STATE OF NEW JERSEY

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

COMPLIANCE AUDIT

CAMCARE HEALTH CORPORATION
FINAL AUDIT REPORT

Marc Larkins
ACTING STATE COMPTROLLER

February 10, 2014

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BACKGROUND

As part of its oversight of the Medicaid and New Jersey FamilyCare programs, the Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted an audit of CAMcare Health Corporation (CHC), a Federally Qualified Health Center (FQHC). FQHCs provide primary care medical services to Medicaid and New Jersey FamilyCare recipients. CHC has one main office and seven satellite facilities, the majority of which are located in Camden, New Jersey.

In accordance with state and federal regulations, FQHCs' services are provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists and clinical social workers. FQHCs must provide their services regardless of the patient's ability to pay or health insurance status. CHC's specific services include, but are not limited to, primary medical care, obstetrics and gynecology (Ob/Gyn), dental care and podiatry.

FQHCs are guaranteed a specific reimbursement amount for every Medicaid patient encounter they bill. A billable encounter occurs when a patient comes to an FQHC and has a face-to-face contact with a qualified practitioner, receiving medically necessary services. The reimbursement amount during the period of our audit was approximately $140 per encounter. FQHCs receive this reimbursement either on a fee-for-service basis directly from the state's Division of Medical Assistance and Health Services (DMAHS), or on a managed care basis in which a managed care organization (MCO) and DMAHS combine to pay the total guaranteed reimbursement amount.

Fee-for-service encounters occur when a Medicaid recipient who is not enrolled in a Medicaid MCO receives a medically

necessary service from the FQHC. For those 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 all, a portion or none of the encounter claim. If the MCO pays less than the total amount of the encounter claim (approximately $140 per encounter), DMAHS makes a supplemental payment to make up the difference. For example, if the MCO pays $60 on an encounter claim, DMAHS is responsible for paying the remaining $80.

To receive these supplemental payments from DMAHS, FQHCs must submit Quarterly Reports to DMAHS. These Quarterly Reports document the number of encounters multiplied by the reimbursement amount per encounter, less the payments received by the FQHCs from the MCOs for the quarter. Overpayments to an FQHC can occur when the FQHC submits overstated numbers of managed care encounters or understated MCO payments, or both.

OBJECTIVE AND SCOPE

The objective of OSC's audit was to determine whether CHC operated under all proper licensing and regulatory standards set forth in the New Jersey Administrative Code and the Code of Federal Regulations for the period January 1, 2009, through December 31, 2010.

This audit was conducted under OSC's authority as set forth under the *Medicaid Program Integrity and Protection Act,* N.J.S.A. 30:4D-53 *et seq.* and N.J.S.A. 52:15C-23.

SUMMARY OF FINDINGS

OSC reviewed CHC's compliance with federal and state regulations and found multiple areas of non-compliance, resulting in state overpayments to CHC totaling more than $480,000.

For example, OSC determined that CHC lacked sufficient documentation to support its quarterly reimbursement requests to the state. Additionally, OSC determined that patient records maintained by CHC were either not properly updated or were inaccurate. OSC's review also determined that in some cases, CHC billed the state twice for the same services.

OSC further found numerous problems at CHC's satellite locations. For example, an inspection of one facility revealed expired medications, unlocked medicine cabinets and confidential medical information in unsecure locations within the facility. Another site was not open during its posted 40 hours per week, resulting in an overstated federal grant. This same site was operating as an FQHC without proper federal approval. Similarly, another CHC site was not an approved Medicaid provider, yet it was submitting for and receiving Medicaid payments.

The findings in this report highlight the inadequacy of the internal controls at CHC, including the lack of appropriate oversight by CHC management.

QUARTERLY REPORTS

On a quarterly basis, CHC submits its monthly encounter and MCO receipts data to DMAHS. DMAHS reimburses CHC

based on the quarterly information that it provides. The quarterly information provided by CHC is set forth in an aggregate spreadsheet format without claim-level detail supporting the encounters listed, or the specific payments received from the MCOs corresponding to encounters that occurred during the quarter. There is no requirement that CHC provide such detailed information with the quarterly reports it provides. The absence of such a requirement may lead to a lack of accountability on the part of CHC with respect to the Quarterly Reports it submits.

Similarly, there is no requirement for the MCOs to submit source documentation to DMAHS concerning the payments they provide to CHC. Such a requirement would allow DMAHS to independently verify the information CHC provides via the Quarterly Reports.

In our testing, OSC compared CHC's internal reports to the quarterly submissions it provided to DMAHS. According to CHC, these internal reports are the source documents that CHC relies on to support the Quarterly Reports it submits.

OSC found that for the period January 1, 2009, through December 31, 2009, CHC overstated its number of encounters by 276, resulting in a state overpayment of $37,257. This overpayment occurred primarily because CHC improperly double billed for certain Ob/Gyn encounters.

For the period January 1, 2010, through December 31, 2010, OSC found that CHC overstated its encounters by 202, resulting in an overpayment of $27,595. OSC could not determine and CHC could not provide specific reasons for the cause of this discrepancy.

To test MCO payments reported by CHC to DMAHS, OSC obtained payment information directly from the MCOs for the

audit period and compared that information to CHC's internal documentation. OSC determined that CHC understated its MCO payments by $5,313, resulting in a state overpayment in that same amount.

As a result of these errors, OSC will seek recovery of $70,165 from CHC.

Recommendation No. 1:

CHC should include only appropriate categories of encounters on its Quarterly Reports.

Recommendation No. 2:

CHC should reconcile its internal monthly reports to the Quarterly Reports it submits to DMAHS for reimbursement.

Recommendation No. 3:

CHC should reconcile source documents reflecting payments received from the MCOs with reports it submits to DMAHS. Any discrepancies should be resolved.

Recommendation No. 4:

DMAHS should require the MCOs to submit to DMAHS on a quarterly basis documentation supporting the payments they made to the FQHCs. DMAHS should further require the FQHCs to submit claim-level documentation supporting their aggregate supplemental payment requests. On a quarterly basis, DMAHS should reconcile the information provided by the MCOs and the information provided by the FQHCs. If a material difference is found, further analysis should be undertaken by DMAHS, the MCO and the FQHC to determine the reason for the difference. This process should occur prior to DMAHS issuing payment to the FQHCs.

PATIENT RECORDS

Pursuant to 42 C.F.R. 491.10 and N.J.A.C. 10:66-1.6, CHC is subject to various patient record requirements. These requirements govern the collection of medical information and specify how patient records must be maintained, protected and stored. For example, regulations require that all physical examinations, diagnostic and consultative findings and subsequent treatment plans stemming from an encounter must be recorded on a progress note. These progress notes must be accompanied by an encounter form that documents the procedure codes for which the physician is billing. A physician's signature must substantiate these encounters.

OSC reviewed a sample of 37 patient records corresponding to 119 dates of service. Our review identified, for example, the following:

- One date of service was missing an encounter form.
- For four dates of service, progress notes were either missing or incomplete.
- There was one date of service where CHC billed for and was reimbursed for an unbillable service.
- There were two consecutive dates of service where the same vaccinations were administered to a patient, indicating a duplicate billing by CHC.

As a result of these deficiencies, OSC will seek recovery of $259,513 from CHC.

OSC found other control weaknesses and compliance deficiencies in CHC's documentation concerning the Vaccines for Children program (VFC). VFC is a federally funded program that is administered by the state's health department.

VFC provides vaccines to children at little to no cost if they are deemed eligible due to being uninsured, underinsured or Medicaid eligible. Eligible children can receive the vaccinations at a participating FQHC or provider's office.

In our testing, OSC found that for 12 of the 56 dates of service on which vaccinations were given to minors, there was no evidence that CHC verified that the minors were eligible for the vaccinations. OSC also found instances where incorrect procedure codes were inputted into the billing system. There were also two dates of service where CHC improperly billed for duplicate encounters.

Recommendation No. 5:

CHC should maintain up to date and complete patient records including all progress notes and encounter forms.

Recommendation No. 6:

CHC should implement policies and procedures for verifying that all children receiving a vaccine under the VFC program are eligible.

Recommendation No. 7:

CHC should implement a system to ensure that duplicate billings do not occur.

Recommendation No. 8:

CHC should ensure that physician procedure codes are properly entered into its billing system.

FACILITY LICENSING/APPROVALS

A. Medicaid Program

As noted previously, CHC operates eight facilities including one main office. An FQHC with multiple locations may bill Medicaid either by using one main provider identification number for all of its sites or by using each site's unique provider identification number. In order to receive reimbursement from the Medicaid program, each site must meet the following requirements:

- Pursuant to N.J.A.C. 10:66-1.3(c)(2) and 42 C.F.R. 491.5(a)(3)(iii), each FQHC site must obtain a federal designation as an FQHC from the federal Centers for Medicare & Medicaid Services (CMS).

- Pursuant to N.J.A.C. 10:66-1.3(b), each FQHC site must obtain an ambulatory care facility license from the state Department of Health (DOH).

- Pursuant to N.J.A.C. 10:66-1.3(a), each FQHC site must individually enroll with DMAHS as a Medicaid provider.

OSC found that contrary to state regulations, DMAHS approved one of CHC's sites, named the Odessa Paulk-Jones site (Odessa), prior to it obtaining CMS approval. Specifically, CHC received Medicaid reimbursement for services provided at that site from January through December 2010, even though CMS did not approve Odessa until November 15, 2011. As a result, CHC received $97,952 in improper Medicaid payments during our audit period.

Another CHC site, Antioch Manor (Antioch), received $43,096 in Medicaid reimbursements during 2009 and 2010 even though it was not an approved Medicaid provider at that time. CHC was able to bill Medicaid for services rendered at Antioch by

using one main provider identification number instead of using each CHC site's unique identification number. Antioch became an approved Medicaid provider on June 1, 2011.

As a result of these errors, OSC will seek recovery of $141,048. OSC will also seek recovery for amounts improperly received by CHC that were outside the audit scope period.

Recommendation 9:

DMAHS should ensure that any FQHC facility has received CMS approval prior to enrolling it as a Medicaid provider.

Recommendation No. 10:

DMAHS should amend N.J.A.C. 10:49-3.3, which currently allows multi-location providers to bill using one provider identification number. This practice allows unapproved Medicaid sites to claim reimbursement under a different site's provider identification. In the alternative, DMAHS should ensure that the servicing location is reported for each claim by providers with multiple sites.

B. Uninsured Program

Under a separate Letter of Agreement (LOA) with DOH's Office of Primary Care, CHC also provides services to patients in the state's Uninsured Program. This program provides coverage for uninsured patients. Pursuant to the LOA, a facility must have an ambulatory care license in order to receive payments from the state under the uninsured program.

