
New Jersey Office of Legislative Services Office of the State Auditor



2013 Annual Report

**Improving the accountability of public funds
and strengthening the operations of government**

Stephen M. Eells, State Auditor

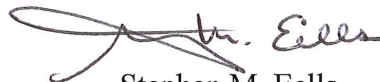
Message from the State Auditor

The Honorable Members of the Senate and General Assembly

Mr. Albert Porroni, Executive Director
Office of Legislative Services

I am pleased to present to you the *Annual Report of the New Jersey Office of Legislative Services, Office of the State Auditor* for calendar year 2013. In conformance with our responsibilities to perform financial, performance, and compliance audits, all state agencies are audited periodically using a risk-based approach. We issued 24 reports during 2013 which identified \$151.1 million in potential cost savings and revenue enhancements. In addition, the state continues to save substantial dollars as a result of the resolution of issues previously reported by the Office of the State Auditor. If you or members of your staff would like additional information or a personal briefing, please contact me.

Our mission is to improve the accountability of public funds and to improve the operations of state government. We serve the public interest by providing members of the Legislature and other policymakers with unbiased, accurate information and objective recommendations on how to better use public resources. In addition to fulfilling our audit mission, we have focused on maximizing the quality of our services and maintaining communication with the Legislature and the agencies we audit. We are committed to providing high quality audit reports. You may be assured we will continue our efforts to improve state government accountability to the Legislature through an effective and constructive audit process.



Stephen M. Eells
State Auditor
March 17, 2014

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INTRODUCTION

BACKGROUND

The Office of the State Auditor, which is in the legislative branch of government, was originally established in 1934 pursuant to P.L. 1933, c.295. A number of statutory amendments dealing with the powers and duties of the State Auditor have been enacted in the ensuing years. The Office of the State Auditor is within the Office of Legislative Services under the provisions of the Legislative Services Act.

The State Auditor is a constitutional officer appointed by the Legislature for a term of five years and until a successor shall be appointed and qualified. On February 11, 2010, Stephen M. Eells, CPA, was confirmed by a joint session of the Legislature as the State Auditor.

The organization of the office within the legislative branch permits the State Auditor to be independent of the executive and judicial branches of government. This independence is critical in terms of meeting professional standards and in providing fair and objective reviews and audits of governmental operations.

Under the provisions of Article VII, Section I, Paragraph 6 of the State Constitution and N.J.S.A. 52:24-1 et seq., the Office of the State Auditor is required to conduct post-audits of all transactions and accounts kept by or for all departments, offices, and agencies of state government. Reports are submitted to the Governor, the Legislature, and the Executive Director of the Office of Legislative Services.

The Public Laws of 2006, Chapter 82 authorized the State Auditor to conduct a performance review of any program of any accounting agency, any independent authority, or any public entity or grantee that receives state funds. The law also requires the State Auditor to conduct a follow-up review to determine agency compliance with our audit recommendations. In addition, at the request of the legislative leadership or the Legislative Services Commission, the State Auditor conducts studies on the operations of state and state-supported agencies with respect to their efficiency, internal management control, and compliance with applicable laws and regulations.

INTRODUCTION

MISSION STATEMENT

The State Auditor provides independent, unbiased, timely, and relevant information to the Legislature, agency management, and the citizens of New Jersey that can be used to improve the operations and accountability of public entities.

VISION STATEMENT

The State Auditor and his staff will approach all work in an independent, unbiased, and open-minded manner.

The State Auditor will provide timely reporting to the Legislature, agency management, and the citizens of New Jersey.

Reporting will be in clear and concise language so it is understood by all users of the report.

Reporting will include recommendations on how to improve the workings of government and how to strengthen agency internal controls.

Reporting will include assurances on the financial operations of the State.

The State Auditor and his staff will perform all work in a professional manner utilizing appropriate standards.

ACCOMPLISHMENTS

During calendar year 2013 we identified \$151.1 million in new cost savings and revenue enhancements. A schedule of cost savings and revenue enhancements is presented on pages 3 and 4. Our compliance review on findings related to audit reports issued during the fiscal year ended June 30, 2012 disclosed that 81 percent of our recommendations have been complied with or management has taken steps to achieve compliance.

The office performs the annual financial audit of the state's Comprehensive Annual Financial Report (CAFR). The CAFR engagement includes the audit of 145 funds and component units which had a full accrual accounting total asset value of \$172 billion at June 30, 2013.

PROFESSIONAL STANDARDS

The Office of the State Auditor's audits are performed in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. These standards require that our operations be reviewed every three years. In 2011, the National State Auditors Association conducted a review of our system of quality control which resulted in an unqualified report.

