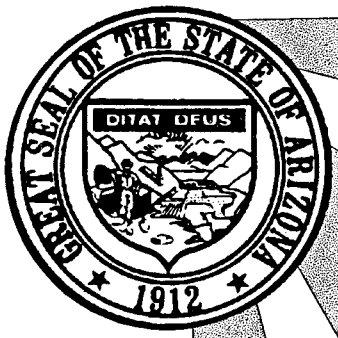

State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES, DIVISION OF BEHAVIORAL HEALTH SERVICES

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General
December 1996
Report 96-19

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
DEPUTY AUDITOR GENERAL

December 16, 1996

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Jack Dillenberg, Director
Arizona 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 17, 1995, 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 that the Division needs to improve its oversight of the behavioral health care system. The Division cannot answer fundamental questions about the quantity, quality, effectiveness, and timeliness of services provided. In addition, in examining services available in the behavioral health system, we found the Division could better ensure that children with behavioral health problems receive prompt care and continue their treatment through completion. Also, the Division could do more to ensure that crisis services in Maricopa County are better coordinated with police and fire departments, and more crisis facilities are available.

Finally, our report includes an analysis by nationally recognized experts on ways to introduce more competition into the behavioral health system in Arizona. They note a number of actions the Division can take to increase the number of bidders for future RBHA contracts.

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

This report will be released to the public on December 17, 1996.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

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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, pursuant to a May 17, 1995, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

The Division of Behavioral Health Services (Division), a division of the Department of Health Services, is responsible for providing mental health and substance abuse services in Arizona. The Division also oversees the Arizona State Hospital. BHS' mission is to "continually improve the effectiveness and efficiency of a comprehensive system of behavioral health care in order to meet the needs of the people of Arizona." BHS currently contracts with five private, nonprofit entities called Regional Behavioral Health Authorities (RBHAs) to deliver community-based services. In turn, each RBHA subcontracts with local businesses to provide most services.

This audit focuses on five areas of legislative interest pertaining to Arizona's behavioral health care system. Specifically, it addresses (1) the Division's oversight role in behavioral health care; (2) the adequacy of services children with behavioral health problems receive; (3) ways Arizona can encourage competition for RBHA contracts; (4) how the Division can better ensure that people experiencing behavioral health crises receive ongoing services; and (5) how the Division can improve the reporting of RBHAs' administrative, case management, and service costs.

Division Oversight of the Behavioral Health System Needs Improvement (See pages 9 through 14)

The Division needs to improve its oversight of the behavioral health system. Oversight is necessary to ensure that clients receive needed services and that the hundreds of millions of dollars appropriated by the state and federal governments is spent as intended on needed care. The Division currently uses several methods to oversee behavioral health services. However, these methods alone do not adequately enable the Division to compare the RBHAs or answer important questions about the accessibility, adequacy, and effectiveness of services. The Division should improve its oversight by collecting complete data on clients and the services they receive, adopting standards defining what services clients should typically receive based on their illnesses, and using this information to monitor RBHA performance.

More Can Be Done to Ensure That Children Receive Timely and Continuing Care (See pages 15 through 19)

Some of the children in the behavioral health system do not receive services within established time frames and do not complete the treatment they need. In 90 files reviewed, 18 children did not receive timely treatment for reasons that could not be explained or due to delays caused by the RBHA or service providers. Similarly, in 23 out of the 90 cases, children dropped out of treatment before services were completed. While some delays are unavoidable, the Division and RBHAs could do more to ensure children receive timely and complete treatment. The Division should monetarily sanction RBHAs if they do not provide services to clients within existing deadlines, and adopt a policy to ensure that RBHAs or providers attempt to contact children's families when children fail to appear for appointments. Additionally, the RBHAs should take further steps to ensure that children receive timely services.

The Division Could Increase Competition in the Behavioral Health Care System (See pages 21 through 26)

The Division of Behavioral Health Services could do more to increase competition in the behavioral health system. In order to evaluate competition in the current system, the Office of the Auditor General hired experts in the economics of behavioral health care. The consultants found that allowing more than one RBHA within a single geographic area to compete to serve clients, as occurs in the Arizona Health Care Cost Containment System (AHCCCS), is not appropriate in behavioral health care. They maintain that competing RBHAs could identify those clients with the most persistent and expensive forms of disorders, and seek to restrict access to services by those clients.

The consultants do recommend increasing competition for the RBHA contract for an area. As part of their study, the consultants identified several reasons why there was only one bidder for the Maricopa County RBHA contract in 1995. The consultants found that competition was limited in part by factors outside of the Division's control. However, they also found that the Division could foster future competition by allowing for-profit organizations to bid, reducing restrictions placed on RBHA board membership and size, and making the bidding process less burdensome than it was in 1995. Additionally, the Division could lessen the financial risk that vendors experienced with the last contract by improving the data bidders receive and agreeing to share financial risk with RBHAs.

Steps Should Be Taken to Ensure That More People in Crises Receive Accessible, Ongoing Care (See pages 27 through 31)

The system for responding to behavioral health crises in Maricopa County could be improved. ComCare (the RBHA for Maricopa County) has made changes that allow it to control access to crisis services so that behavioral health care costs can be kept down. While these changes are in line with the philosophy of managed care, additional changes are needed to ensure that crisis services are accessible and continuous. In particular, the Division should encourage ComCare to make efforts to better coordinate its services with the police and fire departments involved in behavioral health crises so that ongoing treatment can be delivered. In addition, ComCare should address system capacity problems so that the police and fire departments can more easily transfer persons experiencing behavioral health crises to ongoing ComCare services.

The Division Can Improve Reporting of Administrative, Case Management, and Service Costs (See pages 33 through 36)

The Division of Behavioral Health Services needs to change the way RBHAs report costs. The Division's broad financial reporting guidelines allow RBHAs to classify direct program services and a portion of their administrative-related expenses, such as rent and phones, as case management costs. As a result, it is difficult for the Division to assess case management costs and compare RBHA expenses. Equally important, the guidelines may result in understatement of administrative expenses. The Division should adopt financial guidelines similar to those developed by AHCCCS for Arizona Long Term Care System providers. The AHCCCS guidelines only allow case managers' salaries, benefits, travel, and training to be reported as case management expenses. Narrowing what can be reported as case management helps distinguish among costs for services, case management, and administration.

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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, pursuant to a May 17, 1995, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

Description of the Behavioral Health System

The Division of Behavioral Health Services (Division), a division of the Department of Health Services, is responsible for providing publicly funded mental health and substance abuse services in Arizona. The Division also oversees the Arizona State Hospital. BHS' mission is to "continually improve the effectiveness and efficiency of a comprehensive system of behavioral health care in order to meet the needs of the people of Arizona."

The Division does not directly provide services, except for the Arizona State Hospital. It contracts with private, nonprofit entities called Regional Behavioral Health Authorities (RBHAs) to deliver community-based behavioral health services. These RBHAs operate under three-year contracts, with the possibility of two one-year extensions. At this time, there are five RBHAs under contract with the Division:

- Community Partnership for Behavioral Health Care (ComCare), which serves the Maricopa County region;
- Pinal Gila Behavioral Health Association, which serves both Pinal and Gila Counties;
- Behavioral Health Services-Yuma (BHS-Yuma), which serves LaPaz and Yuma Counties;
- Community Partnership of Southern Arizona, which serves two geographic regions in the southern part of the State, including Pima, Santa Cruz, Graham, Greenlee, and Cochise Counties; and
- Northern Arizona Regional Behavioral Health Authority (NARBHA), which serves the northern part of the State, including Coconino, Mohave, Navajo, Apache, and Yavapai Counties.

These five RBHAs administer, coordinate, and monitor the delivery of mental health services within their region. In turn, each RBHA then subcontracts with local businesses to provide client services. Currently, there are 302 providers under contract with the RBHAs.

The RBHA concept dates back to 1984, when Arizona began contracting with private mental health firms to provide behavioral health services. Previously, these services were provided by 125 organizations that received state funding through more than 20 umbrella agencies. However, this structure resulted in high administrative costs and limited accountability.

While the Division does not directly provide community-based services, it nonetheless plays an important role in the behavioral health care system. It is responsible for procuring RBHA contracts, monitoring RBHA performance to ensure that people in need of behavioral health care receive appropriate services, and determining the amount of money each RBHA should receive.

Clients in the System

The Arizona behavioral health system provides services to three major categories of clients, all of whom are primarily indigent. The first category consists of seriously mentally ill adults. Typically, these individuals have a severe, chronic mental illness (such as schizophrenia), that interferes with their ability to function in society. While seriously mentally ill adults account for 19 percent of the clients served by the system (approximately 22,000 people), a disproportionate share of all program monies (47 percent) is dedicated to serving this group.

Children comprise 21 percent of the clients served by the behavioral health system (approximately 24,000 people). Children suffer from a variety of behavioral health problems, such as Oppositional Defiant Disorder, characterized by argumentative or defiant behavior, and Attention Deficit Hyperactivity Disorder, characterized by a short attention span and restlessness. Many young people in the behavioral health system have experienced physical, sexual, or emotional abuse. They are referred to the state behavioral health system through many different sources, such as the juvenile courts, the schools, the Department of Economic Security, or their own families. Thirty-one percent of program monies are devoted to services to children.

Most of the clients served by the system receive general mental health/substance abuse assistance. Typically, these 70,000 individuals have a short-term illness that can be managed with limited outside assistance. As a result, the State spends less money to serve these clients. In fiscal year 1994-95, the General Mental Health/Substance Abuse Program received 22 percent of all the Division's program monies while serving approximately 60 percent of its clients.

Funding

The Division receives monies from several different sources. First, it receives federal Medicaid dollars for behavioral health care for the indigent from the Arizona Health Care Cost Containment System (AHCCCS), the state agency designated by the federal government as the sole recipient of Medicaid assistance in Arizona. AHCCCS contracts with the Department of Health Services to provide mental health and substance abuse services to all clients enrolled in AHCCCS. The Division also receives federal monies directly in the form of general mental health and substance abuse grants.

The State provides matching monies for federal Medicaid dollars provided to the system. Currently, the State finances about one-third of the expense of Medicaid clients' services. Arizona also provides money for services to clients not covered by Medicaid.

Funding for behavioral health services has grown dramatically over the years. As illustrated in Figure 1 (see page 6), the Division received a total of $313.2 million in fiscal year 1995-96, a 208 percent increase in monies from fiscal year 1988-89. This growth can be attributed to two factors. First, Arizona began receiving federal Medicaid monies for behavioral health services in 1990, resulting in an infusion of new dollars and the entitlement of all AHCCCS clients to behavioral health services. Second, the 1981 Arnold v. Sarn lawsuit entitled all seriously mentally ill clients to "a full continuum of mental health services," thus requiring a substantial increase in program funding.

The Division spends some of its appropriated monies on administration (see Table 1, page 7). Nonetheless, much of the money it receives is allocated to the RBHAs for program services. The Division allocates such behavioral health dollars to the RBHAs two different ways. Federal and state Medicaid money is distributed in the form of a capitated rate, meaning that RBHAs receive a fixed amount for *every* AHCCCS client living in their geographic region. The RBHAs and the Division negotiate these rates based on how much they expect AHCCCS members to use services. The RBHAs, as recipients of Medicaid dollars, are then expected to provide all medically necessary behavioral health services to AHCCCS clients.

Non-Medicaid money is distributed to the RBHAs in the form of lump sum payments. These payments to the RBHAs are based on the availability of state funds, and are not made on the basis of the number of people who reside in a geographic area or the estimated prevalence of mental illness in the region. Accordingly, RBHAs do not have to serve non-Medicaid clients in their regions if such funds become low, with the exception of those adults who are or could be deemed seriously mentally ill.

For both Medicaid and non-Medicaid dollars, money is given to the RBHAs to cover program services and other related costs such as case management and administration (see Table 2, page 8). If the RBHAs spend less program service money than they are given, the remainder does not revert back to the State. Instead, the RBHAs can, by contract, direct some or all of the remaining service money to non-service expenses such as information systems that "benefit the behavioral health system."

Scope and Methodology

This audit builds on previous reports issued in 1989, 1992, and 1994 on the Division of Behavioral Health Services. These previous audits focused on several issues, including the need for a more accountable system, the impact of the Arnold v. Sarn lawsuit on the behavioral health system, problems with the Division's automated information system, and limitations in service accessibility and availability. This audit focuses on five specific areas of legislative interest, including: (1) the Division's oversight role in behavioral health care; (2) the adequacy of services children receive; (3) ways Arizona can encourage competition for RBHA contracts; (4) how the Division can better ensure that people experiencing behavioral health crises receive ongoing services; and (5) how the Division can better report case management, administrative, and service costs.

A number of methods were used to measure the performance of both the Division and the RBHAs. First, a file review was conducted to measure the adequacy of children's services. A file review was necessary because the Division's automated system did not provide a complete history of services that clients received. This file review looked at children who entered the behavioral health system between January 1 and March 31, 1995. The file review was narrowed to avoid discrepancies in case comparisons due to ethnicity, gender, and severity of illness. The resulting sample included white male children who were not considered to have extreme problems functioning in society, based on the Division's standard assessment. Due to the time required to review a case, only 90 children's files were reviewed, 60 in ComCare and 30 in NARBHA.

Second, a team of consultants was hired to determine how Arizona can introduce more competition into the RBHA system. These consultants are experts in the economics of behavioral health care who are familiar with managed care contracting in other states. The consultants built on this knowledge in their review of the Division's 1995 RBHA contract procurement process. As part of that review, the consultants analyzed data provided to prospective bidders and compared Arizona's experiences to those of other states. In addition, the consultants interviewed officials from the Division, the Arizona Health Care Cost Containment System, ComCare, and private organizations that considered bidding on the RBHA contracts. A summary of the consultants' qualifications and their final report appears in the Appendix.

Other methods used included the following:

- Conducting a literature review on managed behavioral health care, including over 90 journal articles, books, or reports, and 10 studies from other states;
- Interviewing representatives from the Division, AHCCCS, the RBHAs, providers, other state agencies such as the Department of Economic Security, the Office of the Court Monitor, and mental health advocacy groups;

- Reviewing polices and procedures from the Division, Arizona Health Care Cost Containment System, and the RBHAs;
- Interviewing over 15 representatives from local police and fire departments;
- Interviewing representatives from managed behavioral health systems in 7 other states;
- Observing RBHA contractor and Phoenix Fire Department employees responding to behavioral health crises;
- Examining quality management reports prepared by the Division and the RBHAs;
- Examining Division reporting guidelines for the RBHAs and guidelines developed by the Arizona Health Care Cost Containment System for its contractors;
- Reviewing Division fiscal year 1994-95 expenditure data and the RBHAs' audited financial statements for that same year;
- Analyzing ComCare's independent auditors' working papers for fiscal year 1994-95;
- Reviewing previous studies conducted on the behavioral health system; and
- Reviewing data from responses to behavioral health emergencies by the Phoenix Fire Department, Phoenix Police Department, and ComCare for the week of April 24-30, 1996.

