

INTEGRATED CASE MANAGEMENT

ANNEX A

NAME OF AGENCY:

CONTRACT NUMBER:

CONTRACT TERM:

TO

BUDGET MATRIX CODE:

32

This Annex A specifies the Integrated Case Management services that the Provider Agency is authorized and obligated to deliver pursuant to and in accordance with the Mental Health Fee-For-Service Contract to which this Annex A is attached. In addition to the terms contained in the Mental Health Fee For Service Provider Program Manual and Mental Health Fee-For-Service Contract to which this Annex A is attached, Provider Agency shall comply with all of the terms stated herein.

I. **DEFINITIONS.** For purposes of this Annex A, the following terms are defined as follows:

Advocacy – The ongoing process of assisting the consumer in receiving, and maintaining receipt of, all services and benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services and benefits.

Assessment – The ongoing process of identifying and reviewing a consumer's strengths, deficits, and needs based upon input from the consumer and significant others including, but not limited to, family members and health professionals.

Case Manager – Provider agency's individual staff member responsible for providing case management services to the consumer.

Consumer – individual qualified to receive case management services in accordance with this Annex A.

Consumer Monitoring – the ongoing review by the provider of the consumer's status and needs.

Integrated Case Management Services – individualized, collaborative and flexible outreach services designed to engage, support and integrate consumers with serious mental illness into the community of their choice and to facilitate their use of available resources and supports in order to maximize their independence. Such services are designed to assist consumers in their recovery by helping them gain access to needed mental health, medical, social, educational, vocational, housing and other services and resources.

Ongoing Support Services – the provision of face-to-face individualized support services for a consumer who needs consistent contact to ensure engagement with the case manager and to help the consumer maintain stability and remain linked to needed services. Ongoing support services include support within the consumer’s natural support system, including family, friends, and employers and typically occurs where the consumer resides or frequents.

Risk Category – the three levels of case management involvement, based upon assessed risk of hospitalization, functional level and willingness and/or ability to access needed services. The three risk categories are: high-risk, or intensive case management; at-risk, or supportive case management; and low-risk, or maintenance level case management.

1. **High Risk** – consumers who are in crisis and at immediate risk of decompensation, or who are experiencing situational crisis which, without active intervention, would rapidly lead to decompensation and hospitalization.

2. **At Risk** – consumers who exhibit signs of regression, who stop their medication, who are undergoing major transitions from an inpatient or residential treatment setting, or who are withdrawing or refusing needed aftercare services.

3. **Low Risk** – consumers who are stable but who have a pattern of psychiatric hospitalization, acute care recidivism, dropping out of mental health and non-mental health services, medication non-compliance, disruption of living, working, program and social environments.

Serious Mental Illness – Persons who are:

- a. residents of the State of New Jersey who are age 18 and over;
- b. who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V-R (the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 2013) or the current ICD-CM (International Classification of Diseases, Clinical Modification) equivalent, with the exception of DSM-V-R "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness;
- c. that has resulted in functional impairment that substantially interferes with or limits role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts.

Services Linkage – the referral to and enrollment with other appropriate service providers for the purposes of addressing the needs identified in the consumer's assessment, including facilitating linkages to community resources or services included in the consumer's treatment goals.

Service Planning – the process of organizing the outcomes of the assessment in collaboration with the consumer, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the consumer's needs, planned services to address these needs, and plans to motivate the consumer to utilize services.

Service Provider Monitoring – the process of routine follow-up with the consumer's service providers to assess provision of services as planned in accordance with the consumer's needs and in accordance with the consumer's individualized service plan. Provider monitoring may result in the adjustment of the individualized service plan including provider changes. Service provider monitoring includes the following:

(a) Monitoring the plans, including the medication management plan, for consumers in need of such plans; and

(b) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a consumer's service providers until the consumer exits from the case management program.

Unit of Service – a continuous face-to-face contact with an enrolled consumer, or on behalf of an enrolled consumer, which lasts 15 minutes, not including travel time.

