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Delivering Services for the Mentally Ill and Developmentally Disabled:

A Consumer Choice Model

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EXECUTIVE SUMMARY

With the shift to community programs and the integration of many disabled citizens into the community, vast changes have occurred in the way non-disabled citizens view the disabled and in the way in which services are provided and managed. Increasingly, services for the mentally ill and developmentally disabled are being provided with a focus on self-sufficiency, empowerment and readiness skills. Consumer choice and active participation in service planning are seen as important elements of quality and effectiveness.

Vouchers and other forms of consumer directed purchasing provide a mechanism for states and local governments to provide services in a manner that enhances consumer choice and improves the purchasing relationship between government, providers and consumers. Consumer directed purchasing has advantages over traditional state contracts with providers by focusing more on the needs of the consumer, improving monitoring by families, and enhancing competition among providers.

There are four different models of consumer directed purchasing currently in use, including: vouchers, individualized contracts or funding, direct cash disbursement programs and reimbursement programs. Each has different implications for choice and control over spending for the government agency to consider. These models were reviewed in nine states and one province in departments serving individuals with mental illness and developmental disabilities. In general, the programs reviewed were limited in scope and yet

virtually all of the state and local administrators sought to expand and improve upon their systems.

In considering whether to implement a system of consumer directed purchasing, governments must consider a number of critical issues. These include: consumer and provider eligibility criteria, eligibility and service authorization procedures, reimbursement and financing systems, voucher or fund distribution systems, transition planning, consumer education, monitoring and management information systems. Central to the success of any initiative will be the ability of the state or government agency to fairly direct services and funding to those that are most in need and develop procedures for authorization and funding that are equitable to consumers and providers alike.

In this era of government reform, consumer directed purchasing of services holds forth the promise of empowering consumers, improving service quality, and streamlining government.

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I. Introduction

Almost six percent of the U.S. population consists of individuals with severe mental illness and/or mental retardation. Numerous other Americans are developmentally and physically disabled. In this century we have seen enormous changes in the treatment and care of these individuals. While many of these individuals are cared for by families and private insurance, a significant portion rely upon public funds for their care and support.

Over the last twenty-five years in America, there has been an increasing trend toward the deinstitutionalization of health and human services, particularly for the mentally ill and those with mental retardation. Many states have turned to contracts with private agencies to serve these individuals outside of state institutions. Though contracting efforts have generally proven far more effective and humane in treating the mentally disabled than housing them in large state institutions, problems have arisen in state contracts with private agencies. Program quality has sometimes suffered, costs have risen, cases of fraud have occurred and states have had to increase their vigilance and financial oversight.

Vouchers and other methods of consumer directed purchasing are possible solutions to some of the problems encountered with state service delivery and contract systems. Though voucher programs have not been used to any great extent so far in deinstitutionalization efforts, they are garnering growing support from consumer advocates and families because of the importance of consumer choice and consumer empowerment.

Vouchers help to enhance consumer empowerment by changing the purchasing relationship and dynamic between the state and private providers and by giving consumers an appropriate role in purchasing decisions. The advantages of these systems over traditional contracting methods include: flexibility, consumer choice and improved service quality.

This paper provides a rationale for replacing current state programs for mental health and mental retardation with vouchers and other consumer directed systems. Moreover, trends in human services and the economic characteristics of voucher or consumer directed purchasing are reviewed in more detail in the appendix. Lastly, the steps necessary to overcome barriers and implement a voucher program are detailed.

II. Deinstitutionalization and Public Purchasing

A. The Trend Towards Deinstitutionalization

It has been conservatively estimated that severe mental illness, mental retardation and other developmental disabilities affect between 6 percent and 8 percent of the U.S. population . In Massachusetts alone, the combined budgets for mental health, mental retardation and Medicaid mental health spending are well in excess of $1 billion. Many Americans have family members or friends that have experienced these afflictions and thus can understand the enormous costs, emotional and financial, that are placed upon those families that try to care for their relative.

In the early part of the century, for those with the ability to pay, the usual response by families to such afflictions was to send the family member with mental illness or retardation to one of many private hospitals or schools. Those without sufficient finances turned to state mental institutions or state schools for the retarded. Since the late 1960's, however, individuals with mental illness and mental retardation have increasingly been treated in the community, wherever possible. The advent of psychotropic drugs has made community treatment possible for those with mental illness and there has been a growing realization that the opportunities for learning and growth for individuals with mental retardation are much greater in community settings.

Contributing to the growth of services being provided in communities have been various federal laws. The courts have also contributed to the movement to the community by ordering states to close down their institutions in a number of landmark cases.

Mentally disabled clients who previously spent many of their waking hours medicated or in restraints in institutions have been able to move to the community and begin vocational training and supported employment. The diversity of experience in the community provides numerous opportunities for learning and growth. Families and communities have found new ways to support the mentally disabled and provide opportunities for meaningful employment for individuals previously considered ineducable.

B. Concerns with Deinstitutionalization

States have made different levels of progress in deinstitutionalization and have chosen different methods to close their state institutions. State and federal funding restrictions, community resistance, the availability of appropriate community properties and the determination of state administrators have each, to varying degrees, influenced the progress and outcomes of deinstitutionalization efforts.

Most states have deinstitutionalized their state facilities through purchase of service contracts with private (generally nonprofit) agencies. This has generally improved the quality of life for residents and reduced costs.

While deinstitutionalization has generally enjoyed widespread support, some concerns have been expressed in terms of quality assurance. There have been several examples of fraud and misuse of funds. In Massachusetts, for example, several private agencies were closed due to financial irregularities and/or fraud. In other parts of the country, incidents have been reported of sexual abuse of residents, inadequate supervision by staff and deaths of the mentally ill in community placements. Fearing the loss of public accountability, some families and citizens have voiced concerns about the movement from state-operated to privately-delivered services.

When public agencies contract with private providers to deliver these social services, one of the reasons they are held directly accountable is because they have put themselves in the middle of the decision to purchase services on behalf of consumers. The rapid growth of community services must be accompanied by sophisticated monitoring, evaluation and quality assurance by state agencies. This entails new forms of program oversight and licensing. The problem is that objectively evaluating the performance of third party providers in areas such as mental health and mental retardation is extremely difficult for government to do well. The reason: government officials can only be at the program site a small portion of the time. As a result, they lack information needed to reliably assess program quality.

