Health & Human Services Interim Committee Testimony
Representative Weisz, Chairman
November 17, 2009

Chairman Weisz and members of the Health & Human Services Interim Committee, I am JoAnne Hoesel, Director of the Division of Mental Health & Substance Abuse for the Department of Human Services (DHS). I am here to provide information to the committee on voucher use and provider choice in various human service and other state programs.

Voucher Use and Individualized Service Budgets

In review of DHS programs, in its strictest sense, vouchers are not used but there have been attempts to implement them. During the 05-07 biennium, the Division of Mental Health & Substance Abuse's contract for compulsive gambling treatment services with Lutheran Social Services (LSS) contained language allowing the use of vouchers for individuals who lived a distance from LSS treatment site locations and wanted to access the treatment services of other certified gambling treatment professionals. Utilization of services at the LSS sites did not allow for their implementation.

The Department applied for an Access to Recovery (ATR) grant through the Substance Abuse Mental Health Services Administration (SAMHSA) in 2004. This effort brought together a group of individuals, both public and private, to develop the blue print of the voucher program for substance abuse treatment services. North Dakota was not successful but maintained contact with states that were awarded.

There have been many lessons learned at both the Federal and State levels through this national voucher grant. Adjustments were made

after the initial 2004 grant and a second round of ATR grants was issued in 2007. The Department in discussion with its Recovery Support Advisory Council did not apply due to grant requirements.

As the Department's various Divisions worked on today's testimony, it became clear that while the Department does not use the specific term 'vouchers' in its service delivery, we do use the term 'Individualized Service Budgets' (ISB) in several areas. ISB use the same concept as vouchers and I offer three examples of ISB use.

- **National Family Caregiver Support Program**: Aging Services Division provides caregivers a capped allocation or ISB for respite care and supplemental services. The caregiver chooses their own respite care providers, and is reimbursed for adaptive equipment and devices.
- **Self-Directed Supports Waiver**: Developmental Disabilities Division provides a budget limit and the family/consumer self directs supports, hires their own staff and directs behavior consultation, environmental modifications, equipments and supplies. A contract with a fiscal agent assists consumers to pay staff or vendors authorized in the individualized services budget.
- **Child Care:** Economic Assistance provides recipients an individualized budget limit and child care services of their own choosing are purchased.

Provider Choice

Client choice is accomplished in a variety of methods throughout DHS programs. In addition to the programs already mentioned that use Individualized Service Budgets, programs such as child welfare and mental health, client choice is addressed when the service plan is

developed. The service plan incorporates client choices and preferences to the degree possible in service and provider selection.

In Vocational Rehabilitation, client informed choice is a regulatory requirement and clients are involved in writing their employment plan, selecting their employment goal, and selecting providers.

In the Medicaid program, client freedom of choice is required – which means we cannot restrict a clients choice of providers. There are exceptions allowed through certain regulations or through a waiver, but those exceptions are few and limited.

Rural Frontier Challenges

In a rural frontier state as is North Dakota, service access and provider choice is a balancing act. In accordance with Chapter 50-06.2, the state has a comprehensive human services program. Freedom of choice is addressed in 50-02.2-06.

The DHS regional human service center's structure along with it's contracts with numerous private providers assures regional access. With few exceptions, substance abuse residential services are provided through contracts with private providers. Crisis stabilization is obtained through contracts with private hospitals and foster care residential services and adoption services for children who cannot be reunited with their biological parents are provided through private agencies. These contracts all assure access and qualified service provision.

In some regions of the state a voucher system may provide more options. In Regions 1, 3, 6, and 8, there are very limited service providers. In these regions it is very likely that a consumer would need to travel to another region to use a voucher.

Lessons Learned

Many lessons have been learned in the area of voucher use. SAMHSA issued a 'lessons learned' document in March 2008. The lessons appear to fall within four areas.

Service provider base – outreach and communication is required to persuade providers to become part of the voucher network. Since there is no guarantee of business plus reporting, documentation, reimbursement requirements, hands on training and support is necessary. States are urged to consider the nature of the service, the demand for the service, and the private sector's capacity to deliver the service while the state maintains a core framework.

Client Base- States are urged to balance internal business controls and the activity of pursuing clients in order to take advantage of the existing structure and outreach to new options.

Administrative – voucher management is required to issue vouchers, manage claims, integrate procedures, reconcile outstanding vouchers, and monitor voucher activity.

Outcomes – outreach and training is necessary to assure reporting requirements and data collection procedures are in place.

Opportunity

The Department has learned that another round of ATR grants is planned by SAMHSA. This may provide the state an opportunity to partner with a broad planning group to apply the concept to the rural frontier state of North Dakota.

I would be happy to answer any questions.