

Regional Utilization Management Guidance

Introduction

The System Operations Team developed and on January 10, 2007, the System Leadership Council adopted this Regional Utilization Management Guidance to support the achievement of the vision, articulated in State Board Policy 1036, of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships and to respond to the following recommendations in the report of the Inspector General: *Study of CSB Emergency Services Programs*.

Access Recommendation 1.d states:

It is recommended that DMHMRSAS develop consistent expectations for all state hospitals regarding

- a. Admission of consumers when acute beds are not available in local community hospitals*
- b. Admissions procedures during weekday, evening and weekend hours.*

Access Recommendation 3.b states:

It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not and when it is appropriate for an individual with either of these conditions to be admitted to a state mental hospital.

Guidance Development

The System Leadership Council referred these recommendations to the System Operations Team for action. The Team met with representatives from Health Planning Region (HPR) IV (Central Virginia), Southwestern Virginia Training Center, and the Department's Central Office staff to discuss current practices and issues related to admission and utilization management at state hospitals and training centers, hereinafter referred to as state facilities, and the disposition of consumers with mental retardation and co-occurring mental illnesses or behavioral challenges.

A consensus emerged among Team members that admission protocols for state facilities are linked directly to regional capacities for providing alternative community services for all populations. Several of the seven partnership regions coordinate these activities through census management or utilization management teams composed of staff from community services boards or behavioral health authorities, hereinafter referred to as CSBs, and state facilities. In some instances, local private hospital psychiatric inpatient providers or other public or private providers may be on teams. The Department supports development of these teams in all seven regions. The System Operations Team decided to incorporate the expertise and experience of these teams in this guidance by asking the regions to identify the factors that were instrumental to the success of their teams. These factors are included in this guidance as Appendix 1.

Regional Utilization Management Guidance

In this guidance, a region means the CSBs and state facilities in one of the seven partnership regions. Depending on the context or on particular local or regional circumstances, a region may also include private providers, consumers, family members, or other stakeholders. Given their statutory roles and applicable State Board policies, CSBs and state facilities are ultimately responsible for regional utilization management processes or activities. However, consumers, families, and private providers should be involved in regional utilization management processes or activities whenever appropriate and to the greatest extent possible.

The Team convened a small writing group that developed this response to the Inspector General's recommendations. The following individuals from CSBs, state facilities, and the Department's Central Office served on this group.

Jack Barber, M.D., Director, Western State Hospital (Region 1)
Ruth Ann Bates, Director of Social Work, Central State Hospital (Region 4)
Rosemarie Bonacum, Director of Facility Operations (Central Office)
Derek Burton, Regional Planning Partnership Coordinator (Region 3)
Rebecca Cody, (Region 7)
Jerry Deans, Assistant Commissioner, Facility Management (Central Office)
John Dool, Regional Planning Partnership Director (Region 5)
Kaye Farr, Director of Emergency Services, Fairfax-Falls Church CSB (Region 2)
Paul Gilding, Director of Community Contracting (Central Office)
Ellen Harrison, Regional Planning Partnership Coordinator (Region 1)
John Lindstrom, Clinical Services Director, Richmond BHA (Region 4)
Walton (Mitch) Mitchell, Assistant Director Administration, Catawba Hospital
Lee Price, Director of Mental Retardation Services (Central Office)
Rita Romano, Director of Emergency Services, Prince William County CSB (Region 2)

The group initially focused on regional state facility census management. However, as the group continued to develop this guidance, it became clear that a broader focus would be more helpful. Consequently, this guidance addresses regional utilization management more broadly.

The writing group identified five State Board policies that affect regional utilization management:

STATE BOARD POLICY 1015 *Services for Individuals with Co-Occurring Disorders*,
STATE BOARD POLICY 1035 *Single Point of Entry and Case Management Services*,
STATE BOARD POLICY 1036 *Vision Statement*,
STATE BOARD POLICY 1038 *The Safety Net of Public Services*, and
STATE BOARD POLICY 1041 *Services for Individuals with Mental Illnesses, Mental Retardation, or Substance Use Disorders Who Are or Are at Imminent Risk of Becoming Involved with the Criminal Justice System*.

Copies of these policies are attached to this document as Appendix 2.

Regional Utilization Management Guidance

This guidance includes a vision of regional utilization management, a definition of success for regional utilization management, and tools of leadership for attaining successful regional utilization management. The questions in this guidance are intended to stimulate dialogue and build consensus within regions and between regions and the Department.

01-10-2007

Regional Utilization Management Guidance

It is important to note that implementing the actions in this guidance is the first step in an iterative process through which each region ultimately will produce a set of utilization management processes that reflect the vision in State Board Policy 1036, respond to the cited recommendations in the Inspector General's study, and accommodate the particular circumstances of that region while producing a reasonable and functional degree of consistency across all seven regions. Since this effort is in its infancy, identifying or requiring specific accountability measures at this point would be premature. As this effort evolves, it will be important to establish meaningful and workable measures to assess the success of regional utilization management processes in each region.

In the development of any regional utilization management guidelines or processes, it will be important and useful to distinguish between systemic utilization management, that is how state facilities and CSBs, and private providers and other stakeholders where applicable, act and interact, and individual clinically-oriented utilization management. Systemic utilization management is the subject of this guidance and any subsequent guidelines and processes.

It is also important to emphasize that additional resources will be required at CSBs, the regions, and the Department to fully implement effective regional utilization management processes. Now, many CSBs and the Department are diverting existing staff resources, already stretched thin, from other important activities to support existing utilization management activities. CSBs and the Department are shifting those resources because of the value and importance of those utilization management activities. However, without significant additional staff resources at individual CSBs, the regions, and the Department, the promise and potential positive effects of regional utilization management will not be realized.

Finally, there are admissions to state facilities that CSBs have no control over, such as transfers of forensic patients to civil status in state hospitals, jail transfers, and inter-facility transfers. These admissions are beyond current regional utilization management activities. However, as part of the ultimate development of regional utilization management processes in each partnership region, the Department, CSBs, and state facilities need to identify mechanisms through which these admissions can be included in those processes.

Vision of Regional Utilization Management

Regional utilization management is an essential part of our public mental health, mental retardation, and substance abuse services system because it:

1. provides access to critical inpatient services,
2. manages the census of state hospital and training center beds,
3. focuses on addressing the particular needs of each consumer in the most appropriate manner clinically, rather than focusing only on locating available state or community inpatient facility beds, and
4. balances the demands of and tensions among these activities in a way that promotes and enhances choices for consumers among service alternatives that most effectively meet their needs, as determined by consumers and their service providers.

Regional Utilization Management Guidance

CSBs, state facilities, and the Department, the partners in this public services system, achieve and maintain this balance through a shared ownership, awareness, recognition, and capacity to address day-to-day problems and issues, planning for and anticipating and solving problems and issues.

While it might be desirable for regions to manage the utilization of all public resources in order to exercise prudent stewardship of those resources, CSBs and state facilities possess limited capacities to achieve this goal. Therefore, regional utilization management processes or activities need to focus on resources associated with the following funded initiatives or activities:

1. Discharge Assistance Projects (DAP), including Regional Discharge Assistance Projects and Civil and NGRI Discharge Assistance Projects,
2. Local Psychiatric Inpatient Purchases of Services (LIPOS) and other CSB purchases of local inpatient psychiatric services,
3. State hospital and training center bed utilization, and
4. Crisis stabilization programs, including System Transformation Initiative crisis stabilization programs.