One possible answer to this dilemma is to provide greater control and choice to clients and their families by transitioning these programs to vouchers and other consumer directed methods. Such an approach would allow consumers and family members to choose the service provider that best meets their particular needs and go elsewhere if they are dissatisfied with the service. (See Appendix I for a detailed discussion of the different characteristics of supply-side and demand-side systems of service delivery).

III. The Case for Switching to Voucher-Like Systems

Transitioning to vouchers and other methods that enhance consumer choice potentially has a number of advantages over more traditional ways of delivering services. First, consumers and their families are in a better position than the state to monitor the performance of the contractors. Second, consumer-directed purchasing systems result in a more appropriate focus on the needs of the consumer instead of the needs of the private human service agencies. Third, vouchers create opportunities for consumer choice, empowerment and increased competition among providers.

Advantage #1: Service Quality Benefits

Giving purchasing authority to consumers helps to direct providers attention more squarely to consumer needs. A consumer-directed purchasing system challenges more traditional service providers to re-think the way they deliver services. The definition of "customer" changes for the service provider from the state to the consumer. The traditional supply side method of financing social service systems—where private agencies negotiate budgets with the state—changes to one focused on satisfying and negotiating services with consumers or their family. There is less attention paid to inputs and the process of contract renewal and more attention to consumer benefits and service outcomes.

Advantage #2: Public Agency Benefits

In vouchers and other models of consumer directed purchasing, the administration of the system shifts from focusing on buying services on behalf of consumers to determining eligibility, authorizing services and assisting consumers with making informed purchasing decisions. This is consistent with the efforts to improve monitoring and quality that are underway in many publicly funded health and human service agencies across the country. It is also consistent with efforts to restructure government and minimize government intervention in the provision of services.

Though it cannot be said with certainty that vouchers would reduce program costs for these services, there are several reasons to believe that cost reductions could occur. First, voucher pricing methods can easily permit private subsidization of the cost of services, ie. co-payment or sliding fees. Second, vouchers may result in more standardized, less variable, costs for services because of the way vouchers are often priced. Third, having to compete for clients should reduce provider prices.

Advantage #3: Consumer Benefits

The lack of choice is an increasingly common complaint about publicly funded programs. Vouchers empower consumers to make educated choices with the publicly funded services they purchase. They provide developmentally disabled individuals the same dignity and freedom of choice all of us enjoy, but perhaps take for granted.

Propelled by their purchasing power, vouchers and other consumer-directed purchasing systems give clients the flexibility to customize their services. Instead of being assigned a provider, the opportunity to pick and choose providers enables consumers and their families to develop a program which best meets their needs. Benefits include increased self-esteem and dignity and enhanced consumer behavior. Recipients and their families are empowered to manage their own care and take responsibility for the decisions that most immediately affect them. Ultimately, market forces most efficiently control the quality and responsiveness of providers. When a consumer is given a choice of providers, the provider generally attempts to deliver services of sufficient quality to maintain consumer satisfaction.

IV.Types of Consumer Driven Purchasing Systems:

Vouchers and Other Models

Four of the most common systems of consumer directed purchasing are outlined below: vouchers, individualized contracting, direct cash reimbursement systems and reimbursement programs. The most obvious distinctions between them are: how resources are allocated to the consumer, eligibility requirements, the range of services eligible for purchase, and the level of control over services.

A. Voucher SystemA. Voucher System

Vouchers permit consumers to purchase a specified type of good or service. While vouchers have been used for housing, transportation services, food for the poor (food stamps), day care, education and family support services, in general they have not been widely used for health and human services.

The types of services which can be purchased with vouchers are often limited, primarily because the voucher itself is not a cash substitute. Eligibility and funding are determined by each state based upon the services to be financed or the needs and capabilities of consumers. A state agency may subsidize a percentage of each unit of service with the consumer contributing the difference, or may agree to fully pay for a predetermined amount of services over a period of time, with the consumer being accountable for any purchases exceeding that amount.

Procedurally, a written voucher or a service authorization is obtained by the consumer from a case manager or eligibility worker. The case manager should determine the eligibility of the consumer for services, assess the extent of need and help the consumer and the family to review the qualifications of various providers that might meet the consumer's needs. The consumer will give the selected provider a voucher stating all relevant information: time and dollars reimbursable, types of services that are applicable, and so on. The voucher is submitted to the state by the provider who redeems it for payment.

B. Individualized Contracts or Funding

Another consumer directed option that states have begun exploring is individualized contracting for services. Individualized contracts generally retain the existing contracting procedures, including competitive procurement and reimbursement, but they cover services only to an individual consumer. Often all the services a consumer receives (residential, day, support) are bundled into one procurement.

This approach has the advantage of giving the consumer considerably increased choice over services; however due to the small relative scale of the contracts, it could significantly increase the administrative burdens for both the state and providers. Individualized contracts also retain the same focus by state officials on providers, rather than on consumer needs, and continue the state's role in the middle of the purchasing relationship between consumer and provider. Precisely because of this, however, some states have found it relatively easy to implement individualized contracts on a limited scale and move incrementally away from a contracted system of services.

C. Direct Cash Disbursement Programs

Sometimes referred to as family block grants, direct cash disbursement programs offer eligible families periodic cash subsidies with which they can purchase whatever tangible goods or services they require. Eligibility requirements and funding levels vary from state to state (in states where counties have control over the program, parameters can vary by county). Generally, there are no limitations on types of services that can be purchased, though some state monitoring is required. Funding levels are often smaller than for voucher or reimbursement programs (discussed below).

Once eligibility is determined, the consumer is generally entitled to receive payments. In this regard, most direct cash disbursement programs resemble benefit and entitlement programs. As a result, if the eligibility criteria are in any way subjective, the expenditures of the program may be increased by artificial demand for

these benefits. This is probably less of a problem with mental retardation than it would be with the somewhat more subjective diagnosis of mental illness.

Because funds are distributed in cash, control over spending is more limited in direct cash programs than with vouchers or contracting methods.

D. Reimbursement Programs

In reimbursement programs, the consumer or family/guardian pays for approved services or goods up front, provides proof of purchase and receives reimbursement from the state. The method ensures that funds are used appropriately, while keeping funding flexible to meet the unique needs of the consumer.