II. COMPLIANCE AND MONITORING.

A. Provider agency shall comply with all applicable Federal and State laws and policy, and all implementing regulations, including but not limited to:

1. N.J.A.C. 10:73-1.1 et seq. (Case Management Services rules) and standards incorporated by reference;
2. N.J.A.C. 10:73-2.1 et seq. (Adult Case Management Program rules) and standards incorporated by reference;
3. N.J.A.C. 10:37-1.1 et seq.; and
4. N.J.A.C. 10:37D-1.1 et seq.

B. Provider agency shall provide access to, and cooperate with all monitoring activities conducted by, DMHAS.

C. Provider Agency acknowledges and agrees that DMHAS may, at any time, conduct on-site inspections, conduct on-site reviews of case files, review any and all billing and fiscal records,

collect data, review data collection, and review reporting activities, in order to evaluate and ensure compliance with the terms of contract, all applicable federal and state laws and policy, and all implementing regulations.

III. CONSUMERS.

A. Exclusionary Criteria: The parties acknowledge and agree that the Mental Health Fee-for-Service Program is the payer of last resort. Accordingly, integrated case management services shall not be available to consumers served in the New Jersey Comprehensive Medicaid Waiver Program, Community Care Waiver Program, Programs for Assertive Community Treatment (PACT) (N.J.A.C. 10:37J), Programs for Assistance in Transition from Homelessness (PATH), Community Support Services (CSS) (N.J.A.C. 10:37B), First Episode Psychosis Program, Supervised Residences (N.J.A.C. 10:37A), nursing home or assisted living facility.

B. Inclusionary Criteria: Provider agency shall only provide Integrated Case Management services to consumers with a serious mental illness who do not accept, or engage in, community mental health programs and/or who have multiple service needs and require extensive coordination.

1. The following are the primary target populations:

a. Adults with serious mental illness who recently were referred from a State hospital, county hospital or DMHAS-contracted Diversion bed, and are in need of linkage services to ensure continuity of care with other mental health services.

b. Adults with serious mental illness who are presently hospitalized in a State or county hospital who: 1) either received integrated case management services prior to incarceration or hospitalization; or 2) are being referred to integrated case management services by the hospital inpatient unit upon discharge, or the correctional facility upon release.

2. Consumers with serious mental illness who are at high risk of hospitalization or deterioration in their functioning *and* who require an assertive community outreach service to meet their needs. This targeted group shall be composed of individuals who meet at least two of the following criteria:

a. Have repeated admissions to inpatient services. Provider agency shall give priority to persons with two or more admissions to inpatient psychiatric services within a 12-month period, or two or more uses of emergency/screening services within a 30-day time period;

b. Participate in mental health services, but are not receiving additional services which meet the individual's multiple needs, and who require extensive

service coordination (for example, individuals who are dually diagnosed as mentally ill and chemical abusing);

c. Have a recent history of being a danger to self or others within a time period of three months;

d. Have a history of resistance or non-compliance in use of medication, resulting in a pattern of decompensation and rehospitalization;

e. Are in another service system and in need of assessment and possible treatment prior to linkage to case management (for example, residential, drug and alcohol programs, or shelters for the homeless);

f. Reside with family, in boarding homes, or other residential settings (not referenced in the exclusionary criteria in section IIIA herein) and are not receiving needed mental health services;

g. Recently were referred from a general acute-care hospital psychiatric inpatient unit and are in need of linkage services to ensure continuity of care with other mental health services; and/or

h. Have a recent history of a hospitalization as a result of mental illness and dangerousness to self or others.

IV. PROVIDER AGENCY'S SCOPE OF SERVICES.

A. Provider agency shall make services available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

B. Provider agency's case management services shall include, but shall not be limited to: assessment, service planning, services linkage, ongoing monitoring, ongoing support, and advocacy.

