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**Department of Human Services
Division of Developmental Disabilities
Woodbine Developmental Center**

July 1, 2007 to August 18, 2009

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The Honorable Richard J. Codey
President of the Senate

The Honorable Joseph J. Roberts, Jr.
Speaker of the General Assembly

Mr. Albert Porroni
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Enclosed is our report on the audit of the Department of Human Services, Division of Developmental Disabilities, Woodbine Developmental Center for the period of July 1, 2007 to August 18, 2009. If you would like a personal briefing, please call me at (609) 292-3700.

A handwritten signature in black ink that reads "Stephen M. Eells".

Stephen M. Eells
Assistant State Auditor
November 9, 2009

Table of Contents

	Page
Scope.....	1
Objectives	1
Methodology	2
Conclusions	2
Findings and Recommendations	
Revenue	
Intermediate Care Facility – Mental Retardation (ICF/MR) - Pending Claims	3
Medical Rehabilitation Cottage.....	4
Respite	5
Medicare Part B Billings	5
Welfare Fund.....	6
Galley Operation	7
Auditee Response.....	9

**Department of Human Services
Division of Developmental Disabilities
Woodbine Developmental Center**

Scope

We have completed an audit of the Department of Human Services, Division of Developmental Disabilities, Woodbine Developmental Center (WDC) for the period July 1, 2007 to August 18, 2009. Our audit included financial activities accounted for in the state's General Fund. The audit also included a review of internal controls for allowable costs under the American Recovery and Reinvestment Act - Federal Medical Assistance Percentage (FMAP) that funds the Intermediate Care Facility – Mental Retardation (ICF/MR) program at WDC.

The center maintains non-appropriated funds which are audited by the Department's Office of Auditing. We reviewed the prior audit report findings, conducted surveys, and performed an analysis to gain an understanding of each fund. This process resulted in portions of the Welfare Fund and the Galley Account being included in the scope of this audit report.

The center provides care and rehabilitation to 485 developmentally disabled male consumers at all levels of capability on its grounds. Annual expenditures are approximately \$75 million. ICF/MR billings for consumers were approximately \$83 million in calendar year 2008 and \$53 million in calendar year 2009 through July 2009, of which 50 percent is paid by the federal government. In addition, client care and maintenance cost recoveries and Medicare Part B revenues are approximately \$3 million annually.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the center's programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of significant conditions noted in our prior report dated October 16, 2002.

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

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. 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, if any, taken by the center and walked through the system to determine if the corrective action was effective.

Conclusions

We found that financial transactions included in our testing were related to the center's programs, were reasonable, and were recorded properly in the accounting systems. In making this determination, we noted certain internal control weaknesses and matters of compliance with laws and regulations that merit management's attention. The prior audit report noted billing errors by manual submission of ICF/MR claims. We found that the center has resolved this issue. The department implemented electronic submission of claims in October 2007.

Revenue

Intermediate Care Facility – Mental Retardation (ICF/MR) - Pending Claims

**Management needs to
improve controls over
pending claims.**

The federal ICF/MR program reimburses approximately 50 percent of costs incurred by eligible consumers who are institutionalized at the center. The monthly billing consists of the number of eligible consumer days multiplied by an approved rate which is adjusted annually. The supervisor of patient accounts (SPA) performs a monthly reconciliation to identify total eligible resident days. Unpaid days are summarized in the schedule of pending claims and filed with the monthly reconciliation. These pending claims are primarily due to missing Medicaid information, consumer name mismatches, or ineligibility due to long-term care. When a consumer's Medicaid eligibility is initially approved or subsequently reinstated after a period of ineligibility, the SPA has to enter the Medicaid effective date into the automated billing system. Retroactive claims must be manually resubmitted. When claims are subsequently paid, the SPA deletes the item from the pending claims list. Our review disclosed that Medicaid eligibility dates were not always entered into the system. Retroactive claims were not regularly submitted and follow ups were not made when denied. The center could not provide us with the balance of unpaid pending claims since a receivable account was not set up to track these claims. Using the center's records, we were able to determine that calendar years 2006, 2007, and 2008 outstanding pending claims totaled 6,496 billable days amounting to a \$1.8 million reimbursement due the state. The center has started to bill these outstanding claims. As of August 18, 2009, \$90,000 had been received.