OSC found that CHC's Antioch site received payments under the Uninsured Program even though it was not licensed as an ambulatory care provider.

Recommendation No. 11:

DOH should recover payments to CHC for uninsured visits at the Antioch site during the period when the site was not licensed as an ambulatory care facility.

MEDICAL STAFF LICENSING/CERTIFICATIONS

During our audit period, CHC employed 145 medical staff employees, including physicians, nurse practitioners, dentists and medical/dental assistants. OSC obtained records of licenses/certifications for these employees to ensure that they were properly licensed for and qualified to provide the services they provided.

OSC found that one nurse practitioner was not licensed during an 18-day span during the audit period. During this time period this employee had 76 Medicaid patient encounters. OSC will seek recovery of $10,259 for the services provided by this unlicensed practitioner.

Recommendation No. 12:

CHC should ensure that all nurse practitioners maintain their licenses.

HOURS OF OPERATION

On the Medicaid enrollment application for one of its satellite facilities, CHC indicated that the facility would be open for 40 hours per week. The application for the site's federal funding from the Health Resource Service Administration (HRSA) indicated the same operational hours. According to HRSA

representatives, the number of hours a site is open affects the amount of the HRSA grant to the site.

In October 2011, OSC conducted a site visit to the facility. Contrary to its stated business hours, the facility was closed. CHC initially advised OSC that at the time, the facility was not operating during its normal business hours because one physician was on vacation and another physician was on maternity leave. OSC then obtained daily logs for the facility for the month of November 2010. Those daily logs list the names of the patients that visited the facility each day. There were no entries at all for Mondays, Wednesdays or Fridays during November 2010 for this facility.

OSC presented this information to CHC. CHC stated that the facility began operating in December 2009 and that it was still in a "ramp-up" process whereby eventually it would increase its hours of operation to 40 hours a week as it obtains more patients. In its HRSA grant application, however, there was no mention of the "ramp-up" process CHC officials described. The application simply states that the facility is to be open 40 hours each week. Further, in reviewing the number of patient visits in the other eleven months of 2010, OSC determined that there was no significant increase in visits indicative of any "ramp-up" process.

Recommendation No. 13:

CHC should amend its HRSA and Medicaid applications to reflect the hours the site is actually open.

CHANGE IN SCOPE OF SERVICE

In order to obtain reimbursement from the Medicaid program, FQHCs bill for each patient encounter at a specified rate.

When an FQHC has a "change in scope," the change must be filed with DMAHS so that the applicable reimbursement rate can be revised. A "change in scope" is defined by regulation as:

- The addition of a new FQHC covered service that is not incorporated in the baseline rate or a deletion of an FQHC covered service that is incorporated in the baseline rate;
- A change in scope of service due to amended regulatory requirements or rules;
- A change in scope of service resulting from relocation, remodeling, opening a new clinic or closing an existing clinic site; and/or
- A change in scope of service due to applicable technology and medical practice.

N.J.A.C. 10:66-1.5 (e) (vi) (1).

A "change in scope" application must be filed at least 60 days prior to the effective date of any change(s). OSC found the following two instances in which CHC did not file with DMAHS a change in scope application as required:

- In 2009, CHC instituted an electronic medical record system, which replaced its paper medical records.
- In 2009, CHC opened a new facility.

Recommendation No. 14:

CHC should file a change in scope application with DMAHS for the events stated above, and for any changes that require such an application in the future.

THIRD-PARTY LIABILITY

Medicaid's fee-for-service program entitles providers such as CHC to bill DMAHS directly for each service rendered rather than first seek payment from an MCO if the patient is not enrolled in an MCO. OSC randomly selected ten patients that received medical services from CHC under the fee-for-service program. OSC sought to determine whether these patients were enrolled in an MCO when CHC submitted a fee-for-service bill for services provided to them.

OSC found that one of the ten patients was enrolled in an MCO on the date of service that CHC billed Medicaid for that recipient. CHC should have instead billed the MCO because Medicaid is the payer of last resort in such instances. OSC will seek recovery of $136.61 for this date of service.

Recommendation No. 15:

CHC should implement procedures to ensure that insurance verifications are conducted for each patient visit.

INSPECTION OF FACILITIES

OSC conducted an on-site inspection of CHC's main facility as well as its seven satellite facilities as part of the process of assessing compliance with applicable state and federal regulations.

We found the following:

- There were three instances at three separate CHC facilities where confidential medical information was found in unsecured locations.

- There were five instances at four separate CHC facilities where expired medication/supplies were being administered/used.
- There were two instances at one CHC location where unlocked medication and syringes were observed. These items were readily accessible to any individual in the area.
- There were four instances, three of which were at the same CHC facility, where inspections to check the calibration of medical equipment had not been performed. In addition, there was a biohazard receptacle missing from an examination room at one of CHC's facilities.
- Two CHC facilities did not have an updated refrigerator log.
- Three CHC facilities lacked documentation of recent fire inspections at the facility.
- Two different CHC facilities failed to post required information in the waiting area setting forth federal Department of Health and Human Services contact information.

Recommendation No. 16:

CHC should ensure the security of all confidential medical information. CHC should implement measures designed to identify and assess internal risks associated with the disclosure of such information.

Recommendation No. 17:

CHC should ensure proper medication storage and integrity.

Recommendation No. 18:

CHC should ensure that all of its facilities have updated refrigerator logs.

Recommendation No. 19:

CHC should identify and dispose of expired medications in compliance with federal and state laws and regulations.

Recommendation No. 20:

CHC should conduct periodic inspections and calibrations of all electrical and mechanical equipment to ensure operational safety. CHC should maintain records of those inspections.

PROGRAM EVALUATION

Federal regulations require that FQHCs arrange for or carry out an annual evaluation of their medical program. The evaluation must include "the utilization of clinic or center services, including at least the number of patients served and the volume of services." 42 C.F.R. 491.11. In addition "a representative sample of both active and closed clinical records" as well as "the clinic or center's health care policies" must be included in the evaluation. *Id.* The purpose of the evaluation "is to determine whether the utilization of the services was appropriate, whether the established policies and procedures were followed and if any changes are needed." *Id.* "The clinic or center's staff will then consider the findings of the evaluation and take corrective action, if necessary." *Id.*

OSC found that CHC failed to comply with this regulation by not conducting the required review of its program. CHC submitted its Uniform Data System (UDS) reports to OSC in an attempt to demonstrate that it met this requirement. UDS reports reflect, among other things, demographic information concerning the population of patients the FQHC serves as well as the types of medical services provided to the patients.

However, UDS reports do not meet the comprehensive requirements of this federal regulation as set forth above.

Recommendation No. 21:

CHC should comply with 42 C.F.R. 491.11 to ensure that appropriate internal oversight is being conducted.

APPENDIX A

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER (856) 541-3270
817 FEDERAL STREET, CAMDEN, NJ 08103

December 6, 2013

Richard Goldin
Supervising Auditor
State of New Jersey
Office of the State Controller
Medicaid Fraud Division
PO Box 025
Trenton NJ 08625-0025

RE: CAMcare Health Corporation, Provider Number: [redacted]
Compliance Audit- Revised Draft Audit Report November 13, 2013

Dear Mr. Goldin:

This will serve as CAMcare Health Corporation's ("CAMcare") response to the Office of the State Comptroller ("OSC"); Medicaid Fraud Division's Revised Draft Audit Report ("Revised Report") dated November 13, 2013. This response, being submitted by the December 3, 2013 deadline, is therefore timely filed.

In Response to Revised Draft Audit Report

The OSC's Revised Report largely ignores the evidence of CAMcare's compliance; rather, the Revised Report maintains every finding of noncompliance and does not modify any calculation for alleged overpayments. Accordingly, CAMcare again submits documentation as evidence of compliance with both state and federal standards as set forth by the rules, regulations, and processes established by each of those agencies charged with setting such rules and determining compliance with said rules.

Comptroller Note 23

As previously referenced, Gwendolyn L. Harris, the Commissioner of the Department of Human Services, revised the procedure for obtaining a Medicaid number. CAMcare now includes the Commissioner's memorandum to the NJ Primary Care Association that states that the Department of Medical Assistance and Health Services (DMAHS) allows for the enrollment of FQHC's prior to completion of the Medicare Process (see, e.g., ¶ 3) (See Attachment A).

Comptroller Note 16

In addition, CAMcare referenced a letter from the Department of Health and Senior Services, from John A. Calabria, Director of Certificate of Need and Healthcare Facility Licensure Program, stating that in regards to all FQHC's, "it is the Department's policy when a health care service is provided for eight hours or less per week, a license to operate is not required at that location." CAMcare now includes an example letter from John A. Calabria to Community Health

Center, Inc. on February 13, 2009, in addition to the letter addressed to CAMcare dated February 14, 2008 (See Attachment B).

Comptroller Note 8

In regards to the larger financial finding, CAMcare previously addressed the matter in a similar matter with the State of New Jersey. In the Revised Report, OSC alleges that the medical records were not properly updated. This is contrary to their initial finding; services were performed and recorded in a progress note as outlined in N.J.A.C. 10:66-1.6. Medicare regulations as stated in Change Request Number 6698 states that "in order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information." CAMcare previously provided such statements for the three visits. The Revised Report states that five records were included in their calculation of overpayment for noncompliant patient records.

Comptroller Note 10

As the OSC failed to provide their documentation, CAMcare cannot address whether such findings are accurate. Based on the available evidence, however, CAMcare believes that the records used in the findings do not support the alleged overpayment due to noncompliant records of CAMcare patients (See Attachment C).

In addition, in regards to CAMcare's quarterly reports, OSC previously noted that there is no requirement that CAMcare provide detailed information with quarterly reports it provides. Rather, the Revised Report recommends a state-wide policy level change to the reporting requirements without any finding that CAMcare's quarterly reports are noncompliant with any current laws or regulations. Accordingly, CAMcare respectfully submits that its compliance with current regulations does not constitute noncompliance nor does it comprise overpayment to the DMAHS.

Background

CAMcare Health Corporation will this year be celebrating 35 years of existence. The Federally Qualified Health Center began in a church in 1978 and has grown to eight sites, employs approximately 200 employees, and generates 135,000 encounters a year. CAMcare is located in the City of Camden, ranked as one of the poorest and most dangerous cities nationwide. Forty percent of the population and 57% of all children in this area live below the federal poverty level. Thirty percent of the residents are under or uninsured.