Finally, regional utilization management processes or activities should reflect the values and other relevant provisions in the Central Office, State Facility, and Community Services Board Partnership Agreement. Relevant parts of the agreement are attached to this document as Appendix 3.

Definition of Success for Regional Utilization Management

Regional utilization management is successful when the following conditions exist:

1. Inpatient psychiatric hospital beds are available within a reasonable time for individuals in crisis who cannot be diverted to less intensively structured alternatives, such as crisis intervention or stabilization services, and who need these beds; or
2. Intermediate care facility (ICF/MR) beds are available in training centers or the community within a reasonable time for individuals who need this service setting and choose it instead of less intensively structured or specialized alternatives, such as MR waiver services, and emergency or respite admissions are available at training centers for individuals in crisis who need them; and
3. State hospitals and training centers do not exceed their operational bed capacities (census); and
4. Consumers no longer in need of acute care services do not remain in those settings; and
5. A broad awareness exists among all system stakeholders (CSBs, state facilities, consumers, family members, private providers, advocacy groups, other local human services agencies, and criminal justice agencies) of how the first three conditions will be achieved and maintained; and
6. Forums exist regionally to deal with problems and issues, anticipate needs or problems, plan for and develop initiatives to address these needs or problems, and engage about conflicts and attempt to resolve them.

Regional Utilization Management Guidance

Questions to Answer for Attaining Successful Regional Utilization Management

The System Operations Team developed the following questions as a resource for each region to use in establishing and assessing its regional utilization management processes or activities. A region needs to discuss and agree upon workable answers to the following questions, and perhaps others, in order to be successful in its regional utilization management activities. For purposes of these questions, a region means the CSBs in one of the seven partnership regions and the state facilities that serve them. Depending on the context of the question, a region may also include private providers, consumers, family members, or other stakeholders. These questions are intended to stimulate dialogue to build consensus and address concerns among the stakeholders in the region.

1. What actions does the region take when a consumer needs an inpatient psychiatric bed, no private inpatient bed is available, and the state hospital is at capacity?
2. Similarly, what actions does the region take when a consumer needs a training center bed, no community ICF/MR bed or MR Waiver slot is available, and the training center is at capacity?
3. Has the region established a time limit on how long consumers who need beds can wait in local hospital emergency departments, and, if so, what is that time limit?
4. How does the region handle admissions to state hospitals or training centers after regular working hours or on weekends?
5. What are the region's criteria and processes for admission to state hospitals and to training centers, and what are the region's processes for resolving disputes about these admissions? What roles and responsibilities has the region identified for the Department in addressing these issues?
6. How does the region connect admissions to and discharges from (front and back doors) its state hospital and its training center in its regional utilization management processes or activities?
7. How does the region manage and coordinate state facility and community services for the following populations: individuals with co-occurring mental illnesses and mental retardation, mental retardation with serious behavioral crises, co-occurring mental illnesses and substance use disorders, and substance use disorders, in accordance with State Board Policy 1015 *Services for Individuals with Co-Occurring Disorders*?
8. How does the region ensure that its regional utilization management teams have the ability and capacity to address the unique circumstances and specialized needs of other specialized populations, including older adults and consumers with a forensic status?
9. What roles and responsibilities have the state facilities and CSBs identified and agreed upon for the state facilities in the region and how do they support fulfillment of those roles and responsibilities?
10. How does the region discuss and attempt to resolve utilization management conflicts or raise problems to the region's leadership? What are the Department's roles and responsibilities in these areas?

Regional Utilization Management Guidance

11. How does the region use its regional utilization management processes or activities to ensure that consumers are served in the least intrusive and most appropriate settings and as close to their homes as possible, for instance, so that consumers are admitted to local psychiatric inpatient beds or crisis stabilization beds before they are admitted to state hospital beds, unless compelling clinical needs or circumstances or the unavailability of these community alternatives warrant direct admission to state hospital beds? Also, how does the region use its regional utilization management processes or activities to ensure that consumers who no longer need acute care services do not remain in those settings?
12. How do the region's utilization management processes or activities facilitate and expedite discharges of consumers in state hospitals who were adjudicated and admitted as not guilty by reason of insanity as soon as their discharges are clinically appropriate and legally possible?
13. When and how does the region involve the private sector, especially local hospital emergency departments and psychiatric units and private providers of community mental retardation services, in its regional utilization management processes or activities?
14. When and how does the region involve consumers, family members, law enforcement, and the criminal justice system in its regional utilization management processes or activities?
15. How does the region address inter-regional utilization management issues, such as admissions to state hospitals or local psychiatric inpatient programs, crisis stabilization programs, or training centers from outside the region, with other regions? What are the dynamics of the movement of consumers into and out of the region? How easily are representatives from other affected regions able to participate with the region in discussions about these issues? What roles and responsibilities has the region identified for the Department in addressing these issues?
16. How does the region communicate and implement its regional utilization management processes or activities to and with all stakeholders in the region?
17. How do the region's utilization management processes or activities support the principle of public management of public resources for effective and responsible stewardship of scarce public funds and the achievement consumer-focused public policy goals? This principle is embodied in the single point of entry role of CSBs and their provision of case management services, articulated in STATE BOARD POLICY 1035 *Single Point of Entry and Case Management Services*.
18. How do the region's utilization management processes and activities support the realization of the vision in State Board Policy 1036; promote and enhance choices for consumers among service alternatives that most effectively meet their needs, as determined by consumers and their service providers; and focus on addressing the particular needs of each consumer in the most appropriate manner clinically, rather than focusing only on locating available state or community inpatient facility beds?
19. How do the region's utilization management processes or activities comply with data reporting and other requirements in the current Community Services Performance Contract, and how are they consistent with the regional program model(s) in Exhibit J of the contract selected by the region? Exhibit J is attached to this document as Appendix 4.

Regional Utilization Management Guidance

20. How does the region measure, monitor, evaluate, and manage the success of its regional utilization management processes or activities, as defined by the first three conditions in the Definition of Success on page 4, including the effects of those processes or activities on private providers in the region?

The partnership regions identified the Regional Utilization Management Success Factors, included in this document at Appendix 1. These factors may be a useful resource in the development of regional utilization management processes or activities.

Next Steps and Follow Up Actions

Regional utilization management requires leadership and guidance, at the state level and regionally. The Department developed this guidance in a collaborative process with its partners, but regional utilization management needs to be driven and owned at the local and regional levels to be effective. This Regional Utilization Management Guidance identifies a series of next steps for CSBs, state facilities, partnership regions, and the Department to take as they engage in the iterative process of developing regional utilization management guidelines and processes that will reflect the vision of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships and will respond to the recommendations in the Inspector General's study. However, developing and implementing regional utilization management guidelines and processes should not cause regions to defer addressing pressing current operational issues.

