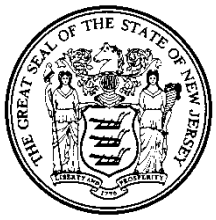

New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Human Services
Division of Mental Health and Addiction Services
Integrated Case Management Services, Program for Assertive Community Treatment, and Intensive Outpatient Treatment and Support Services

July 1, 2011 to September 7, 2016

Stephen M. Eells
State Auditor

New Jersey State Legislature

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The Honorable Stephen M. Sweeney
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Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health and Addiction Services – Integrated Case Management Services, Program for Assertive Community Treatment, and Intensive Outpatient Treatment and Support Services for the period of July 1, 2011 to September 7, 2016. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
January 26, 2017

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Scope

We have completed an audit of the Department of Human Services, Division of Mental Health and Addiction Services – Integrated Case Management Services (ICMS), Program for Assertive Community Treatment (PACT), and Intensive Outpatient Treatment and Support Services (IOTSS) from July 1, 2011 to September 7, 2016.

The division contracts with 23 ICMS providers at an average annual cost of $33 million to provide case management services to 9,700 persistently mentally ill consumers. The division contracts with 12 PACT providers at an average annual cost of $33 million to provide comprehensive treatment services to 2,100 persistently mentally ill consumers with repeated hospitalizations. The division contracts with 20 IOTSS providers at an average annual cost of $8 million to provide comprehensive outpatient services to 3,800 consumers who require more immediate and intense outpatient services upon referral from Designated Screening Centers, hospitals, or other acute care facilities. The annual averages were based on the last three fiscal years.

Objectives

The objectives of our audit were to determine whether the division's procedures for monitoring and evaluating the performance of the ICMS and the PACT programs were adequate and to determine if IOTSS providers are meeting their contracted level of service. An additional objective was to determine compliance with licensing regulations applicable to the programs.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied the administrative code and policies of the division. Provisions that we considered significant were documented and compliance with those requirements was verified by interview and through our review of consumer case records. We interviewed division personnel to obtain an understanding of the programs' internal controls and monitoring procedures. We also reviewed consumer case records at four of twenty-three ICMS providers as well as three of twelve PACT providers.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions on our audit objectives, as well as internal controls and compliance. Sample populations were sorted and transactions were judgmentally and randomly selected for testing. Providers chosen for field visits were judgmentally selected based on analysis of provider data, provider location, and the division's suggestions of model ICMS and PACT providers.

Conclusions

We found that the division's procedures for monitoring and evaluating the performance of the ICMS program were not adequate. Our review found the division did not establish specific regulations for the program, was not able to identify consumers receiving services, and found consumers that did not necessarily require case management services. We found the division's procedures for monitoring and evaluating the performance of the PACT program were adequate. In making this determination, however, we noted opportunities for improvement related to consumer terminations, psychiatrist hours, and hospital reduction reports. We found that IOTSS providers did not consistently meet their contracted level of service. Finally, we found the division was generally in compliance with licensing regulations, but noted a weakness related to the collection of licensing fees.

Integrated Case Management Services

Background

Integrated Case Management Services (ICMS) provides case management services to persistently mentally ill consumers 18 years of age and older and recently discharged from state or county hospitals or short-term care facilities. ICMS provides services 24 hours per day, 7 days per week, predominately off-site. The voluntary program is designed to integrate consumers into the community of their choice and facilitate access or linkages to needed mental health, medical, social, educational, vocational, housing, and other services and resources. The goal of ICMS is to increase the consumer's ability to manage their mental health needs within the community, rather than to utilize emergency or inpatient services. There were 23 ICMS providers in 2015.

Program Monitoring

Procedures for monitoring and evaluating the performance of the ICMS program were not adequate.

No Consumer Data

The division does not maintain a record of ICMS consumers. In order to conduct our audit we had to contact providers to obtain the names of individuals receiving ICMS services as well as other key information such as admission date, termination date, and reason for termination. A database with relevant information of ICMS consumers would improve the ability of the division to monitor the program and track consumer outcomes.

Lack of Regulations

The division has not established regulations for the ICMS program. Draft regulations have been in development since 2007 but have yet to be approved. Regulations are necessary to ensure the program is operating as intended and all providers are operating in a consistent manner to achieve the desired outcomes. In the absence of ICMS regulations, the division referred us to the Division of Medical Assistance and Health Services' Adult Case Management Services regulations.

