

JOINT LEGISLATIVE AD HOC COMMITTEE

ON MENTAL HEALTH SERVICES

FINAL RECOMMENDATIONS

Presented to:

Governor Fife Symington

Senator John Greene, President of the Senate

Representative Mark Killian, Speaker of the House

December 22, 1993

**Senator Ann Day, Cochair
Senator John Huppenthal
Senator Sandra Kennedy**

**Representative Sue Grace, Cochair
Representative Bob Edens
Representative Hershella Horton**



Arizona State Legislature

1700 West Washington
Phoenix, Arizona 85007

December 22, 1993

The Honorable Governor J. Fife Symington, III
State Capitol, West Wing, 9th Floor
1700 West Washington
Phoenix, AZ 85007-2848

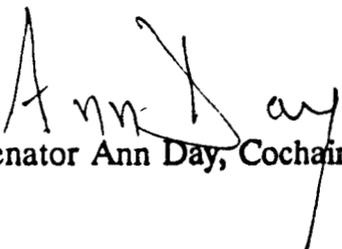
Dear Governor Symington:

Attached are the Recommendations of the Joint Legislative Ad Hoc Committee on Mental Health Services, established February 23, 1993. This report presents short and long-term recommendations which we believe constitute a substantial improvement to our overall delivery system of mental health services in this state for future years.

These recommendations conclude many hours of committee hearings, working groups, planning sessions, and considerable public input and testimony. It is our sincere belief that with the implementation of these administrative and legislative recommendations, a more accessible and accountable mental health delivery system will be devised.

It is our sincere hope that the legislature consider the Ad Hoc Committee's recommendations and commit to improving this states mental health system.

Sincerely,


Senator Ann Day, Cochair


Representative Sue Grace, Cochair



Arizona State Legislature

1700 West Washington

Phoenix, Arizona 85007

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Speaker Mark Killian
Arizona House of Representatives
1700 West Washington
Phoenix, AZ 85007

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Sincerely,

A handwritten signature in cursive script that reads "Ann Day".

Senator Ann Day, Cochair

A handwritten signature in cursive script that reads "Sue Grace".

Representative Sue Grace, Cochair



Arizona State Legislature

1700 West Washington
Phoenix, Arizona 85007

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President John Greene
Arizona State Senate
1700 West Washington
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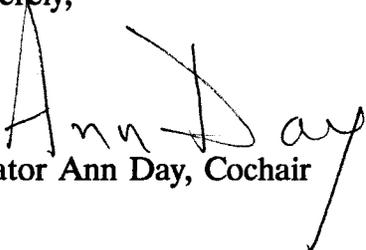
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BACKGROUND AND OVERVIEW

The President of the Senate and Speaker of House of Representative appointed a Joint Legislative Ad Hoc Committee on Mental Health Services established February 23, 1993. Representative Sue Grace and Senator Ann Day were selected to cochair the Committee. Other legislators assigned to the Committee were, Representative Bob Edens, Representative Hershella Horton, Senator John Huppenthal and Senator Sandra Kennedy.

The Committee was charged with reviewing the current mental health delivery system, including counseling services, and with developing recommendations on how to improve the entire system. The Committee was further required to make recommendations on how to implement mental health programs required by Title XIX of the Social Security Act that are not related to services to the seriously mentally ill in a manner that will cause minimal disruption of services to clients currently receiving services.

The decision to immediately appoint an Ad Hoc Committee came following a myriad of complaints to legislators from providers, clients, the regional behavioral health authorities, and health advocacy groups. The following is a sample of criticism pertaining to the existing delivery system:

- the current mental health delivery system has too many administrative levels;
- too much duplication exists at the administrative and provider levels;
- the eligibility process is convoluted and complex;
- little accountability exists for expenditures of state and federal funds;
- behavioral health subvention funds should not be used as a match for federal funds;
- providers are not being paid for services rendered in accord with their contracts;
- providers are operating without signed contracts;
- case management services are repeatedly duplicated;
- clients are not receiving services for which they are eligible;
- the children's capitation rate is unreasonably low;
- no uniformity in contracts;
- there is little coordination of continuity of care between the health plans and RBHAs for the client;
- the claims processing mechanism is not reconciling claims in a timely manner.

From February 1993 until December 1993, the Ad Hoc Committee on Mental Health Services held 14 full Committee meetings. Additionally, the Committee members were assigned to subcommittees and working groups to discuss the specific topic areas and the subcommittees were required to deliver their recommendations to the full Committee.

The Committee members initiated the development of their recommendations by identifying six varying options for mental health delivery systems. These options assisted the members in identifying the benefits and barriers of the different mental health delivery system scenarios. The following is a list of the proposed options:

- Option 1: Status quo. The behavioral health delivery system should remain unchanged, with the current RBHA system overseen by DHS.
- Option 2: The RBHAs should be eliminated and replaced with DHS regional offices. Local councils should continue and should provide input and planning. A sub-option should be to grant DHS discretion to choose to either subcontract with a RBHA or operate a regional office at each geographical area.
- Option 3: Transfer all Title XIX behavioral health services to AHCCCS, retain all subvention or non-Title XIX, programs at DHS. Sub-options included: a) retaining the RBHA system, or b) eliminating the RBHAs.
- Option 4: Transfer all behavioral health programs to AHCCCS. Sub-options include: a) continue using the RBHAs, and b) use health plans only.
- Option 5: This option identifies whether an individual's need is primarily medical-health oriented, or behavioral-health oriented. Clients who are primarily medical would receive both medical and behavioral health treatment through AHCCCS. Clients who are primarily behavioral health candidates would receive both medical and behavioral health treatment through DHS. This option is similar to Long Term Care clients. DHS would likely retain adult SMIs and SEHC children, while most other clients would go to AHCCCS.
- Option 6: Create a separate department composed of Behavioral Health and Developmental Disabilities.

After many hours of discussion and testimony on the proposed options, the Committee determined that certain issues needed to be considered in more detail before any final recommendations concerning the options could be made. Therefore, the Committee divided into three subgroups with the cochairs of the committee requiring the members to develop recommendations and present them to the full Committee. Thus the following subgroups were assigned:

- 1) Data This subgroup was assigned to determine indicators to measure performance outcomes, examine costs of case management, develop a uniform data system and

identify other barriers to performance.

- 2) Eligibility and Services This subgroup was required to examine streamlining the eligibility process, examine outreach programs, examine mental health insurance benefits, devise a service package, develop and coordinate crisis services.
- 3) Statutes This subgroup was assigned to examine the current mental health statutes, define "medical necessity," establish timelines for phasing in adult mental health services, and examine methods for reducing utilization of institutional settings.

As a result of the subgroup's findings and considerable public input, numerous recommendations were presented to the full Ad Hoc Committee. This report includes recommendations from the subgroups which were subsequently adopted by the full Committee. The report focuses on nine specific system areas and includes short and long-term administrative and legislative recommendations. The areas of recommended system modifications include: overall structural changes, licensing, rules and regulations, professional standards, provider contracts, eligibility, insurance, case management, outcome measurements and funding.

STRUCTURAL RECOMMENDATIONS

Recommendation # 1.

All Behavioral Health Services shall be moved to the AHCCCS program over a two-year period, FY 1995 and FY 1996, and completely integrated by FY 1997. The new system would have a unified eligibility criteria, and would provide each client a predefined package of both medical and behavioral health services. Services would be provided by brokers of health care who receive a single capitation rate for both medical and behavioral health services.

The time frames for each stage of a system change would be as follows:

Non-Structural Committee Recommended Changes	Oct. 1, 1994
Title XIX General Mental Health to AHCCCS	Oct. 1, 1994
Behavioral Health Division to AHCCCS	Jan. 1, 1995
Single Licensing Agency	July 1, 1995
Single Cap Rate/New Health Brokers Selected	July 1, 1995
Licensing Review Committee Operational	July 1, 1995
Problems Corrected in New System	July 1, 1996
Resolution of ASH's Future Role	July 1, 1996

Analysis

The current behavioral health system is severely fragmented with too many layers of administration, which spend too much capital on overhead costs and do not place clear authority and responsibility with one agency. A change in structure is only effective in solving problems that are caused in part or in whole by the existing structure. This is certainly the case with the problems mentioned above.

The existing system consists of three types of clients:

- Title XIX clients receiving medical services from AHCCCS, and behavioral health services from DHS, with little coordination.
- State-only MN/MI clients receiving only medical services from AHCCCS.
- State-only Subvention clients receiving only behavioral health services from DHS.