1. Each region needs to take these follow up actions:
 - a. review this guidance,
 - b. identify and engage the internal and external stakeholders needed to answer the questions above,
 - c. develop a regional utilization management process to reflect those answers, and
 - d. maximize awareness of that process among stakeholders in the region.
2. Within about three months of the System Leadership Council's adoption of this guidance, each region should present a report to the Department and the Council for their consideration and possible action that describes immediate barriers experienced by the region to successful implementation of its regional utilization management processes and activities. This report will identify or recommend local, regional, or state level responses or solutions to these immediate barriers whenever possible and appropriate.
3. During those three months, Central Office representatives from the System Operations Team will meet with each region to discuss this guidance, review the region's answers to the questions above, discuss any immediate barriers that may have been identified for subsequent inclusion in the report to the Department and the Council described in the preceding next step, and examine and provide feedback about the region's utilization management process.
4. The Department, the seven partnership regions, and the Virginia Association of Community Services Boards (VACSB), with assistance from the VACSB Data Management Committee,

Regional Utilization Management Guidance

need to identify the data and outcomes that they want to monitor routinely to evaluate the effectiveness of and provide constructive feedback to the regions about their regional utilization management processes and activities.

5. Finally, each region should present an interim status report 12 months after this guidance is adopted and a final report 12 months after that interim report to the Department and the System Leadership Council. The reports will discuss the region's activities to implement regional utilization management, describe the region's successes, and identify the remaining barriers preventing full implementation of its regional utilization processes. The more critical questions in the Questions to Answer section of this document and a region's proposed responses should be prioritized for earlier action. Subsequently, Central Office representatives on the System Operations Team will meet with particular regions as needed to follow up on issues raised by these status reports. Also, the Department, CSBs, state facilities, and partnership regions should use information from these reports to refine any Regional Utilization Management Guidelines or expectations that they subsequently develop.

Conclusion

The System Operations Team and the System Leadership Council offer this Regional Utilization Management Guidance to CSBs and state facilities in each region for their consideration and use. This guidance offers an aspirational framework for CSBs, state facilities, and the Department to move forward together in their efforts to achieve the vision, articulated in STATE BOARD POLICY 1036, address the Inspector General's recommendations, improve the system's stewardship of scarce public resources, and enhance the effectiveness of the state and local public mental health, mental retardation, and substance abuse services system in Virginia.

Regional Utilization Management Guidance

Appendices

1. Regional Utilization Management Success Factors

2. State Board Policies

STATE BOARD POLICY 1015 *Services for Individuals with Co-Occurring Disorders*

STATE BOARD POLICY 1035 *Single Point of Entry and Case Management Services*

STATE BOARD POLICY 1036 *Vision Statement*

STATE BOARD POLICY 1038 *The Safety Net of Public Services*

STATE BOARD POLICY 1041 *Services for Individuals with Mental Illnesses, Mental Retardation, or Substance Use Disorders Who Are or Are at Imminent Risk of Becoming Involved with the Criminal Justice System*

3. Central Office, State Facility, and Community Services Board Partnership Agreement Extracts

4. Community Services Performance Contract Exhibit J

Regional Utilization Management Guidance

Appendix 1: Regional Utilization Management Success Factors

The following Regional Utilization Management Success Factors are appended to the Regional Utilization Management Guidance as a resource for the seven partnership regions in their efforts to adapt and implement this guidance. The success factors reflect the experience of various regions in their efforts to manage various aspects of their utilization of state hospital or training center beds.

General Regional Utilization Management Success Factors

The System Operations Team asked the seven regional partnerships to identify factors that have been instrumental in the success of their regional utilization management activities, and SOT members also discussed success factors. These factors are listed below and are applicable to consumers needing mental health or mental retardation services or both.

- State facility and CSB leadership within a region is committed to the regional utilization management process but delegates day-to-day operational decision making to the clinical staff who implement regional utilization management.
- State facilities and CSBs communicate openly and regularly within their regions.
- Empowered teams, including private hospitals and other providers, are in place and meet regularly to address utilization management within the region.
- Dollars or other resources are available to enhance service delivery and consultative services in the community, like the Regional Community Support Center model. These resources support dental services, neurological evaluations, and psychiatric services for consumers with mental illnesses, mental retardation, or co-occurring mental illnesses and mental retardation.
- Regional utilization management teams deal with every consumer needing safety net services, regardless of his or her diagnosis.
- Training centers serve as sites for short-term or respite admissions; however, trust needs to be built in the region and protocols need to exist to ensure that short-term or respite admissions are short term.
- All participants in regional utilization management committees take ownership and responsibility for admission, discharge, and placement decisions, exercising control of the front and back doors of state facilities and local inpatient programs.
- Regional utilization management committees manage the use of Local Inpatient Purchase of Services (LIPOS) funds.
- Regional utilization management committees develop, communicate, and implement consistent criteria for admissions to state facilities.
- Regions adopt formal memoranda of agreement that govern utilization management activities. Where appropriate, local private hospitals or inpatient psychiatric units are parties to these agreements.
- CSBs and state facilities and, where applicable, private providers make decisions together through regional utilization management processes regarding admitting, serving, and discharging difficult-to-serve consumers with co-occurring mental illnesses and mental retardation.

Regional Utilization Management Guidance

- Regional utilization management committees exhibit a shared commitment to utilization management and a willingness to accept out-of-the-ordinary solutions that respond to the unique needs of consumers.
- A cap on the census of each state facility serving a region is established and implemented through regional utilization management processes. These processes include a mechanism to be followed when it is necessary to exceed the cap and actions to be taken to return utilization to the capped level as soon as possible.
- Procedures are in place to override the state facility attending physician's disapproval of the discharge of a consumer when the state facility director and medical director disagree with the attending physician's decision.

Regional Utilization Management Success Factors for Consumers with Dual Diagnoses or Co-Occurring Disabilities

The MR/MI Council in Southwest Virginia identified these factors as responsible for the success of the Pathways program, which serves consumers with dual diagnoses of mental illness and mental retardation. The Council consists of representatives of each CSB in the region, Southwestern Virginia Training Center, and Southwestern Virginia Mental Health Institute. The Council makes admission and discharge decisions for the Pathways program and reports to the Southwest Virginia Behavioral Health Board on operational issues and outcomes. The Council controls the resources dedicated to the program, including Medicaid mental retardation waiver slots, program beds, and outreach capability.

- Regional CSB and state facility leadership and the MR/MI Council believe in this process and are committed to making it work.
- Contingency plans are developed for consumers who are determined to be at risk and in need of the Pathway program's services.
- Regular operational communication between the Pathways program and the MR/MI Council provides early warning on possible admissions to the program.
- Pathways program staff function in a consultative capacity for CSBs and private providers in the region.
- Most MR/MI Council members are generalists representing mental health and mental retardation services.
- The Pathways program maintains an open back door to expedite the return of consumers who need to quickly access program services.
- When a consumer is admitted to the program, a placement agreement is executed that will be implemented when the consumer has completed the program, and MR waiver slots are held or distributed from those allotted to enable the consumer's discharge.
- Pathways staff follows up on all consumers who were served in the program to ensure that their discharge plans are meeting their needs and to determine the need for consultation or the consumer's readmission to the program.
- Providers are trained about the discharge plans before consumers are discharged from the Pathways program.

