



**New Jersey State Legislature  
Office of Legislative Services  
Office of the State Auditor**

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**Department of Human Services  
Division of Developmental Disabilities  
Community Programs**

July 1, 2009 to July 31, 2013

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**Stephen M. Eells  
State Auditor**

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Enclosed is our report on the audit of the Department of Human Services, Division of Developmental Disabilities, Community Programs for the period of July 1, 2009 to July 31, 2013. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells  
State Auditor  
December 30, 2013

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## *Scope*

We have completed an audit of the Department of Human Services, Division of Developmental Disabilities, Community Programs for the period July 1, 2009 to July 31, 2013. Our audit included financial activities accounted for in the state's General Fund and the Casino Revenue Fund.

The primary objective of the community programs is to provide prompt and effective care, support, and habilitation to consumers with developmental disabilities, and to ensure they are appropriately served and supported to enable them to reside in the community.

Annual expenditures for the community programs during the audit period were \$1 billion. The major component of expenditures was payments to group home providers.

## *Objectives*

The objectives of our audit were to determine whether financial transactions were related to the agency's programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of the significant conditions noted in our prior report dated June 7, 2005.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

## *Methodology*

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, the administrative code, circular letters promulgated by the Department of the Treasury, and policies of the division. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing of financial transactions. We also read the budget messages, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions on our audit objectives, as well as internal controls and compliance. Sample populations were sorted and transactions were judgmentally selected for testing. To ascertain the status of findings included in our prior report, we identified corrective action taken by the division and performed tests to determine if the corrective action was effective.

### *Conclusions*

We found the financial transactions included in our testing were related to the agency's programs, were reasonable, and were recorded properly in the accounting systems. In making these determinations, we noted certain internal control weaknesses, matters of compliance with laws and regulations, opportunities for enhanced revenue, and other matters meriting management's attention. We also found the agency has resolved some of the significant conditions noted in our prior report. Prior report issues concerning community care waiver billing, contract closeout, and skilled sponsor payments have been updated in this report.

We also made an observation that the division could save \$20.7 million by returning 289 consumers placed in out-of-state facilities to New Jersey in order to qualify them for the Community Care Waiver program.

## Community Care Waiver Billing

### *Consumer Eligibility/Enrollment*

**The division needs to closely monitor consumer's CCW eligibility status.**

Community Care Waiver (CCW) is a program that assists consumers with developmental disabilities to live in the community. The federal Medicaid program reimburses the Division of Developmental Disabilities (DDD) for 50 percent of the allowable cost for eligible consumers. CCW program consumers must be eligible for DDD-funded services and meet specific Medicaid income and resource requirements. The division assists consumers with a Medicaid financial packet and is responsible for submitting the completed packet to the Institutional Services Section within the Division of Medical Assistance and Health Services (DMAHS) for eligibility determination. Consumers receiving Supplemental Security Income (SSI) meet the financial requirements. The DDD should ensure that all eligible consumers are properly enrolled in the CCW program in order to maximize federal reimbursements.

During fiscal year 2013, there were 8,928 consumers receiving CCW residential services, 7,488 of which were enrolled for Medicaid reimbursement while 1,440 were not. Based on our review, we found the division did not review consumers' eligibility status timely. We identified 76 consumers residing in division funded group homes and supervised apartments who were not enrolled in CCW while receiving SSI benefits. Based on the information in the division's Consumer Information System, we estimate the division's cumulative revenue loss because of enrollment issues for these consumers to be \$5 million. As of July 2013, 47 of the 76 consumers have been made CCW eligible.

The division's eligibility regulations changed effective January 22, 2013. As a result, new consumers are required to meet both functional criteria and Medicaid eligibility prior to receiving services from the division. Medicaid consumers already receiving services as of January 22, 2013 were permitted to continue to receive services for a period not to exceed March 23, 2013. Provided these consumers met certain conditions, they were allowed to receive services for an additional period not to exceed 30 days. As of July 2013, there were approximately 600 consumers receiving residential services without a Medicaid number and an additional 190 in pending status. The Division is working to identify consumers who are receiving services but are not currently Medicaid eligible, and work with them to obtain Medicaid eligibility.

