Region V Systems
Promoting Comprehensive Partnerships in Behavioral Health

CONSUMER FLEXIBLE FUNDING

Policy and Procedures

Effective July 1, 1999

The Region V Governing Board shall receive an allocation for Consumer Flexible Funding from the Department of Health and Human Services (HHS). Region V Mental Health (Network Management) shall disburse the funds to Providers in Region V's Behavioral Health Provider Network (Network Providers) and oversee the funds. Network Providers shall submit billings to Network Management to receive reimbursement for said services.

Purpose

State dollars allocated for Consumer Flexible Funding are to be used for the direct benefit of consumers to expedite a discharge from, or prevent an admission to, a higher level of care. Consumer Flexible Funding is designed to:

- provide the resources necessary to meet identified treatment/rehabilitation needs that cannot be provided through other funding mechanisms or more traditional service provision modalities.
- assist mental health consumers who cannot be discharged from a Regional Center because their SSI (to pay for housing) has not been approved.
- help SPMI and substance-dependent consumers who face barriers to discharge from a higher level of care (i.e., Regional Centers) to a lower level of care (i.e., residential care facility, assisted living facility, domicillaries, etc.).
- be used until SSI is approved for the consumer or other funds are found to pay living expenses.
- Consumer Flexible Funding is not intended to be a long-term funding solution.

Who is Eligible

Consumer Flexible Funding is available to adult consumers enrolled in Community Support services.

Applicability

- Consumer Flexible Funds shall be used for:
- Transportation (self, e.g., gas, minor car repair)
- Transportation (taxi, bus, handi-van, other)
- Housing (one-time deposit on apartment)
- Housing (rent per month)
- Housing (rental furniture)
- Housing (purchase furnishings)
- Food
- Initial Clothing Needs
- Laboratory Work
- Medications
- Emergencies

Consumer Flexible Funding shall be used **only** for the direct benefit of consumers to expedite a discharge from, or prevent an admission to, a higher level of care. Higher levels of care being defined as:

1. Acute Inpatient (i.e., Regional Centers)
2. Secure Residential (i.e., Regional Centers)
3. Intermediate Residential (i.e., Regional Centers or HHS-funded community substance abuse providers)
4. Transitional Residential (i.e., Regional Centers or HHS-funded community mental health or substance abuse providers)

Note: State funds shall not pay for abortions.

How are Funds Obtained and Managed?
The Regional Governing Board (Network Management) shall receive an allocation for Consumer Flexible Funding from the Department of Health and Human Services (HHS). Network Providers who offer Community Support services shall submit billings to the Network Management to receive reimbursement for said services.

The Network Management is responsible for authorizing, monitoring, and accounting for the Consumer Flexible Fund expenses and for reporting monthly to HHS. Both the Network Provider and Network Management shall ensure that funds are used to purchase goods and services for eligible consumers based on needs identified in the consumer's Individual Service Plan and approved by the consumer's Integrated Treatment Team.

Consumer Flexible Funds should be considered Alast-dollar@ after all other community resources have been explored. Repayment of all, or some part, of the funds will be an expectation for each consumer using the funds. Network Providers shall ensure consumers are fully informed of this repayment procedure and seek to recover the funds. The Network Management deposit into the Consumer Flexible Fund account those funded costs that consumers are able to reimburse.

Every effort shall be made to accommodate the Network Provider's request for funding. Unless there are unusual or questionable circumstances (e.g., not complying with HHS's guidelines), all reimbursements requests shall be granted. If a question arises about the validity of the request, the Network Management shall send a written explanation to the Network Provider as to why the request was not reimbursed. **Any funds provided to the consumer in advance of the reimbursement is at the risk of the Network Provider.** HHS will monitor and review quarterly each Region's Consumer Flexible Funding pool utilization and cost effectiveness and the impact of the resources on consumer outcomes. HHS has the authority to move funds between Regions to serve consumers throughout the state where:

1. The most need is demonstrated, and
2. The goal to eliminate barriers to consumer movement from higher levels of care to non-residential levels of care in the community is being met.