Our mission statement, "We provide high quality comprehensive care to the families we serve". To support this statement CAMcare has been approved by the Joint Commission of Accreditation of Healthcare Organizations on four separate occasions; 2004, 2007, 2010 and 2013. We exist to fill the void of barriers to preventative and primary health care. The dismal health indicators and health disparities among Camden's underserved populations reflect the need for culturally competent delivery of care. Several of our doctors have been rated as "Top Docs" in the South Jersey area. Our providers enjoy the privilege of being teachers and mentors to the residents at Cooper Hospital, the interns at UMDNJ, the physician assistants at Drexel Medicine, the nurse practitioners at University of Pennsylvania, and the nurses at Rutgers.

Only a decade ago, citywide age appropriate immunization rates for two year olds were 32%. Today, those rates approximate 60% and continue to require our on-going vigilance.

Given the lack of access to dental care for the poor in Southern New Jersey, CAMcare accepts patients from as far away as Cape May. Several neighborhoods in Camden lacked access to primary and emergency oral care. High dental need and low access promulgated our decision to open the Odessa Paulk Jones Health Center. CAMcare has operated a site in South Camden since 1983, which was limited to pediatrics and internal medicine. Given the needs of the community, CAMcare decided to bring oral health and prenatal services to this neighborhood site.
Antioch Manor is a housing complex for senior citizens; Antioch Baptist Church built the facility with space for a small medical suite to give proximity access to their seniors for primary care.
Given our various sources of funding, the operations of CAMcare are reviewed periodically by various State and Federal agencies. To date our review scores have been rated as excellent. In our HRSA review which covered the following: need, services management and finance, and governance CAMcare scored in the 90 percentile with a commendation for best practice in customer service.

The Department of Health and Senior Services, Division of Family Health Services, Office of Primary Care and Rural Health have completed two compliance audits in the last three years; we scored in the 98 and 95 percentile.
CAMcare Health Corporation based on its sound reputation, high quality outcomes, and prudent management continues to be a model for FQHC's across the country.

General Objections
The Draft Audit Report contains several inaccurate and inconsistent findings. CAMcare was never overpaid $480,000, these were assessments made by the OSC staff based on the deficiencies found in other State of New Jersey departments whose responsibility it was to guide CAMcare appropriately through certain approval processes. CAMcare based on an evaluation of the findings of the audit is willing to make a payment of $70,307 (Attachment D) to the State of New Jersey Medicaid Program for the wrap-around finding and the remaining payment related to an expired provider license.

There are several findings (which noted below) where CAMcare would have benefitted from audit work papers and other supporting documentation relied on by the auditors. We, therefore request OSC's audit work papers and an opportunity to review all related work paper documents.

Quarterly Wrap-around Reports
OSC Finding
OSC found that for the period January 1, 2009 through December 31, 2009, CHC overstated its encounters by 276 resulting in an overpayment of $37,257.24. This overpayment primarily occurred because, contrary to federal regulations, Ob/Gyn surgical and delivery encounter were included on the wraparound reports.
For the period of January 1, 2010 through December 31, 2010, OSC found that CHC overstated its encounters by 202 resulting in an overpayment of $27,595.22. OSC could not determine the reason for this discrepancy.
To test MCO receipts reported by CHC to DMAHS, OSC obtained receipt information directly from the MCOs for the audit period and compared that information to CHCs internal documentation. As matter of course, the MCOs provide this information directly to DMAHS.

OSC determined that CHC understated its MCO receipts by $5,312.45 resulting in an overpayment by DMAHS by the same amount
As result of these deficiencies, OSC will seek recovery of $70,164.91.

Recommendation No. 1:
CHC should include only appropriate categories of encounter on its Quarterly Report.

Recommendation No. 2:
CHC should reconcile its internal monthly reports to the Quarterly Reports it submits to DMAHS for reimbursement.

Recommendation No. 3:
CHC should reconcile source documents reflecting payments received from the MCOs with reports it submits to DMAHS. Any discrepancies should be resolved.

Recommendation No. 4:
DMAHS should require the MCOs to submit to DMAHS on a quarterly basis documentation supporting the payments they made to FQHCs. DMAHS should further require the FQHCs to submit claim-level documentation supporting their aggregate supplement payment requests. On a quarterly basis, DMAHS should reconcile the information provided by the MCOs and the information provided by the FQHCs. If a material difference is found, further analysis should be undertaken by DMAHS, the MCO and the FQHC to determine the reason for the difference. This process should occur prior to DMAHS issuing payment to the FQHCs.

Comptroller Note 1

A change in the report submission format caused the variance in encounters from our monthly reports to the quarterly reports. In 2009, DMAHS revised its regulations(Newsletter March 2009, Volume 19 No.6) for wrap-around submission inclusive of a carve out for Ob/Gyn services. CAMcare was allowed to carve-out encounters related to Ob/Gyn fee for services, we adhered to the format change, however did not remove the encounters from the standard quarterly wrap-around report thus causing overstatement in encounters. A review of these same data elements for 2010 revealed no overstatements. Therefore, the recommendation suggested by OSC staff had already been accomplished.

Comptroller Note 2

CAMcare implemented a new electronic record and patient management system (GE Centricity and CY Solutions) in fiscal 2010. Over several months, CAMcare staff inclusive of providers, nurses, front desk registrars, and billing staff became acquainted with how the two systems worked individually and with synchronicity. We discovered that during the audit an error could occur when a provider completes orders; if the correct location of care is not linked to the visit, a duplicate ticket is created. We worked with both the Centricity and CPS systems to eliminate the problem. We also discovered a report which identifies any duplicate tickets (encounters) being generated from the system.

In several letters of correspondence DMAHS alleged the need to change, the wrap-around distribution system was based on the greater than 10% of errors found in FQHC processing. Of the 478 encounters OSC indicated were overpayments, compared to the certified 111,250 Medicaid managed care encounters, the error rate for 2009 and 2010 is less than 1 % (.004).

Comptroller Note 3 OSC staff obtained payment reports from the MCO's containing information, which has never been provided to the CHC for reconciliation purposes.

Comptroller Note 4 In accordance with a recent United States District Court, District of New Jersey ruling, "DMAHS had no authority to change the reporting for wrap-around purposes without amending the regulations specifically applicable to those reporting requirements. Furthermore the demand

Comptroller Note 5 that FQHC's "reconcile" their data with MCO data is without basis in the Medicaid statute". As it stands OSC staff lack the legal authority to make any recommendations or findings regarding wrap-around payments or reconciliation procedures.

Recommendation No. 1
What does the OSC consider appropriate? CAMcare has successfully submitted wrap-around reports since the inception of the program.

Recommendation No. 2
This task is currently being performed.

Recommendation No. 3
OSC should require the MCO's to submit quarterly reports to the CHC.

Recommendation No. 4
In accordance with a recent United States District Court, neither DMAHS nor OSC has the authority to change the wrap-around process without first amending the regulations specifically applicable to those reporting requirements.

Patient Records
OSC Finding
OSC reviewed a statistically valid sample of 37 patient records corresponding to 119 dates of services. Our review found the following area to be incomplete and/or inaccurate:

- *One date of service was missing an encounter form for which the encounter could not be substantiated*
- *Four dates of service were missing progress notes or the progress notes were incomplete.*
- *There was one date of services where CHC improperly billed under the VFC program for an adult over the age of 18.*
- *There were two consecutive dates of service where the same vaccinations were administered to a patient indicating a duplicate billing by CHC.*

As Result of these deficiencies, ODS will seek of recovery of $259.513.26.

Recommendation No. 5
CHC should maintain up to date and complete patient records including all progress notes and encounters forms.

Recommendation No. 6
CHC should implement policies and procedures for verifying that all children receiving a vaccine under the VFC program are eligible.

Recommendation No. 7:
CHC should implement a system to ensure that duplicate billings do not occur.

Recommendation No. 8:
CHC should ensure that physician procedure codes are properly entered into its billing system.

Comptroller Note 6

CAMcare disagrees with the findings outlined in this section of the report based on the information we previously provided. OSC staff continues to include a patient [redacted] in the sampling who was not a CAMcare patient. CAMcare addressed this matter several times during the audit, and again in the submission dated May 17, 2012 (Attachment E).

Comptroller Note 7

The State of New Jersey challenged an OIG audit performed on of one their programs stating, "The audit should have verified if the services were provided". 42 CFR 405.2463 notes that what constitutes a visit is a face-to-face encounter between a health center patient and a provider (physician, physician assistant, or nurse practitioner). The information provided in our submission of June 4, 2012 documented the visits occurred. N.J.A.C. § 10:66(1.6) states at minimum a record should include a progress note for each visit, which supports the code billed. It does not state a signature is required (Attachment F).

It is unclear why or on what basis OSC staff is relying on a fragment of Medicare regulations when there is a specific Medicare regulation which addresses how we could remedy a missing signature issue if the service was provided (See Attachment C).

Comptroller Note 8

The providers who performed these services have, under the guidance of legal counsel signed attestation documents certifying they had face-to-face visits with these patients (Attachment G).

Comptroller Note 9

Why did OSC staff add another condition to their findings, which did not exist in their initial report that a date of service was missing an encounter form?

Comptroller Note 10

We disagree that there should be any recovery based on the information we have provided (June 4, 2012), in addition the State failed to provide a revised calculation to support how this penalty was determined with our corrections.

We reiterate the OSC has not provided the names and dates of service listed as missing our incomplete.

Recommendation No.5
The OSC should acknowledge this problem was remedied with EMR system.

Recommendation No. 6
We have included the Newsletter from the State of New Jersey and the CDC to give OSC more guidance in this area (Attachment H).

Recommendation No. 7
We have become more familiar with the report.

Recommendation No. 8
As OSC had indicated any errors noted were subsequently corrected.