It is not good public policy to create three different groups of clients who receive different services based on categorized eligibility groups. Nor does it seem appropriate to classify people by their diagnosis, segregating those who are "mentally ill" from others in need of medical treatment. This type of segregation imposes the stigma associated with mental

illness and does not recognize the close and sometimes blurred relationship between medical and behavioral health needs. The recommendation would create 2 groups: Title XIX and State-only non-Title XIX. All clients would receive the same package of services from the same health plans, with the only difference being that the Title XIX clients would be partially financed by federal funds. The eligibility level for the state-only program shall be set at a level which reflects the current funding level and any increases approved by the Legislature. Savings accrued as a result of implementing these recommendations shall be reinvested to provide increased services to clients.

The recommended system will also eliminate an entire layer of administration by removing DHS. State employees currently required to coordinate between agencies could be utilized in other areas. The Regional Behavioral Health Authorities (RBHAs) and the current AHCCCS health plans would have to provide both medical and behavioral health services in order to bid as a broker of services. They could provide those services themselves, merge with each other, subcontract, or any other option they decide upon. The most efficient and effective would survive.

Additional duplication would also be eliminated under this program. The Division of Behavioral Health has continually had difficulty in producing accurate data on clients and expenditures and has spent large amounts trying to improve first the Behavioral Health Management Information System (BHMIS), and now the Client Information System (CIS). In addition, the Department contracts with a third-party claims payor at a cost to the state of nearly \$1.8 million in FY 1993. AHCCCS has a computer system with the capacity and ability to replace all these systems, resulting in the immediate annual savings of the \$1.8 million paid to the contractor for claims payment. Use of the AHCCCS computer system would also improve the availability and reliability of data.

The commitment to providing services to state-only, non-Title XIX clients would continue. However, these clients would then receive both medical and behavioral health services. Some people currently receiving services would no longer be eligible, while others who currently do not receive services would become eligible. In total, more state-only clients would be served for the same level of funding because of reduced overhead costs and the reinvestment of savings.

An incentive currently exists to treat many low-need clients, and to turn away the very needy clients. The incentive is also against providing prevention services. These incentives were created by an earlier decision to capitate only those clients actually receiving behavioral health services, rather than an "enrolled" population. If a RBHA spends money on prevention, it is expending resources that would reduce its future number of clients and, therefore, its revenue. If you are paid a certain amount for each client, the way to survive

is to accept and keep clients that cost less than the capitation rate, and deny services to those costing more. The solution is to capitate for a larger population as AHCCCS currently does. In this way, the broker of services is responsible for all costs of their enrollees, which encourages prevention and focuses resources on the neediest clients.

Recommendation # 2.

The Behavioral Health Oversight Committee shall review statutes, rules and policies for conflict and continuity on an ongoing basis. The Committee shall also further define, establish and/or clarify statutory definitions for surrogate parents, signature parents, legal custodian, and treatment guardian. Additionally, the Committee shall outline the extent of their authority to provide varying degrees of guardianship to eliminate the "all or nothing" proposition.

The Oversight Committee shall also review the role of regional residential psychiatric facilities, also known commonly as "Puffs" and "Reffs." In addition, the continuing role of the Arizona State Hospital needs to be determined, to include number of patients, types of treatment, which populations shall be served, and whether some patients are better served in community 24 hour treatment centers.

Analysis

Although the Joint Ad Hoc Committee on Behavioral Health Services has spent much time and effort in reviewing the behavioral health system, it is clear that because of the complexity of the system, ongoing reviews are necessary. Since a Behavioral Health Oversight Committee already exists, it seems to be the most likely choice of a platform to study statutes, rules and regulations to correct conflicts and quality.

On a periodic basis, the Committee could choose a particular section of rules to review. The Committee's recommendation does not envision a comprehensive annual review, but rather a plan to deal with the issues in digestible portions.

The guardianship-related statutes shall be revised to ease the ability of providers to treat clients who are in need. For instance, treatment is sometimes denied to children under the custody of state agencies because there is not a parent's signature, even though the child has a diagnosed mental illness. Some parents are unavailable or do not care. The agency is left unable to perform their custodial functions unless they want to become full guardians. An intermediary step could be established to give them the ability to be a signator for medical treatment only.

Additionally, the original purpose of Puffs and Reffs was to provide some residential crisis care in rural areas to avoid costly hospitalization and transfer to metropolitan areas for

transitory conditions that could be served more effectively in the local community. However, in practice it appears that while some are performing this function, much of the funding might currently be used for treatment in metropolitan areas. The location and use of these facilities shall match the purpose for their existence.

The Arizona State Hospital (ASH) has varied in size and purpose over the years. In the early 1960's, ASH had over 1,800 patients; today, ASH averages about 450 patients. This change is a result of deinstitutionalization and more reliance on a community network of providers. However, at no point has there been a distinct discussion on the role of ASH and the adoption of a clear public policy. How many patients shall we treat at ASH? What types of patients shall be treated at ASH? (Forensic patients, children, adolescents, geriatric, all of these categories?) What shall be done with the facilities at ASH? How does ASH fit in with capitation? Why do some counties use ASH extensively and others do not? How shall ASH be funded? All of these are areas for which there is no clear public policy. The Legislature shall review these areas and establish a policy by July 1, 1996.

Recommendation # 3.

A plan shall be developed to convert the Southern Arizona Mental Health Center (SAMHC) from a state agency to a private nonprofit agency by July, 1994.

Analysis

SAMHC is a state-owned service provider that competes with private sector agencies. This has created inequities in funding and has reduced both flexibility and the options available to the Pima County RBHA. By monopolizing certain resources, this has also interfered with the ability of private sector service providers to tailor their services to local client needs. This problem would worsen considerably if behavioral health services were transferred to AHCCCS.

The solution is to develop a plan to convert SAMHC into a private nonprofit provider. The plan shall include discussion of various options for the state-owned facility, to include the lease or sale of the property. The plan shall also address staff transition issues and continuity of care to clients. Under no circumstances shall the resources currently devoted to the operation of SAMHC be removed from their current geographical location.

This recommendation will allow these resources to be redistributed in the local area to providers that have tailored their services to those that are in demand. This shall also result in increased services to clients, at a reduced cost. After conversion, SAMHC will be in a position to compete more favorable and effectively within the provider network.

Recommendation # 4.

Implement the Title XIX general adult mental health and substance abuse program on October 1, 1994, as currently planned.

Analysis

The state shall implement the general mental health and substance abuse Title XIX program on October 1, 1994, when the waiver expires. The location of this program shall be in the same agency that contains all other behavioral health programs, as discussed in Recommendation # 5 below.

Recommendation # 5.

The state shall strengthen and expand prevention services and funding. By July 1, 1994, the director of the Department of Health Services and the director of the Arizona Health Care Cost Containment System shall submit a plan to the Legislature detailing how this policy can be implemented.

Analysis

Prevention services in this state have been woefully underfunded and virtually ignored. The cost savings as well as the avoidance of personal hardship that are inherent in effective prevention programs are just too important to continue to be overlooked and underfunded. Although the statutes require 20% of funding requests to be for prevention services, this has been interpreted very narrowly to apply to only one budget line item, and even then to be optional. The effect has been that although overall behavioral health spending has been increasing, prevention expenditures have actually declined over the last few years.

With an increase in funding comes an increase in responsibility. Prevention programs must be prepared to show positive measurable results. For this reason, the director of the Department of Health Services shall develop a list of prevention programs with proven results. This list shall then be molded into a plan for advancing prevention services and then be submitted to the Legislature for consideration during the 1995 legislative session.

LICENSING RECOMMENDATIONS

Recommendation # 1.

All licensing shall be consolidated and placed in the Department of Health Services (DHS).

Analysis

Currently, multiple agencies are involved in licensing providers for the same services. This is not only unnecessary, but often results in contradictory and excessive rules and regulations. The net effect is additional administrative cost and fewer dollars left to devote to services to clients.

An additional problem is the unfair environment created when a provider is licensed by the same agency that it contracts with for providing services. The provider shall be able to be licensed to operate exclusive of any contractual agreements. An agency with a service contract shall only be able to provide oversight of that contract; they shall not be able to threaten a provider's license for a contract dispute.

Having only one agency license providers will make the process more fair, will significantly reduce provider costs, will eliminate contradictory rules, and will save the state through the elimination of duplicative licensing staff.

Recommendation # 2.

The practice of requiring the state to issue permits for behavioral health programs shall be abolished. The state shall only license providers and provide contract compliance oversight. All permitting shall be done exclusively by local authorities.

Analysis

County and city governments already provide for the zoning of land use and the permission for new provider locations. The duplication of this function by the state is unnecessary, wasteful of resources, and does nothing but place an additional obstacle to the maintenance of a healthy provider network. Any standards that a provider must comply with for the state are more appropriately handled through the licensing process. This unnecessary barrier to provider development shall be eliminated.

Recommendation # 3.

