

TECHNICAL ASSISTANCE REPORT  
FOR THE  
ACCESS TO RECOVERY GRANT  
PROGRAM

PLANNING AND IMPLEMENTING A VOUCHER  
SYSTEM FOR SUBSTANCE ABUSE TREATMENT  
AND RECOVERY SUPPORT SERVICES

A START-UP GUIDE

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# Introduction

During the summer of 2007, the Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, (SAMHSA/CSAT) tasked its Access to Recovery (ATR) technical assistance contract, the Performance Management Technical Assistance Coordinating Center (PM TACC), to develop a set of resource materials for incoming second-round ATR grantees. The PM TACC prime contractor, the American Institutes for Research (AIR), and their subcontractor, JBS International, Inc., brought to this product-development task the experiential knowledge rooted in service to CSAT and the ATR Round 1 grantees throughout all phases of the first-round grants-- from the pre-application roll-out of the Presidential initiative, to early implementation and sustained operation of the grant programs, to their eventual close-out. SAMHSA/CSAT's selected topics for the resource materials target key issues, barriers, challenges, and decision points that faced the first-round grantees during each of these phases. They are written from the PM TACC contract's experiences with the 15 grantees that broke new ground for the substance abuse field by demonstrating the feasibility of using a voucher model for providing publicly-funded treatment and recovery services.

Some of the newly developed resource materials modify, update, and consolidate technical assistance (TA) reports emanating from the Round 1 grantees' TA experiences. Other products provide syntheses of the Round 1 grantees' experiences related to various topics central to effective and efficient planning, implementation and management of an ATR grant. CSAT has requested that these reports be made available to Round 2 ATR grantees so that the new cohort may benefit from the experience and work accomplished by the initial ATR grant recipients. Below are lists of the available reports.

## SYNTHESES

- Access to Recovery Report: Lessons Learned from Round 1 Grantees' Implementation Experiences
- Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantees
- Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services: *A Start-Up Guide*
- Setting Up a System for Client Follow-Up
- Recovery Support Services
- Case Management
- Summary and Analysis of Grantee Fraud, Waste, and Abuse Activities

## TA CONSOLIDATED REPORTS

- Basics of Forecasting and Managing Access to Recovery Program Expenditures
- Compilation of Technical Assistance Reports on Rate Setting Procedures
- Development of a Paper-based Backup Voucher System
- Financial Management Tools and Options for Managing Expenditures in a Voucher-Based System: Round 1 Grantee Experiences

- Motivational Interviewing: A Counseling Approach for Enhancing Client Engagement, Motivation, and Change
- Outreach to Faith-Based Organizations: Strategic Planning and Implementation
- Strategies for Marketing Access to Recovery to Faith-Based Organizations
- Targeted Populations: Technical Assistance Examples

## **About this TA Report**

This document *Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services: A Start-Up Guide* provides comprehensive key considerations for ATR grantees in selecting, designing and implementing a Voucher Management System (VMS) for substance abuse treatment and recovery services. The document delineates several global models that categorize the VMS selected by ATR's initial grant cohort and outlines key considerations for each option. The document describes lessons learned by the Round 1 grantees with respect to their VMS, including challenges (and strategies to overcome them), strengths, and insights for what grantees would do differently the next time. Information for the start-up guide was drawn from a final round of grantee site visits conducted in June-July 2007.

This start-up guide is intended to assist CSAT's new ATR grantees—especially during the early stages of planning and implementation—by offering practical information and suggestions to use in developing their voucher programs. The document will help grantees to examine the key issues they face in planning and implementing a voucher program for substance abuse treatment and RSS.

This guide shares the many insights and ideas gathered from all the first ATR grantees during site visits to their programs, as well as information provided by TA consultants in the ATR program. The guide begins by discussing the many issues in planning and implementing of a voucher system, such as organizational structure, stakeholders, target population, services, implementation, and the perspective of providers. The guide then moves on to consider the two major infrastructure issues in detail—namely, financial and voucher management systems and data management systems. Throughout the guide, new grantees will find basic concepts and ideas combined with the insights and suggestions gleaned from current ATR grantees.

## **About the ATR Program**

ATR is a competitive discretionary grant program funded by SAMHSA that provides vouchers to clients for purchase of substance abuse clinical treatment and Recovery Support Services (RSS). ATR program goals include expanding capacity, supporting client choice, and increasing the array of faith-based and community-based providers for clinical treatment and recovery support services. Key among ATR's goals is providing clients with a choice among qualified providers of clinical treatment and RSS. Under the ATR program, treatment and RSS can be provided by both nonsectarian and faith-based organizations (FBOs).

## **Models for Electronic Voucher Management Systems**

New grantees are immediately faced with the major decisions involved in selecting and implementing electronic information management systems to manage their voucher processes. Grantees need a system that will:

- Support all the functions involved in managing a voucher system to make the operation of the voucher system as efficient as possible
- Coordinate with data systems currently being used by service providers to minimize costs for staff and equipment, and particularly to avoid requiring providers to perform duplicate data entry
- Integrate with State systems that provide essential functions, particularly fiscal management and payment processes

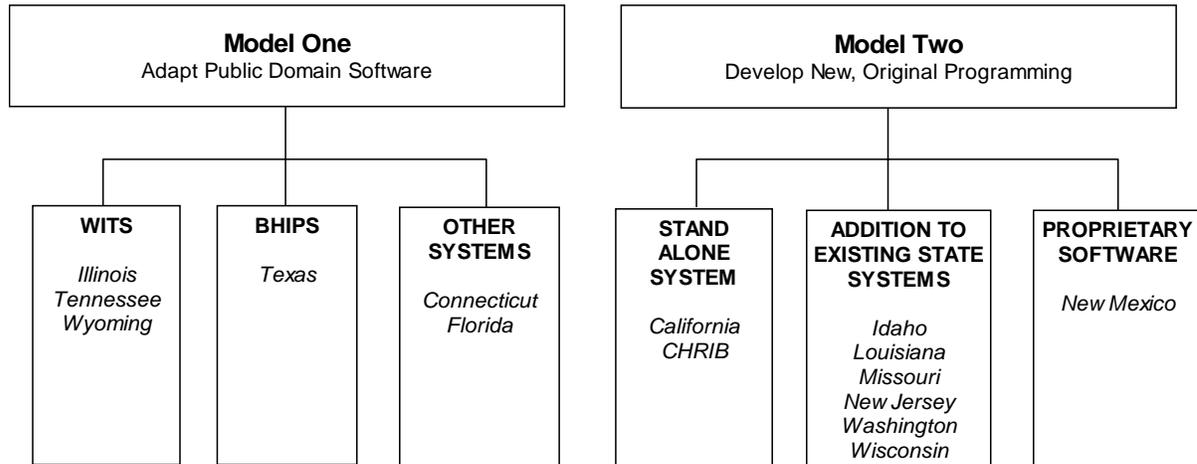
In addition, grantees want a system that:

- Will be relatively easy for all providers, particularly new providers, to use
- The costs for development, implementation, and ongoing maintenance are reasonable and within the limits of the funds available to the grantees
- Can be ready for use on the desired time schedule

Since selecting an electronic information system is such a major component in launching a voucher system, this guide provides as much direction as possible for new grantees based on the experiences of the first round of all grantees. No one perfect solution will meet the needs of all grantees.

However, the decisions made by the first round of grantees provide a great deal of helpful information that can assist the new grantees.

The following chart outlines the two basic approaches used by grantees, namely, **Model One—Adapt Public Domain Software** and **Model Two—Develop New, Original Programming**. For each model, the chart shows the various options that were selected by grantees.



Information on a suggested planning process for selecting an information system, along with details on each of these two models are found in this Manual in *Chapter 4 . Data Systems and Functions*. Specific key information on each system is contained in a spreadsheet in Appendix B of this guide. Additional descriptions of how each grantee developed and used their Voucher Management System is found in a companion document, *Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantees (October 2007)*.

One potential strategy for controlling software acquisition costs and for possibly reducing the time required for system modification is to import software that is already in use by another grantee. Appendix B of this manual includes information on the possibilities of portability for each system currently in use. Grantees interested in this approach would be advised to contact the host State to obtain more detailed information before making such a decision.

## Dimensions of a Voucher System

An analysis of the ATR voucher system requires incorporating three dimensions—the client, the overall system, and the treatment paradigm.

### ***Client Dimension***

From the client's perspective, the ATR voucher system introduces two new elements—namely, choice and the use of vouchers to procure services. Clients in the ATR voucher system have the freedom to choose their service providers from a diverse network of secular and faith-based providers offering treatment and RSS. Clients who are eligible for services are given the choice of at least two providers. The client makes the final decision as to which provider he or she will visit.

Vouchers are the vehicle used by clients to execute the choice process. A typical voucher process includes the following steps:

- ***Screening.*** Clients are screened with a substance-abuse screening instrument. An assessment voucher is issued to individuals who meet the referral criteria for a substance use assessment and program eligibility requirements. Individuals who do not meet the referral criteria are referred to local self-help groups.
- ***Assessment.*** Qualified and trained staff members assess the clients, often at the agency in which the screening was conducted.
- ***Treatment.*** Based on results from the comprehensive assessment, the assessor generates a treatment voucher(s) containing level of care recommendations, as well as information on several providers offering the type and level of care that the assessment indicated is needed. The assessor helps clients compare the various treatment providers' services and capabilities, so that clients can make an informed choice.
- ***Recovery Support Services.*** The assessment provider can offer clients a choice of RSS available at any point during the treatment process—while waiting for treatment, during treatment, and after treatment is completed. Some grantees did not require clients to be receiving treatment to get RSS. RSS typically are provided by a community-based organization or a faith-based provider.

### ***System Dimension***

The ATR voucher program introduces significant systemic change. One of the great benefits of the voucher program is that it expands the capacity of the treatment system by adding so many new providers; this substantially increases the number of clients who can be served. In addition, the nature of the provider network is changed through the incorporation of this new array of faith-based and community-based providers for clinical treatment and RSS. These new providers expand the continuum of care, particularly by providing a wide range of RSS.

ATR also involves a fundamental shift in thinking about clients and services. The program is driven by client choice. It is client centered, not program centered. This shift has a number of implications. It empowers clients and appears to increase retention rates. In addition, clients have simply chosen not to select providers who are perceived as providing inadequate care. Thus, ineffective providers are eliminated from the system, since they do not receive any voucher income.

### ***Treatment Paradigm Dimension***

The ATR voucher approach has shifted the treatment paradigm in several ways. This new system—with its extended range of providers—is beginning to view treatment and recovery from addiction not as an acute disorder, but as a long-term process designed to help with chronic dysfunction. Thus, the continuum of care is being extended after treatment through continuing support services. It is clear that this extended continuum works to the benefit of clients, who need ongoing support during vulnerable periods.

The ATR voucher system incorporates faith- and community-based providers, as well as the RSS they provide, on the same footing as treatment services. What this acknowledges is that there are multiple pathways to recovery from alcohol and drug abuse, and that these include spiritually oriented paths in the community. In ATR, both traditional treatment programs and FBOs are valued as essential to meeting the needs of clients.

# Chapter 1. Planning a Voucher System

## Implications for System Change

Implementing a voucher program for substance abuse treatment and RSS is a major undertaking. A carefully developed, very detailed planning process will help to get the program started smoothly. The experiences of the original ATR grantees, who pioneered the voucher program in substance abuse, can be of great benefit for those planning such a system.

Implementing a voucher system such as ATR will entail four substantial system changes.

- ***A change in the process for funding services.*** Traditionally, most grantees funded substance abuse services through a fee-for-service payment process or through contracts with providers. In both cases, the funding went to service providers to pay for service capacity. In the new voucher process, funding follows the clients. Providers receive funding only when clients choose to use vouchers to purchase services from them.
- ***A dramatic change in the array of services.*** Traditionally, State and local authorities provide funding for defined programs of treatment services and then assign clients to those services. A voucher program opens the door to a wide array of additional services that are determined by the needs of clients. In the ATR program, these services focus on recovery support. The ATR grantees each identified a set of RSS aimed at helping clients to engage in treatment, sustain treatment, and remain in recovery more successfully.
- ***A shift to client choice and empowerment.*** Typically, clients have been assessed by skilled clinicians and then assigned to a level of care that incorporates a specified program of services. A voucher system is revolutionary in that it gives clients a choice—both in determining which services, and which service providers, they will utilize.
- ***A major expansion in the network of service providers.*** As a consequence of the voucher system, the typical set of treatment providers is expanded substantially. The ATR programs added numerous RSS providers from the community, many of whom are characterized as faith-based.

It is easy to see that these four major shifts—which relate to each other in complex ways—mean that a voucher system will bring profound and systemic changes to any delivery system for substance abuse services. Every grantee is different and will make different decisions based on many local considerations. To be most effective, however, a new voucher system needs to be designed according

to local structures, local strengths, and local goals. The current ATR grantees are able to point out many common elements that may be useful for new grantees in their planning for a voucher system.

## Planning Issues

***The planning process.*** To implement a voucher-based system for substance abuse treatment and RSS will require significant change throughout the existing substance abuse service system. This major system change will demand strong and consistent leadership from the highest levels within the State. One significant attribute of the ATR program is its requirement for involvement at the Governor's level—a factor that several grantees point to as being critical for their projects. At the same time, grantees report that the system changes required are too dramatic to allow an exclusively top-down model to work. Extensive participation and collaboration at the local level throughout the process is essential.

Some grantees indicated that, in retrospect, they shortchanged the process of local involvement in their eagerness to get the process moving quickly.

***Cooperation of other State agencies.*** To successfully implement a voucher system also requires the cooperation of multiple parts of the State infrastructure, such as controllers, auditors, and other service agencies. Grantees report that, at the State level, cooperation from a number of other State entities, particularly those that support financial systems, is essential. One-on-one meetings with other agencies are needed to explain how the voucher system is different from current systems, and to explain the implications of vouchers for system operation. Because the voucher concept is new to all parts of the system, it needs to be explained multiple times. Making the distinction between vouchers and current payment systems is critical. In addition, support from the Governor and legislature is essential, both to secure additional State funding and to pass legislation that may be needed to successfully implement the program.

***The critical local buy-in.*** Because a voucher program is essentially a local operation, buy-in at the local level is critical. A voucher program centers on the client and on the environment in which that client seeks treatment and lives in recovery. To help build community cooperation and involvement, extensive collaboration needs to be established with the community from the very beginning of the planning process. Grantees report that the extensive engagement of local communities is extremely helpful for building a successful system. Local stakeholders are invaluable for their help in identifying needs, analyzing gaps in services, and discussing how the voucher program can meet local needs. Predictably, the results of planning will be different in different communities throughout the State.

Engagement of grassroots providers is key to the voucher programs. Engagement of these providers is built on relationships and requires lots of face time, listening, seeking input, attending to complaints, eliciting feedback, and clarifying expectations.

The voucher model relies on utilizing grassroots providers. It is essential to involve these providers in the early planning and to ensure two-way communications early. The ATR grantees indicate that regular meetings—continuing throughout the project—are essential to keep communications open and to keep community engagement alive. Setting up a method of electronic communication with all participants is a useful tool for meeting immediate communication needs. The providers appreciate having a phone number to call with questions or for help.

## **Resources for Planning**

Grantees face an immediate challenge. The government grant program asks them to produce tangible results with the funding as quickly as possible. This urgency for results needs to be balanced with the upfront demands of planning and systems development. Most grantees indicate that taking more time for planning and systems development up front would have saved them time in the long run and would have avoided their having to introduce changes after the voucher process was already implemented. Implementing the use of vouchers before the automated systems are fully developed and tested was reported by some grantees to be both costly and stressful. Changing from an initial paper-based system to an automated system presented substantial difficulties for the grantees that used this strategy. Several of the grantees recommend trying out a small pilot test before going on to full-scale implementation of a new system as one way to streamline the planning and implementation process.

***Leveraging available resources.*** Most grantees observed that adequate time for planning is essential and that the full costs of all staff and resources involved in the planning process often exceeded the allowed administrative limit in the ATR grant. One way grantees expedited the planning cycle was by supplementing ATR funds with additional in-kind services contributed by the State for planning activities. Significant in-kind contributions by State staff are inevitable, so the planning phase needs to alert the appropriate authorities about this need. State entities can then be prepared to dedicate the required resources.

**Summary and Transition.** To get all the components of the new system working together smoothly and effectively, a systematic planning process needs to continue while the voucher system is being implemented. Chapter 2 of this start-up guide discusses key elements of a voucher system, describes some of the issues that need to be considered for each, and conveys some of the suggestions reported by current grantees. The key system elements include: organizational structure, stakeholders, target population, providers, training and TA, services, and early implementation. Chapters 3 and 4 provide detailed information on the critical infrastructure for carrying out data, fiscal, and voucher management.

## Chapter 2. Key Elements in Establishing a Voucher System

### Organizational Structure

This start-up guide addresses the types of voucher systems that are primarily operated either by State agencies or by large tribal authorities. For State entities, the Single State Authority (SSA) appears to be the logical choice as the organizational home for the voucher program. For Tribal entities, the highest level of Tribal government authority would likely be the appropriate choice. The designated entity that will provide overall management and direction for the voucher system is responsible for:

- Fiscal management and oversight
- Development of policies and procedures
- Coordination with other State agencies and organizations
- Forming collaborations with local governments and organizations
- Possessing the knowledge and experience to work with the appropriate service providers
- Coordinating benefits under the ATR program with other State or Federal programs
- Coordination with the Federal funding agency

The sponsoring agency also needs to have an in-depth ability to garner staff and resources. The ATR grantees report that the sponsoring entity needs to have the capacity to contribute substantial in-kind time and resources. Although this is particularly important during the planning phase, it is also relevant throughout the years of system operation. A smaller organization with less organizational depth would not have the resources to field and operate a voucher program of this type.