Our visits to four ICMS providers disclosed differences in their interpretations of the ICMS program. Specifically, we found differing interpretations on the ICMS services to be provided to consumers residing in state and county psychiatric hospitals. One provider stated that case management services should be limited to consumers who were recently discharged from state and county psychiatric hospitals, while another provider enrolled and maintained a "hospital based" consumer group. The number of hospitalized consumers varied by provider with the four providers reporting that approximately 2 percent, 14 percent, 30 percent, and 39 percent of their consumers were in a hospital during fiscal year 2015.

We also noted differences in policies related to consumer referrals and terminations. One provider required a formal referral for all its consumers while another provider required a referral for only some consumers. The two other providers visited hospitals to actively search out consumers and required no formal referral. Regarding terminations, one of the four providers requested the division's approval to terminate only those consumers who had been in a state or county hospital. The other three providers' policy was to request approval for all terminations.

In addition, department licensing regulations state no mental health provider shall operate unless it is properly licensed. Licenses are issued by the Department of Human Services, Office of Licensing (OOL) based on a site inspection every three years. Without regulations, the OOL has not been able to perform these site inspections and license ICMS providers. Periodic inspections and licensing ensure that consumers are receiving the appropriate services from a qualified and trained staff in a safe environment.

Hospitalized Consumers

Approximately 5,000 consumers were receiving ICMS services at the end of fiscal year 2015. Our review found that 1,300 of those consumers were in a state, county, or other psychiatric hospital. We recognize there could be a benefit derived from providers engaging consumers in the hospital to facilitate their future participation in the ICMS program upon discharge. However, we question the use of state contract funds to provide unneeded services to consumers residing in a psychiatric hospital with no imminent discharge date.

Data obtained from seven judgmentally selected providers disclosed their current caseloads included consumers in a state hospital for an average of 3.2 years. The following chart shows the number of hospitalized consumers by time hospitalized for the seven providers.

Provider	Less than 6 months	6 months to less than 1 year	1 year to less than 5 years	5 years to less than 10 years	10 years or more	Totals
1 * ‡	7	4	36	6	9	62
2 * ‡	24	11	61	8	4	108
3	23	1	14	4	2	44
4 * ‡	27	14	18	5	11	75
5	11	3	3	0	0	17
6	7	2	8	5	4	26
7 *	0	0	0	0	0	0
Totals	99	35	140	28	30	332

* Provider visited
‡ Hospitalized consumers had no projected discharge date

Our visits to four of the seven providers found three had caseloads that included hospitalized consumers with no projected discharge date. The three providers generally attempted to engage

hospitalized consumers on a monthly basis.

We further noted one provider's interactions with its hospitalized consumers could not be supported by progress notes. Both Adult Case Management Services regulations and ICMS draft regulations require providers to maintain progress notes documenting the services provided. During our field visit, the provider claimed progress notes documenting interactions with hospitalized consumers were maintained off-site at the state psychiatric hospital. We visited the state psychiatric hospital to determine whether there was documentation of the provider's visits in the case files. We were unable to locate any progress notes in the case files; however, we found evidence that the provider's caseworkers visited the hospital in the hospital's security logs. We followed-up with the ICMS provider who eventually provided us with copies of some progress notes for the consumers in our sample, but the notes were old, dating from 2007 to 2013.

Performance Measures and Evaluation

The division has not established the procedures or performance measures necessary to evaluate the effectiveness of the ICMS program. The division stated they evaluate the performance of the ICMS program using the following methods:

- Comparing Quarterly Contract Monitoring Reports (QCMRs) with contract commitments,
- analyzing Unified Services Transaction Forms (USTF) data, and
- reviewing and approving consumer terminations.

Our review of these methods disclosed the following weaknesses.

Provider prepared QCMRs include data on provider outputs such as consumers served, face-to-face contacts, and linkages to other services. QCMRs do not include information on consumer outcomes nor do they provide the division with information needed to evaluate the program's effectiveness.

USTF is a consumer database of all community mental health agencies funded by the state; however, it only identifies consumers by a randomly assigned number. Consumer data is submitted quarterly by providers via four main forms: acceptance, terminations, incoming transfers, and outgoing transfers. The division was unable to provide documentation of USTF data being used to evaluate the effectiveness of the program.