Providers shall be required to meet one consolidated state licensing standard and have only one agency monitoring compliance with these standards. The license shall apply to all locations of that provider. For instance, if an existing provider opens a satellite facility, it shall not be required to apply for a new license, rather, it shall be able to operate under

its existing license. The Committee recognizes that the Department of Health Services has the authority to accomplish this task administratively and therefore, recommends that the Department begin to consolidate state licensing standards.

Analysis

There shall be a standard, written set of rules that all providers of particular services must meet. Once these requirements are fulfilled, the provider shall be allowed to contract with any state agency without the imposition of supplemental requirements. The providers shall be able to make normal expansions and contractions of their operations without having to seek a new license.

Under the present system, a residential provider that wishes to purchase and operate an additional satellite facility must pursue a license for that location as if it were a new stand-alone provider. This is not only wasteful, but adds a great deal to provider costs. The policy ignores the fact that many required functions can be performed centrally by the staff of the headquarters location. For instance, what is the real difference between three facilities with 10 beds at three different locations, compared to one 30-bed facility. There is no reason that the state shall force the provider in the first case to have three medical directors, three administrative staffs, three licenses, three sets of books, etc.

To remedy this situation, a provider shall have the discretion under their current license to open satellite facilities, providing that the new location does not violate any other current licensing standards. The provider shall also continue to have the option of separately licensing one or more of their facilities.

Recommendation # 4.

The state shall use "deemed status" to reduce the need for multiple licensing of providers. This policy shall be placed in statute to insure its continued usage. The Committee recognizes that the Department of Health Services has the authority to accomplish this task administratively and therefore, recommends that the Department begin to reduce multiple licenses.

Analysis

The term "deemed status" means that the state selects one or more outside licensing agencies that it "deems" equal to or exceeding state licensing standards. The state then accepts the license of these agencies in lieu of its own licensing process.

For instance, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) licenses Title XIX residential facilities. If JCAHO is selected for "deemed status," then those providers that are accredited by JCAHO would not require a separate

state license accreditation. In this way, if the state can accept the standards of other accrediting and licensing organizations, both the state and the providers can save time and money by reducing duplicate licensing.

Recommendation # 5.

Licenses shall be provided for a three-year period, instead of only one year. During the non-renewal years, the Department shall randomly check compliance as necessary. The Department of Health Services has the administrative authority to accomplish this recommendation therefore, the Committee recommends the Department begin amending its licensing periods.

Analysis

Annual licensing is both costly and unnecessary. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which licenses Title XIX facilities, uses a triennial licensing cycle. During the non-licensing years, JCAHO performs a much less costly walk-through review for compliance. This system of licensure is more often used for health care facilities.

The state shall also adopt this timeline for licensing. Not only will it reduce state and provider costs, it will also not adversely effect the quality of operations or services.

RULES RECOMMENDATIONS

Recommendation # 1.

A committee shall be established to review rules and regulations for certification and licensing to eliminate duplicative efforts on the part of state agencies. The committee shall also pursue the use of "deemed status" as a method to streamline the regulatory process. The committee shall be composed of six members, one from the Department of Health Services (DHS), one from the Arizona Health Care Cost Containment System (AHCCCS), one from the Department of Economic Security (DES), and three members from service-provider representatives. All members shall have experience and expertise in licensing issues.

Analysis

While reviewing the current system for delivery of behavioral health services, it has become clear that there are many areas of duplication and contradiction between various agencies. The Joint Ad Hoc Committee on Behavioral Health has not had the time nor the resources to thoroughly review these complex areas and make specific recommendations. It is also doubtful whether such a review would have been in the best venue to have maximum benefit. By forming a committee of agency personnel and service providers, rules will be reviewed by the stakeholders of the system who know the problems best, have the authority to correct problems, and will benefit the most by their correction.

The committee will only be successful if there is a true commitment from the participants to improve and simplify the system. One such improvement appears to be the usage of "deemed status," and this shall be the first area reviewed by the committee.

PROFESSIONAL STANDARDS RECOMMENDATIONS

Recommendation # 1.

The qualifications required to perform an evaluation shall be changed from two licensed physicians/psychiatrists only, to two licensed physicians/psychiatrists if possible or one licensed physician/psychiatrist and one licensed psychologist.

Analysis

In rural areas and other medically underserved regions of Arizona, it is often very difficult and occasionally prohibitive to require two licensed physicians/psychiatrists to perform evaluations. Attracting high-level medical personnel to these areas is a constant struggle. Some areas have part-time care professionals who only visit outlying areas occasionally. To require the presence of two of these professionals at the same time for an evaluation is unnecessarily strict and does not add to the quality of the evaluation.

The reasonable solution is to continue to strive for two physicians/psychiatrists where possible, but where it is not practical to allow a psychologist to substitute for one of them. The requirements for psychologists are stringent enough that this will not significantly reduce the quality of the evaluation. This policy will result in quicker evaluation completion and lower costs.

PROVIDER CONTRACTS RECOMMENDATIONS

Recommendation # 1.

Uniform provider service contracts and uniform definitions shall be established. Each provider shall be able to sign a single contract with the state to provide a specific array of clearly defined services. After that contract is signed, every state agency would be able, but not required, to contract with that provider for those services. Prices would continue to be negotiated individually. No agency could use a provider that did not have a contract with the state to provide those specific services. All state services would be clearly defined, along with the requirements that must be met by each provider. The provider would then select those services that it wished to provide and met the requirements for, and sign a state contract.

Analysis

Each agency defines services differently and requires different and sometimes contradictory requirements. For example, one agency might require a master's level therapist to perform two hours per week of counseling for a specific diagnosis, another may require a PhD level therapist and one hour per week, and still another might require group therapy. As a result, a provider may have three clients, all from different agencies, all receiving different services. To make matters worse, the agency has to hire additional staff to handle each requirement, and each agency has a separate contract, separate audits, and separate case managers.

Under the recommendation, a provider would only have to meet one standard for all state agencies, have one contract, one auditor, and one case manager. Currently, some providers have to have separate contracts with each state agency, with each RBHA or Healthplan, and with each private insurance company. The result is a confusing mess that adds a tremendous administrative burden and reduces the quality of care. The federal government sharply criticized the state for not having contracts signed by each provider. It is not surprising considering the myriad of different requirements. The recommendation of a single uniform state contract would solve this problem.

ELIGIBILITY RECOMMENDATIONS

Recommendation # 1.

All Title XIX eligibility determination shall be centralized. The single determiner of eligibility shall be the Department of Economic Security (DES).

Analysis

The recommendation would greatly simplify the process of entering the system, both for clients as well as for the state agencies. We waste too many resources on confusing, lengthy forms and massive duplication of efforts. In addition, the error rate and the costs both from improperly treating ineligible clients that are mis-identified as well as federal penalties shall be reduced with a single eligibility determiner.

Recommendation # 2.

Once it is made available, the Committee shall review the financial data relating to the proposal to establish Title XIX eligibility on a percentage-of-poverty-level basis. If the Committee decides to adopt such a recommendation in part or in whole, a co-payment schedule shall be included.

Analysis

Recent discussions concerning the effects to the state of seeking a federal waiver to base Title XIX eligibility on a percentage of the federal poverty level have brought up many possible benefits, as well as a few potential problems. The issue definitely deserves more discussion and analysis. Unfortunately, at this point the impact on current state-only populations and on state matching fund requirements is not clear. It is also uncertain what the federal reaction would be to such a proposal, and what the actual details of such a waiver would include. For these reasons, the Committee shall review this proposal at length, and not make a premature recommendation in this area.

INSURANCE RECOMMENDATIONS

Recommendation # 1.

Establishment of a reinsurance program shall be considered for geographical areas where the number of program enrollees is insufficient to adequately distribute risk under a capitated system.

Analysis

A very small population can place excessive risk on a health broker for high-cost individual cases. This may result in financial instability of the broker, a lack of bidders to be the broker, or in the medically inappropriate early termination of services to high-cost clients. A reinsurance program would have the state share in a portion of costs that exceeded a certain pre-established level. This maintains the financial incentive of the broker to reduce costs, while reducing excessive risk from capitating a small population.

CASE MANAGEMENT RECOMMENDATIONS

Recommendation # 1.

Standardized qualifications shall be established for case managers and case coordinators. Case managers shall be licensed by the Arizona Board of Behavioral Health Examiners to insure compliance with these standards. The minimum requirements for licensure shall be a bachelor's degree in a related field and five years of behavioral health experience, or a master's degree in a related field and three years experience.

Case coordinators will not be required to be licensed by the board but are required to be a mental health professional or mental health technician, or a person with a high school diploma or GED and a combination of behavioral health education and experience totaling three years, and must be supervised by a qualified mental health professional or clinical supervisor.