Recommendation

We recommend that WDC management draft detailed procedures, provide proper oversight, and establish a pending claims receivable account to track unpaid claims. Part of management's

oversight should include regularly reviewing the amount, activity, and age of pending claims. The detailed procedures should require the SPA to closely monitor and inspect monthly claims to identify payment of pending claims and to correct and/or submit manual adjustments monthly for all retroactive or denied viable claims.

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Medical Rehabilitation Cottage

Revenues can be enhanced if the MRC is ICF/MR certified.

Consumers with greater medical needs and those recovering after hospital visits stay at the center's medical rehabilitation cottage (MRC). Once recovered, they are released to an ICF/MR certified cottage. However, recovery time varies and consumers could reside at the MRC for long periods of time. The center does not bill for consumers residing at the MRC since it does not meet the active treatment standards required by the ICF/MR program. The average daily population living at the MRC was 13 consumers who may be potentially eligible for ICF/MR billings during calendar year 2008. We noted that two of the state's other developmental centers have MRC facilities that are ICF/MR certified. We also noted that the center had 80 beds available at various ICF/MR certified cottages at December 2008. Had these consumers recovered in an ICF/MR certified facility, an additional 4,758 days or \$1.4 million could have been reimbursed to the state in calendar year 2008.

Recommendation

We recommend that the center perform a cost benefit analysis to determine what steps are necessary to qualify consumers residing in the MRC for ICF/MR benefits. Such change could include converting an ICF/MR certified cottage to an MRC equivalent cottage for recovering consumers.

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Respite

Revenues can be enhanced if respites are regular admissions.

The center provides care to consumers admitted as respites. N.J.S.A. 30:4F-2 defines respite or respite care as infrequent and temporary substitute care for a frail or severely disabled adult. Respite care shall not exceed a maximum of 30 consecutive days or 60 days in any calendar year. As of June 29, 2009 nine respites were living in one of the ICF/MR certified cottages. Five respites stayed in the center over one year. The center does not bill for respites since they are ineligible for Medicaid benefits due to their classification. If these five respite consumers had qualified for ICF/MR, additional reimbursements of \$485,000 could have been generated in calendar year 2008.

Recommendation

We recommend that the center in conjunction with the division determine the status of the respite consumers after 30 days and if appropriate bill the ICF/MR program.

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Medicare Part B Billings

Preparation and submission of Medicare Part B claims needs to be improved.

The center can recover partial costs for covered services when a consumer with Medicare Part B sees a doctor. Doctor visits and procedures performed on consumers are recorded in each consumer's binder. A billing clerk reviews these binders regularly and records billable visits on a Medicare Part B billing log sheet. Billable visits on the log sheet are coded and entered into the Division of Developmental Disabilities' Meditrak billing system. Claims are then submitted for reimbursement under the Medicare Part B program. When reimbursements are received, the division prepares a cash receipt document and enters the information into the state's accounting system to the credit of the center. Neither the center's billing unit nor the business office are notified of the status of submitted claims. It is the division's responsibility to submit claims for reimbursement

and process rejected claims. The division's records showed it processed an average of 4,813 paid claims and revenues averaged \$187,609 per year. Our review disclosed the following.

- Three hundred forty - six consumers living in the center are enrolled in Medicare Part B. The Meditrak billing system did not list Medicare Part B numbers for 12 eligible consumers. No billing histories were found for these consumers.
- Five consumers' Medicare Part B number was incorrectly listed in the Meditrak system. Claims for two consumers were affected. One consumer, admitted in 2007, had 45 claims from calendar year 2007 to June 2009 and none of the claims were paid. The other consumer, admitted in 2005, had 61 unpaid claims during the same time period.
- We reviewed five consumers' binders and identified 105 billable medical visits in calendar year 2008. The calendar year 2008 billing summary report from the division only identified 42 visits had been processed.