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF COST SAVINGS AND REVENUE ENHANCEMENTS
REPORTS ISSUED DURING CALENDAR YEAR 2013**

<u>REPORT</u>	<u>COST SAVINGS AND/OR REVENUE ENHANCEMENTS</u> (In 000's)
Department of Children and Families	
Division Of Child Protection and Permanency	
Contracted Foster Care and Related Services	\$ 13,616
Department of Community Affairs	
American Recovery and Reinvestment Act	
Weatherization Assistance Program	
Multi-Family Buildings	1,736
Department of Education	
Marie H. Katzenbach School for the Deaf	1
Office of Special Education Programs	26,300
Department of Environmental Protection	
Land Use Management and Selected Programs of Compliance and Enforcement	1,000
Department of Human Services	
Division of Aging Services	
Office of the Public Guardian for Elderly Adults	645
Division of Developmental Disabilities	
Community Programs	30,055
Division of Mental Health and Addiction Services	
Greystone Park Psychiatric Hospital	6,672
Department of Human Services and Office of the State Comptroller	
Division of Medical Assistance and Health Services and Office of the State	
Comptroller – Medicaid Fraud Division	
Medicaid Third Party Liability (TPL) Recovery Services	23,813
Department of Labor and Workforce Development	
Unemployment Insurance Contribution Revenue	36,737
Department of Military and Veterans' Affairs	
New Jersey Veterans Memorial Home at Menlo Park	1,866
New Jersey Veterans Memorial Home at Paramus	1,277
Department of the Treasury	
Office of Public Finance	417
<i>Subtotal Cost Savings and Revenue Enhancements</i>	<i>\$144,135</i>

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF COST SAVINGS AND REVENUE ENHANCEMENTS
REPORTS ISSUED DURING CALENDAR YEAR 2013**

<u>REPORT</u>	<u>COST SAVINGS AND/OR REVENUE ENHANCEMENTS</u> (In 000's)
<i>Subtotal Cost Savings and Revenue Enhancements</i>	\$144,135
Judiciary	
Adult Drug Court Program	400
Motor Vehicle Commission	
Payroll Expenditures	237
Pleasantville Board of Education	<u>6,332</u>
<i>Total Cost Savings and Revenue Enhancements</i>	<u>\$151,104</u>

AUDIT REPORTS

TYPES OF AUDITS PERFORMED

Financial Audits

Financial audits are designed to provide reasonable assurance about whether the financial statements of an audited entity are fairly presented in conformity with generally accepted accounting principles. The primary annual financial audit conducted by the office is the state's Comprehensive Annual Financial Report (CAFR) which is published by the Department of the Treasury. Two other financial audits were issued in calendar year 2013.

Performance Audits

The objectives of this type of audit are to determine whether financial transactions are related to an agency's programs, are reasonable, and are recorded properly in the accounting systems. This type of audit may also focus on specific performance issues. Where appropriate, these engagements may also provide economy and efficiency comments. Audits are selected using a risk-based approach. Larger departments are audited on a divisional, agency, or program basis rather than on a department-wide basis because of their size and complexity. We completed 19 performance audits in calendar year 2013. These audits encompassed \$10.8 billion and \$11.1 billion of expenditures and revenues, respectively.

Information Technology Audits

The objectives of this type of audit are to determine whether the data maintained by a particular computer system is reliable, valid, safeguarded, and recorded properly; whether agency networks are properly managed to provide for business continuity and the prevention of system abuse; and whether system development and maintenance is performed in accordance with guidelines and best practices. During calendar year 2013 we reported on the Department of Labor and Workforce Development, Local Office Online Payment System (LOOPS).

The office has trained all audit staff on the basics of integrated auditing, where field auditors learn how to review IT controls applicable to the scope of their audit. If the system they are reviewing has more complex controls, an IT auditor can be consulted or the system itself can be assigned to the IT unit as a separate audit. This effort will allow for review of a greater number of IT controls.

School District Audits

N.J.S.A. 18A:7F-6d authorizes the Office of the State Auditor to audit the accounts and financial transactions of any school district in which the state aid equals 80 percent or more of its net budget for the year. We audited one such school district in 2013. In addition, in accordance with N.J.S.A. 18A:7A-57, the State Auditor is authorized to perform a forensic audit of school districts with a general fund deficit and meeting additional specific criteria as stated in the statute. We audited one of these school districts in 2013, for which the report is pending.

AUDIT REPORTS

Legislative Requests

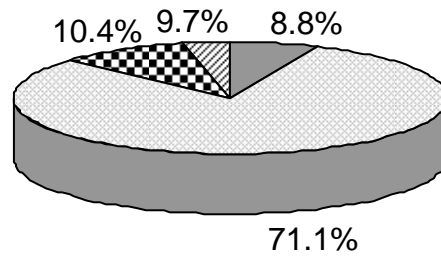
From time to time the Legislative Services Commission and Legislative leadership request the State Auditor to conduct special projects of the fiscal practices and procedures of the state and state-supported agencies, and to report findings to the Commission.

