State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES—Reporting Requirements

Report to the Arizona Legislature
By Debra K. Davenport
Auditor General
December 2001
Report No. 01-33

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AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

December 10, 2001

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. Catherine R. Eden, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, a review of the reporting requirements in Arizona's behavioral health system. This report is in response to Laws 2001, Chapter 195, §1 which directed this Office to identify any duplicative or outdated reporting requirements, look for ways to streamline reports, and consider criteria that measure the performance of the Division of Behavioral Health Services (Division) in the Department of Health Services. I am also transmitting with this report a copy of the Report Highlights for this review to provide a quick summary for your convenience.

As outlined in its response, the Department of Health Services agrees with all of the findings and recommendations.

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 11, 2001.

Sincerely,

Debra K. Davenport
Auditor General

Enclosure

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SUMMARY

The Office of the Auditor General has conducted a review of the reporting requirements in Arizona's behavioral health system. Laws 2001, Chapter 195, §1 directed the Office to identify any duplicative or outdated reporting requirements, look for ways to streamline reports, and consider criteria that measure the performance of the Division of Behavioral Health Services (Division) in the Department of Health Services.

The Division, its contracted Regional Behavioral Health Authorities (RBHAs), and their contracted providers prepare reports to meet legal, contractual, and judicial requirements. In total, auditors identified 63 reports prepared by these organizations. The reports enable the Division and its funding organizations, including the Arizona Health Care Cost Containment System (AHCCCS), to monitor essential aspects of system performance such as service quality, client protection, continued availability of services, and financial accountability.

The Division Can Streamline Some Reports and Eliminate Others (See pages 5 through 13)

The Division can eliminate six reports.

Although most of the 63 reports are necessary to oversee the behavioral health system and qualify to receive federal monies, the Division recently combined 2 reports and can eliminate 6 others without compromising oversight of the behavioral health system or losing federal funding. In addition, it can make other improvements to simplify reporting. Combining two costly and time-consuming case file reviews, and their associated reports, should satisfy federal requirements while reducing the burden on RBHAs and service providers. One of these reviews, called the Independent Quality Evaluation, entailed hiring an independent reviewer to examine a sample of cases for a specific population, such as substance-abusing pregnant women, or

people with schizophrenia. The other review, called the Medicaid Case File Review, involved review by RBHA staff of a sample of Medicaid client files for compliance with federal regulations. The Division and AHCCCS combined these two reviews through a contract amendment effective October 3, 2001.

Six additional reports can potentially be eliminated, including three outdated reports that were originally established by the Legislature. The reports that may be eliminated are:

- Three financial and claims reports that are duplicative or unnecessary, including two reports on the use of tobacco tax monies.

- A report requested by a former legislator to monitor shifts of appropriated monies. Such shifts can no longer occur due to a law passed in 2000.

- A report established to monitor spending of a special appropriation. This requirement in an appropriation footnote has ended.

- A report based on an involuntary commitment statute for chronic alcoholics. No such commitments have occurred in recent years, so no report has been prepared. The Legislature should consider reviewing and revising the statute and then, if appropriate, eliminating the associated report.

However, three other reports related to settlements on two class-action lawsuits appear necessary to demonstrate progress toward meeting the lawsuit settlement agreements. These reports cannot be eliminated or streamlined until the court and plaintiffs are satisfied with the State's performance.

Finally, the Division could simplify reporting if it can improve the data entry process for its two databases. Specifically, it should continue its efforts to enable the RBHAs to send data records only once, instead of sending them separately to both databases.

Division Can Continue To Improve Performance Measurement in Four Key Areas (See pages 15 through 22)

The Division measures clinical quality in several ways.

The Division measures performance in all four areas auditors were directed to consider, although performance measurement can be improved in each area. First, the Division measures clinical quality in several ways, including case file reviews and a variety of other oversight activities. It should continue its progress in developing service-planning guidelines that identify best practices for specific client diagnoses. Second, the Division measures service availability, using provider network reports, waiting list information, and reports on the length of time clients wait to receive services. However, it has only recently developed uniform definitions for some service availability performance measures. It should use these new measures consistently in the future. Third, the Division measures quality of service as rated by the patient or the patient's family, primarily through a Statewide Consumer Perception Survey administered by mail. However, this measurement is hampered by low survey responses. The Division should use alternative survey administration methods in order to obtain more meaningful results.

Finally, the Division currently measures the fourth area, quality of RBHA services as rated by providers, for only one of the five RBHAs. This measurement is part of the Incentive Pilot Program established in 1994. Although provider dissatisfaction with RBHA services does not appear to be widespread, the Division should consider surveying providers statewide in order to identify and address any problems. The relationship between RBHAs and providers is important because the Division relies on both to deliver services to clients, and unresolved dissatisfaction might affect the quality of behavioral health services clients receive.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a review of the reporting requirements in Arizona's behavioral health system. Laws 2001, Chapter 195, §1 directed the Office to identify any duplicative or outdated reporting requirements, look for ways to streamline reporting, and consider criteria that measure the Division's performance.

Arizona's behavioral health system is administered by the Department of Health Services' Division of Behavioral Health Services (Division), which provides publicly funded mental health services and substance abuse treatment and prevention services. According to the Division, in fiscal year 2001, the Division received approximately $389 million, including about $199 million in Title XIX (Medicaid) monies from the Arizona Health Care Cost Containment System (AHCCCS) and $39.2 million in non-Title XIX federal monies. All but approximately $15.5 million was allocated among five contracted Regional Behavioral Health Authorities (RBHAs), which operate like health maintenance organizations to coordinate services in their geographic regions. The RBHAs contract with a network of more than 350 service providers to offer a broad range of behavioral health services to over 100,000 consumers throughout the State.

Sources of Reporting Requirements

Sixty-three reports originate from contractual requirements, legislative requests or mandates, and judicial mandates.

Each organization in the behavioral health system, including the Division, the RBHAs, and the service providers, prepares reports to meet contractual, legislative, and judicial requirements. The Appendix (see pages a-i through a-xiii) lists 63 required reports and the primary sources establishing the requirements. The three main sources of reports are:

- **State and Federal Requirements**—Forty of the 63 reports are prepared in response to state and federal laws and regulations. Arizona laws and regulations establish require-

ments for 13 of these 40 reports. For example, an Arizona statute requires the Division to submit monthly reports on expenditures, persons served, and units of service. Federal laws and regulations, including those governing the use of Medicaid, establish the other 27 of the 40 reporting requirements.

- **Contractual/Grant Requirements**—Twenty additional reports are required by contracts or grants. The primary sources for 10 reports are contracts between AHCCCS, the Division, the RBHAs, and the providers. For example, the Division's contracts with the RBHAs and the RBHAs' contracts with their providers establish reports to monitor spending, services, and compliance with state laws, and to gather information needed for the Division's reports to AHCCCS.