Regional Utilization Management Guidance

- The Southwestern Virginia Mental Health Institute provides access for emergency admission contingencies and other needed services that are not available at the Pathways program.

Other respondents identified additional factors needed to ensure the success of regional efforts to serve consumers with dual diagnoses or co-occurring disorders.

- All regional resources should be made available and used proactively to serve these consumers, and the region should establish protocols for their use.
- Out-of-region referrals should be worked out between the affected regions, with Central Office involvement being a last resort.
- The regional utilization management (RUM) committee should identify those individuals who are known to the services system as being at the highest risk for needing specialized care and should develop expertise and resources within the region in planning services for these consumers.
- The RUM committee should establish an outreach team to work proactively, reviewing plans, solving problems in current placements with staff, and establishing contingency service plans for more restrictive or alternative placements as needed.
- The RUM committee should make recommendations to the leadership of the CSBs and state facilities about filling the gaps in the regional array of services for these consumers.
- The RUM committee should act to broker services in the region needed by and in the best possible locations for these consumers. The committee should monitor the flow of consumers through services to ensure that no particular service provider is overwhelmed beyond its capacity to care for these consumers.

Regional Utilization Management Guidance

Appendix 2: State Board Policies

Several State Board policies cited in or applicable to this guidance are summarized below and copies of these and other applicable policies are attached at the end of this appendix.

STATE BOARD POLICY 1035 describes the role of CSBs as the single points of entry into publicly funded mental health, mental retardation, and substance abuse services and related CSB case management responsibilities, reflecting the status of CSBs as the only approved providers of Medicaid mental health and mental retardation targeted case management services.

STATE BOARD POLICY 1036 articulates the vision of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership.

STATE BOARD POLICY 1038 states that the Department and CSBs, as partners in the public mental health, mental retardation, and substance abuse services system, are jointly responsible for assuring to the greatest extent practicable the provision of a safety net of appropriate public services and supports in safe and suitable settings for individuals with serious mental illnesses, mental retardation, substance use disorders, or co-occurring disorders who:

- are in crisis or have severe or complex conditions;
- cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and
- are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.

The policy defines the safety net of public services as:

- local emergency services provided by each CSB,
- in-home assistance and support or out-of-home respite care provided by each CSB or through regional arrangements with other CSBs,
- non-hospital based crisis stabilization or detoxification services provided by each CSB or through regional arrangements with other CSBs,
- acute stabilization in local hospital psychiatric or substance abuse inpatient services or substance abuse inpatient medical detoxification services provided by each CSB or through regional arrangements with other CSBs, and
- specialty services provided by the Department through its state facilities on a regional or statewide basis.

The policy also states that CSBs shall manage and review access to and utilization of public safety net services. Where they share and use the most intensive and costly public safety net services, such as inpatient and residential crisis stabilization services, on a regional or subregional basis, CSBs shall manage and review access to and utilization of these services, working in partnership with each other. This will assure those services are provided in the most integrated and least intrusive setting for the individual and ensure scarce public safety net resources are used as effectively and efficiently as possible. Supporting and implementing the safety net of public services is one of the purposes of regional utilization management processes.

Regional Utilization Management Guidance

Appendix 3: Central Office, State Facility, and Community Services Board Partnership Agreement Extracts

Section 1: Purpose

Collaboration through partnerships is the foundation of the Virginia public system of mental health, mental retardation, and substance abuse services. The Central Office of the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Central Office), State Hospitals and Training Centers (State Facilities) operated by the Department, and Community Services Boards (CSBs), which are entities of local governments, are the *operational partners* in Virginia's public system for providing such services. CSBs include local government departments with policy advisory CSBs and behavioral health authorities that are established pursuant to Chapters 5 and 6 respectively of Title 37.2 of the *Code of Virginia*.

Pursuant to State Board Policy 1034, the partners enter into this Partnership Agreement to implement the vision statement articulated in State Board Policy 1036 and to improve the quality of care provided to consumers and to enhance the quality of consumers' lives. The goal of this Agreement is to establish a fully collaborative partnership process through which the CSBs, Central Office, and State Facilities can reach agreements on operational and policy matters and issues. In areas where it has specific statutory accountability, responsibility, or authority, the Central Office will make decisions or determinations with the fullest possible participation and involvement by the other partners. In all other areas, the partners will make decisions or determinations jointly. The partners also agree to make decisions and resolve problems at the level closest to the issue or situation, whenever possible. Nothing in this Partnership Agreement nullifies, abridges, or otherwise limits or affects the legal responsibilities or authorities of each partner, nor does this Agreement create any new rights or benefits on behalf of any third parties.

The partners share a common desire for the system of care to excel in the delivery and seamless continuity of services to consumers and their families, and we seek similar collaborations or opportunities for partnerships with consumer and family advocacy groups and other stakeholders. We believe that a collaborative strategic planning process helps to identify the needs of consumers and ensures effective resource allocation and operational decisions that contribute to the continuity and effectiveness of care provided across the public mental health, mental retardation, and substance abuse services system. We agree to engage in such a collaborative planning process.

The Central Office, State Facility, and CSB Partnership reflects a common purpose derived from:

1. Codified roles defined in Chapters 5 and 6 of Title 37.2 of the *Code of Virginia*, as delineated in the Community Services Performance Contract;
2. Philosophical agreement on the importance of consumer-driven services and supports and other core goals and values contained in this Partnership Agreement;
3. Operational linkages associated with funding, program planning and assessment, and joint efforts to address challenges to the public system of services; and
4. Quality improvement-focused accountability to consumers and family members, local and state governments, and the public at large, as described in the accountability section of this Partnership Agreement.

This Partnership Agreement also establishes a framework for covering other relationships that may exist among the partners. Examples of these relationships include Part C of the Individuals with Disabilities Education Act and regional initiatives, such as the Region IV Acute Care Pilot Project, the Discharge Assistance and Diversion program in northern Virginia, reinvestment and restructuring projects, the initiative to promote integrated services for individuals with co-occurring mental illnesses and substance use disorders, and the system transformation initiative. For

Regional Utilization Management Guidance

example, the provisions of this agreement would describe interactions between the Central Office and those CSBs that participate in Part C.

Section 2: Roles and Responsibilities

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, mental retardation, and substance abuse services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

Central Office

1. Ensures through distribution of available funding that a consumer-driven and community-based system of care, supported by community and state facility resources, exists for the delivery of publicly funded services and supports to individuals with mental illnesses, mental retardation, or substance use disorders.
2. Promotes at all locations of the public mental health, mental retardation, and substance abuse service delivery system (including the Central Office) quality improvement efforts that focus on consumer outcome and provider performance measures designed to enhance service quality, accessibility, and availability and provides assistance to the greatest extent practicable with Department-initiated surveys and data requests.
3. Supports and encourages the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
4. Ensures fiscal accountability that is required in applicable provisions of the *Code of Virginia*, relevant state and federal regulations, and State Mental Health, Mental Retardation and Substance Abuse Services Board policies.
5. Promotes identification of state-of-the-art, best or promising practice, or evidence-based programming and resources that exist as models for consideration by other operational partners.
6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, the Department of Medical Assistance Services and other state agencies, and federal agencies that interact with or affect the other partners.
7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of consumers and to identify and address statewide interagency issues that affect or support an effective system of care.
8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, mental retardation, and substance abuse services.
9. Problem solves and collaborates with a CSB and State Facility together on a complex or difficult consumer situation when the CSB and State Facility have not been able to resolve the situation successfully at their level.