1. Assessment shall be the ongoing process of identifying, reviewing and updating a consumer's strengths, deficits, and needs, based upon input from the consumer and significant others, including family members and community and hospital professionals. The assessment process shall continue throughout the consumer's entire length of stay in the program. Assessments shall be updated periodically based upon availability of consumer information and the requirements of this Annex A. Provider agency shall determine the consumer's risk status in accordance with the risk levels (high risk, at risk and low risk as defined in Section I above) and shall provide the following level of service:

a. High Risk – shall be provided intensive case management;

b. At Risk – shall be provided supportive case management; and

c. Low Risk – shall be provided maintenance level case management.

2. Service Planning shall be the process of organizing the outcomes of the assessment in collaboration with the consumer, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the consumer's needs, planned services to address these needs, and plans to motivate the consumer to utilize services and remain in the community. The service planning process continues throughout the consumer's entire program length of stay.

3. Services linkage shall be the ongoing referral to, and enrollment in, a mental health and/or non-mental health program. Mental health program linkage means that the consumer has completed the mental health program's intake process, that the consumer has been accepted for service, and that the consumer has effectively participated in the program.

4. Ongoing monitoring consists of both consumer monitoring and service provider monitoring by the case manager.

i. Consumer monitoring shall be the ongoing review of the consumer's status and needs, the frequency of which is contingent upon the consumer's risk status and reported changes from the consumer, significant others and/or service providers. An update of the service plan may result from the monitoring process to address changing needs.

ii. Service provider monitoring shall be the process of routine follow-up with the consumer's service providers to assess provision of services as planned in accordance with the consumer's needs, in accordance with the consumer's individualized service plan. Provider monitoring may result in the adjustment of the individualized service plan including provider changes. Service provider monitoring includes the following:

(a) Monitoring the plans, including the medication management plan for consumers in need of such plans; and

(b) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a consumer's service providers until the consumer exits from the case management program.

C. Ongoing support shall be the provision of face-to-face individualized support services for consumers who need consistent contact to ensure engagement with the case manager and to help the consumer maintain stability and remain linked to needed services. Ongoing support services include support within the consumer's natural support system, including family, friends,

and employers and typically occurs where the consumer resides or frequents. The frequency of support services is contingent upon the consumer's risk status and individual needs.

D. Advocacy shall be the process of assisting the consumer in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services. Consumer advocacy by the case manager continues throughout the consumer's entire program length of stay.

E. Pre-Admission Services. The parties acknowledge and agree that pursuant to Section III.B of this Annex and consistent with the target populations set forth at N.J.A.C. 10:37-5.2, DMHAS and the provider agency shall maximize the utilization of all DMHAS-contracted ICMS services for consumers being referred from State hospitals, county hospitals and DMHAS-contracted Diversion beds. Accordingly, in addition to all of the services identified in this Section IV, provider agency shall provide the following pre-admission services to consumers being referred to ICMS by the aforementioned hospital staff upon anticipated discharge from same:

1. Attendance and participation in hospital discharge planning meetings;
2. Attendance and participation in an Initial Treatment Plan Meeting;
3. Completion of the initial intake interview; and
4. Face-to-face meeting(s), when necessary, with consumers who are discharge reluctant.
5. Work in conjunction with the consumer, and with the State and county psychiatric hospital placement entity (as defined by Administrative Bulletin 5:11) or Diversion bed staff (as applicable), to identify and secure appropriate housing.

F. In-Reach Services.

1. The Provider Agency shall provide in-reach services in accordance with the In-Reach Guidelines included as Appendix A in the Mental Health Fee-for-Service Program Provider Manual.

2. The Division shall pay the Provider Agency for in-reach services in accordance with the In-Reach Guidelines included as Appendix A in the Mental Health Fee-for-Service Program Provider Manual at the rate set forth in Annex B-2.

3. In-reach services shall include:

- a. Attendance and participation in hospital discharge planning meetings;
- b. Attendance and participation in the Initial Treatment Plan Meeting and any other treatment meetings required by hospital staff;

c. Face-to-face meeting(s), when necessary, with consumers who are discharge reluctant.