  The primary sources for the remaining ten reports are grants from the federal government, which include reporting requirements as a condition of receiving grant monies. Currently, the Division, RBHAs, and providers have grants from several federal programs. The majority of these grants are funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency within the Department of Health and Human Services.

- **Judicial Requirements**—Finally, judicial requirements dictate the preparation of three reports. One report and a case file review are prepared as a result of the *Arnold v. Sarn* lawsuit.[1] The Division prepares these items to show progress toward meeting the criteria for exiting the lawsuit. Beginning in November 2001, a more recent lawsuit settlement, *J.K. v. Eden*, will also require a report.[2]

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[1] In 1981, the Superior Court of Arizona found that the Department of Health Services did not provide the level of services promised in state law to seriously mentally ill persons in Maricopa County. An agreement negotiated with the plaintiffs in 1995 establishes criteria for exiting the lawsuit, and until those criteria are met, a court-appointed monitor oversees compliance with the court-ordered agreement.

[2] The Division and AHCCCS entered into a settlement in 2001 to resolve a 10-year-old lawsuit filed on behalf of AHCCCS-eligible children who need mental health services. The agreement is based on a set of principles that stress family involvement and collaboration among agencies.

Purposes of Reporting

Oversight of the behavioral health system is critical to ensure that clients receive needed, quality services.

Collectively, the behavioral health system reports serve as monitoring tools for the Division and its funding organizations, including AHCCCS and the federal government. Oversight of the behavioral health system is critical to ensure that clients receive needed, quality services. Reporting on availability and quality of services is particularly important under Arizona's system because RBHAs receive payment in advance, based on a capitated rate per Medicaid-eligible person, instead of receiving payment for services once they have been delivered. This approach can help control costs, but may also give RBHAs an incentive to keep their own costs down by limiting care. As indicated in a 1999 performance audit of the Division (Auditor General Report No. 99-12), the Division has made substantial efforts to improve oversight compared to previous audits, including improving the way it monitors RBHA performance through required reports. Behavioral health system reports enable oversight of several essential aspects of contractor performance:

- **Service to clients**, including appropriateness based on the client's diagnosis, timeliness of services, use of appropriate assessments, treatment planning, treatment delivery by qualified individuals, and client and family satisfaction with services;

- **Client outcomes**, measured using clinical scores that show changes in client condition; for example, decreased substance abuse, as well as client and family satisfaction with outcomes, and mortality rates;

- **Client protection**, including monitoring client rights, treating clients in the least restrictive environment possible, and addressing grievances, appeals, and incidents of fraud or abuse appropriately;

- **Continued availability of services**, measured by adequacy of the existing provider network in offering services in geographic areas, as well as by contractors' financial viability; and

- **Financial accountability**, including compliance with restrictions on the use of state and federal monies.

Scope and Methodology

This review addresses the following purposes identified in Laws 2001, Chapter 195, §1 regarding behavioral health system reports:

- To identify duplicative and outdated reporting requirements and recommend ways that the reporting requirements can be streamlined into a more meaningful format.

- To consider criteria that measure the Division's performance, including clinical quality, availability of services, quality of service as rated by the patient or patient's family, and quality of RBHA services as rated by service providers.

To address these issues, auditors reviewed reporting requirements established in contracts, legislation, and court decisions; interviewed Division, RBHA, and provider staff to identify other reports they prepare; examined and compared reports to their reporting requirements; and interviewed report recipients about the way they use the reports and the effect of eliminating or streamlining the reports.

This report contains recommendations in two areas:

- The Division can streamline some reports and eliminate others.

- The Division can continue to improve performance measurement in four key areas.

The report also includes an Appendix (see pages a-i through a-xiii) that lists 63 reports required by the behavioral health system.

The Auditor General and staff express appreciation to the Director of the Department of Health Services, the Deputy Director of the Division of Behavioral Health Services, the RBHAs, AHCCCS, and their staff for their cooperation and assistance throughout the review.

FINDING I

THE DIVISION CAN STREAMLINE SOME REPORTS AND ELIMINATE OTHERS

The Division has the opportunity to combine some reports and eliminate others without compromising oversight of the behavioral health system. Two of the 63 reports currently produced were consolidated during the audit because they are essentially similar, and 6 others can be eliminated because they are no longer necessary. However, 3 reports prepared as a result of the settlement of two class-action lawsuits cannot be combined or eliminated until the court and plaintiffs are satisfied with the State's performance. Still, the Division can simplify and streamline processes for the remaining reports by eliminating the need to enter data into two separate computer databases.

Two Costly and Time-Consuming Case File Reviews and Reports Were Recently Combined

Combining two extensive but similar case file reviews will significantly reduce the reporting burden.

Until October 3, 2001, the Division conducted two extensive but similar case file reviews, with each review resulting in a separate report covering such issues as quality and appropriateness of care. Both examined large, statistically valid samples of client files across all RBHAs, and both were conducted to satisfy federal mandates. Because the two reviews and reports had similar purposes, included some of the same information, and relied on some of the same case files, the reviews have been combined. This should significantly reduce the reporting burden on RBHAs and their providers. The two file reviews were as follows:

- **Independent Quality Evaluation**—This annual review was conducted to satisfy a federal requirement. It evaluated quality of care for a selected client group or diagnosis by assessing treatment approaches, comparing treatment provided

against service-planning guidelines, and reviewing client outcomes. A different client group or diagnosis was chosen each year. For example, the review and report addressed children in 1999, substance-abusing pregnant women in 2000, and people with schizophrenia in 2001. Federal regulations mandate that an independent reviewer conduct this review. The Division spent approximately $350,000 per year on it, using administrative dollars provided by AHCCCS.

The review placed substantial demands on the RBHAs and their providers. The provider file samples reviewed have ranged from 122 to 1,689 total cases, depending on the topic.[1] RBHAs and providers had to gather case files from all their locations, prepare or copy them for review, and assist the independent reviewers by answering questions and helping set up meetings with key RBHA and provider staff. Given the review's size, this work was extensive. For example, in 2001, one provider reported spending 175 staff hours making copies of client files for the independent reviewer.

- **Medicaid Case File Review**—This review, also conducted annually to satisfy a federal mandate, assessed compliance with federal requirements for Title XIX/XXI clients, including timeliness of treatment, whether services are rendered by providers with appropriate expertise, quality of care, and client outcomes. A federal regulation allows qualified staff or an independent evaluator to conduct this review. Using Division records, auditors estimated that the 1999 review, conducted by RBHA staff, cost approximately $75,000.[2]

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1 For the 2001 evaluation, AHCCCS and the Division initially agreed on a sample size of 2,371 client files. In order to reduce the burden on providers, the sample size was reduced to 1,689 before the evaluation was conducted.