Community Services Boards

1. Pursuant to State Board Policy 1035, serve as the single points of entry into the publicly funded system of consumer-driven and community-based services and supports for individuals with mental illnesses, mental retardation, or substance use disorders, including individuals with co-occurring disorders in accordance with State Board Policy 1015.
2. Serve as the local points of accountability for the public mental health, mental retardation, and substance abuse service delivery system.

01-10-2007

Regional Utilization Management Guidance

3. To the fullest extent that resources allow, promote the delivery of community-based services that address the specific needs of individual consumers, particularly those with complex needs, with a focus on service quality, accessibility, integration, and availability and on consumer self-determination, empowerment, and recovery.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility and local community services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem solve and collaborate with State Facilities on complex or difficult consumer situations.
8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs of consumers.

State Facilities

1. Provide psychiatric hospitalization and other services to individuals identified by CSBs as meeting statutory requirements for admission, including the development of specific capabilities to meet the needs of individuals with co-occurring mental illnesses and substance use disorders in accordance with State Board Policy 1015.
2. Within the resources available, provide residential and training services to individuals with mental retardation identified by CSBs as needing those services.
3. To the fullest extent that resources allow, provide services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability and on consumer self-determination, empowerment, and recovery.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility and local community services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem solve and collaborate with CSBs on complex or difficult consumer situations.

Recognizing that these unique roles create distinct visions and perceptions of consumer and service needs at each point (statewide, communities, and state facilities) of services planning, management, delivery, and evaluation, the operational partners are committed to maintaining effective lines of communication generally and to addressing particular challenges or concerns. Mechanisms for communication include the System Leadership Council and its subgroups; the System Operations Team; representation on work groups, task forces, and committees; use of websites and electronic communication; consultation activities; and circulation of drafts for soliciting input from other partners. When the need for a requirement is identified, the partners agree to use a participatory process, similar to the process used by the Central Office to develop Departmental Instructions for State Facilities, to establish the requirement.

These efforts by the partners will help to ensure that individuals have access to a public, consumer-driven, community-based, and integrated system of mental health, mental retardation, and substance abuse services that maximizes available resources, adheres to the most effective, evidence-based, best, or promising service delivery practices, utilizes the extensive expertise that

Regional Utilization Management Guidance

is available within the public system of care, and encourages and supports the self-determination, empowerment, and recovery of consumers.

Section 3: Core Values

The Central Office, State Facilities, and CSBs, the partners to this Agreement, share a common desire for the public system of care to excel in the delivery and seamless continuity of services to consumers and their families. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal governments, other funding sources, consumers, and families. The partners embrace common core values that guide the Central Office, State Facilities, and CSBs in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

Vision Statement

Our core values are based on our vision, articulated in State Board Policy 1036, for the public mental health, mental retardation, and substance abuse services system. Our vision is of a consumer-driven and community-based system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership.

Core Values

1. The Central Office, State Facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
2. As partners, we will focus on fostering a culture of responsiveness instead of regulation, finding solutions rather than assigning responsibility, emphasizing flexibility over rigidity, and striving for continuous quality improvement, not just process streamlining.
3. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.
4. Services should be provided in the least restrictive and most integrated environment possible. Most integrated environment means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible (28 CFR pt. 35, App. A, page 450, 1998).
5. All services should be designed to be welcoming, accessible, and capable of providing interventions properly matched to the needs of consumers with co-occurring disorders.
6. Community and state facility services are integral components of a seamless public, consumer-driven, and community-based system of care.
7. The goal of all components of our public system of care is that the persons we serve recover, realize their fullest potential, or move to independence from our care.
8. The participation of the consumer and, when one is appointed or designated, the consumer's authorized representative in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.
9. The consumer's responsibility for and active participation in his or her care and treatment are very important and should be supported and encouraged whenever possible.
10. Consumers have a right to be free from abuse, neglect, or exploitation and to have their basic human rights assured and protected.

01-10-2007

Regional Utilization Management Guidance

11. Choice is a critically important aspect of consumer participation and dignity, and it contributes to consumer satisfaction and desirable outcomes. Consumers should be provided as much as possible with responsible and realistic opportunities to choose.
12. Family awareness and education about a person's disability or illness and services are valuable whenever the individual with the disability supports these activities.
13. Whenever it is clinically appropriate, children and adolescents should receive services provided in a manner that supports maintenance of their home and family environment. Family includes single parents, grandparents, older siblings, aunts or uncles, and other individuals who have accepted the child or adolescent as a part of their family.
14. Children and adolescents should be in school and functioning adequately enough that the school can maintain them and provide an education for them.
15. Living independently or in safe and affordable housing in the community with the highest level of independence possible is desired for adult consumers.
16. Gaining employment, maintaining employment, or participating in employment readiness activities improves the quality of life for adults with disabilities.
17. Lack of involvement or a reduced level of involvement with the criminal justice system, including court-ordered criminal justice services, improves the quality of life of all individuals.
18. Pursuant to State Board Policy 1038, the public, consumer-driven, and community-based mental health, mental retardation, and substance abuse services system serves as a safety net for individuals, particularly people who are uninsured or under-insured, who do not have access to other service providers or alternatives.

Section 4: Indicators Reflecting Core Values

Nationwide, service providers, funding sources, and regulators have sought instruments and methods to measure system effectiveness. No one system of evaluation is accepted as the method, as perspectives about the system and desired outcomes vary, depending on the unique role (e.g., as a consumer, family member, payer, provider, advocate, or member of the community) that one has within the system.

Simple, cost-effective measures reflecting a limited number of core values or expectations identified by the Central Office, State Facilities, and CSBs guide the public system of care in Virginia. Any indicators or measures should reflect the core values listed in the preceding section.

Section 6: Consumer and Family Member Involvement and Participation

1. **Consumer and Family Member Involvement and Participation:** CSBs, State Facilities, and the Central Office agree to take all necessary and appropriate actions in accordance with State Board Policy 1040 to actively involve and support the participation of consumers and their family members in policy formulation and services planning, delivery, monitoring, and evaluation.
2. **Consumer and Family Member Involvement in Individual Services Planning and Delivery:** CSBs and State Facilities agree to involve consumers and, with the consent of consumers where applicable, family members, authorized representatives, and significant others in their care, including the maximum feasible degree of participation in individualized services planning and treatment decisions and activities, unless their involvement is not clinically appropriate.

Regional Utilization Management Guidance

Appendix 4: Community Services Performance Contract Exhibit J

Exhibit J: Regional Program Procedures

Regional Program Definition

A regional program provides services to individuals who are consumers of a group of Boards, and it may be managed by the group of Boards, have multiple service sites, and provide more than one type of service. Regional programs also include self-contained, single purpose programs (e.g., providing one type of core service, usually residential) operated by one Board for the benefit of other Boards or programs contracted by one Board that serve consumers from other Boards. Finally, some programs (e.g., substance abuse residential or mental health day support programs) that are operated by individual Boards also may serve consumers from other Boards through contractual or purchase of service arrangements. These individual Board programs are not regional programs, but some of these principles, concepts, and models could be applied to them.