After eligibility is approved, consumers are generally entitled to be reimbursed for payments for approved types of services, up to a certain dollar amount. Reimbursement requests are usually evaluated on a case-by-case basis. The administrative costs for the program are similar to vouchers though they tend to be more focused on the review and approval of reimbursement requests rather than the review of services needed by consumers.

Funding levels for reimbursement programs nearly always have an individual cap to control for costs. This is either a fixed amount per consumer or a pre-authorized amount per consumer. Income as an eligibility determinant varies considerably by state.

E. Summary of Models

Vouchers are preferable where there is a relatively well defined set of services to be used with existing providers and consistent costs so that uniform rates can be set. Cash subsidy or reimbursement programs may be preferable for services with limited funding and where there is a high degree of variability in the timing and need for services by consumers. Cash subsidies are somewhat equivalent to benefit programs and may increase the ability of individuals to remain in the community but they can only cover a minimal level of the costs for the consumers. Reimbursement programs, on the other hand, generally have more flexibility for consumers to buy specific and unique services, but they transfer the burden of the administrative complexities to consumers. Finally, individual contracting can help in the transition from contract systems to consumer directed purchasing but tend to result in a high level of paperwork.

V.State Experiences with Consumer Choice Models for Delivering Human Services

Few examples of voucher use in services to the mentally ill, mentally retarded or developmentally disabled exist. State experimentation with market-based forms of purchasing for most human other has been slow. With the likely expansion of state block grants, however, the opportunities to implement consumer directed purchasing options should grow.

As a part of the research for this paper, agencies serving individuals with mental illness and developmental disabilities in fourteen states and two Canadian provinces (Alberta and Nova Scotia) were contacted. Managers and staff in these state agencies were asked to report on examples of consumer directed purchasing options in services to the mentally ill or mentally retarded in their state or others. At that time, five states and one province reported no examples of vouchers or consumer directed purchasing, though several were interested in expanding services in this area. The remaining states reported examples of consumer directed purchasing for a variety of limited services (primarily for family support services to families of the disabled). The majority of these programs took the form of cash subsidies, individual contracting, or reimbursement programs. Table 1 summarizes the states and programs that reported

consumer directed purchasing initiatives.

A. Voucher Programs

In the fourteen states and two provinces surveyed, only two examples of true voucher programs were found: Massachusetts day care vouchers and a private program in Denver for the physically disabled (see box). No publicly funded voucher programs were found for services to the developmentally disabled or mentally ill.

Vouchers have been used in Massachusetts and a number of other states to fund day care services for welfare recipients in training and back-to-work programs. Prior to implementing day care vouchers, the state purchased many day care services as a social service option for low-income individuals. Voucher management agencies were established across the state to provide referrals, educate consumers and manage the provider payment process.

Table 1: State Experiences with Consumer Choice Models

State	Type of Service	Method	Eligibility
Massachusetts	Day Care Residential & day services to individuals w/mental retardation	Vouchers Individual Contracts	Income Disability
Denver, Colorado	Family support, United Way funded	Vouchers	Disability and Need
Missouri	Various for developmentally disabled	Individual Funding	Disability
Illinois	Home-based services for adults mentally ill or developmentally disabled	Individual Funding	Disability
North Dakota	Family subsidy-developmental disabilities	Reimbursement	Disability
Pennsylvania	Family support services-mental retardation	Reimbursement	Disability
Michigan	Family support subsidy Respite care-children with developmental disabilities	Direct Cash Subsidy Reimbursement	Disability/income Disability
Connecticut	Family support	Direct Cash Subsidy	Disability/income
Illinois	Family support subsidy	Direct Cash Subsidy	Disability- MH/DD
Rhode Island	Family support for families with children under 18 with developmental disabilities	Direct Cash Subsidy	Disability
Alberta, Canada	Services to adults with mental retardation	Individualized Funding/ Direct Cash Subsidy	Disability Income

*** Eligibility criteria for all consumer directed purchasing initiatives are based upon either a determination of a disability (developmental or mental illness) in a child or adult or disability coupled with a determination of financial need based upon family income level. The income levels varied widely, from poverty levels to $70,000 a year.**

In Massachusetts, consumers showed a preference for family day care services when given the choice, saving the state 11 percent. Despite these findings and a supportive administration, Massachusetts has had difficulty expanding the program due to concerns raised by group day care providers, particularly those in low income neighborhoods that currently have contracts with the state. Many other states have provided vouchers for child care assistance and recent federal legislation should further expand its use.

B. Individualized Funding Programs

Examples of individualized funding programs, or individualized contracts, were found in Missouri, Illinois and Massachusetts.

The Missouri "Show Me Choices" Program. Operated by the Division of Mental Retardation and Developmental Disabilities, the program authorizes the release of a check from an individual bank account established and managed by the state in the consumer's name. The check is delivered by the consumer to the service provider upon completion of service. Arrangements and service authorizations are made by a state employed case manager assigned to the consumer.

Illinois Home Based Support Services Program. This is an individual funding initiative for adults with disabilities. Services are authorized by service facilitators who submit payment authorization forms to the state. Recipients may choose their facilitator and select providers for their services. Services may be authorized for up to $1,338 per month. While there is no physical voucher issued to the consumer in this program, the program is functionally very similar to a voucher program because consumers are able to exercise a high degree of choice and payments are authorized by a state or contracted agent.

Massachusetts Program for Individuals with Mental Retardation. To enhance consumer involvement in service planning, Massachusetts has developed a number of individualized contracts for services for some mentally retarded state clients. This effort has been implemented informally and incrementally, within existing contracting and procurement guidelines. Residential and day services to individuals have been "bundled" into one RFP for services. Providers who do not deliver all the required services must subcontract with other organizations for the services. Consumers have an active role in developing the RFP (based upon their individual service plans) and in selecting a provider. The system enhances consumer choice within existing contracting methods, but is likely to result in an increase in administrative, financial and contracting functions by both the state and providers.

C. Reimbursement Programs

Reimbursement programs have been implemented in Michigan, Pennsylvania and North Dakota. Each of the programs supports families of children with disabilities, helping to keep the children in their homes and out of residential care. Some of the problems reported with the programs involved delays in payment and cumbersome procedures for the submission of invoices.

Some of the reimbursement programs studied place annual limits on reimbursable expenditures, e.g. $5,200 in North Dakota, or eligibility limits depending on a family's income. Others, such as Pennsylvania's Family Support Services Program and North Dakota's Family Subsidy Program have no maximum income limit for families or individuals.