The roles of the Case Management and the alternative of Case Coordination shall also be clearly defined. Case Managers shall be responsible for managing a patient's mental health services consisting of a set of services and activities which are identified, planned, obtained, coordinated, monitored, and continuously evaluated. The process of case management is based on the results of the assessment, the evaluation and treatment planning, and is structured around the unique needs of the patient. Development of the individual service plan, monitoring and evaluation of the continued need for service is the primary responsibility of the case manager.

The case coordinator is responsible for the basic individual service plan coordination, identification of service providers, authorizing services based on the individual service plan and follow up. Case coordinators are prohibited from developing individual service plans.

Analysis

Case managers play a very important role in patient care and are the principal administrator of a patient's overall treatment and service plan. Additionally, the case manager handles the contact between the patient, family, and service providers. For these reasons, patients shall be provided some guarantee that case managers are competent and qualified professionals. Therefore, minimum standards of qualifications for all case managers must be established.

This recommendation shall also be adopted to support recommendation # 3, which would eliminate the assignment of multiple case managers for a single patient. Currently, some agencies argue that they must assign a case manager because another agency's existing case

manager is not qualified to make behavioral health decisions. If all agencies are required to maintain the same standards, this will no longer be a problem.

Recommendation # 2.

Case management shall only be used when appropriate. When a case manager is not required, the health broker shall use case coordinators to approve treatment in accordance with the patient's treatment plan, and the service provider shall be held accountable for patient treatment.

Patients who are receiving services from more than one provider or patients receiving treatment for more than 30 days may require a case manager. Patients who have only one provider or patients who receive less than 30 days of treatment shall not be assigned a case manager, but shall instead use a case coordinator. For instance, a person who requires two weeks of treatment at one provider, would be assigned to a case coordinator who would then select an appropriate provider. The provider would then be responsible for the treatment of that individual.

Patients receiving substance abuse counseling shall not use a case manager. Substance abuse clients are best served when the provider of services is allowed to perform the functions currently performed by an external case manager.

This recommendation is directed to all state agencies responsible for contracting for case management and case coordinator services. Such agencies shall strive to implement the Committee's recommendations pertaining to the appropriateness of case management utilization.

Analysis

Given the diversity of levels of need of services for behavioral health patients, case management services are often times necessary. However, some patients need very little or no case management at all; rather, their services could be monitored easily by a case coordinator. Therefore, case management services shall be utilized to assist patients with numerous providers and case coordinators shall be utilized to monitor patients with one provider. On average, case coordinators are able to handle case loads of nearly 10 times the amount of case managers. This will not only result in significant savings, but also focuses resources on those clients who will benefit the most.

The system has also deprived some providers of the ability to practice medicine. Currently, a RBHA determines a client's treatment plan, picks out a provider, and then has a case manager, contract managers, and quality assurance personnel constantly overseeing and ordering the method of treatment. The provider is then unable to treat the client in the

way they feel is most appropriate. Each provider is required to meet stringent licensing requirements and is staffed with professional medical personnel. This intrusion into specific treatment decisions by personnel who may have little or no behavioral health education or experience is clearly inappropriate and often treatment averse. The provider shall be allowed to treat the individual, and then be held accountable for the success or failure of their efforts, without constant case-by-case intrusion.

Case management shall not be determined by diagnosis. For instance, a Seriously Mentally Ill (SMI) client who is committed to the Arizona State Hospital (ASH) shall not have a case manager. The staff of ASH shall be held responsible to provide those services to the patient. There has been some evidence that payments have been made for case management for clients in similar situations in which little or no actual work was required on the part of the case manager.

Recommendation # 3.

One agency shall be established as the lead agency responsible for establishing a patient's service plan when more than one agency is involved. For patients who are involved with more than one agency, the agency that has custodial responsibility for the patient shall be the lead agency. In the absence of custodial responsibility, the first agency to treat the client shall remain the lead agency.

The lead agency is responsible for establishing the patient's service plan and shall be accountable for case managing that patient. All other agencies involved with the treatment of the patient must comply with the service plan established by the lead agency. The lead agency shall be responsible for all costs of implementing the treatment plan that are not subsequently covered by other agencies.

For example, a child under the jurisdiction of the Department of Youth Treatment and Rehabilitation (DYTR) would have DYTR as his lead agency. DYTR would then develop an individualized treatment plan (ITP) with personnel that meet the standard licensing criteria. If the child was eligible for Title XIX or other programs, DYTR could refer the child to those programs. Those programs could not change the ITP or assign an additional case manager. They would pay for those portions of the ITP that they covered, and the lead agency would pay for all uncovered services.

Analysis

When more than one agency is involved in delivering care, in order to ensure continuity of care and coordination of services without service duplication a lead agency must be established. The current system results in chaos. Clients have a different case manager for each agency, ITP's are developed by each agency which are many times contradictory, and

custodial agencies are not allowed to fulfill their fiduciary responsibility to their clients. The duplication of services and interagency arguments cost the state significant sums of money while simultaneously reducing the quality of services. Clients are left in the middle, trying to sort out how to receive treatment.

If each agency must employ case managers that meet minimum licensing standards, then another agency shall not be allowed to second guess the first agency. In the same spirit, the lead agency shall be ultimately responsible for paying for the uncovered portions of the ITP, since they were the ones that developed it. This change will result in substantial savings by reducing duplication and eliminating some interagency squabbling. The client will also benefit by dealing with only one case manager and one ITP.

Recommendation # 4.

The performance of Case Managers shall be evaluated. Since the use of case managers is both costly and critical to the effectiveness of treatment for some clients, evaluation criteria shall be established to measure the effectiveness of each case manager.

This recommendation is directed to all state agencies responsible for contracting for case management services. Such agencies shall strive to implement the Committee's recommendations pertaining to the over utilization and duplication of case management services.

Analysis

Case managers shall be evaluated based on the same factors that require their use. For instance, case managers are needed to guide clients between various providers, arrange transportation, and insure that the client does not fall through the cracks. Therefore, the case manager shall be evaluated on factors such as the following:

- Percentage of appointments missed by the client.
- Length of time between initial call by client until services are received.
- Percentage of clients who complete intake but never receive treatment.
- Improvement in client's illness.
- Improvement in client's ability to work, go to school, remain in the community.
- Percentage of clients enrolled in SSI, Title XIX, etc.

OUTCOME MEASUREMENTS RECOMMENDATIONS

Recommendation # 1.

Every dollar spent in the system shall have a purpose and a goal. The broker of behavioral health services shall be required as part of the contract requirement to develop treatment goals and to measure outcomes. These outcomes shall be measured over at least one year, in addition to other shorter-outcome measurements.

The broker of services shall be required to report these results to the state agency responsible for the program. After the first year, the state agency shall review these submissions from various brokers of services, and select the best methodologies for tracking results. These methods shall then be established as standards for all of the brokers of services.

For example, funds expended for prevention shall be directed toward the prevention of a specific illness. The prevalence of this illness occurring in the treated population shall then be compared to a control group of non-treated people to determine the effectiveness of the program.

Analysis

Currently, we have little, if any, indication as to the effectiveness of behavioral health expenditures. Citizens of Arizona are entitled to know what benefit they are receiving for their tax dollars. Simply spending money efficiently for behavioral health does not ensure any improvement in the quality of life for citizens. It is imperative to know which programs work, and which do not. This can only be accomplished through establishment of goals, and measurement of outcomes. Those programs that work can be expanded, and those that do not can be ended. This will maximize the benefit for each dollar expended.

Recommendation # 2.

A system shall be instituted which will provide interlocking incentives throughout the system to improve the delivery of services. One component of this effort shall be the establishment of monthly client satisfaction surveys which would be tied to financial rewards. To insure impartiality, the surveys shall be conducted by an independent polling company or by the Auditor General. Another component shall be the establishment of monthly public reports that detail the number of clients and payments made to each provider. When implemented properly, these incentives will help to drive the entire system to focus on excellence.

Analysis

The existing system does not provide incentives to provide high quality care, nor does it provide information to the public on which providers are doing well. By providing these incentives, significant strides can be made in improving the system.

The independent survey company would survey each month a random 10% of the clients of each provider. The clients would rank the provider they received services from on a scale of 1 to 10. The surveyor would then calculate an average client satisfaction score for each provider. Each RBHA, or broker of services, would then receive a score based upon the weighted score of the providers that they use. The state agency responsible for behavioral health would receive a score based on the weighted scores of the brokers of services.

These scores would then be published monthly. Areas of the state or individual providers with very high scores would be readily identified, as would areas or providers with low scores. This information would make it easier to find areas to focus on improvement, and areas to copy successes. A RBHA will focus more resources with providers with high scores, which will in turn encourage providers with low scores to improve. Most importantly, the prime benefactor will be the clients. This is because their satisfaction becomes the driving force in the system.

In addition to the independent client survey, a monthly survey of provider satisfaction with the brokers and the state agency shall be conducted, as well as a survey of the satisfaction of the brokers with the state agency. In this way, all levels will be able to reflect their satisfaction or dissatisfaction with other levels.

