EXECUTIVE SUMMARY

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
FEDERALLY QUALIFIED HEALTH CENTERS

We found encounters that were submitted by the FQHCs to the division for wraparound reimbursements that were not properly supported. In addition, we found medical records and the related reimbursements that did not agree with the claims data recorded in the New Jersey Medicaid Management Information System (NJMMIS). In making these determinations, we found FQHCs that did not submit changes in scope information to the division which could result in an adjustment to their reimbursement rate, quarterly invoices for wraparound reimbursements did not identify receipts from third parties and may have resulted in overpayments to the FQHCs, and the division does not review the servicing providers on fee-for-service claims to determine if they are approved Medicaid eligible providers, as well as other reportable conditions. We also observed that the FQHCs are not submitting wraparound invoices timely, nor are they fully utilizing the division’s appeal process to challenge the HMOs’ determinations of invalid Medicaid claims.

AUDIT HIGHLIGHTS

• Since a 2013 court ruling, any request for a wraparound payment by an FQHC must be properly supported by claim data. We requested claim data directly from 17 FQHCs, for three quarters from 2010 to 2012, a period when FQHCs were not required to submit documentation. The centers could not provide adequate supporting documentation. Differences were noted in the number of encounters, receipt amounts, and prior period adjustments that were being reported by the FQHCs.

• In our testing of claim activity prior to the court ruling, we determined that the state reimbursed FQHC encounters totaling $9 million in wraparound payments for encounters that were not approved by the HMOs in the NJMMIS.

• We could not trace service providers on the FQHC billing documents to medical records for 117 (23%) encounters tested. FQHCs billed services under other provider’s National Provider Identification number. Service providers must be credentialed by the HMOs or the claim will be denied. Some FQHCs billed for services using a credentialed provider to ensure reimbursement, even though the provider did not provide the service. This practice is inappropriate and should be further investigated by the division.

• We visited six FQHCs and determined that five centers had 67 changes in scope of service. However, only nine were submitted to the division and only two resulted in an adjustment to the providers’ APM rates. The other seven changes did not result in an APM adjustment because the applications were incomplete.

AUDITEE RESPONSE

The department generally concurs with our findings and recommendations.

For the complete audit report click here.