***Selecting an organizational approach.*** A voucher system can be organized in a variety of ways. Many grantees operated their voucher system as a separate program within the SSA. The organizational approach utilized by some grantees was to contract with an administrative services organization (ASO) for substantial portions of the operation of the voucher system. The grantees who used this approach generally reported satisfaction with the arrangement. In most cases, these grantees already had a working arrangement with the ASO and were able to incorporate the implementation of the voucher system into an existing agreement. If a new ASO had to be selected, a great deal of additional start-up time and expense would be required.

In a few cases, grantees developed a coalition model, using one provider as an ASO to handle the administrative work for other small provider organizations. Many RSS providers in the voucher program are small community organizations or FBOs that do not have the capacity to manage computerized data and lack access to an infrastructure for record keeping and billing. Designating and training one of these providers to serve as an ASO for a group of smaller providers proved to be an ingenious solution to this issue.

***Adapting the approach to existing structures.*** Grantees report a number of other organizational arrangements that they developed as part of their overall implementation plan. Each of these arrangements represents an adaptation to existing structures. Some examples include:

- Implementing the voucher program in six counties—one in each of the State’s six service regions. The counties were already accustomed to taking responsibility for planning and implementing services, so the State agency gave them maximum flexibility with management and decision making concentrated at the local level.
- Capitalizing on existing State service infrastructure by working with the State entities that already monitor and contract for child care, rather than creating new child care arrangements
- Organizing on a regional basis, utilizing regional ATR coordinators who know the communities and the natural relationships; these coordinators are thus able to capitalize on existing relationships within the local community.
- Working through existing networks of service providers to facilitate access to treatment services
- Building on existing networks and coalitions of FBOs, clergy, and community organizations

## **Stakeholders**

The planning process needs to locate the power, control, and influence that will be necessary to help this project succeed. What are the pressure points where opposition could scuttle this project and how can opponents be turned into allies?

***Engaging and involving the stakeholders.*** The importance of engaging all stakeholders cannot be overestimated. Every one of the stakeholders will come into play at some point—either to become an active participant, an active advocate or supporter or to provide some essential service that is necessary for the voucher program to succeed.

Grantees identified a wide range of stakeholders who had some involvement and interest in the voucher project and could serve as valuable advisors, supporters, or collaborators. The players who emerged as most influential and critical to success varied across the grants, depending on differences in State structures and circumstances. Typically, these included:

- Executive branch: the governor and staff

- Legislative branch: State legislators and staff
- State agencies: Commissioners and staff of agencies that provide and oversee such services as health and human services, child welfare, child and family services, higher education, and public schools
- Public safety: Judges, chiefs of police and other law enforcement officers, probation and parole staff, adult corrections, and juvenile corrections
- Judicial systems: Judges, the legal community, and drug courts
- State administrative services: Commissioners and staff of State agencies that provide such essential administrative services as fiscal, audit, information technology (IT), data security, and confidentiality
- Officials of local and regional governmental units: Officials in jurisdictions where the voucher program will be operating have an immediate concern about the welfare of citizens whom the voucher program will serve. These officials know, and perhaps are funding, some of the organizations that will be providing voucher services.
- Service providers: Both current and potential providers, as well as their coalitions, associations, and organizations
- Faith-based and community organizations: Groups or individuals who may be supportive of the venture because it meets the needs of individuals in their faith community, those who may be actively engaged in offering voucher-supported services, or may be opposed to this venture for some reason
- Coalitions, advisory boards, and alliances representing organizations that have an interest in the project
- Representatives from client groups, including clients in recovery and from groups that are typically underserved, including racial and ethnic minorities

Grantees recommend that all the relevant stakeholders be identified and engaged right at the beginning, so they can become involved in the planning process and begin to develop a sense of ownership. Forming advisory committee(s) encompassing all relevant groups would have been a good measure that many grantees did not have time to implement initially.

***The need for marketing.*** The role of public relations and marketing is essential when a program as different and far reaching as the voucher program is being introduced. Many State grantees repeatedly stressed the importance of communications—that marketing and communication with all these constituencies was essential for the success of their project. Grantees report it is necessary to identify strategies that will engage stakeholders and involve them in the project in ways that are meaningful and appropriate for them.

## **Target Population**

Determining the target population that will be served by the voucher program is basic to the planning process. Interviews with all 15 ATR grantees clearly document that vouchers work with all types of populations. Specifically, the ATR program showed the population that can benefit from a voucher program is not limited by age, sex, race or ethnicity, geography, level or type of need, religious affiliation, legal status, family situation, or living situation. Clients served successfully ran the gamut across all these characteristics.

Factors to consider in choosing a target population include:

- **Estimated number:** Look at the amount of unmet need and determine that there is a sufficient population to target services efficiently.
- **Accessibility (urban or rural):** Implementation of the program was difficult in sparsely populated areas, but the program did work well in some rural areas.
- **Primary treatment need:** This might include opioid treatment, methamphetamine treatment, co-occurring disorders, intensive outpatient, and residential services.
- **Legal status:** At least one State found some of the probation regulations ran counter to the concept of client choice, while others indicated that drug courts welcomed additional services for their clients.
- **Service history:** Vouchers can serve clients who have never received services before or chronic clients who have a treatment history and are already in the service system.
- **Level of need:** The system can serve clients seeking high or low intensity treatment and/or clients who want support in recovery.

For planning purposes, the grantees made reasonable estimates of the eligible population to whom the services would be directed. To determine feasibility, they used available data related to all of the

factors listed above. Because the process for providing services and the nature of the services provided differed so dramatically from previous norms, most grantees had to continue to adjust their estimates of level and type of need as the programs unfolded. Grantees also had to continue to adjust their projections of the number of clients they could expect to serve and to adjust their target populations accordingly.

## **Providers**

### ***Planning for Marketing and Recruitment***

According to grantees, it is impossible to overestimate the amount of time and attention required to inform potential service providers about the details of a voucher program and then engage them in participating. For the ATR program, the marketing task had to include recruiting traditional treatment providers who would be willing to participate in a voucher system. It also meant engaging—for the first time—faith-based and other grassroots community organizations that were interested in providing services to individuals who needed or were receiving substance abuse treatment. Since these faith-based and community organizations and the grantees typically had no experience in working with each other, the recruitment process was very challenging.

The key for engaging diverse providers is a comprehensive marketing strategy. States indicate that it is challenging to get everyone to understand the meaning of a voucher system and how it differs from contracts and from a fee-for-service system. Grasping these differences requires repeated explanations for both current treatment providers and for new providers. For organizations that were new to working with the State, more than just the voucher system was new. All the documentation requirements as well as processes for funding and client outcomes were new. Much misinformation and many negative perceptions had to be dealt with before these new providers were willing to be engaged. All grantees reported that the ATR program had indeed increased their provider pool and has created successful, ongoing partnerships.

## **Strategies that Worked for Marketing and Recruitment** **Suggestions from Grantees**

- Engage in informational campaigns at State, regional, and local government levels to secure the support of public officials
- Work with existing networks and organizations, including treatment provider organizations, coalitions of clergy, places of worship, and community service organizations
- Provide information widely through brochures, newspapers, Web sites, and other publications as well as electronic media such as radio and local TV channels
- Make presentations at conferences, meetings, and forums
- Recruit regional and locally based marketing staff who know the community systems and relationships and have local contacts

Most States indicated that the most effective approach was in-person communication with organizations. This enabled the organizations to receive immediate responses to their questions and to express their reservations and concerns.

### ***Engaging Faith-based Providers***

A significant hallmark of the first ATR program was the substantial number of FBOs that were recruited and engaged, primarily in providing RSS, at all grantee sites. In most cases, recruiting the FBOs required a deft touch. Some grantees employed an FBO coordinator and/or a marketing/outreach coordinator—both of which offered clear advantages for reaching out to these organizations. Generally, just publicizing the opportunity was not sufficient to attract enough participating FBOs. This new voucher system, as it brings in a whole new class of providers, needs the expertise of individuals who are experienced community organizers. Since this process was totally new for many State agencies, many States needed TA on strategies for accomplishing this outreach.

A few grantees were fortunate enough already to have organizations of clergy or FBOs that could serve as a starting point. In some cases, community and/or religious leaders publicly endorsed ATR,

which had a positive influence on public opinion about the program. Everywhere, outreach and marketing were required to get people engaged. The ATR programs needed to set up extensive communication providing accurate information; they also needed to structure appropriate and accurate expectations. All grantees reported that lots of hand holding and one-on-one education were needed.

According to one grantee, “Lots of pieces of paper don’t work with the faith-based groups. You need lots of face-to-face, listening, getting input, soliciting feedback, and attending to concerns.”

### *Selecting Treatment and RSS Providers*

Establishing qualifications—for both treatment and RSS providers—is an essential component of planning. Setting qualifications for treatment providers is unlikely to be an issue. Grantees indicated that qualifications for treatment providers are already specified in their State regulations. Typically, clinical provider organizations are licensed by State authorities, with the qualifications for clinical treatment staff generally being set by State or national organizations and accrediting agencies. An important note: Some new voucher programs may be focused on populations underserved in their traditional treatment system. In this case, the program needs to ensure that their treatment provider staffs are prepared and qualified to provide service to the new populations that will be entering the service system.

The process of defining standards for the new RSS providers was more difficult. Most States developed an application process that required some of the following information:

- Information on the business model of the organization
- Documentation on business operations, such as the last 2 months’ financial statements
- Documentation on compliance with local and State regulations, including State and local zoning requirements and fire inspections, as well as standards of the Department of Housing and Urban Development (HUD)
- Evidence of liability insurance coverage
- Licenses or certificates appropriate for the designated services, such as child care licenses or appropriate driver’s licenses

Grantees indicated they also had to be very explicit to ensure that new providers fully understood the requirements of participation. These minimum requirements are listed in the box below.

**New Provider Requirements**  
**Suggestions from Grantees**

**What new providers must do to participate:**

- Engage in necessary training
- Comply with documentation requirements for client records
- Collect and submit the required Government Performance and Results Act (GPRA) data
- Utilize the appropriate procedures for submitting bills

Some grantees indicated that, in the future, they would be somewhat more rigorous in the requirements they established for RSS providers. For example, they would consider requiring the organizations to have 501(c)(3) status.

***Uniting All Organizations within One System***

Most grantees indicated that the ATR voucher program has made a lasting impact on their substance abuse service system. Typically, grantees indicate that one major benefit has been the growth that has occurred in the size and composition of their entire provider community with numerous new providers added. However, it is inherently challenging to bring together “traditional” treatment providers in a close collaboration with community organizations, primarily faith-based, that are providing RSS. Every State reports that building good working relationships among all providers is critical for implementing the voucher system, but that this is a very difficult process.

Grantees faced two interrelated challenges:

- Challenge No. 1 was to get all the participating providers to work as a team and to collaborate in a spirit of respect for the contributions that each group brings to the clients’ well being.
- Challenge No. 2 was to provide all the necessary training, TA, and support that are needed to enable all providers to participate successfully.

***The typical treatment provider’s perspective.*** Traditional treatment providers brought years of expertise and experience in providing a range of treatment services to clients, who are often some of

the most difficult clients to serve. These providers were understandably protective of their role. Consequently, many traditional treatment providers initially resented seeing “treatment” funds being dispensed to new organizations. They believed that the new organizations lacked knowledge about substance abuse and would interfere with good treatment. Since the new organizations do not share the same professional credentials, traditional providers generally considered that the new organizations were not professional and not competent to work with substance-abusing clients.

***The typical FBO’s perspective.*** On the other hand, FBOs generally entered the process believing that they could not work with the government unless they compromised their mission and shortchange their beliefs. These new groups also believed that the treatment organizations do not respect what FBOs had to offer. On the positive side, many of these FBOs were committed to providing service to those in need, and often had already provided an array of support services. However, FBOs usually had not been reimbursed for these services. Often their staff members had professional training in other areas and brought a different perspective to working with clients. Because of their mission, FBOs often had ready access to individuals who may never before have come in contact with traditional treatment service providers.

***Methods to develop collaboration.*** States used various approaches for building understanding and collaboration between their traditional providers and the new non-traditional and FBOs, most of whom focused on RSS. One State indicated their plan for building a working collaboration among all providers was based on their treatment philosophy—an approach that begins with identifying strengths. This State started by identifying and stressing the strengths that each organization brings to the overall system. Rather than looking for differences and barriers, this approach honors the existing expertise of each group and looks for what they have in common—for what unites them.

## **Approaches for Promoting Collaboration**

### **Suggestions from Grantees**

- Help participants learn about the missions and values of all organizations, so that everyone has an understanding and appreciation for them
- Learn to understand the language of the FBOs and develop ways to communicate the government's language and acronyms to them
- Stress the fact that the purpose of the available funds is to meet the needs of the clients, not to meet any organization's needs
- Ensure that implementation of the project continues to be client-driven
- Create an environment where all organizations are accepted and can freely acknowledge problems so that solutions can be identified
- Establish a central point of contact where providers can call with questions and concerns

Most States developed schedules for regular meetings of all providers (local, regional, or statewide) and provided common training experiences. Participating together in planning activities and training sessions gave all the organizations a common experience, which helped to build trust.

None of the ATR grantees found it easy to incorporate all organizations into their service provider network, but at this point all can readily cite the multiple benefits of having done it successfully. Some of the benefits of a treatment/recovery support collaboration are that it:

- Extends the number and types of service providers
- Adds the dimension of RSS to the treatment continuum
- Makes services possible that are more explicitly oriented toward spiritual values
- Adds diversity to the mix of providers, which in turn often leads to a more diverse population of clients who are receiving services. (States report engaging both more clients of diverse

racial and ethnic backgrounds, as well as large numbers of clients who have not sought services before.)

States that successfully solidify relationships among all their providers believe this outcome is the one that will bring lasting benefits for clients. Another significant outcome is that FBOs who were already providing some services to clients with drug problems are now able to do this more effectively and professionally by more full and open coordination with treatment providers.

### ***Training and Technical Assistance***

All providers need intensive initial training to prepare them for the requirements of a voucher system. Many grantees also reported that a program of ongoing and refresher training was essential for implementing changes and for maintaining quality. Grantees reported that having training that brings together both traditional providers and FBOs was very beneficial in providing a common experience and strengthening the bonds. The training activities provided common experiences that contributed to building a cohesive, united provider network.

As a base, all providers—traditional treatment, as well as the new community-based providers—needed training on the voucher system and on the grant’s data collection and reporting requirements. The following box lists the range of topics in which many providers needed training.

## **Useful Training Topics** **Suggestions from Grantees**

- Financial: Administrative procedures, voucher management, billing policies and procedures, business practices, and sustaining a program when the external funding ends.
- Service management: Documentation and client record management
- Data: Data collection, reporting requirements and procedures, and computer skills training
- Professional issues: Ethics, confidentiality, background on addiction, boundary setting, confidentiality, common language, and mentoring
- Clinical/program issues: Sustaining recovery, de-escalation, emergency management, methamphetamine, RSS, outcomes, building the service continuum, best practices, group dynamics, family dynamics, mental illness, outreach ministries, and methadone maintenance

***Specialized training for FBOs.*** In addition to training specifically on the voucher system and data collection, many FBOs needed both substantial additional training and ongoing support. Many small organizations needed this help to create an internal infrastructure for managing their segment of the program. Areas of particular need included:

- Developing policy and procedure start-up guides
- Basic computer skills
- Managing vouchers
- Billing procedures
- Basic business practices

Engaging in this project was a major undertaking for small organizations, many of which were accustomed to operating on donations and relying on volunteers. Many providers required TA in setting up procedures and processes and establishing systems that could meet the requirements of the voucher program.

Information system training needed to be extensive. Staff from many of the FBOs had little or no experience with e-mail or data systems; they could find this training to be overwhelming. Since computer training is such a big challenge, one grantee suggested that it was a mistake to provide such training as the first training event. Recognizing that the computer training is all new, it works best to space it out and to plan to repeat the key concepts. Retraining will be needed when there is staff turnover. Brief fact sheets are more useful than big manuals.

Training should be adapted to the needs of the individual trainees. Some people will not be comfortable speaking up with questions in large groups. Some trainees will learn better in one-on-one or small group settings.

***Sources of continuing help.*** Some method of continuing help will be important for providers. Some grantees provide ongoing training by using conference calls; PowerPoint handouts are sent out prior to the call so participants can follow along with a printed version. Most grantees also set up a help desk that could answer provider questions, particularly those related to technical procedures. A clickable page on the grantee Web site set aside exclusively for new information and updates was another approach. Providers at many sites commented on how helpful this was.

## Services

### ***Assessment***

Assessment of the client to determine the client's needs begins the process of voucher-based services. In some cases, screening for eligibility precedes the actual assessment. The goal of this assessment process is to work with the client to determine what services are needed—and then to ensure that the client has choices. The client is empowered to choose what services are to be received and who will provide these services.

***The independent assessment.*** The aim is to have an independent, objective assessment done by a person who is open-minded and relatively free of biases toward specific providers. The assessment will then reflect the actual needs identified by the client and supported by the clinician.

Some grantees do the clinical assessment and the RSS assessment separately and some do it all as one process. Some programs require all clients to have a clinical assessment and to be assigned to traditional clinical treatment. These clients are eligible for RSS only if they are in treatment. Other programs have determined that some clients may need only RSS, so they allow clients the option of just receiving RSS. Where this is an option, grantees report that the assessment for RSS can be a gateway to treatment. The treatment/RSS can also be linked, with recovery support occurring at specific stages in the treatment process.