Audit Limitations

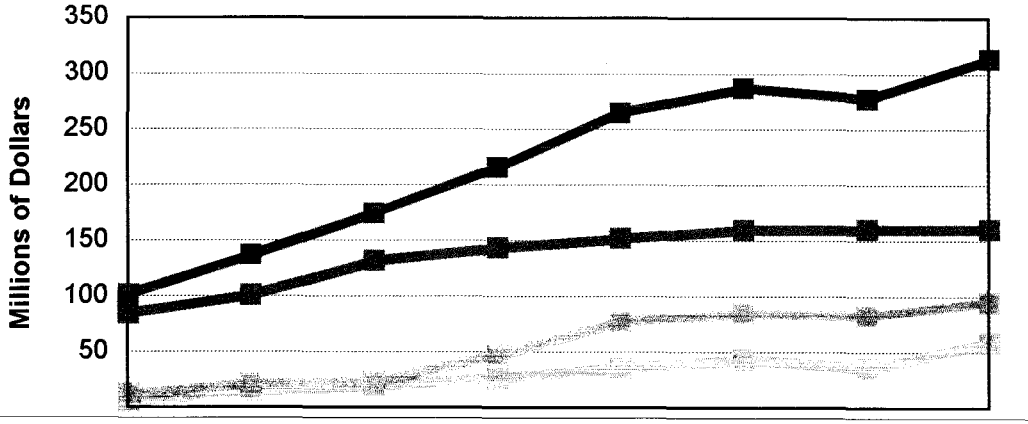
Auditors encountered several serious limitations during this audit. First, some information reported on the Division's client information system appears to be incomplete or inaccurate. For example, three studies in 1995 found that information on the Division's automated system pertaining to client services was incomplete in many cases. However, other centralized data is believed to be complete, such as reasons given for case closures. As a result, only some centralized data could be used to assess client services. Second, complete client files were not centrally located, and their content was voluminous. As a result of these limitations, auditors were able to review information at only two of the RBHAs—ComCare and NARBHA.

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, the RBHAs, and their staffs for their cooperation and assistance throughout the audit.

Figure 1

Department of Health Services–
Division of Behavioral Health Services
Revenues in Millions of Dollars
Years Ended June 30,1989 through 1996
(Unaudited)



	1989	1990	1991	1992	1993	1994	1995	1996
State Appropriations	$ 84.4	$100.6	$131.5	$143.1	$151.8	$159.3	$159.7	$160.4
Federal Revenue	12.2	21.6	23.3	46.7	77.5	84.7	82.8	94.8
Other Revenue[1]	5.1	14.8	19.8	26.2	35.7	43.5	35.3	58.0
Total Revenues	$101.7	$137.0	$174.6	$216.0	$265.0	$287.5	$277.8	$313.2

State Appropriations Federal Revenue Other Revenue Total Revenues

[1] Includes a variety of nonappropriated monies, such as revenue from intergovernmental agreements, other contracts, donations, and fines.

Source: Auditor General staff analysis of the Department of Health Services Financial Online System data for the years ended June 30, 1989 through 1994 and the Uniform Statewide Accounting System *Appropriation Activity Detail* and *Revenue Listing for the Agency* reports for the years ended June 30, 1995 and 1996.

Table 1

Department of Health Services—Division of Behavioral Health Services
Statement of Revenue and Expenditures in Millions of Dollars
Year Ended June 30, 1995
(Unaudited)

Revenue	$277.8
Expenditures	
Administration	20.4
Program Service	244.1 [a]
Total Expenditures	264.5
Excess of revenues over expenditures	$ 13.3 [b]

[a] Includes $216.4 million disbursed to the six regional behavioral health authorities during fiscal year 1994-95.

[b] Of the $13.3 million, $9.7 was reverted to the State General Fund and $3.6 million was carried forward to the next fiscal year.

Source: The Uniform Statewide Accounting System *Appropriation Activity Detail* and *Revenue Listing for the Agency* reports for the year ended June 3, 1995.

Table 2

Department of Health Services—Division of Behavioral Health Services
Statements of Revenues, Expenses, and Changes in Fund Balances
for Six Regional Behavioral Health Authorities
Year Ended June 30, 1995

	ACCM[1]	BHS-Yuma	ComCare	NARBHA	PGBHA	SEABHS[2]	Total
Revenue	$54,362,424	$7,877,533	$136,112,305	$21,344,767	$13,250,831	$8,845,218	$241,793,078 [3]
Expenses							
Program service	32,354,061	5,685,415	87,389,982	17,613,247	7,733,248	6,966,004	157,741,957
Case management[4]	6,907,581	1,065,230	29,241,766	1,604,459	1,347,743	1,251,039	41,417,818
Administration	4,224,536	768,323	9,217,058	1,642,181	859,624	856,190	17,567,912
Other					96,575	507,500	604,075
Total	43,486,178	7,518,968	125,848,806	20,859,887	10,037,190	9,580,733	217,331,762
Excess revenue over (under) expenses	10,876,246	358,565	10,263,499	484,880	3,213,641	(735,515)	24,461,316
Fund balance beginning of year	(13,805,531)	1,020,046	(7,181,814)	2,669,609	3,168,418	2,144,247	(11,985,025)
Accrual of contingent liability					(1,620,002) [5]		(1,620,002)
Fund balance end of year	$(2,929,285)	$1,378,611	$ 3,081,685	$3,154,489	$ 4,762,057	$1,408,732	$ 10,856,289

[1] ACCM was the regional behavioral health authority for Pima County and ceased operations during fiscal year 1995-96.

[2] SEABHS was the regional behavioral health authority for southeastern Arizona and a predecessor of the Community Partnership of Southern Arizona, the current regional behavioral health authority for Pima County and southeastern Arizona.

[3] Federal, county, and nongovernmental receipts; net changes in recoupment payable and accounts receivable; and a one-time advance payment to ComCare account for the approximate $25.4 million difference between total behavioral health authority revenue and Department of Health Services disbursements.

[4] Case management expenses for some regional behavioral health authorities include administration and program-service related expenses. (See Finding V, pages 33 through 36).

[5] According to PGBHA's financial statements, this total comprises a $450,000 performance bond required by ADHS to indemnify the payment of claims and help ensure financial stability plus the accrual of a contingent liability in the amount of $1,170,000. The contingent liability is management's estimate of future claims payable due to the probability that ADHS will require payment for services in future years for which no additional funding will be provided.

Source: Audited regional behavioral health authority financial statement for the year ended June 30, 1995.

FINDING I

DIVISION OVERSIGHT OF THE BEHAVIORAL HEALTH SYSTEM NEEDS IMPROVEMENT

The Division of Behavioral Health Services' oversight of the behavioral health care system needs to be improved. Oversight is necessary to ensure that RBHAs provide needed services and that public dollars are spent as intended. While the Division uses a variety of valuable monitoring methods, it still cannot answer some important questions about the availability, adequacy, and effectiveness of services provided. The Division needs to adopt service standards, collect client information, and develop additional means of monitoring the RBHAs to maintain effective public stewardship and ensure that people with behavioral health problems receive much-needed services.

Oversight of the Behavioral Health Care System Is Crucial

The Division plays a critical role in overseeing Arizona's behavioral health care system. It is responsible for monitoring and evaluating the performance of the RBHAs and the services they deliver to behavioral health care recipients. The Department's contract with the state Medicaid agency, AHCCCS, requires the Department to ensure that Medicaid-funded behavioral health services are available, adequate, and cost-effective.

Contract provisions aside, monitoring the behavioral health care system is critical to ensuring that clients with serious behavioral health problems receive needed services. Because RBHAs are given a fixed amount of money for managing the care of people in a geographic region, an incentive may exist for RBHAs to deny services or deliver too few or inappropriate services. Monies for services that are received by the RBHAs and are not subsequently spent can, by contract, be directed to non-service related expenses as long as it "benefit(s) the behavioral health system." Thus, oversight is necessary to ensure that needed services are not denied, and that the hundreds of millions of dollars appropriated by the state and federal governments for behavioral health services in Arizona are spent effectively.

Important Questions Unanswered

The Division currently relies on a variety of means to monitor services provided to behavioral health clients. While these methods do have value, they do not yield enough information for the Division to adequately assess RBHA performance. They also do not allow the Division to determine whether the specific services RBHAs provide are accessible, adequate, or effective in helping clients cope with their illnesses.

Several methods used—The Division currently relies on several methods to assess RBHA performance and determine whether clients receive needed care. For example, the Division performs or requires RBHAs to conduct:

- Client satisfaction surveys. The Division asks service providers to distribute surveys to clients to assess whether clients are satisfied with the services they receive. Clients mail the surveys back to BHS so results can be compiled.

- Client file reviews. The Division requires RBHA staff to select and review a small number of client files. Staff fill out a checklist stating whether they believe the services clients receive appear to be adequate, effective, and timely based on information contained in the client's case file.

- Analyses of service data. The Division compares each RBHA's use of inpatient and residential services. If one RBHA shows a significantly higher rate of inpatient service, this may signal that it is providing too few preventative services.

Critical questions unanswered—While methods used to monitor the RBHAs have some value, they alone do not adequately enable the Division to compare the RBHAs or answer important questions about the accessibility, adequacy, and effectiveness of their services. Specifically, the following questions cannot be fully answered:

- *Do different RBHAs provide the same level of service to similar clients?*

  If the Division could answer this question, it could more easily assess each RBHA's performance, and identify cases to review to ensure services are not being denied inappropriately.

- *Are services helping clients function better at home, school, or work? Are any services particularly effective? Cost-effective?*

  The answers to these questions could help the Division and the RBHAs assess the effectiveness of existing services so that limited resources can be put to the best possible use.

- *How long does it take adult clients to receive services?*

  If the Division could answer questions about the timeliness of adult services as it currently can for children, it could enforce service timeliness requirements. In addition, it could help to determine whether a sufficient number of service providers exist.

- *Do clients receive the types of services that scientific evidence would suggest are adequate and appropriate?*

  The answer to this question is essential to evaluating whether the RBHAs provide or deny needed, medically appropriate care.

The Division Lacks Means Necessary for Adequate Oversight

Two major factors contribute to the Division's inability to answer important questions about service timeliness, adequacy, and effectiveness. First, the Division does not collect sufficient information about clients and services to evaluate service provision. Second, it has not developed service standards defining what services people should typically receive.

Current data incomplete—BHS lacks information needed to perform oversight of the behavioral health system. Specifically, the Division's automated system lacks critical information about:

- **Client characteristics**—The Division's automated system lacks critical information about behavioral health clients. For example, a review of 1,848 automated children's records from ComCare (the RBHA for Maricopa County) revealed that 47 percent were missing information about the child's diagnosis, and 28 percent lacked information about how well children were functioning at home and at school. Such information is needed to 1) identify clients with similar problems so the Division can determine disparities in the number of services provided by different RBHAs; 2) evaluate whether people receive services that scientific evidence would suggest are appropriate for someone suffering from a particular illness; and 3) learn whether services received are effective in helping clients function better.

- **Services received**—Evidence suggests that the Division's automated system does not contain a complete record of services clients receive, even though the Division requires RBHAs to report such information. Audit work revealed that in 90 cases reviewed of children who entered the behavioral health system during the first 3 months of 1995, 19 cases (21 percent) showed discrepancies between services documented in the case file and on BHS' information system. Similarly, three 1995 studies by an actuarial consulting firm the Division hired found that fiscal year 1993-94 service data was often incomplete. For example, a common type of counseling session was considered to be underreported by 25 percent. The absence of accurate service information hinders the Division's ability to describe what services clients receive or compare service provision between RBHAs.

Besides service data being incomplete, it is also not categorized in a way that would enable the Division to assess service timeliness. The RBHAs currently report some clinical and case management services together, as one service occasion. As a result, the Division does not currently track how long it takes adult clients of any RBHA to receive services after their initial clinical assessment.

Such problems with incomplete data are not new. A 1992 report by the Auditor General (Report 92-1) also noted problems with missing data. At that time, the audit revealed that client service information was missing in over one-fourth of the records reviewed.

Standards not yet defined—In addition to not collecting needed information, the Division is still in the process of developing standards defining what services clients should typically receive based on their illness. Such standards, commonly referred to as practice guidelines, could help the Division assess whether the amount or types of services the RBHAs provide are appropriate and sufficient. While standards are not widely used nationally as a means of ensuring quality at present, some private managed behavioral health care firms have begun to develop and integrate these standards into their quality management efforts. These standards are used as a "red flag," signaling that treatment is different from what would otherwise be expected, and thus requiring service providers to explain treatment decisions that deviate from the standard. Although the Division has begun to develop such standards, it has not set a target date for their completion, or integrated such standards into its quality management plans.

The Division Needs to Take Steps to Improve Oversight

The Division should take several steps to better perform its oversight role. First, it should work toward improving information it keeps about clients and the services they receive. Second, it should adopt needed service standards. Finally, the Division should consider using additional means of monitoring the care RBHAs deliver.

Collect complete information and adopt standards—The Division needs to take steps to collect more complete client information. This could be accomplished in several ways. First, the

Division should begin to enforce the current RBHA contract requirement that service data be complete. By contract, the Division can charge the RBHAs up to $5,000 if they fail to report Medicaid-funded service occasions. Nonetheless, the Division has not issued any such monetary sanctions to date. Second, the Division should add a provision to future contracts requiring RBHAs to pay sanctions if they fail to submit documentation of non-Medicaid funded service occasions. Third, it should examine current processes for collecting and entering information about a client's diagnosis and severity of illness. Interviews with RBHA and division information systems staff suggest that they do not know why such information is incomplete. Finally, the Division could withhold payment to RBHAs if client diagnosis and severity of illness information is incomplete, as the current RBHA contracts allow.

Besides improving information, the Division should continue to develop service standards such as those used by private managed behavioral health care firms and complete such standards by December 1997. The Division should also incorporate these standards into its 1998 quality management plan.

Use more complete information to monitor RBHA performance—When information is complete and standards are developed, the Division can use additional means to monitor service adequacy and effectiveness. For example, the Division could:

- Compare the severity of impairment before and after services to determine whether services help clients. Once the Division determines the effectiveness of services, it could compare such information to service costs to conclude which services are cost-effective.