2 Auditors calculated this figure using 1999 Arizona Community Behavioral Health Wages information for clinically qualified staff and BHS staff estimates of time spent reviewing case files. Source: Information provided by the Division, using *4th Quarter 1999 State Occupational Employment-Arizona and Wage Estimates* and *4th Quarter 1999 National Occupational Employment and Wage Estimates.*

The 1999 Medicaid Case File Review examined 1,189 case files.

Like the Independent Quality Evaluation, this review placed demands on both RBHAs and providers. The 1999 review examined 1,189 case files. In addition to gathering and preparing the files for review, the RBHAs supplied qualified staff who conducted the reviews using a 94-question Quality of Care Case File Instrument.

The Division and AHCCCS began discussing the potential for combining the two reviews during the audit, and combined them in an October 3, 2001, contract amendment. To meet federal requirements, an independent evaluator will need to conduct the combined review. An AHCCCS official believes a statistically valid, independent review of a target population, including a review of the factors currently assessed in the Medicaid case file review, will satisfy both requirements. Because approximately 50 percent of the Division's clients are not Title XIX/XXI eligible, the Division will also need to ensure that these individuals are included in the combined review.

Six Reports Can Be Eliminated

Three reports are not used at all or contain information that is available in other reports.

Six of the behavioral health system's 63 reports are no longer necessary and can therefore be eliminated without affecting oversight of behavioral health programs. Three of these six reports are either not used at all or contain information that is available in other reports. Two of the six are prepared in response to earlier legislative mandates that are no longer applicable. A sixth report pertains to a statutory provision that is outdated and has not been used in some time. In addition, the Division should eliminate the annual reporting requirement for the cost allocation plan and require reports only when the cost allocation method changes.

Three financial and claim reports are duplicative or unnecessary—Three reports appear unnecessary because they duplicate material in other reports or are not used at all. Although eliminating any one of these reports would not result in substantial time savings for any one provider or RBHA, the combined effect could be significant. Each report requires preparation at more than one level in the behavioral health system. Further, at the

RBHA and Division levels, the reports received from providers and RBHAs are reviewed, combined, and submitted elsewhere. The three reports are as follows:

- **Provider Affiliation Tape (also called Provider Network File)**—The RBHAs and the Division use this report to submit a list of authorized providers and identification numbers for comparison with AHCCCS' records. The Division and AHCCCS recently agreed to replace it with a more efficient online process for comparing the information. However, as of October 3, 2001, the contract between AHCCCS and the Division still requires this report.[1]

- **Tobacco Tax Revenues and Expenditures Report**—This report, which the Division submits to the Department of Health Services' budget analyst, is not necessary. The report explains how each RBHA uses monies from the tobacco tax; however, the budget analyst uses a different report for this purpose—the legislatively mandated Tobacco Tax Evaluations Report.

- **Tobacco Tax Cash Activity Report**—Similar to the Tobacco Tax Statement of Revenue and Expenses, RBHAs prepare this report for the Department budget analyst, but the analyst does not use it.

Two reports are no longer needed because the mandate no longer applies.

Three legislatively mandated reports no longer needed—In three cases, reports prepared in response to legislative mandates can be eliminated. Two of these reports are no longer needed because the mandate no longer applies. The third, which has not been prepared in nearly 10 years, relates to a seldom-used procedure for involuntarily committing a chronic alcoholic for treatment. The Legislature should consider reviewing the statute that makes this report necessary.

[1] The AHCCCS contract lists this item as two separate reports, a tape and a file. However, according to the Division, the tape was the physical medium for transmitting the file to AHCCCS. The Division now uses disks instead of magnetic tapes for transferring computerized records, but the contract was never modified to delete the reference to the tape.

- **Non-Title XIX/XXI Children's Behavioral Health Services Summary (also called Grace Report)**—This report, originally requested by a former legislator to monitor whether monies appropriated for non-Title XIX children were actually used for such children, is no longer necessary. Laws 2000, Chapter 2, §1 prohibits the Division from moving monies from one budget line item to another, such as from non-Title XIX children to other uses.

- **Quarterly Medications Report**—This report, prepared in response to a 2-year legislative requirement that ended in 1999-2000, is no longer necessary. In 1998 and 1999, the Legislature appropriated a total of over $16 million for psychotropic medications, and required the Division to report on how the monies were being used. This requirement in an appropriation footnote has since expired. The Division can continue to monitor spending on medications through its annual medications report, without requiring RBHAs to submit this quarterly report. Information on expenditures for psychotropic medications can readily be gathered from the RBHA computer systems as needed.

- **Involuntary Commitment Report**—Pursuant to A.R.S §36-2026.01, the Director of the Local Alcoholism Reception Center (LARC), located in Maricopa County, may petition the court for involuntary commitment of a person deemed a chronic alcoholic, and must submit a report to the Division about such commitments. However, the current LARC program manager has never petitioned the court for involuntary treatment, and the Division has not received a report since 1992. Further, since the time this statute was enacted, delivery of behavioral health services, including alcoholism services, changed. The County no longer has primary responsibility for such services, and LARC is now operated by a private, nonprofit organization. Additionally, involuntary commitment is not consistent with best practices in substance abuse treatment, and there are other ways of treating clients. The Legislature should consider reviewing and revising the involuntary commitment statute and eliminating the associated report, if appropriate.

The Legislature should consider reviewing the involuntary commitment statute and the associated report.

One financial report not needed annually—The Annual Cost Allocation Plan, which the Division receives from each RBHA, defines direct and administrative costs and describes the RBHA's allocation methodology. The AHCCCS contract with the Division sets a limit on recovery of administrative costs at 8 percent of the value of direct services provided. Further, such costs must be allowable under the federal Office of Management and Budget (OMB) Circular A-122. Currently, the Division requires each RBHA to submit a plan every year. However, the Division should work with AHCCCS to eliminate the annual requirement for a complete report, and instead require reports only when the plans change. If there have been no changes to their plans, the RBHAs should be required to annually submit a statement that the existing plan is not outdated.

In addition, the Division should improve its oversight of the RBHAs by reviewing the plans. Currently, the Division does not review the plans it receives. However, it should compare the listed items against approved administrative costs identified by the OMB Circular, and require the RBHAs to correct their plans when needed.

Reports Related To Judgments on Class-Action Lawsuits Are Still Needed

Reports on two class-action lawsuits appear necessary to demonstrate progress until the court and plaintiffs are satisfied with the State's performance.