Vaccine for Children Program (VFC)
OSC Finding

- *12 of the 56 dates services where vaccinations were given to minors under the VFC program showed no evidence that CHC performed independent eligibility screening for participants in the program in circumstances where it is required. In most instance, CHC simply determined eligibility for the VFC programs by verifying Medicaid eligibility*
- *Under the VFC program, providers are permitted to bill their services to the Medicaid program under an administration procedure code. Both the VFC federal operations guide and the New Jersey Department of health (DOH) polices prohibit providers from billing their services under the vaccination procedure code. OSC determined that DMAHS, via its November 2004 newsletter to providers and contrary to other state and federal regulations, permits providers to bill their services under both the vaccination procedure code and the administrative code. Billing and resulting payments done under the vaccination code skew the payment of services provided by the VFC program because the services are supposed to be free of charge.*
- *OSC found that, on 52 dates of services, CHC billed its services under the VFC program using both an administrative procedure code and the vaccination procedure code, and on 10 of those dates, CHC was reimbursed on the vaccination procedures code, contrary to the VFC federal operations guide and DOH policies.*

According to Centers for Disease Control and Prevention, which also has the responsibility to oversee VFC programs outlined children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccine (See Attachment I):

- Medicaid eligible: A child who is eligible for the Medicaid program. (for the purposes of the VFC program, the terms "Medicaid-eligible" and "Medicaid-enrolled" are equivalent and refer to children who have health insurance covered by a stated Medicaid program)
- Uninsured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act(25U.S.C.1603)
- Underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC eligible for non-covered vaccines only.) Underinsured children are eligible to receive VFC vaccines only through a federal Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement

Comptroller Note 11 OSC determined CAMcare followed the procedures outlined in a DMAHS newsletter (November 2004 Volume 15, Number 55), which required providers to bill their services under both a vaccination and administrative codes. CAMcare is again concerned we are being cited for deficiencies where we observe the procedures outlined by the governing State agencies.

Comptroller Note 12 In reference to OSC recommendations, CAMcare electronically enters Eligibility Screening Data into the NJ Immunization Registry (NJIIS), as required for VFC administration. All children

receiving initial vaccination are entered into the Critical Information Section of NJIIS. The Critical information Section contains the Eligibility Screening Information required by the CDC VFC Screening Record. Anytime a patient's insurance status changes, we are required to update the form in the NJIIS Registry to remain in compliance. We verify the patient's insurance status at the time of each visit. Any changes are made in the NJIIS registry, as required. The VFC Screening Information is permanent part of the NJIIS registry.

Facility Licensing & Approvals

OSC Finding

- *OSC found that one of CHC's sites Odessa Paulk-Jones (Odessa) received Medicaid reimbursement for a period of January through December 2010 without having CMS approval until November 15, 2011. As a result, CHC received $97,952.14 in improper Medicaid payment for this period.*
- *Contrary to state regulation, DMAHS approved Odessa as a Medicaid provider prior to Odessa receiving CMS approval.*
- *DOG's Licensing Division and DOH's Office of Primary Care have conflicting policies with regard to the uninsured program. Specifically, the Licensing Division allows an exemption from licensure when a facility operates less than 8 hours per week and the Office of Primary Care does not permit an exemption for Licensure regardless of hours that a facility to receive payment under LOA for the uninsured program if it is not licensed. CHC's Antioch Manor sire, operating less than 8 hours a week, received payment for the uninsured program even though it was not licensed.*
- *OSC found that the Licensing Division does not require a site to list all of its approved services on the ambulatory care license. Two if CHC's sites Gateway and East were approved to provide Dental and Ob/Gyn service but these services were not listed on the license.*
- *OSC found that one of CHC's sites, Antioch Manor received $43,096.33 in Medicaid reimbursement during 2009 and 2010 although it was not an approved Medicaid provider. CHC was able to bill claims to Medicaid for Antioch by using one main provider ID instead of each site's unique ID numbers. Antioch Manor became approved Medicaid provider effective June 1, 2011.*

As result of these deficiencies, OSC seek recovery of $141,048.47

Recommendation 9:
DMAHS should ensure that any FQHC facility has received CMS approval prior to enrolling it as a Medicaid provider.

Recommendation No. 10
DMAHS should amend N.J.A.C 10:49-3.3, which currently allows multi-location providers to bill using one provider identification number. This practice allows unapproved Medicaid sites to claim reimbursement under a different site's provider identification. In the alternative, DMAHS should ensure that the servicing location is reported for each claim by providers with multiple sites.

Comptroller Note 13

As a matter of federal law CAMcare's receipt of Section 330, Public Health Service Act funds qualify the health center as a Federal-Qualified Health Center ("FQHC"). 42 U.S.C § 139d (1) (2) (B). All of the services and sites at issue in this OSC finding are within CAMcare's section 330 scope of project. The draft audit reports fails to consider that section 1396d(1) (2) (B) defines an FQHC on an "entity" basis, not a site specific basis.

Comptroller Note 14

HRSA in a Notice of Grant Award dated November 18, 2007 approved the change in scope for the Antioch Health Center. It is at this juncture Antioch Health came under the auspices of the grantee, CAMcare Health Corporation.

Comptroller Note 15

HRSA in a Notice of Grant Award dated May 22, 2009 approved the change in scope for the CAMcare Roosevelt Manor Health Center. The effective date in the memorandum is April 15, 2009. Local legislators changed the name to the Odessa Paulk-Jones Health Center to honor a local constituent.

Odessa-Paulk Jones

The findings in this section should be considered form over substance. Even Mr. McCoy during the exit conference was confused that CAMcare was being penalized for billing claims with the proper Medicaid number. OSC staff states DMAHS approved Odessa as a Medicaid provider prior to receiving the correct CMS approval.

Comptroller Note 23

In 2003, Gwendolyn L. Harris , Commissioner of the Department of Human Services revised state policy to allow the enrollment of FQHC's into Medicaid (DMAHS) prior to their completion of their Medicare enrollment process.

Another argument, would be if the letter sent to Medicaid of Medicare approval by CMS failed to meet enrollment specifications, is it not the responsibility of DMAHS to alert CAMcare we failed to meet enrollment specifications. We met our obligation and received Medicaid approval to bill for Medicaid services. Clearly based on the recommendation put forth by OSC staff, DMAHS is at fault not CAMcare.

Effective 12/01/2009 CAMcare was approved for participation in the New Jersey Medicaid Program as a Federally Qualified Health Center, Medicaid provider ID# [redacted]. How can our payments be deemed improper if we had been approved to bill for services for Medicaid beneficiaries by the proper agency?

Comptroller Note 16

Antioch

OSC staff cites NJAC 10:66(1.3b) that each site must obtain and ambulatory care license from the DOH. Again, CAMcare followed the instruction of the New Jersey Department of Health, which governs licensing of ambulatory care facilities, outlined in a memo the Department would not require a licensure for this endeavor for services provided less than 8 hours per week. As cited by OSC staff, how was CAMcare to proceed if licensure was not a requirement, John Calabria indicated this type of operation could come under the umbrella of the Ambulatory License of another facility. We identified this facility based on proximity to be the South Camden facility, which we operated since 1983.

OSC staff continues to list recommendations for DMAHS and DOH, should these be listed under a separate cover to initiate improvements in those departments. These OSC recommendations verify findings that determined DMAHS and DOH have demonstrated certain deficiencies in their governance or application of guidelines for participation as an FQHC.

The final findings outlined by OSC staff list five of seven recommendations directed at DMAHS and DOH, stating they are not familiar with regulations outlined in 10:66. Why should CAMcare be penalized for following the instructions of those maintaining these programs? CAMcare opposes the recovery of the $141,048.47 for the reasons stated.

Comptroller Note 17

A license does not have to list Dental and Ob/Gyn services as these are considered primary care services for an FQHC. As defined in Section 330 of the Public Health Service Act (42 USCS § 254b) (1) required primary health services. (A)(i)(I) health services related to family medicine, internal medicine, pediatrics, Obstetrics, or gynecology and (hh) preventative dental services.

Comptroller Note 15

The bottom line is CAMcare was always and has been an FQHC at Odessa Paulk Jones, the services rendered to Medicaid patients there were lawful and CAMcare was/is entitled to receive full FQHC reimbursements ($97,952.14) for these face to face encounters, anything less would amount to a thief of services.

Recommendation No 9
Is the OSC making a recommendation that DMAHS should not follow the instruction of the Commissioner of Health?

Recommendation No.10
OSC recommends changes in Medicaid Regulations by DMAHS, why is this recommendation being made to the CHC?

B. Uninsured Program
OSC Finding
OSC found that CHC's Antioch site received payments under the Uninsured Program even though it was not licensed as an ambulatory care provider.
Recommendation No. 11:
DOH should recover payments to CHC for uninsured visits at the Antioch site during the period when the sire was not licensed as an ambulatory care facility.

Recommendation No. 11
We have demonstrated where the Department of Health continues to state that a license is not necessary to operate a site which operates less than 8 hours a week. We should not be financially penalized for following the instructions of those with FQHC oversight.

Medical Staff Licensing/ Certifications
OSC Finding

- *One nurse practitioner was not licensed during an 18-day span during the audit period. During this time period the employee had 76 Medicaid encounter. OSC will purse recovery of $10, 259.24 for the encounter provided by an unlicensed practitioner.*
- *Contrary to CHC's internal policies, three medical assistant did not have certifications within three months of their employment at CHC.*

Recommendation No. 12
CHC should ensure that all nurse practitioners maintain their licenses.

Recommendation No. 12
We have implemented new procedures to assure all providers are delivering care under a current license.

Comptroller Note 18

The recovery balance listed by OSC staff does not take into consideration the restitution made to MCO's and Medicaid on behalf of CAMcare once this licensure issue was brought to our attention. The amount listed does not agree with the initial assessment (Attachment J).

Hours of Operation
OSC Finding
OSC conducted a site visit to the Odessa facility. Contrary to its stated normal business hours, the site closed. CHC advised OSC that Odessa was currently not operating under normal business hours because a physician was on vacation and another physician was on maternity leave. As part of our testing, OSC obtained daily logs for the month log November 2010. A daily log lists the names of the patient that visited the facility that day. There were no entries for Monday, Wednesday, and Friday during November 2010 for the Odessa site. OSC verified that the total number of visits on the daily logs for November 2010 agreed with the total number of encounters included on CHC's internal reports. Therefore, Odessa did not treat any patient on Monday. Wednesday, and Fridays during November 2010.

OSC presented this information to CHC. CHC explained that Odessa began operating in December 2009 and that it was part of a "ramp-up" process whereby eventually new facilities over period, increase its hours of operation to 40 hours a week as it obtains more patients. In reviewing the HRSA grant application, OSC did not find any explanation for the ramp-up process that CHC officials described. The grant application simply stats Odessa is to be open 40 hours of week. Further, in reviewing the number of visits in the other 11 months of 2010, OSC determined that there was no significant increase in visits indicative of a ramp-up process. As such, it appears that Odessa does not operate 40 hours a week in contradiction of its grant application.

Recommendation No. 13
CHC should amend its HRSA and Medicaid application to reflect the hours the site is actually open.

Recommendation No. 13
This is another clear indication the OSC staff wants to change laws and regulations to fit how they think an operation should be conducted. We will again provide them with regulations that do not stipulate how long a facility must be open. We will again furnish them written proof where CAMcare in its application noted we would ramp up services as demand increases. This would be an easy postulate for any business major that you increase production with demand, or in our case, days of coverage as required by demand (Attachment K).