AUDIT REPORTS

DISTRIBUTION OF AUDIT HOURS

The distribution of audit hours used in performing audits during calendar year 2013 is depicted on the following chart.

DISTRIBUTION OF AUDIT HOURS



- Financial Audits - 8.8%
- Performance Audits - 71.1%
- ▣ Information Technology Audits and Support – 10.4%
- ▨ School District Audits - 9.7%

AUDIT REPORTS

HOW AND TO WHOM AUDIT REPORTS ARE ISSUED

Findings and recommendations developed as a result of our independent audits are intended to provide accountability and improvement of government operations. All reports are discussed with agency officials prior to finalization and modifications are made where warranted. Management comments to the final report are incorporated in the document. All issued reports of the Office of the State Auditor are public documents and are available on the New Jersey Legislature's web site at www.njleg.state.nj.us/legislativepub/auditreports.asp.

Reports are statutorily required to be sent to the:

- Governor
- President of the Senate
- Speaker of the General Assembly
- Executive Director of the Office of Legislative Services

In addition, copies of reports are routinely sent to the:

- Legislature (all members)
- Executive directors of partisan staff
- Management of the audited entity
- State Treasurer
- State Comptroller
- State Library

ORGANIZATION

HUMAN RESOURCES

The Office of the State Auditor is one of eight units within the Office of Legislative Services. The State Auditor's office is comprised of 91 professional and 6 support staff positions. All auditors must have a bachelor's degree in accounting or a related field and a minimum of 24 credit hours in accounting. Fifty-two staff members, 57 percent of the professional staff, possess professional certifications or advanced degrees. Working for the office qualifies for the one year intensive and diversified experience needed to become a certified public accountant in the State of New Jersey.

The office provides a minimum of 80 continuing professional education credits biennially and diversified work experience to enhance each individual's professional development. The audit staff attends professional development programs encompassing a myriad of accounting and auditing topics. In addition, staff members actively participate as officers, board members, and committee members of local, state, and national accounting and auditing organizations, including the Association of Government Accountants, Institute of Internal Auditors, National State Auditors Association, and New York/New Jersey Intergovernmental Audit Forum. The office also participates in the national peer review program under the auspices of the National State Auditors Association.

AUDIT STAFF

The audit staff is the primary operating group in the office. They plan, conduct, and control the audit engagements and prepare and edit the reports. The audit teams report the results of their work to the auditee on an ongoing basis and at the conclusion of the engagement by means of a written report. In an effort to develop expertise, field managers are assigned specific departments. This practice enhances the quality and efficiency of our audits and ensures all programs are audited within a reasonable cycle. Information technology support is also provided by the field and IT support staff.

The office maintains seven active committees staffed by individuals in various titles to provide guidance in the areas of information technology (hardware/software and information), personnel, planning, policy, sampling, and training. An intranet site is also maintained that contains staff information, budget and appropriation information, and commonly used accounting and auditing research and reference internet sites that the audit staff can access through their computers.

ORGANIZATION

QUALITY ASSURANCE

The quality assurance staff is responsible for technical compliance and quality control, oversight of staff training, and research of technical issues. Quality assurance is achieved through reviews of working papers and reports to ensure adherence to professional standards. The quality assurance staff, through its research of accounting and auditing issues, also responds to surveys, questionnaires, and exposure drafts relating to proposed accounting and auditing standards.

ADMINISTRATIVE STAFF

The administrative staff processes, files, and distributes all reports. This group is responsible for the office library, purchasing and maintaining office supplies, and other general administrative functions.

**OFFICE OF THE STATE AUDITOR
STAFF ROSTER
AS OF DECEMBER 31, 2013**

STATE AUDITOR

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ASSISTANT STATE AUDITOR

John J. Termyna, CPA

Jill Bodnar, Secretary

ASSISTANT STATE AUDITOR

Gregory Pica, CPA

Robyn Boyer, Secretary

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Hal Bauman
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Shrushti Trivedi
Kurt Zadworney

ADMINISTRATIVE STAFF

Pamela J. Puca, Principal Audit Processor
Anthony Arena, Support Services Assistant

IT SUPPORT STAFF

John Garrett, Data Analyst

Certification Legend:

CEH – Certified Ethical Hacker
CFE – Certified Fraud Examiner
CGAP – Certified Government Auditing Professional
CGFM – Certified Government Financial Manager
CIA – Certified Internal Auditor
CISA – Certified Information Systems Auditor
CMFO – Certified Municipal Finance Officer
CPA – Certified Public Accountant
CPT – Certified Penetration Tester
MAccy – Master of Accountancy
MBA – Master of Business Administration
MS – Master of Science
PSA – Public School Accountant

ACCOMPLISHMENTS AND RESULTS

SUMMARY

This section highlights five of the more significant audits issued during the past year that individually contained cost savings and revenue enhancements greater than \$10 million and collectively totaled \$130.5 million. Information on these reports is presented on pages 13 through 26. The office issued 11 other reports with cost savings totaling \$20.6 million. This other section also contains the significant findings and observations from five additional audits on pages 27 through 31. In addition, our reports contain non-monetary findings addressing areas of noncompliance with laws or regulations, weaknesses in internal controls, and economies and efficiencies to improve operations.