- Contrast the services provided to clients with the same diagnosis and severity of illness to determine whether different RBHAs provide dramatically different levels of service.

- Compare information on services provided to clients with the same diagnosis and impairment severity to service standards. This would allow the Division to determine if clients receive services that scientific evidence would suggest are appropriate.

Recommendations

1. The Division should make efforts to collect more complete information about client services. To do so, it should:

   - Enforce the current RBHA contact requirement that Medicaid-funded service data be complete and sanction RBHAs that fail to comply;

   - Add a provision to future contracts requiring RBHAs to pay sanctions if they fail to submit documentation of non-Medicaid funded service occasions;

   - Examine current processes for collecting and entering information about a client's diagnosis and severity of illness;

   - Withhold payment to the RBHAs if client diagnosis and severity of illness information is incomplete, as the current RBHA contract allows.

2. The Division should complete its development of service standards by December 1997. In addition, the Division should incorporate these standards into its 1998 quality management plan.

3. The Division should adopt additional methods of monitoring once service standards have been developed and information is complete.

FINDING II

MORE CAN BE DONE TO ENSURE THAT CHILDREN RECEIVE TIMELY AND CONTINUING CARE

The need for the Division to increase its oversight of the behavioral health system, as discussed in Finding I, is evidenced when reviewing the services provided to children. Both the Division and the Regional Behavioral Health Authorities can do more to ensure children receive timely and continuous care. The behavioral health system serves more than 24,000 children with serious behavioral health needs. However, as shown in the case example, some of these children do not receive services within the 30 days required by division policy, while others fail to complete needed treatment. The Division and the RBHAs should take steps to reduce delays and better ensure that children receive needed care.

Children in the Behavioral Health Care System Have Serious Needs

The Division serves thousands of Arizona children with serious behavioral health needs. During fiscal year 1994-95 alone, more than 24,000 children were enrolled in the state behavioral health system. These children are attempting to cope with a wide array of behavioral health problems, ranging from depression due to a parent's divorce to post-traumatic stress disorder resulting from sexual abuse.

The Division provides varying services to these children based on the nature of their illness and how well they function at home and at school. Children who have severe difficulty coping at school and at home (based on a BHS standard assessment) are assigned a case manager who is expected to coordinate their services and regularly monitor their progress through phone calls and personal visits.

Children who function relatively better according to the standard assessment may or may not receive case management services, depending on the RBHA in which they are enrolled. For example, NARBHA (the RBHA for northern Arizona) provides case management to all children regardless of how well they function in society. In contrast, ComCare (the RBHA for Maricopa County) only provides case management for the approximately 30 percent of its 10,000 adolescent clients who function poorly. The other 70 percent of ComCare children are assigned a service coordinator who authorizes their providers to perform services. Service coordinators rarely have contact with clients, in part because each manages over 700 cases.

While ComCare's non-case managed (service coordinated) children are considered to function better at home and at school, they nonetheless have serious behavioral health care problems. For example, the following children were not assigned a case manager at the time of this audit:

- A ten-year-old boy who threatens his family with kitchen knives. The child entered the behavioral health care system after his brother died of cancer, his parents divorced, his father threatened the family with suicide, and his home was burglarized twice. Moreover, he was victimized by his uncle, who sexually molested him.

- An eleven-year-old boy who recently moved away from his physically abusive father. He often threatens his mother and his siblings when he feels that he is not the center of attention.

To evaluate the experiences of children in Arizona's mental health care system, a case file review was conducted. Ninety cases of children who entered the behavioral health care system during the first quarter of calendar year 1995 were studied. Due to time constraints, the review was limited to ComCare and NARBHA clients. These two RBHAs were chosen due to the large number of clients they serve.[1] The 90 cases comprised 30 male ComCare children who functioned fairly well in society and were not case managed; 30 male ComCare children who did not function well in society and were assigned a case manager; and 30 male NARBHA children who functioned fairly well in society and were assigned a case manager.

Some Children Do Not Receive Timely Services

Although timely services are critical to successful treatment, our file review revealed that some children experience long delays before receiving care. In 90 files reviewed, 18 children did not receive treatment within the 30 days required by Division policy for reasons that could not be explained or due to delays caused by the RBHA or service providers. Furthermore, another 15 children in the file review did not receive timely care because the child failed to appear for treatment, canceled an appointment, or was in jail. While some delays are unavoidable, the Division and the RBHAs, such as ComCare and NARBHA, could do more to ensure children receive timely treatment.

Service delays exist—Although timely services are critical to successful treatment, the file review revealed that some children experience long delays before receiving their first service. According to the American Psychological Association, early identification and intervention for children with emotional problems increases the likelihood of positive outcomes. The

[1] The current RBHA for Pima County and southeastern Arizona, the Community Partnership of Southern Arizona, was not chosen for the file review since it did not operate during the time period studied.

Division, recognizing such a need for timely services, requires RBHAs to provide treatment within 30 days of completing a client's initial clinical assessment. Nonetheless, in 90 files reviewed, 18 children did not receive services within 30 days as required. These 18 cases include:

- Thirteen ComCare non-case managed children. These children waited an average of 59 days to receive service;
- Three ComCare case managed children. These children waited an average of 42 days for service;
- Two NARBHA cases. One child waited 33 days before receiving service, while the other waited 86 days.

In all 18 of these cases, delays were either unexplained or attributed to the RBHA or service provider. In 6 of these 18 cases, the child was waiting to see a psychiatrist.

In addition to these 18 cases, another 13 children experienced delays because they canceled or missed appointments. Parents may contribute to such delays since children rely on their parents to provide transportation to services and to act as a liaison between the child and the service provider. Finally, in another two cases, the children did not receive timely services because they were in jail.

Steps needed to reduce delays—While some service delays may be unavoidable, more can be done to ensure that children receive timely services. First, the Division should enforce existing timeliness rules. Although the Division currently requires RBHAs to provide services within 30 days of the client receiving an assessment, the Division's own monitoring reports suggest that most RBHAs consistently fail to comply with this requirement. While the Division's quality management reports have been plagued with erratic data collection and reporting methods, they nonetheless suggest that only BHS-Yuma and the Pinal Gila Behavioral Health Association have ever been able to ensure that clients receive services within 30 days (excluding delays for which the RBHA has a valid excuse, such as the child was in jail) since the Division began measuring timeliness on a quarterly basis in January 1995.

The Division's contract with the RBHAs allows it to issue monetary sanctions against RBHAs that fail to provide timely services. According to the contract, the Division can require a RBHA to pay $2,500 for every month that it fails to meet timeliness standards. Nonetheless, the Division has sanctioned RBHAs only for their failure to provide initial clinical assessments in a timely manner. Division staff responsible for monitoring the RBHAs suggest that the Division has been reluctant to issue such sanctions because it prefers to work cooperatively with the RBHAs to improve performance. While such cooperation can be useful, the Division also needs to enforce its policies when RBHAs fail to comply with them.

The Division should also monitor what efforts RBHAs are taking to improve service timeliness. It currently appears that while RBHAs are making some efforts, such efforts could be improved. For example, ComCare is currently working to improve delays for non-case managed children. Recognizing that its service authorization process for non-case managed children contributes to delays, ComCare began to streamline its service authorization process in May of 1996. Instead of requiring providers to submit a written request to begin services, ComCare now allows providers to deliver up to $162 worth of services per month per child without prior written authorization. While such policy change is an improvement, it appears that ComCare needs to do more to inform its providers of this new policy. As of June 1996, only three out of the six ComCare providers' clinical directors contacted indicated they were aware of the policy change.

Many Cases Closed Before Treatment Is Complete

In addition to not receiving timely services, many children do not complete their prescribed treatment. Even though service completion is vital to a child's future mental health, many children drop out of treatment before it is successfully completed. Although parents may contribute to children failing to complete services, the Division and the RBHAs could be more proactive in trying to keep children in needed treatment. The Division should require that RBHAs attempt to contact parents an established minimum number of times before closing cases.

Many children fail to complete treatment—Although service completion is critical, a number of children never finish needed treatment. According to an expert on children's mental health issues, adequate services are needed to ensure that children stay on track in reaching their full social and educational development. Nonetheless, in 23 of the 90 case files reviewed, children dropped out of treatment before services were completed. In addition, analysis of the Division's automated information system records for all children's cases closed during the first three months of 1995 shows over 40 percent of the cases were closed because the children dropped out of the system. Forty-five percent of all NARBHA and 42 percent of all ComCare cases were closed during this period because contact was lost with the child. These figures do not include another 11 percent of all NARBHA cases and ComCare cases that were closed because the child moved.

As with service delays, parents may contribute to children's cases closing without the RBHA having further contact with the child. The file review revealed that many parents of children in the behavioral health system have drug, alcohol, or other problems. Such parents may fail to schedule or appear for their child's needed appointments.

More efforts needed before cases are closed—While parental inaction explains some children's failure to complete treatment, the behavioral health system could do more to ensure that children receive all the services they need. Division policy currently states the RBHAs "will make every effort" to engage clients in the treatment process when they refuse services or fail to appear for appointments. Nonetheless, the RBHA or provider did not make any attempt

to contact children or their families before cases closed in several of the cases reviewed. For example, no attempt was made to contact the mother of a four-year-old boy who failed to return for treatment. His case was closed without further contact, even though the child bites and hits himself and has expressed a desire to kill himself.

Division policy should specify how many contacts should be attempted before cases are closed. Such a policy would require RBHAs and providers to make reasonable attempts to ensure that children remain in treatment.

Recommendations

1. The Division should monetarily sanction RBHAs if they do not provide services to clients within 30 days of clients' initial assessments.

2. The Division should monitor ComCare's efforts to streamline service authorization for non-case managed children.

3. The Division should adopt a policy specifying how many contacts should be attempted before cases are closed due to lack of contact with the client.

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FINDING III

THE DIVISION COULD INCREASE COMPETITION IN THE BEHAVIORAL HEALTH CARE SYSTEM

The Division of Behavioral Health Services could do more to increase competition in the behavioral health care system. While the Division appropriately allows vendors to vie for Regional Behavioral Health Authority contracts in each geographic area, it could do more to increase the number of bidders competing for such contracts. Although some factors outside of the Division's control have limited competition in the past, the Division can take steps to increase competition for lucrative RBHA contracts in the future.

Competition has received considerable attention as a tool for reforming or improving the health care system. Competition is important because it can help states to deliver more effective services at lower prices. It can reduce service costs, while increasing service quality. Additionally, competition provides a choice among vendors delivering such services.

Experts reviewed competition in Arizona—In response to legislative interest, the Office of the Auditor General hired experts in the economics of managed behavioral health care who are familiar with managed care contracting in other states.[1] The consultants were asked to answer two questions: (1) Would it be appropriate for RBHAs to compete for enrollees in Arizona's behavioral health care system?; and (2) Why was there only one bidder for the 1995 Maricopa County RBHA contract? To answer these questions, the consultants built on their extensive experience by reviewing Arizona's 1995 RBHA contract procurement process. As a part of that review, the consultants analyzed data provided to prospective bidders and compared Arizona's experiences to other states. In addition, the consultants interviewed officials from the Division, the Arizona Health Care Cost Containment System, ComCare, and private organizations that considered bidding on the RBHA contracts. This finding summarizes the consultants' conclusions. The full text of their report is located in the Appendix (see pages a-i through a-xix).

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[1] Richard G. Frank, Ph.D. of the Harvard Medical School; Howard H. Goldman, M.D., Ph.D. of the University of Maryland School of Medicine; and Thomas G. McGuire, Ph.D. of the Boston University Department of Economics. Haiden A. Huskamp, a doctoral candidate in health policy at Harvard, also co-authored the consultants' report. The consultants' qualifications are summarized in the Appendix.

Not All Kinds of Competition Are Appropriate

According to the consultants, Arizona's behavioral health system uses the most appropriate type of competition. In managed health care, vendors can compete for state contracts and/or for enrollees. Although competition for the RBHA contracts is desirable, the consultants found that competition for behavioral health care clients (enrollees) can cause problems.

Types of competition—Two main types of competition in managed health care exist: competition for contracts and competition for enrollees. In Arizona's behavioral health system, competition for contracts currently exists. Multiple vendors bid on a contract to serve as the single RBHA for a geographic area. The one winning bidder is expected to serve all enrolled clients in the geographic area. Similarly, Arizona's medical health care system for the indigent (AHCCCS) also allows multiple vendors to compete for state contracts. However, AHCCCS goes a step further by awarding contracts to multiple health plans that then compete for enrollees within the same geographic area. Therefore, in contrast to behavioral health, there can be several medical health care contractors operating within the same geographic region. The Office of the Auditor General asked the consultants to determine whether competition for enrollees would be appropriate for Arizona's behavioral health care system.

Competition for individual clients problematic—The consultants found that competition for clients does not work well in behavioral health care. Specifically, such competition would be problematic for the following reasons:

- **Competing plans may avoid enrolling certain clients.** Because the RBHAs receive a fixed payment, they might avoid clients with more expensive needs while enrolling clients with less expensive needs. Many behavioral health problems are unusually persistent and severe and RBHAs could identify potential enrollees who are likely to face ongoing, expensive illnesses. Although health care plans may also wish to avoid high-cost enrollees, it is more difficult to identify such clients out of the larger population.

- **Some state monies would be difficult to divide among multiple behavioral health care plans competing in a single area.** Unlike AHCCCS, the Division provides a significant amount of monies to RBHAs through lump sum payments. The lump sum payments are divided among the RBHAs based on the availability of state funds, not on the basis of how many clients each RBHA is expected to serve. If clients could choose among competing plans within the same geographic area, it would be even more difficult to decide how much money to give each RBHA.

- **Multiple plans would increase administrative costs.** If there were multiple RBHAs operating in a given area, each RBHA would have an administrative function. Some of these functions, and their associated costs, would be unnecessarily duplicative. The consultants believe that total costs would increase by as much as 5 percent if more than one RBHA were to compete for clients in a geographic area.

In contrast, competition for the RBHA contracts avoids these problems while still reducing costs, improving quality, and allowing the State to choose among vendors.

The Division Can Take Steps to Increase the Number of Bidders for Future Contracts

In addition to determining whether competition for enrollees is appropriate, the consultants also determined why only one bidder existed for the 1995 Maricopa County RBHA contract. The consultants found that several factors, some of which were outside of the Division's control, limited the number of bidders. They also concluded that the Division could increase future competition by eliminating some requirements placed on bidders in the past and limiting the financial risk that bidders associate with the RBHA contracts.