Grantees use several different approaches to assessment:

- **Central intake units.** Assessment occurs at one central unit, at regional assessment units, or at a select number of designated providers. For example, the grantee may contract for assessment with one provider per county.
- **Assessment by mobile clinicians.** Licensed clinicians may go to do assessments at the RSS providers; alternatively, assessments can be provided by mobile providers who go to wherever the clients are—in churches, transitional housing, jails, homeless shelters, or detoxification centers.
- **Assessment by treatment providers.** Some grantees authorize all treatment providers to perform assessments for both clinical and RSS. Other grantees feel that, when treatment providers conduct assessments, they will tend to direct clients to their own services and not give them real choices.

Careful monitoring is required if treatment providers are to be the assessors and conduit to services. Assessors must be open and unbiased in referring clients to treatment and RSS in order to preserve client choice.

Some grantees mandate use of screening assessment and placement tools, which collect comparable data across all clients. Standardized instruments used include the Substance Abuse Subtle Screening Inventory (SASSI); Addiction Severity Index (ASI); American Society of Addiction Medicine's *Patient Placement Criteria* (ASAM PPC); Addiction Severity Index – Multimedia Version (ASI-MV); Global Appraisal of Individual Needs (GAIN); and CAGE Adapted to Include Drugs (CAGE-AID). A few grantees have developed assessment tools specific to the need for RSS.

Following the assessment to determine level of care, clients are given choices about where to receive their services. The various grantees give clients information about provider locations at different levels of specificity. Some simply give clients a list of providers located within the client's county of residence. One system uses global positioning system (GPS) technology to help clients pinpoint providers who are close to their homes or places of residence. Some systems also furnish clients with information about the accessibility of programs, such as their proximity to bus and train routes. Most systems also give clients information about the services offered and business hours of each provider. Staff in several States said they planned to add information on client outcomes—a form of report card on individual providers.

## **RSS**

All grantees use the voucher program to provide traditional treatment services as well as the newly defined category of services—RSS. RSS are a distinctive component in ATR. While the meaning of the term may appear to be self evident, States have operationalized it in many different ways. A broad definition would be: RSS includes any service, including purchase of tangible goods appropriate under the circumstances, which can reasonably be provided, that will assist individuals to make progress addressing their addiction or dependency at some level. The box on page 27 lists RSS recommendations from grantees.

**Defining RSS.** Because RSS was new to all participants, the grantees did extensive work to develop the set of RSS that would be most appropriate for meeting their clients' needs. States worked with providers to develop their initial lists of appropriate recovery support services. However, as vouchers began to be issued, grantees found that face-to-face meetings and assessments with individual clients were surfacing new and unexpected needs. As clients identified the barriers they were facing, unanticipated service needs became apparent. Many grantees reported that this process dramatically expanded their vision of treatment from a set agenda to a flexible spectrum of needs—adapted to the particular individual. Grantees also report that definitions for these new services have to be clear and specific—not too broad or open-ended. Points that can help to make the definition specific may include:

- Duration of the service
- Whether the service is group or individual
- What qualifications the individual who provides the service must have
- Preceding or succeeding conditional service requirement
- The structure in which the service is provided (i.e., hourly, by day, by unit of service, or by completion of the process)

Another challenge is how to engage RSS providers who will be able to provide defined services that are in the greatest demand, while also having providers who are flexible enough to meet new needs as they emerge for each client. At least one State deals with this issue by making a small discretionary fund—about \$200 per client—available through the providers or case managers. These small sums can be used to meet unanticipated expenses that could derail a client who is in treatment or recovery, such as for a car battery for transportation to treatment or a job.

Some States include the purchase of personal necessities in their voucher plan, while others decline to include them because they feel this is an area that offers great potential for fraud, waste, and abuse. One State provides dental care for clients whose teeth have been damaged by methamphetamine use; clients must be drug-free at least 6 months to qualify for this care.

Many States indicate that RSS comes into play throughout the treatment and recovery cycle. These States indicate that recovery services play a critical role at all stages of contact with individuals: pre-treatment, during treatment, and post treatment. RSS may help get clients engaged in treatment by removing some of the barriers to treatment; may keep clients engaged by eliminating some of the problems that may lead them to terminate treatment prematurely; and may assist clients to continue in active recovery by providing needed supports and diverting possible barriers.

One State indicates the approach of their case managers is “Let's see if we can get this approved” rather than saying “That service is not on our list.” As a result, the service mix continues to grow.

## **An Overview of Potential RSS: Suggestions from Grantees**

- Case management and service coordination
- Basic necessities: Transportation, housing, food, child care, personal necessities, incidental expenses
- Spiritual orientation: Pastoral guidance, spiritual guidance, traditional healing, spiritual support services
- Education/employment: Employment, vocational training, job development, employment coaching, GED support
- Life skills education, daily living skills, anger management
- Social connectedness: Drug-free activities (bowling, horseback riding), structured recreation
- Counseling/coaching: Mentoring, residential recovery support, recovery support coaching (individual and group), family support/parenting, support counseling (individual or family), individual/group peer support, intensive recovery support, relapse prevention
- Medical: Medical services, dental services
- Alternative therapies: Massage, acupuncture

The grantees have discovered many positive aspects to making RSS available as part of the service continuum. Throughout treatment, clinicians are able to treat clients as whole persons, because they now have access to services that can meet a wide range of needs beyond the specifics of treatment.

The new services also lengthen the time during which clients receive ongoing support—a factor that is highly beneficial for most clients. The many other benefits of RSS and an extended continuum of care include:

- RSS are generally lower in cost than standard treatment services, so their use extends treatment dollars.
- The nature of the RSS providers and the context in which services are provided increases the likelihood that services will be culturally appropriate.
- RSS can be provided at more locations in the community, which makes the provision of services more flexible and provides clients with the opportunity to recover in their community.
- The flexibility of RSS makes them useful as interim services for clients who are waiting for admission to treatment and, in some cases, may serve as pretreatment to help clients decide they are ready for treatment.
- The variety of RSS empowers clients by providing them opportunities to make meaningful choices as part of their treatment and recovery.

A number of grantees are in the process of tracking long-term client outcomes for their ATR clients. The initial data—and informal consensus among grantees—indicate that RSS appears to extend the length of stay of clients, thus promoting long-term recovery.

### ***Case Management***

The need for care coordination is great in a voucher system where clients are typically receiving services from multiple entities. Virtually all grantees have designated individuals to be responsible for this coordination. These individuals have such titles as transitional coordinators, recovery support specialists, care coordinators, case managers, outreach workers, case workers, peer mentors, regional coordinators, or recovery coaches. All these individuals are charged with the responsibility of assuring that a client receives a complete assessment and is offered choices of providers who will deliver the appropriate services. These coordinators track the client's progress and make adjustments to services as required; identify new, unmet needs as they emerge; and generally provide support and coordination as the client moves through the course of services.

## **Selected Implementation Issues**

### ***Costs of Implementing a Voucher System***

All grantees reported that developing the voucher system requires considerable expense as well as time. (In this section, the term “voucher system” is used to refer to the entire management infrastructure of the voucher program. The software used for fiscal and data management is referred to as the “Voucher Management System” (VMS) and is included as one of the costs of the voucher system.). Current ATR grantees indicated that, in addition to ATR funds, in-kind contributions from State, SAPT Block Grant, or other funds played an essential role in developing the voucher system. In several cases, the ASO or contractor also invested resources not reimbursed by ATR funds to add features to the system and to build for the future. The following section analyzes all the costs identified by grantees for developing a voucher system, regardless of funding source.

Grantees felt that the ATR limit on administrative costs had constrained the timely development of the voucher system. Several stated that additional in-kind contributions were essential, because the ATR grant funds would not have permitted them to develop a successful voucher system. Some grantees had some previous experience with other voucher systems and with ASOs. They indicated that, without this experience, their costs and the time required for implementation would have been greater. Several grantees chose to build on existing systems; they use practices and software developed for voucher management in other substance abuse programs.

***Methodology for cost estimates.*** Estimates of the costs of implementing a voucher system presented in this guide are based on interviews with nine current ATR grantees. These estimates were developed through a retrospective cost allocation exercise. In other words, all staff and other costs that were associated with implementing the ATR program and developing the VMS system were included in these cost estimates, regardless of whether the ATR program actually paid for the costs. Prior to the on-site interviews, the fiscal reviewers examined the budgets from the initial and revised applications submitted by each of the grantees. In the interviews, the reviewers used templates to gather information that was as consistent as possible about the staff involved, percentage of their time devoted to implementation of the voucher system, and the time periods for the functions specific to the voucher system. This knowledge of the grantee budgets suggested questions that could assist the grantees to identify the resources they had utilized. For example, the grant application included contractual items that might, or might not, be involved in the development of the voucher system.

After the first two site visits, interviewers sent these templates to the grantees in advance, so the grantees could prepare costs estimates to discuss with the reviewers during the site visits. These templates also gave grantees some knowledge about the types of questions that would be asked and the sources of information they would need in order to answer the cost questions asked at the interviews.

Following the interviews, reviewers used the data provided by grantees to calculate estimated costs based on salaries, fringe benefits, indirect costs, and other items in the application budget. If ASOs were operating major functions of the voucher system, then reviewers obtained similar information about the ASOs from the application budget or on-site interview. Costs for the nine grantees that provided cost data were comparable, with some limitations. ATR sites varied widely in terms of items included in each cost center, as well as in the functionality provided by the voucher system. For all these reasons, the costs identified below are estimates prepared by the reviewers based on information from the current grantees. In spite of their limitations, these cost estimates may provide valuable guidance to new grantees as they plan the implementation of their voucher system.

***Components included in voucher system development costs.*** Cost components, and total level of effort included as elements of the start-up and development of the ATR voucher system as a whole were categorized as follows:

- Planning and determination of feasibility
- Development of policies and procedures
- System design
- Provider recruitment and training
- Procurement/development and implementation of a voucher payment system in several categories, including:
  - VMS procurement
  - Payment system development (including rate setting)
  - Implementation and testing
  - Acceptance and full deployment of the automated system
  - Maintenance of the automated system

Thus, for these cost estimates and start-up level of effort estimates, voucher system implementation does not include costs that would have been required for other CSAT-funded programs, such as quarterly reports or financial status reports.

Table 1 presents the total allocated costs on a retrospective basis, as estimated by the grantees including all in-kind and other costs that may or may not have been directly paid for by the ATR grant, by category, and by year for the ATR grant period. Chapter 4, Data Management, discusses in

further detail the direct or indirect costs associated with the approach chosen for developing the VMS. If an outside contractor was used, those costs are included as appropriate.

As table 1 shows, the costs of implementing the system were an estimated average of \$2,000,000 including all funds. In the nine States that provided data, reported costs range from a minimum of \$880,000 to a maximum of \$2,710,000.

**Table 1. Range of Estimated Costs for ATR Grantees by Categories and Years**

Action Step	Year 1	Year 2	Years 3 and 4	Total Costs
Planning and feasibility study	\$10,000– \$140,000			\$10,000– \$140,000
Development of policies and procedures	\$20,000– \$30,000	\$30,000– \$100,000		\$20,000– \$100,000
System design	\$180,000– \$680,000	\$250,000		\$180,000– \$680,000
Provider recruitment and training	\$40,000– \$360,000	\$20,000– \$260,000	\$60,000	\$40,000– \$360,000
Procurement of electronic voucher management system	\$10,000– \$110,000			\$50,000– \$1,250,000
Payment system development, implementation, testing, acceptance, and full deployment	\$140,000– \$370,000	\$100,000– \$260,000	\$360,000	\$140,000– \$370,000
Maintenance	\$0–\$480,000	\$260,000– \$960,000	\$360,000 \$880,000	\$260,000– \$960,000
Total (not addition of rows above)			Lowest -- \$880,000 Highest -- \$2,710,000	

**Experience of the current ATR grantees.** The total retrospective estimated cost to develop the entire ATR voucher system did not appear to differ significantly, whether the cost was incurred by the grantee alone or whether an ASO was used as a contracted management entity. In addition, there appeared to be no significant impact on cost whether the scope of the project was local, regional, or statewide.

In many cases, design and development costs continued throughout the duration of the ATR project for several reasons:

1. Revisions to the ATR program in most cases required continuing adjustments to services—and, therefore, policy revisions, training, and revisions to the automated system.
2. The costs associated with maintenance of the automated system and payments to ASOs continued in all years.
3. The slow start-up, peak demand times, and phase-out caused the voucher system administrators to continuously devote considerable time and close attention to voucher system problems.

One ATR project director said table 1 was so well laid out that she wished it had been available as a plan for developing the voucher system.

***Possible Cost Planning Model for New Grantees (based on current grantees' experience)***

**Cost estimates.** The available data gathered from the first group of ATR grantees may be helpful for new grantees in estimating the costs of beginning their voucher systems, as well as in determining the staffing needs for successful planning and implementation. Table 2 utilizes the data from table 1 to present a sample for estimated costs by year for developing a voucher system. It is important to note that these costs are estimates based on data collected from diverse States across the country. The relative amounts required for different categories and the extent to which the costs in some categories extend throughout the grant period may be particularly useful for new grantees.

**Table 2. Estimated ATR Grantee Costs for Developing a Voucher System by Category and Year**

Action Step	Year 1	Year 2	Year 3 and extension	Total Costs
Planning and feasibility study	\$70,000			\$70,000
Development of policies and procedures	\$30,000	\$30,000		\$60,000
System design	\$190,000	\$50,000		\$240,000
Provider recruitment and training	\$150,000	\$100,000	\$60,000	\$310,000

Action Step	Year 1	Year 2	Year 3 and extension	Total Costs
Procurement of electronic voucher management system (if applicable)	\$100,000			\$100,000
Payment system development, Implementation, testing, acceptance, and full deployment	\$200,000	\$100,000	\$ 50,000	\$350,000
Maintenance		\$350,000	\$620,000	\$970,000
Total	\$740,000	\$630,000	\$730,000	\$2,100,000

**Staffing estimates.** While each project’s needs will be different, there are similarities in the staffing requirements. The project director for ATR may be paid from the project or may be at a management level within the substance abuse division of the grantee organization. Key substance abuse management staff, such as the treatment director, are likely to devote significant time to the development of the voucher system and these costs may be in-kind contributions. Likewise, the fiscal and IT staff of the grantee organization will be involved in systems development, as well as in fiscal management and payment of the large number of providers or vendors participating in the ATR voucher system.

Two grantees recommended that, for guidance, new ATR staffs look at examples of the staff required for the original ATR programs.

Certain skills are required for successful implementation and management of a voucher system. Table 3 shows the kinds of ATR staff that may be needed for the ATR project, based on staff configurations reported by the original ATR grantees. These staff positions may be at the grantee level or at the contractor level with an ASO.

**Table 3. Estimated ATR Grantee Staffing for Developing and Implementing a Voucher System**

Position Title	Percent of Time
Program Director/Manager	100%
Administrative Assistant	100%
Contract Director/Monitor	50%
Data Coordinator	100%
IT Systems Developer	100%
Recovery Support Specialists (2) (paid from client services reimbursement)	100%

Position Title	Percent of Time
Utilization Management Coordinator	100%
Community Liaison	100%
Fiscal Director/Analyst	30%
Claims Processors (2)	100%

The staffing level estimates in this section are simply meant to provide guidance for planning and estimating costs. They are based on information collected from current grantees on how they had staffed their projects over the past three years. They are not meant to serve as recommendations or to suggest specific staffing requirements.

### ***Importance of a Pilot Phase***

The grantees' experience indicates that the administrative infrastructure—particularly the fiscal and data systems—should be in place before vouchers are issued.

Several grantees recommended that new voucher programs undertake a pilot testing phase. A pilot test with a few providers carrying out all the steps in the voucher process on a trial basis can identify potential problems and save having to retrain the entire system if changes need to be made. Starting too soon will initiate a system without adequate controls and will introduce procedures that are not up to the expected standards. Trying to get operations up to standard later will be difficult and quality may suffer. It may also turn out that the designated populations that were targeted were not the best to utilize a voucher choice program, or that financial considerations (demand versus cost and supply) were not correctly projected by the operations model. For example, a grantee may have designated that housing costs were \$600.00 per month and that 3 months was an adequate bridge, when in reality housing costs were \$1,000.00 per month, and that recovering clients needed 6 months of housing to get on their feet. That would drive the demand and costs to exclude all other services. This is what happened to some grantees.

Typically, small, carefully controlled pilots of a limited number of providers and clients included:

- Conducting assessments
- Creating vouchers
- Delivering treatment and RSS
- Tracking client progress
- Performing all the necessary data collection
- Communicating with providers as necessary

Grantees that were not able to have a pilot phase found themselves issuing multiple corrections and changes of previously announced procedures and level of services which disrupted services to clients

and were a disincentive to providers in maintaining continuity and ongoing care. In these cases, grantees sometimes found themselves unable to reconcile payments to agencies that had already delivered services under the previous rules.

### ***Effective, Ongoing Communications***

Virtually every grantee indicated that effective ongoing communications are critical. Progress reports, procedural changes, and other updates should be communicated to all providers simultaneously. Some grantees held regularly scheduled conference calls with referral sources, such as judges and drug court coordinators. Weekly or biweekly calls with all providers were a useful tool. They provided a way to give information and answer questions, which helped to keep unity in the project and to dispel any rumors or misinformation that surfaced. Most grantees developed an informational Web site for providers that contained such aids as a handbook, training materials, and a calendar of events.