Based on information provided by the brokers, a monthly report shall also be published by the state agency, listing the number of clients and payments made to each provider. Providers that are not getting referrals can compare themselves to those that are in order to improve their methods of operation. These reports shall be made after the contracts have been negotiated so as not to interfere with the sealed bid process.

An additional option would be to provide small incentive payments to providers who receive high-satisfaction scores. This would heighten the incentive to improve these scores.

FUNDING RECOMMENDATIONS

Recommendation # 1.

Title XIX and non-Title XIX programs, for both children and adults, shall be budgeted as separate line items and footnoted to restrict non-Title XIX funds from being expended for Title XIX programs.

Analysis

Without separate line items of funding, any shortage in Title XIX funding can be easily covered by using non-Title XIX funds. Due to the frequency of Title XIX cost overruns, this could result in the system becoming a Title XIX-only system. Since the Legislature has consistently supported continued non-Title XIX subvention funding, a separate line item shall be budgeted to insure that a certain amount of the total system funding is dedicated solely to state-only clients.

Recommendation # 2.

Capitation rates shall be based on a total population, not just on those currently in treatment. In addition, where warranted due to special circumstances, special consideration shall be given to add-on capitation rates. Examples of this are areas where transportation is required from remote locations, there is a lack of economies of scale due to low-client counts, and areas where it is difficult to attract personnel without additional compensation stipends.

Analysis

An incentive exists to treat only low-need clients, and to turn away very needy clients. There is also no incentive to provide prevention services. These poor incentives were created by an earlier decision to capitate only those clients actually receiving behavioral health services, instead of an "enrolled" population.

If a RBHA spends money on prevention, it is expending resources that only reduce its future number of clients and, therefore, its revenue. If you are paid a certain amount for each client, the way to survive is to accept and keep clients that cost less than the capitation rate, and deny services to those that cost more.

The solution is to capitate for a larger population, as AHCCCS currently does. In this way, the broker of services is responsible for all costs of their enrollees, which encourages prevention and focuses resources on the neediest clients, because this is the most effective way for the health care brokers to reduce their greatest exposure to costs.

There will continue to be difficulties in providing adequate care to rural areas, sparsely populated areas, and other medically underserved areas until special cost factors are recognized and funded. To give the same per-person capitation rate to pay for services in a high-volume hospital in Phoenix as to transport a client from Page to Flagstaff for treatment with overnight stays, is unworkable. Blind capitation without reasonable adjustments for such factors will continually underfund rural areas and actually widen the gap between metropolitan and rural health care services. As a state, we shall provide equal services to all of our residents.

**Joint Legislative Budget Committee
Staff Memorandum**

DATE: December 15, 1993

TO: Representative Sue Grace

FROM: Michael Bradley, ^{MMB} Senior Fiscal Analyst

SUBJECT: REQUESTED GRAPHS

As you requested, the 11 attached graphs show the distribution of funding and clients, as well as a historical perspective on state behavioral health expenditures. Graph 1 demonstrates the increases that have been made in funding, as well as the impact of new federal funds due to Title XIX implementation. Graphs 2-4 show the size of behavioral health within the Department of Health Services (DHS) budget. Graphs 5-7 show the distribution of funding based upon client category. Graphs 8-11 show the numbers and percentages of clients by category and by RBHA.

Some of the numbers used to generate these graphs were estimated, but any variance would not significantly impact the information that is depicted. If you would like further information, please let us know at 542-5491.

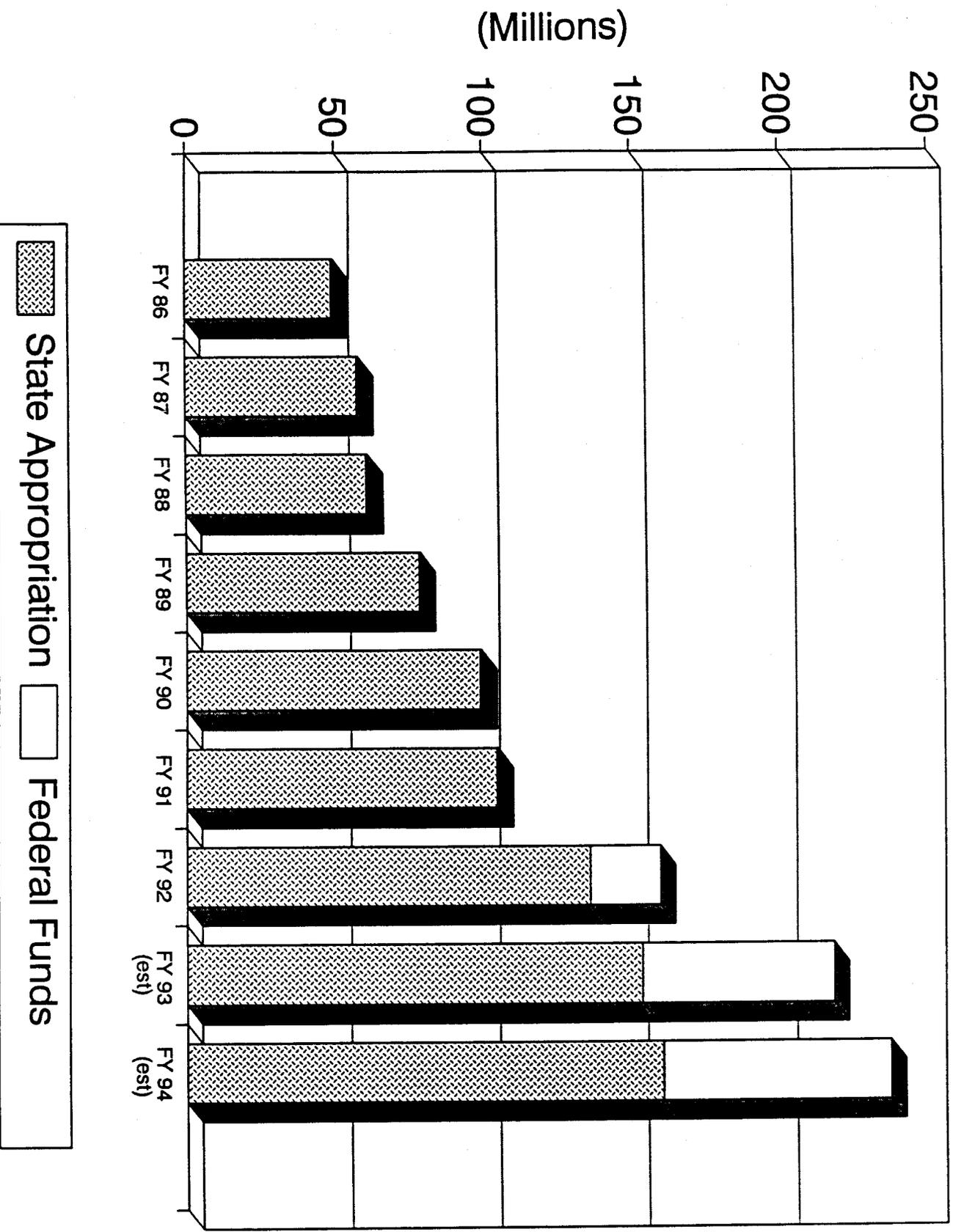
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Attachments

xc: Joint Ad Hoc Committee on Behavioral Health Members
Joint Ad Hoc Committee on Behavioral Health Staff
Ted Ferris, Director JLBC