Three of the 64 reports are related to settlements on two class-action lawsuits. These reports appear necessary to demonstrate progress toward meeting the lawsuit and settlement agreements and cannot be eliminated or streamlined until the court and plaintiffs are satisfied with the State's performance. However, the Division and the Maricopa County RBHA should work with the court monitor to streamline the process for the lawsuit pertaining to seriously mentally ill adults. The two suits and related reports are as follows:

- ***Arnold v. Sarn***—The 1995 agreement negotiated by the Department of Health Services and the plaintiffs in the *Arnold v. Sarn* lawsuit, which focused on the State's obligation to seriously mentally ill adults in Maricopa County, includes an

annual case review and a regular status report.[1] The case review is the primary tool used to demonstrate progress in meeting the agreement obligations. Specially trained RBHA staff conduct these reviews, answering 329 questions for each case based on a review of the file and interviews with the client, case manager, and other persons. Division staff certified by the court monitor review the RBHA staff findings in a process called case judging. Each of these reviews takes approximately 3 full days to conduct, including the file review, the interviews, writing the findings, and case judging.

In 1999, the Auditor General suggested the Division consider having the court monitor conduct the case file reviews as part of her independent review, since she retained the right to negate the Division's findings and had done so in the past (Report No. 99-12). The Division and the court monitor worked together to develop the current procedure and training, and hope this will result in agreement on the findings. The Division and the court monitor should continue working together to streamline the process. For example, they could eliminate questions once the monitor is satisfied that the underlying criteria have been addressed.

- ***J.K. v. Eden***—Under the terms of the settlement in this case, which addressed AHCCCS-eligible children who need mental health services, the Division is required to prepare an annual action plan describing strategies and activities relating to agreed-upon obligations, such as statewide training and expanding services for this population.[2] In addition, in-depth case reviews and interviews with family and relevant individuals in the child's life are required.

Procedural Improvement Could Simplify Reporting

In addition to streamlining or eliminating certain reports, the Division may be able to simplify reporting by improving the data

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1 160 Ariz. 593; 775 P.2d 521; 1989, Maricopa County C-432355.

2 *J.K. v. Eden,* Arizona Federal District Court Case, No. CIV91-261.

entry process for the Division's databases. The Division currently requires RBHAs to enter information separately into two databases: the Client Information System (CIS), which contains billing information; and the Client Enrollment, Disenrollment, and Assessment Reporting (CEDAR) system, which contains client information. Currently, RBHAs transmit partial client data records from their own computer systems to CIS. CIS assesses the accuracy and completeness of the record as submitted, and sends it back to the RBHA. The RBHA then adds demographic and clinical data and submits the data record to CEDAR. Therefore, the RBHAs must send each record twice. The Division has begun exploring ways to enable the RBHAs to send data only once. Division officials hope to include an improved data entry process with other changes that will be required by October 2002 to implement the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which mandates federal standards for computerized systems.

Recommendations

1. The Division should eliminate the following reports:

   a) Provider Affiliation Tape (also called Provider Network File)

   b) Tobacco Tax Revenues and Expenditures Report

   c) Tobacco Tax Cash Activity Report

   d) Non-Title XIX/XXI Children's Behavioral Health Services Summary (also called Grace Report)

   e) Quarterly Medications Report

2. The Division should work with AHCCCS to eliminate the annual requirement for the Cost Allocation Plan, and

   a) Require reports only as needed when the plans change; and

   b) Review the plans and compare them against approved administrative costs identified by Office of Management and Budget Circular A-122 and require the RBHAs to correct their plans when needed.

3. The Legislature should consider reviewing and revising the involuntary commitment statute for chronic alcoholics in A.R.S. §36-2026.01 and eliminating the associated report, if appropriate.

4. The Division should continue working with the court monitor to streamline the *Arnold v. Sarn* case file review.

5. The Division should continue its efforts to improve the data entry process for the Client Information System (CIS) and Client Enrollment, Disenrollment, and Assessment Reporting (CEDAR) system databases.

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FINDING II

DIVISION CAN CONTINUE TO IMPROVE PERFORMANCE MEASUREMENT IN FOUR KEY AREAS

The Division measures performance in all four areas auditors were directed to consider. Most measurement occurs for clinical quality. The least amount of measurement is done of provider satisfaction with RBHA services. However, measurement can be improved in each area.

Laws 2001, Chapter 195, §1 instructed auditors to consider whether the behavioral health system reports contain criteria that measure the performance of the Division in the following areas:

- Clinical quality,
- Availability of services,
- Quality of service as rated by the patient or the patient's family, and
- Quality of regional behavioral health authority services as rated by their service providers.

Clinical Quality Measured in Several Ways but Measurement Can Be Improved

The Division assesses clinical quality in several ways. However, the Division should continue its efforts to develop a comprehensive set of service-planning guidelines describing quality-of-care standards.

The Division measures clinical quality through case file reviews.

Division has multiple mechanisms for measuring clinical quality—The Division measures clinical quality through case file reviews. It recently combined two separate reviews that examine aspects of clinical quality, such as whether services are appropriate and delivered by qualified providers. One of these reviews, the Independent Quality Evaluation, examines clinical quality measures using an evaluation tool composed of quality standards particular to a certain population.

Clinical Quality

Quality of services in a treatment setting as determined by accepted standards and best practices.

In addition, the Division measures clinical quality in the following ways:

- Medical care evaluation studies, performed by certain providers, help to ensure that services are consistent with patient needs and established health care standards.

- Through reports from RBHAs, Division staff examine the use of client seclusion and physical restraints, and monitor whether caregivers use the least restrictive method of treatment.

- Division staff assess the success of clinical treatment methods by examining how long clients must stay in treatment, and how often clients must be readmitted for additional treatment.

- The State's participation in the Mental Health Statistics Improvement Program (MHSIP)[1] provides benchmarks for access to services, quality of services, appropriateness of services, outcomes, and general satisfaction.

The Division uses this information to identify needed improvements and develop plans to address any problems identified. For example, the medical care evaluation and seclusion and restraint

[1] The Mental Health Statistics Improvement Project (MHSIP) is a national effort to develop benchmarks for mental health services. Arizona is 1 of 16 states participating in the development of these benchmarks under a grant from the federal Substance Abuse and Mental Health Services Administration.

measures are included in an annual Operational and Financial Review the Division conducts at each RBHA. A Corrective Action Plan is developed to address problem areas identified in this review.

Division can continue to improve clinical quality assessment— While the Division has a number of clinical quality measures, some of them are not tied to a comprehensive set of service-planning guidelines and best practices. A 1996 Auditor General report (No. 96-19) recommended that the Division develop standards of care through service-planning guidelines across the spectrum of needs it strives to meet. The Division has made progress in doing so. So far, it has guidelines for 15 client groups or diagnoses, including substance-abusing pregnant women and people with schizophrenia. It uses these guidelines to inform providers and RBHAs of best practices, and to assess client treatment plans in its case file reviews. However, there are many other conditions patients are being treated for, such as bipolar disorder, that currently lack guidelines. The Division needs to continue its efforts to develop guidelines and standards for other client diagnoses.