All reports issued in calendar year 2013 are identified on a schedule on pages 32 to 33 and are available for review on our website.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD PROTECTION AND PERMANENCY
CONTRACTED FOSTER CARE AND RELATED SERVICES

Inefficiencies and Questionable Costs

It is the Department of Children and Families (DCF), Division of Child Protection and Permanency’s (division) responsibility to review and approve provider budgets. Primarily, providers are paid by the division on a monthly basis at an amount equal to one-twelfth of the budgeted amount. The division is responsible to ensure costs incurred by the provider are reasonable and supported. These payments are reconciled by DCF contract administrators quarterly and at the end of the contract period when providers submit their final report of expenditures. The division also has an internal policy that requires provider expenditures be tested and traced to source documents on an annual basis, but we found no evidence of such testing. Our review of \$13.5 million in contract expenditures for the period January 1, 2010 through June 30, 2011 disclosed inefficiencies and questionable costs totaling \$4.2 million.

Contract Closeouts

Contract administrators, budget analysts, and accounting personnel are responsible for closing out contracts, which according to DCF policy is to occur 150 days following the expiration of the contract period. To effectively closeout the contracts, the closeout personnel must ensure that providers have fulfilled all obligations and the division has received the benefits for which it contracted. A proper closeout would ensure costs claimed on the final report of expenditures were incurred, allowable, and reasonable. The closeout process also enables the division to identify and recover unspent contract funds.

Our review of the three most recent contracts from each of the 20 contracted foster care providers disclosed 15 of the 60 contracts were either current or no closeout was necessary. The remaining 45 contracts totaling \$84.5 million are analyzed in the chart below, which shows 73 percent of contracts are either not closed, or were closed an average eight months late.

Contract Closeout Timeframe

Description	Number of Contracts	Contract Value (in millions)	Average Months Outstanding (past 150 days)	Percentages of Contracts
Contracts closed timely	12	\$12.3	0	27%
Contracts not closed	7	\$17.5	10	15%
Contracts closed after due date	26	\$54.7	8	58%
Total	45	\$84.5		100%

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD PROTECTION AND PERMANENCY
CONTRACTED FOSTER CARE AND RELATED SERVICES

Twenty-two of the 38 closed contracts indicated no balance due. However, further review disclosed nine of these closeouts were performed incorrectly by using original budget amounts rather than actual expenditures when reporting the results. Our request that the department revisit these nine closeouts resulted in the identification of a provider owing \$125,000 to the department.

Outstanding and Uncollected Funds

DCF policy requires providers to submit audited financial statements annually. These statements are used in the closeout process to help identify and recover unspent contract funds. We reviewed the most recent audited financial statements and the department records for 12 providers and found that the DCF had not collected \$3.9 million in unspent contract funds dating back to 2007. As a result, DCF began to expedite its closeout process. One provider is negotiating \$1.7 million of the amount due, in part, because of the untimely collection efforts by the department. In addition, we compared the audited financial statements to payroll tax records from the Department of Labor and Workforce Development and found two providers that owed a combined \$3.3 million in state and federal taxes, including fines and penalties. These liabilities were funded by DCF contracts; however, the providers never remitted the full payments.

Unspent Funds Due Back to the Department and Unpaid Taxes

Description	State Taxes	Federal Taxes	Balances Due
Unspent Contracts Funds			\$ 3,896,542
Unpaid Taxes	\$ 2,322,026	\$ 1,023,214	\$ 3,345,242
Totals*	\$ 2,322,026	\$ 1,023,214	\$ 7,241,782

*of this amount, \$6.2 million is due back to the State

Statewide Uniformity of Foster Care Rates

Foster Care Payment Differences

The division contracts foster care and related services to 20 providers throughout the state. Of these 20 providers, there are eight whose contracts do not include funds for foster care board payments. In these cases, the division makes those payments directly to the families. We reviewed the remaining 12 providers that are responsible for making the monthly board payments to the foster care families.