### ***Quality Control and Monitoring***

Most grantees struggled to institute adequate monitoring systems for their providers. In some cases, employees who were monitoring treatment providers through other programs were able to add ATR issues to their monitoring protocol; this meant that ATR activities could be monitored at no cost to the ATR budget. In other cases, ATR staff did some site observations and client interviews, elicited feedback from providers, and conducted chart audits. Some States had staff who began by doing TA and conducting outreach, but then gradually shifted to doing more monitoring and providing follow-up TA.

***Identifying documentation problems.*** The most common problem found by monitors is a lack of adequate documentation to justify a provider's claims for funds. Some grantees found this problem among both traditional treatment and RSS providers. Particularly in States that are not already using a fee-for-service system, providers are not familiar with such documentation requirements as treatment and RSS plans, attendance rosters, travel logs, encounter forms, or narrative notes. Standardized client files will make it easier to monitor the voucher program, especially the documentation.

***Catching problems early.*** Gathering input from clients is a good way to identify emerging provider problems. Grantees that provided an 800 number for complaints from clients were alerted early to some potential problems with providers. Most grantees use some form of consumer survey, which also provides useful information on areas that may need adjustment.

Toward the end of their first contract period, some grantees began developing and monitoring provider performance measures. Some plan to institute incentives for providers. As more

information becomes available about provider performance, clients will be able to use this information to make informed decisions.

### ***Provider Perspectives***

Provider organizations—old and new, treatment and recovery support, secular and faith-based, large and small—represent the front line in operating the ATR voucher system. Plans and ideas developed at the administrative level play out in the lives of individual providers and their clients.

The overwhelming tone of all the provider interviews reflected a sense of accomplishment. Again and again, the providers demonstrated their understanding that they were part of a significant effort that is making life better for many of the individuals they serve. Many new providers talked about the value of the ATR training—and how it has helped them to serve a difficult clientele more effectively. As was the case with the grantee interviews, the providers who contributed their ideas also identified many aspects of the program that were not perfect and fell short of their expectations. The prevailing refrain was that the ATR voucher system presents many challenges, but that it provides opportunities for their clients that were not available previously. Given the option, the providers would choose to continue their participation in the voucher program.

## Comments from Providers

### **Positive observations on the voucher program:**

- ATR helps retain clients in treatment longer.
- New services available through ATR reduce stress, which helps recovery.
- Transition housing removes clients from their enabling environment.
- The inclusion of spiritual and faith-based providers provided continuum of care clinical elements that were not previously funded and that greatly assisted client recovery and abstinence.
- ATR provides the flexibility to meet immediate needs that help recovery.
- Clients hold the power to their recovery, and many want to choose faith-based services.
- RSS and treatment complement each other.
- RSS meet needs that could not be met before.
- The ATR system has encouraged provider networking.
- For referrals and peer-to-peer assistance, it is necessary for providers to form collaborative relationships.
- Transportation is critical and is a means to successful outcomes.

### Some Challenges Frequently Mentioned by Providers

- Because ATR continues to evolve, it is critical for grantees to communicate with providers in an ongoing way, keeping them informed of changes and new developments.
- The voucher process is new, and generally providers lacked understanding on how a voucher system works. The nuts and bolts of its operation are very challenging.
- Government acronyms and substance abuse terms are confusing.
- Extensive training is needed in cases where a new computer system is introduced. Especially for novice computer users, brief computer training in a group is not sufficient.
- Both writing a policy and procedures manual and creating personal client files are challenging tasks for non-traditional providers.
- Providers find it difficult to estimate how many clients will choose them. Uncertainty about continued funding makes it difficult for providers to manage clients who are already admitted.
- Billing is difficult. Lack of clear policies for billing and payment makes it harder.
- When an ASO manages the voucher system, billing can be simpler. Payment delays if the State cannot pay promptly create hardship for providers.

One of the indications of the hopefulness of providers was that most indicated they will carry on their recovery support activities, even if ATR funds are ended. Many of these new providers are looking for a means to sustainability. They reported writing grant proposals, being selective about which services to continue, introducing income-generating activities, approaching local organizations to sponsor some activities, seeking insurance fees, using online support groups, and contacting local government officials.

## Chapter 3. Fiscal Infrastructure and Functions

### **Voucher Management**

As they implemented the first ATR voucher program, many grantees became aware that decisions on program and clinical services had to be made in tandem with the development of financial controls and planning. Good financial management practices ultimately drove the plans for service provision. This chapter describes best practices for developing a business-based model for a voucher program, drawing heavily on lessons learned by the first ATR grantees. This business-based model of operations is intended to fully integrate clinical program planning with financial operations, and includes suggestions about how to develop various budget and service demand models prior to implementing a voucher program.

### **Planning a Business-Based Model for Financial Operations**

In implementing the ATR voucher program, one of the most significant challenges for grantees was how to manage the financial operating differences between a voucher program and their traditional programs. Many grantees found they initially underspent as the program began slowly and then, as the program caught on, they overspent the allowed grant funds. When overspending occurred, agencies had to backtrack abruptly and limit the service levels and number of vouchers issued, sometimes with little advance notice to their providers. With the emerging knowledge that is now available on voucher management, programs will be able to look at and plan for the financial implications of voucher policies prior to implementing them. Some key areas for new programs to consider include:

- How to develop service operating budgets and forecast expenditures accurately
- How to support optimal service delivery through steady and deliberate resource management
- How to monitor spending and variances more precisely on a real-time basis throughout the life of the program
- How to make program changes that will foster better financial management, avoid future errors or unallowable costs, and provide better client outcomes

A business model—with upfront controls and planning to keep expenditures steady—is an important way to maintain the optimal delivery of treatment and recovery services to all clients.

Voucher services operate quite differently from traditional treatment funding. State substance abuse agencies are accustomed to administering SAPT Block Grants, which, even if they are allocated to providers on a fee-for-service basis, are driven by the supply of Federal and State dollars. Typically, providers are allocated a fixed amount of dollars over time and are expected to serve as many clients as possible within

that dollar amount. By contrast, voucher programs are driven by client demand. The demand for services increases once the ATR voucher programs begins to engage clients and to produce positive client response. Predicting and managing ATR voucher project budgets becomes a challenge because client demand—and their somewhat unpredictable use of the vouchers—is what triggers levels of expenditure. Historical data on client demand and service use did not apply to the ATR program. Building on the experiences of the past 3 years, this start-up guide provides some guidance for grantees on how to more accurately forecast and plan voucher programs.

Later in this chapter, a financial model is presented that is based on some of the principles in the box above. Using this model will help programs test their assumptions on a spreadsheet before trying them in the real world.

## **Establishing Optimal Voucher Management Policies**

### **Suggestions from Grantees**

- Thoroughly understand the legislative rules and payment mechanisms of the State or other governing agency prior to developing an operational infrastructure for the voucher program.
- Keep voucher-allowed time periods or voucher life relatively short, which will encourage clients to engage promptly and will avoid creating a large backlog of obligated funds that are not being used.
- Establish a dollar “cap” or limit per client for vouchers.
- Do not issue vouchers on an open-ended basis.
- Limit the number of vouchers issued per month to ensure that the program can always serve existing clients. Increase the allocation of vouchers slowly, but be sure that issuance is carefully controlled once the program has become stabilized.
- Have client data available in real time at the State level for tracking utilization and completion rates and, most importantly, voucher termination; one aim is to avoid tying up unused funds. Ideally, providers would enter voucher service data on a daily basis.
- Start initially with somewhat limited services and a limited number of providers and, with experience, expand them. This strategy reduces the probability of costly backtracking and policy reversals.

### ***Working with State Governing Laws and Payment Mechanisms***

***Governing laws.*** An initial step in developing a voucher-based program is to conduct a thorough analysis to determine:

- The impact of State laws regarding any necessary voucher program authorization or operations, and regarding drawdowns of Federal or other funds
- The impact that State payment mechanisms may have on the voucher program and how providers can be paid on a timely basis

The answers to these questions are crucial for developing a time frame for implementation of an IT system, procedures for invoicing and payment, and other operating infrastructure. States vary greatly in their legislative environments and payment mechanisms. Many States have unique legislative regulations and unique payment systems. Some States can pay a large number of providers directly and promptly and others cannot. These issues must be addressed up-front in planning for a voucher program.

### **Examples of Pitfalls Around State Legislative Issues:** **Suggestions from Grantees**

- One State agency received their ATR grant funding and was ready to implement only to discover that the ATR program required State legislative approval—but because the legislature was not in session, they were not able to implement on a timely basis.
- A second State managed to secure legislative approval 6 or 7 months after receiving their ATR grant funding, but then had to wait additional months for approval from the Governor's Office. These delays in State approvals contributed to their delay in implementing the ATR program.
- Other State agencies also reported that they needed legislative authority to proceed with the program.

The initial ATR grantees found that State laws and payment mechanisms could be a major factor in delaying program implementation. The lesson is that, if they need it, ATR grantees should obtain legislative authority for the program prior to award or should be ready to obtain authority immediately upon receiving the grant. This is critical to the timing of implementation, since many State legislatures are only in session for a few months during the year.

A new ATR grantee must also consider whether the program needs State obligatory authority for ATR funding—yet another level of State approval. This was an issue for several grantees. Some States reported that, before they could proceed with budget changes during the program, they first needed legislative approval for authority to make budget changes. One State had to shut down its ATR program for almost 6 months when it was realized that, according to State law, they were not allowed to commit to any expenditures (to authorize vouchers) prior to actually having the cash on hand from an ATR drawdown. The dilemma was that the program could not receive ATR funds until they demonstrated that they had actually expended them. The program was deemed to have been exceeding its budget authority. This State law was a major problem for that agency, and for its clients and providers.

Grantees recommend, “Don’t forget to check your State approvals! Don’t wait until the last minute, because legislative approvals could be needed for the ATR program or for overall budget authority.”

*State payment mechanisms.* State payment systems—systems for paying providers—are also critically important to voucher implementation and operations. Staff who are planning a voucher program need a thorough knowledge of how the State’s payment systems work as a base for developing clinical and fiscal operations for their vouchers. The current State payment systems will be integrally related to the new accounting, fiscal, budgeting, and voucher management data systems, as well as to the operation of the whole voucher program. Understanding State payment systems early in the planning process provides the information needed to develop strategies for working with the actual payment system. These strategies need to accommodate to and work within the State’s payment system. Alternatively, the State’s established payment systems may lead to the use of an ASO for the new voucher system.

A voucher system requires a prompt mechanism for paying providers. This is particularly critical when new providers—many of them small organizations—are being integrated into the service system. In the early stages of building provider capacity, a slow payment process may penalize and discourage these new providers. States that do not have the capacity to issue checks directly to providers, or to issue them directly to a large number of providers on a timely basis, will need to consider this in their planning.

Establishing a prompt payment system was a problem for many of the original grantees. The problems they faced included:

- A number of grantees had no mechanism to pay outside providers, especially with the large number of providers requiring individual monthly checks.

- Other grantees did not have a prompt payment mechanism. They could issue checks but payment was very slow—up to 60 days—which was hard on new and small service providers.
- One State was not allowed by State law to issue checks to providers who were not in their substance abuse database. Such providers already had a full contract and agreement with the State agency, which met requirements for the SAPT Block Grant but were not necessary for the ATR grant. In fact, this requirement was particularly inappropriate for RSS providers, because they are not required to be licensed and credentialed as treatment providers are.

***Using an ASO to reimburse providers.*** Because of these payment system problems, some States chose to use an ASO to reimburse the providers on a timely basis. ASOs can also perform other administrative and clinical functions for the grantee.

However, States that choose this option need to ensure that the ASO has the financial capacity to advance funds, that they understand when reimbursement from the State will typically occur, and that they understand the financial risk involved. The ASO needs to be aware that it assumes a major financial risk when it takes responsibility for large sums of money for provider reimbursement under a voucher program, then expecting to be reimbursed by the State. States often have budget shutdowns and other financial crises that could prevent an ASO from being reimbursed.

***Using treatment providers to reimburse RSS.*** Another option used by some original ATR grantees is to make the treatment providers responsible for paying the recovery support vendors. In these States, the treatment provider generally arranges and pays for RSS for clients in treatment according to the treatment plan. This limits the number of payments that must be made each month on behalf of the client. If a State uses treatment providers as a mechanism for paying other vendors, then timely State payments to the treatment providers become critical. When payment to providers is slow, then the vendors who deliver RSS will face long waits to be reimbursed.

### ***Establishing Voucher Rates and Service Definitions***

The process of setting rates involves two sets of critical decisions:

- Establishing realistic service reimbursement rates on an appropriate per unit dollar amount, which then serves as the basis for setting voucher caps and limits.
- Establishing and publishing clear definitions for each service so that, from the beginning, providers are in accordance with the services definitions, and there are no misunderstandings that may result in disallowing a provider's bill for services.

**SAMHSA guidelines.** SAMHSA application guidelines indicate that the 2007 ATR grants should be managed on the basis of “reasonable costs.” The guidelines allow flexibility as long as the State or other administering agency justifies the basis for the costs. SAMHSA did not set strict rates for each treatment service unit, but did suggest a reasonable range for broad categories of treatment services. For RSS, SAMHSA did not specify cost ranges, mostly because these costs can vary greatly according to the particular support service supplied, and extensive historic data on these services is not available to use as a basis for setting rates.

SAMHSA encourages ATR grantees to provide a full array of clinical treatment and RSS. Some ATR grantees target specific types of underserved clients, such as juvenile justice clients, those addicted to opiates, or clients being released from incarceration. Other grantees are serving a more general population of substance abusers, sometimes in geographically underserved or low-income areas. All these demographic and geographic factors affect a State’s decisions on rates and voucher types.

**Examples of rate setting and service definitions.** All State grantees initially had to establish individual unit rates in order to develop a reasonable cost-per-client voucher or voucher episode and to build their voucher model. The ATR grantees established their reasonable costs for services in different ways, depending on their State profiles. Factors that enter into the decision include current service rates, the cost basis for rates, equitable rates across providers, rates for different regions in the State (e.g., urban vs. rural), and rates allowed by other State and Federal programs, such as Medicaid or HUD programs. Following are rate decisions made by some grantees:

- **Rates for services.** For treatment services, many States chose to use rates comparable to the rates currently set for their existing substance abuse programs under the SAPT Block Grant. Comparable data were not available to help in setting rates for RSS, since States generally did not have experience with funding services of this type.
- **Compensatory rates for higher risk.** Some States chose to set ATR voucher rates slightly higher than the existing rates; this was to compensate for the risk that providers took in participating in the new voucher program. Providers faced having to hire staff and implement new systems without any guarantee of revenue, since they had no control over the number of clients who would choose their services. This was especially true for recovery support service providers, many of whom were new and had to gear up for the program.
- **Higher rates for assessment.** Some States chose to set higher rates for assessment services. At initial intake and assessment, ATR counselors are expected to identify a plan for services, which dictates the initial type of voucher that a client will receive and possibly their entire treatment program. This takes more time than the typical unit of treatment assessment service.

Early in the process of setting rates, some States solicited input from providers. Others recommend setting up an advisory committee to gather input from providers and, in some cases, from clients. This is an especially attractive approach for RSS, because it means that providers and faith-based groups new to State treatment programs can help establish realistic rates for housing, job counseling, transportation, and other services they provide.

Most ATR grantees have a provider manual or other formal administrative guide, accessible on their ATR Web site, that includes rates and service definitions. It can be very helpful for new grantees to review the rates and service definitions that the original grantees established. (For Web site addresses, see Appendix A.)

Table 4 illustrates with a sample of services how one State developed a menu of services with voucher limits that are based on reasonable costs. The voucher limits listed under “Maximum Value” do not mean that the client needs or must use all the services; it simply establishes a reasonable maximum voucher cap for each particular service.

**Table 4. Sample Voucher Limits Established for Selected Assessment, Treatment, and RSS**

Type of Voucher	Allowable/Billable Services	Maximum Value
Comprehensive assessment of treatment and recovery support	Assessment services	\$150
Recovery support assessment only	Assessment services	\$75
Outpatient treatment	Treatment planning, individual and group counseling, individual family therapy, multiple family group therapy, education group, drug testing	\$1,750
Adolescent residential treatment (60-day maximum)	Residential bed-day	\$10,500
Recovery support	Educational services, employment services, mentoring, spiritual coaching, transportation, childcare	\$650
Residential recovery support (60-day maximum)	Residential recovery support bed-day	\$2,400
Care coordination	Care coordination services	\$400

This State then tied in service definitions, including a description of the administrative and other costs that are included. This gives providers a clear understanding of expectations. Samples of service definitions and reimbursement rates are shown in table 5.