Purposes of Regional Program Principles, Operational Concepts, and Models

The regional program principles, operational concepts, and models enable Boards to implement, manage, and account for and the Department to monitor regional programs on a more consistent basis and help ensure that performance contracts and reports contain all needed information, completely and accurately, about consumers and services.

Regional Program Principles

The following principles should guide the development and operation of regional programs.

1. All revenues, expenses, and costs for a regional program should be reported only once.
2. Each consumer who is served should be reported only once for a particular service. However, a consumer receiving services from more than one Board should be reported by each Board for the service(s) that it provides.
3. Each service provided by a regional program should be reported only once.
4. Double counting a service or a consumer receiving a service must be avoided.
5. For certain regional programs, where a Board (the case management Board) refers its consumer to a regional program that is operated by a contract agency and paid for by the region's fiscal agent Board, the case management Board should report the service, even though it did not provide or pay for it, since there would be no other way for information about it to be extracted through the CCS 2.
6. Avoiding duplicate reporting of consumers, services, revenues, expenses, and costs should be addressed, preferably in an Exhibit D or less preferably in a regional memorandum of agreement (MOA).
7. Boards should be able to transfer state, local, and federal funds to each other to pay for services that they purchase from each other.
8. Because the CCS 2 is the basis for all statewide individual consumer information, all individuals served by a Board in any manner must be included in the Board's information system, so that the necessary consumer and service information can be extracted by the CCS 2 and provided to the Department.
9. Existing reporting systems (the CCS 2 and the CARS) should be used wherever possible, rather than developing new reporting systems, to avoid unnecessary or duplicative data collection and entry. For example, the special project function in the CCS 2 could be used to report additional data elements that are not in the CCS 2 for special projects, instead of establishing new, stand-alone reporting mechanisms. This would reduce Board workload.

01-10-2007

Regional Utilization Management Guidance

10. Any new service or program should be implemented as simply as possible regarding reporting requirements. For example, allocating all of the Regional Discharge Assistance Project funding to one (fiscal agent) Board rather than to each Board based on approved DAP ISPs may create significant extra work for Boards with little appreciable gain in accountability.
11. Boards and the Department have provider and local or state authority roles that involve non-direct services tasks, such as utilization management and regional authorization committees. These roles cause additional administrative and management expenses for regional programs. Boards should report these expenses as part of their costs of delivering regional services.
12. The Department should factor in and accept these administrative and management expenses as allowable costs of regional programs.
13. Board and state costs for a service should be the same: the true cost, not the subsidized (reduced) cost that may be identified and reported now for some regional programs. True costs should be reported to the General Assembly and used for other accountability purposes.
14. If a Board participating in a regional program supplements the allocation of state or federal funds received by the Board operating that program by transferring resources to the operating Board, the participating Board should show the transfer as an expense on financial forms but not as a cost on service forms in its performance contract and reports. Then, the participating Board will avoid displaying an unrealistically low service cost in its contract and reports for the regional program and double counting consumers served by and service units delivered in the regional program, since the operating Board already reports this information.
15. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.
16. Unexpended balances of regional program funds should not be retained by the participating Boards to which the regional fiscal agent Board or the Department has disbursed the funds. Those balances should be available for redistribution during the fiscal year among the participating Boards to ensure maximum utilization of these funds. Each regional program should establish procedures for monitoring expenditures of regional program funds and redistributing those balances. These procedures should be stated, preferably in an Exhibit D or less preferably in a regional MOA.
17. Regional program funding issues, such as the amount, sources, or adequacy of funding for a regional program, the distribution of state allocations for it among participating Boards, and the financial participation of each Board whose consumers receive services from the regional program, should be resolved at the regional level among the Boards participating in the program, with the Department providing information or assistance upon request.
18. If possible, regional funding and reporting approaches should be developed that encourage or provide incentives for the contribution of local dollars to regional activities.
19. If a Board that operates or serves as the fiscal agent for a regional program cannot satisfy the statutory minimum 10 percent local matching funds requirement due to the state funds that it receives for that regional program, the Department, in accordance with provisions in the Community Services Performance Contract, State Board Policy 4010, and § 37.2-509 of the *Code of Virginia*, shall grant an automatic waiver of that matching funds requirement.

Regional Program Operational Concepts

The following concepts provide a framework for the development, implementation, and operation of regional programs.

Regional Utilization Management Guidance

1. **Management Approach:** The regional approach is an invaluable tool for maximizing the use of resources and for increasing the effectiveness of the services system. The regional approach is a highly effective tool for allocating and managing resources and for coordinating the delivery and managing the utilization of services. However, individual consumers generally will continue to be served by particular Boards; services will continue to be provided by individual Boards directly or through contracts with other providers; each Board will continue to contract for and report on the consumers that it serves and the services that it provides; and each consumer will access services through and have his or her individualized services plan managed by a particular Board. Boards are the only organizations identified in the *Code of Virginia* and the Appropriation Act that the Department can fund for the delivery of community mental health, mental retardation, or substance abuse services. This is consistent with the statutory identity of Boards as the single points of entry into publicly funded mental health, mental retardation, and substance abuse services, and Boards are the local points of accountability for the coordination of those services.

2. **Individual Board Reporting:** Implementation of the CCS 2, a secure and HIPAA-compliant individual consumer data reporting system, makes it even more important that a Board reports all of the services that it provides directly or contractually to consumers. Because the CCS 2 is the basis for all statewide individual consumer information, all individuals served by Boards in any manner must be included in individual Board information systems, so that necessary consumer and service information can be extracted by Boards and provided to the Department using the CCS 2. The Department will be extracting performance contract report information about consumers and services from the CCS 2, rather than continuing to receive some separate CARS contract reports containing this information. If a Board does not collect information about all of its consumers and services, including those in regional programs, in its information system, it will not be able to extract and report complete information about its operations to the Department, and the CCS 2 will not be complete.
Therefore, each Board participating in a regional program will admit the consumers that it serves through the regional program to the Board and will maintain CCS 2 data about those consumers in its information system. For performance contract and report (CARS and CCS 2) purposes, each participating Board will maintain and report revenue, expense, cost, consumer, and service information associated with the regional program for each consumer that it serves through that program. If one Board operates a regional program on behalf of other Boards in a region, it admits all consumers for services provided by that regional program, maintains CCS 2 data about these consumers in its information system, and maintains and reports revenue, expense, cost, consumer, and service information for all consumers that it serves through that program.