V. **RESPONSIBILITIES.**

Provider agency shall perform the specified scope of case management services in accordance with the following:

A. Provider agency shall provide ongoing support to enrolled consumers in their own environment, who are at risk of hospitalization or deterioration in function, to enable them to function in the community and to enable them to access other mental health services whenever possible;

B. Provider agency shall provide or arrange for an offsite service capability to enrolled consumers twenty-four (24) hours a day, seven (7) days a week;

C. Provider agency shall provide community-based engagement activities, coordination, and integration for enrolled consumers;

D. Provider agency shall provide ongoing, individualized support and monitoring to maintain stability until the consumer participates effectively in other needed services; and

E. Provider agency shall seek and accept referrals within provider capacity of consumers from emergency/screening services, local inpatient units and other structured sites, such as homeless shelters or jails, and other referral sites as identified at the local level.

F. Prior to discharge, provider agency shall complete and submit to DMHAS for approval applications for discharge, which applications must be submitted through the New Jersey web based Community Services Information System (CSIS).

G. Access to case management services shall not be contingent upon the use of certain providers.

H. Consumers shall have no more than a single case manager at one time and provider agency shall reassign a case manager to a consumer upon the consumer's request when feasible.

I. Case Managers are prohibited from serving as gatekeepers and/or making determinations as to what is medically necessary.

J. Case Managers shall not provide direct medical or related services unless such services are billed as something other than case management.

K. Case Managers shall provide the following services to consumers:

1. Identify consumers with a serious mental illness in need of Case Management services regardless of type of residence (for example: family residence, boarding home, etc.);
2. Provide assessment of the consumer's strengths, needs, resources, motivation, level of functioning, mental status, and risk category;
3. Provide functional assessment of the consumer's skills (daily living, self-care, social, vocational, and other skills);
4. Provide intensive community-based engagement services to maximize the consumer's access to services and ability to function adequately and integrate into the community;
5. Provide or arrange for direct intervention;
6. Provide assessment of the need for crisis intervention, and assistance to providers of psychiatric emergency services in resolving crises, which assistance shall include but not be limited to obtaining any existing Advance Directive for Mental Healthcare and if none exists, making periodic and repeated efforts to obtain one from the consumer;
7. Provide assessment of the consumer's substance abuse symptoms;
8. Provide assessment of available social services, health and mental health resources and the ability of these services to meet each consumer's needs;
9. Develop consumer individualized service plans with the primary goal to motivate the consumer to access, appropriately use, and remain in community programs;
10. Provide education and support needed to encourage adherence to medication management plan;
11. Provide ongoing service planning and periodic reviews and revisions of such plans;
12. Provide access to appropriate services, and ensure the consumer receives needed transportation in order to attend services;
13. Ensure that the consumer engages in the community mental health and non-mental health systems through provision of ongoing individualized support and monitoring;
14. Provide consultation with other providers in a consumer's network;
15. Coordinate and integrate services from multiple providers until the consumer exits from the Case Management services/program, which shall include coordination of treatment team meetings of the service providers of a consumer in the community.
16. Monitor service delivery to meet a consumer's changing needs;

17. Identify resource gaps and problems of service delivery, and advocate for the resolution of these issues;

18. Provide direct service support to the consumer's natural support system, including family, friends, employers, self-help and other natural support groups; and

19. Develop discharge plans, in conjunction with other State, county, Diversion psychiatric hospital or short-term care facility treatment team members (as applicable), for consumers assessed as able or willing to access or engage in necessary community mental health services after hospital discharge.

VI. TERMINATION OF CONSUMER SERVICES.

DMHAS shall determine, in its sole discretion, if termination of a consumer's integrated case management services complies with all applicable policies and procedures. In accordance with the above Section V(F), provider agency shall apply for termination of a consumer's services and seek approval from DMHAS when:

A. Provider agency has made repeated and documented offers of services and the consumer repeatedly and consistently refuses such services;

B. Provider agency has made repeated and documented attempts to meet and locate the consumer and the consumer has had no contact with provider agency for three (3) or more months;

C. Consumer is sentenced to serve and incarcerated for a term that exceeds ninety (90) days;

D. Consumer moves out of the State of New Jersey;

E. Consumer relocates to another county within the State of New Jersey and is linked with that county's integrated case management services;

F. Provider agency determines that the consumer no longer meets the definition of serious mental illness; or

G. Provider agency determines that the consumer no longer requires integrated case management services and all appropriate supports are in place.

