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March 20, 2017

VIA CERTIFIED AND ELECTRONIC MAIL

Dr. Pamela Clarke
President and Chief Executive Officer
Newark Community Health Centers, Inc.
741 Broadway
Newark, NJ 07104

RE: Final Audit Report – Newark Community Health Centers, Inc. (MFD-[redacted])

Dear Dr. Clarke:

The New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), conducted an audit of Newark Community Health Centers, Inc. (NCHC) covering the period July 1, 2014 through December 31, 2014. OSC selected NCHC, a Federally Qualified Health Center (FQHC), for a limited scope review to determine whether NCHC received proper Medicaid wrap-around payments for services rendered. This final audit report includes OSC's findings and NCHC's response.

Executive Summary

In order for an FQHC to be reimbursed for services rendered, the FQHC first seeks payment from the appropriate Managed Care Organization (MCO). Based on the level of coverage, the MCO may pay the FQHC all, a portion or none of the claim. If the MCO reimbursement is less than the total amount of the encounter claim, the FQHC will then submit a claim for the balance due to the Medicaid program, which will then make a supplemental payment ("wrap-around") to the FQHC for the difference.

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid/NJFC) programs, OSC conducted a limited scope audit of NCHC that focused on the reconciliation of wrap-around payments made to NCHC. As part of this audit, OSC confirmed with the MCOs whether NCHC received payments for the encounter claims that correlate with information on NCHC's quarterly wrap-around reports. Using this approach and after several reconciliations

with NCHC, OSC determined that NCHC was overpaid for 25 encounter claims totaling $3,473.62. The overpayment is attributed to instances where NCHC's wrap-around reports did not reconcile with reports NCHC submitted to the MCOs or to reports indicating that the MCOs denied payments.

Background

FQHC services are provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists and clinical social workers in accordance with State and federal regulations. FQHCs operate in underserved communities, servicing individuals who have Medicaid, Medicare, private insurance, or no health insurance. FQHCs must provide services regardless of a patient's ability to pay or health insurance status.

FQHCs are guaranteed a specific reimbursement amount for every Medicaid recipient encounter billed. A billable claim occurs when a patient visits an FQHC, has face-to-face contact with a qualified practitioner and receives medically necessary services. FQHCs receive reimbursement for billable claims either on a fee-for-service (FFS) basis directly from Medicaid or on a managed care basis (encounter) where an MCO and the Medicaid program establish a methodology to pay the total guaranteed reimbursement amount. FFS payments occur when a Medicaid recipient who is not enrolled in an MCO receives a medically necessary service from an FQHC or when the State Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has carved out of the MCO contract the particular service rendered and pays on a FFS basis. For Medicaid recipients who are enrolled in an MCO, the FQHC bills the MCO for the encounter. Based on the level of coverage, the MCO may pay the FQHC all, a portion, or none of the encounter claim. When an MCO pays the FQHC for a portion of an encounter claim, the Medicaid program makes a supplemental payment to the FQHC to make up the statutorily required difference. When an MCO denies an FQHC claim, the FQHC and MCO must resolve the denied claim before the FQHC can submit it to the State's Medicaid program for payment.

FQHCs are required to submit quarterly wrap-around reports to the Medicaid program in order to receive supplemental payments for MCO encounter claims. This quarterly report documents the number of MCO encounters multiplied by the reimbursement rate per encounter, less the payments received by an FQHC from an MCO for each encounter, during the quarter. Overpayments to an FQHC may occur when the FQHC submits overstated numbers of MCO encounters, understated MCO payments, or both.

NCHC is an FQHC provider located in Newark, New Jersey. NCHC enrolled in the Medicaid program effective July 1, 1987.

Objective

The objective of this audit was to determine whether NCHC's quarterly wrap-around reports were supported by the appropriate documentation.

Scope

The scope of this audit entailed a review and reconciliation of NCHC's quarterly wrap-around reports to corresponding MCO information for the period beginning July 1, 2014 through December 31, 2014. The audit was conducted under the authority of *N.J.S.A.*52:15C-1, *et seq.* and the Medicaid Program Integrity and Protection Act, *N.J.S.A.* 30:4D-53 *et seq.*

Audit Methodology

The audit methodology entailed the reconciliation of quarterly wrap-around reports NCHC submitted to Medicaid with the documentation that NCHC submitted to the MCOs for the period audited.

Audit Finding

Wrap-Around Encounter Reconciliation

After several attempts to reconcile NCHC's wrap-around reports, OSC's final reconciliation found that NCHC's wrap-around reports did not reconcile with the MCO documentation as follows:

1. OSC identified 23 encounters with payments totaling $3,197.24 that were reported to Medicaid on quarterly wrap-around reports that were denied by the MCOs. NCHC's documentation did not include any evidence that NCHC and the MCOs had resolved any of these denied claims. NCHC must resolve all MCO denials before submitting the claim to the Medicaid program for payment. NCHC did not resolve these 23 denied claims before submitting them to the Medicaid program. Consequently, OSC seeks to recover the overpayment totaling $3,197.24.