3. **Regional Program Funding, Contracting, and Reporting:** Depending on the design of a regional program, the Department may disburse the state or federal funds for a regional program to each participating Board or to one Board that operates a regional program or agrees to serve as the fiscal agent for a regional program. Sections 37.2-100, 37.2 -504, and 37.2-508 of the *Code of Virginia* define and establish the community services performance contract as the mechanism through which the Department provides state general and federal funds to Boards for community mental health, mental retardation, and substance abuse services and through which Boards report on the use of those funds.
 - a. If the Department disburses regional program funds to each participating Board, each participating Board will follow existing performance contract and report requirements and procedures for that portion of the regional program funded by that participating Board.
 - b. If the Department disburses regional program funds to the Board that operates a regional program on behalf of the other Boards in a region whose consumers receive services from

Regional Utilization Management Guidance

that regional program, the operating Board will follow existing performance contract and report requirements and procedures, as if the regional program were its own program.

- c. If the Department disburses regional program funds to a Board that has agreed to serve as the fiscal agent (fiscal agent Board) for the regional program, disbursements will be based on, accomplished through, and documented by appropriate procedures contained preferably in an Exhibit D or less preferably in a regional MOA and in electronic data interchange (EDI) transfer records.
 - d. When funds are disbursed to a fiscal agent Board, each participating Board will identify, track, and report regional program funds that it receives and spends as funds for that regional program. Each participating Board, including the fiscal agent Board, will reflect in its CARS reports and CCS 2 extracts only its share of the regional program, in terms of consumers served, services provided, revenues received, expenses made, and costs of the services. Any monitoring, reporting, and accountability related to the fiscal agent Board's handling of the state or federal funds will be accomplished through the performance contract and reports.
 - e. The Department and participating Boards may decide to establish parallel but separate, more detailed reporting, contracting, and management processes for some regional programs, when more information beyond that contained in the performance contract and reports and the CCS 2 is needed to monitor or manage the program. These processes should be documented in procedures contained preferably in an Exhibit D or less preferably in a regional MOA.
 - f. Even when there are a separate reporting and monitoring procedures in place, each Board participating in a regional program still must include the relevant consumer, service, revenue, and expense information in its CARS reports and CCS 2 extracts. This will ensure that a Board's information, accumulated through automated processes such as the CARS and the CCS 2, reflects all of its consumer, service, revenue, expense, and cost information, including the regional programs in which it participates.
4. **Regional Program Monitoring and Management:** Monitoring and management activities may be carried out differently, depending on how a particular regional program is structured and operated. Generally, it is desirable for the participating Boards to establish an organization or use an existing one to manage and monitor the operation of a regional program. Procedures for and operations of these monitoring and management activities, such as regional authorization or utilization management committees, should be described preferably in an Exhibit D or in a regional MOA.

Four Regional Program Models

The following models have been developed for Boards and the Department to use in designing, implementing, operating, monitoring, and evaluating regional programs. These models are paradigms that could be altered by mutual agreement among the Boards and the Department as regional circumstances warrant. However, to the greatest extent possible, Boards and the Department should adhere to these models to support and reinforce more consistent approaches to the operation, management, monitoring, and evaluation of regional programs. Boards should review these models and, in consultation with the Department, implement the applicable provisions of the model or models best suited to their particular circumstances, so that the operations of any regional program will be congruent with one of these models.

Regional Utilization Management Guidance

1. Operating Board-Funded Regional Program Model

1. The Board that operates a regional program receives state and sometimes other funds from the Department for the program. This operating Board provides the services, projects the total consumers served, units of service, static capacity, revenues, expenses, and cost for the regional program in its performance contract and contract revision(s), and reports total actual consumers served, units of service(s) delivered, revenues, expenses, and cost(s) in its performance contract reports (CARS) and Community Consumer Submission 2 (CCS 2) extracts. Other Boards that refer consumers to the regional program for services project and report nothing for the regional program in their contracts, CARS reports, and CCS 2 extracts.
2. The operating Board admits consumers receiving services from the regional program to the Board, enrolls them in the service(s) provided by the regional program, and develops individualized services plans (ISPs) for them. When consumers complete receiving a service from the regional program, they are released from that service. When consumers complete receiving all services from the regional program, they are discharged from the operating Board, unless they are consumers of and are receiving other services from that operating Board. The operating Board provides appropriate information about the services provided and other clinical information to the Board that referred the consumer to the regional program for clinical record keeping purposes at the referring Board.
3. The operating Board ensures that the appropriate information about consumers and services in the regional program is entered into its information system, so that the information can be extracted by the CCS 2 and reported in the CCS 2 and applicable CARS reports. Thus, for performance contract and reporting purposes, individuals receiving services from a regional program operated by that Board are consumers of that operating Board.
4. Each of the other Boards whose consumers receive services from this regional program admits those consumers to the Board and enrolls them in a service, such as case management, consumer monitoring, or another appropriate service, but not in the service(s) provided by the regional program. Thus, consumers receiving services from a regional program will appear in the CCS 2 extracts for two Boards and will be reflected in the CARS reports for two Boards (unless they are consumers only of the operating Board), but not for the same service(s).
5. If the other Boards whose consumers receive services from this regional program provide additional funds to the operating Board to supplement the funds that the operating Board receives from the Department for the regional program, these other Boards show the revenues and expenses for this supplement on the financial forms in their performance contracts, contract revisions, and reports. However, these other Boards do not show any services provided, consumers served, or costs for the regional program's services on the service forms in their contracts, revisions, or reports. These other Boards include an explanation on the Financial Comments page of the difference between the expenses on the financial forms and the costs on the service forms. The operating Board shows the services provided, consumers served, and total costs (including costs supported by supplements from the other Boards) for the regional program's services on its service forms, but it does not show any revenues or expenses associated with the supplements on the financial pages in its contract, contract revision(s), and reports. The operating Board includes an explanation of the difference between the expenses on the financial forms and the costs on the service forms on the Financial Comments page.
6. All of the Boards, to the extent practicable, determine individual Board allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreed-upon formula.
7. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

Regional Utilization Management Guidance

2. All Participating Boards-Funded Regional Program Model

1. Each Board that participates in, meaning whose consumers receive services from, a regional program that is operated by one of those Boards receives state and sometimes other funds from the Department for that program. Each participating Board may supplement this amount with other funds available to it if the funds received from the Department are not sufficient to cover the regional program's expenses. Each participating Board uses those funds to purchase services from the regional program for its consumers, projects the consumers served, units of service(s), static capacity, revenues, expenses, and cost for the regional program in its performance contract and contract revision(s) and reports actual consumers served, units of service(s) delivered, revenues, expenses, and costs in its performance contract reports (CARS) and Community Consumer Submission 2 (CCS 2) extracts only for its consumers.
2. The regional program operated by one of the participating Boards functions like a contract agency provider. All of the consumer, service, static capacity, revenue, expense, and cost information for the whole program is maintained separately and is not included in the contract, contract revision(s), reports (CARS), and CCS 2 extracts of the Board operating the program. The participating Boards, including the Board operating the regional program, include only the parts of this information that apply to their consumers in their contracts, contract revisions, reports, and extracts. The regional program is licensed by the Department, when applicable, and develops and maintains individualized services plans (ISPs) for consumers that it serves.
3. Each participating Board admits consumers receiving services from the regional program and enrolls them in the services provided by the regional program and in any other appropriate services. The services provided by the regional program are listed in the ISPs maintained by the participating Boards for these consumers. When consumers complete receiving a service from the regional program, they are released from that service. When consumers complete receiving all services from the regional program, they are discharged from the participating Board, unless they continue to receive other services from that participating Board. The regional program provides appropriate information about the services provided and other clinical information to the Board who referred the consumer to the regional program, just as any contract agency provider would provide such information to the contracting Board.
4. Each participating Board, including the Board operating the regional program, ensures that the appropriate information about its consumers and their services is entered into its information system, so that the information can be extracted by the CCS 2 and reported in the CCS 2 and applicable CARS reports for that participating Board.
5. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