**Table 5. Sample of Selected Service Definitions and Reimbursement Rates**

Service	Service Definition	Reimbursement Rate
Treatment planning	The process necessary to develop an initial, individualized treatment plan based on the comprehensive assessment. Treatment plan updates should occur in individual counseling sessions, be documented as such, and be billed under individual counseling. A maximum of one unit of service may be billed for this activity for the life of any one voucher.	Treatment planning is reimbursable at \$64 per initial treatment plan.
Education group	A planned, structured, didactic presentation at the treatment program that provides health and wellness information on a broad range of topics related to the client’s substance use and its effects on the client and his/her family. Possible topics include skill building, violence prevention, and health issues (sexually transmitted diseases, tuberculosis, hepatitis, nutrition, smoking cessation, family planning).	Education groups are reimbursable at \$30 per 60-90 minute session.
Care coordination	Assistance to the client in obtaining needed services with follow-up within at least 14 days to ensure access to services, and tracking of the client’s progress across ATR providers by contacting the client at least once per month. It includes planning, linking, monitoring, and advocacy for clients. Billable time includes: (1) helping a client access RSS via a voucher in the domains where need is identified; (2) collecting the required GPRA data from the client at specified intervals; and (3) progress check-ins.	Care coordination is reimbursable at \$20 per 15-minute unit of service for a maximum of 10 units (2.5 hours) per month.
Educational services	Services may include academic tutoring, homework assistance, life skills development, parenting responsibilities, family reunification, financial literacy, health promotion, anger management, and violence prevention. These services also may include such educational enrichment activities as sports, leadership development, recreational activities, or skill building in the visual or performing arts, and music.	Educational services are reimbursable at \$42 per individual session or \$10 per individual in a group session. Both individual and group sessions must be between 60-90 minutes.
Mentoring	A face-to-face, one-on-one contact between the client and an adult who is matched with the client by a sponsoring	Mentoring is reimbursable at \$25 per

Service	Service Definition	Reimbursement Rate
	organization that is an eligible ATR provider.	60-90 minute contact.
Spiritual coaching	Help to an individual or group of individuals in developing spiritually as a way to initiate or sustain recovery. Services include establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one’s life, achieving serenity and peace of mind, learning to make responsible decisions, and expanding social engagement and family responsibility.	Spiritual coaching is reimbursable at \$25 per individual session of 60 minutes or \$10 per individual in a group session of 60-90 minutes.

***Setting Policies for Voucher Issuance, Expiration, and Termination***

Most ATR grantees report experiencing a fairly difficult start-up period—contending with new information systems, new services, and new providers, as well as unpredicted volatility in their pattern of expenditures. All grantees acknowledge there was a great deal to be learned about managing a demand-driven voucher process. Because many grantees could not track client data in real time, they could not track demand for services or client utilization of services. Most important, they could not track clients who were not using services for which they had received authorization.

Grantees with automated VMS could send up a “red flag” to help providers keep track of inactive clients. One State sent a daily notice—in red lettering—to inform providers about any client who was inactive or approaching the expiration date of his or her vouchers. Notices went first to the clinicians and then to the provider’s administrative staff. The outcome—providers could reach out to “no-shows” and the rate of client inactivity declined dramatically.

***The need to track and de-obligate unused voucher funds.*** The lack of ability to track and terminate inactive clients and, therefore, vouchers that were issued but unused, became a significant financial challenge for many agencies. Many grantees realized they had obligated ATR funds for vouchers that were in fact not being used by clients. Some agencies “overobligated” at least 50 percent of their ATR funds.

If they could not accurately track clients, the grantees could not accurately determine what funds could be de-obligated and returned to the pool of available funds for other clients to use. This was a major problem with two significant repercussions:

1. Tying up these unused obligated funds penalized providers and potential new clients, because it held back funds that could have been used for new clients.
2. These unused vouchers indicated on a clinical level that, in many cases, clients were not being adequately engaged and retained in treatment and recovery services.

Tracking of unused vouchers provides an opportunity to gain important clinical as well as financial information.

There is no one correct way to issue and control vouchers. However, the ATR grantees agree on a number of important concepts concerning how to do this. Basic issues to consider relate to the bundling or unbundling of services and the time frame in which vouchers will be valid and then terminated.

***Bundled and unbundled voucher types.*** In an unbundled voucher system, a separate voucher is issued for each service provided. On the other hand, bundled vouchers combine multiple services into one voucher. In reality, most ATR grantees use a combination of bundled and unbundled services, according to their program needs. To help control utilization and expenditures, some grantees switched from bundled to unbundled services, while others did the reverse. Some program managers split their vouchers into three basic categories:

- Assessment voucher
- Treatment voucher(s)
- RSS voucher(s)

Many States issue a separate assessment voucher, since an assessment is the first step for a new client and is a discrete process. The assessment provider—whether working in a central intake unit or from various locations—refers clients for appropriate treatment and RSS and offers clients a choice of providers. Since the assessment provider is not necessarily in the role of providing further services, the voucher is separate.

Some grantees found it easier to bundle their treatment vouchers but kept the RSS unbundled, since these services were new, could vary greatly, and often came from different providers. Other grantees kept all services unbundled. The reasoning was that unbundling provided a better way to offer a more extensive range of services. Unbundling services will also provide more adequate compensation to providers, because it allows them to bill for each discrete service.

***Effective time and termination policies for vouchers.*** Voucher expiration period, effective time period, or voucher “life” refers to how long a voucher may reasonably remain valid for a given service from the day it is issued. Voucher termination refers to a voucher being closed, either because the time period has expired or because the client is not engaging in activity as expected. Vouchers that have expired or been terminated can be returned to the pool of total voucher funding, making the money available to be re-obligated for other clients. The two voucher conditions—voucher expiration and voucher termination—are often mentioned interchangeably; both can be used to track clients and to foster client engagement.

The voucher life allowed for a given service is often meant to reflect, in clinical terms, the expected and realistic time frame for a potential client to receive that service. A typical assessment voucher might be valid for 30 days to allow a client to schedule and follow through with an initial assessment. A treatment voucher might be valid for 60 or 90 days or 6 months—whatever the State agency deems appropriate for receiving those clinical services. Some grantees allow voucher life to be extended on a case-by-case basis, if justified by discussions with the provider. Otherwise, a voucher expires at the end of the set period, and the funds can be returned to the pool.

If a client does not actively engage in services in a certain period of time, termination policies are needed. Initially, some States had very lenient voucher lives and no real termination policies. At the other extreme, one State issued all vouchers for only 30 days and, if a client had not presented for services within 14 days, the voucher was terminated.

Grantees reported that keeping voucher times short—and terminating vouchers when clients are inactive—motivated clients to engage in treatment and motivated providers to help clients become engaged.

As stated previously, many grantees had major initial problems in tracking unused and expired vouchers and de-obligating these funds. When they realized that client utilization or completion initially was lower than projected, most grantees acted to shorten voucher terms and/or tighten up their termination policies.

## **Financial Management and Forecasting**

One clear message from ATR grantees is that it is difficult to manage voucher programs financially and to forecast expenditures. To help the ATR grantees more accurately track and forecast expenditures, SAMHSA developed a guide, “Forecasting and Managing Access to Recovery (ATR) Program Expenditures” (Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, September 2006). This document concentrates on the direct services portion of the operating budget, rather than on start-up and ongoing administrative costs. It provides tools that allow planners to experiment with various voucher and utilization assumptions on a spreadsheet,

prior to making actual policy changes in the real world. The experiences of ATR grantees indicate that the ATR staff should include individuals with expertise in fiscal management and forecasting.

This section discusses specific strategies for setting up a projected operations budget for a voucher program. The real focus in projecting a specific, time-oriented budget for stabilized operations is to structure disciplined financial- and service-oriented thinking by grantees. This is a thoughtful activity that can structure the pattern of grant expenditures in the most productive way for financial managers. Even more important, this effort can structure funding in the most productive way for clients. Because ATR funds are limited, there needs to be a reasoned analysis of how to cap enrollment and services over time—both at the outset of the program and during the program—so that existing resources are allocated in a rational manner that best serves clients.

### ***Developing a Forecasting Model***

The model described in SAMHSA's document on forecasting and managing expenditures is used for the discussion on voucher systems that follows. This start-up guide briefly introduces the forecasting model and gives an orientation on how it can be used to control expenditures throughout the full course of a voucher program.

The key financial management concepts for voucher planning and implementation are to:

- Manage voucher dollars before they are spent.
- Ensure a smooth flow of resources to clients, since repeated and contradictory program changes will amplify the volatility of expenditures, detract from the program's credibility, and possibly affect client outcomes.
- Provide a predictable level of funding for the treatment and recovery support providers, so they are not subjected to unexpected cutbacks and limitations on funds for services provided.

***Building the model.*** SAMHSA's guide on forecasting expenditures uses an automated operating budget model, which is strongly recommended. An automated model will enable grantees to estimate the flow of expenditures at the beginning of the program. Even more important, an automated model enables grantees to change their assumptions as necessary and to incorporate these changes into the budget planning. A change in assumptions may be needed to keep program expenditures and levels of service flowing in a smooth manner, with a minimum of disruption to providers and clients.

To construct a realistic operating budget model for voucher services, planners need to build a baseline model on an automated spreadsheet. This spreadsheet will take the assumptions used in the original grant application and spread them more realistically over the 3-year life of the ATR grant. These

assumptions reflect the variables that are expected to affect services. Monthly expenditure projections can be more detailed, and they can take into account such factors as the time needed for startup and to close down the program on a given schedule. Table 6 provides a sample spreadsheet.

In the face of uncertain demand for a new voucher program, it is important to be able to adjust the assumptions carefully over time to avoid spending the funds too fast or having too large a balance remaining at the end of the program. The baseline model provides a good framework for projecting and making these adjustments over time. Table 6 shows a baseline operating budget model for a sample ATR grantee, constructed on an Excel spreadsheet. This template is designed to project a realistic path of monthly expenditures, using the concept of stabilized operations. This baseline model has built-in formulas that are linked to baseline assumptions; these assumptions can be adjusted easily to forecast results under different operating scenarios.

A grantee needs to make some carefully thought-out assumptions before developing an actual model of an operating budget. Some assumptions used in building the data for the sample baseline operating budget in table 6 include:

- The overall grant amount
- The allocation of funds between administration, treatment services, and RSS
- The number of clients projected to be assessed per month
- The designated lifetime of vouchers
- The anticipated progress of clients from higher treatment services to less intensive services
- The dollar cap on vouchers

*Using the model to forecast.* Clearly, the sample grantee in table 6 cannot be certain about the validity of all the initial assumptions or know all possible variables that may affect the budget. As an example, this grantee assumed a “best case” scenario, with all clients completing each level of service and with demand levels continuing at their historic projected rate. Any changes, such as clients not completing any or all of the services as projected, could significantly shift the projections.

An advantage of using an interactive electronic spreadsheet is that this grantee can run several scenarios using different assumptions, which will show what the spending patterns would look like under different conditions. This enables planners to make alternative plans in advance, so they can be proactive rather than reactive in adjusting the ATR program.

This automated budget can be used during the life of the program to forecast spending scenarios at any point in time, enabling ATR managers to keep up with or ahead of any changes in conditions or assumptions. Grantees who are trying to increase or decrease their voucher spending pace could use this type of analysis, so they can project realistically what would happen under different scenarios.

**Table 6. Sample Budget Projection for Stabilized Operations (Voucher Services Only)**

<b>YEAR 1</b>														
(Months)	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	
<b>Clinical/RSS:</b>														
New Clients Receiving Vouchers					128	128	128	128	128	128	128	128	<b>1024</b>	
Monthly Clients Served (duplicate count)					128	256	384	512	640	768	768	768		
Monthly Cost Per Client					\$500	\$500	\$405	\$358	\$329	\$310	\$310	\$310		
Total Monthly Expenditure					\$64,000	\$128,000	\$155,520	\$183,040	\$210,560	\$238,080	\$238,080	\$238,080	<b>\$1,455,360</b>	
<b>YEAR 2</b>														
(Months)	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	
<b>Clinical/RSS:</b>														
New Clients Receiving Vouchers	128	128	128	128	128	128	128	128	128	128	128	128	<b>1536</b>	
Monthly Clients Served (duplicate count)	768	768	768	768	768	768	768	768	768	768	768	768		
Monthly Cost Per Client	\$310	\$310	\$310	\$310	\$310	\$310	\$310	\$310	\$310	\$310	\$310	\$310		
Total Monthly Expenditure	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	<b>\$2,856,960</b>	
<b>YEAR 3</b>														
(Months)	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	
<b>Clinical/RSS:</b>														
New Clients Receiving Vouchers	128	128	128	128	128								<b>640</b>	
Monthly Clients Served (duplicate count)	768	768	768	768	768	640	512	384	256	128	0	0	5760	
Monthly Cost Per Client	\$310	\$310	\$310	\$310	\$310	\$272	\$215	\$215	\$215	\$215				
Total Monthly Expenditures	\$238,080	\$238,080	\$238,080	\$238,080	\$238,080	\$174,080	\$110,080	\$82,560	\$55,040	\$27,520	\$0	\$0	<b>\$1,639,680</b>	
										<b>TOTAL CLIENTS SERVED:</b>				<b>3,200</b>
										<b>TOTAL EXPENDITURES:</b>				<b>\$5,952,000</b>

## ***Looking at Variances***

Once program operations begin, grantees can use their projections of stabilized operating budget to compare actual performance to budgeted performance. By tracking expenditure and utilization data on a continual and timely basis, preferably with automated reports, grantees can make program adjustments before a crisis occurs. Taking into account current and historic data is the only way to project how to spend the remaining program funds with accuracy. On the basis of such data, grantees can be continually prepared to revise their projections and their program policies if necessary. Being caught by surprise and being forced to make hasty changes can adversely affect clients and providers.

***Analyzing data on client and overall expenditures.*** There is no single or “correct” way to analyze client and expenditure data. The most important concept is for grantees to make sure they are capturing the data they need, on a time-appropriate basis, and analyzing it routinely to make program adjustments. The key for ATR grantees is to monitor their expenditures continuously—at least monthly—against all their baselines (budgeted, cumulative year to date, and cumulative program to date). Grantees need to do this to make sure that they are not experiencing any unexpected spending volatility and that they are on track within the 3-year time and funding allotments of the ATR program. On at least a monthly basis, grantees need to collect and measure ATR-specific historic data against time-specific periods and against budget by means of standard reports. Being able to use this type of analysis for client and expenditure data depends on whether the grantees’ financial management system can provide accurate and complete data. While these systems may not be perfect, and some manual tracking may need to be done, it should be possible to capture the most important data elements described in this section. If not, a variance report can be designed to point out where the data collection systems need to be enhanced.

***Client data example.*** Table 7 shows a sample template table that tracks client intake statistics. The table shows a snapshot in time at the end of June 2006 (almost at the end of the second fiscal year of the ATR program). It captures just one area of important ATR client data—the numbers and ratios of ATR clients who are screened and assessed compared to those who actually receive vouchers to enter treatment and recovery services. The table is a summary chart designed to enable top program managers to assess the status of client assessments and admissions to the voucher program in real time, seeing where further analysis or changes need to be made. The template shows actual monthly data in comparison to cumulative and annual expenditures or client data statistics. This table demonstrates how regularly produced, time-oriented variance reports can assist in program analysis and spending control.

**Table 7. Sample ATR Program Summary—Client Intake Data**

**Date: June 30, 2006**

	Last 3 Months						Cumulative 2006 Fiscal Year (FY) Data (August 2005–August 2006) 2 <sup>nd</sup> Program Year			Cumulative Actual Program to Date (August 2004– June 2006)
	June 2006		May 2006		April 2006		Cumulative Actual to Date (Aug. 2005– June 2006)	Total FY 2006 Budgeted Assumptions	Actual vs. Budget) (one month remaining in FY) Numbers and Percent	Total to Date
Client Statistics	Actual	Budgeted	Actual	Budgeted	Actual	Budgeted				
Number of Clients Screened							1,975	2,200	- 225 clients (under) (90% of projected)	
Number of Clients Assessed							1,679	1,870	- 191 clients (under) (90% of projected)	
Ratio of Screening to Assessments							85%	85%	85% (on target)	
Total Vouchers Issued (clients entering into services after assessment)							1,202	1,536	- 334 clients (under) (78% of projected)	2,466
Ratio of Clients Entering Program to Assessments							72%	82%	(10% under projected)	
Total Vouchers Issued							1,202	1,536	-334 clients (under) (78% of projected)	
Region 1							460	482	- 22 clients (under) (95% of projected)	
Region 2							337	695	- 358 clients (48% of projected)	
Region 3							365	359	+ 6 clients (over) (102% pf projected)	

For example, the statistics in table 7 show that the current data on client intake does vary from projections in the following ways:

- The program is underspending its projected allocation for year 2.
- The total of vouchers being issued after assessment is not meeting the projected target, even though the comparison data shows that the numbers of clients being screened and assessed are close to projections.
- Region 2 is falling below the target for Total Vouchers Issued.

As the next section discusses, grantees should use a variance chart to monitor not just total spending, but also the various important detailed elements concerning actual dollar expenditures. These include:

- Dollar value of vouchers issued
- Dollar value of vouchers expired (with remaining funds)
- Dollar value of accrued provider expenditures
- Dollar value of provider claims paid

### ***Special Considerations for Voucher Expenditure Accounting***

Using a budget forecasting model should prevent sudden swings in the operating budget, because grantees can tell where their overall spending pattern is going and will be able to adjust the level of services accordingly. However, in the short term, some grantees have experienced difficulties in tracking actual expenditures. This is partly because ATR voucher clients may not utilize all the services offered or may not complete their treatment and recovery plans.

***Tracking actual expenditures.*** Administrators know that funds set aside for a particular client must be obligated (not available for other clients) in the tracking system, but that these funds may remain unexpended. The unused portion of an obligated voucher can be returned to the pool of uncommitted grant funds and used for other clients only after that voucher has expired.

ATR program administrators need to track voucher expenditures on several levels, all of which provide different views of the pattern of expenditures, for different analytic reasons. One key in analyzing expenditure patterns for the ATR program is to understand the difference between a cash basis and an accrual accounting system. In a cash-basis system, expenditures are recorded when invoices are actually paid. In an accrual system, expenses are recognized as they are incurred rather than when they are paid.