Recommendations

We recommend that the center ensure that all consumers participating in Medicare Part B are properly listed in the billing system with a valid Medicare Part B number. The center should also ensure that Medicare Part B claims are accurately processed. The division should notify the center regularly of the status of claims submitted.

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Welfare Fund

The purpose of the Welfare Fund is to provide funding for items or events that benefit the entire population. The Department of Human Services Welfare Fund Accounts Manual requires that the fund not maintain a large surplus. The balance of the fund has remained between \$400,000 and \$420,000 for the last three years. During this

**The Welfare Fund
balance is excessive.**

period, annual expenditures of approximately \$75,000 have been equal to revenues, thus the fund balance remains fairly constant, with \$350,000 of the fund balance being invested in the state's cash management fund. The center also receives a state appropriation to pay for consumer recreation and rehabilitation related expenses. These expenses were \$77,000 in fiscal year 2008 and \$69,000 in fiscal year 2007. A cursory review of purchases charged to the appropriation account, such as holiday party supplies, therapeutic equipment, and animal care products, noted these items could have been paid from the welfare fund since these items benefit the general consumer population.

Recommendation

We recommend that the center utilize the welfare fund to pay for all purchases of items or events that benefit the entire population.

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Galley Operation

Controls over the galley operation need to be strengthened.

The center has an on-grounds restaurant/general store (the galley) which serves consumers, employees, and visitors. Our review of the galley operations disclosed internal control weaknesses with one individual performing multiple control procedures. This increases the risk of errors and irregularities not being detected. A sound internal control system provides for adequate segregation of duties between purchasing, receiving, and handling cash. Our review disclosed the following duties performed by one individual.

- Places purchase orders for the galley,
- signs the receiving receipt when goods are delivered,
- receives money when there is a sale,
- closes out the register and counts cash at the end of the day, and
- gives the money to the business office for reconciling and depositing.

Our review also noted that inventory procedures and the preparation of a proper profit and loss statement are not undertaken. Financial statements provide management with an oversight tool to measure results of operation, to ensure that assets are accounted for and safeguarded, and to help ensure irregularities do not go undetected.

Recommendation

We recommend that the center strengthen internal controls by adequately segregating duties. The center should perform year-end inventory counts that facilitate the preparation of financial statements.

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JON S. CORZINE
GOVERNOR

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November 5, 2009

Stephen M. Eells
Assistant State Auditor
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Dear Mr. Eells:

This is in response to your letter of October 7, 2009 concerning the draft audit report entitled "Department of Human Services, Division of Developmental Disabilities, Woodbine Developmental Center." The audit covered the period July 1, 2007 to August 18, 2009 and was intended to determine whether financial transactions were related to the center's programs, were reasonable, and were recorded properly in the accounting systems. The auditor also tested the resolution of prior conditions.

The auditor concluded the financial transactions were related to the center's programs, were reasonable and were reported properly in the accounting system. The auditor noted the correction of prior findings. However, the auditor cited internal control weaknesses and legal compliance concerns.

The draft report contains six findings and recommendations. The findings, recommendations and the Division's responses are provided below:

Finding

The audit disclosed that Medicaid eligibility dates for patients of the Woodbine Developmental Center (WDC) were not always entered into the automated billing system. Retroactive Medicaid claims were not regularly submitted and follow-ups were not made when payments were denied. The auditor determined that for calendar years 2006, 2007 and 2008 outstanding claims totaled 6,496 billable patient days amounting to \$1.8 million reimbursement due to the State. The Center has begun billing these days and had received \$90,000 as of the end of the audit period.

Recommendation

The auditor recommends that WDC management draft detailed procedures, provide proper oversight, and establish a pending claims receivable account to track unpaid claims.

Response

The Division concurs with the finding and recommendation. Detailed procedures were developed to provide proper oversight and are available for review. The Business Manager or designee will review each pending claim submitted for compliance with the procedure and to ensure the maximization of potential revenue. A pending claims receivable report has been designed to track any unpaid claims. The report will reflect payment received and balance of unpaid claims.

We have reviewed the unpaid claims cited by the auditor and will collect all available payments for these and future claims.