Comptroller Note 19

In researching the facts about FQHC's OSC staff would have discovered "HRSA Health Center Programs (Section 330) have no site-specific hours that a particular site must be open. Nevertheless, in our scope change application we stated the following: "The site will house three dental operatories, which will open five days/week, and a three room prenatal suite, which will initially be open one day/week, until demand increases". Therefore, the recommendation put forth by OSC staff has no merit (See Attachment L).

Change in Scope of Service
OSC Finding
OSC found the following two instances where CHC did not file a change in scope application with DMAHS as required:

- *In 2009, CHC instituted an electronic medical record (EMR) system, which replaced its paper medical records.*
- *In 2009, CHC opened a new site in Camden, NJ with dental and Ob/Gyn services. DMAHS notified CHC that a change in scope of services application was required to be submitted to DMAHS in order to receive reimbursement for Medicaid covered service provided at the new site.*

Recommendation No. 14
CHC should file a change in scope application with DMAHS for the events stated above, and for any change that require such an application in the future.

Recommendation No. 14
If the Division of Medical Assistance and Health Services would meet timely action requirements, we would comply with meeting other filing requirments.

CAMcare completed the Gateway Health Center in 2004, a project that allowed for the construction of a 38,000 square foot, three-story medical practice facility that consolidated in one location the primary care site and corporate headquarters. CAMcare, in accordance with N.J.A.C 10:66-1.5(d) 1.vi completed the necessary change of scope application to have our PPS rate adjusted for the increased cost of providing services.

DMAHS and CAMcare exchanged correspondence for years until Mr. Bryant spoke with the Commissioner. DMAHS finally approved the CIS application on July 12, 2010. The correspondence outlined adjustments in the PPS rate for the year 2004 and 2005. CAMcare has requested DMAHS fulfill their obligation to pay for the post phase in periods from 2006 thru the current period. In August 2012, we formally requested from DMAHS payment of $3,264,955 for those years, which required an MEI adjustment to the then revised PPS rate (See Attachment M).

We will file the necessary change of scope applications once issues related to this initial application are resolved with DMAHS.

Third-Party Liability

OSC Finding

OSC found that one of the ten patients was enrolled in an MCO on the date of service that CHC billed Medicaid for that recipient. CHC should have instead billed the MCO because Medicaid is the payer of last resort in such instances. OSC will seek recovery of 136.61 for this date of service.

Recommendation No. 15:
CHC should implement procedures to ensure that insurances verifications are conducted for each patient visit.

Recommendation No. 15
As a fiscal best practice we verify all insurances prior to service delivery.

Health Maintenance Organization (HMO) Eligibility

OSC Finding

Out of ten recipients, one recipient was found to be eligible under an HMO on the date of service CHC billed Medicaid directly for that recipient. In this case, CHC should have billed the HMO first because Medicaid is the payor of the last resort; OSC is seeking recovery of $136.61 for the encounter date of service that the recipient was eligible under HMO.

Comptroller Note 20

For the case cited by OSC staff we provided information to the contrary, the patient was not a member of a Medicaid HMO at the time of service. Nevertheless, the patient was Medicaid eligible, the payment of the PPS rate would have been the same.

Tour of Facilities

OSC Finding

OSC found numerous problems that could negatively impact a patient's quality of care in seven of the eight CHC locations. The list below identifies what OSC found during our tour of CHC's facilities.

- *There were three instances at three separate CHC facilities where PHI was found in unsecured locations.*
- *There were five instances at four separate CHC facilities where expired medication/supplies were being administered.*
- *There were two instances at the same CHC location where unlocked medication and syringe were observed. These items were readily accessible to any patient walking by.*
- *There were four instances, three of which were at the same CHC facility; where inspection calibrations were not being performed. In additional, there was biohazard receptacle missing from a patient examination room at one of CHC's facilities.*
- *There were two instances at two separate CHC faculties that did not have an updates refrigerator log.*

- *There were three instances at three separate facilities that lacked up to date fire inspections for the facility.*
- *There were two instances at two different CHC faculties that lacked necessary posted information in the patient waiting area with regard to the Federal Department of Health and Human Services contact information.*
- *There was one instance at one CHC facility that displayed an expired dental assistant's license hanging in the patient waiting area.*

Recommendation No. 16
CHC should ensure the security of all confidential medical information. CHC should implement measures designed to identify and assess internal risks associated with the disclosure of such information.

Recommendation No.17
CHC should ensure proper medication storage and integrity.

Recommendation No.18
CHC should ensure that all of its facilities have updated refrigerator logs.

Recommendation No.19
CHC should identify and dispose of expired medication in compliance with federal and state laws and regulations.

Recommendation No. 20
CHC should conduct periodic inspection and calibration of all electrical and mechanical equipment to ensure operational safety. CHC should maintain records of those inspections.

Comptroller Note 21

CAMcare management could only verify the findings at one site given senior management staff were not allowed to accompany OSC staff throughout all the CAMcare locations.

Program Evaluation
OSC Finding
CHC failed to fulfill the requirements of 42 C.F.R. 419.11. Specifically, CHC failed to conduct an annual evaluation of its total program, which includes a review of representative sample of both active and closed clinical records as well as failed to incorporate their policy and procedures into any such finding that resulted from its annual program evaluation. Any findings based on the evaluation should have then been subject to a corrective action plan. CHC submitted its requirement; however, the UDS Report does not fulfill the requirements of the regulation and are intended more for use at the Federal Level.

Recommendation No.21:
CHC should comply with 42 C.F.R. 491.11 to ensure that appropriate internal oversight is being conducted.

Comptroller Note 22

Recommendation No. 21:

We take exception to the finding we failed to conduct annual evaluations of our program. We provided to the OSC staff all the documents they requested. Listed below are examples of reports we prepare and the OSC staff had access to, upon request:

- Annual Audit- OMB A 133- **OSC Reviewed**
- Uniform Data System Report (UDS) - **OSC Reviewed**
- Financial Status Report
- Annual Board Minutes (Annual Statistics) - **OSC Reviewed**
- PMS 272-Quarterly
- 330 –Single Grant Application- submitted annually - **OSC Reviewed**
- FQHC Medicare Cost Report - **OSC Reviewed**
- IRS 990 Report
- Pension Audit Report- (5500 Form)
- FQHC Medicaid Cost Report - **OSC Reviewed**
- Uncompensated Care Monthly Report
- State Tax 941 Wage Report
- Medicaid Quarterly Wrap-around Report - **OSC Reviewed**
- Medicare Credit Balance Report
- Senior Dental County Report
- Loan Covenant Calculations as required by lending agencies
- Monthly Financial Statements - **OSC Reviewed**
- Revenue Report by Payor
- Annual Operating Budgets
- Quality Improvement Reports - **OSC Reviewed**
- State of New Jersey- LOA Compliance Audit Findings - **OSC Reviewed**
- Managed Care Capitation Reports - **OSC Reviewed**

We request you take the above considerations into account when issuing the Final Draft Report. If you have any questions pertaining to this submission, please contact me. If for some reason we fail to find an amenable solution to the findings, we reserve the right to present our concerns to an administrative judge.

Sincerely,

David L. Whaley
Executive Vice President/ CFO

Enclosures

cc: Mark Bryant, President/ CEO
Michael McCoy, Manager/ Fiscal Integrity Unit

Attachment A

State of New Jersey

November 26, 2003

Katherine Grant-Davis
Executive Director
NJ Primary Care Association
14 Washington Road, Bldg. 2
Princeton Junction, NJ 08550-1030

Dear Ms. Grant-Davis:

I am writing in follow up to my letter August 25th concerning provider enrollment of new Federally Qualified Health Centers (FQHC's). Thank you for bringing this matter to our attention.

As you know, we both share the common interest and goal to assure timely, efficient and quality services to all citizens of New Jersey. It is our commitment to provide access to needed health services through all types of health care providers, including the high quality services provided through FQHC's. It is our intent to work collaboratively with you and NJPCA in an effort to minimize any hardship on the beneficiaries and provider community to the greatest extrent possible.

Historically, the Medicaid program requires all eligible providers to enroll in the Medicare program in order to participate in Medicaid. This assures the Medicaid client will receive high quality care, as well as provide Medicare funding where appropriate. However, I recognize the importance of FQHC's to the Medicaid population. I too recognize the delays in Medicare provider enrollment process. The Division of Medical Assistance and Health Services (DMAHS) is revising our historical policy to allow enrollment at FQHC's prior to the completion of their Medicare enrollment process. FQHC's will be required to file for Medicare participation as a condition of the Medicaid approval. I am sure you will agree, your facilities will need to work cooperatively with Medicare to complete the enrollment process in a timely fashion.

Thank you again for bringing this matter to our attention. If you or any NJPCA members have any additional questions or concerns in this regard, please

contact either Dennis Doderer, Office of Premium Support, at 609-588-4380 or John Guhl, Chief Financial Officer, DMAHS, at 609-588-7933.

Sincerely,

Gwendolyn L. Harris
Commissioner

GLH:2:11
c: Dennis Doderer
John Guhl

Attachment B

State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 358
TRENTON, N.J. 08625-0358

JON S. CORZINE
Governor

www.nj.gov/health

HEATHER HOWARD
Commissioner

February 14, 2008

VIA UNITED PARCEL SERVICE
Mark K. Bryant
President and Chief Executive Officer
CAMCare Health Corporation
Gateway Health Center
817 Federal Street
Camden, NJ 08103

Re: Antioch Manor

Dear Mr. Bryant:

I am responding to your letter dated January 30, 2008, in which you state physicians from CAMCare Health Corporation (CAMCare) will provide primary medical services to residents of Antioch Manor, a senior housing facility and residents who reside in close proximity to the facility for no more than 8 hours per week. You further state that these services will be provided in the two first floor exam rooms and a medical suite of approximately 850 square feet at Antioch Manor.

The Department of Health and Senior Services (Department) will not require a license for this endeavor by CamCare and because you plan to provide the aforementioned service for only 8 hours per week. This determination is based upon your representations in your letter.

If you have any further questions concerning this matter, please contact Ms. Judy Brown of my staff at (609) 292-7228.