In contrast with other states, only one bidder vied for the multi-million dollar contract to provide behavioral health care services in Maricopa County. The contract's value was expected to exceed $75 million, and for the first time the contract permitted RBHAs to reinvest any savings earned. In comparison, other states, such as Colorado, Iowa, and Massachusetts, received multiple bids for behavioral health contracts.

Factors outside of the Division's control limited competition in the past—The consultants found that some factors outside of the Division's control may have kept potential bidders from submitting bids for the RBHA contracts in 1995, including:

- **Growth and change in the behavioral health system.** Potential bidders may have been hesitant to submit proposals because the State's behavioral health system was undergoing rapid, dramatic reform. Experts have described Arizona's pace of change as "dizzying."[1] As a result, vendors were not certain what was going to happen.

- **Perception of lower profits in Arizona's system.** Potential bidders may have believed that there were fewer opportunities to profit in Arizona than in other states. Managed care organizations have typically profited by applying cost-savings strategies in states with long-standing Medicaid programs. These programs typically tended to spend a lot of money to hospitalize clients. Managed care organizations profit by reducing the number of expensive hospital admissions, instead providing community-based services. However, Arizona was one of the last states in the nation to begin a Medicaid-funded program and it quickly adopted cost containment strategies. Therefore, since Arizona already relied on less expensive, community-based treatment, vendors may not have believed significant cost savings and resulting profits could be achieved.

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[1] McGuirk, Frank D. et al., *Blueprints for Managed Care: Mental Healthcare Concepts and Structure,* U.S. Department of Health and Human Services (Center for Mental Health Services). 1995: 37.

- **Requirements resulting from the Arnold v. Sarn lawsuit.** Potential bidders may have been discouraged because the 1981 Arnold v. Sarn lawsuit increased the standards that RBHAs must meet. The Court found that the Division, through the RBHAs, must provide a "full continuum of mental health services to all class members [seriously mentally ill, indigent adults in Maricopa County]" and meet numerous requirements. Furthermore, the Court Monitor, who oversees the lawsuit's settlement, did not disclose to inquiring vendors that the existing RBHA had not met these requirements and was not sanctioned for failing to meet them.

- **Financial losses incurred by existing RBHAs.** Vendors may have been discouraged from bidding because some existing RBHAs were losing money at the time. For example, ComCare experienced a deficit of over $7 million for fiscal year 1993-94. In addition, another RBHA, the Arizona Center for Clinical Management, lost $7.7 million in fiscal year 1993-94 and eventually ceased operations in 1995.

Although some of these factors that limited competition in 1995 still exist today, other changes affecting competition could occur. The consultants noted that the national market is currently very competitive, but that existing providers (nationally and locally) are consolidating, which could reduce competition in the future. Therefore, they recommended that the Division either rebid the current RBHA contract when it expires in 1998, or extend the contract for no more than one year.

Excessive requirements placed on bidders—In addition to factors outside of the Division's control, the consultants found that several requirements placed on bidders as part of the RBHA procurement process also limited competition. First, the Division did not allow for-profit organizations to bid on RBHA contracts in 1995.[1] This requirement kept many managed behavioral health care firms from bidding since the industry consists predominately of for-profit vendors. The Division created this requirement because it mistakenly believed that only nonprofit organizations could receive certain federal dollars. However, a recent clarification of federal government rules suggests that for-profit organizations can receive these federal grant monies. As a result, the Division can eliminate this restriction in the future.

Potential vendors were also restricted by requirements pertaining to the RBHA boards of directors. The 1995 request-for-proposals (RFP) specified that the winning bidder's board of directors must have between 9 and 13 members, including representatives of the medical community, an alternative provider of health care (not a medical doctor), a facility representative, a consumer of services (a client), a client's family member, a representative of the community, a program representative, and a business representative. Such requirements were more extensive than those required by other states. Few existing organizations could have met these standards without restructuring their boards.

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[1] For-profit vendors were allowed to set up a separate nonprofit unit or form a partnership with a local nonprofit organization. However, no for-profit vendors chose this option to bid on the 1995 Maricopa County RBHA contract.

The Division developed these criteria because a court order resulting from the Arnold v. Sarn lawsuit requires that both a client and a client's family member serve on the RBHA board. However, this agreement does not specify that the board has to have between 9 and 13 members or that it must include all the representatives specified in the RFP. Thus, the Division could drop requirements not mandated by the lawsuit in future RFPs. Instead, the Division could achieve representation by requiring RBHAs to establish advisory boards.

The consultants also found that the large number of detailed questions contained in the 1995 RFP kept some potential vendors from submitting bids. In fact, the consultants characterized Arizona's RFP as among the most burdensome in the country. They also noted that vendors would have found it difficult to respond to the RFP questions without previous, intimate knowledge of the State's behavioral health care system. For example, the RFP asked bidders to describe in detail their plan to collect data for a prevention program specifically designed for Arizona. By reducing the number and detail of such questions in future RFPs, the Division can attract more competition for the RBHA contract.

Financial risk associated with the contracts—In addition to placing excessive contract requirements on bidders, the consultants also believed that the amount of financial risk associated with the contract also limited the number of potential bidders. The RBHA contracts could have been perceived as risky for two reasons.

First, the Division provided inadequate data to potential bidders. Vendors need past information on service expenses, number of services provided, and number of clients enrolled in order to estimate the amount for which they would agree to provide services. Without reliable information, bidders can be exposed to financial losses. While such information was critical, the Division did not adequately provide such data in 1995. For example, the consultants found that the data given to vendors about service expenses and the number of clients served covered different time periods and, therefore, could not be used to determine capitation rates (amount for which the RBHA agrees to provide services per person).

Second, the RBHA contracts did not limit losses and profits that a RBHA could incur. The consultants believe that more vendors may have been willing to bid if a "risk-sharing" arrangement existed between the vendor and the Division. Under such an arrangement, vendors would have assurance that they would not face unreasonable losses. Other states, such as Colorado, Iowa, and Massachusetts, have risk-sharing arrangements with their vendors.

The Division could make changes so that RBHA contracts appear less financially risky in the future. First, it could provide adequate data to potential bidders. Second, the Division could adopt risk-sharing methods. For example, the State could set a "risk corridor," a maximum dollar or percentage loss that a RBHA could experience in relation to the contract. If a RBHA's service costs exceed this amount, then the State would pay a percentage of these costs.

Conversely, the State would share any profits over a similar threshold.[1] Both Iowa and Massachusetts have such profit-sharing arrangements with vendors.

Before any risk-sharing arrangement is established, the Division would need to determine which form of risk sharing is most appropriate for Arizona. The Division has studied a form of risk sharing in the past. However, the Division did not consider other forms, such as risk corridors, which the consultants believe could be beneficial.

Recommendations

1. The Division should either rebid the current Maricopa County RBHA contract in 1998, or extend it for no more than one year.

2. The Division should revise future RFPs so that for-profit organizations can bid on RBHA contracts.

3. The Division should write future RFPs for RBHA contracts so that the only required members on the winning vendor's board of directors are a client and a client's family member, as required by the Arnold v. Sarn lawsuit.

4. The Division should change and reduce the number of questions asked of bidders in future RFPs so that potential RBHA vendors without extensive experience in Arizona can bid.

5. The Division should improve data provided to potential bidders. For example, the Division should ensure that data about the number of clients served, the monies spent on services, and the services provided are for the same time period.

6. The Division should determine which form of risk sharing is the most appropriate for Arizona. It should then report to the Legislature regarding the possible restructuring of future RBHA contracts to include financial risk sharing with vendors. Based on the report, the Legislature should consider directing the Division to restructure future contracts.

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[1] In effect, the State already assumes risk for a RBHA's financial failures. For example, in 1994, the Legislature authorized the use of $5.6 million in behavioral health monies to pay the debts of a failed RBHA in order to avoid penalizing service providers for the RBHA's financial failure.

FINDING IV

STEPS SHOULD BE TAKEN TO ENSURE THAT MORE PEOPLE IN CRISES RECEIVE ACCESSIBLE, ONGOING CARE

The Division should do more to ensure that more people in Maricopa County experiencing behavioral health crises receive accessible, ongoing behavioral health services. ComCare (the RBHA for Maricopa County) has made changes that allow it to control access to crisis services so that behavioral health care costs can be contained. While this change is in line with the philosophy of managed care, changes are needed to better coordinate services and make them more accessible to the police and fire departments. The Division should encourage ComCare and police and fire departments to work together so that ComCare is more involved in police and fire responses to behavioral health crises. In addition, the Division should ensure that ComCare increases the number of urgent care centers and mobile crisis teams so police and fire workers can more easily transfer people to ComCare for assessment and ongoing services.

Background

The Division of Behavioral Health plays an important role in ensuring that people experiencing behavioral health crises receive needed care. State law requires the Division to ensure that a comprehensive continuum of behavioral health services exists, including services for people experiencing behavioral health crises. Through the Department of Health Services' contract with AHCCCS, the Division is also responsible for ensuring that behavioral health services are available and accessible for Medicaid recipients experiencing behavioral health crises. In particular, AHCCCS's contract with the Department requires BHS to ensure that an adequate number of facilities exist in enough locations to provide emergency services.

In order to fulfill its statutory responsibility, the Division contracts with each RBHA to provide crisis services. These contracts require each RBHA to ensure that people experiencing behavioral health crises are assessed and treated in a timely manner. While each RBHA has this contractual obligation, the system established for responding to such crises differs between regions. This audit examined ComCare's system for responding to behavioral health crises in Maricopa County. ComCare's system was selected for review due to its size and because fire and police departments involved in responding to behavioral health crises had expressed concerns in the past two years about the ComCare system.

Crisis System Changes in Maricopa County Create New Challenges

In order to control behavioral health care costs, ComCare has made changes to control access to state-funded behavioral health care services. While such change is in line with the philosophy of managed care, ComCare's efforts may have created new problems. In particular, the changes may result in police and fire departments handling behavioral health crises without ComCare's involvement. Such involvement by ComCare is often needed to ensure that people receive ongoing behavioral health treatment.

System for delivery of crisis services changed—Starting in January 1995, ComCare made significant changes to the system for responding to behavioral health care crises in Maricopa County. Previously, people experiencing behavioral health crises could go directly to contracted providers to receive crisis counseling. In addition, contracted service providers had the ability to decide when a mobile team of crisis counselors should be sent to someone's home, or when a person experiencing an acute crisis should receive intensive, inpatient services. Since providers generally received a fee for each service delivered, they had little incentive to restrict costly services provided to people.

Starting in January 1995, ComCare began controlling access to state-funded crisis services. Under the new system, ComCare does not allow providers to treat walk-in clients for crisis counseling. Instead, anyone experiencing a behavioral health crisis must first be assessed to determine what type of care is most appropriate given the seriousness of their condition. Such assessments are performed by crisis hotline workers, mobile crisis team counselors, ComCare case managers, or clinicians at an urgent care center located in central Phoenix.

New system has benefits—ComCare's changes to its crisis service delivery system has benefits. By controlling access to more costly, intensive services, ComCare can better control behavioral health care costs by assessing when costly services are medically necessary. In addition, it can better ensure that people receive care appropriate for their condition, and that treatment occurs in the least restrictive setting possible. Such efforts to control costs and assess when expensive services are needed are a feature common to much of managed health care.

New system has inhibited ongoing care—While the new system may control costs, its implementation may have also created new problems. As a result of these problems, police and fire departments began handling some behavioral health crises without ComCare's involvement, even though such involvement is necessary to ensure that people receive continuous behavioral health treatment beyond the immediate crisis.

When changes in the crisis system first occurred, ComCare did not adequately inform police and fire department workers involved in behavioral health emergencies of system changes. In addition, it became more difficult for police and fire department employees to transfer someone experiencing a behavioral health crisis to ComCare for services. Police and fire department employees could no longer simply transport a person who seemed to be

experiencing a behavioral health crisis to a service provider or to an inpatient facility. Instead, they had to either 1) wait for a mobile crisis team to perform an assessment of the person in crisis; or 2) transport the person in crisis (sometimes at great distances) to the central Phoenix Urgent Care Center and wait with the person for an assessment before more intensive services could be authorized.

As a result of poor communication and the more time-consuming process, police and fire workers sometimes began to handle behavioral health crises alone without ComCare or its contracted providers' involvement. ComCare has subsequently made some efforts to better inform fire and police employees about behavioral health services. Nonetheless, many calls are still handled without ComCare's involvement. In our review of the Phoenix Fire Department's responses to behavioral health care crises during the week of April 24 through 30, 1996, only 10 of the 26 responses involved ComCare as well as the fire department. Even in the 7 cases where the person in crisis was an enrolled ComCare client, ComCare was involved in only 3 of them.

Changes Needed to Ensure Crisis Services Are Ongoing and Accessible

The Division should ensure that crisis services in Maricopa County are made more accessible. First, it should encourage ComCare to better coordinate its services with police and fire departments involved in behavioral health crises so that ongoing treatment can be delivered. Second, the Division should encourage ComCare to increase the number of urgent care facilities and mobile crisis teams currently available. Finally, the Division should specify just how many mobile crisis teams and urgent care centers should be available in future RBHA contracts so that RBHAs can be held accountable for maintaining an adequate and accessible crisis system.

Better coordination needed—The Division should encourage ComCare to make efforts to better coordinate behavioral health services with police and fire departments. According to the National Institute of Mental Health, state mental health agencies need to initiate such working relationships since numerous agencies share responsibility for supporting the needs of the mentally ill.

Currently, several opportunities exist for enhanced cooperation in Maricopa County. For example, because the police and fire departments are involved in behavioral health incidents, it is important for ComCare to either be involved in or made aware of such crises so that it can deliver the ongoing care that is needed to prevent further crisis episodes.

The Division should work with ComCare, police, and fire departments to develop a written agreement between the three groups to improve coordination. Such an agreement could ensure that ComCare providers are called to respond to behavioral health related 911 calls whenever possible. The agreement could also include a commitment that those departments routinely

notify ComCare of the event. A similar agreement currently exists between police and the Department of Mental Health in Los Angeles.

System capacity should be increased—The Division could also encourage ComCare to increase the number of mobile crisis teams and urgent care centers so that crisis services are more accessible. Currently, the number of urgent care centers available appears to be inadequate. Only one such center currently operates in Maricopa County, even though a 1994 panel of national experts convened by the Division determined that Maricopa County needed four urgent care centers. In addition, ComCare lacks a sufficient number of mobile crisis teams. ComCare's contracted mobile crisis team providers responded to only 616 clients per month on average in 1995, even though the same panel of experts suggested that there is a need for mobile crisis teams to be able to respond to 1,243 crisis episodes per month in Maricopa County.