Finding

Patients with greater medical needs and those recovering from a hospitalization stay at the WDC medical rehabilitation cottage (MRC) pending recovery and release to an ICF/MR certified cottage. The center does not bill for these MRC patients since the cottage does meet the active treatment standards of the ICF/MR program. Had the MCR patients recovered in a certified facility, an additional 4,758 patient days or \$1.4 million could have been reimbursed to the State in calendar year 2008.

Recommendation

It was recommended that WDC perform a cost benefit analysis to determine what steps are necessary to qualify consumers residing in the MRC for ICF/MR benefits.

Response

The individuals in this area have intensive medical and personal needs that are best met in the MCR. Woodbine will re-evaluate the individuals' needs, meet with the guardians, determine if client is ICF eligible and prepare a comprehensive safe plan for individual transfer into an ICF setting as appropriate.

Finding

The Center provides care to consumers admitted as respites. N.J.S.A. 30:4F-2 defines respite or respite care as infrequent and temporary substitute care for a frail or severely disabled adult. Respite care shall not exceed a maximum of 30 consecutive days or 60 days in any calendar year. As of June 29, 2009 nine patients were receiving respite care in one of the ICF/MR certified cottages. Five consumers receiving respite care stayed in the Center over one year. The Center

does not bill for respite care since these consumers are ineligible for Medicaid benefits. If these five respite care consumers had qualified for ICF/MR services, additional reimbursement of \$485,000 could have been generated in calendar year 2008.

Recommendation

The Center in conjunction with the Division should determine the status of the respite care consumers after 30 days and if appropriate, bill the ICF/MR program.

Response

The Division concurs with the finding and recommendation. The individuals identified in this audit had their status changed from respite to regular admission as of September 1, 2009. The Center billed for the individuals that are ICF eligible. The Center will evaluate future respite admissions after 30 days to determine eligibility for the ICF/MR program.

Finding

The Center can recover partial costs for services when a consumer with Medicare Part B sees a doctor. Doctor visits are recorded in each consumer's binder. The binders are regularly reviewed and billable visits are recorded on a Medicare Part B billing log sheet. Billable visits on the log sheet are entered into the Division's Meditrak billing system. The auditor found:

- The Meditrak billing system did not list Medicare Part B numbers for 12 eligible consumers. No billing histories were found for these consumers.
- Five consumers' Medicare Part B numbers were incorrectly listed in the Meditrak billing system. Claims for two consumers were affected. One consumer had 45 claims from 2007 to 2009 that were not paid. The other consumer had 61 unpaid claims.
- Five consumers' binders identified 105 billable medical visits in calendar year 2008. The billing summary report from the Division identified that only 42 visits had been processed.

Recommendation

The Center should ensure that all consumers participating in Medicare Part B are properly listed in the billing system with a valid Medicare Part B number. The Center should also ensure that Medicare Part B claims are accurately processed. The Division should notify the Center of the status of claims submitted.

Response

This process will change with the implementation of the new Meditrak system in that the agency will be able to see and correct all rejected claims. Seeing the rejections will serve as a learning

tool in that the Medicare Part B billing unit will come to understand the reasons for rejection and thus will be able to correct future coding errors. This may involve educating the physicians as well.

Numerous medical necessity edits are built into the new system. All edits must be passed for a claim to be considered a valid billable claim. If rejected claims appear to be coded correctly, but relate to inconsistencies with the built-in edits of the application, an email notification system has been built into the new system to report the rejections to DHS-CO so that programming corrections can be made to the corresponding edits.

- The new Meditrak system will allow claims to be entered into the Medicare Part B billing application without a Medicare Part B identification number. This ID number, better known as the HIC #, validates the consumer's Part B eligibility. Though the claim information is collected into the system, the claim will not be sent to Medicare for reimbursement if the HIC number is missing.

To rectify this problem, the Medicare Billing Unit and the SPA at the facility must communicate to ensure that all consumers eligible for Medicare Part B are properly listed in the billing system with the correct HIC number. In the current system, consumers with missing HIC numbers are listed on the "Superhost Error Report." All errors on this report will be corrected by the facility.