ACCOMPLISHMENTS AND RESULTS SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF CHILDREN AND FAMILIES DIVISION OF CHILD PROTECTION AND PERMANENCY CONTRACTED FOSTER CARE AND RELATED SERVICES

Foster care rates paid to foster care families vary depending upon the age and medical condition of each child. These rates are derived from the United States Department of Agriculture (USDA) guidelines and should be uniform across the foster care population. During our review, we found the rates paid directly by the division were uniform throughout the state, but the rates paid by provider agencies were either higher or lower than the USDA guidelines. For example, from July 1, 2009 to December 31, 2011, the monthly payment made directly by the division to the families ranged from \$713 to \$1,238, while payments made by the contracted agencies ranged from \$500 to \$1,439.

When notified of the disparity, the department conducted a retroactive analysis of underpayments for a 4-month period that resulted in an additional \$67,000 being sent to foster care families. Their analysis did not include payments that exceeded the guidelines. Our analysis for the period from July 1, 2009 through December 31, 2011 identified payments below the minimum required USDA rates totaling \$251,000 and payments above the guidelines totaling \$2.4 million. By not monitoring and standardizing the rates paid to all foster care families, the division overspent a net \$2.2 million during this period. If provider payments were standardized using USDA guideline rates, the division would realize a savings of \$875,000 annually.

NJSPIRIT Payments

In 2007, DCF implemented the New Jersey Statewide Protective Investigation, Reporting, and Information Tool (NJSPIRIT). This software application serves as an electronic case record and also processes certain fiscal functions for the department. During our review, we noted that a combination of human error and a NJSPIRIT limitation resulted in overpayments to providers totaling \$630,000 from July 1, 2008 through April 30, 2012. The division began an internal review after this matter was brought to their attention.

Level of Service Measurements

Level of service (LOS) is a performance measurement used to determine whether or not actual services are being delivered in the expected quantities agreed upon in the contract. It is the division's policy to monitor and compare the actual LOS to the contracted LOS on a quarterly basis.

This monitoring by contract administrators can help assess the success or failure of individual programs, as well as identify underperforming programs for remedial action, including the downward adjustment of contract funding when warranted. For the contracts we reviewed, we found that while the division monitors the LOS, it does not ensure the LOS is accurately prepared by the provider nor does it generally act upon low performance indicators. We noted the following three programs where the underperforming LOS warranted timely attention.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD PROTECTION AND PERMANENCY
CONTRACTED FOSTER CARE AND RELATED SERVICES

- An emergency shelter care program for up to five girls between 13 and 17 years of age was contracted at a fixed annual cost of \$669,500, equating to a daily rate of \$367 per child, if at full capacity. We determined the occupancy rate of this shelter was only 30 percent during fiscal year 2011. We also noted that another DCF contracted shelter program existed three miles away and provided similar services to the same population at a full-capacity cost of \$124 per child. The second shelter was also underutilized and could accommodate the capacity of the first shelter, usually without additional compensation. Placing the children in the second shelter would eliminate the need for the first shelter resulting in annual savings up to \$669,500.
- A program to provide substance abuse assessments was contracted for \$2 million annually. We noted that during fiscal years 2010 and 2011, the LOS was 40 percent and 48 percent respectively, though the program remained fully funded throughout both years. If the LOS was properly monitored and acted upon, the contract may have been modified for the lower levels of expected participants and funding reduced.
- A pediatric program was established to provide services and referrals for up to ten children whose families had been affected by the AIDS virus at an annual cost of \$195,000. The provider failed to submit the correct LOS documentation for an entire year and this went unnoticed by the division. Using available records, we noted the LOS was never more than 40 percent and yet the program remained fully funded. After 19 months of low performance, the program was terminated. If the low LOS was monitored and acted upon in a timely matter, contract payments could have been reduced to reflect the lower level of participants or terminated earlier.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION PROGRAMS

Special Education Medicaid Initiative

SEMI Revenues

The state and the districts could collect over \$10 million annually in additional revenue if all districts were to maximize participation in the Special Education Medicaid Initiative (SEMI) program. The administrative code states that all districts shall strive to achieve maximum participation in the SEMI program. Maximum participation means obtaining a 90 percent return rate of parental consent forms for all SEMI-eligible students. In fiscal year 2012, there were 207 districts with more than 40 SEMI-eligible students participating in the program and 144 of those met the 90 percent criteria. These 144 districts collected a combined 124 percent of their projected SEMI revenues. If the other 63 districts had achieved the 90 percent criteria while collecting revenue at a similar rate, the districts could have generated \$6.5 million in additional SEMI revenues, \$2.3 million for the districts and \$4.2 million for the state. Applying similar criteria to fiscal year 2011, we estimate that participating districts could have generated an additional \$3.2 million, \$1.1 million for the districts and \$ 2.1 million for the state.

