New Jersey State Legislature
Office of Legislative Services
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Department of Health and Senior Services
Division of Aging and Community Services

July 1, 2004 to August 31, 2006

Richard L. Fair
State Auditor
The Honorable Jon S. Corzine  
Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

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

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Health and Senior Services, Division of Aging and Community Services for the period of July 1, 2004 to August 31, 2006. If you would like a personal briefing, please call me at (609) 292-3700.

Thomas R. Meseroll  
Assistant State Auditor  
December 19, 2006
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Department of Health and Senior Services  
Division of Aging and Community Services

**Scope**  
We have completed an audit of the Department of Health and Senior Services (DHSS), Division of Aging and Community Services for the period July 1, 2004 to August 31, 2006. Our audit included grants-in-aid and state aid payments covered under the program classification “Programs for the Aged”, the Community Care Alternatives Program, and the Home Care Expansion Program. Our audit included expenditure activities accounted for in the state's General Fund and the Casino Revenue Fund.

The prime responsibility of the Division of Aging and Community Services is support and monitoring of programs to improve the quality of life for New Jersey’s older citizens. Annual expenditures were $133 million.

**Objectives**  
The objectives of our audit were to determine whether expenditure transactions were related to the programs, were reasonable, and were recorded properly in the state's accounting system.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, 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 State Comptroller, and policies of the department. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of expenditure transactions. We also read the budget
message, reviewed financial trends, and interviewed department personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of expenditure transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample transactions were sorted and transactions were judgmentally selected for testing.

**Conclusions**

We found that the expenditure transactions included in our testing were related to the programs, were reasonable, and were recorded properly in the state’s accounting system. In making this determination, we noted internal control weaknesses meriting management’s attention.
Community Care Program for the Elderly and Disabled

The Community Care Program for the Elderly and Disabled (CCPED) is a federal Medicaid waiver program whose purpose is to help eligible individuals to remain in the community or return to the community, rather than be cared for in a long term care facility or hospital setting. Services available to CCPED clients from approved Medicaid providers include: care management, home health services, homemaker services, medical day care, social adult day care, non-emergency medical transportation, and respite care. There were 4,145 clients in the program during our review.

The costs to Medicaid for services provided under CCPED generally cannot be greater than the costs of institutionalization of the individual. The state established cap was $2,841 per month during the review period. Care management providers are responsible for authorizing the level of care and ensuring projected costs do not exceed the established cap. The Division’s Office of Community Programs performs reviews of the clients’ care plans, but they do not compare the projected costs to the actual expenditures. In addition, further investigations are not being performed by this monitoring unit in cases where expenditures exceed the cap.

We summarized and analyzed costs by client for October, November and December 2005. During this period, 82 recipients received monthly benefits in excess of $3000. Five clients exceeded the cap for all three months, while 21 exceeded it for two months. Some of these may be acceptable based on the care manager authorizing additional services for a short period of time.

When a client dies the care manager is required to notify the department’s Long Term Care Field Office (LTCFO). The LTCFO notifies the County
Deceased clients should be removed from the MMIS in a timely manner.

Welfare Agency (CWA). The CWA is responsible for entering the termination date on the Medicaid Management Information System (MMIS).

Our match of Medicaid files with the department’s vital statistics death files identified 150 clients who had died between July 1, 2004 and December 31, 2005. These individuals remained on the system between one and 495 days and averaged over 140 days. The untimely removal of deceased clients allows providers to bill for services after the date of death. In 15 instances, providers billed approximately $4,300 for services provided after the clients’ date of death.

Recommendation

We recommend that the department periodically analyze costs to identify and investigate individuals who have exceeded the monthly service cost cap. The Division of Aging and Community Services’ monitoring unit should compare actual costs to the projected service costs when performing their scheduled reviews. Finally, the department should implement procedures to ensure that deceased clients are terminated in a timely manner.
To: Barbara Fuller, Administrative Director  
Division of Aging and Community Service

From: Suzanne Watson, Supervisor of Long Term Care Programs  
Office of Community Programs

Date: December 1, 2006

Subject: Response to CCPED Audit Report

The Division of Aging and Community Services (DACS) has taken or will take the following actions to correct the deficiencies noted by the State Auditors:

1. Audit Observation: Monitoring of client costs should be strengthened.
   Audit Finding: 82 CCPED participants (1.98% of those audited) received monthly benefits in excess of $3,000 from October 2005 – December 2005. Five participants exceeded the cap for all three months, while 21 exceeded it for two months.
   Audit Recommendation: Periodically analyze costs to identify and investigate individuals who have exceeded the monthly service cost cap. The Division’s Office of Community Programs’ (OCP) Quality Assurance Survey Unit should compare actual costs to the projected service costs when completing its file reviews.

Corrective Action Plan:

   • Spending for the 26 individuals identified in the Audit Report, who chronically exceed the CCPED cost cap will be compared to spending for the same individuals for the first 10 months of 2006. OCP will contact the Care Managers in cases that continue to exceed the cost cap to seek justifications and plans of correction for unjustified excess expenditures.

   • OCP has begun to obtain CCPED Waiver and State Plan Service itemized claim information for all CCPED participants. Participant Plans of Care and explanations for benefits in excess of $3,000 monthly will be required from Care Managers. Plans of Correction will be required, if warranted, and survey visits will include a review of Plan of Correction implementation.

NOTE: For the Centers for Medicare and Medicaid Services’ (CMS) purposes, the aggregate spending for the CCPED waiver is considered, rather than the individual spending cap for each person. DACS is well within the federal approval for aggregate spending.

2. Audit Observation: Deceased recipients should be removed from the Eligibility File in a timely manner.
   Audit Finding: Match of Medicaid files with Department vital statistics death files identified 150 CCPED participants who died between 7/1/04 and 12/31/05. These individuals remained on the system between one and 495 days, averaging over 140 days. A total of $4,300 was billed for a total of 15 CCPED participants after dates of death.
   Audit Recommendation: Implement procedures to ensure that deceased participants are disenrolled in a timely manner.

Corrective Action Plan:

   • Systems are already in place to recoup claims paid for services after a participant’s date of death. Health Management Systems, a contractor to the Department of Human Services, Division of Medical and Health Services, processes the Deceased Recipient Report, Q2100r01, and recovers Medicaid and PAAD payments made after the date of the recipient’s death. Enhancements are soon to be implemented, which will include a tie-in with vital statistics to streamline the notifications to reduce the possibility of payment of claims for a deceased person.

   • OCP is investigating the cause of late date of death entries into the Eligibility File. Once the cause is identified, OCP will collaborate with other Divisions and Departments, no later than December 31, 2006, to take actions to resolve the problem(s).

   • Instructions are being given to all Care Managers during monitoring visits regarding the need to notify providers of a recipient’s death as soon after the occurrence as possible.