The new system will report on missing HIC numbers and send warnings as "potential loss in revenue" if the blank HIC numbers remain uncorrected.

- Both consumers whose claims were affected had inconsistencies with their HIC numbers. One of the consumers also had a missing middle initial. Woodbine, based on a Social Security inquiry, will validate HIC number and let the DHS Office of Finance know so that rejected claims can be re-billed using the validated number.

The problem exists in both the current and new systems. There is a field edit on the format of the HIC number. If the format is correct, the system assumes eligibility. The facility must ensure the validity of the HIC number.

Of the 105 billable visits, only 42 were processed for Medicare reimbursement. All others were rejected for numerous reasons such as "unprocessable" or "lacks information for adjudication." With the new system, this type of rejection will be apparent and the facility should be able to resolve the problem.

Some claims were entered into Meditrak but never transferred to the DHS Office of Finance to be processed for payment. This was due to a physician who did not have a number in Meditrak (a.k.a. PTAN number) which indicates that he/she reassigned his/her Medicare benefits to the State of NJ. Woodbine made the correction and claims are being billed. The new system will monitor and report on physicians with blank PTANs, and provide a warning as "potential loss of revenue" if blank PTANs

persist. The new system will regard a blank PTAN as that physician “not yet belonging to the Medicare billing group at that facility”.

Some claims were never keyed into Meditrak. The five consumers’ medical records were reviewed a second time for unbilled services.

Finding

The purpose of the Welfare Fund is to provide funding for items or events that benefit the entire population. The Department of Human Services Welfare Fund Accounts Manual requires that the fund not maintain a large surplus. The balance of the fund has remained between \$400,000 and \$420,000 for the last three years. During this period annual expenditures of approximately \$75,000 have been equal to revenues, thus the fund balance remains fairly constant, with \$350,000 of the fund balance being invested in the State’s cash management fund. The Center also receives a State appropriation to pay for consumer recreation and rehabilitation related expenses. These expenses were \$77,000 in fiscal year 2008 and \$69,000 in fiscal year 2007. A cursory review of the purchases charged to the appropriation account, such as holiday party supplies, therapeutic equipment, and animal care products, noted these items could have been charged to the welfare fund since these items benefit the general consumer population.

Recommendation

The Center should utilize the welfare fund to pay for all purchases of items or events that benefit the entire population.

Response

All expenditures against the General Welfare Fund are appropriate and approved by the State Board. As recommended by the auditors, Woodbine will ensure that all future activities that benefit the general population will be funded from the General Welfare Fund, rather than State appropriations when appropriate.

Finding

The Center has an on-grounds restaurant/general store (the Galley) which serves consumers, employees, and visitors. Our review of the Galley operations disclosed internal control weaknesses with one individual performing multiple control procedures. This increases the risk of errors and irregularities not being detected. The review disclosed the following duties being performed by one individual

- Places purchases orders for the Galley
- Signs the receiving receipt when goods are delivered
- Receives money when there is a sale
- Closes out the register and counts cash at the end of the day, and
- Give the money to the business office for reconciling and depositing.

Inventory procedures and the preparation of a proper profit and loss statement are not undertaken. Financial statements provide management with an oversight tool to measure result of operation, to ensure that assets are accounted for and safeguarded, and to help ensure irregularities do not go undetected.

Recommendation

The Center should strengthen internal controls by adequately segregating duties. The Center should perform year-end inventory counts that facilitate the preparation of financial statements.

Response

The Division concurs with the finding and recommendation. A segregation of functions was implemented on August 27, 2009. Our financial statement is prepared as a fund balance report as required by the State Board. As of September 14, 2009, weekly inventory is performed and a daily requisition from stock is completed. In the future, the financial statement will include information on the inventory within this operation and all net profits at the end of the fiscal year will be transferred to the General Welfare Fund.

If you have any questions or require additional information, please contact me at (609) 631-6501.

Sincerely,



Kenneth Ritchey
Assistant Commissioner for the
Division of Developmental Disabilities

- c. Jennifer Velez
- Christopher Bailey
- Robert Armstrong
- Patricia Howell
- Audrey Prentice