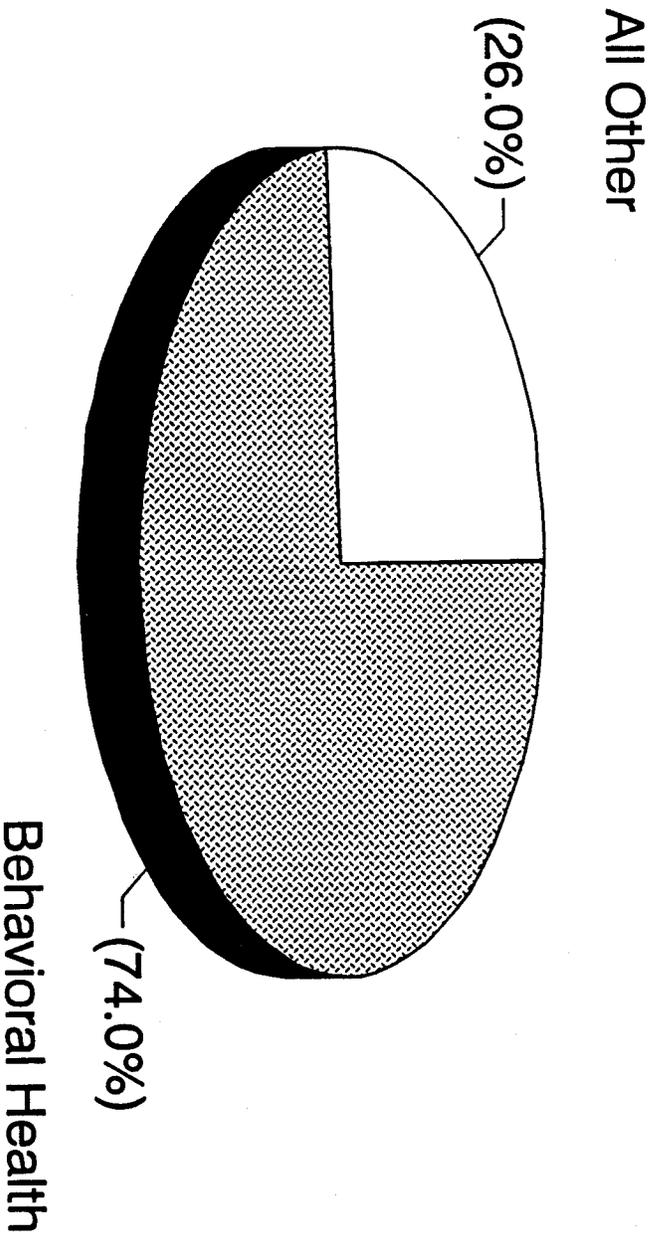
JLBC

State and Federal Funding of Behavioral Health FY 1986 to Present

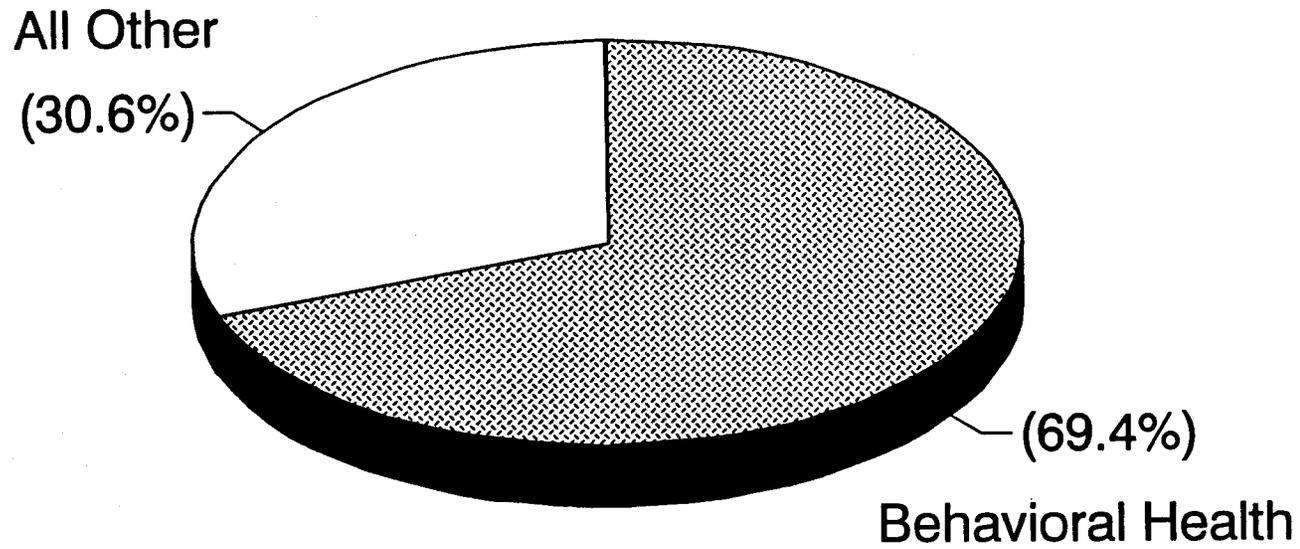


Department of Health Services

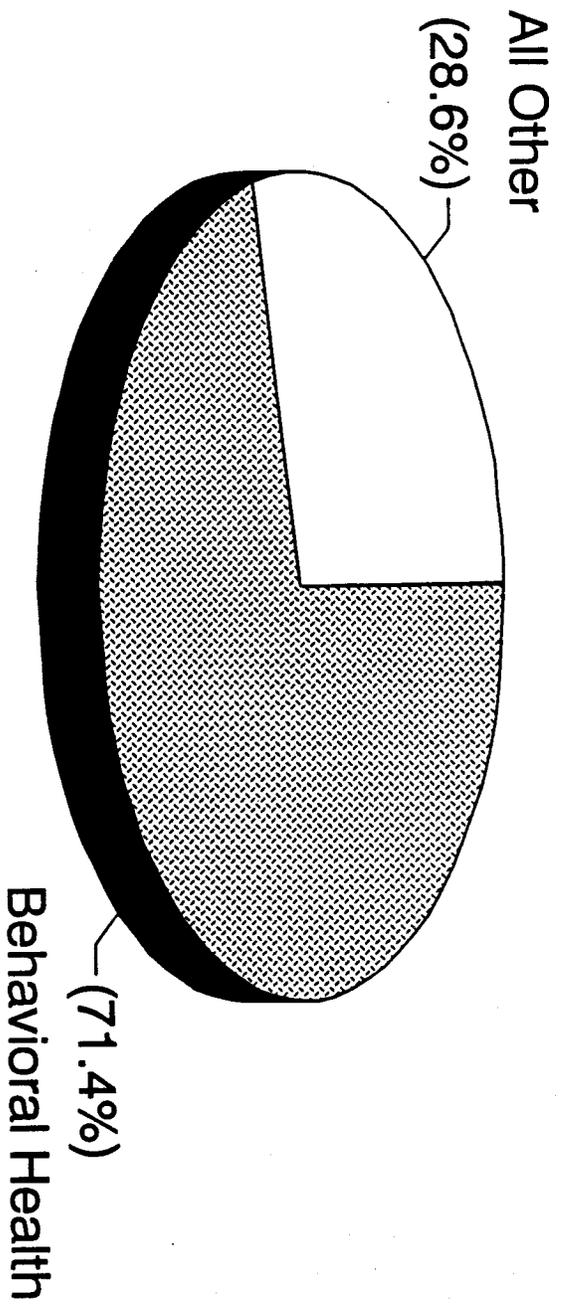
FY 1994 Appropriation



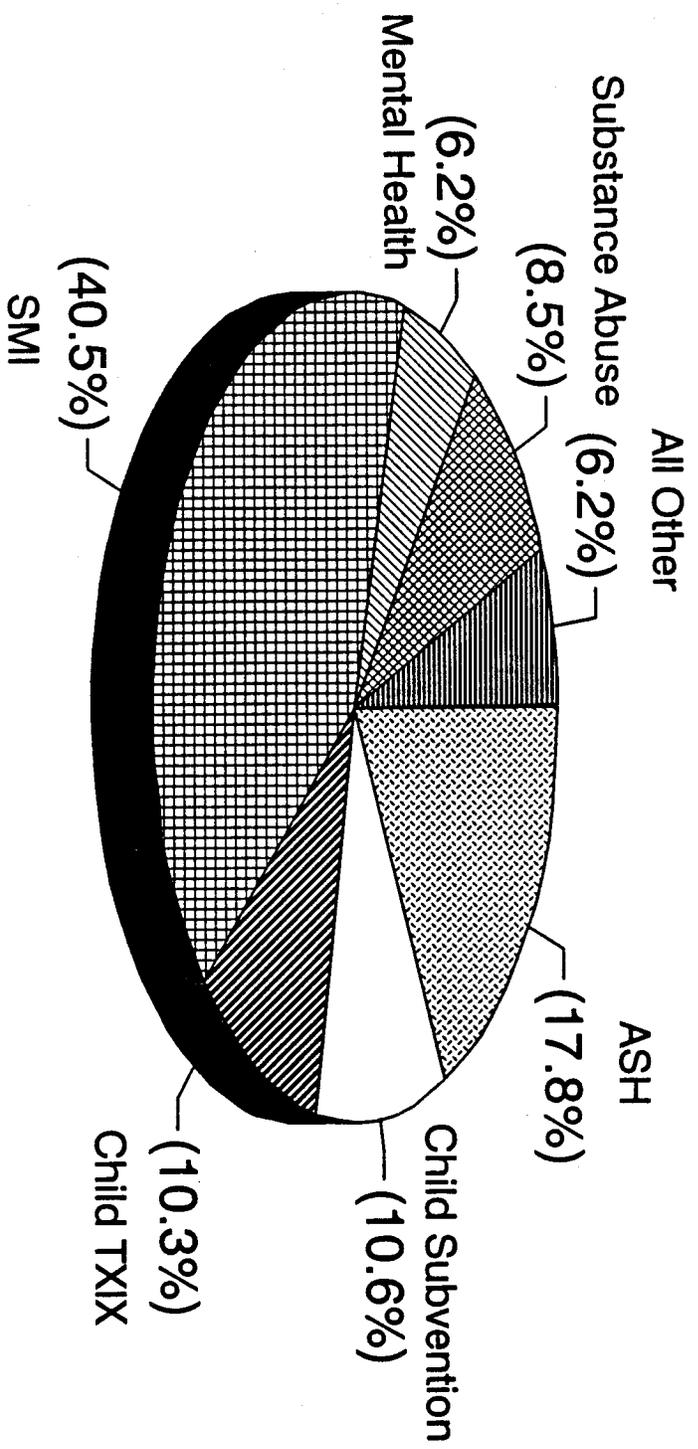
Department of Health Services
FY 1994 Non-Appropriated
(Estimates)