During our review, we also noted that between fiscal year 2008 and 2013, the division submitted \$420,000 in CCW unallowable claims for 94 ineligible consumers in out-of-state facilities. In May 2013, the division refunded Medicaid \$175,000. The division needs to refund the remaining \$245,000 back to the Medicaid program.

*Untimely Attendance Reporting*

**The untimely submission of attendance reports by providers has resulted in lost federal reimbursements.**

Under the guidelines of the CCW program, the division must submit eligible claims within one year of the date of service to receive federal reimbursement. These claims are based on attendance reports received electronically from the division's contracted providers. The division utilizes a system generated missing attendance report to keep track of unsubmitted reports and the potential loss of revenue. The report however, requires a great deal of manual work to accurately reflect missing attendance. We reviewed fiscal year 2009 through 2012 missing attendance reports and determined that because of untimely attendance report submissions, the division lost approximately \$3.4 million in federal reimbursements for the period, as noted in the following chart.

Fiscal Year	Amount
2009	\$ 920,000
2010	\$1,000,000
2011	\$ 790,000
2012	\$ 680,000
Total	<u>\$3,390,000</u>

*Final Expenditure Reporting by Providers*

**The final waiver billing rates should be prepared timely.**

When billing for the CCW federal reimbursements, the division uses both interim and final rates approved by the DMAHS. Final rates reflect actual costs and are calculated after the division gathers sufficient cost and attendance data for the fiscal year. In the absence of final rates, the division is authorized to use interim rates which attempt to approximate costs and enable the division to claim reimbursements until final rates are calculated. Once the rates are finalized, a retroactive adjustment is made for the difference. Since final rates are generally higher than interim rates, these adjustments normally result in additional federal reimbursements. As noted in our prior audit report, final rates should be calculated soon after the end of the fiscal year so this additional revenue may be received more timely. Because final expenditure reports are not submitted timely by the providers, the final rates can not be prepared timely. In May 2012, the department completed the final habilitation, personal care, supportive living, and self-determination rates for fiscal year 2009. In November 2012, the

department completed the final habilitation, personal care, and self-determination rates for fiscal year 2010. The estimated effect of the final rate adjustments for the personal care and habilitation, the two largest services, was additional federal revenue of \$14.6 million for fiscal year 2009 and \$12.2 million for fiscal year 2010. Fiscal year 2011 and 2012 rates have not been completed yet. We project final rates for fiscal years 2011 and 2012 may result in an additional \$27.7 million in federal reimbursements.

### **Recommendation**

The division should closely monitor consumers' CCW eligibility status to ensure their timely enrollment in order to maximize federal revenue. In addition, the division should continue its efforts to comply with current eligibility regulations requiring consumers to qualify for Medicaid before receiving services. The division should also refund the Medicaid program for unallowable claims. Lastly, the division should consider withholding a portion of payments to providers to ensure timely submission of attendance and expenditure reports and revise the missing attendance report to accurately present missing attendance data.



## **Contract Closeouts**

### **Untimely reporting and contract closeouts may inhibit overpayment recoveries.**

The Division of Developmental Disabilities contracts with provider agencies to render services to DDD consumers living in the community. Contracts are for one or two years and are normally renewed for subsequent years. The Department of Human Services (DHS) policy requires the provider to submit all required financial and audit reports to the department within 120 days of the contract expiration. The division is responsible to reconcile payments to the final report of expenditures. The closeout process also enables the division to identify and recover unspent contract funds.