Although we found evidence of the division's review and approval of consumer terminations on a case by case basis, the division was unable to demonstrate how termination data was compiled and used to evaluate the effectiveness of the program. The division stated it is in the process of developing a web-based program to capture termination data in a more usable format and anticipates the system will serve as a more formal and viable manner of extracting information regarding consumer terminations. In addition, the data we obtained directly from providers

disclosed there is no standard terminology regarding terminations. Establishing such standards and defining what constitutes a successful termination would help the division evaluate the performance and effectiveness of ICMS programs.

Recommendation

We recommend the division improve its monitoring of the ICMS program by:

- Developing a database of consumers to improve the ability of the division to monitor the program and track consumer outcomes,
- establishing ICMS regulations to ensure all providers are operating in a consistent manner with the same understanding of the program, and allow for proper inspections,
- developing procedures to monitor hospitalized consumers to determine if continued ICMS services are necessary, and
- developing the performance measures and procedures necessary to evaluate the effectiveness of the ICMS program.

ICMS Level of Service

ICMS providers did not achieve their contracted level of service.

ICMS providers are paid on a cost reimbursement basis via contracts that include various commitments such as consumers served, face-to-face contacts, and linkages to other services. Providers are expected to achieve 90 percent of their contract commitments. The division uses provider prepared Quarterly Contract Monitoring Reports (QCMRs) to monitor provider performance. Program analysts monitor QCMR data against the contract commitments and if the quarterly numbers are continually low, a corrective action plan may be requested from the provider.

Testing of a judgmental sample of 10 of 23 ICMS providers for 2013, 2014, and 2015 found providers did not achieve 90 percent of their contract commitments for linkages to other services the majority of the time. Of the 86 linkage commitments tested, 49 were not achieved, 31 were achieved, and 6 could not be determined due to a QCMR either containing errors or not being submitted by the provider.

Seven of the ten providers did not achieve 90 percent of their contract commitment for at least one of the three linkage categories for all three years tested. The division did not request a corrective action plan from any ICMS providers during the three years tested.

The division is in the process of implementing a new fee-for-service payment method to replace the current contract payment method. Under the fee-for-service method, ICMS providers will

be paid a set rate for each service they provide and contract commitments in their current form will not exist. Regardless of the payment method, the division should establish some expected level of service.

Recommendation

We recommend the division establish an expected level of service and related monitoring procedures for ICMS providers under the new fee-for-service payment method.

Program for Assertive Community Treatment

Background

The Program for Assertive Community Treatment (PACT) is a community-based program for adults with a serious and persistent mental illness who have experienced repeated involuntary hospitalizations. Consumers are referred to the PACT program and must be approved by the division prior to enrollment. The PACT's goal is to reduce hospitalizations for consumers by providing treatment which allows consumers to maintain the highest level of independence possible. Services are provided 24 hours per day, 7 days per week and are offered for an unlimited time. There are 12 PACT providers comprising 31 teams. Each PACT team is typically comprised of ten individuals from different disciplines who serve a caseload of 60 to 80 consumers. Payment is based on maintaining the required caseload of consumers. Including consumers who are not eligible or available for services may preclude others from receiving services.

PACT Consumer Terminations

PACT terminations were not timely, resulting in payments for consumers not being served and possibly preventing other consumers from receiving services.

While PACT services have no specified duration, consumers may be terminated for reasons including psychiatric hospitalization or incarceration for six continuous months, placement in a nursing home or similar institution with no projected discharge date, or when a consumer moves out of the provider's area of geographic responsibility. All PACT terminations require division approval.

Providers did not always request terminations timely. We found the following at two of the three providers visited.

- A consumer was in a state psychiatric hospital for 20 months before the provider requested termination.

- A consumer was terminated 22 months after being incarcerated.

- A consumer was terminated 10 months after being incarcerated.

- A consumer lived in Michigan for at least 20 months without being terminated.

- A consumer was not terminated until 28 months after she had moved to California.

- Six consumers were terminated for various reasons an average of 13 months after their last face-to-face contact with the PACT team.

- Two consumers were terminated for loss of contact 15 months after their last face-to-face contact with the PACT team.

