STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Addendum To Department Of Human Services Standard Language Document For Social Service and Training Contracts For Mental Health Fee-For-Service Contracts

WHEREAS, the New Jersey Department of Human Services ("the Department"), Division of Mental Health and Addiction Services ("the Division") has adopted a program whereby certain community-based mental health services previously funded by the Division under cost-related contracts with provider agencies are now funded under a non-cost related contract through a fixed rate payment methodology ("the Mental Health Fee-for-Service Program"); and

WHEREAS, the Provider Agency identified on the signature page of this Addendum seeks to provide mental health services that are now part of the Mental Health Fee-for-Service Program; and

WHEREAS, there are terms and conditions applicable to participation in the Mental Health Fee-for-Service Program that are not addressed in the Standard Language Document for Social Service and Training Contract ("the Contract") between the Division and the Provider Agency attached to this Addendum; and

NOW THEREFORE, the Division and the Provider Agency agree that the following additional terms and conditions are incorporated into and form a part of the Contract to which this Addendum is attached.

1. Additional Definitions

NJ Mental Health Application for Payment Processing (NJMHAPP): The secure web-based application developed by the Department to collect information from provider agencies participating in the Mental Health Fee-for-Service Program needed to process payment for services provided under this Contract.

2. Contract Services

The specific services that the Provider Agency is authorized to deliver under this Contract are listed in the Annex(es) A. The Provider Agency is authorized to deliver services under this Contract only at the sites as identified

in the Agency Administrative Information Form attached to and incorporated as part of this Contract.

The Provider Agency is authorized to deliver those services only to consumers who meet the eligibility criteria for those services as set forth in applicable regulations, policies, guidelines and/or Annex(es) A.

The Provider Agency shall not deny services to an otherwise eligible consumer solely because the consumer will receive services funded by the State at the rate set forth under this Contract.

3. Payment

Payment for services delivered under this Contract shall be at the rate per unit of service delivered as set forth in Annex B-2.

Payment will be made for authorized services delivered based on claims data entered into the NJMHAPP by the Provider Agency. Claims will be paid on a bi-weekly basis.

For programs that are authorized to receive payment for pre-admission services under this Contract, payment for those services is contingent on the consumer's discharge from the hospital and admission to the Provider Agency's program.

Prior authorization for services under this contract is not a guarantee of payment for those services.

4. Monthly Limits

The Provider Agency shall be subject to the monthly limit on payment set forth in Appendix B-2 for services delivered under this Contract. The monthly limit is the limit for payment for all programs that the Provider Agency is authorized to deliver under this Contract except for Community Support Services, which has a separate monthly limit. For programs that are authorized to receive payment for pre-admission services under this Contract, payment for those services is not counted against the monthly limit.

a. Provider Agency Requests to Increase Monthly Limits

A Provider agency may submit a request for an increase in the monthly limit to the Division if the Provider Agency's claims for the month exceed 90% of its monthly limit. The request must include the justification for increasing the limit and how long the increase is needed. The maximum length

of time that the monthly limit can be increased is the remaining number of months of the Contract period, including the month for which the request is made. Requests must be submitted no later than the 15th of the month following the applicable service month. Requests for an increase in the monthly limit shall be granted at the discretion of the Division depending on the justification of the request and available resources.

b. Division-initiated Modifications to the Provider Agency Monthly Limits

Provider Agency acknowledges that the monthly limit set forth in Appendix B-2 typically is based on Provider Agency's available claims history during its prior contract term. Provider Agency therefore consents to a modification to the monthly limit during the term of this contract if, the Division determines in its reasonable discretion that the claims submitted by the Provider Agency justify a modification of the Provider Agency's monthly limit. Any such decision will be based on a review of at least six (6) months of claims data.

c. Roll-overs of unused amounts of the monthly limits

i. Monthly Limit for Programs other than Community Support Services

To insure that available resources are used to meet the needs of consumers, the Division expects that the total amount billed based on the Provider Agency’s claims during a month will be at least 80% of its monthly limit. For example, if a Provider Agency’s monthly limit is $100,000, then it is expected to submit claims totaling at least $80,000 during the month.

If the Provider Agency’s claims for payment are under the monthly limit, the entire unused portion of the monthly limit will roll over to the following month only if the Provider Agency has met the 80% threshold. If the Provider Agency’s billing for the month is less than 80% of the monthly limit, then only 50% of the unused portion of the monthly limit will roll over to the following month. For example, if the monthly limit is set at $100,000 and the Provider Agency claims total $80,000 during the month, then the entire remaining $20,000 will be rolled over to the following month. If the Provider Agency bills only $50,000 during the month, then only 50% of the remaining $50,000 will be rolled over to the following month.