Our review found provider agencies are not submitting the required financial information and the division is not performing the contract closeouts timely. Per the June 12, 2013 closeout document tracking report, 101 (63 percent) final expenditure reports and 107 (67 percent) audit reports were not submitted for contracts ending in 2012. Of these, 57 final expenditure reports and 58 audit reports were over seven months past due.

The division is in the process of closing fiscal year 2011 contracts. According to the May 1, 2013 contract status report, the division had closed approximately 27 percent of fiscal year 2011 contracts. In addition, the division was waiting for supporting documents for 26 contracts (including one fiscal year 2009 and two fiscal year 2010 contracts), seven contracts were pending DHS contract audit (including two fiscal year 2010 contracts), and 111 contracts were under review (including two fiscal year 2009 and ten fiscal year 2010 contracts). The status report also listed 29 contracts in a dispute status, some dating back to fiscal year 2005, totaling

over \$4.8 million in overpayments to providers. Delays in submission of required financial reports by providers and the untimely contract closeouts by the division could inhibit the recovery of overpayments from providers.

### **Recommendation**

The division should perform contract settlements in a timely manner and, as mentioned previously, consider withholding a portion of the contract payment to encourage timely submission of financial information by the providers.

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## **Contribution to Care and Maintenance**

**The division should improve the assessment and billing of care and maintenance.**

When a consumer receives residential services from the Division of Developmental Disabilities, the consumer is required to contribute to the cost of care and maintenance. The contribution requirements are set forth in the administrative code. The ability to contribute is evaluated annually. We identified 90 consumers that had not been assessed and billed care and maintenance between July 1, 2010 and June 30, 2013, with estimated lost revenue to the division of \$965,000. The division's assessment process did not include matching the accounts identified on the Consumer Information System with assessment data, resulting in non-detection of unassessed consumers.

### **Recommendation**

The division should improve its current process to include matches of systems data, to ensure that all consumers have been assessed and billed for the required contributions to their cost of care and maintenance.

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## **Client Banking System**

**Records in the Client Banking System should be updated timely.**

Records in the Client Banking System (CBS) should be updated timely to reduce the risk of misuse of consumer funds. The Social Security Administration requires the maintenance of separate records for each beneficiary for whom the division is a representative payee of benefits. The division utilizes the CBS to record all receipts and disbursements from consumer funds. The division maintains an account in the system for every consumer that receives residential services regardless if the division is representative payee.

The consumers' information in the CBS is not updated timely. As of May 2012, there were 1,546 accounts within the CBS requiring closure because of consumers' death, discharge from DDD services, or change of service provided. Also, the division should have transferred approximately \$92,000 to the maintenance account, including over \$43,000 in deceased consumer funds. In addition, we identified 231 consumers without an account and 113 consumers whose social security numbers in the CBS did not match the division's Consumer Information System. The division began correcting these issues once we brought them to their attention.

### **Recommendation**

The division should update information in the CBS and open and close consumer accounts in a timely manner. The division should also ensure accuracy of the consumer information so that it can be effectively matched to other systems within the department.

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### **Provider Contract**

#### **The division should reconsider contracting with a vendor.**

The division contracted with a provider that operates ten group homes, an apartment, and two adult training centers for \$4 million annually. While reviewing division contract closeout procedures and the overpayment receivable report, we noted that for the provider's 2005 through 2011 contracts, overpayments amounted to over \$1 million. The provider started making monthly \$7,481 repayments to the division in January 2011. However, after the provider defaulted on the obligation, the division withheld the last 2012 contract payment of \$356,000 and in May 2013 started a series of seven \$64,320 monthly withholdings that represent the total general and administrative costs of the 2013 contract. As of June 2013, the outstanding overpayment balance on contracts through 2011 for the provider was \$300,000. According to the division, the estimated overpayment for the 2012 contract is \$185,000.

