

## Chapter 5

# *Public Financing of Mental Health and Developmental Disability Services<sup>1</sup>*

**Lorens A. Helmchen**

The public financing of services for persons with developmental disabilities or mental illness is part of the state's social insurance commitment to shield these population groups from the risk of financial hardship that disabilities of this kind entail. As such, the state pays providers to serve patients, and the provider reimbursement system plays an important role in achieving the goals of a social insurance system that provides residential, therapeutic, and rehabilitation support for persons with developmental disabilities and mental illness.

Any reimbursement system should strive to be transparent and affordable. It should be transparent in that it makes explicit the eligibility criteria for receipt of services, the standard of care, and the desired level of patients' health and well-being. It should be affordable in that it attains these goals at minimum cost to the taxpayer.

Notably, both the level and the structure of the provider reimbursement system will affect the ability of the program to achieve its goals.

In this regard, the existing method of reimbursing providers by specifying separate payment rates for a large number of inputs is deficient on several dimensions. Most importantly, the overall level of expenditure for serving persons with developmental disabilities or mental illness is unlikely to be the least-cost expenditure because the state does not know what the true costs are and it is too costly to obtain this information in a timely manner. Thus, the state will set reimbursement rates incorrectly and too many generously reimbursed services will be provided and not enough

poorly reimbursed services will be provided. Not only will such reimbursement affect the cost of providing care, but it will also distort providers' choice of inputs and the quality of care delivered.

In addition, as providers are paid for inputs, they may overuse or overreport their use of resources and thus inflate the cost of service provision without a corresponding guarantee that specified outcomes are achieved. By limiting the quantity of services allowed, the state attempts to counteract the tendency of beneficiaries to overutilize services. Presumably, however, the optimal volume of services varies across individuals; therefore, while a uniform cap may be simpler to implement, it may allow some persons to overconsume, while forcing others to underconsume.

For most services, the desired treatment outcome is never really specified beyond noting that services should be provided according to a person's needs. Yet, without explicit target levels of patients' health and well-being, society at large, and developmentally disabled and mentally ill persons and their stakeholders in particular, cannot know which level of quality and access the state is aiming to attain for them and how well the current reimbursement system is succeeding in achieving this goal.

In the following, alternative reimbursement mechanisms are presented that hold the promise of allowing the state to purchase a given level of quality at lower cost; make the state's expenditure on services for persons with developmental disabilities or mental illness more predictable; give patients and their stakeholders greater ability to choose the kind of service they prefer; and encourage providers to innovate and reduce cost.

### **Define a Standard of Quality to Achieve Transparency and Accountability**

The current reimbursement system relies heavily on paying providers to use specific inputs in specific proportions to provide care. Yet, this neither guarantees that specific levels of patient health and well-being are achieved, nor does it guarantee that the cost of achieving these health and well-being standards is minimized.

Therefore, the state should consider developing a set of indicators that reliably measure all aspects of the beneficiary's health and well-being

that are affected by the provider's quality of service. The adoption of such a set of quality indicators and the choice of their associated target values effectively defines an explicit standard of quality. In this way, the state reveals the level of care that it is committed to achieving for its citizens who suffer from developmental disabilities or mental illness. An explicit definition also constrains the state in its ability to gradually renege on this commitment. In other words, defining an explicit minimum standard of patient health and well-being makes the goals of the state, and of society in general, transparent; and it allows patients to hold the state accountable if these goals are not attained. Consequently, instead of reimbursing providers for the inputs they use, the state should reimburse providers for achieving carefully defined levels of health and well-being among the patients in their care.

### **Create an Auditing and Penalty Mechanism to Minimize Abuse**

If quality is costly to provide, providers may be tempted to reduce quality. Yet, mentally ill and developmentally disabled persons often cannot assess the quality of services they receive or cannot articulate complaints about quality. As a result, they are at risk of being subject to abuse by providers. To minimize this risk, reliable systems to monitor outcomes must be put in place by the state.

Some quality indicators are less costly to obtain than others. Therefore, to remain credible, the state's choice of quality indicators will be limited by the resources it will devote to auditing providers.

The audit mechanism can consist of two components:

- An independent contractor that carries out recurring but unpredictable spot checks.
- A grievance process, by which patients and their stakeholders can alert the independent contractor about providers whose service is alleged to be substandard.

To complement its audit mechanism, the state should penalize

providers who fail to adhere to the standards they contract to achieve. This penalty could consist of revoking the provider's right to compete for service provision in the future; it could also involve monetary fines or prison sentences.

### **Use Prospective Payments to Encourage Innovation in Service Provision**

Once a standard of quality has been defined, providers should be paid to achieve this level and given maximum flexibility in attaining that standard. This is best achieved through a prospective payment system. This mechanism encourages innovation and cost control because it leaves providers free to choose or develop the technology and combination of inputs that are most efficient. However, to reduce risk selection whereby providers avoid high-risk program participants, some part of provider payment should be based on retrospective costs. For example, providers can be made responsible for the first 10% of any expenditure that exceeds the contracted payment. Beyond this expenditure, providers may receive additional payments.

