscal year 1992-93.

Overauthorization of services has also pushed ACCM toward collapse. According to personnel within both ACCM and BHS, ACCM views itself as a service provider organization whose sole responsibility is to care for the mentally ill of Pima County, regardless of the cost. This view was bolstered by the Arnold vs. Sarn lawsuit requirements (see Finding II, pages 16 through 21), which provided a basis for ACCM to authorize services without adequate fiscal resources.

Remedial Actions May Be Insufficient

Although ACCM and BHS management have taken steps to address ACCM's financial crisis, they may be too late to avoid a loss to the State of between $11.6 and $19.4 million. Because it is doubtful ACCM will be able to meet the capitalization requirements of HB 2067 (see page 12), ACCM is not likely to be awarded a contract after the current one expires in June 1995. And, because ACCM and the State acted too late, ACCM is not expected to recover from its financial problems in the time remaining in its contract term.

Remedial actions taken – To improve ACCM's current situation and prevent future problems, ACCM and BHS management took the following measures:

- Increased ACCM's Financial Management staff to include five degreed accountants including one CPA candidate.

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[1] The five-day operating period is calculated using the defensive interval ratio. This ratio is commonly used to measure an organization's solvency and projects the days an entity could operate if revenues stopped.

- Developed the Expenditure Reduction Plan on April 28, 1994. Elements of this plan include:
  - reduction of SMI sites from 5 to 2,
  - reduction of staff by 15 percent,
  - implementation of a new client assessment program,
  - billing Medicare as applicable, and
  - renegotiating ACCM's contract with the Kino hospital.

- Renegotiated the Pima County Intergovernmental Agreement (IGA), increasing funding by $400,000.

- Requested and received a supplemental appropriation ($2.75 million) and residual subvention funds from another RBHA ($1.8 million) in late March 1994.

- In addition, BHS started providing on-site financial assistance at ACCM in January 1994.

BHS response was untimely and insufficient – However, these actions may be 'too little, too late'. In January 1993, ACCM management notified BHS that they were running a deficit of approximately $1,000,000. In July 1993, both ACCM and a BHS official notified BHS management of ACCM's continuing financial problems. While BHS management responded in 1993 by meeting to renegotiate the IGA between ACCM and Pima County and sending a BHS manager to conduct a preliminary review; changes in ACCM's operations did not occur until April 1994. In an October 1993 memo to BHS, ACCM management said that BHS follow-up to ACCM's problems had been very slow because of the other issues facing the Department. Similarly, DHS management told us that their delayed response to ACCM's problems was due to limited staff, who were busy assisting ComCare, which was also near the brink of collapse.

In addition to being untimely, actions taken may not be sufficient to address the magnitude of ACCM's financial crisis. BHS management does not expect to see improvements from any remedial actions until July 1994. Furthermore, administrative overhead accounts for only $3 million of total expenditures exceeding $50 million. Consequently, changes such as reducing staff 15 percent and site locations from five to two result in a negligible cost savings. To complicate matters, ACCM's contract expires in June 1995, and ACCM projected its turnaround to occur over a three-year period, ending June 1997.

Ultimately, total losses to taxpayers may be from $11.6 to $19.4 million.[1] ACCM and BHS management believe that the remedial actions taken will cause ACCM to break even in the third year of its contract term, which will still result in potential liabilities

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[1] The $19.4 million projection for the end of the contract term assumes losses in fiscal year 1994-95 equal to the those of fiscal year 1993-94.

to the State of over $11.6 million. However, if ACCM's performance in fiscal year 1994-95 mirrors that of the prior fiscal year, an additional $7.7 million could be lost. In a March 1994 memo to the governor and 17 legislators, the Governor's Office of Strategic Planning and Budgeting asserted that ACCM's debts are likely a legal and political liability of the State.