If funds are not used, or underused in one Region, each Region must agree to the movement of funds to another Region. Regions which have a need for additional Consumer Flexible Funds above the contracted amount will be able to request the funds through a contract amendment request by identifying a specific amount of funds needed and why.

Since reimbursement of these funds will be on a first-come, first-served basis, the Network Management shall keep Network Providers apprised of the remaining available balance of Consumer Flexible Funds. This will be accomplished by the Network Management providing monthly tabulations of funding that remain for Consumer Flexible Funds. This information will be provided to the Network Provider at monthly Network Provider meetings or by memorandum. Network Providers will also be notified when the total remaining amount of Consumer Flexible Funds is less than 10 percent of the total Region V allocation. When total available funds reach this level, it will be necessary for the Network Providers to receive prior approval for reimbursement.

System Requirements
To receive Consumer Flexible Funds:

- The Network Management shall ensure the utilization of Consumer Flexible Funds comply with the 204 NAC4-005 and 204 NAC4-006 regulations pertaining to allowable and unallowable costs.
- The Network Provider shall agree to comply with *Region V's Consumer Flexible Funding Policies and Procedures* and submit claims for Consumer Support Funds on the forms specified by Region V.
- All Network Providers shall comply with the Nebraska Department of Health and Human Services, *Consumer Flexible Funding Pool State Policy and Procedures*, July 1, 1999; *Community Support Flexible*

Funding Guidelines, 3/1/98; and *Community Support Flexible Fund Guidelines Allowable & Unallowable Costs*, 2/26/98.

Reimbursement Request Process

- Network Providers may request up to $500 per consumer, per month, without prior approval from the Regional Program Administrator.
- The consumer's name must be documented on the Magellan Behavioral Health's Turn Around Document (TAD) for Community Support for the month the expenditure was incurred.
- A Network Provider shall complete and send to the Region a Region V BH-4c (Individual Consumer Flexible Funds Expenses Report) and Region V BH-4b (Monthly Total Flex Fund Expenses Report) to support the amount of funds requested for Consumer Flexible Fund services. Each expenditure shall be tied to a Treatment Plan Goal.

Instructions for completing these forms follow:

Form RV BH-4c (Individual Consumer Flexible Funds Expenses Report)
This form shall be:

1. Completed in its entirety for each client that the provider is seeking reimbursement.
2. Signed by the Network Provider (Agency Director only).
3. Submitted to the Network Management (Regional Office) in conjunction with the Network Provider's regular monthly request for services provided the prior month.
4. Submitted via fax for prior approval, if applicable.

Form RV BH-4b - Monthly Total Flex Fund Expenses Report
This represents a summary of all the consumer reimbursement request(s) for the month. *Note: A separate form must be used to request mental health, substance abuse, or dual diagnosed service reimbursement.* This form shall be:

1. Completed in its entirety
2. Signed by the Network Provider (Agency Director) or Comptroller/Business Manager
3. Submitted to the Network Management (Regional Office) in conjunction with the Network Provider's regular monthly request for services provided the prior month. This form shall also be submitted in conjunction with the RV BH-4c form(s).

Prior Authorization Process

When the total available funds is less than 10 percent of the total Region V allocation, or if the request is for more than $500, the Network Provider must receive prior authorization to obtain funds. To receive prior authorization from Network Management, the Network Provider shall:

1. Complete the RV BH-4c form and fax it to the Network Management (Regional Office). (Prior approval of the request does not have to be obtained before the Network Provider authorizes payment to the consumer; however, the Network Provider is not guaranteed reimbursement from the Network Management [Regional Office] without prior approval.)

2. Fax the RV BH-4c form to the Network Management (Regional Office). The request will be reviewed by Network Management, and notice of approval will be given to the Network Provider within 24 hours via fax. The original request will be maintained at the Network Management (Regional Office); however, the Network Provider must submit a copy along with its RV BH 4-b summary.