The Division should encourage ComCare to increase system capacity to levels recommended by the 1994 panel of experts. Although the Division had previously unsuccessfully requested an increase of $4.3 million to expand crisis services, it appears that ComCare possesses enough money to enhance system capacity. ComCare currently has a fund balance that includes $10.8 million in unrestricted monies. The Division should analyze whether this sum is sufficient to expand and sustain service capacity to recommeded levels. The Division should make additional appropriations requests only if existing funding is inadequate.

Changes needed in future contracts—The current RBHA contracts do not contain specifics regarding the necessary capacity of the RBHAs' crisis service systems. As a result, the Division has limited means of ensuring that ComCare or any other RBHA develops sufficient crisis system capacity. While the Division may be able to encourage the RBHAs to improve system capacity during its capitation rate negotiations, the Division should also adopt more specific language in RBHA contracts outlining how many and what types of crisis services should be available so it can also sanction the RBHAs if system capacity is deemed inadequate.

Recommendations

1. The Division should encourage ComCare to develop a written agreement with the police and fire departments to ensure that ComCare providers are called to respond to behavioral health related calls. The agreement would also include a commitment that those departments routinely notify ComCare when they have responded to a person experiencing a behavioral health crisis.

2. The Division should encourage ComCare to use available monies to increase the number of urgent care facilities and mobile crisis team providers. The Division should request additional appropriated funds only if analysis reveals existing monies available to ComCare are inadequate.

3. The Division should specify in future RBHA contracts how many and what types of crisis services should be available so it can also sanction the RBHAs if system capacity is deemed inadequate.

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FINDING V

THE DIVISION CAN IMPROVE REPORTING OF ADMINISTRATIVE, CASE MANAGEMENT, AND SERVICE COSTS

The Division of Behavioral Health Services needs to change the way RBHAs report costs. The Division's broad financial reporting guidelines allow RBHAs to classify direct program services and a portion of their administrative-related expenses as case management costs. As a result, it is difficult for the Division to assess case management costs, compare RBHA expenses, and contain administrative costs. The Division should adopt financial guidelines similar to those developed by AHCCCS for Arizona Long Term Care System providers so that costs for services, case management, and administration can be better assessed and compared.

The behavioral health system has been criticized for high administrative costs. The Health Care Financing Administration, the federal overseer of behavioral health Medicaid assistance, criticized Arizona's behavioral health system in 1993 for its multiple layers of administration and high administrative expenses. Such high costs were also noted in a 1992 Auditor General report (Report 92-1). That report estimated the Division's administrative costs (including service provider administrative costs) to be over 20 percent of the total money it received for seriously mentally ill adults.

In addition to its concern with high administrative costs, the Health Care Finance Administration has also expressed concern about the cost of case management services. In fact, large amounts of money are spent on such services. For example, the Maricopa County RBHA, ComCare, reported $29 million in case management expenses in fiscal year 1994-95.

While financial statements for all RBHAs were examined in the review of behavioral health expenses, in-depth analysis of how RBHAs report expenses was limited to three RBHAs due to time constraints. ComCare was chosen for review due to its size and the large number of dollars it reports it spends on case management. The other two RBHAs, BHS-Yuma and SEABHS, were chosen since their method of reporting expenses facilitated examination of administration and case management costs.

Costs Difficult to Assess or Compare

The Division's broad financial reporting guidelines allow RBHAs to report some administrative and service-related expenses as case management expenses. As a result, it is difficult to assess

actual case management costs or compare RBHA expenses. In addition, such broad reporting guidelines may lead to RBHAs understating their administrative costs.

Administrative and service-related expenses reported as case management—Currently, the Division's financial reporting guidelines allow RBHAs to report some administrative-related costs as case management services. For example, rent for buildings where case managers work and costs of phones and phone lines used by case managers can be reported as case management expenses. Examination of financial statements for three RBHAs—ComCare, BHS-Yuma, and Southeastern Arizona Behavioral Health Services (SEABHS)—revealed that all three reported such expenses as case management.[1] Most organizations consider such expenses to be administrative costs rather than case management expenses.

The Division's financial reporting guidelines also allow some service expenses to be reported as case management costs. For example, ComCare currently reports salaries for people such as clinicians who work at case management sites as case management expenses. Consequently, service and case management costs cannot easily be distinguished.

Broad guidelines make it difficult to assess and compare costs—Because the Division's financial reporting guidelines allow administrative and service-related expenses to be reported as case management, it is difficult to determine the actual costs for case management services the RBHAs deliver. As a result, it is difficult to compare service and case management expenses between RBHAs. Such comparisons are needed for the Division to assess the performance of the contracted RBHAs.

Guidelines may allow understatement of administrative expenses—In addition to making it difficult to compare costs, the Division's current financial reporting guidelines may result in RBHAs understating administrative costs. For example, administration costs would appear much higher if administrative-related expenses currently reported as case management expenses were reclassified, as shown in Figure 2 (see page 35).

Such understatement of administrative costs may undermine attempts to ensure services are cost-effective. The Division currently requires RBHAs to spend no more than 8 percent of the Medicaid money they receive on administration. Since current financial reporting guidelines allow some administrative expenses to be reported as case management, such efforts to contain administrative costs may be thwarted.

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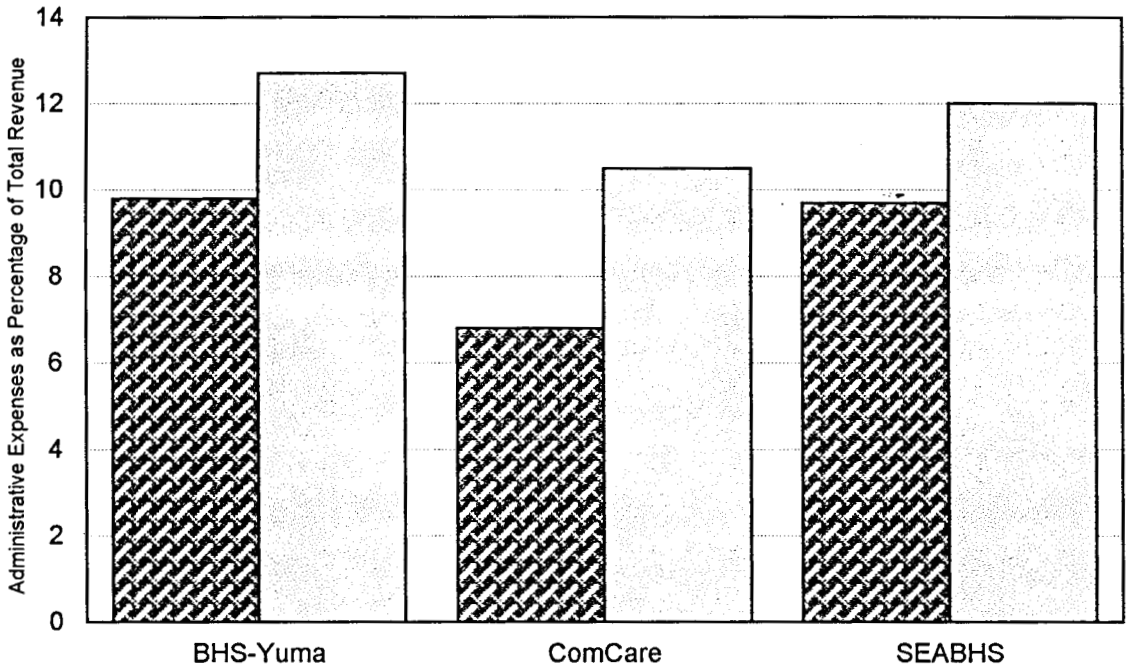
[1] SEABHS is a former RBHA for southeastern Arizona. SEABHS combined with other providers to become of the Community Partnership of Southern Arizona, the current RBHA for both Pima County and southeastern Arizona.

Figure 2

**Department of Health Services—
Division of Behavioral Health Services
Administrative Expenses for Three Regional Behavioral
Health Authorities as Percentage of Total Revenues
Year Ended June 30, 1995**



Administrative expenses reported in audited statements.

Administrative expenses plus occupancy, depreciation, and operating costs that are currently reported under case management.

Source: Auditor General staff analysis of regional behavioral health authority audited statements of revenues and expenses and statements of functional expenses for the year ended June 30, 1995.

The Division Should Change Reporting Guidelines

The Division should adopt financial reporting guidelines similar to those adopted by AHCCCS Arizona Long Term Care System (System) contractors. By changing its financial guidelines, it will be easier to determine actual costs and compare such costs between RBHAs.

Arizona Long Term Care System contractors are similar to RBHAs in that they contract with a state agency (AHCCCS) to provide long-term health services, including case management to the poor. However, the financial reporting guide used by these contractors is different than the reporting guide the RBHAs used. The reporting guide developed by AHCCCS for System-contracted providers only allows costs of case managers' salaries, benefits, travel, and training to be reported as case management expenses. As a result, AHCCCS is able to discern how much is spent on case management, and compare costs for case management and administration costs between System providers. The Division should adopt similar financial guidelines so it can better assess costs and compare RBHA expenses.

Recommendation

1. The Division should develop detailed accounting guidelines that allow RBHAs to report only salaries, benefits, travel, and training as case management costs. Other costs currently deemed "case management" should be reclassified as either service or administrative expenses.

Agency Response

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Arizona Department of Health Services

Office of the Director

1740 W. Adams Street
Phoenix, Arizona 85007-2670
(602) 542-1025
(602) 542-1062 FAX

FIFE SYMINGTON, GOVERNOR
JACK DILLENBERG, D.D.S., M.P.H., DIRECTOR

December 11, 1996

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

Dear Mr. Norton:

Thank you for requesting our response to your recent report on the performance audit of the Arizona Department of Health Services, Division of Behavioral Health Services. Overall, we were pleased that your staff noted our continuing improvement in a variety of areas. As noted in your report, the amount of change faced by our system of care in the past few years has been "dizzying". We continue to address problems as quickly as possible, and build toward increasing access and accountability. We appreciate your feedback on our programs, and will share this report with our contractors.

Finding I: Division Oversight of the Behavioral Health System

As noted in the report, the Division uses several methods to oversee behavioral health services. Currently, there are numerous data elements that are collected with regard to demographic information, as well as services that are delivered. We are currently reviewing our system to ascertain whether there are changes we need to make in order that our oversight responsibilities can be improved, and our administrative requirements streamlined. Our data system is not designed as a clinical information system. It is designed to collect demographic and encounter data. Our clinical oversight is best conducted through on-site case reviews. A thorough review of clinical records is necessary to accurately ascertain quality of care, and determine programmatic trends.

As pointed out in your report, even the national private firms have only begun to develop service standards that will be integrated into their quality management efforts. The Division of Behavioral Health Services, through the efforts of its medical directors, has developed an entire series of clinical practice guidelines for use by treatment professionals in the field. We are ahead of national efforts in this area, and are pleased with our progress. Your recommendation to set time frames for better integration into our quality management system is a good one, and we will work with the medical directors on this issue.

We are also reviewing ways to streamline our administrative requirements and collect only those clinical data elements that will assist in making determinations about improved health outcomes. This information alone cannot address quality of care. Client Satisfaction Surveys, client file reviews, and analysis of service data must also be used to develop an overall picture of system functioning. For example, if one RBHA has different levels of service for similar clients, yet their client satisfaction is high; their quality of care is good, as measured through review of their client records; and, their financial picture is stable, then perhaps they have found a better way to serve their clients. The use of clinical practice guidelines should only serve as a guide toward system expectations, not as the definitive measure of whether quality of care has been delivered.

Since the implementation of Title XIX, the Division has had a grievance and appeals system for addressing complaints arising from clients, their guardians/custodians and designated representatives. We track the number of complaints handled through this process and trend this information over time to determine areas for improvement in the service system. We both initiate individual as well as system wide corrective action through this process.

We are working with our stakeholders to identify system goals. From those goals, we will begin development of performance measures to better identify which clients are functioning better at home, in school, or at work. This process will cover the bulk of the next year, as members of communities across the state will be asked to work with us on identifying reasonable goals and performance measures. In the process, we also hope to remove administrative barriers that may be reducing the accessibility of our system. While we cannot provide services to everyone who may need them, due to funding constraints, we can continue to improve our accessibility for the people we serve. We appreciate your recommendations in these areas, and will work on them in the upcoming year.

Finding II: More Can Be Done To Ensure That Children Receive Timely And Continuing Care

You recommended that we sanction Contractors for failure to meet certain timelines. We have sanctioned Contractors for failure to meet required deadlines, and will continue to do so when it is determined that substantial progress is not being made as soon as necessary. We will also review our policies for when sanctions should be applied.

In addition, we will review our policies with regard to maintaining contact with families. As noted, unless court ordered, our system cannot force families into treatment. Involvement of the families in treatment is a critical component of treatment success. We accept the responsibility that we must provide the supportive services necessary to make access to treatment easy and affordable. However, families must be responsible for following up with the necessary appointments, and for maintaining contact with treatment personnel.

We would like to clarify some issues about case management. In the past, our system has been criticized for case management clinical team costs, especially for children and adults whose problems are not as severe. We have been evaluating our case management requirements, and now allow more flexibility in how case management functions are provided.

Some therapists may provide case management services, and clinical teams may provide services for only the most complex situations. Each geographic service area has been modifying its system of care to be the most effective and cost efficient. COMCARE, in particular, has been reviewing its approach to case management and service coordination in order to streamline its process and ensure its effectiveness. For children who have their services coordinated, the treatment therapist may provide many case management functions, rather than someone at the RBHA. We are continuing to review the evolution of our case management system, and will likely develop additional guidelines in the next year.

Finding III: The Division Could Increase Competition in the Behavioral Health System

As you know, this area has been discussed for the past few years. We appreciate your efforts to retain a consultant in this area who acknowledged our use of the most appropriate type of competition. Unlike typical insurance plans, our services must be available to both people who are insured through Medicaid, as well as those members of the community who are uninsured or underinsured. We do not have a defined group of eligibles. Our responsibility is both to meet community needs and the individual needs of our clients. As your consultant pointed out, some of our state monies would be difficult to divide among multiple behavioral health care plans in a single area. In addition, it is likely that multiple plans would increase administrative costs.

As we move toward our next bid cycle, there will be a number of issues to identify and resolve. The recommendations you presented, as well as recommendations for change that we have received from other sources will be used to develop the best proposal process possible. While we want to inject as much competition as possible into the system, we also want our bidders to be able to respond to community needs and requirements. We will investigate further your suggestion on risk sharing options with vendors.