The likelihood of recurrence — The financial crisis that occurred at ACCM is less likely in the future. As was discussed in Finding I (see pages 6 through 15), legislation passed last session provides more protection to the State in the event of RBHA financial collapse. Specifically, the organizations are required to be well capitalized at the outset and must carry performance bonds. Although the legislation is a step in the right direction, there is still no guarantee that financially healthy organizations will bid in each region, possibly leaving BHS limited options again. Implementing Recommendation 2 in Finding I (see page 15) may also help to avert similar crises in the future. If BHS had a sufficient number of experienced financial review staff, the problem at ACCM may have been addressed sooner.

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JACK DILLENBERG, D.D.S., M.P.H., DIRECTOR

October 19, 1994

Douglas R. Norton
Auditor General
2910 N. 44th Street, Suite 410
Phoenix, AZ 85018

Dear Mr. Norton:

The Arizona Department of Health Services (ADHS) applauds the Office of the Auditor General for recognizing the significant progress our current management has achieved toward an improved and stabilized behavioral health care system. Additionally we are gratified that the Auditor General has expressed confidence in ADHS to complete the job of producing a fully effective and accountable system within three years.

Let me now take the opportunity to respond to the audit findings. However, we feel we must withhold comment on possibly the boldest recommendation of the audit, that is Finding II which calls for the Legislature to step in and end the Arnold vs. Sarn lawsuit. As a party to the lawsuit, ADHS is prohibited from taking any position on Finding II and will not comment on the opinions and recommendations contained in Finding II.

Regarding Finding I, the problems of the past are primarily due to the constantly changing program requirements. For example, due to a federal mandate the state was required to implement the children's Title XIX program in October 1990. While most other states had 1 to 2 years to plan for their Title XIX program, Arizona had to bring up its system in less than 1 year because the Health Care Finance Administration (HCFA) told the state it could no longer be waived from providing Title XIX mental health services to children. The start up time frames did not allow for proper planning for implementation. This was further exacerbated by the lack of systems, personnel, and funding to properly support and comply with the requirements brought on by Title XIX. In the past year, management and staff have implemented a variety of specific actions to resolve these outstanding issues.

In addition to the Title XIX program having to be implemented in October 1990, the system underwent additional massive changes during the past 4 years as a result of the following:

- In May 1991, the "Blueprint" called for a "seamless" system of care to be developed in Maricopa County, leading to the merging of three "Entities" and the County Behavioral Health System into one Regional Behavioral Health Authority (RBHA).

- In November 1992, Senate Bill 1502 required the implementation of a "Managed Care System" for the Title XIX mental health program.

- The Auditor General's 1992 report recommended significant contract changes to limit the "Entities" ability to develop and retain financial reserves.

While each of these requirements has in fact led to a better and more accountable system, the impact and disruption caused by implementing all these simultaneously has been taxing on consumers, providers, the RBHAs, other state agencies and ADHS.

This has been a monumental undertaking. Every routine business practice has changed; corporate cultures at the state and local levels have had to develop and change; new technologies have been developed and implemented; policies and rules were changed; contracts were changed and renegotiated; financial management practices were changed; new MIS and payment/billing systems were designed and implemented; monitoring protocols were revised and implemented; the list goes on.

The task assigned to ADHS and Behavioral Health Services (BHS) was nothing short of a complete redesign of the entire system. Anyone who has been involved in this project for the past two years would acknowledge that there is still much to be done and that this task could have been less painful if accountability systems and other infrastructure had been put into place before undertaking remaining changes. We have, in fact, been attempting to "ride the bike while changing the tire".

The recommendation ADHS be given three years to fully implement the managed care behavioral health system comes as a welcome respite from constant change. As you indicate, there have been a plethora of studies on the behavioral health system which have identified areas for improvement. As the bulk of your report suggests, ADHS/BHS is making progress in addressing the issues that have been identified by previous reports. However, the statement that "BHS has been unable to account for the provision of quality, cost-effective services" leaves the impression that this is a current criticism, rather than a statement from prior reports. In fact, BHS is currently distributing monthly reports that are quite detailed about the expenditure of funds and services provided. BHS has developed a comprehensive 3-year Strategic Plan which is another of the many improvements that your staff observed when they conducted their review.