Division Is Making Progress in Measuring Service Availability

The Division addresses service availability in two primary ways. First, it monitors how long it takes clients to receive services by comparing referral dates to dates of first service, and works with the RBHAs to develop corrective action plans for addressing problems. Second, it assesses availability of services by geographic area, and monitors provider waiting lists for certain clients and certain types of services. It requires RBHAs to provide this information in annual provider network reports. In these reports, the RBHAs must identify what services are needed but unavailable and propose plans to correct service gaps. The Division is currently establishing a baseline of provider network capacity, and plans to take "snapshots" of network changes in an automated quarterly report. As recommended in the 1999 performance audit of the Division (Report No. 99-12), the Division is using mapping software to help it assess the sufficiency of the

Network reports show availability of services by geographic area.

statewide provider network. Due to the passage of Proposition 204 in November 2000, which expanded eligibility for services, analyzing the provider network is an especially important function at this time to ensure services are available for existing and new clients. The Division should continue improving the assessment of provider network availability.

Although the Division has made progress in measuring availability, the measures it uses have not been fully consistent. For example, the Division only recently defined the term "enrolled," which caused some inconsistencies in calculating various performance measures that rely on enrollment. One such measure is penetration rate, which measures the number of clients enrolled and served compared to the number of potential clients in the population. This measure is an aspect of service availability, since low penetration rates can indicate needed services are not available. The Division recently developed a uniform definition for this measure and other terms used to calculate it. The Division should use the new definitions consistently and ensure that it develops complete, uniform definitions when it adds or modifies performance measures in the future.

Quality-of-Service Ratings Are Hampered by Low Survey Responses

The Division monitors quality of service as rated by the patient or the patient's family primarily through a survey sent to patients and their families. This is a useful instrument, particularly because the results can be benchmarked with results from other states, but low response rates from those surveyed diminish the meaningfulness of Arizona's results. The Division can take steps to increase the response rate.

Survey assesses client and family satisfaction in four areas.

Consumer Perception Survey offers opportunity to benchmark Arizona's performance with other states—The primary measurement tool addressing quality of service as rated by the patient or the patient's family is the Statewide Consumer Perception Survey. The survey assesses client and family satisfaction with services provided. Every 2 years, the Division and the RBHAs survey clients. The survey instrument, available in both English

and Spanish, measures four areas of satisfaction: access to services, quality and appropriateness of services, outcomes, and general satisfaction. For example, in 1999, clients were asked to indicate their levels of agreement or disagreement with 25 statements, including:

- I like the services that I received here
- I was able to get all the services I thought I needed
- Staff returned my calls within 24 hours
- Staff told me what side effects to watch for
- As a result of services, I deal more effectively with daily problems
- As a result of services, I do better in school and / or work

The survey includes questions drawn from the national Mental Health Statistics Improvement Project (MHSIP), which will allow the Division to benchmark itself against other states. The Division sends survey results to MHSIP, produces a biennial report, and submits survey results to the Arizona Master List of State Government Programs to show consumer satisfaction rates.

Division needs to improve response rates by using alternative survey administration methods.

Low response rate affects reliability of results—While the survey can provide useful information, the Division needs to improve response rates in order to make the results more meaningful. In 1999, the response rate was only 19 percent, making it impossible to generalize results statewide. The 2001 survey yielded similar low response rates. Both surveys were conducted primarily by mail, a method that often gives poor response rates. To improve the response rate, the Division needs to consider alternative survey administration methods. The MHSIP project work group is currently evaluating various methods, including face-to-face interviews conducted by consumers. Other states have reported response rates as high as 84 percent when using face-to-face survey methods.

Consumer satisfaction also measured in other ways—In addition to the Consumer Perception Survey, client satisfaction is also

a factor in two case file reviews, which include interviews with clients and family members. For example, beginning in November 2001, as part of an annual action plan to satisfy *J.K. v. Eden* settlement agreement stipulations, the Division will conduct patient and family interviews as well as case file reviews. This information will provide the Division additional perceptions of families' and children's quality of care. Finally, one RBHA conducts a consumer survey as part of its pilot incentive program.

RBHA Services Rated by Providers for Only One of Five RBHAs

In contrast to its efforts with regard to the three other types of performance measures auditors were asked to address, the Division does relatively little to gather information about the quality of RBHA services as rated by the providers that contract with each RBHA. The Division formally measures providers' perceptions of quality at only one RBHA. The Division should consider measuring such perceptions system-wide.

Provider satisfaction measurement of one RBHA is tied to incentive program—The measurement of providers' satisfaction with one RBHA is done as part of a pilot incentive program established by Laws 1994, Chapter 1, §24.[1] The pilot program provides financial incentives to the RBHA based on providers' satisfaction with the services the RBHA provides. For example, in January 2001, the RBHA received $751 based on the results of a provider satisfaction survey. Provider staff responded to ten questions, such as, "Does the RBHA process claims and pay bills on time?" and "Do you receive the technical assistance you need from the RBHA?" The results show that provider satisfaction

[1] The incentive program includes two other components besides provider satisfaction. Specifically, both providers and the RBHA can earn incentive payments based on the results of client and stakeholder surveys. All three surveys consist of six to ten questions and are administered three times a year. In fiscal year 2002, a total of $100,000 is available for these incentives. The January 2001 surveys resulted in incentive payments totaling $2,704 out of a possible $3,004 paid to the RBHA, and $22,441 out of a possible $29,726 paid to providers. Eleven providers earned incentives in that period. The Department of Health Services suggested eliminating this pilot program in September 2001 as part of its budget reduction proposal.

improved slightly over the first 5 years of the pilot program. Specifically, the percentage of providers responding "always" to these questions increased from approximately 16 percent in 1997 to about 26.5 percent in January 2001.

Division does not survey other RBHAs' providers—Instead of surveying other RBHAs' providers, the Division uses other means for monitoring provider satisfaction. For example, in addition to the pilot program, the Division has a grievance mechanism that allows dissatisfied providers to complain. In calendar year 2000, providers filed 248 grievances, 246 of which were related to nonpayment. The Division also holds provider forums and monthly meetings with providers. Results of the pilot program and the number of grievances filed do not indicate widespread dissatisfaction with RBHA services as rated by providers.

Division may wish to survey providers of all five RBHAs.

Provider satisfaction surveys could be expanded—The Division may wish to proactively obtain feedback from providers regarding quality of services provided by all five RBHAs. The Division could administer the ten-question provider survey statewide to measure RBHA services to providers. The Division should then use the results of the survey to focus on RBHAs with low satisfaction rates, because dissatisfaction could affect the quality of behavioral health services clients receive. Further, because the Division is dependent on RBHAs and providers to ensure there is an adequate network in place to provide behavioral health services to clients, the relationship between RBHAs and providers is important to the Division.