### **Use Competition Among Providers to Maximize Cost Efficiency**

As outlined above, prospective payment systems obviate the need for providers to report cost, but they also make the state liable to overpay for services. To encourage providers to pass on their cost savings to the state, all providers that satisfy the minimum standard of quality should have to compete to serve patients. As they compete for patients, the technologically most efficient providers will be able to offer the best quality at the lowest price and thereby attract additional patients. At the same time, less efficient providers will lose patients. In this way, competition among providers and choice by patients or their guardians will ensure that the state's expenditures are continuously shifted to the most efficient providers. As a result, the state avoids overpaying for services.

Two mechanisms that have providers compete for serving Illinois citizens who suffer from developmental disabilities or mental illness can be distinguished: competition for contracts and competition for enrollees. Under

the first, providers compete for a contract to serve all members of a well-defined population; under the second, providers compete for serving members of this population individually.

### **Competition for Contracts**

Under this award mechanism, the state defines the population to be served and also sets the minimum level of care that providers must offer recipients. Providers compete for contracts to provide, at the specified level of quality, services to all persons in a defined geographic area who meet the eligibility criteria established by the state. The provider offering to serve this population at the lowest price is awarded the contract. In practice, the state could request that providers submit their contract terms on a specific date and then select the best offer or it could keep accepting successively better offers from additional providers within a certain time frame. For example, the state could publish how much it is paying current awardees and periodically invite new providers to compete for these contracts.

In this type of competition, the most efficient provider will win the contract and typically will make a profit. The prospect of earning a profit encourages potential providers to enter the competition, thereby putting pressure on current awardees to innovate. This process ensures that providers' efforts to reduce cost continue to translate into lower expenditures by the state.

Profits also deter current providers from cheating on the contract: Only if it is profitable to serve persons who suffer from developmental disabilities or mental illness, providers will find it costly to lose this business. In particular, if the penalty for noncompliance is the lost profit, any increase in profit that providers could achieve by noncompliance would raise the penalty for doing so by the same amount. In this way, providers' fear of losing this profit will promote greater compliance than a fixed penalty payment set by the state. Specifically, if the penalty amount is set too low, providers may find it cheaper to cheat and pay the fine than to comply.

Under this system, there are two ways in which incumbent providers can lose the contract:

- They are found to be providing care below the contracted level of quality, in which case the contract is terminated and the provider may be excluded from participating in future rounds of competition.
- They are undercut by a lower-cost competitor's offer at the next, periodically held round of competition.

These two reasons for possible discontinuation of a provider's contract suggest that the state has two levers to raise the likelihood of compliance.

- More frequent auditing of quality raises the probability that a noncompliant provider will lose his profit and thereby raises the expected penalty payment.
- Less frequent rounds of competition raise the period of time that providers who were awarded a contract will be protected from lower-cost competitors. The longer intervals between rounds of competition raise providers' profits and thereby the penalty payment if they are found to violate the terms of the contract.

If incumbent providers anticipate that they will lose their contract in the next round of competition, however, future profits will decline, as the contract period draws to an end. In this case, the prospect of losing future profits in case of noncompliance will not provide enough of an incentive to maintain quality toward the end of the contract period. Therefore, it may be optimal to gradually add a fine that increases as the end of the contract draws nearer, so that the penalty for noncompliance matches the provider's entire profits throughout the contract period.

This award mechanism encourages a maximum of innovation and cost control because providers are free to choose or develop the technology and combination of inputs that reduce cost most while maintaining the mandated level of care. As providers compete for contracts, their competitive offers to win the contract will reflect their true cost of serving the defined

population at the mandated level of care, thereby passing on any cost advantages to the state.

On the other hand, given that providers aim to minimize expenditure, they may cut quality in those dimensions that are hardest to measure and audit by the state. Thus, competition for contracts will fail to take into account those patient preferences that are both costly to satisfy and costly to monitor objectively. The state will have to decide whether any additional expenditures to audit providers' compliance with these, mostly intangible, dimensions of care are justified by the additional health and well-being of the program beneficiaries.

Once eligibility is defined, the risk of variation in the actual number of patients claiming care is borne by the providers, so that once the contract has been awarded, the state's expenditures for providing services are perfectly predictable for the duration of the contract.

In addition, the fact that one organization is in charge of providing services to the entire population of patients defined by the state prevents providers from serving only the most profitable segments of this group, such as patients whose needs of medical attention and overall supervision are minimal or who can work for pay in a suitably adapted environment.