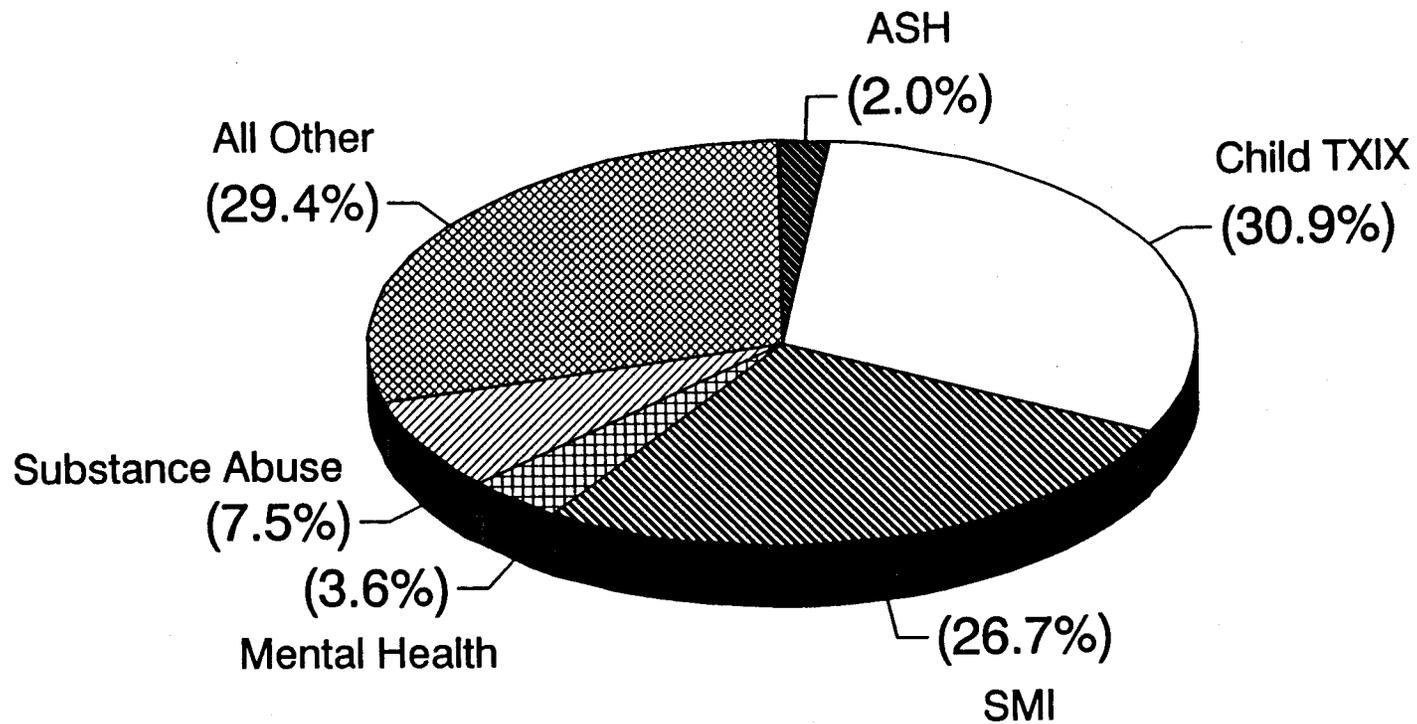
Department of Health Services
FY 1994 Total Resources



Department of Health Services FY 1994 Appropriated

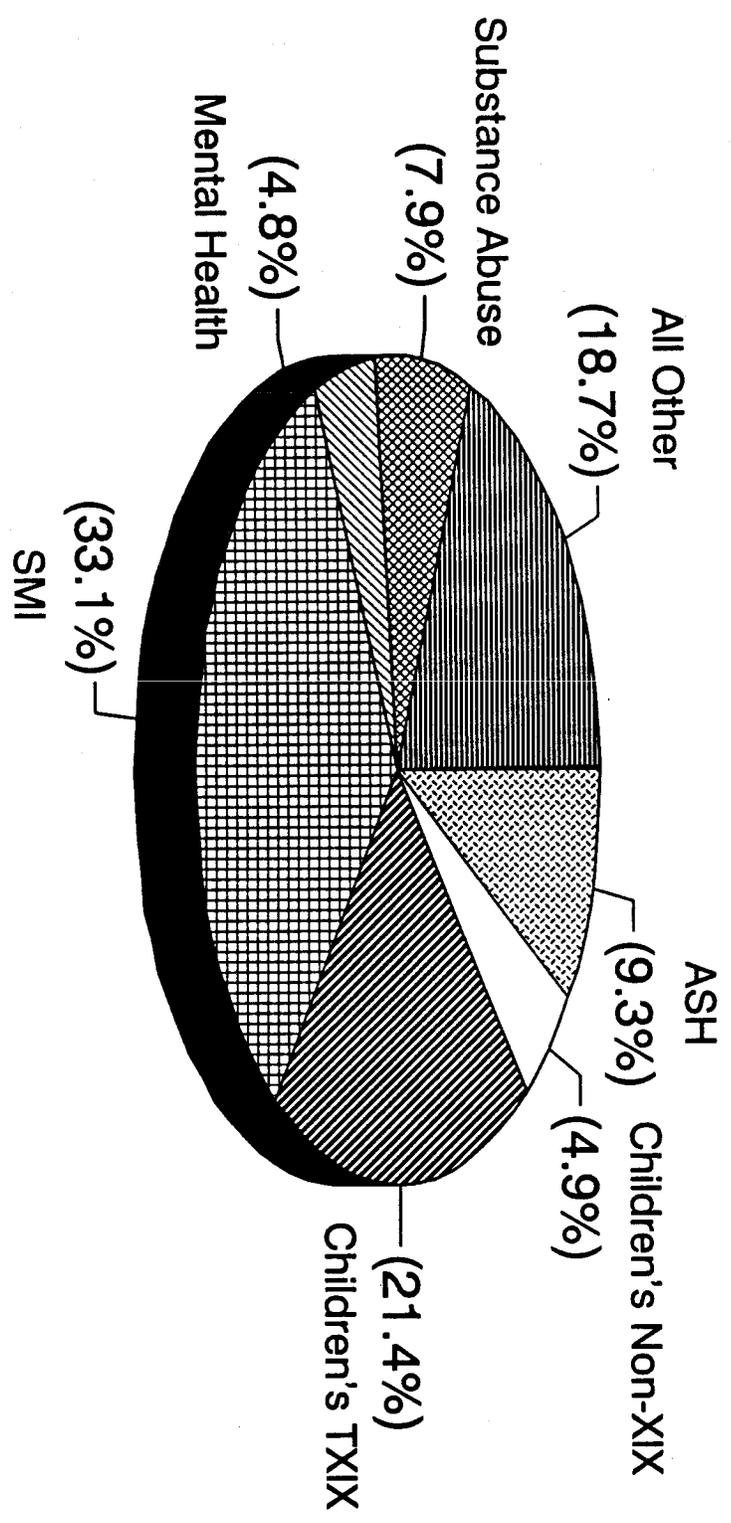


Department of Health Services
FY 1994 Non-Appropriated
(Estimated)