Sincerely,

John A. Calabria

John A. Calabria
Director
Certificate of Need and
Healthcare Facility Licensure Program

c: Ms. Brown
Ms. Wisn

page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

  "I, _____[print full name of the physician/practitioner]____, hereby attest that the medical record entry for _____[date of service]____ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

Attachment D

CAMcare Health Corporation
Schedule of Payment Recovery

Quarterly Wrap-around Reports	
2009	$ 37,257.24
2010	27,595.22
Medical Staff Licensing/Certificate	5,454.54
	$ 70,307.00

Attachment E

Chrystal Downes-Burns

From: Chrystal Downes-Burns
Sent: Wednesday, May 09, 2012 3:36 PM
To: Wroten, Stephanie
Cc: Dorothy.Henry[redacted]
Subject: RE: Contact

Here are my questions:

If the doctor originally coded incorrectly and we get a denial from the carrier to resubmit with the correct code does the doctor have to do a new order or can we append with a notation in the chart stating what was done?

Also, under the patient information you still have the patient [redacted] listed as a problem but we informed you (auditors) that he was not in our system or the mother. Remember you supplied me with everything and every way to check but we found nothing. Remember(smile)

Please inform.

From: Wroten, Stephanie [redacted]
Sent: Wednesday, May 09, 2012 11:57 AM
To: Chrystal Downes-Burns
Cc: Goldin, Richard; Henry, Dorothy; DeMilio, David; Ali, Arsala
Subject: Contact
Importance: High

Good Afternoon Chrystal,
My email address is: [redacted]. Please feel free to contact me with your questions.

Stephanie J. Wroten, MS, RN, LNC
Investigator/Medical Review Analyst
Medicaid Fraud Division
Office of the State Comptroller
20 W. State Street, 4th Floor
P.O Box 025
Trenton, NJ 08625-0025
[redacted]

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER
817 FEDERAL STREET CAMDEN, NJ 08103

(856) 541-3270

May 17, 2012

Richard Goldin
Supervising Auditor
State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
PO Box 025
Trenton, NJ 08625-0025

Re: CAMcare Health Corporation
Provider Number [redacted]
Patient Records

Dear Mr. Goldin:

We have reviewed appendices D and E, and we determined your team (David DeMilio and Arsala Ali) were both informed very early in the audit that [redacted], initially [redacted] was not a CAMcare patient. We requested a more detailed search of Medicaid files to determine how this patient was selected for financial examination.

We have made a lot of progress in finding the missing items outlined during the exit conference. Attached to the summary are the missing encounter forms, progress notes, and medical record /procedure code matches.

If there are any questions pertaining to this submission, please do not hesitate to contact Susan Wurst or Sharon Buttress, MD.

Sincerely,

David L. Whaley
Executive Vice President/CEO

administrative duties and not billed by the facility. Administrative duties shall be considered a direct cost of the facility and shall be included in the clinic payment.

10:66-1.6 Recordkeeping

(a) An individual record shall be prepared and retained by an independent clinic that fully discloses the kind and extent of the service provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary, as well as the medical necessity for the service.

(b) At a minimum, a beneficiary's record shall include a progress note for each visit which supports the procedure code(s) billed, except where specified otherwise.

(c) Additional requirements governing medical records in an ambulatory surgical center are located in N.J.A.C. 10:66-5.

(d) The information described in this subsection shall be made available to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs or is agents upon request.

10:66-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services is $ 5.00 a visit for clinic visits, except when the service is provided as indicated in (e) below.

1. A clinic visit is defined as a face-to-face contact with a medical professional under the direction of a physician or dentist, which meets the documentation requirements of this chapter.
2. Clinic visits include medical professional services provided in the office, patient's home, or any other site, excluding a hospital, where the beneficiary may have been examined by the clinic staff. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:66-9.
3. Clinic services which do not meet the requirements of a clinic visit as defined in this chapter, such as surgical services, immunizations, laboratory or x-ray services, do not require a personal contribution to care.
4. Encounter procedure codes billed by Federally Qualified Health Centers do not require a personal contribution to care.

(c) Clinics are required to collect the personal contribution to care for the above-mentioned NJ FamilyCare-Plan C services if the NJ FamilyCare-Plan C services Identification Card indicates that a personal contribution to care is required and the

Attachment H

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 14 No. 55 November 2004

TO: Physicians, Advanced Practice Nurses, Independent Clinics – **For Action**
Health Maintenance Organizations - **For Information Only**

SUBJECT: **Revised Billing Procedures for New Jersey Vaccines for Children (VFC) Program**

EFFECTIVE: Claims with service dates on or after September 1, 2004

PURPOSE: To notify practitioners of revised billing procedures for administration of VFC-covered vaccinations.

BACKGROUND: The VFC program offers practitioners the opportunity to obtain free vaccines for certain Medicaid/NJ FamilyCare-eligible children under 19 years of age.

In June of 1999, the Division terminated Medicaid/NJ FamilyCare fee-for-service (FFS) coverage and reimbursement for vaccines available from the VFC program. Vaccines for individuals age 19 and over continue to be covered by the Medicaid/NJ FamilyCare FFS program (Please see Newsletter Volume 9, Number 33 for additional information).

The Division provides an enhanced FFS administration fee of $11.50 for the administration of vaccines ordered directly from the VFC program and administered to children who are eligible for Medicaid/NJ FamilyCare. The administration code for administering a single vaccine is 90471 ($11.50). For two or more vaccines, the administration code is 90472 ($11.50 per injection administered).

ACTION: Effective for claims with service dates on or after September 1, 2004, you must report <u>both</u> a vaccine administration CPT code <u>and</u> the associated VFC vaccine CPT code when requesting payment for the administration fee(s) of VFC vaccines.

The date of service you report on the claim for vaccine administration CPT codes 90471 and 90472 must be the same as the date of service you report on the accompanying claim for the vaccine CPT code. If the dates are different or missing, the claim will be denied payment by Error Code 778, "No immunization code provided on same date of service."

Although the provider is receiving the vaccines from VFC program, the charge amount(s) for the actual vaccine(s) CPT code must reflect a provider's usual and customary charge for the vaccine.

Vaccine Administration CPT codes

90471	Initial vaccine	$11.50
90472	Two or more vaccines	$11.50 per injection administered

VFC Vaccine CPT codes

90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90645	Hemophilus influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90647	Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90655	Influenza virus vaccine, split virus, preservative-free, for children 6-35 months of age, for intramuscular or jet injection use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular or jet injection use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years of age, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than 7 years, for intramuscular use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use

90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated, (DtaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90748	Hepatitis B and Hemophilus influenza B vaccine (HepB-Hib), for intramuscular use

If you have any questions concerning this Newsletter, please contact the Office of Preventive Health Services, DMAHS at (609) 588-2739.

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB (BLUE TAB MARKED "5")

Attachment G

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER
817 FEDERAL STREET, CAMDEN, NJ 08103
(856) 541-3270

CERTIFICATION OF [redacted]

I do hereby certify to the following:

I am New Jersey licensed physician [redacted] and the Medicaid number is [redacted]

I am employed at CAMcare Health Corporation from July 1, 1994 to the present date.

On or about January 13, 2009 I saw a patient by the name of [redacted] at the CAMcare facility located at Gateway OB/GYN 817 Federal Street, Camden, NJ 08103 and provided the following service [redacted]

Due to an oversight on my part I omitted entering the services provide on the written record until I was informed of my mistake on or about December 5, 2011. I promptly reviewed the file and completed the patient's file on or about February 7, 2013.

I hereby certify that the above statements I have made are true to the best of my knowledge and if the statements I have made are found to be willfully false I am subject to punishment.

Date 2/7/13

By [redacted]

Attachment K

CAMcare requests a Change in Scope of Project to add an additional site, the Roosevelt Manor Health Center, to be located in Centerville neighborhood of Camden City to bring much needed prenatal and oral health services to the underserved populations in South Camden.

CAMcare has operated a project site in South Camden since 1987; limited to pediatrics and internal medicine. This office is located across the street from the site of the former Roosevelt Manor, a public housing project built in 1954. The Housing Authority of the City of Camden pursued a HOPE VI demolition and redevelopment grant to complete the Centerville Neighborhood Revitalization Plan. This was awarded in 2004 with the plans demolish and build 582 new affordable housing units, including a community center with a medical suite to be occupied by CAMcare. Roosevelt Manor was demolished in 2007.

An early phase of redevelopment was the construction of Antioch Manor; an affordable housing complex for senior citizens built by the Antioch Baptist Church. The housing complex was designed to support a variety of services, including a small medical suite. In October 2007, CAMcare was issued a CIS to add the Antioch Manor site. This site is open one day/week and primarily serves senior citizens.

The final phases are nearing completion and in early 2009, the Roosevelt Manor Community Center with designated medical space will be completed. The space was originally planned as a replacement site for CAMcare's South Camden site, however, the final space is only 1,500 square feet. Given the needs of the community, CAMcare decided to bring oral health and prenatal services to this site, while maintaining the existing South Camden and Antioch sites. The nearest prenatal sites are at CAMcare's Gateway Center, 2 miles away. The site will house three dental operatories, which will operate five days/ week, and a three room prenatal suite, which will initially be open one day/week, until demand increases. All three sites will be within a two block radius of each other in this redeveloped area.

In July 2008, the NJ Department of Health and Senior Services issued a competitive RFP to support capacity building of federally qualified health centers to increase access to preventive and primary health care for the State's underserved and uninsured. CAMcare was a successful applicant in proposing to fit-up the new Roosevelt Manor site. Using time-limited State funds, CAMcare will be able to provide for initial startup; outfitting most of the three dental operatories; three medical exam rooms; lab, modeling, and sterilization rooms; reception and waiting room space at the new Roosevelt Manor site. CAMcare will assume on-going maintenance costs for the site. CAMcare is not requesting additional federal dollars at this time.

Why do you want to add the service site?

CAMcare has operated a project site in South Camden since 1987; limited to pediatrics and internal medicine. As part of a HOPE VI demolition and redevelopment grant, construction of 582 new affordable housing units, including a community center with a medical suite to be occupied by CAMcare was planned. An early phase of redevelopment was the construction of Antioch Manor; an affordable housing complex for senior citizens built by the Antioch Baptist Church. The housing complex was designed to support a variety of services, including a small medical suite. In October 2007, CAMcare was issued a CIS to add the Antioch Manor site. This

site is open one day/week and primarily serves senior citizens.

The final phases are nearing completion and in 2009 the Roosevelt Manor Community Center with designated medical space will be completed. The space was originally planned as a replacement site for CAMcare's South Camden site, however, the final space is only 1,500 square feet. Given the needs of the community, CAMcare decided to bring oral health and prenatal services to this site, while maintaining the existing South Camden and Antioch sites. The nearest prenatal sites are at CAMcare's Gateway Center, 2 miles away. The site will house three dental operatories, which will operate five days/ week, and a three room prenatal suite, which will initially be open one day/week, until demand increases. All three sites will be within a two block radius of each other in this redeveloped area.