The monthly limit for the purpose of establishing the 80% threshold is not affected by the amount rolled over from the prior month. Thus, if the Provider Agency's monthly limit is set at $100,000 and the Provider Agency bills only $80,000 during month one, then the monthly limit will remain at $100,000 for month two for the purpose of establishing whether the Provider Agency has met the 80% threshold even though the Provider Agency will be able to bill up to $120,000 in month two. If the Provider Agency bills only $80,000 during month two, then the Provider Agency will have met the 80% threshold and all unused funds available in month two ($40,000) will be rolled over to month three.

The total amount that can be rolled over to the following month is capped at 100% of the Provider Agency's original monthly limit. Further, the Provider Agency will not have access to unused funds available at the expiration of this Contract.

ii. Community Support Services

All unused funds will be rolled over to the following month except that the total amount that can be rolled over to the following month is capped at 100% of the Provider Agency's original monthly limit. Further, the Provider Agency will not have access to unused funds available at the expiration of this Contract.

5. Reporting Requirements

a. NJMHAPP: The Provider Agency shall register all consumers in the NJMHAPP and complete all applicable sections.

The Provider Agency shall implement internal controls sufficient to insure that information entered into the NJMHAPP is accurate. This obligation includes, but is not limited to, insuring that all claims recorded in NJMHAPP were provided to the consumer named, on the dates and for the time period indicated, and in conformance with any applicable regulatory or contractual requirements.

b. Other reporting requirements: Use of the NJMHAPP does not negate the Provider Agency's responsibility to submit other reports or information in accordance with Division requirements, including but not limited the Quarterly Contract Monitoring Reports (QCMRs) and Unified Service Transaction Forms (USTFs).

6. Payer of Last Resort

The Mental Health Fee-for-Service Program is the payer of last resort. As such, the Provider Agency shall insure that there is not another source of payment for the service. In that regard, the Provider Agency shall:

a) Maintain its status as a Medicaid Provider during the term of this Contract.

b) Confirm that the consumer does not have third party liability that covers the service to be provided, including Medicaid, Medicare, private or commercial health insurance or charity care. The consumer's status with regard to third party liability shall be monitored throughout treatment and specifically prior to recording an encumbrance or claim through the NJMHAPP. Prior to submitting any claim through NJMHAPP, Provider Agency is required to use the eMevs system to check the Medicaid status of a consumer.

c) Assist the consumer with obtaining Medicaid when the consumer is not a current Medicaid beneficiary and the Medicaid eligibility screen module in the NJMHAPP indicates that the consumer might meet the fiscal eligibility standard for Medicaid.

i. The Provider Agency is encouraged to become a qualified entity to perform Medicaid presumptive eligibility determinations to facilitate the process of insuring that eligible consumers are enrolled in Medicaid.

ii. If the Provider Agency is not a qualified entity to perform Medicaid presumptive eligibility determinations, than it shall assist consumers with a positive Medicaid screen in the NJMHAPP with submitting a Medicaid application.

d) Confirm that consumers meet the fiscal eligibility criteria for participation in the Mental Health Fee-for-Service Program through completion of the income eligibility module in the NJMHAPP.

7. Limitation of Use of Payments under this Contract

Payments under this Contract may not be used to supplement third party payment obligations.

Payments under this Contract may not be used to pay for a consumer's insurance deductible or co-payment obligation.

8. Consumer co-payments

The Provider Agency shall collect co-payments from consumers eligible to participate in the Mental Health Fee-for-Service Program pursuant to the Provider Agency's current policy.

The Provider Agency shall report revenues generated through collection of consumer co-payments on a monthly basis on a form that will be made available by the Division. Such revenue will be deducted from future payment to the Provider Agency. Revenues generated through collection of consumer co-payments reported after the final payment made under this Contract will be reimbursed to the Division through an alternate mechanism.

9. No guarantee of referrals

The Division makes no assurance of consumer referrals to programs under this Contract.

10. Wraparound support funding

The Provider Agency may apply for wraparound support funds as set forth in the Division's Wraparound (Wrap) Support Guidelines and Procedures. Such requests shall be granted at the discretion of the Division based on the factors idenfied in those guidelines and subject to the availability of funding. Wrap funds shall not be counted against the Provider Agency's monthly limit(s) as set forth in this Contract.

11. Term of Contract Addendum

This Addendum shall have the same effective date and end date as the Contract to which it is attached.

CONTRACT ADDENDUM SIGNATURES AND DATES

The terms of this Contract Addendum have been read and understood by the persons whose signatures appear below.

BY:	_____ (Signature)	**BY:**	_____ (Signature)
	_____ (Type name)		Valerie L. Mielke, MSW (Type name)
TITLE:	_____ (Type)		Assistant Commissioner (Type)
PROVIDER AGENCY:	_____ (Type)	**DEPARTMENTAL COMPONENT:**	DMHAS (Type)
DATE:	_____	**DATE:**	_____

Contract Number: _____

Contract Effective Date: _____

Contract Expiration Date: _____