The accrual accounting method will give ATR administrators a much better picture of actual spending patterns than a cash-basis accounting system can. This is because there is often a significant delay between the time when an ATR provider supplies a voucher unit of service and the time when the provider actually gets paid. This delay also affects when the payment is recorded in the cash accounting system.

**Sources for expenditure reporting.** Most grantees integrate the ATR grants management process with other standard financial management functions that are related to their government grants and other funding. For reporting and for some tracking and forecasting purposes, several of these financial management sources and processes can give grantees different snapshots of their expenditure patterns.

Table 8 shows several different sources of record for expenditure information, as well as different types of spending that must be tracked by grantees. The table briefly highlights each measure and how it can be used. For grantees, thinking within this larger structure will provide a framework for understanding the ATR expenditure process. This broader perspective will also lay the groundwork for being able to track and forecast the program more accurately.

**Table 8. Sources for Expenditure Reporting**

<p><b>State-Level and Federal-Level Accounting Reports</b> (officially recorded ATR drawdowns and expenditures)</p>	<ul style="list-style-type: none"> <li>• Grantees must periodically report actual drawdowns of ATR funds to CSAT and must reconcile the State and Federal accounting systems when closing down the program.</li> <li>• However, State- and Federal-level accounting systems are not reliable for tracking and forecasting levels of expenditures for true operating purposes.</li> <li>• States differ from each other in their accounting and disbursement systems. As an example, systems may pay providers out of general funds well before requesting an ATR drawdown, which will show a large balance remaining when in fact the funding has already been spent.</li> </ul>
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<p><b>Budgets</b></p>	<ul style="list-style-type: none"> <li>• Budgets are by nature projections and should never be used to report actual expenditures.</li> <li>• Operating budgets should be updated at least monthly to take into account what has actually occurred in the last month or last time period as a basis for predicting the next budgeted time period.</li> </ul>
<p><b>ATR Vouchers Issued</b></p>	<ul style="list-style-type: none"> <li>• Each voucher committed to a client represents a funding obligation and is an important expenditure benchmark. Obligated vouchers should be tracked at least weekly.</li> </ul>
<p><b>Accrued Provider Expenditures</b></p>	<ul style="list-style-type: none"> <li>• Accrued expenditures represent actual services that have been rendered by providers against a voucher, whether or not they have been paid for on a cash basis.</li> <li>• Accrued expenditures are the most important measure for grantees to track their actual expenditure rate. If expenditure patterns are volatile, accrued expenditures should be tracked at least weekly.</li> <li>• Accrued expenditures can be tracked through actual invoices or through more frequent, informal reporting by providers. The latter method is better if the grantee requires invoices on a monthly or less frequent basis.</li> </ul>

***Provider Invoicing and Payment Policy Options***

Most grantees or their ASOs issue vouchers—either virtual and/or real vouchers—that are actually authorizations with at least two choices of providers for each service. (Hereafter, the terms vouchers and authorizations are used interchangeably.) These authorizations include the number of units of service, the time period (number of days), eligibility, and release of information. In some States, vouchers are issued to treatment providers for both treatment and RSS. In other States, vouchers are usually issued to vendors for RSS, such as housing, day care, and basic needs.

***Exploring the invoice options.*** A variety of invoicing methods are being used. In at least two States, an automated voucher system prepares the invoices for providers based on the services that providers enter into the automated system. The ASO prepares the invoices and regularly sends them to the providers for verification and signature. In other States, the vendor or provider prepares the bill; the grantee/ASO verifies the appropriate calculations at the time the claims are reviewed for payment.

As the bills are received, they are matched to these authorizations by the grantee/ASO. Some States compare the bills with the authorizations electronically, and the system adjudicates the payment or denial of claims.

Identified errors in claims may cause a claim to need to be resubmitted. An appeals process exists for denied claims. Bills must be processed in a certain number of days and then checks are mailed to the providers or vendors. In some States, checks are issued from the State Treasury, while in others the ASO writes the checks to the providers and vendors.

***Setting time limits for submitting invoices.*** How frequently the providers submit bills or provide real-time client data is significant, because it affects the State's ability to maintain spending control and to de-obligate funds so the monies may be spent for other clients. The original ATR grantees had a wide variety of requirements for when providers were to submit invoices and when or if they needed to report data on services rendered. Some requirements work better than others. The variety includes:

- Requirements for submitting invoices vary by grantee from a 7-day requirement (weekly) for submission of provider invoices to a 60-day requirement.
- Some grantees require no intermediate reporting by providers for services rendered except for the invoice. These providers have no way to track data in real time.
- At least one grantee requires that providers report, through the electronic data system, every 3 days on what services were rendered during that time.
- Some States have monthly billings that provide the first documentation that services have been performed. These grantees have a great deal of difficulty determining the utilization rate for use of services.

To maintain spending control and to monitor the availability of funds against a particular voucher, it is preferable for grantees to require both reporting of services and invoicing on a relatively short-

term basis. So as not to burden the provider unduly with too frequent invoicing requirements, a grantee may want to consider using a combination system. In this system, the provider reports all services that have been rendered on a weekly—or even better, daily basis—using the electronic data system. This allows the grantee to keep track of services provided on an accrual basis and in real time. The provider can then submit an actual invoice, preferably electronically, on a bi-weekly or

For the best monitoring control, providers need to report both their services rendered and their invoices on the shortest timeframe possible.

monthly basis. Some providers may actually prefer to invoice more frequently in order to get paid sooner.

***Using invoices to support program goals.*** Authorizations and invoicing are a good example of how financial tools can be used to support the goals of the program. One ATR State ties each request for services to the need for GPRA data. When authorizations are issued, the first for 30 days and then at 60-day intervals thereafter, the provider must submit GPRA data for that client at the time of each reauthorization. Until the GPRA data are submitted, the claim will not be paid. For this reason, the State has a high rate of compliance with the initial and status GPRA requirements—above national averages. In this particular State, the discharge GPRA is not tied to payment—and their success with obtaining the discharge data is markedly lower.

Several grantees recommend that the best method for insuring collection of the GPRA data is to tie GPRA data to payments. One State is proposing to tie final payment for services to the discharge GPRA.

## **Monitoring and Auditing Controls for Fraud, Waste, and Abuse**

Providers and vendors must be monitored to ensure that they have performed the services for which they are paid. If grantees use an ASO, the functions of the ASO must also be monitored. During the initial planning stages of the voucher system, programs need to develop both controls and guidance on those controls.

Automation may be very helpful in managing the volume of transactions, contractors, and providers that need to be monitored. Where grantees have that capability, the first control is generally the verification of invoices to the authorizations in the automated voucher system. Next, program staff actively monitor automated client history-based reports, provider-based reports, and aggregate reports.

***Vehicles for monitoring.*** Special monitoring needs to be done of “mismatch” reports, financial reports, and burn rate reports. Information from these program reviews can be provided to monitors located in the programs or in a centralized auditing function. Another way to be alerted to potential irregularities is to monitor client satisfaction survey reports at least quarterly. Hotlines for reporting complaints are a good control mechanism.

Based on risk assessments, site visits can be scheduled by either the program monitors or the auditors. One State reported that on-site monitoring was helpful in identifying areas where the ATR staff wanted to give more guidance.

According to grantees, the providers' documentation on client records is frequently inadequate. Providers often need training to improve the required documentation that supports payment for services.

Fiscal staff will verify billings or invoices to determine that all costs are allowable. Generally, the ATR program director approves all bills to the ATR program. The financial officer then enters the invoices into an electronic agency financial system that is part of the overall State system. The ATR program is then included as part of the State

Auditor's work to audit Federal programs and perform reviews of subrecipient monitoring procedures. Other auditors, such as county auditors or agency internal auditors, may include ATR payments in their audits of their respective organizations.

***Vehicles for remediation.*** Most States report that remediation may be deductions from the current billing. This can be done if the discrepancy is identified prior to payment. When payment has already been made, the questioned billings can be offset from the next payment to that provider or vendor. In some States, the providers or vendors are required to make reimbursement to the State.

Grantees report that they have identified little fraud, waste, or abuse. Generally, errors are in documentation or from a misunderstanding of the rules. The return of the questioned cost and corrective actions regarding procedures have been sufficient to resolve issues. The effectiveness of these control mechanisms is demonstrated by one State's experience with a region that underperformed in the early stages of the ATR grant. The State reallocated the unspent allotment for this region to the other regions. Subsequently, this region improved to become one of the best performers. In another case, one provider had consistently lower scores on the client satisfaction results as compared to other providers. The State investigated the reasons for the low satisfaction scores, improved processes, and improved the provider's satisfaction scores over time.

## Chapter 4. Data Systems and Functions

A critical IT need and immediate task facing new grantees is the decision on what type of electronic information system to select for managing the voucher process. ATR grantees agree that an electronic, Web-based VMS is critical to successful management of a large voucher-based service system. The ideal system would also incorporate core functionality and be embedded in the existing client data collection system. [Note: The term “voucher system” is used to refer to the entire management infrastructure of the voucher program. The software used for fiscal and data management is referred to as the “Voucher Management System” (VMS).]

**Electronic systems.** The ATR staffs interviewed for this start-up guide agreed that paper management systems are inefficient, prone to error, not secure, and not workable when volume increases. While all the ATR projects desired and planned to implement electronic systems, several started with paper-based systems and managed to function for a brief time using only faxes and spreadsheets. This time was used to develop and clarify the business rules that would eventually drive their electronic systems. To transition a project in full operation from paper-based to the electronic system was reported to be very challenging and time consuming.

"We literally burned up two fax machines trying to handle all the paper. We had stacks and stacks and stacks of paper on the floor."  
—ATR staff member describing the early days of ATR implementation

***A rising volume of clients and providers.*** ATR grantees can expect a significant increase in the number of providers and clients who need to be tracked through their databases. The client base may increase by as much as 50 percent, while the provider base may increase by as much as 100 percent. Data systems must be adequate to handle this increase in volume.

***A shift in data focus.*** Additionally, ATR grantees must expect to alter the focus of their data collection. For their SAPT Block Grant funding, grantees collect client data at three points in time: admission, transfer, and discharge. However, a voucher system also requires States to collect service-level data. For a voucher system, grantees must also be able to track clients each time they receive services. This changes the focus of the data collection process and also causes an exponential increase in the volume of data collected.

**Web-based systems.** ATR staffs interviewed were in near unanimous agreement that Web-based systems provide the optimum technology environment for a VMS. The Web environment is considered the ideal, because it allows both grantee and provider staff to gain real-time access to

client data collected by multiple organizations. This ability allows grantee and program staffs to monitor authorizations against caps and to monitor expenditures against authorizations.

**Incorporating core functionality.** At the time this start-up guide was produced, two ATR projects were in the process of developing comprehensive data management systems that would incorporate all of the core functionality (payment, registration, authorization, and service tracking). However, most States were required to interact with centralized accounting, payment and/or budgeting systems; they did not have the luxury of developing comprehensive, integrated systems. In these cases, the staffs agreed that the VMS should be designed to produce reports or assemble electronic files that would require minimal manual work for interaction with external systems.

**Embedding in client data collection.** ATR staffs also agreed that the optimum VMS should be integrated or embedded in the existing, agency-wide, client data collection. Eight of the ATR grantees have developed integrated VMS/agency-wide client data collection systems. Staff at these agencies believe that introducing a new data reporting system would have caused a "fire storm" among provider organizations. At all sites visited, provider staffs were adamant about their desire to minimize the number of data systems with which they had to interact.

The decisions made by current grantees took them in several different directions, and their experiences can be useful and informative for new grantees. However, before making a decision about which strategy to choose, grantees need to do careful analysis and planning about their needs and requirements. This chapter briefly outlines a standard process for structuring this decision process and then discusses possible strategies for securing and implementing a VMS.

## **Business Planning**

*A clearly defined business plan is the first step in planning for a VMS.* The grantee's mission is to assist people to recover from addiction. This business mission should drive all technological decisions. The data system assists a grantee to accomplish its mission by (1) providing information that can be used to improve service delivery, (2) maintaining orderly business processes, and (3) freeing staff to concentrate on clinical and policy issues.

In order to succeed, any data management project must be based on a clearly defined business plan.

Table 9 lists the key sections that a business plan for an ATR grantee should contain, and indicates the critical information to include in each section.

**Table 9. Business Plan for ATR**

Topic	Contents	Importance to IT Planning
Management Summary	<ul style="list-style-type: none"> <li>• <i>Mission</i> or "reason for being," including a description of the target population</li> <li>• <i>Vision</i> or "where the project will be in the future"</li> <li>• <i>Strategies</i> or tactics and approaches</li> </ul>	Provides the overall direction of the project
Needs Assessment and Trend Analysis	<ul style="list-style-type: none"> <li>• Describes the need for services among the target population</li> <li>• Describes developments that may influence the need for services, including innovations in service delivery, as well as new or emergent populations</li> </ul>	Provides information about the anticipated volume of data that must be collected
Resources and Organizational Analysis	<ul style="list-style-type: none"> <li>• Describes resources available to the project, including internal staff and partners, as well as the current organizational structure supporting the project.</li> </ul>	Provides information about the staff resources available to participate in the IT project
Implementation Plan	<ul style="list-style-type: none"> <li>• Describes how the mission, vision, and strategies will be implemented in practical terms, including:               <ul style="list-style-type: none"> <li>-Goals or benchmarks</li> <li>-Objectives or subgoals</li> <li>-Assignments</li> <li>-Timelines</li> <li>-Costs</li> </ul> </li> </ul>	Provides information about timelines and strategies

## Business Rules

After developing the ATR business plan, the next step is to set up a clear set of business rules that specify the details needed for the VMS to support operation of the voucher system. Issues related to operation of the voucher system must be decided up-front so they can be included in the VMS. Table 10 outlines some of the business rules that should be specified in the IT planning process.

**Table 10. Business Rules**

Category of Rule	Samples of Business Rules That Must Be Specified
Services	<p>Clarify the services that will be offered through vouchers, including:</p> <ul style="list-style-type: none"> <li>• A list of the services offered</li> <li>• Succinct definitions of each of the services</li> <li>• Specifications concerning which providers will be authorized to be reimbursed for which services</li> </ul>
Voucher caps and limitations	<p>Define the limits that will be placed on vouchers, including:</p> <ul style="list-style-type: none"> <li>• Authorizations: Communicating requests and authorizations between providers and a central or regional authority</li> <li>• Validity dates: Rules governing the length of time in which vouchers are valid, a process for determining the duration of voucher validity, and the relationship of these rules to the type of services authorized</li> <li>• Limitations on the number of services: These will include caps by total cost, number of services, and time period</li> </ul>
Funding sources	<p>Explain the accounting rules; that is, the methodology that will be used to determine the source of funding assigned to the services provided. These rules will cover:</p> <ul style="list-style-type: none"> <li>• Multiple funding sources: How to identify the funding source that is attached to the service and client</li> <li>• Point in the process at which funding sources are assigned: Rules for assigning the funding sources</li> </ul>
Information to inform client choices	<p>List the types of information that will be presented to clients to assist them in selecting a provider. Such information may include location, program accessibility, the services offered and business hours, language spoken and cultural relevance, treatment philosophy, faith-based vs. secular orientation and client outcome information.</p>
Integration with other business systems	<p>Define the points of integration with other State systems, including:</p> <ul style="list-style-type: none"> <li>• Required interface and interaction with State financial (payment and accounting) systems, contracting and/or provider registration, and Federal GPRA reporting systems</li> <li>• Requested electronic interface, wherever possible, with the State substance abuse client data collection and Treatment Episode Data Set (TEDS)</li> <li>• Potential interface with other systems, such as Medicaid, criminal justice, and Temporary Assistance for Needy Families (TANF)</li> </ul>
Response time	<p>Specify whether the VMS will provide "real-time" information and communication capacity, which is usually made possible by Web-based and Web-enabled systems.</p>

**Information Technology Planning**

Ideally, IT planning would take place after business planning. However, the time pressures placed on grantees to implement their ATR systems quickly require them to do their business planning and IT planning within relatively short time periods. The following section provides insight gained from interviews with States that have already implemented VMS; these insights may help grantees "jump start" their IT planning.

An in-house IT steering committee is critical to success. This team should include representatives from all functional units within the organization, particularly individuals who will work with the system every day, such as data entry clerks, administrative assistants, and research staff. Include at least a few members who have less experience with technology. They can provide valuable user insights to the IT team.

### ***Functionality***

***Core functions.*** The core functions of the VMS include:

- Register and track clients.
- Authorize and make payments.
- Accept data from the provider and/or intermediary organizations.
- Transmit client-level data to SAMHSA.

**Register and track clients.** The client registration function allows central intake units and/or treatment and recovery support providers to enroll clients into the ATR program. Typically, client registration and tracking functions collect:

- Identifying information
- Demographic information
- Eligibility information, such as income, insurance, and treatment needs assessments
- Information about services received
- Follow-up and discharge assessments

Most State substance abuse agencies provide clients with system-wide unique identifiers so that admission and discharge data can be matched. This unique statewide client identifier is particularly important in a VMS, where services available to the individual may be capped by a time period or a dollar limit, and multiple providers may serve the same client and receive remuneration for service delivery.

Web-based systems generally provide the best opportunity to ensure that an identifier assigned to an individual is truly unique to that person and that a given individual has only one identifier across providers and over time. This is because on-line systems allow provider staffs to view information from central tables and to query clients about how well the information fits. For example: staff can ask, "Did you ever live at 100 Main Street? Is your nickname Bob?" The answers assist provider staff to make informed decisions about clients' identities. On-line identification systems must be implemented cautiously to assure adherence to requirements of Federal confidentiality (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act (HIPAA).