The division has not established a formal policy regarding the length of time a provider should attempt to locate a consumer without success before requesting termination. Guidelines issued in December 2013 stated "if there is no response to the initiation of efforts to reach the individual who is lost to contact within 30 days, the agency will follow its established policy for the termination of services." A review of the policies of six PACT providers disclosed an inconsistency regarding the number of days without contact before requesting termination. We noted policies of 30, 60, and 180 days with some policies making no reference to a timeframe.

The division does not require notification when a consumer enters a nursing home or similar institution to allow for the determination of whether continued PACT services are necessary. We noted five consumers at one provider were in a nursing home or similar institution from 6 months to 4.5 years with no projected discharge date. Only one of these five consumers had been terminated at the time of our site visit. Another provider requested the termination of five consumers an average of six months after they entered long-term care. Two of those five consumers were in long-term care for more than 10 months prior to the request.

Recommendation

We recommend the division take steps to ensure the timely termination of consumers who meet termination criteria so that payment is not made for consumers not being served and another consumer can receive services. We further recommend the division establish a policy regarding the time a provider should attempt to locate a consumer before requesting termination. The division should also be notified when a consumer enters a nursing home or similar institution to allow for their determination of whether continued services are necessary.

Psychiatrist Hours

Psychiatric time with consumers should be prioritized by the division and actual weekly psychiatric time should be monitored.

PACT regulations require that each team has a psychiatrist who provides a minimum of ten hours of psychiatric time, face-to-face with consumers and/or team members, each week for a caseload of 56 consumers, increased on a pro-rated basis for larger caseloads.

Regulations specify the total weekly hours required but do not establish how many of those hours should be face-to-face with consumers versus with team members. Analysis of a judgmental sample of 12 of the 31 PACT teams found, on average, only 38 percent of the psychiatrists' required weekly hours were spent directly with consumers. The division should consider requiring prioritization of time spent with consumers.

We also noted that one provider with four teams and a total caseload of 272 consumers has only one psychiatrist on staff to provide the required 48 hours of face-to-face psychiatric time per week. Timesheets from June 2015 to June 2016 indicated the psychiatrist did not work enough hours to satisfy the weekly requirement in 24 of 50 weeks. The provider employs an advanced practice nurse to perform the duties of the psychiatrist when he is unavailable. PACT regulations specify these duties are to be performed by a psychiatrist. A recent site review by the department's Office of Licensing (OOL) found the provider was in compliance with the regulation related to the psychiatrist's weekly hours. This determination was based on the psychiatrist's weekly schedule as OOL's review protocol does not include an examination of the actual hours worked by the psychiatrist.

Recommendation

We recommend the division consider requiring the prioritization of face-to-face psychiatric time with consumers. We also recommend the division address the PACT provider who is not providing the required face-to-face psychiatric time per week by monitoring actual time as reported on approved timesheets.

Hospital Reduction Reports

Unverified hospitalization data is being used to measure the effectiveness of the PACT program.

Reducing inpatient psychiatric hospitalizations is a main objective of the PACT program and teams are expected to achieve a 50 percent reduction in hospitalization days during the consumer's first full-year in PACT in comparison with the year prior to joining PACT. The division calculates each provider's performance based on data submitted by providers. The division does not verify this data.

We judgmentally selected three providers and attempted to support the hospital days of all 63 consumers included on their 2014 hospital reduction reports. The providers were not able to provide adequate documentation of the hospital days reported for 49 of the 63 consumers. We found hospital days were both overstated and understated for the year prior to and for the first year of PACT. Furthermore, one provider, in the event they did not receive pre-PACT hospital days from the referring agency, labeled the hospital days as "not available" or left the consumer off the hospital reduction report completely. The inability of providers to support their hospitalization data, along with the lack of verification by the division, inhibits the division's ability to measure the effectiveness of the program.

Recommendation

We recommend the division verify the accuracy of the provider's data and assess the effectiveness of the hospital reduction percentage as a performance measure for the PACT program.

Intensive Outpatient Treatment and Support Services

IOTSS Level of Service

IOTSS providers did not achieve their contracted level of service.