In July 2008, the NJ Department of Health and Senior Services issued a competitive RFP to support capacity building of federally qualified health centers to increase access to preventive and primary health care for the State's underserved and uninsured. CAMcare was a successful applicant in proposing to fit-up the new Roosevelt Manor site. Using time-limited State funds, CAMcare will be able to provide for initial startup; outfitting most of the three dental operatories; three medical exam rooms; lab, modeling, and sterilization rooms; reception and waiting room space at the new Roosevelt Manor site. CAMcare will assume on-going maintenance costs for the site. CAMcare is not requesting additional federal dollars at this time.

Describe how adding this site will benefit your health center and the patients it will serve? (Please provide a summary of one page or less.)

The proposed site represents the same target population receiving comprehensive primary medical services served by our South Camden and Antioch Manor sites, but adds dental and ob/gyn services. It provides closer access for seniors at Antioch Manor, who are often limited in mobility both geographically and physically. The site will house three dental operatories, which will operate five days/ week, and a three room ob/gyn suite, which will initially be open one day/week, until demand increases. All three sites will be within a two block radius of each other in this redeveloped area. The nearest prenatal sites and dental offices are at CAMcare's Gateway Center, two miles away, thus removing an additional barrier to care and services. It will improve compliance and show rates by having services locally, rather than a bus ride away.

Does the budget include any special grant, foundation or other funding that is time-limited, i.e., will only be available for 1 or 2 years?

YES

6a. *If Yes, how will you support the site when these funds are no longer available? (Please provide a summary of one page or less.)*

The Housing Authority of the City of Camden HOPE VI grant was awarded in 2004 with the plans to build 582 new affordable housing units, including a community center with a medical

suite to be occupied by CAMcare. Originally planned as a replacement site for our South Camden office, the final rendering was approximately 1,500 square feet. Therefore we designated dental and prenatal services for this site. CAMcare did not have to pay for the building of this site.

In July 2008, the NJ Department of Health and Senior Services issued a competitive RFP to support capacity building of federally qualified health centers to increase access to preventive and primary health care for the State's underserved and uninsured. CAMcare received a time-limited grant to fit-up the new Roosevelt Manor site. Using these funds, CAMcare will provide for initial startup; outfitting most of the three dental operatories; three medical exam rooms; lab, modeling, and sterilization rooms; reception and waiting room space at the new Roosevelt Manor site. CAMcare will assume on-going maintenance costs for the site. CAMcare is not requesting additional federal dollars at this time. Service utilization should support the site after June 30, 2009, when the NHDHSS grant expires.

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER
817 FEDERAL STREET, CAMDEN, NJ 08103

(856) 541-3270

CERTIFICATION OF [redacted]

I [redacted] hereby certify to the following:

I am New Jersey licensed physician [redacted] and the Medicaid number is [redacted]

I am employed at CAMcare Health Corporation from September 1, 1989 to the present date.

On or about August 26, 2009 I saw a patient by the name of [redacted] at the CAMcare facility located at South Pediatrics 8th Carl Miller Blvd., Camden, NJ 08102 and provided the following service [redacted]

Due to an oversight on my part I omitted my signature for the services provided on the written record until I was informed of my mistake on or about December 5, 2011. I promptly reviewed the file and completed the patient's file on or about February 8, 2013.

I hereby certify that the above statements I have made are true to the best of my knowledge and if the statements I have made are found to be willfully false I am subject to punishment.

Date 2/8/13

By [redacted]

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER
617 FEDERAL STREET, CAMDEN, NJ 08103
(856) 541-3270

CERTIFICATION OF [redacted]

I, [redacted] hereby certify to the following:

I am New Jersey licensed physician [redacted] and the Medicaid number is [redacted]

I am employed at CAMcare Health Corporation from July 5, 1993 to the present date.

On or about October 30, 2009 I saw a patient by the name of [redacted] at the CAMcare facility located at East Pediatrics 2610 Federal Street, Camden, NJ 08105 and provided the following service [redacted]

Due to an oversight on my part I omitted my signature for the services provided on the written record until I was informed of my mistake on or about December 5, 2011. I promptly reviewed the file and completed the patient's file on or about February 8, 2013.

I hereby certify that the above statements I have made are true to the best of my knowledge and if the statements I have made are found to be willfully false I am subject to punishment.

Date 2/8/13

By [redacted]

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Attachment I

VFC Eligibility Criteria

Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccine:

- **Medicaid eligible:** A child who is eligible for the Medicaid program. (For the purposes of the VFC program, the terms "Medicaid-eligible" and "Medicaid-enrolled" are equivalent and refer to children who have health insurance covered by a state Medicaid program)
- **Uninsured:** A child who has no health insurance coverage
- **American Indian or Alaska Native:** As defined by the Indian Health Care Improvement Act (**25 U.S.C. 1603**)
- **Underinsured:** A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFCeligible for non-covered vaccines only). **Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC)** or under an approved deputization agreement.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

The Children's Health Insurance Program (CHIP), known as Title XXI, enables states to expand health insurance coverage for uninsured children. Title XXI children enrolled in a separate Children Health Insurance Program are not VFC-eligible because these children are considered insured. Title XXI children enrolled in a Medicaid-expansion CHIP program are Medicaid eligible and entitled to VFC program benefits. Some states have implemented their CHIP programs as a combination plan with some children becoming Medicaid eligible through an expansion plan and some children enrolled in a separate CHIP. The Medicaid-eligible children are entitled to VFC program benefits, and the children enrolled in the separate CHIP program are considered insured and are not entitled to VFC program benefits.

What is an FQHC?

An FQHC is a health center that is designated by the Bureau of Primary Health Care (BPHC) of the Health Services and Resources Administration (HRSA) to provide health care to a medically underserved population. FQHCs include community and migrant health centers, special health facilities such as those for the homeless and persons with acquired immunodeficiency syndrome (AIDS) that receive grants under the Public Health Service (PHS) Act, and "look-alikes," which meet the qualifications but do not actually receive grant funds. They also include health centers within public housing and Indian health centers.

What is an RHC?

An RHC is a clinic located in a Health Professional Shortage Area, a Medically Underserved Area, or a Governor-Designated Shortage Area. RHCs are required to be staffed by physician assistants, nurse practitioners, or certified nurse midwives at least half of the time that the clinic is open.

Provider Responsibility to Screen for VFC Eligibility

Screening to determine a child's eligibility to receive vaccines through the VFC Program must take place with each immunization visit, although the screening form need be replaced or updated only if the status of the patient changes. The patient eligibility screening record provides a means of recording parent responses to VFC eligibility questions. The parent, guardian or provider may complete this form. Verification of parent/guardian responses is not required. To maximize efficiency, providers may elect to incorporate these screening questions into an existing form; however, any revision must include the core screening information listed on the CDC-developed form and be approved by the state Immunization Program. Patient eligibility screening records should be maintained on file for a minimum of 3 years after service to the patient has been completed unless state law/policy establishes a longer archival period.

- Patient Eligibility Screening Record [56KB, 6 pages] (/vaccines/programs/vfc/downloads/vfc-op-guide/19-appx-3-forms.pdf#screening) (page 1 of appendix 3)
- Patient Eligibility Screening Record - VFC Program in Family Planning Clinics [56KB, 6 pages] (/vaccines/programs/vfc/downloads/vfc-op-guide/19-appx-3-forms.pdf#clinic) (page 4 of appendix 3)

Page last reviewed: August 31, 2012
Page last updated: February 15, 2013
Content source: National Center for Immunization and Respiratory Diseases

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - Contact CDC--INFO

Attachment J

CAMcare Health Corporation

[redacted]

JUNE 01, 2009 THROUGH JUNE 18, 2009

Total Enc:	76.00
Times PPS Rate:	134.99
Payment Requested by State	10,259.24

Insurance Carrier	Pmts Made Nov-11	Encounters
Medicaid	$3,374.75	25
Horizon	$74.06	39
Americhoice	296.89	12
Total	$3,745.70	76.00

	MCO Enc	PPS Rate	Total
MCO encounters on wrap report	51	134.99	$6,884.49
Reduce by Horizon Cap Payment			-$819.00
Reduce by Americhoice cap payment			-$240.00
Reduce by Fee for Svc payments reimbursed			-$370.95
Balance due to State			$5,454.54

Attachment L

services. Applicants can be existing g

- Expanded Medical Capacity Grants pro rent service area (e.g. by adding new medical provider or medical services or expanding hours of operation). Only existing grantees are eligible to apply.
- Service Expansion Grants provide funding to add new or expand existing mental health/substance abuse, oral health, pharmacy, and enabling services for special populations at existing health centers. Only existing grantees are eligible to apply.
- Service Area Competition Grants provide ongoing competing continuation funding for service areas currently served by health center grantees. Both currently funded section 330 grantees whose project periods have expired and new organizations proposing to serve the same areas or populations being served by existing section 330 grantees may apply.

Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers (see Migrant Health for more information), Health Care for the Homeless Programs, and Public Housing Primary Care Programs.

Full text of this document, Title 42 of the U.S. Code, Chapter 6A, Public Health Service Act, and section 254b, (the equivalent of Section 330) is available at the Legal Information Institute website.

Can a for-profit clinic be a health center?

No. A health center must be a public entity or a private non-profit.

Is a board of directors required?

Yes, health centers receiving Section 330 grants and look-alikes must be governed by a board of directors. The board must include a majority (at least 51%) of active, registered users of the health center who are representative of the populations served by the center. The governing board ensures that the center is community based and responsive to the community's health care needs. Under certain conditions the board composition requirements can be waived for migrant, homeless, public housing only health centers.

Are there location requirements for FQHCs?

Are there location requirements for FQHCs? It depends. Each FQHC that receives PHS 330 grant funding must meet the requirements of that grant. However, community health centers must serve a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). To determine if your area qualifies, search the MUA/MUP database. If an area does not have the MUA/MUP designation they can apply for it and can put in an application for a PHS Section 330 grant while the designation is being processed.

For additional information regarding the MUA/MUP designation contact the Shortage Designation Branch: sdb@hrsa.gov or 1.888.275.4772. Press option 1, then option 2.

Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care Programs do not need to meet the MUA/MUP restriction. FQHCs may be located in rural and urban areas.

Are there special staffing requirements for health centers?

No, there are no specific requirements for staffing mix at health centers. Health Centers are required to have a core staff that is able to carry out the necessary functions of the health center. This will vary from health center to health center based on the needs of the community. It is recommended that they maintain a staffing level that allows for between 4,200-6,000 visits per year for each full-time equivalent health care provider. Additional information about staffing and other requirements is available in HRSA's Health Center Program Requirements.

