ASSEMBLY CONCURRENT RESOLUTION No. 172

STATE OF NEW JERSEY
216th LEGISLATURE

INTRODUCED JUNE 26, 2014

Sponsored by:
Assemblywoman ANGELICA M. JIMENEZ
District 32 (Bergen and Hudson)
Assemblywoman SHAVONDA E. SUMTER
District 35 (Bergen and Passaic)
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District 35 (Bergen and Passaic)
Assemblywoman ANNETTE QUIJANO
District 20 (Union)

Co-Sponsored by:
Assemblywoman Pinkin, Assemblymen McKeon, O'Scanlon,
Assemblywomen Riley, Watson Coleman, Assemblyman Burzichelli,
Assemblywoman Tucker and Assemblyman Diegnan

SYNOPSIS
Urges Governor to take necessary measures to ensure full, prompt payment of Medicaid wraparound payments to federally-qualified health centers.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 10/17/2014)
A CONCURRENT RESOLUTION urging the Governor to take the necessary measures to ensure full, prompt Medicaid wraparound payments to federally-qualified health centers.

WHEREAS, The Medicaid program, established pursuant to 42 U.S.C. ss.1396 et seq., provides medical assistance to certain low-income people, including families with dependent children, pregnant women, people over 65 years of age, and people who are blind or who have a total or permanent disability, who meet certain income and other eligibility requirements; and

WHEREAS, The Medicaid program is jointly funded by state and federal governments but is entirely administered by the individual states, which must meet certain federal requirements when implementing that state’s Medicaid program; and

WHEREAS, States participating in the Medicaid program must offer non-profit federally-qualified health centers (FQHCs), which provide health care services to medically underserved communities; and

WHEREAS, In New Jersey, FQHCs are reimbursed for Medicaid-eligible claims through the Prospective Payment System (PPS), which assesses a set rate for reimbursement amounts; and

WHEREAS, New Jersey has adopted a managed care program that provides health care services through managed care organizations (MCOs), which receive prospective payments from the State based on a fixed monthly fee per patient and anticipated use of services; and

WHEREAS, MCOs in the State contract with FQHCs to provide health care services and reimburse the FQHCs for Medicaid-covered encounters out of the prospective payment funds provided by the State; and

WHEREAS, Frequently, the contracted-for payments from MCOs to FQHCs are less than the full amount FQHC is entitled to receive under the PPS; in these situations, the State is required by the federal Medicaid statute to make a supplemental payment at least once every four months, known as a “wraparound payment,” to make up the difference between the MCO payment and the full PPS amount; and

WHEREAS, In 2011, the State Department of Human Services (DHS) announced that it was revising the formula for calculating wraparound payments out of a concern that the formula then in use was resulting in substantial overpayments by the State to FQHCs for possibly invalid Medicaid claims; and

WHEREAS, The revised formula required that FQHCs report additional information when making reimbursement claims, and additionally required that an MCO have provided payment for a Medicaid-eligible claim as a prerequisite to the State reimbursing the FQHC for the balance of the claim, on the theory that this process would
help ensure the validity of any Medicaid claims submitted for reimbursement; and

WHEREAS, The New Jersey Primary Care Association (NJPCA) brought a lawsuit against the DHS in the United States District Court of New Jersey claiming the new formula violated the federal Medicaid statute; and

WHEREAS, The district court ruled in favor of the NJPCA and the State appealed to the Third Circuit Court of Appeals in N.J. Primary Care Ass’n v. State Dep’t of Human Servs., 722 F.3d 527 (3d Cir. 2013); and

WHEREAS, The Third Circuit held on appeal that, because it is possible that MCOs may improperly deny Medicaid-eligible claims, the State’s requirement that wraparound payments be contingent on prior MCO payment could result in underpayment of wraparound payments in violation of the federal Medicaid statute requirement that FQHCs receive full, timely wraparound payments for all Medicaid-eligible claims; and

WHEREAS, The Third Circuit ruling enjoined use of the new wraparound payment formula absent a process by which an FQHC may promptly and effectively challenge an adverse MCO payment determination within the statutorily-mandated time period; and

WHEREAS, The NJPCA has indicated that the State is not in compliance with the Third Circuit Court ruling, and delayed and underpaid wraparound payments have resulted in cash flow problems for FQHCs; now, therefore,

BE IT RESOLVED by the General Assembly of the State of New Jersey (the Senate concurring):

1. The Legislature of the State of New Jersey respectfully urges the Governor to take all necessary steps, including directing State departments and agencies to take appropriate action, to ensure the State is in compliance with the ruling of the United State Third Circuit Court of Appeals in N.J. Primary Care Ass’n v. State Dep’t of Human Servs., 722 F.3d 527 (3d Cir. 2013).

2. Copies of this resolution, as filed with the Secretary of State, shall be transmitted by the Clerk of the General Assembly or the Secretary of the Senate to the Governor, the Commissioner of Human Services, and the Director of the Division of Medical Assistance and Health Services in the Department of Human Services.

STATEMENT

This concurrent resolution urges the Governor to take all necessary steps, including directing State departments and agencies to take appropriate action, to ensure the State is in compliance with
the ruling of the United States Third Circuit Court of Appeals in
N.J. Primary Care Ass’n v. State Dep’t of Human Servs., 722 F.3d
527 (3d Cir. 2013), which held that the State’s revised formula for
calculating wraparound reimbursement payments for Medicaid-
eligible services to federally-qualified health centers (FQHCs)
violates the requirement in the federal Medicaid statute that the
FQHCs receive full, timely wraparound payments for all Medicaid-
eligible services.

Currently, under the federal Medicaid statute, FQHCs are
entitled to a certain level of reimbursement for providing Medicaid-
eligible services to patients. When a managed care organization
(MCO) does not provide the full level of reimbursement for a
Medicaid-eligible claim, the State is required to provide
supplementary reimbursement that covers the balance of the full
reimbursement amount to which the FQHC is entitled. The State is
required to make these supplementary payments, which are known
as “wraparound payments,” at least once every four months.

In 2011, out of a concern that the formula then in use for
calculating wraparound payments may have resulted in significant
overpayments to FQHCs, the State revised the formula for
calculating wraparound payments to require FQHCs report
additional information when submitting claims and to require that
an MCO approve and provide payment for a claim as a precondition
for the State’s wraparound payment for the balance of the claim.

The Third Circuit Court of Appeals found that MCOs may
improperly deny Medicaid-eligible claims for any number of
reasons, resulting in underpayment of the appropriate wraparound
payment amount. Because the federal Medicaid statute requires
prompt wraparound payments to fully compensate FQHCs, the
court found the risk of underpayment under the revised formula
constitutes a violation of the federal Medicaid law, and enjoined
implementation of the revised formula.

This concurrent resolution respectfully urges the Governor to
take all necessary steps to ensure the State is in compliance with the
ruling of the United States Third Circuit Court of Appeals.