D. Direct Cash Subsidy Programs

Michigan, Connecticut, Rhode Island and Illinois all have used direct cash subsidies to finance some social services. Michigan's Family Support Subsidy Program provides eligible families (those who have a developmentally disabled child and have an annual pre-tax income of less than $60,000) with $222 a month in benefits to support the care of the disabled child in the home. Audits performed to verify the use of the funds revealed only a rare misuse of funds by consumers.

Connecticut, Illinois and Rhode Island had similar programs funding support services to families.

Connecticut had an income test as well as a disability test, while program eligibility in Rhode Island and Illinois were both based solely upon disability. The amounts of grants vary, from $222 a month in Michigan to $446 a month in Illinois.

Rhode Island's program is very small (approximately 100 families). Once services have been authorized by the state, a check for the full amount is sent to the family. The primary goal of the program is to assist families in gaining consumer awareness.

In Alberta's Individualized Service Planning and Funding Program, families and guardians of developmentally disabled adults receive individually authorized grants to purchase required services. Funding is received by consumers after services have been delivered, often requiring up-front payments similar to reimbursement programs. Families are monitored on a monthly basis by an independent third party to verify the use of services.

Alberta's Program is perhaps the most studied consumer directed purchasing program. Problems reported in the program typically relate to the lack of real consumer choice in many areas of Alberta. The program is somewhat unique in that the individualized grants are negotiated and distributed directly to consumers.

E. General Findings

Both reimbursement and cash subsidy programs seem to be limited to providing family supports to enable children to remain at home. They are rarely used for placing children in residential care. States generally do not want to promise reimbursement or give cash grants on an unlimited basis. Family support initiatives have grown because the benefit level can be kept to a minimum and the cost effectiveness of these funds—by avoiding out-of-home placement—can be high.

A major advantage of direct cash subsidy programs is that benefits give some economic support to keep a child at home rather than seeking state care. Often this is enough to make a difference for a family. At the same time, these benefits often come to be viewed as entitlements, making it difficult for state administrators to change the use of funds. As benefit programs, these often have less flexibility than vouchers or individualized funding efforts due to the accountability and equity difficulties inherent in approving different subsidy levels for different individuals.

The more complex and variable the services are, however, the more the state has to be involved with the authorization of services and the management of provider payment procedures. As services become more costly, some reimbursement options are not possible due to the cash flow requirements on families. Individualized funding efforts have some similarities to vouchers though they avoid the need for consistent rules concerning pricing or services to authorize and they may more easily fund multiple services. However, the flexibility of these programs makes them difficult to control financially. Careful supervision and financial controls over service authorization decisions are essential.

Vouchers require states at the outset of the program to make some comprehensive decisions about authorization procedures, funding policies and which services are covered. Based upon these decisions, vouchers can be used to fund a variety of services or just a single service, but they are inherently less individualized than some of the individual contracting procedures being used in Massachusetts and Alberta, for instance. However, because the voucher administration is handled separately, state agency case management staff can stay more involved with service provision in voucher programs. Rates for providers are generally on one of several class rates (same rate for all similar providers) or are independently negotiated with providers. Of the consumer purchasing systems, vouchers have the best combination of flexibility and control for consumers, while at the same time achieving a reasonable level of financial control for the state.

VI. Evaluating Whether a Service Is Appropriate for

Consumer-Directed Purchasing

Three conditions are necessary to ensure the success of any program of vouchers or consumer directed purchasing: 1) The service must be appropriate for consumer choice and there must exist sufficient capacity in the private sector; 2) Consumers and their families must have the capacity to make an informed choice; and 3) Economically, the benefits of the transition to consumer directed purchasing must exceed the costs. Each of these criterion should be reviewed by senior public officials when initially considering services for transition to vouchers or other consumer directed purchasing.

A. Service RequirementsA. Service Requirements

A service must be appropriate for the exercise of consumer choice. Services are appropriate for consideration for vouchers if they are voluntary, require flexibility in order to best meet the needs of consumers and are in markets that can quickly develop a supply of services available to consumers. Family support programs are common in consumer directed purchasing efforts because families often need a unique combination of flexible timing and relatively low cost services to support them. They also can purchase or develop these services from existing formal (approved organizations) and informal (individuals) providers.

There are some services that may not be appropriate for consumer choice, such as certain mandated services, like child abuse counseling. Other essential, low volume and/or highly specialized services, such as dental, education and medical services for state school residents may not meet the requirements for economies of scale reasons. In addition, crisis intervention services for the mentally ill would not be appropriate since access to providers on a 24-hour basis is essential. These services require a minimum of risk and a steady and predictable source of revenue for the provider.

An often-cited concern about vouchers is whether there would be enough providers to provide choice for consumers for certain low volume services or in rural areas. For example, in sparsely populated North Dakota, one might anticipate problems ensuring an adequate supply of services. In reality, however, North Dakota officials reported that the supply of services has increased as a result of the consumer demand generated from their reimbursement model of consumer purchasing. This has created opportunities for new providers.

B. Consumer Requirements

Consumers and/or their families must be physically and mentally capable of exercising a choice. Highly and moderately functioning developmentally disabled consumers are the first usually identified for "choice" programs, because of their capacity to be aware of their needs and ability to differentiate between services. Consumers may need to be represented by families, guardians, case managers or advocates in purchasing services, managing cash subsidies or submitting expenses for reimbursement. Case managers or advocates can help consumers find or develop services to fit their unique requirements.

Sufficient education should be provided to support consumers and/or their families as their decision-making responsibility increases. This function is generally performed by case managers or service coordinators working for the state or under contract to the state. Families and individuals could be placed in "at risk" situations if all responsibility for managing personal affairs is suddenly shifted to them. Every state official interviewed in the research for this paper emphasized the need for support services.