We reviewed the provider's independent audit reports for fiscal year 2005 through 2011 and noted a multitude of significant audit findings in the early reports. We also noted that each year the provider's current liabilities significantly exceeded current assets raising a concern over the provider's ability to continue operations. This concern was expressed by both the independent and the Department of Human Services (DHS) auditors. In addition, the independent audit reports state that based on the DHS review, the provider may be liable to the division for \$258,000 and \$403,000 for contract year 1997 and 1998 overpayments. According to the division, these amounts could not be verified or recovered as the supporting documentation for the contracts are no longer available.

We also noted the provider was operating group homes in New York City. According to a newspaper article, the provider declared bankruptcy twice and its former executive director and chief financial officer were charged with embezzlement. Additionally, the provider had been continually cited for licensing violations, serious lapses of care, and for failing to meet minimum federal health and safety standards. In June 2011, the New York Office for People With Developmental Disabilities placed the vendor on Early Alert status for serious concerns related to agency internal controls as well as significant compliance issues. The Early Alert status refers to a process to monitor the performance of a provider that has been unable to sustain compliance with New York state laws and regulations and/or has been unable to demonstrate sound governance practices, including management of fiscal resources. The provider remained on the Early Alert status beyond April 2012 and was imposed monetary fines for violations such as failure to provide sufficient and adequate food at various sites, fire safety deficiencies, and failure to assure appropriate medical services at various sites. The DHS responded to our inquiry as to the care provided by the vendor in New Jersey that the ten group homes were inspected in January 2013 and nine were issued full licenses through March 31, 2014. One group home was first issued a three month provisional license because of several substantial noncompliant deficiencies, including failure to fully carry out physicians' orders. This home was re-inspected in May 2013 and issued a full license. Issues of this nature should be considered when contracting with providers.

### **Recommendation**

The division should ensure that contracted providers are financially sound and reconsider contracting with the above provider because of the issues noted and to avoid possible losses. Also, contract settlements should be performed timely to limit potential overpayments.



## **Community Care Provider Payments**

### **Payments to Community Care providers should be properly monitored.**

The division contracts with Community Care providers (an adult person or family in a private home or apartment) to provide care and/or training to consumers with developmental disabilities. The level of compensation is determined by the division's regional offices through the Placement Review Team based upon the level of care needed. The compensation includes a room and board fixed rate and a skill level component determined based on an individual's health, mobility, self-care, and behavior. The compensation is based on a number of days an individual remains under the provider's care. The Community Care provider is required to inform the regional office when the individual moves or is hospitalized. If the individual is hospitalized, the division pays the provider up to 30 days of the room and board component and discontinues the skill level payment. Full compensation is continued for consumers at skill level IV and to those granted special exceptions.

The Community Care providers were prepaid by the division monthly. Pay adjustments were made during subsequent months based on the calculations submitted by four regional offices along with the monthly billing reports prepared by the Community Care providers and approved by the regional office staff. The division did not review providers' monthly billing reports before making payment adjustments. Our review of 49 fiscal year 2011 and 2012 payments to providers disclosed seven billing reports were missing, totaling \$8,000. We also verified whether the consumer's hospitalization was properly reported and the provider compensation adequately adjusted. Out of 201 fiscal year 2011 and 2012 hospitalizations, 47 were not properly reported by the providers or adjusted by the division, resulting in approximately \$15,600 in overpayments to 43 providers. The division did not have the provider's monthly billing reports to support 37 of 47 payments.

Since our review, payments are made by the division after submission of the monthly billing reports by the providers, which detail actual days of care.

### **Recommendation**

We recommend the division ensure the propriety of payments to Community Care providers and recover overpayments.



### **Unusual Incidents**

**The division should verify the severity of selected unusual incident cases.**

N.J.S.A. 30:6D-17 stipulates that every developmentally disabled person shall have adequate protection from abuse and be provided a wholesome living environment. The Department of Human Services (DHS) Administrative Order 2:05 establishes policy and expectations for the reporting of unusual incidents by each facility, institution, school, or program operated by the respective division that affects the health, safety, and welfare of the department's service recipients. Unusual incidents can range from serious to minor and include, but are not limited to: death, physical or sexual assault, verbal or psychological abuse, mistreatment, neglect, exploitation, injury, Danielle's Law requirement, and incidents of a medical or operational nature.