Finding IV: Steps Should Be Taken To Ensure That People In Crises Receive Accessible, Ongoing Care

As your report indicated, COMCARE is working with both Phoenix police and fire departments to better coordinate their efforts. COMCARE installed a direct line to Crisis line supervisors for the exclusive use of police and fire agencies. Current and planned Urgent Care Centers have a separate entrance for the police and fire personnel accompanying clients into the Centers. COMCARE set a performance standard of having police and fire personnel spend no more than 10 minutes dropping off a client, unless they are a witness for the petition process. Police are on the planning committees for the West and East Urgent Care Centers. Calls to 911 "jump" all other calls in the COMCARE crisis line phone queue. Finally, Agreements on the COMCARE Crisis Response Network and the 911/fire interface process were approved by the City of Phoenix Fire Department.

Since the change to the crisis system, COMCARE has been meeting weekly with police and fire personnel to improve coordination. These meetings are now held on a monthly basis,

since the number of coordination issues has declined. ADHS/BHS has also made efforts to increase education for police with regard to mental health issues and how to work with people exhibiting behavioral health problems. We worked in collaboration with AZ Post to develop a video telecourse that was attended by over 1,000 police and criminal justice staff statewide. AZ Post reported that it was one of the best training programs they had produced.

With regard to system capacity, an additional Urgent Care Center for the West side has opened. An Urgent Care Center for the East Valley is being planned for FY 1997. Three other Urgent Care Centers are planned in the South, North and Southwest, if resources allow and need is documented. Currently, there are 12 adult, 9 child/adolescent mobile crisis teams, and 3 psychiatric ambulances. In addition, there are 12 transport teams to alleviate tying up a mobile team for transport only. COMCARE is currently assessing the data to evaluate response time. If the complement of current teams can respond to a crisis request within the proposed 15 minute time limit, it may not be necessary to expand the number of crisis teams at this time. ADHS/DBHS will continue to work with COMCARE in this needs assessment process. In addition, we will continue to monitor the service quality and accessibility of the crisis network.

With regard to financial resources, your report mentioned COMCARE's current fund balance. Some explanation is necessary. Of the $18,767,307 that is reported as COMCARE's ending fund balance for FY 95-96 in their audited financial statements, $7,917,701 is required for capitalization, performance bond requirements, and Board designated capitalization. These requirements must be met and the funding cannot be utilized for ongoing operations. That leaves a balance of $10,844,606. Of the $10,844,606, $5,000,000 is one-time only funding from Maricopa County for reconciliation of prior years. In fact, the annual contribution from the County declined by $500,000 in the current year. COMCARE's FY 96-97 operating budget includes the remaining $10,844,606, which are being designated for support of programs. The $7,917,701 amount of the fund balance which is designated for capitalization and performance bond is 4.5% of COMCARE's total operating budget for FY 96-97. It would be prudent that they reserve these funds for payment of provider claims, since their future revenue may decline as the Title XIX eligible population decreases as a consequence of welfare reform. This fund balance is used both to cover short term dips in operating funds, and to build services across all programs, not just programs for people with serious mental illness.

Finding V: The Division Can Improve Reporting Of Administrative, Case Management, and Service Costs

In this finding, you recommended that ADHS/DBHS review and adopt financial guidelines similar to those adopted by AHCCCS Arizona Long Term Care System (ALTCS). While the ALTCS system is not totally comparable to our acute care based model, we will review the financial guidelines and necessary changes. The ALTCS system does not use a clinical team in the same way that a clinical team is used in our system, so some of the requirements may not be appropriate for our clinical model. However, we are always looking for ways to improve our financial reporting requirements, and will evaluate this approach, as recommended.

We want to thank you and your staff for your time and effort in providing recommendations that will help us improve our system of care. As always, your staff were committed to understanding the facts surrounding the issues and to making recommendations for improvement. If you have any further questions, please call me at 542-1025.

Sincerely,

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

JD/RB:bm

Appendix

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Report to the Auditor General
State of Arizona

Behavioral Health Care Competition

Richard G. Frank

Howard H. Goldman

Haiden A. Huskamp

Thomas G. McGuire

August 5, 1996

Executive Summary

The Auditor General of the State of Arizona requested that we assess the use of competition for the delivery of publicly-funded behavioral health care services in Arizona. Specifically, we assess the feasibility of awarding multiple managed behavioral health care contracts within each region of the state and examine why only one organization bid on the Maricopa County Regional Behavioral Health Authority (RBHA) contract. In this summary we present an overview of our conclusions on each of the two sets of issues we were directed to study.

- **Adverse Selection poses an important threat to the use of competition for enrollees**—The term "competition for enrollees"describes markets where competition occurs by allowing multiple competitive health plans to compete to enroll members of a specific population. The AHCCCS program relies heavily on competition for enrollees. The behavioral health care area poses special challenges to using this form of competition. Competing RBHAs would have a tendency to compete for good risks in the pool of potential enrollees by making their plan unattractive to persons with the most persistent and expensive forms of mental and addictive disorders. In a managed care environment, services used by the most severely impaired individuals may be very heavily managed to deter such individuals from joining the plan. Managed care organizations can control access to services, which effectively reduces coverage. Persons with severe mental illnesses and substance abuse problems disproportionately make use of residential treatment, day hospital services and mobile treatment. Competing RBHAs have an incentive to strictly limit use of such services so as to make their plan less desirable to enrollees with severe and persistent mental and addictive disorders. The likely result is that competition between multiple RBHAs will lead to overly restrictive access and lower quality for the types of services used to treat the sickest people.

- **The approach to funding public behavioral health care by blending Title XIX and state appropriation dollars creates practical problems for the use of multiple plans**—If eligibility for services is tied to an enrollment process, such as under Title XIX, per person premiums can be readily established. The RBHA, however, is the funder of last resort and must serve individuals who are indigent and in need of behavioral health care services. A substantial part of all behavioral health care funds are not tied to Title XIX and cannot be associated with a well-defined population. As a result, allocating those funds to competing agencies could not easily be done on a per-person basis. Some other allocation method would need to be developed which distributed funds in a fair manner rather than according to arbitrary guidelines (a difficult task).

- **Competition for a single contract can produce desirable outcomes on quality and price without creating problems linked to adverse selection and blended funding–**

- **The dramatic changes in the behavioral health care system in Maricopa County created risks and uncertainty that may have reduced the enthusiasm of potential bidders**—The organizational, financing and legal environments in Maricopa County have been in a state of flux that is nearly unprecedented in recent history of behavioral health in the U.S. The uncertainty regarding: a) the rules governing the system, b) the level of funding and c) the structure of organizations that will serve as RBHAs made planning for the future challenging. The large swings in the financial health of RBHAs between 1992 and 1994 created the perception of risk and volatility, as did the Arnold v. Sarn criteria for the seriously mentally ill. Finally, the limited nature of the data base for calculating capitation rates and assessing financial risk exposed potential bidders to financial uncertainty. These factors added to the perceived level of risk involved with taking on these pure capitation contracts (which are "risky" to begin with because the contractor assumes full risk with pure capitation).

- **Key choices regarding the structure, ownership and information provided in the RFP served to substantially limit which organizations could readily bid on the contract**—The requirements for bidders to be non-profit, the specific directives regarding board structure for winning bidders and the lack of a solid database for making financial projections were likely to have significantly limited the number and types of managed behavioral health care organizations that would bid. This created a missed opportunity to make use of rigorous competition for contract used by other states.

- **The Arnold v. Sarn legal case created standards and regulations in the system that limit the scope of management activities. These circumstances appear to have been aggravated by incomplete provision of information to organizations outside of Arizona with respect to the compliance with standards and the consequences of being out of compliance**– Information that was formally provided to potential bidders by the Court was by and large limited to the Blueprint document. A more complete information set may have contributed to a more balanced appraisal of the nature of the significant challenge posed by Arnold v. Sarn.

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Introduction

This report was prepared for the Auditor General of the State of Arizona and is intended to assess the nature of competition for providing behavioral health services in the state, determine the feasibility of alternative forms of competition, and explore why only one entity bid on the Maricopa County contract. The report will first provide a brief overview of the procurement process for the regional behavioral health authority contracts, which would take effect in Fiscal Year 1996. Second, the document will discuss the appropriate form of competition for behavioral health services. Finally, the report will focus on the level of competition in Maricopa County and examine potential reasons for the lack of bidders for this contract.

Fiscal Year 1995 Procurement Process

On December 1, 1994, Behavioral Health Services (BHS) of the Arizona Department of Health Services (ADHS) issued a request for proposals (RFP) for contracts with a single regional behavioral health authority (RBHA) in each of six regions (called geographic service areas or GSAs) in the state.[1] At that time the state was under contract with a RBHA in each GSA whereby the RBHA received a capitated payment for all Title XIX eligible individuals in that region in addition to other funds to provide services to non-Title XIX eligibles as well. The existing RBHAs were all non-profit organizations which had the responsibility of operating the service delivery network and coordinating the provision of behavioral health services in their respective region. The new contracts would be three years in duration beginning July 1, 1995 with two one-year optional renewals.

Proposals in response to the RFP were initially due February 1, 1995, although this deadline was subsequently extended to February 10, 1995 to allow bidders extra time to complete their proposals. In order to bid on this RFP, the potential contractor was required to be a non-profit organization, to meet various financial requirements (e.g., minimum financial ratio standards), and to meet specified requirements regarding the composition of its board of directors. For the first time, RBHAs would be permitted to directly provide services.

The RFP listed specific issues and questions which bidders were to address in their proposals. Bidders were also asked to provide separate capitation fee quotations for serving Title XIX children and Title XIX seriously mentally ill (SMI) adults. Some prior expenditure and utilization data were included in the RFP for use in calculating the capitation rates.

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[1] GSA 1 includes Mohave, Coconino, Yavapai, Navajo, and Apache Counties; GSA 2, La Paz and Yuma Counties; GSA 3, Greenlee, Graham, Cochise, and Santa Cruz Counties; GSA 4, Pinal and Gila Counties; GSA 5, Pima County; and GSA 6, Maricopa County.

The RFP outlined five general criteria against which proposals would be evaluated and listed the proportion of total points which would be allocated to each category.[1] An evaluation committee of sixteen people reviewed each proposal and were given a detailed list of specific issues/questions for each scoring category (a list not given to potential bidders) on which to base their scores for each proposal. Maximum and minimum acceptable capitation rates were calculated before proposals were received. These rates were not shared with bidders.

In three of the six geographic service areas (GSA 1, GSA 4, and GSA 6, which is Maricopa County), only 1 organization submitted a bid. In the other three regions (GSA 2, GSA 3, and GSA 5), two organizations bid in each. Many expected that the more rural counties might have only one bidder, yet most expected that Maricopa County (the largest county in the state) would have more than one. In most counties the existing RBHA bid on the contract. In GSAs 3 and 5, the winning bidder (Community Partnership of Southern Arizona) was a partnership of an existing RBHA, an HMO, and a practitioner group.

How should competition in the procurement of behavioral health services be structured—In recent years competition has received much attention as a tool for reforming or improving the health care system. Proponents argue that competition simultaneously decreases cost and increases quality of care. The AHCCCS model, for example, uses competition among health plans in an effort to stimulate lower cost and higher quality by forcing multiple (certified) health plans within a geographic area to compete for enrollees.[2] This approach of competition for enrollees (in contrast to competition for a contract) typically trades off increased duplication and extra administrative costs involved with running and monitoring (by the state) of multiple plans on the one hand, with the potential improvement in quality and decrease in costs to the state which proponents believe will result when health plans compete against each other for enrollees.[3]

While the model of competition for enrollees seems to have been somewhat effective in certain areas/demonstrations for general health care plans, does this model hold as much promise for behavioral health services?

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1 "Ability to perform services as reflected by the offeror's narrative plan for the accomplishment of the required services and as reflected by past experience" (20%); "Ability to perform services as reflected by the adequacy and credibility of the offeror's proposed plan for the accomplishment of administrative, (monitoring, needs assessment, referral, etc.), prevention, case management, utilization management, and treatment services. Ability to provide services to the Title XIX and non-Title XIX population. Ability to develop and monitor provider networks. Adherence to standards for Boards of Directors. Demonstration of or plan for meeting minimum financial standards." (35%); "Ability to perform services as reflected by the adequacy of the offeror's administrative infra-structure, including accounting, financial and management information systems" (15%); "Ability to perform services as reflected by the adequacy and credibility of the offeror's plan for community involvement and coordination" (10%); "Compensation for Contracted service" (20%).

2 The Clinton Health Plan as well as numerous other reform attempts also use the competitive model.

3 The latter category would also include any intrinsic value to enrollees associated with having a choice of health plan.

Rather than contract with multiple competing RBHAs within a region, the ADHS has instead chosen to contract with a single organization (or RBHA) in each of six geographic regions over the past several years. Several other states follow this approach of competition for a contract for their Medicaid programs, including Massachusetts, Iowa, Nebraska, Hawaii, Washington, Oregon, and Colorado.[1] There are three main reasons to continue this practice rather than using competing vendors: (1) adverse selection; (2) difficulty of distributing block grant funds across competing RBHAs and coordinating the system of care; and (3) economies of scale. The first is by far the most important.

Adverse Selection

Many mental health and substance abuse problems are persistent, and therefore the need for future treatment is more predictable for some individuals making choices among competing behavioral health plans. Individuals with severe mental disorder are typically treated so that they make relatively heavy use of certain types of services such as residential services, rehabilitative care, day hospital care and case management. The sickest potential enrollees will seek plans that offer the best access and highest quality for the services they are most likely to use. Adverse selection occurs because insurance plans operating in a competitive environment have a strong financial incentive to avoid the most costly and difficult-to-treat individuals by making their plans unattractive to sub-populations of potentially costly clients such as the severely mentally ill.

Assume for a moment that the state chose to contract with multiple managed care organizations (MCOs) within a geographic region. In this context, adverse selection takes the following form: if the state sets a per-person payment rate that diverges from the expected costs of providing services to a particular individual, the MCO has a strong incentive to attract the person to its plan if that person's expected costs are less than the payment amount (i.e., a "healthy" person unlikely to use services) and a strong incentive to discourage that person from joining the plan if their expected costs are greater than the payment amount (i.e., a "sick" person who is likely to use services). If competition for a contract is used, the winning vendor is responsible for all eligible individuals, both the sick and the healthy.