At the same time, however, the state is liable to define the population covered in each contract in a way that does not allow providers to deliver services at minimum cost. For instance, a larger patient population may enable a given provider to spread fixed costs such as on-the-job training of staff, construction of care facilities, program administration, or negotiations with suppliers over a greater number of beneficiaries and thereby reduce expenditure per capita. In this case, the state would forego these cost savings if it chose too small a beneficiary population to be included in the contract.

To implement this award mechanism, the state needs to set up an effective auditing system of quality control to ensure that providers actually deliver on the quality they committed to when they were awarded the contract. For instance, patients and their guardians should be informed about the quality that the state has purchased for them and that they are entitled to

receive. As outlined above, an easily accessible grievance process that allows patients or their guardians to report a breach of contract would help alert the state about noncompliance. In addition, third-party licensure bodies can be used to examine all provider organizations that want to participate in the competition and to enforce minimum standards of care among the contract awardees.

The state also needs to prevent current and prospective providers from conspiring to submit worse offers when they compete for contracts than if they acted independently. This is achieved best if the eligibility criteria to participate in the competition are transparent. Also, the more profitable the contract for potential providers, the more firms will enter the contest, and the harder it will become for contestants to coordinate the terms of their offers.

### **Competition for Enrollees**

Instead of defining a minimum level of care and having providers compete to serve a specific population at the lowest cost, the state can set a fixed payment amount and let providers compete on the basis of quality of service. To ensure that enough providers will find it attractive to compete, the state can gradually raise the payment until the number and variety of competitors promise to guarantee a predetermined minimum level of care.

Once the pool of qualified providers has been defined, the state grants vouchers to all eligible recipients of services. Each program beneficiary, in conjunction with family members and his or her guardian, then selects a provider who accepts the voucher in lieu of payment. Note that this award mechanism would allow relatives or friends to care for the patient and to be compensated at the same rate as institutional providers.

Competition for program beneficiaries among providers will ensure that recipients receive the highest quality of care that is technologically feasible at the set payment level. At the same time, the state no longer chooses a provider for the recipient. As in the case of competition for contracts, this system maximizes providers' flexibility in delivering care and rewards those who innovate and cut cost. In particular, under this mechanism, the state does not specify the size of the patient population

served by a provider. Instead, providers are allowed to vary in size. For example, urban providers may take advantage of centrally located day-care facilities and serve a larger number of patients than rural providers, for whom the cost of transporting the patient between the home and the day-care setting or workplace may be more important.

In contrast to competition for contracts, providers have a strong incentive to exceed the minimum standard of care by satisfying those intangible patient preferences that are cheap to honor but very costly to monitor objectively. As the provider choice now rests with patients instead of the state, the variety of services offered will match the diversity of patients much more closely than under competition for contracts. For instance, providers may try to fill market niches by choosing to build group homes close to relatives, specialize in treating a subset of patients who suffer from a specific developmental disability or mental illness, or offer differentiated menus of day-care activities and meals that cater to distinct patient groups.

By allowing patients to “detect and defect,” the state enlists the help of the users themselves to broaden the range of quality variables that are monitored. Compared to the model of competition for contracts, this mechanism of selecting providers imposes greater demands on recipients’ ability to evaluate the services they receive and to exercise their option of switching providers effectively. Periodic review of facilities and certification of personnel by the state can ensure that patients, regardless of their choice of provider, receive a minimum level of care. In addition, active involvement of guardians, family relatives, and other stakeholders in patients’ welfare can help recipients choose the provider that is best for them.

The state’s expenditure per beneficiary is predictable under this system, but the state bears any risk of unforeseen fluctuation in the number of beneficiaries.

In contrast to competition for contracts, which forces awardees to serve all members of a well-defined patient population, providers competing for enrollees might design services in such a way that attracts low-cost patients and deters high-cost patients. In this way, providers would be able to serve only the most profitable beneficiaries, leaving the most costly patients

without care. To prevent this form of risk selection, it would be necessary to offer additional reimbursement to providers who care for the most difficult patients. For example, beneficiaries' vouchers might vary in size according to fixed and observable characteristics that reliably predict the cost of treating the patient. Similarly, providers might be granted additional compensation if they demonstrably incurred above-average cost to treat the most severe cases.

As in the case of competition for contracts, the state must prevent providers from conspiring to lower the level of care for all beneficiaries, which would render useless patients' option to "detect and defect." Transparent rules of certification to participate in the competition for enrollees and an effective appeals system for providers who feel they are denied the right to compete minimize the cost to potential providers of participating in the competition. At the same time, the higher the payment that providers can expect for serving the mentally ill and developmentally disabled, the more potential providers will find it profitable to serve this population, resulting in more vigorous competition.

These recommendations would increase the ability of the state to provide mentally ill or developmentally disabled persons with a quality of services that is both transparent and affordable. They would strengthen the confidence of patients, providers, and the public that tax revenues dedicated to serving this population are spent effectively and fairly.

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**Note**

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