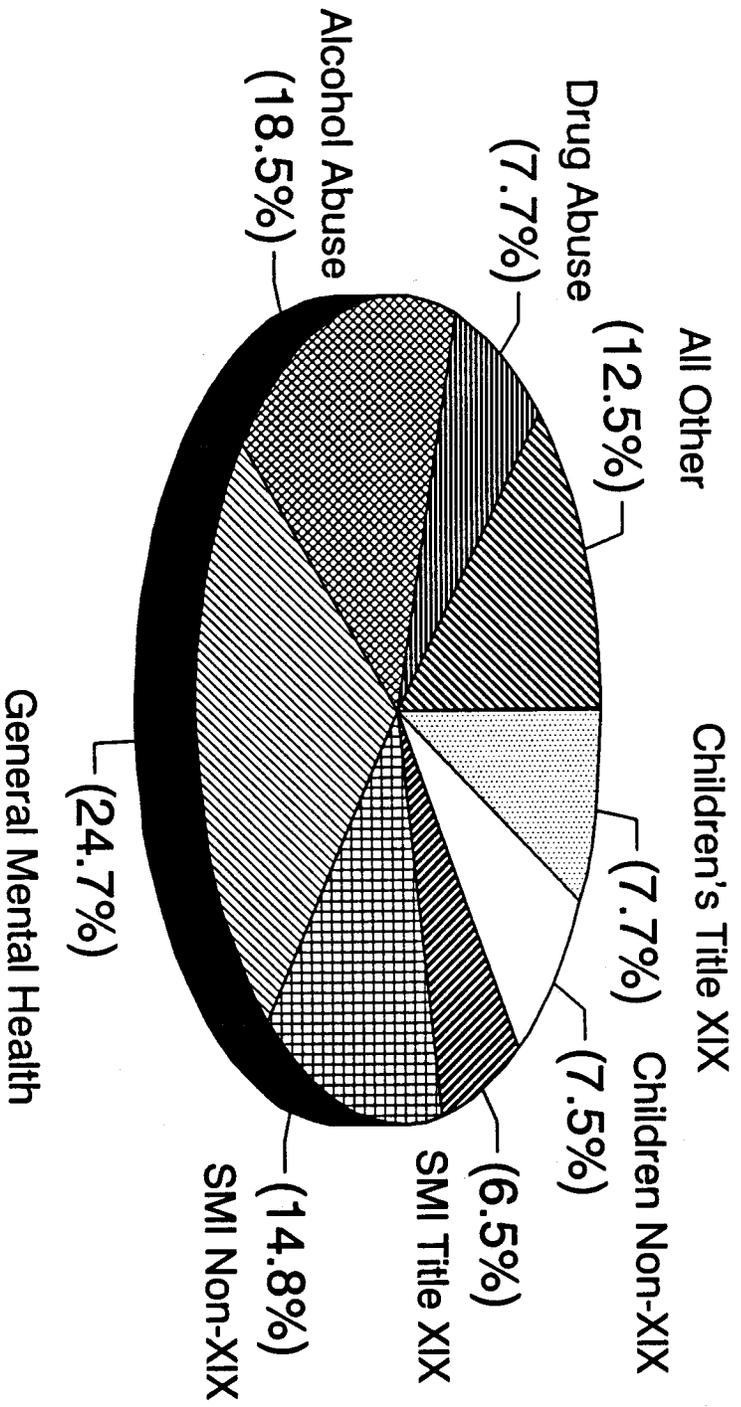
Department of Health Services

FY 1994 Total Resources



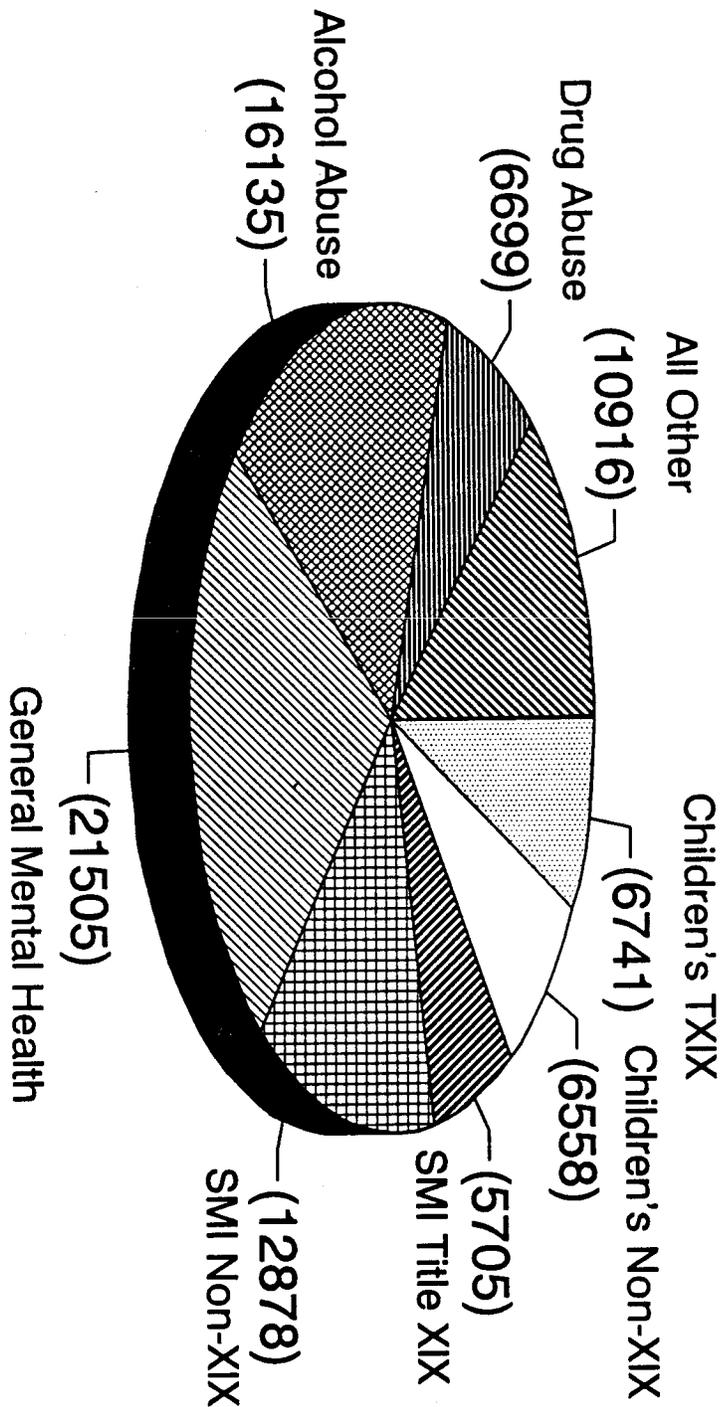
Percentage of Population by Category

(As of October 15, 1993)



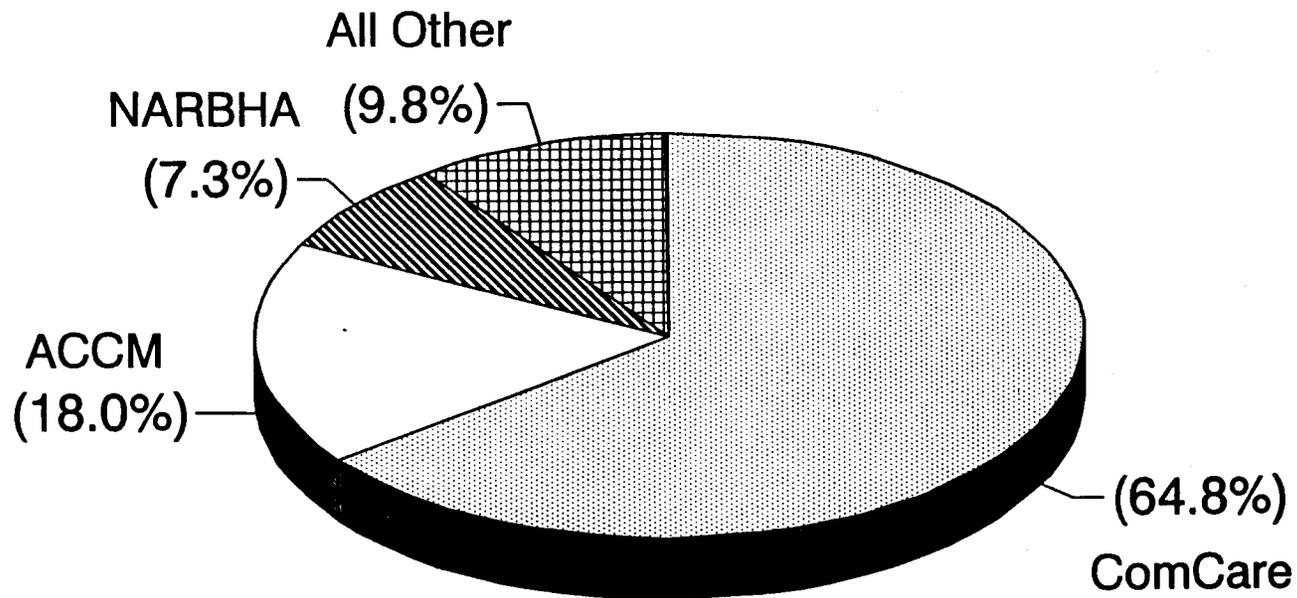
Number of Clients by Category

(As of October 15, 1993)



Percentage of Clients by RBHA

(As of October 15, 1993)



Number of Clients by RBHA

(As of October 15, 1993)