VII. STAFF MEMBER QUALIFICATIONS.

A. Prior to the expiration of the first year of employment with provider agency, every member or new hire of provider agency's staff must complete the ICMS training modules as provided by the Rutgers UBHC Technical Assistance Center. In the alternative, provider agency's staff may complete an equivalent training program (including a minimum of two live training sessions) with prior, written DMHAS approval.

B. Provider agency must employ an Integrated Case Management Services Program Director, who shall:

1. possess a Master's Degree in social work, counseling, psychology or related field, from an accredited institution *and* possess one (1) year of relevant supervisory experience; or
2. possess a Bachelor of Arts in social work, counseling, psychology or related field, from an accredited institution, and possess three (3) years of post-graduate work experience in mental health, *and* possess one (1) year of relevant supervisory experience.

C. Case Managers shall:

1. possess a Master's Degree in social work, counseling, psychology or related field, from an accredited institution; or
2. possess a Bachelor of Arts in a behavioral health field from an accredited institution *and* one (1) year of relevant, post degree experience; or
3. possess an Associate's degree in a direct care field (e.g. psychosocial rehabilitation or psychiatric nursing) from an accredited institution *and* two (2) years of relevant post degree experience; or
4. possess a minimum of a high school degree, have the ability to use his/her lived experience of recovery from mental illness, *and* either possess or complete a nationally or NJ approved peer certification training program within one year of hire; and
5. At least eighty (80%) percent of Provider Agency's Case Managers must possess a minimum of the Bachelor of Arts requirements contained in this subsection VII(C)(2).

VIII. AFFILIATION AGREEMENTS.

Provider agency shall develop and maintain written affiliation agreements with primary referral sources, addiction resources and other key entities that serve ICMS eligible consumers.

IX. DOCUMENTATION.

A. Provider agency shall maintain and keep individual records as are necessary to fully disclose the kind and extent of services provided to consumers and to provide DMHAS with the information necessary to evaluate Provider Agency's performance and efficacy. The necessary records shall specifically include, but not be limited to: assessments/reassessments and frequency thereof, monitoring by case managers, formulation of service (individual recovery) plans, timelines for services described in the plan, progress notes toward treatment goals (for face-to-face contact, telephone contacts and collaborative contacts), needs for coordination with other

programs, and units and dates of treatment. Documentation must include authenticated signature, title, date and time of authorship.

B. Provider agency shall also comply with all of the documentation requirements as specified in the DMHAS Fee For Service Program provider Manual (NJMHAPP).

C. Provider agency shall complete the following assessments in the time provided:

1. Comprehensive Assessments must be made and completed within one (1) month of enrollment into integrated case management services or, if the consumer is being referred from a hospital then within one (1) month from the date of discharge. Each Comprehensive Assessment shall be developed, when appropriate, with the consumer and his/her family members. Each Comprehensive Assessment shall identify the consumer's needs and strengths and specifically address the following:

- a. Reason for referral;
- b. Mental health history (including medications);
- c. Prior history and current involvement with mental health services and social services;
- d. General physical health (including allergies) and needs;
- e. Financial resources;
- f. Housing situation and ability to access safe and affordable housing;
- g. Family relationships;
- h. Legal status and issues;
- i. Functional skills and deficits;
- j. History of alcohol, tobacco and other drug use;
- k. Employment history and needs;
- l. Social supports and recreational preferences;
- m. Cultural and spiritual orientation; and
- n. Consumer choices, goals and willingness to participate.