C. Economic Requirements and Planning Issues

The economic and market requirements for consumer directed systems involve a number of dimensions. The scope and functional requirements of the procurement system will depend on the answers to questions in the following areas:

•**The extent of need for services**. How many potential consumers are there How many receive services

now What is the volume of administrative and financial accounting work that is necessary to manage these services Is the volume of services currently being purchased enough to warrant the cost of the change to vouchers

•**The availability of state and private financing resources**. Do consumers have sufficient resources to purchase some services Should vouchers fund the full cost of services, or should there be some consumer/family contribution for each service Will voucher amounts set by the state be high enough to enable providers to include sufficient returns on investment, recovering any up-front capital and generating profits What is the level of capital needed to start the service (It is quite different for residential providers than it is for ambulatory services.) Are there other sources of capital available

•**The maturity of the local human service market**. Is the demand well known among potential suppliers Is the demand predictable or will it change readily with the next change in the environment Are the costs of doing business in the market understood and predictable

•**The technology of services**. What training and implementation requirements exist for services Does the state have an adequate information system capacity for the new purchasing system

•**Competition among providers**. To what degree is there competition to provide services among established providers Are there unique requirements of providers that will limit the available pool of providers

In designing the program, state administrators will have to balance the benefits of addressing the often divergent needs of the stakeholders with the costs of the program in each of the above areas.

VII. Potential Obstacles to Implementing Voucher and Consumer Directed Systems

Despite billions of dollars spent annually on deinstitutionalization efforts across the country over the last twenty years, few models exist of voucher use or consumer directed purchasing. There are several reasons for this:

•Program administrators' fear of unintended consequences;

•Provider opposition; and

•Advocacy groups' fear of change.

These represent the main obstacles that public officials are likely to encounter in transitioning to voucher programs.

A. Fear of Unintended Consequences

Public administrators fear increased demand for unintended, unanticipated and now unfunded services from a voucher program in which eligibility for services is somewhat subjective. In response, they raise the specter of service rationing (despite the fact that the current system results in the same outcome). Careful drafting of legislation or regulations will help to minimize such potential consequences, as will establishing timely and accurate information systems to track authorizations for service.

B. Provider Opposition

As a result of the financial risks in consumer directed purchasing for established providers, many providers

will perceive more "costs" than "benefits" in a conversion to vouchers or consumer directed purchasing. Providers are often the single most vocal, and sometimes only, lobby opposing these changes. They will argue against change because it destabilizes the reimbursement and funding streams for agencies currently in the service system.

Those most threatened by a conversion will often be those who are not confident about their abilities to effectively market their services and who as a result feel that the conversion will present a financial threat. State officials must attend to these concerns because providers are often extremely well connected politically. Overcoming provider opposition will require training and an effective transition policy that gives time for providers to acquire the necessary skills for a consumer driven market.

State agencies seeking to counter provider resistance should work closely with consumers to educate them about the benefits vouchers provide, such as giving clients more choices and encouraging active client participation in treatment planning. Consumers must feel that the transition to a new purchasing method is in their best interests. This will help to blunt the efforts of providers who will be perceived as resisting change out of their own self interest.

There is often a core group of providers who are confident in their level of consumer satisfaction and their ability to market to consumers and who may favor the conversion to demand side driven systems. Using these providers—along with the likely support of advocates—to actively support a transition effort can help to lessen provider resistance.

C. Client Fear of Change

Some degree of initial consumer/family apprehension to change should be expected—not all consumers/families will be inclined to be in an empowered role. Implementation efforts and policies should ensure adequate outreach and education efforts. Education and guidance are crucial to support families, especially when the program is new or when a new family enters the system. In most programs, the case manager or advocate, whether a state employee or a contracted individual, plays a key role in supporting the consumer.

VIII. The Nuts and Bolts of Transitioning to Demand-Side Systems

Government agencies, particularly those with well established systems of purchased services, should consider vouchers and other consumer directed purchasing options for all new areas of program expansion or anytime there is a substantive change in contracts, such as a competitive bid for the services or in the implementation of managed care initiatives. State administrators should first determine whether the services meet the requirements outlined earlier, whether there is a sufficient supply of services already in the community, and then identify the policies and procedures to be used in the administration of the program.

For existing services, the size of the procurement and the anticipated benefits must warrant the costs—economic but mostly political—of the change to a consumer directed purchasing program. Benefits should include some potential, albeit minimal, service and administrative cost savings plus the benefits to the system and to consumers of increased consumer empowerment and improved self-sufficiency. States seeking to change existing systems should develop a phase-in transition plan to ease any anticipated negative effects on consumers and providers. Sufficient time should be allowed during all phases of implementation to plan adequately and observe the early results of the new program.

Once the decision to implement a consumer directed purchasing system has been made, states must develop detailed implementation plans. Outlined to the right is a step-by-step model for implementing a voucher or consumer directed program. States will probably want to set up task forces or committees to develop

recommendations and oversee the implementation of these areas.

Step #1: Define Consumer Eligibility

First, a clear definition and criteria for consumer eligibility must be created. Eligibility categories might be based upon disability, income level, medical and/or psychological conditions, age and/or dependency status. Generally these are determined by legislation or state regulations. If a voucher or consumer directed purchasing system is being implemented in an existing program, keeping existing eligibility definitions in place will minimize the disruption in services to clients. *However, states should avoid creating eligibility criteria that result in an "entitlement" for services and the inevitable growth in funding and clients that tend to result from entitlement programs*.(For a detailed examination of this phenomenon see Reason Foundation Policy Study #192). Legislative authorization should clearly state that there are limits on appropriations and authorize waiting lists for services when demand exceeds available funding and no services are immediately available.

Step #2: Define and Implement Provider Eligibility Criteria

Criteria for provider eligibility should be established. Criteria should initially be based upon the level of the existing supply of services. One of the major advantages cited by state officials of consumer based purchasing, however, is the ability for consumers to receive services from unlicensed providers that may meet their specific needs. Initially, the state may want to only approve existing providers, adding additional providers later in the implementation. This will decrease the amount of competition over the short-run but could also reduce provider resistance in the transition period.

Step #3: Develop Client Eligibility and Service Authorization Procedures

Eligibility must be determined according to fair and reliable procedures. This will probably involve meetings with eligibility staff and their review of documentation submitted by the consumer or family. Eligibility determination should generally be a state responsibility or managed by an independent organization in order to control eligibility procedures. Consumers would be identified at local or regional offices of a public agency, at a private health or human service organization, or through other community services. Formal appeals procedures should be developed in the case of disagreement on eligibility decisions. Procedures should specify policies for "waiting lists" or similar procedures for managing expenditures in the program.

Once consumers are determined eligible, services or funds must be authorized using fair and clearly defined procedures. Authorization procedures should be clear early in the procurement process to help gain acceptance of the plan from consumers, advocates and providers. Depending upon the plan, services can be authorized at pre-determined benefit levels or be based upon case specific authorizations as part of individualized service planning.