There were 29 and 35 districts in fiscal year 2011 and fiscal year 2012, respectively, with more than 40 SEMI-eligible students that did not participate in the SEMI program. We estimate the state could have collected an additional \$2.3 million and \$3.3 million in fiscal years 2011 and 2012, respectively, if these districts had participated in the program and maximized participation. The estimated district share of this additional revenue would have been \$810,000 in fiscal year 2011 and \$1.1 million in fiscal year 2012. Despite having more than 40 SEMI-eligible students, 43 percent of the districts tested had a waiver for fiscal year 2012. We found the waivers were often approved without adequately demonstrating that the district would have fewer than 41 SEMI-eligible students or there would be no cost benefit to the district, as required.

Furthermore, if the approximately 350 non-participating districts with fewer than 41 SEMI-eligible students had participated in the program and maximized SEMI revenues, the state and the districts could have shared increased revenues of \$4.8 million and \$6.2 million in fiscal years 2011 and 2012, respectively. In fiscal year 2012, there were 44 districts with fewer than 41 SEMI-eligible students but still participated in the program and generated \$1.3 million in SEMI revenue for the state and the districts. In fiscal year 2011, 52 such districts generated \$1.3 million in SEMI revenue. Exempting districts simply because they have fewer than 41 SEMI-eligible students may unnecessarily reduce revenues for both the state and the districts.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
COMMUNITY PROGRAMS

Community Care Waiver Billing

Consumer Eligibility/Enrollment

Community Care Waiver (CCW) is a program that assists consumers with developmental disabilities to live in the community. The federal Medicaid program reimburses the Department of Human Services, 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 Department of Human Services, 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.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
COMMUNITY PROGRAMS

Untimely Attendance Reporting

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	<u>\$ 680,000</u>
Total	<u>\$3,390,000</u>

Contribution to 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.

ACOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
COMMUNITY PROGRAMS

Observation

Consumers in Out-of-State Facilities

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.

**ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS**

**DEPARTMENT OF HUMAN SERVICES AND OFFICE OF THE STATE
COMPTROLLER – DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES AND OFFICE OF THE STATE COMPTROLLER – MEDICAID FRAUD
DIVISION – MEDICAID THIRD PARTY LIABILITY (TPL) RECOVERY SERVICES**

Background

Third Party Liability (TPL) occurs when Medicaid beneficiaries have access to other health care coverage in addition to qualifying for Medicaid. According to state regulations, if a beneficiary has third party health insurance coverage, such as Medicare and private health insurance, the Medicaid service provider generally must bill the recipient's primary coverage before billing Medicaid. Federal and state regulations require the state to maintain a system to identify third parties that may be legally obligated to pay for medical services provided to Medicaid recipients. Since 1986, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has contracted with the current vendor to identify and verify other health coverage of Medicaid beneficiaries and to recover Medicaid payments when third party coverage exists. In addition, the vendor updates beneficiaries' files to identify third party coverage. Recoveries of \$102 million and cost avoidance of \$402 million were reported in the Office of the State Comptroller's 2012 Annual Report. Based on information provided by the Office of the State Comptroller, Medicaid Fraud Division (MFD), below is a chart which identifies the vendor's significant effort to the Medicaid program's third party recoveries and cost avoidance (in millions).

Medicaid Recoveries and Cost Avoidance for 2012

<u>Vendor Services</u>	
TPL Recoveries	\$ 71.8
Cost Avoidance	402.0
RAC and other Audit Recoveries	8.2
Sub Total	<u>\$482.0</u>
<u>Medicaid Fraud Division</u>	
Recoveries and other Settlements	\$ 13.6
<u>Other</u>	
National Settlements	\$ 8.8
Total	<u><u>\$504.4</u></u>

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

**DEPARTMENT OF HUMAN SERVICES AND OFFICE OF THE STATE
COMPTROLLER – DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES AND OFFICE OF THE STATE COMPTROLLER – MEDICAID FRAUD
DIVISION – MEDICAID THIRD PARTY LIABILITY (TPL) RECOVERY SERVICES**

Third Party Liability Re-verification

During the period July 1, 2010 through January 31, 2013, the vendor billed the state \$34.3 million for updating 565,428 Medicaid records identifying third party liability health coverage. These identifications enable the Medicaid program to cost avoid payments when other insurance resources are available to the beneficiaries.

According to the contract, Request for Proposal (RFP) Section 3.5, Identification and Verification of TPL Information, the contractor is to “identify and verify the existence of health insurance which has not been disclosed, identified, or utilized by clients...” Based on our review of the vendor’s monthly billing data, we determined the vendor billed for identifying TPL health coverage that had previously been identified. Our review noted that the vendor billed the division \$7.5 million for updating approximately 112,000 beneficiary records during their re-verification process, where no *new* health insurance coverage was identified. We found the vendor has billed for re-verification since 2008. The vendor invoiced these services using commodity codes associated with the identification of *new* TPL information. According to the contract, re-verification is a “normal follow-up to the update procedure, for the purpose of keeping the TPL data current and accurate; the vendor would re-verify beneficiaries’ updates that are older than 12 months.” There is no provision that these services were intended to be billable outcomes under the contract.