Recommendations

1. The Division should continue its efforts to develop service-planning guidelines for additional behavioral health diagnoses.

2. The Division should consistently use its newly developed uniform definitions for service availability performance measures.

3. The Division should work to improve the response rate for its consumer survey by considering alternative survey administration methods, instead of relying on mail surveys.

4. The Division should consider expanding its survey of providers regarding their satisfaction with RBHA performance to include all RBHAs.

Appendix

Appendix

Behavioral Health System Reports
As of October 2, 2001

	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirememts
System-wide service appropriateness, delivery, and quality reports. Enable recipients to monitor key aspects of service delivery and system-wide operations.					
1	*Annual Report* Financial and programmatic report summarizing revenues and expenditures, administrative costs, State Hospital average daily census, accomplishments, and number of people served by category.	Annually	BHS	Governor, President of Senate, and Speaker of the House of Representatives	**State Law** A.R.S §36-3405(A)(B)
2*	*Case File Review Report* RBHA staff review of Title XIX / XXI client files to determine compliance with requirements for timeliness, appropriateness, coordination of services, and inclusion of client and family in service planning.	Annually	RBHA	BHS	**Federal Law** 42 C.F.R. §434.53
3	*Community Mental Health Services Performance Partnership Block Grant Report* Behavioral health system achievements, problems with action plans, goals with measures, and indicators.	Annually	BHS	Federal SAMHSA	**Grant** Performance Partnership Block Grant
4	*HB2003 Implementation Report* Progress report on mental health services funded by tobacco litigation settlement monies.	Semi-Annually	RBHA	BHS	**State Law** Laws 2000, Chapter 2, §1

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5*	*Independent Quality Evaluation/Audit* Report from contracted specialist on services to clients. Study based on provider case file review for particular member group and can include interviews with key RBHA staff.	Annually	BHS	AHCCCS	**Federal Law** 45 C.F.R. §96-136
6	*Medical Care Evaluation Study Results* Title XIX Level I inpatient and residential treatment centers' report on results of their analysis of admissions, duration of stay, and services. Includes recommendations for change, if appropriate.	Annually	Provider	RBHA	**Federal Law** 42 C.F.R. §456.141-145, §456.241-245
7	*Member Survey* Report on plan, implementation, and results of a client satisfaction survey.	Biennially	RBHA BHS	BHS AHCCCS	**Federal Law** SSA §1932
8	*Operational and Financial Review of the RBHAs* Includes financial reporting systems, and appropriateness of service level determinations, congruence of services authorized with level of care criteria and prior authorization policy, appropriateness of case management services.	Annually	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §434.6, §434.50
9	*Prevention Evaluation Report* Describes programs intended to prevent problems such as substance abuse, domestic violence, school dropout, teen pregnancy, and other problems. Includes program goals and results.	Annually	RBHA	BHS	**Grant** Federal Substance Abuse and Treatment (SAPT)

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10	*Quality Management/Utilization Management Plan (also called Performance Improvement Plan)* Report on system to monitor RBHA compliance with requirements in clinical care and administrative functions, with progress on goals and objectives set in prior year's plan.	Annually	BHS	AHCCCS	**Federal Law** 42 C.F.R. §456.6, §482.21, §434.34, §456.100 et. seq., §456.200 et. seq.
11	*Quality Management Report* Performance indicators and action plans for addressing problems. Includes penetration rates, first service within 30 days of referral, symptomatic and health status outcomes, inpatient days per thousand, average length of inpatient stay, and trends in grievances.	Quarterly	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §434.6, §434.34
12	*Waiting Lists* Clients waiting for specified substance abuse services. Some RBHAs also maintain for certain residential services.	Quarterly or monthly	Provider RBHA	RBHA BHS	**Grant** Federal SAPT (Substance Abuse Prevention and Treatment)
13	*Vocational Plan* Plan for increasing satisfactory employment of clients with serious mental illness.	Annually	RBHA	BHS	**Contract** BHS/RBHA

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Program and project-specific reports. Enable stakeholders to monitor specific programs and projects.					
14	*Annual Action Plan/Report* Plans and progress in meeting terms and conditions of the J.K. Lawsuit Settlement Agreement.	Annually (begins 11/01)	BHS and AHCCCS	J.K. Lawsuit defendants	**Judicial** *J.K. v. Eden* settlement agreement
15	*Arizona Substance Abuse Treatment Needs Assessment* Substance use problems, treatment needs, and treatment programs. BHS contracts with a variety of researchers, including the University of Arizona Rural Health office, to conduct the studies.	Annually	BHS and various contracted researchers	Federal SAMSHA	**Grant** Federal, State Substance Abuse Needs Assessment program
16	Arnold vs. Sarn *Case File Reviews* Plans and progress in meeting terms and conditions of the *Arnold v. Sarn* exit stipulation	Annually	Value Options/BHS	Court monitor	**Judicial** *Arnold v. Sarn* exit stipulation
17	*Compulsive Gambling Treatment Program Report* Expenditures, services provided, and number of people served through hotline and other services for compulsive gamblers.	Quarterly	BHS	Lottery	**Contract:** Lottery/BHS
18	*Correctional Officer/Offender Liaison Program Report* Substance abuse services for offenders released to community supervision.	Quarterly	RBHA	BHS	**Contract** Department of Corrections/BHS
19	*Evaluation of Housing Approaches for the Seriously Mentally Ill* Evaluation of three approaches to housing people with a serious mental illness: Supported housing, supportive communities, and supervised apartments. BHS contracts with three researchers, including Arizona State University, to conduct the evaluations.	Once only, at end of project (approx. 12/01)	BHS and various contracted researchers	Federal SAMHSA	**Grant** Federal Supported Housing Grant

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
20	*Incentive Program Pilot* Survey results from clients, providers, and referring agencies regarding RBHA performance. Used for distributing incentive monies. Applies only to PGBHA.	Three times per year	BHS	Representative Huppenthal	**State Law** Laws 1994, Chapter 1, §24
21	*Integrated Treatment Consensus Panel Evaluation* Evaluation of project to improve treatment of persons with co-occurring mental health and substance abuse disorders.	Once only, at end of project (1/31/02)	BHS and University of Arizona	Federal SAMHSA	**Grant** Federal Phase II Community Action Grant
22	*Inventory of Substance Abuse Prevention and Treatment Programs* Program names/locations, funding, clients served (number/demographics/problems), summary of services provided, and evaluation of results achieved.	Annually	Arizona Drug & Gang Prevention Resource Center (using information provided by RBHAs)	Governor, President of the Senate, Speaker of the House of Representa-tives	**State Law** A.R.S. §36-2023(c)
23	*Mental Health Statistics Improvement Project (MHSIP) Report* Results of using common performance indicators with 15 other states in pilot project. Indicators incorporated into BHS' member survey.	Once only at end of project, (7/1/02)	BHS	Federal Center for Mental Health Services (CMHS)	**Grant** Federal MHSIP