Off-line identification systems usually rely on client matching routines. These routines can provide high match rates, but they will never achieve the accuracy rates that can be attained through live systems. For a description of methodologies used to match client records, see a series of CSAT-sponsored papers at <http://www.csat.samhsa.gov/IDBSE/idb/tools.aspx>.

Another resource: *Integrating State Administrative Records to Manage Substance Abuse Treatment System Performance* at: <http://download.ncadi.samhsa.gov/Prevline/pdfs/SMA07-4268.pdf>.

**Authorize and make payments.** To accomplish this function, the VMS must interface and/or communicate with several additional data systems that complete payment processes. Some or all of these systems may be housed in separate agencies. These systems include:

- **Accounting:** In its simplest form, the accounting system tracks how much money has been encumbered and how much has been paid by funding source.
- **Payment:** Payment systems cut and deliver checks either through electronic funds transfer or through printed checks.
- **Contracting and/or Provider Registry:** The contracting and/or provider registry databases provide information about which organizations are eligible to receive checks or fund transfers.

Most ATR grantees were required to use central accounting and payment systems managed by separate entities. Many of the States were also required to use separate contracting and/or provider registry/certification systems. Based on their experiences, these ATR grantees report that, in cases where the VMS must interface with external systems, the program must be capable of both transmitting and receiving data from the external systems. Yet, independent management systems are frequently incapable of transmitting and accepting transfer files. In such cases, the VMS must produce necessary reports that make data entry and/or other methods for communicating with the external systems as efficient as possible. The need for supplemental spreadsheets and hand calculations should be kept to a minimum.

**Accept data from provider and/or intermediary organizations.** The voucher payment system is triggered by data received from providers and/or intermediary organizations. Staff at ATR agencies use several different methods for interfacing with provider systems. The decision regarding the optimum type of interface will generally depend on the level of technological sophistication exhibited by the provider community. Many of the new providers, including both faith-based and other grassroots organizations, are less sophisticated technology users. Frequently, they lack the necessary equipment and have limited experience with information systems and e-mail.

Most ATR staffs believe that the optimum system would allow provider staff to enter data directly through a Web interface, but would also be capable of accepting electronic batch transfer files from provider systems. However, some grantees argued against developing the capacity to accept transfer files. One argument against file transfer capability is that providers must be given lead time to change the programming that generates the batch files. This can increase the time required to make changes or updates to the central system. Another argument is that file transfer programming and testing can be labor intensive for State staff and are prone to delays when authorization checks and quality control processes are applied to the batch records.

While ATR staffs disagreed over the merits of accepting or importing data from providers, all agreed that the VMS should be capable of exporting data back to provider systems. The data exports allow providers to monitor original data against data accepted by the central system.

**Transmit client-level data to SAMHSA.** All ATR States are required to submit GPRA data to a central registry. GPRA submissions are made in batch transfer files. File specifications are available through the SAMHSA Office of Applied Studies.

Include on the ATR advisory board representatives from technologically savvy organizations, and ask them to provide advice and assistance as VMS development unfolds.

### ***Optional Functions***

The VMSs used by grantees also include several optional functions, which are:

- Register and authorize new providers.
- Schedule client appointments.
- Register for and track participation in training.
- Create treatment and RSS plans.
- Track progress notes.

- Track consent to release information.
- Manage access to the VMS.

**Register and authorize new providers.** The provider registration function allows providers to apply for and receive certification/approval to participate in the ATR program. Typically, the provider registration function collects information about:

- **Identifiers:** Provider-identifying information most often includes the corporate Employer Identification Number (EIN), provider site identifier, State-assigned identification number, and contract identification number (if appropriate).
- **Demographic information:** Provider demographic information often includes location/address, city, and zip code; hours of operation; and accessibility to public transportation.
- **Service information:** Provider service information often includes license numbers, the array of authorized services, languages, whether the organization is faith-based, and its licensed and/or funded capacity.

**Schedule client appointments.** The scheduling functions employed by grantees vary widely in sophistication. Some programs allow central intake and/or provider staff to schedule appointments with partner agencies on-line. Other programs provide the necessary information so that staff can place phone calls to partner agencies.

**Register for and track participation in training.** Grantees agree that training is vitally important to the quality of the data management system. Several States include on-line modules that allow providers and/or intermediary staff to register for training; the system then tracks whether registrants participate in training.

**Create treatment and RSS plans.** Several grantees include modules in their VMS that allow providers to create client treatment and RSS plans.

**Track progress notes.** Several grantees include modules in their VMS that allow providers to create and log client progress notes, as well as to tie progress notes to treatment and recovery plans.

**Track consent to release information.** Several grantees include modules in their VMS that track whether clients have given signed consent to release confidential information to outside agencies. These modules generally collect the following information: (1) the organization granting the consent to release information; (2) purpose of the consent; (3) date the consent will expire; and (4) providers' certification that client charts contain appropriately signed consent forms.

**Manage access to the VMS.** This function allows IT staff to identify staff roles and to give staff in these roles access to the data they need to perform their duties. Typical roles include:

- ***Provider clinical, clinical supervisory, intake/assessment, and data entry staff.*** These staff members need to be able to enter and review information about clients with whom they work directly. Such information includes client assessments, treatment plans, service provision, and progress notes. Clinicians and clinical supervisors need to be able to enter and view client-identifying information.
- ***Provider management staff.*** These staff members need to be able to review information about services budgeted, delivered, invoiced, and paid. Depending on the structure of the organization, management staff may need rights to enter and view client-identifying information.
- ***State agency's fiscal staff.*** These staff need to be able to enter and review information about budgets, contracts/encumbrances, provider licenses and authorizations, funding sources and parameters, and payments. Fiscal staff also needs to be able to audit financial information against clinical records. State agency fiscal staff generally do not need to see client identifiers beyond the agency-created unique statewide ID. State agency fiscal staff who conduct onsite audits may also need to be able to see provider-assigned identifiers if these are collected in the central system.
- ***State agency's management and data/research staff.*** These staff need to be able to review both clinical and financial information. They do not need to see client identifiers beyond the agency-created unique statewide ID, a year of birth, information about race and ethnicity, and client residence or location.
- ***State agency's IT staff.*** These staff need to be able to manage the data collection system. State agency IT staff may need to view client-identifying information in order to create the unique statewide ID.

### ***Data Architecture***

In general, a VMS includes three categories of relational tables: (1) client tables, (2) service tables, and (3) provider tables. The client and provider tables are each keyed by a unique statewide client identifier; this unique identifier is used to tie all of the tables within the set together. The client and provider tables tie to each other through the service tables, which are keyed by both the unique client and the unique provider identifier.

**Client tables.** Client tables include information about the individuals who receive services. These tables include information that is germane to the client, but do not include the services that the client receives. Tables may include (1) client identifiers, (2) client assessments; and (3) client aliases.

**Client identifiers.** Several of the elements in this table may be used to create a unique statewide client identifier, as is required for reporting under GPRA. The elements in this table have a one-to-one relationship to the unique statewide client identifier.

- **The unique statewide client identifier (key).** This unique identifier is usually created by the State agency. States generally use one of two approaches to create unique client identifiers: (1) master client index—an automated centrally administered sequential number that is linked to and dependent upon the lookup and matching of various client identifiers and (2) synthetic client identifier—an identifier constructed using components of various client identifiers (such as characters of the first name, last name, date of birth, last four characters of the SSN, etc.).
  
- Elements used by States to create the unique statewide identifier include:
  - Client's first name
  - Client's last name
  - Client's birth first name
  - Client's birth last name
  - Client's middle name
  - Social Security number
  - Date of birth
  - Race<sup>1</sup>
  - Ethnicity<sup>1</sup>
  - Zip code of residence<sup>1</sup>
  - County of residence<sup>1</sup>
  - Address of residence<sup>1</sup>
  - Medicaid identifier (if one exists)
  - Criminal justice identifier (if one exists)
  
- **Client assessments.** Client assessments include information about clients' status at different points in time throughout the treatment process. All organizations funded by the ATR and SAPT Block Grant are required to collect and report client admission and discharge data. These requirements are outlined in SAMHSA's TEDS admission and discharge manual available at: <http://www.dasis.samhsa.gov/dasis2/teds.htm>. TEDS includes most of the

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<sup>1</sup> These elements are often unreliably reported and/or prone to frequent change. They are used primarily to strengthen the probability of a match rather than to negate the likelihood of a match.

GPRA measures required by the ATR grants. However, some of the measures vary slightly, so that GPRA and TEDS data are reported separately. ATR grantees are also required to collect regularly scheduled status updates. The updates contain the TEDS and GPRA required information, as well as any additional information desired by the State.

- **Client aliases.** The organization may also wish to maintain client alias tables, which tie alternate identifiers (such as alias names or stolen Social Security numbers) to the main client identifier table. The client alias tables have a many-to-one relationship to the unique statewide client identifier. Programs that target criminal justice clients may find the alias tables to be particularly useful.

**Service tables.** The service tables create the link between the client and provider tables. All service tables need to include both client and provider identifiers. Service tables often consist of information on (1) authorizations, (2) service delivery, and (3) service management.

**Authorizations.** Authorization tables assist grantee and provider staff to track clients' eligibility for services. Typical information includes:

- Client identifier
- Service identifier
- Number of authorized units or amount of authorized cost
- Effective date of authorization
- Expiration date of authorization

Some grantees authorize services to providers, while others allow the client to seek out a provider after the authorization has occurred. In cases in which the service is authorized to a particular provider, the grantee should also collect the identifier for that provider (or providers).

**Service delivery.** Grantees employ varying methods to collect information on service delivery. Some States not yet participating in the ATR program do not collect this information at all, some collect aggregate information about the number of services that clients receive each month, and others collect information each time a service is delivered. A VMS usually requires information to be collected each time a service is delivered. Typical information includes:

- Client identifier
- Provider identifier
- Service identifier
- Date of service delivery
- Number of units delivered

**Service management.** Service management tables consist of information necessary to manage and pay for services. These tables are generally maintained by staff of the State agency. Typical information includes:

- Service identifier
- Service description
- Type of cap/limitation on number of services (such as annual or lifetime)
- Caps/limitations on number of services
- Rate paid per unit of service

**Provider tables.** The provider identifier should pinpoint two pieces of information: (1) the provider's corporate identity and (2) the provider's location. Depending on the grantees' organizational structure, the provider identifier may also be used to tie provider information to contract and licensure/certification tables.

## **Models for Information Technology Development**

The ATR States followed one of two paths in developing their voucher management systems:

- Model One—Adapt public domain software
- Model Two—Develop new, original programming

Appendix B of this guide provides information on grantees' choice of VMS models.

### ***Model One—Adapt Public Domain Software***

ATR agencies that chose to adapt software that was in the public domain were divided about the merits of this approach. They were quick to point out that, while the approach "sounds good," it is never free of cost. Programming is always required to adapt public domain software to systems currently in place. In some cases, the public domain programs simply will not work within a State's technological framework. Finally, the State staff may lack the expertise necessary to keep the software updated.

## **Issues for Evaluating Public Domain Software**

### **Suggestions from Grantees**

Before choosing to adapt and use public domain software, a grantee needs to carefully consider:

- Does the staff have the expertise necessary to adapt the software to our system?
- Does the staff have the expertise necessary to maintain and update the software?
- Will the current hardware configuration support the application?
- Will the current software configuration support the application?
- What is the skill set of the provider community?
- Does the provider community have the necessary technology infrastructure?
- With what external programs will the program interact?

After conducting internal analyses, five ATR projects chose to adapt existing public domain/quasi-public domain software. In four cases, the adapted systems operated on a stand-alone basis, separate from the agencies' other client data collection systems. As a result, provider agencies participating in the voucher program were required to report ATR data separately from other State-required client data.

Three States adapting public domain software chose the VMS module of the Web Infrastructure for Treatment Services (WITS). One State chose a program available from the United Way, while a fourth State chose the Behavioral Health Integrated Provider System (BHIPS). The final State adapted software used by a local service agency. However, this system had fairly low-level functionality and was heavily dependent on manual processes.

The WITS and BHIPs software products are described below.

**WITS.** Several ATR States chose to adapt WITS voucher management system and its related software for client data collection. CSAT originally developed WITS, so the source code remains in the public domain. However, since its original development, the system has been modified and updated. Most States that chose to adapt and use WITS have entered into the WITS collaborative partnership, which is a shared licensing arrangement with FEI, Inc., the company that maintains the current source code.

WITS is Web-based and offers numerous optional modules, including client demographics, scheduler, treatment planning, progress notes, admission and discharge, service utilization, consent to release of confidential information, report writer, and contract and voucher management. The WITS application uses the .Net framework. The application is compliant with Federal confidentiality regulations for substance abuse treatment clients (42 CFR Part 2), as well as with HIPAA. WITS is described in detail on its Web site: <http://www.witsweb.org/>.

Staff at the WITS sites reported that one advantage to WITS was the vendor's ability to deploy the program rapidly. Staff also reported that they appreciated the support provided by other States that participated in the WITS network. Staff reported that the chief disadvantage to the program was that it operated separately from other client data collection systems in place and did not interface with the State accounting and payment systems. The system also required double data entry on the part of providers. While most States using WITS reported being satisfied with its functioning, one State indicated that they were not successful in getting the software to meet their needs and expectations.

**BHIPS.** This comprehensive, Internet-based client data collection system was developed by the State of Texas. Like WITS, the BHIPS code is "open source" or freely available to all States. BHIPS was originally developed using Active Server Pages (ASP), Microsoft's server-side script engine. In 2005, it was converted to the Microsoft .NET framework. Both versions of BHIPS are available to States as possible bases for their codes. However, the State of Texas does not intend to maintain the ASP version of BHIPS. Thus, States who are considering BHIPS should consider also migrating to .NET so they can obtain subsequent updates.

BHIPS is comprised of numerous inter-connected modules for client data collection that include: assessment, treatment planning, service delivery, progress notes, referrals, follow-up and discharge, and consent to release of confidential information. BHIPS functionality is described through the following link: [http://www.nasdad.org/resource.php?doc\\_id=874](http://www.nasdad.org/resource.php?doc_id=874).

BHIPS requires providers to enter data directly into the system and does not accept file transfers from independent systems. The application is compliant with Federal confidentiality regulations for substance abuse treatment clients (42 CFR, Part 2) and with requirements of HIPAA. The BHIPS is described in detail on the Texas Department of State Health Services Web site: <http://www.tcada.state.tx.us/BHIPS/index.shtml>. Texas plans to replace BHIPS with Clinical Management Behavioral Health Services (CMBHS) in December 2007.

### ***Model Two—Create Original Programming***

Nine ATR States chose to create original software programs. Some States already were using Web-based systems, so they were able to develop additional modules to accommodate the needs of a

voucher system. Other States developed new systems. For States developing new systems, it generally took 1 to 2 years to obtain necessary approvals and to roll out their newly developed VMS. The time frame for new development (similar to the time frame for adaptation of public domain software) appears to depend mainly on the State and agency policies that govern approval of IT plans and expenditures. States that were required to obtain approvals from external organizations generally took longer than States in direct control of the approval processes.

Four States that created original programming did so through ASOs or intermediaries. Seven of the new programs and one of the adapted public domain programs are fully integrated into their States' comprehensive databases for clients in substance abuse treatment. Therefore, these VMS programs are not likely to be portable to other States.

One new system, shared by two ATR projects, was developed as a stand-alone system. This software is available in the public domain and, because it is stand-alone, could conceivably be portable to another State given the above caveats. This VMS uses the Net V1.1 framework but may be converted to the V2.0 framework in the future. The system cost approximately \$500,000 to develop and costs an additional \$5,000–\$6,000 per month to maintain. This system uploads data to SAMHSA and generates management reports, including authorizations and expenditures. Providers use the system to make voucher requests, which are approved or denied from a central site. Vouchers authorize a total dollar expenditure, rather than a specific array of services. The vouchers are machine readable. Functionality is presented to users through ASPX Web pages.

Staff reported that the chief advantage to creating custom software was that it could be made to integrate well with other State client and administrative databases. However, this was not done in all cases. Another advantage was that State staff was able to understand and control development. This empowered the staff to plan for future development and manage ongoing maintenance. The chief disadvantage to developing original custom programming was the length of time required to obtain necessary approvals and the difficulty recruiting and retaining qualified staff.

One ATR project chose to purchase a license for a newly developed VMS software package. This license was purchased by the State's ASO and is proprietary. This VMS is "Web-enabled" rather than "Web-based." This means that provider organizations must install special software on each computer used to report data to the central system. Staff at this ATR site reported that purchasing software reduced the time required for system development. They also believed that working through an ASO speeded up the development process, because ASOs are not required to obtain numerous approvals for software purchases as many State agencies are. The disadvantage to this approach is that the VMS is not integrated with other State data systems, particularly data collection for treatment client data collection. As a result of this, providers were required to enter duplicate data into two data systems. In addition to the fee for purchasing the license, the State pays fees to the ASO that cover data management and licensing fees for individual sites.

### *Comparative Cost Analysis*

Some ATR States did feasibility studies on the most cost-efficient path to use. These studies indicated a marginal difference in the total estimated costs of the adaptation vs. new development. The information reported by States varied widely in terms of which items were included in their cost centers, so costs across grantees are only roughly comparable. The ATR sites also varied in the functionality included in their VMS. With these caveats, the average cost to develop new systems appeared to be only slightly higher than the average cost to adapt existing public domain programs. The following table shows the States' reported development costs. The costs reported include both actual costs, as well as in-kind contributions of staff time.