IOTSS contracts include various commitments such as consumers served, face-to-face contacts for individual therapy, group therapy, medication monitoring, and case management. Providers are expected to achieve 90 percent of their contract commitments and performance is monitored through provider prepared Quarterly Contract Monitoring Reports (QCMRs).

A judgmental sample of 10 of 20 IOTSS providers' contracts for 2013, 2014, and 2015 found IOTSS providers did not achieve the 90 percent level of their commitments as follows:

- 13 of 30 commitments not achieved for consumers served,
- 14 of 30 commitments not achieved for individual therapy,
- 11 of 30 commitments not achieved for group therapy,
- 22 of 30 commitments not achieved for medication monitoring, and
- 13 of 30 commitments not achieved for program case management.

The division could not provide evidence of how it has addressed the IOTSS providers who did not achieve their contract commitments.

We also noted an inconsistency regarding a consumer's average stay in IOTSS from provider to provider. During our initial survey, the division stated IOTSS was a 90-day program, but a review of the same ten providers' QCMRs disclosed an average stay of 127 days with two providers reporting more than 200 days. One provider reported their consumer's average time in treatment days instead of calendar days. The division could not provide an explanation for these inconsistencies.

Recommendation

We recommend the division take steps to investigate and address any IOTSS providers who are not achieving their contract commitments as well as the inconsistent treatment time being reported by providers.

Licensing Fees

Licensing fees of mental health providers were not billed and collected.

The licensing standards for mental health programs require providers to pay annual renewal fees of $575 for each program element and $287.50 for every additional program. The Office of Licensing is responsible for determining appropriate provider fees to be billed, while the Office of Finance is responsible for billing and collecting the fees.

A review of the licensing fees billed and collected for fiscal years 2012 through 2015, as of September 2015, disclosed licensing fees were not being billed and collected as required.

- FY 2012 – No fees were billed, but a small number of providers paid the required fees regardless. The department was unable to tell us how much of the $254,400 that should have been billed was collected.
- FY 2013 – The Office of Finance took over the billing process and providers were billed $288,000 with a total of $235,000 collected.
- FY 2014 – No fees were billed, but $10,300 was paid by providers.
- FY 2015 – No fees were billed, but $6,600 was paid by providers.

The department took steps to address this issue during our audit. As of June 2016, providers were billed $607,000 for fiscal years 2014 and 2015 with collections totaling $521,000. Fiscal year 2016 billings were expected to take place in September 2016.

Recommendation

We recommend the Department of Human Services, Office of Licensing and the Office of Finance continue to work together to ensure that the required licensing fees are billed and collected.

Observation

Impact of New Payment Method

The division will need to monitor fee-for-service payments.

The division is in the process of implementing a new fee-for-service payment method to replace the current contract payment method for most mental health programs for fiscal year 2017. Under the new fee-for-service method, providers will be paid a set rate for each service they provide. Issues in this report related to ICMS and IOTSS providers not achieving their contracted level of service will be affected by this change in payment methodology as ICMS is included in the change to fee-for-service, while IOTSS will remain a contracted service during the initial transition.

Inherent risks associated with a fee-for-service model may entice providers to provide more services than are necessary. The division will need to monitor fee-for-service claims to ensure payments are proper and providers are achieving some expected level of service.

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DEPARTMENT OF HUMAN SERVICES
PO BOX 700
TRENTON NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

January 24, 2017

John J. Termyna, Assistant State Auditor
Office of Legislative Services
Office of the State Auditor
125 South Warren Street
PO Box 067
Trenton, NJ 08625-0067

Dear Mr. Termyna:

The Department of Human Services is in receipt of your office's draft audit report of the Integrated Care Management Services, Program for Assertive and Community Treatment, and Intensive Outpatient Treatment and Support Services administered by the Division of Mental Health and Addiction Services for the period July 1, 2011 to September 7, 2016.

In accordance with your request, the Department's responses are attached for inclusion in the final report's addendum. If you have any questions or require additional information, please contact Valerie Mielke, Assistant Commissioner at (609) 777-0702.

Sincerely,

Elizabeth Connolly
Acting Commissioner

Attachment

c: Valerie Mielke
Christopher Bailey
Mark Talbot
Anthony Tarr
Roger Borichewski

Integrated Case Management Services (ICMS)

Consumer Data

Develop a database of consumers to improve the ability of the Division to monitor the program and track consumer outcomes.