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24	*Project to Assist in Transition from Homelessness (PATH) Report* Value Options, NARBHA, and CPSA only. Services and clients served in program for homeless people with serious mental illness; includes placements in housing.	Monthly Annually	Provider RBHA BHS	RBHA BHS PATH	**Grant** Federal PATH
25	*Project MATCH (Multi-Agency Team for Children) Report* Accomplishments, services, and people served in a Pima County program intended to provide an integrated system of care for seriously emotionally disturbed children and their families.	Quarterly	BHS	Federal SAMHSA	**Grant** Federal SAMHSA
26	*Status Report on the Terms and Conditions of the Exit Stipulation* For facilitating discussion in meetings with plaintiffs in *Arnold v. Sarn* lawsuit. Includes update on strategic plans for four areas, identified in a supplemental agreement to the exit stipulation.	Three times per year	BHS	Court monitor and *Arnold v. Sarn* plaintiffs	**Judicial** *Arnold v. Sarn* Court monitor
27	*Substance Abuse Prevention and Treatment (SAPT) Block Grant Report* Expenditures and services provided with the Block Grant monies.	Annually	BHS	Federal SAMHSA	**Grant** Federal SAPT Block Grant
Client protection reports. Enable report recipients to monitor compliance with requirements related to client rights, safety, and welfare.					
28	*Grievances and Appeals Report* Number and types of appeals and grievances filed by members, providers, and RBHAs.	Quarterly	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** 42 C.F.R. §434.63

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29	*Incident and Accident Report* Summary of reported accidents, deaths, and incidents including physical and sexual abuse.	Quarterly	Provider	RBHA	**Federal Law** 42 C.F.R. §455.13
30	*Incidents of Potential Fraud or Abuse* Observation and circumstances.	Upon occurrence	RBHA BHS	BHS AHCCCS	**State Law** A.R.S. §36-2918.01
31*	*Involuntary Commitment Report* Treatment plan and discharge summary for individuals involuntarily committed to treatment by a Local Alcoholism Reception Center (LARC) director's petition.	Upon occurrence	LARC	BHS	**State Law** A.R.S. §36-2026.02(C)
32	*Seriously Mentally Ill Client Mortality Report* Circumstances of death of client with serious mental illness.	Upon occurrence	RBHA	BHS	**State Regulation** Arizona Administrative Code R9-21-409
33	*Seriously Mentally Ill Client Seclusion and Restraints* Reports use of seclusion or restraints to manage client behavior.	Monthly	Provider	RBHA	**State Regulation** Arizona Administrative Code R9-21-204.(R)
34	*Showing Report* Physician certifying need for Level I inpatient and residential treatment center care.	Quarterly	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §456.160
Provider network reports. Enable report recipients to monitor service availability statewide.					
35*	*Provider Affiliation Tape (also called Provider Network File)* Data for electronic matching of provider network information between BHS and AHCCCS.	Monthly	BHS	AHCCCS	**Contract** AHCCCS/BHS

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
36	*Provider Network Status Report (also called Provider Network Evaluation and Sufficiency Report)* Narrative analysis of provider network sufficiency and list of providers by geographic service area and type of service.	Annually	RBHA BHS	BHS AHCCCS	**Federal Law** SSA §1932
37	*Provider Network Status Update/Report* Lists providers added and deleted, and changes in facilities' licensure. Identifies material gaps in the provider network and status of any corrective actions, including progress on using technologies such as mapping software and telemedicine.	Quarterly	RBHA BHS	BHS AHCCCS	**Federal Law** SSA §1932
38	*Unexpected Changes That Could Impair the Provider Network* Provider termination, suspension, or failure to meet licensing criteria.	Upon occurrence	RBHA	BHS	**Federal Law** SSA §1932
Service authorization and provision reports. Enable recipients to monitor quantity and dollar value of services provided and compliance with contractual stipulations defining who can provide and receive services.					
39	*Encounter Reporting* Client services reported electronically from providers through RBHAs and through BHS to AHCCCS. Encounter data is used to set capitation rates and evaluate quality of care.	Monthly	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** 42 C.F.R. §433.32

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
Financial reports. Enable report recipients to monitor contractor's financial soundness and compliance with restrictions on use of state and federal monies.					
40	*25th of the Month* Compares total expenditures for the month and year to date as compared to prior years' totals. Must also include potential shortfalls in programs and potential federal and other funds.	Monthly	BHS	Selected legislators and staff[1]	**State Law** Laws 2001, Chapter 232, §12
41	*Budget* Budgeted schedule of revenues and expenses, required by some RBHAs.	Annually	Provider	RBHA	**Contract** RBHA / Provider
42*	*Cost Allocation Plan* Defines direct and administrative costs and describes the RBHA's allocation methodology.	Annually	RBHA	BHS	**Federal Law** 45 C.F.R. §95.501 Subpart E
43	*Disclosure Statements* Ownership, related party transactions, creditors, board members, key managers, and subcontractors.	Annually	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §455.100, §1002.3, §1124, §1128(a), §1902(a)38

[1] President of the Senate, Speaker of the House of Representatives, Chairmen of the Senate and House Appropriations Committees, and the Director of the Joint Legislative Budget Committee.

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
44	*Division Monthly Report* Shows Title XIX and non-Title XIX funding, administrative and case management expenses, persons served, and units of service by RBHA.	Monthly	BHS	Governor, House Speaker, Senate President	**State Law** A.R.S.§36-3405(D)
45	*Federal Financial Participation Reimbursement* Estimated cash requirements for outreach (ends 12/01)	Bi-weekly	BHS	AHCCCS	**Federal Law** Cash Management Improvement Act (CMIA) of 1990 (Public Law 101-453) as amended by CMIA of 1992 (Public Law 102-589)
46	*Financial Viability Ratios Statement* Ratios used for evaluating a RBHA's financial condition.	Annually	BHS	AHCCCS	**Federal Law** 42-C.F.R. §433.32, §434.50
47	*Incurred But Not Reported Claims (also called Lag Report)* Costs associated with health care services incurred during a financial reporting period but not reported to the prepaid health care provider until after the reporting date.	Quarterly	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §433.32
48*	*Medications Report* Spending for psychotropic medications, and related client and prescription counts.	Quarterly Annually	RBHA	BHS	**State Law** Laws 1998, Chapter 2, §8 and Laws 1999, Chapter 6, §5