**Table 11. Estimated Costs Associated with Two VMS Development Models**

<b>Approach</b>	<b>Minimum Cost</b>	<b>Maximum Cost</b>
Model One—Adapt public domain software	\$50,000	\$1,190,000
Model Two—Develop new, original programming	\$94,500	\$1,250,000

### **Implementation and Training**

All ATR staffs stress that the most critical components of VMS implementation are a sequence of: (1) training, (2) clear definitions of services, (3) more training, (4) provision of a help desk/TA, and (5) ongoing training! Staff also stressed that the training must be available not only to provider agencies but to internal management staffs. The training must be ongoing. In other words, the sequence must be: “train, practice, train again.”

ATR staffs offered a range of advice about how best to implement IT training, including the following.

- Require that provider staff receive training as a condition for receiving funds.
- Incorporate experiential learning into the training.
- Hire central management staff who have the personality, abilities, and skills to serve as trainers to staff of the provider agencies.
- Keep the training fun and simple.

- Provide ongoing training opportunities through various media, such as newsletters, Web-alerts, and fact sheets.
- Use lay person's terms during the training presentations and make sure that the training materials and user guides are clear and easy to understand.

The ATR grantees report that there is an advantage to providing training in different settings. Several ATR sites provided both onsite learning labs, as well as traveling training programs. In the traveling mode, trainers go to the providers for on-site training. New providers, especially those with limited experience with IT, will likely require more training and support to become fully capable in utilizing the VMS.

“When we started, we created the big typical IT manual. We used up reams and reams of paper, and everybody hated it. What people liked were brief fact sheets.”—  
Staff at an ATR site

The grantees recommended staffing the help desk with staff from the program rather than from the IT area. By keeping careful track of help desk requests, program staff can then use these requests to help develop the training curriculum and ongoing training communications. Several ATR sites pointed out that having providers fill out a TA form led to a much more efficient and productive help desk process. Completing an assistance request form sometimes helped providers diagnose the nature of the problem they were experiencing.

## **Maintenance and Performance Management**

The amount of ongoing VMS maintenance that is required could take some new programs by surprise. VMS maintenance can be broken into two categories: (1) break/fix, which includes programming necessary to maintain current functionality, and (2) enhancement, which includes programming that will improve current functionality. Both will require a substantial commitment of program and IT staff, as well as financial resources.

The requirements imposed on the VMS from other systems will change. Technology will change. Maintenance requires an ongoing, systemic effort on the part of the organization. VMS costs are not always separable from other system operation and maintenance costs, so estimates of actual costs vary widely. Informal estimates provided by grantees ranged from the low range of \$5,000-\$6,000 to \$40,000-50,000 at the high end for monthly costs for maintenance and support.

Once systems are in place, ATR staffs will be freed to pay attention to ongoing system improvement and system maintenance issues. Some staff at the various sites used their available data in developing and monitoring a series of quality improvement (QI) and management reports, including:

- GPRA submissions
- Reports on potential fraud, abuse, and waste
- Client outcome reports

### ***GPRA Submissions***

Most grantees said that GPRA reporting requirements created a substantial challenge for their organizations in the early days of the program. GPRA requires a first assessment interview to be completed and reported 30 days after the initial assessment. Subsequent assessments must be reported every 60 days until discharge. Records are considered to be delinquent if they are conducted more than 14 days after the expected date.

Providers had difficulties in meeting these deadlines. To assist providers, ATR staffs found it necessary to create reports that would closely track these assessments. The reports give providers feedback about compliance with the various due dates for GPRA assessment. TA is available through SAMHSA to assist grantees with GPRA training.

### ***Reports on Potential Fraud, Abuse, and Waste***

Some grantees created reports that show the patterns of use exhibited by their provider organizations. These reports allow the ATR grantees to flag an organization for a special audit when they see an organization that is experiencing growth or other expenditure patterns exceeding the norms exhibited by other providers.

### ***Client Outcome Reports***

Several grantees were in the process of developing provider reports on client outcomes, using the National Outcome Measures (NOMs), as well as other measures germane to the specific State system data collections. For example, several of the States collected and analyzed Addiction Severity Index (ASI) scores. Some of the sites analyzed data showing client outcomes (such as NOMS, treatment completion, ASI scores) by types of clients (such as clients with primary drug of methamphetamine or alcohol or clients with criminal justice histories). At least one State published provider report cards on its Web site, so they were easily available to clients seeking services.

## Appendix A. ATR 2004 Grantees

2004 Grantee	Web site
<b>California</b> California Access to Recovery Effort (CARE)	<a href="http://www.californiacares4youth.com">http://www.californiacares4youth.com</a>
<b>California</b> California Rural Indian Health Board (CRIHB): California American Indian Recovery (CAIR) Program	<a href="http://www.crihb.org">http://www.crihb.org</a>
<b>Connecticut</b>	<a href="http://www.saintfranciscare.com/110418.cfm">http://www.saintfranciscare.com/110418.cfm</a>
<b>Florida</b> MyFlorida ATR	<a href="http://www.dcf.state.fl.us/mentalhealth/sa/atr.shtml">http://www.dcf.state.fl.us/mentalhealth/sa/atr.shtml</a>
<b>Idaho</b>	<a href="http://www.accesstorecovery.idaho.gov">http://www.accesstorecovery.idaho.gov</a>
<b>Illinois</b> Pathways to Re-Entry and Recovery	<a href="http://www.dhs.state.il.us">http://www.dhs.state.il.us</a>
<b>Louisiana</b>	<a href="http://www.dhh.louisiana.gov/offices/?ID=154">http://www.dhh.louisiana.gov/offices/?ID=154</a>
<b>Missouri</b>	<a href="http://www.dmh.missouri.gov/ada/ATR/ATRgrant.htm">http://www.dmh.missouri.gov/ada/ATR/ATRgrant.htm</a>
<b>New Jersey:</b> New Jersey Access Initiative (NJAI)	<a href="http://www.nj.gov/humanservices/das/QualityTrtmnt.htm">http://www.nj.gov/humanservices/das/QualityTrtmnt.htm</a>
<b>New Mexico</b> Access to Recovery New Mexico (ATRNM)	<a href="http://www.atrnm.com">http://www.atrnm.com</a>
<b>Tennessee</b> Tennessee Access to Recovery (TN-ATR)	<a href="http://www.state.tn.us/mental//A&amp;D/ATR/index.htm">http://www.state.tn.us/mental//A&amp;D/ATR/index.htm</a>
<b>Texas</b>	<a href="http://www.dshs.state.tx.us/sa/atr.shtm">http://www.dshs.state.tx.us/sa/atr.shtm</a>
<b>Washington</b>	<a href="http://accesstorecovery.adhl.org">http://accesstorecovery.adhl.org</a>
<b>Wisconsin</b> Wisconsin Supports Everyone's Recovery Choice (Wiser Choice)	<a href="http://www.county.milwaukee.gov/AccessToRecovery9887.htm">http://www.county.milwaukee.gov/AccessToRecovery9887.htm</a>
<b>Wyoming</b> Wyoming Access to Recovery (WATR)	<a href="http://wdh.state.wy.us/mhsa/treatment/atr.html">http://wdh.state.wy.us/mhsa/treatment/atr.html</a>

## Appendix B. Models for ATR Voucher Management System

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
<b>MODEL ONE—ADAPT PUBLIC DOMAIN SOFTWARE</b>								
<b>1. WITS</b>								
Illinois— Department of Human Services, Division of Alcoholism and Substance Abuse (DASA)	ISTARS-Lite (Illinois Service Tracking for Addiction and Recovery Services) data management system was developed through modifications to the WITS (Web Infrastructure for Treatment Services) system. It is used only for the ATR program.	The ISTARS program is not yet fully operational and uses a combined manual and electronic VMS system. Illinois maintains a separate system for clients funded from other funding.	Adapted public domain software—WITS. Used contract with FEI, Inc. to add voucher management modules.	Stand alone	State	\$1,190,000	8 months	Limited potential for portability. Uses a combination of paper and web-based data. Includes state specific modifications.
Tennessee— Division of Alcohol and Drug Abuse Services manages TN-ATR	TN-WITS was developed by the ATR program from the basic WITS system and is used exclusively for the voucher program.	TN-WITS was new to the State. State used paper-based system for the first 8 months of implementation.	Adapted public domain software—WITS. Used contract with FEI for modifications	Stand alone	State	\$262,000	3 months once authorization was received from State	Uses WITS plus unique modules for Tennessee requirements. Portable with contract with FEI, Inc.
Wyoming— Department of Mental Health, Substance Abuse Division	Uses WITS Web-based system for ATR module only. The system was implemented at the same time service delivery began in May 2005.	The WITS system was adapted from an existing WITS-based system in Illinois.	Adapted public domain software—WITS. Used contract with FEI, Inc. for modifications	Stand alone	State	\$50,000	9 months	State indicates it would be portable.

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
<b>2. BHIPS</b>								
Texas—The Department of State Health Services (DSHS) administers the Creating Access to Recovery program.	Texas uses the Behavioral Health Integrated Provider System (BHIPS), a Web-based screening, assessment, voucher issuing, clinical record and billing system developed by DSHS prior to ATR. DSHS plans to replace BHIPS with Clinical Management Behavioral Health Services (CMBHS) system for mental health and substance abuse in December 2007.	BHIPS was upgraded with modules in June 2005, such as voucher and GPRA modules, in order to meet ATR's needs. BHIPS is used at all levels of service delivery by assessment providers, RSS providers and treatment providers, and contains all information regarding the client and available services.	Adapted existing State software—BHIPS. Work was done by DSHS staff to add modules for voucher management.	Integrated with State client data system	State	\$250,000	10 months	State indicates BHIPS is freely available but its dependency on internal contract management software impedes its portability. CMBHS is expected to be more portable.
<b>3. OTHER PUBLIC DOMAIN SOFTWARE</b>								
Connecticut—The Department of Mental Health and Addiction Services (DMHAS)	The State uses a combined paper-based and electronic system that was initiated in August 2005. Providers submit paper copies of assessments and voucher requests to the administrative services organization (ASO), which then stores the information into an electronic VMS software application and sends hard copies of vouchers to the providers.	The ASO added an ATR module to a VMS prototype created by the United Way of Connecticut.	Adapted public domain software from the United Way. Software was modified by the ASO.	Stand alone	State	\$421,500	11 MONTHS	United Way software could be adapted for use by other grantees. CT indicates they are heavily dependent on the ASO for software services.
Florida—The State Department of Children and Families (DCF) administers the	MyFlorida uses ATR KIS Express, an electronic system that was implemented in July 2005 and is managed by Knight	The ASO purchased a license for the KIS Express system, which was similar to a system being used	Purchased software license—KIS. Modified by the ASO to add a	Stand alone. Not integrated into the State client data system.	ASO	\$123,560	10 months	Grantee would have to contract with the ASO to modify the software to meet

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
MyFlorida ATR Program.	Information System, (KIS) the administrative services organization (ASO).	by the State for other treatment programs and over approximately 2 months created ATR KIS Express, which is a web-enable system, not a web-based system.	voucher management module.					State's needs.
<b>MODEL TWO—DEVELOP NEW, ORIGINAL PROGRAMMING</b>								
<b>1. STAND ALONE SYSTEMS</b>								
California—Department of Alcohol and Drug Programs receives Federal grant funds for the California Access to Recovery Effort (CARE) program.	The VMS was created and is maintained by MAXIMUS as a joint effort with another ATR grantee, California Rural Indian Health Board (CRIHB). The system, which was implemented in July 2005, issues and monitors vouchers, tracks service use and associated costs, collects provider outcome and financial data, and reviews and authorizes payment to providers to the State Controller's Office for payment.	The grantee did not have an electronic VMS in place prior to ATR. The CARE and CRIHB ATR programs combined their administrative funds to contract with MAXIMUS (serving as an administrative services officer) to develop an ATR-specific system. For a short time, the grantee was using a manual system to begin to accept clients before the MAXIMUS system was operational.	MAXIMUS developed new software program. Product is owned by MAXIMUS.	Stand alone. Not integrated into State client data system.	ASO	\$1,051,951	10 months	Software is owned by MAXIMUS. Other grantees would have to contract with MAXIMUS to use the software.
California—Rural Indian Health Board (CRIHB) receives federal funding for the California American Indian Recovery (CAIR)	The VMS was created and is maintained by MAXIMUS as a joint effort with another ATR grantee, the State of California. The system is a web-based client enrollment, voucher, data	There was no electronic VMS in place prior to ATR. The CARE and CRIHB ATR programs combined their administrative funds to contract	Developed new program	Stand alone	ASO	\$963,500	July 2005	Software is owned by MAXIMUS. Other grantees would have to contract with MAXIMUS to use the software.

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
ATR program.	collection, and billing system that can also function manually.	with MAXIMUS (serving as an administrative services officer) to develop an ATR-specific system.						
<b>2. ADDITION TO EXISTING STATE SYSTEMS</b>								
Idaho—The Department of Health and Welfare (DHW) administers the Access to Recovery—Idaho (ATR-I) program	ATR-I's ASO, Behavior Psychology Associates (BPA) enhanced its prior system to manage issuance, redemption and payments for ATR-I vouchers. The data is then transmitted and loaded into the State's in-house data warehouse which was enhanced to store ATR-I client and voucher data for reporting to CSAT. .	The ASO was a pre-existing contractor with the DHW at the time of the ATR grant award. Client tracking and payment systems existing at that time were enhanced to meet the new needs of the ATR-I program. The system is not web-based.	Enhanced existing State software. Work was done by the ASO.	Integrated with State client data system	ASO	Unknown	8 months	Portability is doubtful. ASO could contract to provide similar services for other grantees.
Louisiana—Office for Addictive Disorders, Department of Health and Hospitals administers the LA-ATR program	Louisiana Addictive Disorders Data System (LADDS) is a web-based application developed by the State to manage alcohol and drug client data. LADDS existed prior to ATR but without the voucher modules. At the time of the ATR award, LA had LADDS configured into a standalone client-level data system. Within 7 months the system was operational for ATR	Initially an Access-based back-up system was used until the web-based system was completed.	Developed new software and then added voucher management modules. Developed by University of Louisiana at Lafayette Center for Business Information and Technology	Integrated with State client data system	State	\$1,250,000	5 months	State indicates it may be portable.
Missouri—Missouri Division of Alcohol and Drug Abuse	Consumer Information Management Outcomes Reporting (CIMOR)— A Web-based replacement	A bridge system was initially developed and implemented for the Web-based	Developed new State software. An ATR module was added by the	Integrated with State client data system	State	\$241,567	System was ready when program began admitting clients.	Is not portable, but State could consider serving as a host for other

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
	data system for substance abuse, mental health and developmental disabilities agencies was implemented in early October, 2006. An add-on module was developed specifically for ATR.	Infrastructure for Treatment Services (WITS) until the CIMOR system was operational.	contractor assisted by State staff.					grantees.
New Jersey— Division of Addiction Services in the Department of Human Services (DHS), operates the New Jersey Access Initiative (NJAI) program	An add-on module was developed for the existing New Jersey Substance Abuse Monitoring System (NJ-SAMS), a web-based, real-time system. Staff at DHS developed both the NJ-SAMS system and the ATR module.	The NJ-SAMS data system existed prior to implementation of the ATR program. The module to accommodate the NJAI management needs was in place early in the ATR program implementation.	Enhanced existing State software. Added ATR module with work done by State staff. Uses QuickBooks for provider payments.	Integrated with State client data system	State			Could possibly be portable. Is public domain.
Washington— Division of Alcohol and Substance Abuse (DASA) in the Department of Social and Health Services (DSHS)	Treatment and Assessment Reports Generation Tool (TARGET) is the Web-based VMS system used in Washington. The TARGET system is integrated into the DASA Substance Abuse Management Information System (SAMIS), the state MIS system.	The State added the following modules to TARGET: financial tracking tool, voucher and authorization module, ATR financial reporting and ATR client service reporting modules (services and dollar amounts authorized, utilized/spent, remaining), and a GPRA data entry module. The ATR modules, however, are add-ons to the TARGET system which became operational in June	Enhanced existing State software— Work was done by State staff	Integrated with State client data system	State	\$94,500	10 months	State indicates system would not be portable since it contains many State-specific business rules.

Grantee/ Program Name	Voucher Management System	Development Approach	Process	Relation To State Client Data System	Manager	Cost Estimate	Estimated Months to Implementation	Possible Portability
		2005. Continuing upgrades were made in 2005-2006.						
Wisconsin— Department of Social and Health Services operates the Wiser Choice program.	An enhancement was completed to the pre-existing CMHC-MIS system owned by Milwaukee County.	The CMHC-MIS tracking and monitoring system (original voucher software) was undergoing modifications at the time of the ATR grant award. Software is not web-based. Includes both electronic and paper components.	Enhanced existing County software – CMHC. Work done by external contractor.	Integrated with State client data system	ASO	\$184,681	Is implemented but revisions continue.	Not portable
<b>3. PROPRIETARY SOFTWARE</b>								
New Mexico— Department of Health, Behavioral Health Services Division (BHSD)	ValueOptions manages the ATR program in coordination with the BHSD.	The ATR module was developed by ValueOptions as an add-on to the existing ValueOptions proprietary software.	Intermediary uses proprietary software to which the voucher management module was added.	Integrated with software used for ValueOptions client data collection.	ASO	NA	NA	Not portable. BHSD owns the voucher management module, but this module is part of the ValueOptions proprietary software system.