In any event, purchasing agencies must ensure that vouchers are only authorized when funds are available. If demand exceeds available funding, state agencies must prioritize vouchers for those most in need, or first in line. This can often be difficult to accomplish equitably without well developed standards and procedures. The timeliness and accuracy of decisions is also important and this requires automated information systems that accurately report on vouchers authorized and funds encumbered.

Services should be part of an individualized care plan developed and periodically reviewed by the case manager. Ideally, consumers should have some flexibility in their choice of case manager or advocate. Case managers may be employed by the state or a private organization under contract with the state. In states where case management is contracted out, the state should closely monitor the quality of decisions made by case managers.

Step #4: Develop Reimbursement and Financing Systems

Payment procedures must be developed for providers under voucher-style systems. Bills submitted by

providers must be reviewed based upon the eligibility of the recipient for services and the volume of service that has been approved. Traditional voucher programs require the submission of the voucher to the state for payment to the provider. Using the voucher identification number, the state should confirm the consumer eligibility, type of services authorized and the volume and effective dates of these services. Government agencies should also consider involving consumers or family members by adopting procedures for consumer approval of invoices for services.

Consumers should probably contribute a minimal amount, perhaps on a sliding fee, for services. Similar to many medical plans, consumer co-payments create incentives for consumers to balance the costs and benefits of services. Payment systems need to properly charge and account for consumer and state, or public, sources of funds.

States employ a variety of payment procedures. In Missouri's paperless voucher or individual funding system, service providers are paid with a check written from a bank account in the consumer's name upon service completion. In Massachusetts' day care voucher program, the child resource agencies that issue the voucher also receive the provider bill, invoice the state and then pay providers. A cash or check payment is made by families in Michigan from funds that have been directly paid by the state to a bank account in the family name.

In developing a plan for financial monitoring, it must be decided whether to require consumers to document their expenditures. In addition, overall program expenditures should be tracked and a clear method developed to permit the tracking of authorized but unbilled services.

Step #5: Develop Voucher/Fund Distribution Procedures

Choosing a method of distributing the funds or vouchers will require considerable internal review by the various state agencies involved with the procedures. Funds and/or vouchers can be distributed either directly to the consumers or through an intermediary management agency, as in Massachusetts' day care vouchers.

Funds that are distributed directly to consumers are generally mailed to the eligible consumer or guardian. Procedures vary as to whether the states require documenting costs. The majority did not, leaving wide latitude to the consumer for purchases. If costs are to be reported, quarterly reporting should be adequate.

For voucher systems, the vouchers should be distributed to the consumer, in person or by mail, following the service authorization meeting. Each voucher or authorization should have a unique identifying number, dates, type and volume of services authorized. This permits the level of service that was authorized to be effectively communicated to providers for their service planning and billing. The authorization should be recorded and some method utilized to track how many vouchers have been issued and the amount of funds authorized.

Voucher implementation efforts without automated systems are likely to be administratively cumbersome and result in payment delays—a significant problem in Massachusetts during the early implementation efforts of their program. Automated systems for the authorization and issuance of vouchers and the payment against the vouchers, are similar to purchase order systems, and should be able to be readily adapted to a wide area network for statewide use. Utilization management software will streamline the administration process of program oversight and save taxpayer dollars over the long term.

Step #6: Transition in the Program

For existing services, the negative financial impact upon existing providers can be minimized by phasing in the program. This is also ensures for continuity and stability of services to consumers. All providers should have one opportunity to participate in discussions and contribute their opinion to planning the transition.

During the initial design and planning efforts, state administrators should keep realistic implementation time frames in mind. Too many programs fail because decisions are made too hastily. Large-scale voucher or

reimbursement programs should ideally provide for a minimum of six months for detailed planning and implementation of the program after financial resources have been committed. The state should also identify providers who need technical assistance in acquiring the new skills required to succeed in a competitive market.

During the transition, the increased instability of the market could favor larger organizations, particularly with downward pressures on pricing occurring. Larger organizations in all likelihood will be better prepared to market services to consumers and temporarily manage any reduced cash flow. The net result might be a consolidation of the provider industry, resulting in a possible negative impact on smaller, more informal community services. If absorbed by larger organizations, smaller providers could become less sensitive to the community as they become more accountable to their parent. To offset this, the state might consider offering temporary assistance to providers experiencing difficulties due to low volume (especially when the low volume results from poor marketing, rather than poor service quality).

Step #7: Educate Voucher Consumers

A vital component of a consumer directed purchasing program is the provision of education and support for consumers and their families. States considering a voucher program must decide who will provide the educational services and how they will be provided. Most states we contacted, including Illinois, North Dakota, Missouri and Rhode Island, indicated that consumer education was conducted by case managers. Consumer education and referral services are available in Massachusetts for the day care voucher program from the child care resource and referral agencies. Another option is to develop consumer hotlines to facilitate access to appropriate providers.

Step #8: Monitor Service Delivery

A principal reason for shifting to a consumer directed model of care is that the consumer is in the best position to monitor the quality of services, and when dissatisfied, can choose to purchase services elsewhere. Nevertheless, the quality of service delivery still needs to be monitored to some degree. To ensure a continuous standard of quality, the system should incorporate: consumer satisfaction surveys; outcome measures that are incorporated into billing and regular MIS functions; randomized inspections and licensing. Satisfaction surveys seem to be a minimal requirement given the importance of the consumer in the purchasing relationship.

Step #9: Develop Management Information Systems

Payment for direct cash benefit programs can be tracked using relatively simple systems. Reimbursement programs, on the other hand, may require the tracking of expenditures by category and allowability of expense. This would likely require software and systems support, though it might be accomplished with a relatively simple "Accounts Payable" application. Vouchers systems require the ability to match invoices from providers with authorized vouchers for those services.

The financial and management information requirements of a voucher system require an investment in appropriate software and hardware to support the program. The alternative is an extremely cumbersome manual process, excessive paperwork to match invoices with vouchers and late payments to providers. Service authorizations from state agency staff need to be sent to the units responsible for provider payments. Outstanding service authorizations need to be encumbered. A claims payment system with prior authorization capabilities helps to control service costs and reduce administrative costs.

Managed care organizations and other organizations with systems of prior authorization and claims payment may be able to provide a central administrative structure and system to permit telephone based service authorizations. This would minimize the initial cost of information system hardware for the first efforts with vouchers.