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
49*	*Non-Title XIX/XXI Children's Behavioral Health Services Summary (also called Grace Report)* Shows how money appropriated for children's behavioral health services is actually spent.	Monthly	RBHA BHS	BHS Legislature	**State Law** Laws 2001, Chapter 232, §12
50	*Notice of Real Property Transactions* Property purchase or sale notification.	Upon Occurrence	RBHA	BHS	**Contract** BHS/RBHA
51	*Quarterly Expenditure Reports* Actual and projected administrative expenditures for outreach activities (ends 12/31/01)	Quarterly	BHS	AHCCCS	**Federal Law** 42 C.F.R. §433.32, §434.50
52	*Schedule of Deferred Revenue* Revenues received but not yet earned, including the source and use of the revenue.	Monthly	RBHA	BHS	**Contract** BHS/RBHA
53	*Single Audit: Audited Financial Statements (draft and final)* Statement of financial position, statement of activities with changes in net assets, statement of cash flows, functional statement of expenses, and notes.	Annually	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** Single Audit Act Amendments of 1996 (all organizations spending $300,000 or more of federal dollars)
54	*Single Audit: OMB Circular A-133 Reports* Auditors' reports on federal grant funding and compliance.	Annually	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** Single Audit Act Amendments of 1996 (all organizations spending $300,000 or more of federal dollars)

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	Report name and description	Frequency	Preparer	Recipient	Primary Source of Requirement
55	*Single Audit: Restated Fourth Quarter Statement of Activities and Changes in Net Assets* Explains differences between year-end and audited statement of activities based on auditor adjustments.	Annually	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** Single Audit Act Amendments of 1996 (all organizations spending $300,000 or more of federal dollars)
56	*Single Audit: Statement of Financial Position Reconciliation* Explains differences between year-end and audited financial statements based on auditor adjustments.	Annually	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** Single Audit Act Amendments of 1996 (all organizations spending $300,000 or more of federal dollars)
57	*Statement of Activities* Shows year-to-date revenue and expenses for Title XIX/XXI and non-Title XIX/XXI. Quarterly report also includes changes in net assets.	Quarterly; monthly from RBHA	Provider RBHA BHS	RBHA BHS AHCCCS	**Contract** AHCCCS/BHS
58	*Statement of Cash Flows* Provides information about cash inflows and outflows during the period.	Quarterly; monthly from RBHA	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** 42 C.F.R. §433.32, §434.50
59	*Statement of Financial Position* Illustrates the financial position in balance sheet format.	Quarterly; plus monthly from RBHA	Provider RBHA BHS	RBHA BHS AHCCCS	**Federal Law** 42 C.F.R. §433.32, §434.50
60	*Summaries of RBHA Financial Information* Summary reports; includes financial statements viability ratio analysis, and analysis and review.	Quarterly	RBHA BHS	BHS AHCCCS	**Federal Law** 42 C.F.R. §433.32, §434.50

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61*	*Tobacco Tax Cash Activity Statement* Cash flow of tobacco tax monies year-to-date. Includes beginning cash balance, cash received, and cash disbursed.	Quarterly	RBHA	BHS	**Contract** BHS/RBHA
62	*Tobacco Tax Evaluations Report* Use of monies allocated by A.R.S. §36-2921 for behavioral health service program established in A.R.S. §36-3414.	Annually	BHS	JLBC	**State Law** A.R.S. §36-2907.07[1]
63*	*Tobacco Tax Revenues and Expenditures Report* Revenues and expenditures of tobacco tax monies on an accrual basis.	Quarterly	RBHA	BHS	**Contract** BHS/RBHA

[1] In 2001, Senate Bill 1313 amended A.R.S. §36-2907.07, changing reporting requirements for tobacco tax evaluations beginning on July 1, 2002. The Auditor General is to evaluate and report on tobacco tax programs administered by the Department of Health Services, with the first report due on November 15, 2004.

* Auditor General staff recommends streamlining, eliminating, or modifying the frequency of these reports (see Finding I, pages 5 through 12).

AHCCCS=Arizona Health Care Cost Containment System
BHS=DHS Division of Behavioral Health Services
CFR=Code of Federal Regulations
CPSA=Community Partnerships of Southern Arizona
NARBHA=Northern Arizona Regional Behavioral Health Authority
PGBHA=Pinal Gila Behavioral Health Authority
RBHA=Regional Behavioral Health Authority
SAMHSA=Substance Abuse and Mental Health Services Administration
SSA=Social Security Act
Title XIX/Title XXI=Medicaid/KidsCare

Agency Response

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Debra K. Davenport
Auditor General
2910 N. 44th Street
Phoenix, Arizona 85008

Dear Ms. Davenport:

Thank you for an opportunity to respond to your office's review of the behavioral health system's reporting requirements.

We agree with the report and plan to implement all of its recommendations. We commend the audit team for developing a thorough understanding of our reporting requirements, our performance measurement system, and our quality improvement efforts.

Once again, thank you for your professionalism and your fair and thorough evaluation.

Sincerely,

Catherine R. Eden
Director

Other Performance Audit Reports Issued Within the Last 12 Months

01-1 Department of Economic Security—Child Support Enforcement
01-2 Department of Economic Security—Healthy Families Program
01-3 Arizona Department of Public Safety—Drug Abuse Resistance Education (D.A.R.E.) Program
01-4 Arizona Department of Corrections—Human Resources Management
01-5 Arizona Department of Public Safety—Telecommunications Bureau
01-6 Board of Osteopathic Examiners in Medicine and Surgery
01-7 Arizona Department of Corrections—Support Services
01-8 Arizona Game and Fish Commission and Department—Wildlife Management Program
01-9 Arizona Game and Fish Commission—Heritage Fund
01-10 Department of Public Safety—Licensing Bureau
01-11 Arizona Commission on the Arts
01-12 Board of Chiropractic Examiners
01-13 Arizona Department of Corrections—Private Prisons
01-14 Arizona Automobile Theft Authority
01-15 Department of Real Estate
01-16 Department of Veterans' Services Arizona State Veteran Home, Veterans' Conservatorship / Guardianship Program, and Veterans' Services Program
01-17 Arizona Board of Dispensing Opticians
01-18 Arizona Department of Corrections—Administrative Services and Information Technology
01-19 Arizona Department of Education—Early Childhood Block Grant
01-20 Department of Public Safety—Highway Patrol
01-21 Board of Nursing
01-22 Department of Public Safety—Criminal Investigations Division
01-23 Department of Building and Fire Safety
01-24 Arizona Veterans' Service Advisory Commission
01-25 Department of Corrections—Arizona Correctional Industries
01-26 Department of Corrections—Sunset Factors
01-27 Board of Regents
01-28 Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29 Department of Public Safety—Sunset Factors
01-30 Family Builders Program
01-31 Perinatal Substance Abuse Pilot Program
01-32 Homeless Youth Intervention Program

Future Performance Audit Reports

Arizona State Lottery Commission

Arizona Health Care Cost Containment System