Regional Utilization Management Guidance

3. Fiscal Agent Board-Funded Regional Program Model

1. One Board receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program, such as a reinvestment or restructuring project. The Department disburses the regional allocation to the fiscal agent Board on behalf of all Boards participating in the regional program.
2. The fiscal agent Board, in collaboration with the other participating Boards, develops agreed-upon procedures that describe how the Boards implement the regional program and jointly manage the use of these funds on a regional basis. The procedures also establish and describe how unused funds can be reallocated among the participating Boards to ensure the greatest possible utilization of the funds. These procedures should be documented, preferably in an Exhibit D or less preferably in a regional memorandum of agreement (MOA).
3. The fiscal agent Board receives the semi-monthly payments of funds from the Department for the regional program. The fiscal agent Board disburses the regional program funds to individual Boards, including itself when applicable, in accordance with the procedures in paragraph 2. The fiscal agent Board displays such disbursements on a Transfer In/Out line of the applicable revenue page in its final performance contract revision and its reports. The other Boards receiving the transferred funds show the receipt of these funds on the same line. Boards provide more detailed information about these transfers on the Financial Comments pages of contract revisions and reports.
4. Each Board implementing a regional program accounts for and reports the revenues and expenses associated with that program in its final performance contract revision and CARS reports. The fiscal agent Board displays the total amount of the allocation as a revenue and all Transfers Out in its CARS reports, but it only displays in its reports the expenses for any regional program that it implements.
5. As an alternative to paragraphs 1 through 4 for some kinds of programs, such as a Regional Discharge Assistance Project, and with the concurrence of the Department, instead of one Board acting as a fiscal agent, all Boards participating in that program establish a regional mechanism for managing the use of the regional program funds. The Boards decide through this regional management mechanism how the total amount of funds for the program should be allocated among them on some logical basis (e.g., approved regional discharge assistance project ISPs). The region informs the Department of the allocations, and the Department adjusts the allocation of each participating Board and disburses these allocations directly to the participating Boards. Those Boards agree to monitor and adjust allocations among themselves during the fiscal year through this regional management mechanism to ensure the complete utilization of these regional program funds, in accordance with procedures in paragraph 2.
6. Each Board implementing a regional program ensures that appropriate information about its consumers and their services is entered into its information system, so that the CCS 2 can extract the information and report it in the CCS 2 and applicable CARS reports.
7. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

Most reinvestment and restructuring programs are examples of this model. A variation of this model, the Fiscal Agent Board-Funded Regional Local Inpatient POS Program Model, can be used to implement and manage regional local acute psychiatric inpatient bed purchases.

Regional Utilization Management Guidance

3.a. Fiscal Agent Board-Funded Regional Local Inpatient POS Program Model

1. One Board agrees to act as the fiscal agent for the regional Local Inpatient Purchase of Services (LIPOS) program. The Department disburses the regional LIPOS allocation to the fiscal agent Board on behalf of all of the Boards participating in the regional LIPOS program.
2. The fiscal agent Board, in collaboration with all of the participating Boards and with consultation from the Department, develops procedures that describe how the Boards will implement the regional LIPOS program and jointly manage the use of these funds on a regional basis. The procedures include regional utilization management mechanisms, such as regional authorization committees (RACs) and regional procurements of beds through contracts with private providers. Such contracts may reserve blocks of beds for use by the region or purchase beds or bed days on an as available basis. The procedures also establish and describe how unused funds can be reallocated among the participating Boards to ensure the greatest possible utilization of the funds. These procedures should be documented, preferably in an Exhibit D or less preferably in a regional memorandum of agreement (MOA).
3. The fiscal agent Board receives the semi-monthly payments of funds from the Department for the regional LIPOS program. The fiscal agent Board disburses regional LIPOS funds to individual Boards or uses such funds itself to pay for the costs of local inpatient hospitalizations that have been approved by a regional review and authorization body established by and described in the procedures in paragraph 2. The fiscal agent Board displays such disbursements on a Transfer In/Out line of the Mental Health Revenue page in its final performance contract revision and reports, and the Board receiving the transferred funds shows the receipt of these funds on the same line. Boards provide more detailed information about these transfers on the Financial Comments page of contract revisions and reports.
4. The Board that purchases local inpatient services accounts for and reports the revenues and expenses associated with its LIPOS in its final performance contract revision and CARS reports. The fiscal agent Board displays the total amount of the allocation as a revenue and all Transfers Out in its CARS reports, but it displays in its reports only the expenses for its own LIPOS.
5. The Board that purchases the local inpatient services ensures that appropriate information about consumers, services, and costs is entered into its management information system, so that the CCS 2 can extract the information and report it in the CCS 2 and applicable CARS reports.
6. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

Regional Utilization Management Guidance

4. Fiscal Agent Board-Funded Contract Agency Regional Program Model

1. One Board receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program that is contracted by this fiscal agent Board to a public or private agency. The Department disburses the regional allocation to the fiscal agent Board on behalf of all Boards participating in the contracted regional program.
2. The fiscal agent Board contracts with and provides set monthly payments to a regional program provided by a public or private contract agency on behalf of all of the Boards participating in this regional program. The contract may purchase a pre-set amount of specified services from the contract agency and pay the agency a predetermined cost, whether or not the participating Boards use the services.
3. Each participating Board referring one of its consumers to this contracted regional program admits the consumer, enrolls him in the regional program service, and refers him to the contract agency. The contract agency provides information to the referring (case management) Board, and that Board maintains information about the consumer and the service units in its information system, where the CCS 2 can extract the information.
4. The fiscal agent Board provides program cost information to each referring Board, based on its use of the regional program, and the referring Board enters this information in the cost column of the program services form (pages AP-1 through AP-3) but does not enter any revenue or expenditure information in its performance contract report (CARS). The fiscal agent Board enters the revenue and expenditure information associated with the regional program on the financial forms in its performance contract report, but it enters consumer, service, and cost information on the program services form only for the consumers that it referred to the regional program. Each Board will explain the differences between the financial and program service forms in its performance contract report on the Financial Comments page. The Department will reconcile the differences among the participating Boards' reports using these comments. Because of the difficulty in calculating the program cost information for each participating Board, program cost information would only need to be included in fourth quarter performance contract (CARS) reports.
5. All of the participating Boards, to the extent practicable, determine individual Board allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreed-upon formula.
6. Regional programs should receive the same state funding increases as regular Board grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

The crisis stabilization program operated by Rubicon in Region 4 is an example of this model. The main features of this model could be used to reflect services that one Board purchases from another Board. However, as the Regional Program Definition at the beginning of this exhibit notes, this individual Board program would not be a regional program. Unlike the model described above, both Boards would input the applicable consumer, service, and financial information, which would then be extracted by the CCS 2.