Under competition for enrollees, making a plan less attractive to individuals with severe mental illness might be accomplished by making access to services such as residential care and day hospitals difficult, while allowing easier entry to care favored by less severely ill people, such as short term counseling. Access can be affected by utilization review policies, the location of treatment facilities in the network and the number of specialized providers included as part of the treatment network. Competitive HMOs have long instituted practices that serve to limit access to intensive forms of MH/SA treatment. For example, many HMOs define their area of responsibility as acute care, thus case management and day hospital care are viewed as long-term or chronic care and are not considered a part of the HMO's responsibility. The result is that the HMO refers enrollees in need of such care to a public agency for care. This has been

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[1] Some of these states have a single statewide contract (Iowa, Massachusetts, Nebraska, and Hawaii), while others divide the state into geographic regions and have a single contract for each region (Washington, Colorado, and Oregon).

observed in Minnesota and Wisconsin when competing HMOs were given responsibility for all mentally ill individuals under Medicaid.

Distribution of block grant funds and coordination of public systems of care

A second reason for the state to contract with a single entity in each region relates to the nature of funding for behavioral health. In addition to Title XIX funding, which comes in the form of capitated payments for children, SMI adults, and more recently non-SMI adults, each RBHA receives state funds intended to provide general MH/SA services to non-Title XIX eligibles (i.e., fund the overall public system). These non-Title XIX funds are flat dollar amounts, the amount of which is not calculated based on the size of the population covered (in other words, as the number of eligibles or individuals needing services increases in a given year, the block grant amount stays the same). If the state contracted with multiple organizations within a geographic region, the distribution of these funds would be problematic. With Title XIX, the population is clearly defined because of the enrollment process so it would be easy to distribute Title XIX funds across competing plans by paying a set fee per enrollees. By contrast, with the non-Title XIX funds, there is no denominator of enrollees for these general services so there is no way to assign funds to competing health plans for individuals independently of the services they use. Thus assigning this non-Title XIX portion of the behavioral health budget in each RBHA across competing plans would require a somewhat arbitrary allocation method which would be prone to error and increased financial risk for vendors. Also, since some of the grant funds are devoted to increasing the capacity of the treatment system in general (rather than production of direct services) there may be no efficient way for building and maintaining the overall system across competing health plans.

Economies of scale

The final reason for contracting with a single contractor in each region is the potential economies of scale involved with centralizing various administrative functions and case management processes. In testimony before the Institute of Medicine panel this year an executive of COMCARE stated that 7 to 8% of COMCARE's budget goes to administrative expenses. With multiple organizations competing for enrollees, each organization would probably have administrative costs of a level comparable to that of COMCARE. Although only some of these management costs are subject to economies of scale (whereby increasing the number of units produced or individuals served reduces per- unit costs)[1], creating more than one RBHA in each area might lead to administrative cost duplication which would increase costs significantly. There are also economies of scale associated with case management and crisis response services. Case management plays a "brokerage" function and serves to enhance consumer decision making. Allowing this function to reside in individual competing plans instead of having a single MCO that is responsible to the state a provide all case management could create a conflict between plan interests and consumer interests. There are also clear advantages to having a single crisis response system in place to simplify the process and improve coordination with

[1] Once you have the administrative infrastructure in place, the per unit cost of providing these services decreases as the number of services provided increases because you spread the fixed costs of performing these function over a great number of people.

other state or local agencies involved in crisis response (e.g., police, judicial system). Finally, if multiple organizations were competing against each other, additional dollars would be spent by the plans on marketing and enrolling new members and the state would have to spend additional funds to monitor these activities.

This begs the question of whether competition for a single contract is strong enough to achieve the desired outcomes of competition mentioned above (i.e., higher quality, lower cost). In the private behavioral health contracting market where large private employers or state employees pools carve out their MH/SA benefit and typically contract with a single managed behavioral health care (MBHC) vendor to cover all their employees (or all but the HMO enrollees), there has been intense competition for contracts. Typically 3 – 6 MBHC vendors submit bids for any given contract with active competition over both price and managed care program features. If the market of potential bidders were large enough the same should be true for Arizona's behavioral health system. A threat of viable competition in the next round of procurement would provide an incentive for controlling cost and providing high quality as long as the contract was viewed as potentially profitable. If the threat of competition was not real, however, the same level of benefits of competition might not be achieved.

Why did only one firm bid on the Maricopa County Behavioral Health Contract—In assessing the competitive conditions for the managed behavioral health care (MBHC) contract in Maricopa County we identified two general sets of factors that were likely to have affected the level of competition for the contract.[1] They were: 1) the general environment for operating a MBHC carve-out company in Maricopa County, and 2) specific choices made by state government with respect to the timing and content of the request for proposals. We discuss the impacts of each of these factors below. We then offer some observations on changes already underway that will facilitate future competition and make suggestions about measures the state government might take to further enhance competition for the contract.

The Environment Arizona's public behavioral health care system can be characterized as having experienced tremendous growth in funding, fundamental change in the approach to allocating resources, frequent change in rules governing managed behavioral health care organizations that contract with the state, and important rigidities in the delivery system due to court-mandated service requirements. There is a large and extremely competitive behavioral health care industry operating nationally and in the southwestern United States. That industry consists primarily (although not exclusively) of for-profit organizations. These organizations have not entered the public behavioral health care market in Arizona to any significant degree, although they have entered the public market in other states (e.g., Colorado, Iowa, Massachusetts, Nebraska). The unique circumstances of Arizona's funding and regulatory climate have contributed to substantial uncertainty regarding the Arizona behavioral health care delivery system.

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[1] Although we were asked to focus on why Maricopa county had so little competition for the RBHA contract, many of the reasons below apply to the low level of competition found in the other regions as well.

A striking feature of the Arizona public behavioral health care system is the rapid rate of change it has experienced since fiscal year 1989. Total revenues for behavioral health grew from $101.7 million in fiscal year 1989 to $269.0 million for fiscal year 1995. Much of the increase in funds available for behavioral health care services stems from implementation of the Title XIX MBHC plan (which began in 1990) and the requirements set out by a state court related to the Arnold v. Sarn lawsuit.

It is also important to consider that prior to 1992 no fee-for-service Medicaid program existed in Arizona. Thus, the patterns of Medicaid spending that have drawn private MBHC vendors to bid on Medicaid contracts in other states were not present in Arizona. Specifically, in 1990 about 70% of the average state's Medicaid behavioral health dollar was devoted to inpatient care. MBHC vendors have developed sophisticated techniques for creating treatment plans that rely on less restrictive and less costly alternatives to hospitalization. Significant savings (and contractor surpluses) in Massachusetts' Medicaid program were realized by virtually eliminating the use of 28-day inpatient substance abuse detox programs and by significantly reducing the use of inpatient psychiatric care. Because of the lack of a fee-for-service Medicaid program and because Arnold v. Sarn had required the development and use of community-based services as alternatives to inpatient care, the opportunity for a large reduction in costs (i.e., "savings") in Arizona may not have been evident to MBHC vendors.

Accompanying the dramatic increase in public funds was the transformation of the public mental health system from a traditional grant-based funding system that directly funded service organizations to a funding and delivery system that delegates responsibility and financial risk for supplying public behavioral health care to private non-profit organizations. Beginning in 1992 Arizona implemented a "capitated" managed care model of behavioral health care delivery for Title XIX and created RBHAs which were charged with blending a number of public funding streams. This change in the approach to public provision of behavioral health care initially called for development of new contractual relations with organizations (RBHAs) that would manage but not directly provide behavioral health care.

Capitation funding in combination with lump sum funding (for non-Title XIX services) creates significant financial risk for RBHAs. However, under the 1992 contracts the contractors were not permitted to retain surpluses and thus had no ability to cushion the blow of a loss under a capitated payment system. In addition, a demonstration of only minimal ability to bear risk was required in the 1992 contracting cycle. Subsequently, in the 1995 procurement, the state altered a number of key requirements for RBHAs, requiring them to meet relatively rigorous standards demonstrating the ability to bear financial risk (i.e., capitalization requirements) and allowing them to retain surpluses. This set of rapid alterations to some central features of the contractual relations between state government and RBHAs have made the long-run nature of the contractual arrangements in Arizona's behavioral health care system difficult to anticipate.

The blending of funding streams is a strategy that behavioral health care policy experts have long proposed. Blended funding encourages coordination of services for individuals according to their clinical circumstances rather than the structure of their insurance. This creates the flexibility that managed care techniques can use to improve service delivery in an efficient

manner. Historically, fragmentation in service delivery has resulted in a fragmented delivery system where patients often were given inappropriate levels and combinations of treatments.

Nevertheless, dealing with both a capitated "insurance-like" program such as Title XIX and also public financing mechanism that is similar to a lump sum payment in order to manage an entire public mental health system requires expertise not typically found among private behavioral health care vendors. We know of only one state, Massachusetts, that has attempted to use a private MBHC vendor to blend funding streams in a similar fashion to the approach taken in Arizona. That procurement was limited to Medicaid funds and acute care non-entitlement funds. The fact that most MBHC vendors do not have experience in the blending of public funding streams increases the perceived risk and complexity of managing care associated with the Maricopa county contract.

The Arnold v. Sarn case articulated a complex set of standards that must be met to comply with the conditions of the settlement of the case. For example, the Court has stated that "Maricopa County and ADHS are both responsible for providing a **full** continuum of mental health services to **all** class members" (Arnold v. Sarn Mediation Decision November 1995). However, the complexity and the scope of coverage has prevented the behavioral health care system from achieving compliance with the rulings of the court.

It seems likely that some bidders may have been discouraged from bidding after reading the "Blueprint" document, which contains the judicial standards for the care of the severely mentally ill. According to the Office of the Court Monitor, four potential bidders (private managed behavioral health care firms in this case) who ultimately elected not to submit a proposal contacted the Office of the Court Monitor to inquire about the Arnold v. Sarn case. These organizations were given a copy of the "Blueprint"by the Office of the Court Monitor. This document outlines "required" standards for the system but does not discuss the expected level of compliance, the level of compliance achieved by the current RBHA (which was far less than full compliance), or the fact that there were no penalties for failure to fully comply. On the advice of legal counsel, the Court Monitor provided little or no verbal feedback regarding previous compliance.[1] A local competitor who was familiar with the Arnold v. Sarn case and its current impact on the existing RBHA would be at an advantage in relation to an outside competitor.

The Arnold v. Sarn conditions have had other consequences as well that may have affected competition for the Maricopa county contract. First, the "Blueprint" document calls for consumers and family members to be part of the board of the RBHA in Maricopa county. Second, the Court Monitor has become a de facto "regulator" in the county. This means that programmatic decisions involve the Arizona Department of Health (ADHS), the RBHA and the Court Monitor and less directly AHCCCS which sets capitation rates for behavioral health care. The Court effectively established a separate entitlement for members of the severely mentally ill class which did not correspond closely to existing funding arrangements. The result

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[1] BHS staff reported that no potential bidders made inquiries totem about Arnold v. Sarn. A copy of the Blueprint was available in the offeror's reference library, however.

is a set of unclear financial liabilities, restrictions on the boards of provider organizations and managerial rigidities, all of which might be expected to attenuate the enthusiasm of potential entrants to compete for the contract. Recently, the Court set out "Exit Criteria" which modify the "Blueprint" requirements to a set of standards that are more likely to be achievable and which match existing resources more closely.

Although there was no competition in the Maricopa procurement, this cannot be attributed to a lack of potential vendors. The MBHC carve-out market is highly competitive and growing rapidly. In 1995 Open Minds identified 39 firms that offer MBHC services. They range from "risk-based" network behavioral health carve-out programs to EAP-only services. Seventeen of the 39 firms enroll over 1 million lives each, including Medicaid contract enrollees. There are also a variety of MBHC vendors that are more local or regional in scope that are typically not captured by the Open Minds data system. The firms in the industry are overwhelmingly for-profit organizations as mentioned above – only three of the largest national vendors are not for-profit organizations – and competition for contracts is very robust. During the recent Massachusetts procurement for Medicaid behavioral health services, five proposals were submitted encompassing eight managed care firms (several joint ventures were represented among the proposals). Iowa evaluated eight bids for its Medicaid behavioral health contract. In southeastern Colorado, involving a relatively small contract, three bidders submitted proposals.

A recent survey by the National Association of County Behavioral Health Directors sought to examine the interest in bidding on county government behavioral health care contracts on the part of national MBHC vendors. Twenty-two of the largest for-profit firms were sent a survey probing the interest of those firms in providing specific types of MBHC services. Fourteen of the firms surveyed responded that they would be willing to provide a full array of services. In general the survey reflects interest in contracting with county-run public behavioral health care programs.[1]

Choices Made by State Government

The State of Arizona through various agencies made a number of choices that served to influence the intensity of competition for the Maricopa County contract. We focus on six choices regarding the content of the RFP, the procurement process and the availability of information to each of the parties in the procurement. The six factors are discussed in turn below.

- **Ownership Status of Vendors**—The RFP calls for bidders to be non-profit (NP) organizations. In our discussion with people inside and outside government in Arizona two sets of reasons were given for this requirement. First was the view that the federal government requires organizations receiving funds from the Alcohol, Drug Abuse and Mental Health Block Grant (ADMBG) to be non-profit. The second concern was that for-profit firms operating in an environment of risk-based payment arrangements (such as

[1] Egnew, Robert C., *Refining the Concept of Public/Private partnerships* Behavioral Health Care Tomorrow (April 1996) 37-39.

capitation) have a stronger incentive to reduce quality and limit access than non-profit entities. Regarding the first point we discussed the Arizona interpretation of the ADMBG with several people at the Substance Abuse and Mental Health Services Administration (SAMHSA). They suggested that there was nothing in the ADMBG regulations that prohibits use of for-profit MBHC vendors. The SAMHSA staff we spoke with did note that the interpretation of the ADMBG rules had only recently been clarified and so past confusion was understandable. It was also noted that several states (e.g., Massachusetts, Colorado) are using for-profit managed care companies and providers for delivery of services funded by the ADMBG.

The second point is one that often arises when human services to vulnerable populations are under consideration. Other states have required their managed behavioral health care vendors to be non-profit organizations (e.g. Utah, Hawaii[1]). Typically, when such a choice is made competition is not used as a "contracting tool". That is, competitive bidding is not used by these states to obtain favorable capitation rates or quality of care commitments from managed care organizations. Typically more regulatory approaches are adopted to ensure acceptable levels of cost and quality when only non-profit organizations are used. Concerns over incentives to undertreat and to reduce quality are legitimate and are supported by the history of use of HMOs to deliver Medicaid services. There are, however, alternative ways of curbing incentives to profit by reducing access to care and quality of services. One approach is to specify a reimbursement system that places limits on the level of profits. For example, many private companies who buy MBHC for their employees define a capitation rate. Some of these companies are concerned that the incentives to reduce costs may be too strong and they respond to that concern by placing a limit on profits that can be earned by the vendor if actual costs are less than the target capitation rate. Some define a risk corridor on both sides of the capitation rate (as opposed to the profit side only as above) that serves to limit both the potential profits and losses of the vendor (i.e., a form of reinsurance at the contract level as opposed to the individual enrollees level). The risk corridor is defined as the capitation rate plus or minus a percentage (e.g., 10%). Thus, in this example, after a 10% reduction in costs has been realized the vendor would have to return all additional savings to the state and after costs exceeded the target by 10% the vendor would no longer be at risk financially.[2] Clearly, this limits the incentive to reduce access and quality in order to earn additional profits. Several states also limit profits that can be earned by contractors, including Massachusetts and Iowa. A similar mechanism can be applied to non-Title XIX funds where the expected budget serves as a target around which risk corridors can be constructed. Thus, there could be two types of payment mechanisms within the RBHA contract — one for Title XIX and one for non-Title XIX.