ADHS's commitment to make Arizona's behavioral health system the best it can be is paying off. Listed below are areas of progress which are not acknowledged in your report.

- In order to continue to improve the behavioral health system, ADHS developed and submitted to the Governor a comprehensive 3-year strategic plan. A copy of the plan and transmittal letter to the Governor is attached with the request that it be included as part of our response. This plan maps out the actions to be taken by ADHS over the next three years in order to satisfy all areas of systems compliance.

- You state that HCFA found ADHS did not meet deadlines for reporting financial information. Currently, all financial reports are up to date and on time. In addition, BHS has recently established a financial review team and hired highly trained and experienced staff to oversee the financial requirements of the program.

- You state that HCFA will require AHCCCS to return federal monies until RBHA accounting and MIS systems are corrected. In their letter of August 2, 1994 HCFA stated that as a result of "significant progress since our initial review" HCFA has dropped its earlier threat to withhold federal funds. In addition, ADHS has negotiated a new capitation payment methodology with AHCCCS that will preclude future recoupment and has been in negotiations with AHCCCS that will likely lead to an increase in the SMI Title XIX capitation rate.

- You report that Mercer found that information on expenditure by category of services or client characteristics is not presently available. Since July 1994, ADHS has produced and distributed a monthly report that describes open and active clients, services provided, expenditures by types of service, value of services, and client demographics. In addition, while limited information was previously available from Electronic Data Systems (EDS) and Client Information System (CIS), daily downloads are now available to the RBHAs. I believe Arizona is unique in its ability to provide this type of information, not only on the Medicaid client, but on non-Medicaid eligible clients as well. I would feel comfortable in comparing our MIS capabilities to any other state mental health authority in the country.

With regard to the monitoring capability, we have just completed our second annual operational and financial review of all six RBHAs. BHS has established three core monitoring teams. Each team is assigned to two RBHAs and will analyze the reports and follow up with each RBHA to ensure appropriate corrective action is implemented where needed. Our second annual independent quality review will be conducted in January 1995. In addition, we continue to monitor quality of service through our quarterly showing and practice-pattern reports and through our grievance system. These reports contain information about service utilization by clients in order to assure medically necessary services are provided in the most appropriate setting.

In the coming months we will use the reporting systems we now have in place to further our quality monitoring capacity. We have under way a client satisfaction initiative and a new method to track the level of service to be provided to SMI clients and we will begin work on defining and capturing new outcomes measures.

The following comments are provided in response to specific comments in the report:

On page eight of the report there is a discussion about recoupment following the heading **Problems effectively reduce service dollars**. The explanation of the recoupment process is misleading as it is currently written. The recoupments did not occur as a result of problems

with accountability or the data system. The recoupments occurred because individuals did not receive the minimum number of Title XIX covered services which were required by HCFA for the specified time period. It must be emphasized that no one was denied medically necessary Title XIX services. In some cases the individual may not have needed the minimum number of services.
For those individuals who received no services, there were no funds expended on their care. Thus, there was no impact on the individual being served. In other cases, clients did not receive covered Title XIX services during the time period, but did receive non-Title XIX services. The problem was more with system design in requiring a minimum number of Title XIX services. Recognizing this, ADHS and AHCCCS have requested HCFA to change this requirement retroactively to October 1, 1994.

While underreporting of services has occurred, that is not a function of the data system. It is created because providers and/or RHBAs did not report the services into the data system as required. It is not surprising that there would be problems with reporting services in a new system. In fact, nationally, there is a 12% - 20% documented underreporting of services in the health care field. ADHS and the RBHAs are working with providers with the largest underreporting problems to obtain compliance with reporting requirements.

On page nine, it is more accurate to state that ADHS management "has identified and begun to address the full range of problems confronting the system", rather than "management has yet to address the problems." Such a statement would be more consistent with many of the other statements in your report.