The unusual incidents are filed by the providers with regional unusual incident reporting coordinators, but can also originate through phone calls or anonymous letters from parents or other concerned individuals. The division also manages a hotline to receive phone calls regarding incidents of abuse. We noted the hotline information is not included on the division's website.

The incidents are entered into the Unusual Incident Reporting and Management System (UIRMS) and based on the severity, are organized into four reporting levels and categorized based on 89 codes. The Office of Program Integrity and Accountability (OPIA) within DHS has direct responsibility for incident investigations, licensing of human services programs and facilities, and ensuring fiscal and program accountability of community programs. After an incident is logged in UIRMS, it is auto-routed based on the codes assigned to the OPIA's Critical Incident Management Unit (CIMU), Special Response Unit (SRU), Office of Licensing (OOL), or directly to the Division of Developmental Disabilities for review and/or investigation. The unusual incidents at the developmental centers are investigated by the Office of Investigation, overseen by DHS.

In general, the majority of the unusual incidents are reviewed by the division. The unusual incidents of an operational nature are investigated by the OOL through site visits. Minor cases of abuse and neglect are desk reviewed and evaluated by CIMU without site visit follow-ups. The community providers have 45 days to conduct an investigation and prepare the necessary documentation for CIMU's review. Civil investigations of the most severe allegations of abuse, neglect, and exploitation are conducted by SRU. The SRU unit consists of 15 investigators who each investigate an average of 24 cases annually. The investigators usually spend the first week of a new investigation making arrangements to meet with the alleged perpetrators, witnesses, and victims involved. It could take one to three weeks before the first on-site visits are conducted. By that time, physical evidence of an incident may no longer be verifiable.

Between January 1 and October 17, 2012, there were 13,800 unusual incidents reported in UIRMS for consumers receiving services from the division, not including the seven developmental centers. The majority of these cases do not require in-person investigation, however, the division does not have a standard procedure to routinely substantiate the severity of reported incidents. This could be done by dispatching a division employee (e.g. a case manager) to the location within 24 to 48 hours of an incident coded as abuse, assault, injury, and neglect. Based on our review of 2012 reported incidents, we estimate 2,100 cases would have been subject to this new procedure.

### **Recommendation**

The division should develop a standard procedure to routinely affirm the severity of reported incidents by dispatching a division employee to the location within 24 to 48 hours of the incident. The division should also update its website to include easily accessible hotline information.

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## Observation

### Consumers in Out-of-State Facilities

**The division should expedite returning consumers in out-of-state residential facilities back to the state in order to maximize federal revenue.**

As of July 2013, the division funded 467 consumers placed in out-of-state residential facilities. Fiscal year 2012 payments to out-of-state providers amounted to \$67.7 million and ranged from \$20,000 to \$250,000 per individual. During the fiscal year, the division incurred an additional \$600,000 in medical costs on behalf of these consumers. Two hundred eighty-nine (289) of these consumers resided in non-Community Care Waiver (CCW) residential facilities and hence were not eligible for cost reimbursements from the federal government. We estimate the division could increase federal Medicaid reimbursements by \$20.7 million annually by returning these consumers to New Jersey and placing them in CCW qualified facilities.

In 2009, the division started a “Return Home New Jersey” initiative focused on returning consumers back to New Jersey in CCW settings. The division is currently not placing any consumers out-of-state. The division should expedite returning consumers placed in out-of-state facilities to New Jersey.

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CHRIS CHRISTIE  
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December 17, 2013

Mr. Stephen M. Eells  
State Auditor  
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PO Box 067  
Trenton, NJ 08625-0067

Dear Mr. Eells:

Enclosed is the Department of Human Services' response to the Community Programs Audit for July 1, 2009 to July 31, 2013 conducted by your office. This response was prepared by staff from the New Jersey Division of Developmental Disabilities. If you have any questions, please contact Janet Hand at 609-631-2269.