Response #1:

DMHAS has employed the Unified Services Transaction Form (USTF) data-tracking system, which contains client specific identifying codes for each unique ICMS consumer. The USTF Client Termination form contains client information on data of program application, date of first consumer service contact, date of program termination, reason for termination (Circumstance at time of termination), and program/non-program needs at the time of termination. The USTF does not have the capability to track consumer outcomes for each program.

Per guidance issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) The Division is planning a significant upgrade of its client level data (CLD) system, which is expected to enhance and advance data collection related to consumer admission, termination, client progress and client outcomes. This dataset will be able to track the "flow" of consumers through the continuum of care, as they are served by different providers and programs. Therefore, the CLD also will be able to track the relative performance and effectiveness of funded programs and agencies. The Division already has significant federal funding needed to develop and launch the CLD.

Regulations

Establish ICMS regulations to ensure all providers are operating in a consistent manner with the same understanding of the program, and allow for proper inspections.

Response #2:

DMHAS has initiated planning to conduct standardized monitoring of ICMS contracts in the Fee-for-Service system. The first step is development of a set of contract expectations for this program element, which will become part of the Fee-for-Service contract executed with each ICMS provider. Monitoring activities will be designed to ensure that the requirements of each ICMS program are being met, or if not, to identify the areas requiring corrective action. The requirements to be established would include the baseline components necessary to ensure that ICMS providers are operating with a common set of admission criteria, termination criteria, policy and procedure expectations, expectations for affiliating and coordinating with other service providers, and documentation requirements. A protocol will be developed to implement monitoring activities, to ensure that monitoring occurs in a consistent manner statewide. The target date to implement monitoring is July 2017, when all of the ICMS programs will be converted to FFS contracts. Prior to the transition to FFS, this level of monitoring was not possible because we did not receive consumer or encounter level data.

Hospitalized Consumers

Develop procedures to monitor hospitalized consumers to determine if continued ICMS services are necessary.

Response #3:

One of the tools available to DMHAS in the tracking and monitoring of state hospital consumer needs is the Individual Needs for Discharge Assessment (INDA). The INDA is a multi-dimensional needs assessment that examines 13 distinct areas of need (e.g. level of care, finances, medical needs, etc.). In addition to exploring specifically outlined needs and/or barriers within these categories, the INDA requires the treatment team to document their plans for addressing each of these areas of need as part of their effort to prepare each consumer for discharge. The Assigned Service Provider completes a section of the INDA, the focus of which is how the assigned service provider plans to build on the consumer's strengths and address the consumer's individual needs, ensuring continued integration within the community. The ICMS staff's interventions with hospitalized consumers are tied to the needs documented in the INDA.

Through its multifaceted approach, DMHAS can use the INDA to monitor hospitalized consumers, identifying clinical and systemic trends in discharge needs and barriers and apply data-driven problem-solving techniques in facilitating discharge and community integration. Assignments to ICMS, PACT, Supportive Housing, etc. are to be indicated on the INDA and will be able to be reported electronically.

The Fee-for-Service system, implemented January 2017, includes guidelines through which providers may seek DMHAS payment for ICMS in-reach services. The guidelines limit payment to ICMS providers for services rendered to hospitalized patients to eight (8) units per episode of hospitalization. ICMS providers are expected to provide services to or on behalf of consumers during periods of inpatient care or incarceration to ensure continuity of services and a successful return to the community for consumers who received PACT or ICMS immediately prior to admission to the inpatient setting or correctional facility and consumers who are being referred to PACT or ICMS by the inpatient unit or correctional facility, upon release (NJ DMHAS Mental Health Fee for Service Program Provider (NJMHAPP) Manual Version 1.0, November 7, 2016, page 16).

Performance Measures and Evaluation

Develop the performance measures and procedures necessary to evaluate the effectiveness of the ICMS program.

Response #4:

As noted in the response to the Auditor's first recommendation, implementation of the Client Level Data (CLD) system will facilitate the Division's ability to track consumer outcomes. Once a monitoring process is in place, performance measures can be established and monitoring of performance can be incorporated into the contract monitoring process.

ICMS providers' Level of Service.

Establish an expected Level of Service and related monitoring procedures for ICMS providers under the new fee-for-service payment method.