Updating existing TPL information would have been a billable service, if it led to the identification of *new* or *undisclosed* health insurance coverage. At that time, it becomes a *new* “identification”, which is billable and complies with the intent of the contract. The intent of the contract is further supported by the manner in which the contract fees are structured. The vendor is compensated based on an annualized cost savings/avoidance for identifying *new* TPL. However, when no *new* coverage is identified, there is no added benefit or cost savings. The Medicaid system would continue to deny all claims relating to the existing TPL coverage whether it was re-verified or not.

Furthermore, our review of the contract, RFP Section 4.4.6, Price Schedule, found descriptions and price listings for 51 types of TPL identifications and recovery fees permissible under the contract. The contract’s Price Schedule does not describe or list a unit price for the re-verification of TPL coverage that had previously been disclosed. If the re-verification of TPL information results in *new* or *undisclosed* health insurance, that *new* identification would be a billable service under the contract. All services covered under the contract must be listed under the “vendor’s services” section with the corresponding unit price. Proper monitoring of the contractor’s invoices could have disclosed these invalid charges.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

**DEPARTMENT OF HUMAN SERVICES AND OFFICE OF THE STATE
COMPTROLLER – DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES AND OFFICE OF THE STATE COMPTROLLER – MEDICAID FRAUD
DIVISION – MEDICAID THIRD PARTY LIABILITY (TPL) RECOVERY SERVICES**

Legal Settlements

The vendor is responsible for pursuing TPL recoveries when Medicaid beneficiaries enter into legal settlements for tort cases. The vendor determines the recovery amount requested based on the paid Medicaid claims related to the incident. During the period July 1, 2009 through December 31, 2012 the vendor was responsible for pursuing recoveries on 2,719 cases. We sampled 13 cases to determine the accuracy of the vendor's requested recovery amounts with the assistance of the DMAHS, Office of Legal and Regulatory Affairs (OLRA) and found all of the amounts were inaccurate. The vendor included claims that were not related to the incidents, resulting in recovery requests for six cases that were \$51,800 more than the actual Medicaid claims paid. Conversely, seven cases did not include all the Medicaid related claims, resulting in recovery requests that were \$325,800 lower than the actual Medicaid claims paid. Inaccuracies in the vendor's recovery amounts have been brought to the attention of the vendor, however, these inaccuracies still consistently occur. The vendor needs to accurately identify claims when determining the Medicaid recovery amounts so that the Medicaid program has the ability to recover the proper amount while allowing beneficiaries to receive an accurate settlement amount.

Pursuant to N.J.S.A. 30:4D-7.1b, prior to determining the Medicaid recovery amount, the vendor must deduct generally one-third from the total Medicaid recovery amount to reflect the pro-rata share of attorney fees for cases unrelated to certain motor vehicle or Workers' Compensation incidents. We reviewed four applicable cases and found two did not deduct the attorneys' share totaling \$38,600.

Although the vendor is responsible for the recoveries related to tort cases, many of these cases are referred to the OLRA for closing. This transfer of cases usually occurs because the OLRA was informed by outside sources, usually attorneys, that the vendor was non-responsive or acted untimely to attorney inquiries regarding the settlement of the cases. Complaints are received on a regular basis and several cases are closed by the OLRA. However, documentation as to the number closed by the unit was not maintained because the staff simply closed each case as the referrals were received. Once an inquiry is received from an attorney, it takes the OLRA approximately one to two days to provide the necessary information. Correspondence from attorneys document that the vendor took a period of three months to three years to respond to attorney inquiries. In one instance an attorney responded that they had been trying to resolve a case with the vendor for three years and when it was referred to the OLRA, it was immediately settled and \$84,000 was returned to the Medicaid program. In another instance, the vendor stated there was no money due back to the Medicaid program when \$13,000 was due back. These examples are indicative of the recurring issues that the OLRA is experiencing regarding the vendor. Although monthly meetings are held with the vendor to discuss these and other issues, the problems still persist.