Sincerely,

A handwritten signature in black ink that reads "Dawn Apgar".

Dawn Apgar, PhD, LSW, ACSW  
Deputy Commissioner

Enclosure

c: Jennifer Velez, Commissioner  
Elizabeth Shea, Assistant Commissioner  
Christopher Bailey, Chief Financial Officer

**Department of Human Services  
Division of Developmental Disabilities  
Community Programs  
Audit Response  
December 13, 2013**

**Community Care Waiver Billing:**

The Division needs to closely monitor consumer's CCW eligibility status.

**Response:** The Division of Developmental Disabilities (Division) agrees with this recommendation and in January 2013, revised its eligibility regulations to require individuals to be Medicaid eligible in order to receive Division services. In February 2013, the Division notified individuals who were receiving Community Care Waiver (CCW) level of service that they must enroll in the CCW. The Division designated a staff person to monitor the process and follow up directly with families. Individuals who do not cooperate with the Medicaid eligibility and CCW enrollment requirements are being reviewed for service changes or termination. In addition, the Division has developed a CCW database to track and monitor the CCW eligibility statuses. Staff immediately initiate a re-application process for individuals who lose CCW eligibility.

The Division also instituted a CCW Claims Management function to monitor claim activity. The Claims Management staff work to verify questionable claims and to determine corrective action.

With regard to the out-of-state claims, approximately \$190,000 has been refunded to the Medicaid program to date. The remaining claims require manual adjustments on a case by case basis. That process is underway.

**Untimely Attendance Reporting:**

The untimely submission of attendance reports by providers has resulted in lost federal reimbursements.

**Response:** The Division agrees and is transitioning to a Medicaid fee-for-service model, which will be implemented in 2014. It will require agencies to become approved Medicaid providers and to directly bill Medicaid for reimbursement. Attendance reports for CCW claims will no longer be needed. In the meantime, the Division continues to monitor missing attendance reports and notify agencies of the need to enter and certify attendance. Agencies that fail to comply risk having their contract placed in default and payments withheld.

**Final Expenditure Reporting by Providers:**

The final waiver billing rates should be prepared timely.

**Response:** The Division agrees and is transitioning to a Medicaid fee-for-service model, which will be implemented in 2014. It will require agencies to become approved Medicaid providers and to directly bill Medicaid for reimbursement. Final expenditure reports and

attendance reports will no longer be required. In the meantime, the Division continues to monitor final expenditure and missing attendance reports and notify agencies of the need to submit the information in a timely manner. Agencies that fail to comply risk having their contract placed in default and payments withheld. The FY2011 cost reports have been submitted for review or are in process. The FY2012 cost reports are in process and are expected to be submitted within the next two months. This may result in the recoument of funds back to the Division.

### **Contract Closeouts:**

Untimely reporting and contract closeouts may inhibit overpayment recoveries.

**Response:** The Division agrees and is transitioning to a Medicaid fee-for-service model in 2014, which will require agencies to become approved Medicaid providers and to directly bill Medicaid for reimbursement. Final expenditure reports and audits required for closeout purposes will no longer be required.

In the meantime, the Division has instituted a centralized tracking system to monitor outstanding reports and to enforce timeframes. The Division notifies agencies of the need to submit the information in a timely manner. Agencies that fail to comply risk having their contract placed in default and payments withheld. At present, seven final reports of expenditures and six audits remain outstanding for FY2012 for closeout purposes.

Fifty-five (55) percent of the FY2011 closeouts have been completed and 22 contracts require supporting documentation. For prior year contracts, 60 contracts remain under review, and no prior year contracts are pending DHS contract audit. There are 17 contract closeouts in dispute and in varying levels of resolution, dating back to the 2008 contract term. The total value of the closeouts in dispute for FY2008 through FY2011 is \$1.9 million for compliance issues and underspending. Providers have the opportunity to provide additional information and reconciliations for consideration as part of the dispute resolution process. Through this process, the Division will seek to recover all appropriate dollars.