2. Comprehensive Service (Individual Recovery) plans must be completed within one (1) month of enrollment into integrated case management services or, if the consumer is being referred from a hospital then within one (1) month from the date of discharge, or if the consumer is being released from incarceration then within one (1) month from the

date of release. Thereafter, Comprehensive Service plans shall be made and revised as frequently as necessary and minimally every three (3) months. Comprehensive Service plans shall be properly authenticated with the Case Manager's signature, date and title and shall be approved and signed by the Case Manager's supervisor. The Comprehensive Service plan must document the consumer's involvement and family involvement (when appropriate); if there is no consumer and/or family involvement, then the plan must document the reason for same. The Comprehensive Service plan shall be based on the Comprehensive Assessment and the consumer's goals, and shall specifically address the following:

- a. Consumer's goals and time-framed, measurable objectives; and
- b. Specific interventions, the frequency of same, and the staff responsible.

3. Risk of Hospitalization Assessments must be made and completed within ten (10) days of enrollment into integrated case management services or, if the consumer is being referred from a hospital then within ten (10) days from the date of discharge. Thereafter, Risk of Hospitalization Assessments must be made and completed every six (6) months from the date of enrollment.

4. Termination Summaries must be made and completed within thirty (30) days from the date of DMHAS approval of the application for Termination.

D. Provider agency shall complete the following additional assessments for consumers who are hospitalized:

1. Community Assessment plans must be made and completed within seven (7) days of the date of admission.

2. Interim Community Assessment plans must be made and completed within seven (7) days of admission for consumers who are re-hospitalized within sixty (60) days of the previous discharge date.

3. Discharge follow up document must be made and submitted to the appropriate hospital within seventy-five (75) days of the date of discharge and a copy provided to DMHAS

E. Provider agency shall also maintain the following data in support of all payment claims:

1. Name of the consumer;
2. Name of the provider agency and the name and title of the individual providing service;
3. Dates of service;

4. Units of service;
5. Length of time of all face-to-face contact (excluding travel to or from a consumer contact);
6. Name(s) of individual(s) with whom face-to-face contact was maintained on behalf of consumer; and
7. Summary of services provided.

F. Provider agency shall maintain a complete roster of all active consumers.

X. PROVIDER AGENCY POLICY AND PROCEDURE MANUAL.

Within sixty (60) days of the date of execution of the Fee-For-Service Contract to which this Annex A is attached, Provider Agency shall develop and implement written policies and procedures contained in a manual to be provided to all consumers and their families upon their request. The policies and procedures shall ensure that all contracted services are provided, that all services meet industry and quality standards, and that all services are adequately monitored and maintained. The policies and procedures shall include, but shall not be limited to:

- A. Use of Risk of Hospitalization scale with time frames;
- B. Referral and coordination of services;
- C. Monitoring of consumer's utilization of mental health resources and community services;
- D. Identification of and response to consumer crisis situations, including coordination with other providers;
- E. Monitoring of quality of assurance including but not limited to:
 1. Waiting time;
 2. Prioritization and triage of referrals;
 3. Evaluations of consumer criteria for services;
 4. Documentation standards; and
 5. Billing.
- F. Staff supervision and training; and
- G. Lost to Contact guidelines.

XI. BILLING AND PAYMENTS.

A. Provider agency shall bill only for those services authorized in this Annex A. Provider agency is expressly prohibited from: a) classifying direct delivery of underlying medical, educational, or social services funded by other programs, as case management services; b) billing for any services that are identical to services provided by other groups or individuals in the community; c) duplicating payments made to public agencies or private entities under other program authorities for this same purpose, including, but not limited to, the Home and Community Based Service Waiver programs; and d) duplicating payments for case management services which are an integral part of another provider service.

B. Provider agency shall comply with Appendix A of the DMHAS Mental Health Fee-For-Services Program Provider Manual.

XII. TERM AND TERMINATION OF ANNEX A.

A. The term of this Annex A shall be coterminous with, and will automatically terminate upon the expiration of the Fee For Services Contract to which it is annexed;

B. This Annex A will automatically terminate if the Fee-For-Services Contract to which it is annexed terminates early for any reason.