Response #5:

Prior to the transition to FFS, this level of monitoring was not possible because we did not receive consumer or encounter level data. Level of Services expectations for ICMS are driven by individual consumers' needs. Monitoring will begin upon implementation of NJMAPP to first ensure that the MHAPP process is functioning as intended. As the NJMHAPP system matures, later iterations of FFS contract monitoring will be developed to include qualitative monitoring of the services rendered.

Program for Assertive Community Treatment (PACT)

PACT terminations.

Take steps to ensure the timely termination of consumers who meet termination criteria so that payment is not made for consumers not being served and another consumer can receive services. We further recommend the division establish a policy regarding the time a provider should attempt to locate a consumer before requesting termination. The division should also be notified when a consumer enters a nursing home or similar institution to allow for their determination of whether continued services are necessary.

Response #1:

The Acute Care Project Specialist requires that all PACT providers update their "Lost to Contact Policy" to adhere to Division guidelines prepared in December 2013, which state, "if there is no response to the initiation of efforts to reach the individual who is lost to contact within 30 days, the agency will follow its established lost to contact policy for the termination of services." PACT providers may choose the length of time before initiation of termination, not to exceed 60 days. The Acute Care Project Specialist will maintain copies of each PACT provider's lost to contact policy.

The Division has been working with one of the three PACT providers identified in the Auditor's report on developing a caseload management tracking system so that admissions to hospitals, nursing homes, and similar institutions can be closely managed. All three of the identified providers will be required to review these caseload logs with their staff on a monthly basis and submit copies to the Acute Care Project Specialist on a quarterly basis. This monitoring will be expanded, as necessary.

Psychiatrist Hours

Consider requiring the prioritization of face-to-face psychiatric time with consumers and address the PACT provider who is not providing the required face-to-face psychiatric time per week by monitoring actual time as reported on approved timesheets.

Response #2:

The Division already has required corrective action by the provider identified in the Auditor's report. In addition, the Acute Care Project Specialist requires all PACT providers to conduct a psychiatrist time study in order to determine how much staff resource time is spent in provision of face-to-face time with consumers.

Hospitalization Data

Verify the accuracy of the provider's data and assess the effectiveness of the hospital reduction percentage as performance measure for the PACT program.

Response #3:

With reduction of hospital bed use as a primary goal of the PACT program, the Division is committed to 50% reduction as the benchmark. Verification of this data is essential to the process. Therefore, the Acute Care Project Specialist will request source data for 20% of the eligible cohort, in order to verify the hospital days reported.

Intensive Outpatient Treatment and Support Services (IOTSS)

IOTSS providers' level of service.

Take steps to investigate and address any IOTSS providers who are not achieving their contract commitments as well as the inconsistent treatment time being reported by providers.

Response #1:

The IOTSS program will remain in the cost-based, deficit-funded contract system using the current Annex A's and QCMR's for reporting of level of service. Because IOTSS is particularly sensitive to the unique configuration and access issues in each county variations in level of service are to be expected. The Division's task is to ensure that the volume of service is reasonable in consideration of the funds that are invested into each program, and that the length of stay is managed to ensure both access to the program for new referrals, and appropriate continuity of treatment for consumers in service. Explanations for the variations will be recorded in providers' Annex A with supporting documentation and consideration given to modifying contract commitments (Annex A's) during the contract term if DMHAS agrees that changes in commitments are warranted.

Licensing Fees

Licensing fee collection.

Office of Licensing and the Office of Finance should continue to work together to ensure that the required licensing fees are billed and collected.

Response #1:

The Office of Finance has billed the required Mental Health Licensing Fees. As of November 22, 2016, the following has been billed and collected: FY2012, billed $254,400 and collected $180,637 (71%). FY2013, billed $288,050 and $250,723 collected (87%). FY2014, billed $295,874 and collected $274,887 (93%). FY2015, billed $319,238, collected $293,211 (92%). The Office of Finance will continue to work with the Office of Licensing to ensure accurate billing and efficient collection of outstanding Licensing Fees.

Observation

Impact of New Payment Method

Need to monitor fee-for-service claims to ensure payments are proper and providers are achieving some expected level of service.

Response #1:

Developing and implementing a monitoring process reflective of the FFS transition is a high priority for the Division.