Restricting eligible bidders to NP organizations potentially limited the field of possible bidders quite significantly given that a large proportion of MBHC vendors are for-profit

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1 Hawaii's program covers only Title XIX eligibles who meet the state's criteria for severe mental illness.

2 The risk corridor is often symmetric as in this example. However, it is not necessary to have symmetry thereby allowing a higher level of risk sharing (reinsurance), for example 30%.

organizations. For-profit vendors could, however, choose to set up a separate non-profit arm specifically for this contract or could form a partnership with a local non-profit organization to bid on the RFP.[1] No partnership of this type was formed in order to bid for the FY 1995 Maricopa county contract, although one for-profit firm approached COMCARE with the idea of forming such an arrangement. (COMCARE instead chose to bid alone.)

- **Financial Risk**—Vendors interested in the Maricopa county RBHA contract faced a great deal of financial risk stemming from how the payment method is structured, which could potentially have discouraged bidding by some MBHC organizations. There are essentially two payment methods used by the State of Arizona. The first applies to Title XIX eligibles. ADHS pays the RBHAs three separate capitation rates: a) SMI adults ($33.13 in July 1996 for Maricopa County), 2) Children and Adolescents ($16.97) and 3) Adult non-SMI ($9.53). The second payment method is a lump-sum payment from the state (which includes both state and federal funds) that is used to pay for people and services not covered by Title XIX.[2]

  The vendor facing these payment arrangements is subject to several types of risk. First, under the capitation payment the vendor is at risk for the costs of care per enrollees. (Thus there is no enrollment risk — revenues increase as the number of enrollees increases.) The capitation rate in Maricopa County for children and adolescents ($16.97) is in the middle of the distribution of state Medicaid programs. For example, in Massachusetts one of the most expensive states, the AFDC capitation rate covering children was $22.05 in 1995. Iowa and Colorado had child rates of $13.80 and $9.87 in 1994. For the SMI the Maricopa rate of $33.13 is low relative to other states. For example, Massachusetts had an SSI rate of $88.14 in 1995, Iowa's rate was $63.72 for 1994 and Colorado paid for SSI adults at a rate of $66.13 in 1994.

  Second, the non-Title XIX grants place the MBHC vendor at risk for both enrollment and per person costs because the size of the grant does not vary with the number of enrollees and the RBHA, which becomes the payer of last resort for Maricopa county, is responsible for providing services to individuals who need them and are not Title XIX-eligible. Moreover, the low SMI capitation rates coupled with the Arnold v. Sarn requirements makes it likely that significant claims will be made against these funds to supplement Title XIX funds. The state offers vendors no risk sharing for these funds. The consequence of this choice is to effectively increase the "costs" of undertaking the contract because the vendor must bear so much risk (this "cost increase" is often referred to as a risk premium because the vendor may seek a higher payment due to the uncertainty or risk involved with the contract).

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1 One such partnership, the Community Partnership of Southern Arizona (CPSA), was formed to bid in GSA 3 and GSA 5. This partnership includes an HMO, a former RBHA, and a group of practitioners.

2 Populations not covered include all indigent people not eligible for Medicaid. Services include so-called wrap-around services such as housing.

From our interviews with consultants and state government officials it appears that the ADHS was not provided with a comprehensive set of alternatives for providing vendors with some protection against risk.[1] It is an inefficient form of risk spreading for the State of Arizona to place so much risk on an organization (a RBHA) with total revenues of $170 million. In addition, an important benefit of risk sharing arrangements is that the state government shares in the savings realized from improved efficiency rather than allowing the vendors to retain all unspent funds from the capitation payment. Under capitation contracts all savings become either profit or surplus. Other states share risk with MBHC vendors. For example, Colorado, Iowa and Massachusetts all have risk sharing provisions in their MBHC payment arrangements.[2]

It is also important to note that two of the existing RBHAs had recently experienced significant financial losses. One of these was COMCARE (the RBHA operating in Maricopa county at that time), which carried a deficit of over $7 million from FY 1994. In part because of the large financial risk involved with the contract due to the payment system, some potential bidders may have viewed the contract as very high-risk and unlikely to be profitable. It is worth noting that COMCARE, the MBHC vendor in Maricopa County, did realize significant surpluses in both fiscal years 1995 and 1996, however.[3]

- **Data and Information**—Risk to all parties is also created in part by incomplete information for bidders. The encounter, expenditure, and enrollment data provided to vendors in the RFP was difficult to use for the purposes of constructing capitation rates for sub-populations and for decomposing those rates by types of services to be used. Data from the Blue Book which was issued with the RFP were not sufficiently complete to align expenditures with enrollment information for the purposes of a detailed analysis of capitation rates. Enrollment categories and expenditures were not closely linked nor were dates for expenditures and enrollment. In addition, the encounter data system was flawed so accurate utilization rates for particular types of services could not be calculated. One potential bidder in Maricopa county (Foundation) reported that the difficulty calculating rates using the data provided contributed to their inability to complete a proposal by the deadline. Given the weaknesses

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1 In response to the legislature's request to explore reinsurance for the RBHAs contracts, BHS hired William M. Mercer (an actuarial consulting firm) to determine whether some type of reinsurance should be used. Our interviews with Mercer and staff of the ADHS suggest that only reinsurance of individual patient costs was considered by Mercer in conjunction with the RBHA contracts and Mercer recommended against its use. While this approach helps with risk sharing, it is not the only approach. Risk can also be shared at the level of the organization whereby if total claims were above (or below) the target the state would share in the loss (or savings). Losses at the organizational level are an important concern to the state because of the importance of keeping the RBHAs viable and financially stable.

2 Massachusetts had the greatest amount of risk sharing by the state. Losses and profits were limited to either $1 or $2 million depending on the contract year. Other states place considerably more risk on the vendors.

3 The FY 1995 gross surplus was about $10 million, although the FY 1994 deficit of approximately $7 million absorbed the majority of this gross surplus. The FY 1996 surplus may in part due to one-time fund allocations from ADHS. Some portion of the FY 1995 surplus may also be due to recoupment adjustments and reconciliations.

in the data, it is somewhat surprising that the state did not release the maximum capitation rates that they had calculated and were using in the evaluation of proposals as a guide to bidders.[1]

The State may also have created a disadvantage for itself by not obtaining more information on the potential offerors and their experience in dealing with blended funding streams by using a Request for Information (RFI) process. The State of Massachusetts, for example, issued an RFI to obtain information on the experience of vendors in managing non-Title XIX funds when it expanded the scope of its behavioral health program beyond the Medicaid population. A Request for Information (RFI) was also used by CPSA before submitting its bids in order to assess the readiness of local provider-sponsored networks to participate in the system that the organization was proposing. CPSA found that the RFI process generated useful information and ADHS staff thought it would have been a useful tool in the Maricopa procurement. However, time pressures to move ahead with the procurement were viewed as limiting the practicality of issuing an RFI for Maricopa County. Instead, the RFP with the Blue Book of data was widely distributed to most of the major national vendors and many potential regional MBHC organizations.

- **Board of Directors Composition**—The RFP had very specific requirements for the size and composition of the Board of Directors of the winning vendor. The Board was to have no fewer than 9 and no more than 13 members. The Board was required to have representatives of the following groups: the medical community, an alternative provider of health care (non-M.D.), a facility representative, a consumer of services, a family member, a representative of the community a program representative and a business representative. There are few existing organizations that would easily be able to accommodate these requirements. Based on our interviews in Arizona it appears that these requirements in part stem from the standards in Arnold v. Sarn that call for consumer and family representatives to be on the Board of the RBHA. In order to bring balance to the Board the ADHS seems to have directed the Board to have a specific structure and composition. No other state is so directive in the structure and composition of the Board of the MBHC vendor. However, a number of states have formed advisory committees to the State Medicaid agency which resemble the composition of the Maricopa RBHA.

- **Timing of the Procurement**—Several features of timing are important in this specific procurement. The behavioral health care system was in a period of great flux in late 1994 and early 1995. We have discussed the dramatic changes above. The 1994-95 period was also one where the extant RBHA, COMCARE, had experienced significant financial difficulties during the previous year as noted above. Also, the Pima RBHA was incurring significant financial losses. This information would certainly make the contract seem riskier and thereby less attractive to potential bidders. In addition, the RFP and the request for proposals were developed and implemented over a relatively short time period which

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[1] One consultant at Mercer explained that by not making public the maximum rate one obtained more information from the market. This must be balanced against the level of uncertainty and the role of maximum rate information in allowing bidders to make more sensible offers.

happened to fall over the holiday season. The final deadline for proposals was February 10, 1995, 9 days later than the schedule set out initially in the RFP. It appears that one potential bidder, Foundation Health, requested an extension beyond the February 10 date but was denied.[1] No proposal was submitted by Foundation Health, which is a for-profit MBHC firm based in California.

- **Complexity of the RFP**—Based on interviews with consultants specializing in MBHC contracts the Arizona behavioral health care RFP was quite burdensome relative to other RFPs. The long list of questions and the lack of guidance regarding how proposals would be judged were cited in interviews as adding to the burdensome nature of the RFP. The nature of the questions are partly attributable to the blending of programs and funding streams under the RBHA structure. Thus, some extra burden seems unavoidable. Nevertheless, the large number of questions and the level of detail implied may have created excessive difficulties with providers not intimately familiar with the Arizona behavioral health care system. Such an approach to screening may be in the best interest of the State but it comes at the cost of discouraging bids from "outside" organizations.[2]

Summary

The ADHS made a number of strategic choices that had potentially important implications for the degree of competition for the contract. If one considers that most MBHC vendors are for-profit organizations the requirements to only allow non-profit firms to bid and to be quite directive in terms of the composition of the RBHA Board significantly reduces the ability of much of the industry to bid in their existing corporate forms. While joint ventures with a variety of organizations can and do sometimes occur in this market, such action can be costly to the parties involved (e.g., legal costs associated with establishing the new entity, changes in management and administrative systems necessary for joint work). There is also a significant loss of corporate control and autonomy when the structure of the Board of the RBHA is prescribed in such detail. Finally, the flux in the system, the poor financial performance of COMCARE prior to fiscal year 1995, the low SMI capitation rates accompanied by the strong standards set out by the Court, and the lack of any risk sharing combine to have made the Maricopa RBHA contract a risky venture.

Choices for the State Regarding the Next Round of Procurement—In reviewing the circumstances in Arizona, we have identified two issues which should essentially resolve

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1 BHS staff noted that the extension was denied for three reasons: (1) the agency needed to move ahead quickly with the procurement in order to enable implementation by July 1, 1995 (the beginning of the new fiscal year); (2) an extension to one organization would be unfair to the other bidders who completed their proposals on time; and (3) Foundation should have recognized their need for additional time sooner rather than waiting until the day before the proposal was due.

2 The desirability of such an approach to screening applicants depends on how well those questions separate vendors on the basis of quality and cost versus greater knowledge of program structures that is unlinked to quality and cost.

themselves over time. First, the Arnold v. Sarn case appears to be moving towards resolution. The agreement on exit criteria and the possibility that those standards will be met over the next several years means that the Court case will pose less of a barrier in the future than in the past. It is however, important to note that had the Court or the state presented potential bidders with a more balanced view of the actual costs and risks of the Court case the "Blueprint" may have posed a less daunting challenge. Second, the dramatic changes in funding and structure of payment experienced in recent years will almost certainly not be repeated in the future. Thus, what might have been viewed as a turbulent system is becoming more stable and predictable. This makes planning for the future less risky.

There are several changes that could be made in the method of procurement that might spur more competition for contracts:

- It may not be necessary to limit ownership to non-profit organizations. Non-profit status is not necessary to meet guidelines for federal block grant funds. Use of risk sharing arrangements and quality standards can accomplish much of the intent of restricting RBHAs to non-profit status with respect to ensuring that the profit motive does not result in the restriction of access to high quality care.

- The state could beneficially be less directive regarding the structure and composition of the board of the RBHA. One option used by other states is to require the creation of an advisory board and dictate the structure, composition, and function of that group rather than require the contractor's own board of directors to meet certain specifications.

- Use of risk sharing in conjunction with capitation and lump sum payment arrangements may protect the public from undesirable vendor behavior, allow the state to share in any savings achieved by the contractor rather than allowing the contractor to keep all remaining state dollars as "profit," and offer financial protection to vendors thereby making the contract more attractive to potential bidders. Given the dramatic changes in the structure and financing of the Arizona public behavioral health care system in recent years, reducing financial risk has the potential to enhance competition and permit the state to further develop its oversight capabilities. Once the system has stabilized, other risk-bearing arrangements might sensibly be explored.

- Providing clear and balanced descriptions of the behavioral health care environment in Arizona and Maricopa county to potential bidders would serve to further reduce uncertainty and would permit vendors to develop proposals that are more sensitive and appropriate to local issues.

- Data system improvement. We found evidence suggesting that the quality of the data and the actuarial base are improving through ongoing efforts by the ADHS and COMCARE. Nevertheless, there remain clear shortcomings in terms of the flexibility, speed, and completeness of the data system. Further development of the managed care model requires that additional efforts and/or resources be devoted to data system improvement.

- Timing of the next procurement. The evolution of the behavioral health system in Maricopa County suggests that waiting for the "Exit criteria" to be met (and the Court case to be resolved), rather than letting the Maricopa contract within the next 18 months, would encourage competition. On the other hand, existing providers are consolidating and opportunities for competition (especially from local groups) may be diminished if the state extends the existing contract beyond the initial three years. However, there appears to be significant uncertainty regarding when the "Exit criteria" will be met. Participants in the process offer predictions ranging from 3 to 6 years. It is our judgment that delaying beyond 3 years would lead to reduced future competition. The national market is very competitive in 1996 and is likely to remain so for a few years. Hence we favor letting a new contract within 3 years.

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