What types of services do health centers provide?

Health Centers must provide primary care services for all age groups. Health Centers must provide preventive health services on site or by arrangement with another provider. Other requirements that must be provided directly by a health center or by arrangement with another provider include:

- Dental services
- Mental health and substance abuse services
- Transportation services necessary for adequate patient care
- Hospital and specialty care

For more information, please see HRSA's Health Center Program Requirements.

Are there minimum hours that an FQHC must be open?

HRSA Health Center Programs (section 330 grantees or look-alikes) have no site-specific requirements on the number of hours that a particular site must be open. These health centers are required on an organizational level to provide services at times and locations that assure accessibility and meet the needs of the population to be served and to record their hours of operation in the current scope of project (as described on Form 5B). However, health centers may be subject to minimum hour requirements to receive certain FQHC and other benefits. For example, there are minimum hour requirements for providers to receive FTCA coverage, which is discussed in the FTCA Manual. As another example, there are minimum patient-care hour requirements for NHSC providers. Additionally, individual state Medicaid agencies, CMS, and private third party insurers may have their own policies regarding operational hours and schedules. Each health center is responsible for ensuring that they comply with the requirements of the benefit/third party payor programs they participate in.

Is a sliding fee scale required?

Yes, health centers must use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. Health centers must be open to all regardless of their ability to pay. For more information, see HRSA's Health Center Program Requirements.

What are the Medicare Administrative Contractors (MACs) and what is their role in administering Medicare Part A and Part B?

Section 911 of the Medicare Modernization Act of 2003 mandates that the Secretary for Health & Human Services replace the current contractors administering the Medicare Part A or Part B fee-for-service programs with new Medicare Administrative Contractors (MACs). Part A/Part B MACs will replace the current fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Administrative Contractors.

Attachment M

CAMcare
HEALTH CORPORATION

GATEWAY HEALTH CENTER
817 FEDERAL STREET, CAMDEN, NJ 08103

(856) 541-3270

April 2, 2013

Valerie Harr
Director Division of Medical Assistance and Health Services
Department of Human Services
State of New Jersey
P.O. Box 712
Trenton, New Jersey 08625-0712

Re: CAMcare Health Corporation
Change of Scope- Gateway Health Center

Dear Ms. Harr:

Last August 2012, and most recently two weeks ago I contacted both Micheal Keevey and Ronald Varella regarding the outstanding change in scope settlement due CAMcare from the State of New Jersey. DHMAS partially settled with CAMcare on July 10, 2010 processing a payment for $749,073 to cover fiscal years 2004 and 2005. In my conversation with Mr. Keevey, he affirmed his staff was reviewing our data. Upon questioning Mr. Varella, he said his department was very busy and did not anticipate addressing this matter until the wrap-around situation was resolved.

I am confused, in the past when we have expressed concerns about meeting the changing procedural requirements or time demands imposed by the State; the expectation was that we would meet them without question.

We are approaching a third year since we received the partial settlement and the notice a settlement payment for 2006 through the current period would be forthcoming. CAMcare Health Corporation is due $3,264,955 based on the supporting documentation. Can you ascertain from your staff when a settlement check will be generated? Based on the progression of the MEI we anticipate our PPS rate for fiscal year 2013 will be adjusted to $145.39.

If you have any questions pertaining to this submission, please contact me at 856-541-3270 or via email at Whaleydl@camcare.net. Thank you for your assistance in this matter.

Sincerely,

David L. Whaley
Executive Vice President/ CFO

cc: Mark Bryant
CAMcare President/ CEO

Enclosures

CAMcare Health Corporation
Summary of Revised PPS Rates based on 2005 Blended Rate

The blended rate for 2005 as determined in application CAM-051 at [redacted] (Col . 9)

Year	MEI % Increase	Revised Rate	Less: Previous Rate	PPS Increment	Annual Encounters	Estimated Adjustment
Blended rate for 2005:		[redacted]	[redacted]			
2006	2.8			7.46	62,680	467,558
2007	2.1			5.92	67,250	397,814
2008	1.8			6.02	72,031	433,706
2009	1.6			6.11	73,366	448,501
2010	1.2			6.19	77,042	476,616
2011	0.4			6.21	83,952	521,143
2012	0.6			6.25	83,174	519,657
						$ 3,264,995

APPENDIX B

COMPTROLLER NOTES ON AUDITEE RESPONSE

1) The March 2009 Newsletter, Volume 19 No. 6 allows for the carve-out of Ob/Gyn surgical and delivery encounters applies to service dates on and after July 11, 2008. Once CHC became aware of the change in the report submission format, corrected quarterly reports should have been submitted to reflect the proper number of encounters. CHC should have reimbursed the state for the overpayments received as a result of the erroneous reports which double counted the OBGYN/surgical and delivery encounters.
2) OSC requested copies of the duplicate ticket (encounter) reports in order to determine whether duplicate billings occurred, but was told by CHC that the reports were not available for 2009 or 2010. Therefore, OSC could not review the reports for the period under audit.
3) OSC provided an update on November 13, 2013 to the MCO payment support previously provided.
4) Every Medicaid provider is required to submit accurate claims information to DMAHS and to have adequate documentation to support the claims. To ensure that the Medicaid Managed Care Receipts Report submitted to the state is accurate, OSC recommends CHC reconcile what they report as receipts to what the MCOs report as payments. Any discrepancies in the reports must be resolved to ensure the state reimbursement to CHC is proper.
5) The audit was conducted under the OSC's authority to oversee the Medicaid program, as set forth under the *Medicaid Program Integrity and Protection Act*, N.J.S.A. 30:4D-53 *et seq.*, and N.J.S.A. 52:15C-23. As stated in N.J.S.A 30:4D-57, OSC can "perform any other functions that are necessary or appropriate in furtherance of the mission of the office. In addition but not limited to, OSC can "review the utilization of Medicaid services to ensure

Medicaid funds, regardless of which agency administers the service, are appropriately spent to improve the health of Medicaid recipients" and "to review and audit contracts, cost reports, claims, bills, and all other expenditures of Medicaid funds to determine compliance with applicable laws, regulations, guidelines, and standards and enhance program integrity."

6) The referenced patient is not included in the findings.

7) Additionally, N.J.A.C. 10:49-9.8(a) states "All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete." Furthermore, 42 CFR 491.10 states that the center maintain patient health records that include signatures of the physician or other health care professional.

8) The physician attestations provided by CHC state that the doctors all were made aware of their failure to sign the charts on or about December 5, 2011, but they did not sign until February, 2013. Under the circumstances, OSC requires support to determine what the physicians relied upon to be able to make the attestations.

9) OSC's preliminary findings included a date of service that was missing an encounter form. There were no additional conditions added to the initial report.

10) A revised calculation was provided on November 13, 2013 which uses the same methodology that was explained during the exit conference on May 8, 2012 and the review of the preliminary summary of findings.

11) CHC is correct in stating that they followed the procedures outlined in a DMAHS newsletter; however these procedures incorrectly allowed CHC to be reimbursed on vaccination codes rather than administrative codes. According to the Centers for Disease Control (CDC) Vaccines for Children Operations Guide, "Patients or Medicaid agencies cannot be billed for the cost of the VFC vaccine or state supplied vaccine". OSC has recommended

that DMAHS amend its November 2004 newsletter (Volume 14, No. 55) to comply with federal and state operational guidelines.

12) OSC's review concluded that there were incomplete Eligibility Screening Data sections of the electronic records.

13) In accordance with 42 C.F.R. 491.5, if FQHC services are furnished at permanent units in more than one location, each unit is independently considered for approval as an FQHC. If the billing unit was not approved as an FQHC, it was not entitled to submit and be paid for any claims.

14) Antioch Manor did not become an approved Medicaid provider until June 1, 2011, provided and billed for services to Medicaid recipients during 2009 and 2010. This site would not fall under the auspices of any other facility. Each FQHC site must individually enroll with DMAHS in order to provide services to Medicaid recipients and receive reimbursement from the program.

15) As required by N.J.A.C. 10:66-1.3(c)(2), each facility site must obtain a federal designation from CMS. CMS approved the Odessa site on November 15, 2011(during our on-site audit). The HRSA Notice of Grant Award dated May 22, 2009 approving the change in scope for Roosevelt Manor Health Center (Odessa Paulk-Jones) and also listed grant specific terms for any new site(s) to complete a CMS 855A form (Medicare Enrollment application).

16) OSC understands that CHC was following DOH-Licensing Division's policy that a site operating less than 8 hours per week did not require ambulatory care licensure. However, in order to receive Medicaid reimbursement, Antioch was still required to be an approved Medicaid provider. Therefore, CHC was not entitled to submit claims for services rendered at Antioch, and must repay any amount received for those services.

17) It is OSC's recommendation that all approved services be listed on a site's ambulatory care license.

18) CHC has not provided documentation to support any restitution made to the MCOs and Medicaid on behalf of the encounters billed and paid for services of the unlicensed provider.

19) OSC has concluded that Odessa is not open 40 hours per week as listed on their HRSA notice of Grant.

20) OSC provided proof of HMO eligibility during the on-site audit for the recipient during the period Medicaid was billed. Any payment by the HMO would reduce Medicaid's liability, thus resulting in Medicaid not paying the full PPS rate.

21) CHC's senior management staff accompanied OSC auditors on October 11, 2011, to the Antioch, South and Odessa sites, and on October 12, 2011 to the East site. Findings noted during these visits were observed by CHC personnel. Although CHC representatives were not present during the remaining four site visits, similar findings were observed by the OSC auditors and the OSC RN investigator.

22) The referenced reports fail to show that CHC performed an annual program evaluation, including a review of sampled active and closed clinical records.

23) The Commisioner's memorandum submitted by the Provider in Attachment A, dated November 26, 2003, states that "DMAHS is revising our policy to allow enrollment of at FQHC's prior to completion of their Medicare enrollment process. " In fact, State regulations were never changed to reflect the position taken in the Commissioner's memo. Furthermore, 42 CFR section 491.5 of the Federal regulations requires Medicare enrollment prior to the provision of services and to the submission of claims.

24) In response to DMAHS's comment, the timeline for the history of the appeal for the Medicaid supplemental payments was after the audit period under review. As listed by DMAHS, the first complaint was filed on January 23, 2012 and the final decision was issued by the US Court of Appeals for the 3rd circuit on July 9, 2013. Our audit period was January 1, 2009 – December 31, 2010.

25) In response to DMAHS comment that MCO payment information is submitted on Table 18. DMAHS should ensure all data submitted by the MCO is complete and accurate.