Summary

Vouchers can increase consumer choice, streamline administration of contracts and control spending. State agency service coordination staff would shift their focus to authorizing services for eligible individuals, assisting those that need it with the choice of providers and monitoring progress toward goals. This allows contract management staff to pay more attention to utilization reporting, monitoring, developing new providers and implementing quality assurance systems to maintain quality and cost effectiveness (such as outcome measurement and provider "report" cards).

IX. Conclusion

Interest in consumer directed purchasing options is increasing rapidly across the country. Promising considerably improved levels of consumer involvement in service decisions and service monitoring, vouchers and consumer directed purchasing options can increase competition and increase the influence of market forces on publicly purchased human services.

There has been much debate in recent years about finding the proper role for government in the administration of programs. While much of this debate has been political, the human service field has been actively trying to find roles for consumers that provide greater involvement and empowerment in decision making. This encourages independence, places responsibility for some aspects of the decisions in the hands of the consumer and more effectively motivates consumers to change. Furthermore, consumers are better able to judge quality and outcomes of services than government and to use their purchasing power effectively to seek higher quality. Government agencies are better able to focus on monitoring, licensing and quality improvement.

There has been little systematic study of the cost effectiveness of voucher implementation efforts. Those studies that have been conducted, primarily in day care services, point to the cost effectiveness of voucher efforts because families often end up choosing more cost effective options, especially with financial incentives. Vouchers also have the capacity to easily adapt to self-payment options if states are looking to help defray the public costs of services.

As with all innovations, the change to vouchers is likely to encounter resistance. Incremental change is generally easier to achieve than the radical restructuring of the purchasing relationships that would be implied in a voucher initiative. Unfortunately, this often leads to other unexpected or administratively cumbersome requirements such as with individual contracting methods.

Generally, legislative authority is necessary to overcome these and other administrative obstacles. Statutory authority also helps to clarify the state's ability to ration vouchers and limit expenditures under the program through waiting lists or similar mechanisms. These provisions are often necessary to authorize actions by multiple agencies of the state and to limit services to specified budgetary levels, avoiding the creation of another entitlement program.

In this era of government reform, consumer directed purchasing of services holds forth the promise of empowering consumers, improving service quality, and streamlining government. Public agencies seeking to restructure their service systems, streamline operations and minimize the role of government should consider consumer directed and voucher purchasing options in their restructuring efforts. The implementation steps outlined here should help to guide the numerous committees and planning teams that will be necessary to make these changes. Strong leadership and a consumer focused vision will be necessary to sustain the effort.

About the Authors

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APPENDIX I: Economics of Publicly Purchased Services

In privatization initiatives, government agencies have two principle options to consider. First, they may sell, or transfer ownership of their production or service delivery assets. Examples include the sale of government owned oil reserves or railroad equipment and lines.

Second, where there are no assets or when the state wishes to retain ownership of any assets, they can transfer control for the delivery of services to private organizations. Private organizations can deliver services under contract with the state or directly to the consumers of services as with vouchers and other consumer directed purchasing. The vast majority of health and human service privatization efforts in the U.S. and abroad are in contracts with providers for service delivery to consumers. In consumer focused initiatives, such as vouchers and other efforts, the state transfers resources, e.g. vouchers, cash or Medicaid cards, and the purchasing decision directly to consumers. This increases the consumer demand for services. These differences are best described as "supply-side" v. "demand-side" state privatization efforts.

Understanding the characteristics of supply and demand-side markets in human services helps to explain much of the consumer, provider and state behavior in health and human service privatization efforts. It also points out some of the requirements for demand-side markets, if government agencies shift their funding from supply-side contracting to demand-based systems. Each is briefly discussed below.

Supply-Side Systems: Contracts and Grants

In contracted purchase of service systems, state agencies contract with private service providers to develop and maintain a supply of services. The quantity of service to be purchased is generally a result of competitive bidding and available resources, set by annual appropriations or projections. This supply-side system of purchasing generally has contracts that are in the form of grant, cost-reimbursement or negotiated budgets and individualized unit rates. Examples include most residential purchasing, day and work programs or funding of program staff for the provision of emergency services.

Purchasing a supply of services within a specified budget reduces the budgetary risk for state administrators that demand for services will exceed projections. In health and human services, contracts have also generally been developed with local non-profit agencies who are thinly capitalized, requiring the state to assume some of the financial risk for the providers.

Since the recipient of the service does not pay for the care from the provider of the service, the issue of who is the real customer of the provider, the "state" or the "client", may often lead to confusion over goals for providers and state administrators. Similarly, the power and the control over service quality is often left for

the state and provider to debate, while the consumer's needs are often presumed or prescribed by the state and provider.

Supply-side systems generally result in strong provider associations who seek to influence state policy, appropriations and purchasing decisions. These associations seek to unify and improve communication between the many providers and the "single" state purchaser. They focus on advocating for provider interests and ensuring fairness and due process in purchasing decisions by the state.

State purchasers must consider the perceived fairness of their decisions for providers. This is sometimes known as "provider equity." The rationale underlying provider equity is that a financially stable supply of services from providers is in the public's and consumers' interests. This can often lead to increased rates and reduce cost containment effects of provider competition, since providers may try to act in concert, within the bounds of anti-trust rules. Providers will also resist any perceived reduction in state spending or provider reimbursement. Regardless of the impact on current costs, provider equity has been an obstacle in states that have tried to increase the use of voucher programs.

Demand-Side Systems: Consumer Focused Purchasing

In "demand-side" systems, the state transfers resources directly to consumers (vouchers, cash) and thus creates demand for the service by consumers. This, in turn, creates markets for providers to "sell" their services. Most commercial sectors of our economy involve demand-side purchasing where the consumer has the resources for the purchase of services and negotiates with providers for the level and quality of service desired. Demand-side systems in health and human service procurement include insurance style benefit plans, vouchers, individualized contracting, reimbursement and cash assistance programs.

Demand-side systems generally have an undeniable appeal to consumers and advocates since there is such a significant shift in the control over services. These programs are inherently more consumer directed. Providers have more time to focus on meeting the needs of consumers instead of responding to government RFPs, and consumers or their guardians are generally in a better position than state agency representatives to assess service quality and the need for services. Consumers also often feel that they receive greater benefits when they receive the resources directly.