2. OSC identified 2 encounters with payments totaling $276.38 that were reported to Medicaid on quarterly wrap-around reports that were not included on the encounter data that NCHC submitted to the MCOs. Consequently, OSC seeks to recover the overpayment totaling $276.38.

Overall, OSC seeks the recovery of $3,473.62 for 25 encounters that were improperly reported on wrap-around reports to the State Medicaid program.

Recommendations

OSC recommends that NCHC reimburse Medicaid a total of $3,473.62. Also, NCHC needs to strengthen its internal controls over the review of encounter data submitted to the MCOs by reconciling encounter data submitted to the MCOs with encounter data submitted to the Medicaid and by advising Medicaid of any errors in subsequent quarterly submissions.

Additionally, OSC recommends that NCHC should reinforce the requirements of wrap-around reporting by training its employees in this facet of NCHC's operations.

NCHC's Response

In its response, NCHC did not agree with the Audit's finding or recommendation to strengthen its internal controls over the review of encounter data submitted to the MCOs. NCHC stated that "the balance of 25 encounters out of 48 encounters in your earlier finding totaling $3,473.62 unpaid by the MCOs represented face to face service NCHC provided to its patients." In addition, NCHC did not provide a CAP, which would address the corrective action it plans to take to resolve the issue identified in this audit. In its response, NCHC claims that it "has a strong and efficient internal controls over the review and reconciliation of its wrap process."

The full text of NCHC's response is included as an Attachment to this report.

OSC's Comments

NCHC's response is dismissive. Although NCHC stated that the balance of 25 encounters totaling $3,473.62 were not paid by the MCOs, NCHC did not provide any documentation indicating that it attempted to resolve those denied claims with the MCO before seeking payment from the State Medicaid program. According to DMAHS' July 2014 Newsletter, Volume 24, No. 09, *"FQHC Wraparound Reimbursement: Confirming Policies for Determining Valid Medicaid-Eligible Encounters & FQHC Appeals Process,* FQHCs must first submit an encounter to an MCO before submission to the State (DMHAS) for payment. All MCO denied claims must be resolved before seeking payment from DMHAS. By simply stating that NCHC provided face to face service to its patients, NCHC did not address whether it resolved these claims with the MCOs before submitting them to the State Medicaid program for payment. By ignoring that critical issue, NCHC failed to provide a basis for having sought payment for these claims from the State Medicaid program.

Moreover, NCHC is being somewhat disingenuous in suggesting that it has a strong and efficient internal controls over the wrap payment process. Clearly, NCHC is not adhering to a fundamental aspect of the wrap payment process in that any encounter claim denied by an MCO must first be resolved before a claim can be submitted to the State Medicaid program for payment and NCHC did not provide any evidence to show that it is following that process.

Therefore, OSC maintains its finding and requests that NCHC reimburse Medicaid $3,473.62 and implement specific policies and procedures to address the Audit's Recommendations. To ensure that NCHC implements the necessary policies and procedures, OSC will consider including conducting an audit of NCHC as part of its next or future Annual Audit Plan.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: _____
Josh Lichtblau, Director
Medicaid Fraud Division

Attachment

Cc: Meghan Davey, Director, DHS, Division of Medical Assistance and Health Services
Richard Hurd, Chief of Staff, DHS, Division of Medical Assistance and Health Services
Kay Ehrenkrantz, Deputy Director
Michael Mc Coy, Manager – Fiscal Integrity
Michael Morgese, Audit Supervisor
Glenn Geib, Recovery Supervisor

NCHC Newark Community Health Centers, Inc.

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February 16, 2017

Mr. Mohammad Malik
Auditor - Medicaid Fraud Division
New Jersey Office of the State Comptroller
PO Box 025
Trenton, NJ 08625-0025

RE: Newark Community Health Centers, Inc.'s Response to Audit Report (MFD-[redacted])

In response to your email of February 16, 2017, Newark Community Health Centers, Inc., has reviewed the said encounter report and wish to state that:

1. The balance of 25 encounters out of 48 encounters in your earlier finding totaling $3,473.62 unpaid by the MCOs represented face to face service NCHC provided to its patients.

Newark Community Health Centers, Inc., has a strong and efficient internal controls over the review and reconciliation of its wrap processes. The Billing department under the supervision of the Director of Patient Services in concert with IT department prepares and reviews quarterly wrap reports to ensure that they meet the requirement.

Periodically, our health center engages the services of Billing Consultants to train staff on all billing related tasks including wrap around methodology to ensure compliance. All wrap adjustments including rebilled claims are equally reported under prior period adjustments in current wrap reports. We have also observed that DMAHS bases its wrap payments on the MCOs information rather than all-inclusive face to face interaction between patients and health center's providers.

We have noted your recommendation and will appreciate if you revise the audit findings in your final report.

Thank you for your patience and cooperation.

Sincerely,

Pamela Clarke

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