### **Contribution to Care and Maintenance:**

The Division should improve the assessment and billing of care and maintenance.

**Response:** The Division agrees and has modified the internal reporting system from a manual process to an automated process to identify individuals in need of assessment. In addition to the routine monthly assessment notifications (over 3,100 annually), the Division also sends reminders to individuals who do not submit the completed application as well as provide additional follow up action with the responsible party.

### **Client Banking System:**

Records in the Client Banking System should be updated timely.

### **Response:**

The Division agrees and has designated a staff person to monitor the updating of consumer information maintained in the Client Banking System. The auditors identified a number of inactive accounts in which no funds were present. These accounts were reviewed and

closed as appropriate. If funds were present, the accounts were reviewed and funds were either collected for maintenance or disposed of in accordance with established policy.

**Provider Contract:**

The Division should reconsider contracting with a vendor.

**Response:**

The Division holds quarterly meetings to review the status of agencies with financial and programmatic concerns. Staff from Contract Administration, Fiscal and programmatic units participate. At these meetings, the various Division units discuss agencies that are currently experiencing operational difficulties and recommend actions that should be taken to address the issues including the submission of corrective action plans, increased monitoring, contract termination, and other corrective measures. The agency indicated in the report is included in the list of agencies under review. There are corrective measures in place and increased oversight in the programmatic areas. In addition, outstanding fiscal recoveries for this agency are now less than \$100,000 and will be resolved by February 2014.

**Community Care Provider Payments:**

Payments to Community Care providers should be properly monitored.

**Response:** The Division agrees that overpayments were the result of a reconciling payment system. As of Fiscal Year 2013, it was switched to a "fee-for-service" model in which payments are made based on actual services rendered in the prior month, drastically reducing the possibility of over-payment. With respect to 2011 and 2012 overpayments to Community Care Residence Providers, the Division has submitted all outstanding debts to the Division of Revenue (DOR) for collection. A small number of payment plans are being managed internally and will be referred if in arrears.

**Unusual Incidents:**

The Division should verify the severity of selected unusual incident cases.

**Response:** Both the Department of Human Services (DHS) and the Division have policies regarding reporting and investigation of unusual incidents:

- Administrative Order 2.05 – Unusual Incident Reporting
- Division Circular #14 – Reporting of Unusual Incidents
- Division Circular #15 – Complaint Investigation of Community Programs

In addition, all agencies under contract with DHS and the Division are required to following AO 2.05 and the above referenced Circulars. The Division will send staff, through both announced and unannounced visits, to programs to follow up on any significant allegations, as warranted. The Division also operates a 24/7 on-call system for the reporting of incidents.

Further, DHS operates the Special Response Unit (SRU), which investigates allegations of abuse, neglect and exploitation. The SRU conducts civil investigations of serious abuse,

neglect and exploitation involving individuals with developmental disabilities residing or participating in community programs.

The Division has updated its website's homepage to provide a link to the Abuse reporting hotline number.

**Observation – Consumers in Out-of-State Facilities:**

The Division should expedite returning consumers in out-of-state residential facilities back to the State in order to maximize federal revenue.

**Response:**

One of the Division's major initiatives is "Return Home New Jersey." The Division continues to identify individuals to return from out-of-state facilities to New Jersey so that they may be closer to family members. It also allows the state to maximize federal revenue. Since FY2010, 176 individuals in this initiative have been removed from State only funding. Of these, 109 have been added to the CCW for federal reimbursement, 39 children were transferred to Department of Children and Families, 19 have been transferred to non-Division services and nine are deceased. There are an additional 80 individuals identified to move back to New Jersey in FY2014.