Page ten, third paragraph needs to be clarified. Standardized reporting formats and accounting guidelines do exist as outlined in the AHCCCS Mental Health Policy Manual, Chapter 900. The RBHAs are held to these requirements and have been sanctioned in the past for non-compliance. DHS/BHS has performed the required annual operational and financial review in conjunction with our consultant. Along with findings and recommendations, DHS/BHS has established an annual operational and review instrument which was approved by AHCCCS. In addition, each RBHA is required to undergo a certified annual financial audit as part of the terms and conditions of their contract.

Page 14 addresses the key areas that you suggest the Legislature should monitor. In the area of recoupment, it should be noted that the change to the current HCFA waiver will eliminate recoupment. As noted earlier, the minimum service requirement will change retroactive to October 1.

Another area of the report (page 21) that needs correction is the section on the financial condition of ACCM. The $19 million estimated deficit you report is an extreme worst case scenario and assumes that no corrective actions are being taken by ADHS and ACCM. This is incorrect. Corrective actions are having the desired effect and there is no potential for such a worst case scenario to be realized. While it is true that ACCM has serious financial problems, current information indicates that its deficit at the end of FY 1994-95 will be closer to $8 million

than the $11.6 million minimum you reported. This estimated deficit includes a liability for ACCM to pay back the $4.25 million supplemental payment approved by the 1994 Legislature. For the first two months of FY 1995, ACCM has reported a $450,000 surplus. If ACCM is successful in its corrective actions, and they currently are on track, they should be able to generate $3.7 million this year to be applied to the $11.6 million unaudited deficit they are projected to begin the year with. In addition, as I stated earlier, DHS is currently negotiating a SMI Title XIX rate increase with AHCCCS which, when approved, will also have a significant impact on ACCM's projected deficit.

I would also like to emphasize that ADHS reacted without delay to respond to ACCM's problem. Although our resources were stretched thin, I believe our actions were timely, and successfully prevented a serious crisis in service delivery. Here is a chronology of ADHS actions:

- July 1, 1993, ADHS began meeting with Pima County to renegotiate the IGA, which was one of the primary issues identified by ACCM as creating financial difficulties. On 8/4/93 and 8/24/93 my staff met with the ACCM CEO and her financial staff to discuss the financial issues . These meetings were held to ascertain ACCM's cash flow situation, and actions they were taking to correct their problem. These meetings initiated our site visit to ACCM on September 13, 1993.

- During August and September, my staff worked with ACCM to analyze their financial situation. On September 21, 1993, my staff prepared a report indicating the factors that we believed contributed to the financial situation.

- In October, 1993, ACCM provided additional information pursuant to our request. Since BHS had scheduled the Annual Operational and Financial Review for November 10 and 11, we requested our consultant pay special attention to ACCM's financial situation.

- On November 11, 1993, we requested ACCM provide BHS with their financial information on a monthly basis rather than quarterly.

- On November 26, 1993, we received a corrective action plan from ACCM regarding their fiscal problem.

- In January, BHS requested consultants to further identify any financial issues and check to ensure that the ACCM corrective action plan was appropriate.

- During the period from July, 1993 - December, 1993, ADHS staff and management had several conversations and meeting with ACCM staff about their fiscal situation. BHS staff worked on reconciling ACCM's FY 93 revenue, researched their request for transition funds, and worked on amending the Pima County IGA.

- In February, 1994, ADHS requested and received approval for a supplemental appropriation in order to provide ACCM with a supplemental payment.

- In July, 1994 ADHS began biweekly joint meetings with ACCM to ensure the corrective actions are successful.

- In July, 1994 ADHS began providing a staff member two days per week to provide on site assistance.

In closing I will summarize:

- As a result of the numerous changes mandated from 1990 through 1992, the current system was brought up without sufficient planning, resources or infrastructure.

- Several positive actions have occurred during the past two years which have improved all aspects of the system.

- ADHS has developed a three-year strategic plan in order to move forward in an efficient and effective manner to continue to improve the system.

- Actions have been completed to improve accountability.

- Problems have been identified and are being addressed or have been corrected.

Sincerely,

Jack Dillenberg, D.D.S., M.P.H.
Director

JD/CC/RA:se

Attachment