One of the key differences of demand side compared with supply-side systems is that the development of service capacity in demand-side systems generally involves more initial perceived risk on the part of investors. It is often difficult for investors and entrepreneurs to assess the extent of demand for some human services unless they already exist, as with housing and day care vouchers. As a result, vouchers and other methods of consumer directed purchasing must have adequate pricing for a return on the start-up investment. States may also have to recruit business people and facilitate their entry to the market. Predictability of the volume of vouchers and reimbursement will help to reduce the perceived risk of providers in developing new businesses or transitioning to voucher methods of purchasing.

Demand-side systems require developing policies for pricing vouchers or assistance levels. If benefits are going to be limited, requiring a portion of self-pay, finding the right benefit levels is often very difficult to resolve because it raises issues of consumer, as well as provider, equity. Care must be taken in developing eligibility and voucher authorization guidelines to avoid the budgetary problems often created by "entitlement" programs, like welfare, Medicaid or Medicare. With limited state resources, rationing procedures, (e.g. waiting lists), must be clear and specific.

Demand-side systems must also develop monitoring procedures to determine whether the anticipated benefits from the transfer of resources to consumers are being received. Are consumers and the government receiving the services or benefits that were anticipated Answering this question requires reimbursement policies for the use of the funds by consumers, audits of consumer funds and provider financial and programmatic audits and evaluations.

ENDNOTES

1. The National Association for the Mentally Ill reports that in any given year, 2.8 percent of the adult population suffer from severe mental illness. A similar percentage (3 percent) is reported for children. Almost 12 percent of children are estimated to have either mental, behavioral or developmental disorders. Similarly, the Association for Retarded Citizens reports that from 2.5 percent to 3 percent of Americans have mental retardation, with significantly more having other forms of physical and developmental disabilities.
2. P.L. 94-142, for example, mandates funding of services to individuals with disabilities in the public schools or the least restrictive environment possible.
3. The Boston Herald ran a series in February of 1993 focused on the perceptions of excessive executive pay in non-profit providers, purchases of vacation homes, luxury cares, and overbilling practices. Articles criticized the state for their inability to terminate the contracts with these vendors.
4. In voucher programs, the state can achieve more control over the use of funds than with most other consumer directed purchasing options because of the requirements agencies can place on the types of eligible services, prior authorization procedures and the procedures for the financial management of the distribution of vouchers. Providers may prefer vouchers over some other consumer directed options because of the restrictions that can be placed on the eligible providers for vouchers. The administration of vouchers can be efficient and provide a primary focus on the assessment of consumer needs rather than on administrative paperwork as in individual contracting and reimbursement programs that are described further below. As a result of these control and administrative efficiencies, vouchers may be a preferred method of program administration for consumer directed efforts that involve a transition from contract procurement methods. The accounting methods that are used are similar to those used in accounting for purchase orders in which the expense is accrued when the purchase order is issued.
5. A variation on this approach is what can be called individualized funding. As distinct from individual contracts with their significant paperwork, individualized funding efforts have flexible funding payable directly to approved providers. Services are authorized by case managers or other state staff and payments issued to providers upon confirmation of receipt of service. This type of system (e.g. Illinois and Rhode Island) results in a great degree of flexibility for payment, but in the eyes of many administrators a greater risk of the inequitable distribution of resources with limited budgets.
6. In reimbursement programs, problems can exist for low income families who must pay providers before receiving funds from the state. There may be significant delays in the receipt of funds from the state due to the paperwork and the time required to issue a state check. This becomes especially difficult in localities, where in order to be eligible for the program, you must be a welfare recipient.
7. Most of the calls were made during the spring and summer of 1994. Research in the use of day care vouchers in Massachusetts was conducted as a part of a previous study (Richard Dougherty and Charles Billings Jr. "Voucher Purchasing Systems: Enhancing Consumer Choice and Market Forces in Human Services," Pioneer Institute, Boston, MA 1991) updated with some additional information. The calls were generally placed to key managers in human service agencies serving the disabled in these states. The survey sought to explore examples or relevant programs and was meant to be a comprehensive survey of all consumer directed purchasing efforts. As a result, there may be examples of programs in these states that are not cited here because we were not made aware of them.
8. Funding for the vouchers was not taken from existing programs. It was new money added to the system as a part of the implementation of federal welfare legislation in the mid 1980's.
9. Occasionally, a consumer or family member must pay for the service in advance of the receipt of

funds. They are reimbursed once a receipt is approved by the state.

10. In most programs, specific income levels are an eligibility determinant.
11. Deb Balsdon, Administrator of Child and Family Support Services, Developmental Disabilities Division, North Dakota Department of Human Services, interview with the authors, June 1994.
12. Another critical issue for initial deinstitutionalization efforts has been the need for capital in the start-up of community programs. Providers have for the most part been inadequately capitalized non-profit organizations, often with no return on investment built into their reimbursement. As a result, when states announce new efforts, providers have sought reimbursement to cover start-up expenses, limiting their risk and their need for cash flow and capital. State agencies have also generally sought out nonprofit providers of care, fearful of the political and potential quality problems associated with excess profits at the expense of services to vulnerable populations.
13. In closing state institutions over the past twenty five years, states have had to ensure a sufficient and stable capacity in community programs, often under court order. This has increased the pressure on state administrators to use contracting procedures that guarantee costs for providers and the supply of services to the state. In using these procedures, state administrators felt that the state had to maintain tight financial and consequently programmatic control over services since consumers were in state custody. In addition, public agencies often need legislative action or administratively complex contracts with management intermediaries to permit the state to operate voucher payment mechanisms.
14. The costs of implementation include the development of procedures for determining consumer eligibility, approving providers, authorizing services, verifying invoices and paying providers. These are offset by any existing costs for these functions. Administrative personnel costs for the management of vouchers and payment of agencies could be lessened with an effective service authorization and claims payment system.
15. John Hall and William D. Eggers, "Health and Social Services in the Post-Welfare State: Are Vouchers the Answer?" Reason Foundation *Policy Study* No. 192, August 1995.
16. Many states have increasingly been using Request for Information (RFI) procedures prior to issuing any Request for Proposals (RFP) or new regulations. This helps provide an opportunity for all parties to provide input into the process. It is important, however that the information received is really considered in the RFP or regulatory development and that advocates and consumers receive this feedback.
17. In Illinois, case managers are employees of contracted nonprofit agencies, whereas in North Dakota and Missouri, case managers are employees of the state.