ACCOMPLISHMENTS AND RESULTS
SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

**DEPARTMENT OF HUMAN SERVICES AND OFFICE OF THE STATE
COMPTROLLER – DIVISION OF MEDICAL ASSISTANCE AND HEALTH
SERVICES AND OFFICE OF THE STATE COMPTROLLER – MEDICAID FRAUD
DIVISION – MEDICAID THIRD PARTY LIABILITY (TPL) RECOVERY SERVICES**

Fees For Updating Beneficiaries' TPL Files

During the period July 1, 2010, through January 31, 2013, the state paid the vendor \$32 million to update beneficiaries' files for TPL coverage. According to the contract terms, the vendor's fee for updating Medicaid beneficiaries' TPL files is determined by charging a percentage of an amount equal to the beneficiary's annualized monthly capitation rate. These rates are paid monthly by the Medicaid program to a Managed Care Organization for each beneficiary enrolled in the plan. The rates vary among beneficiaries based upon health risk factors. Currently, there are over 68 capitation rates used in determining the vendor's fees. These fees range from \$3.00 to \$581 per update of which 61.4% of the updates were charged a fee of \$28 or less. We estimate that had the vendor been paid a flat fee of \$28 per update, the state may have saved \$16 million for the period July 1, 2010 through January 31, 2013. Our review noted the state of New York has a contract with the same vendor and pays a flat fee to perform these updates. The methodology of using beneficiaries' health risk factors to determine the vendor's update fees is unreasonable. With the current contract set to expire on October 31, 2013 and a "Request for Proposal" (RFP) for a new contract to be issued, it would be in the state's best interest to include a flat fee for updating beneficiaries' TPL files and exclude the use of health risk factors as they are not related to the vendor's level of effort when performing these updates.

ACCOMPLISHMENTS AND RESULTS SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT UNEMPLOYMENT INSURANCE CONTRIBUTION REVENUE

Background

Unemployment Insurance (UI) contributions are paid based on periodic reports submitted by employers in accordance with the N.J.S.A. 43:21-14. Employers must file an “Employer’s Quarterly Report” on Form NJ-927 which lists total wages paid, total taxable wages, and contributions due from the employer and their employees. Employers must also file an “Employer Report of Wages Paid” on Form WR-30 which lists each employee by name, social security number, gross wages paid for the quarter, and the number of base weeks worked during the quarter. The NJ-927 is the basis for UI contribution remittances, while the WR-30 is used in calculating unemployment benefit payments. Reports and UI contribution remittances are electronically submitted to the Department of the Treasury, Division of Revenue and Enterprise Services (DORES). DORES electronically transmits the report and payment information to the Department of Labor and Workforce Development (DOLWD) where the information is captured by the Employer Accounts System (EAS), the tax revenue system of the DOLWD. The major functions of the EAS are: processing of employers’ quarterly contribution reports and remittances, maintaining employer accounts, assessing employers, and calculating employer experience rates.

State Vendors’ Contribution Liabilities

Vendors paid for goods or services provided to the state had unpaid UI contributions. We tested 170 vendors that owed a total of \$36.7 million in UI contributions and penalties and interest as of June 2013; \$32.4 million was from December 2011 and prior. These vendors were paid a total of \$78.5 million in fiscal year 2011 and \$32.8 million in fiscal year 2012. We noted one vendor owed \$1.96 million from December 2011 and was paid a total of \$5.6 million in fiscal years 2011 and 2012. This vendor owed \$2.49 million as of June 2013. We also noted another vendor that owed \$1.43 million from December 2011 and was paid a total of \$1.95 million in fiscal years 2011 and 2012. This vendor owed \$1.47 million as of June 2013.

The New Jersey Comprehensive Financial System (NJCFIS) Garnishment Process within the Department of the Treasury withholds payments to vendors that owe the state monies. The DOLWD does not take advantage of this program.

Quarterly Reporting

Not all non-governmental employers are reporting wages paid correctly on their WR-30 and NJ-927 quarterly reports in compliance with state statute and administrative code. N.J.S.A. 43:21-14 states wages paid should be reported on a WR-30. N.J.A.C. 12:16-5.3 states wages paid should be reported on a NJ-927. The amount reported on both reports should therefore agree. Inconsistency in amounts reported could result in the underpayment or overpayment of UI contributions.

ACCOMPLISHMENTS AND RESULTS SIGNIFICANT COST SAVINGS AND REVENUE ENHANCEMENTS

DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT UNEMPLOYMENT INSURANCE CONTRIBUTION REVENUE

There is no certainty of UI contribution correctness without a review of an employer's payroll and accounting records. The Division of Employer Accounts, Audits and Field Services section performs audits throughout the year. While performing audits, they compare the NJ-927 and WR-30 wages to the employer's records. They identified underpaid contributions totaling approximately \$5.5 million during fiscal years 2011 and 2012. A separate departmental unit performs a quarterly comparative analysis of all NJ-927s and WR-30s to identify deficient employer NJ-927s for further review. The results of this activity are not maintained, hence, were not available for our review.

We sampled 127 non-governmental employers and compared the wages paid reported on the WR-30 to the NJ-927 for the four quarters of calendar year 2012. We found 19 employers (14.96%) where the wages paid reported on the two reports did not agree. Five employers reported more wages paid on the WR-30 than on the NJ-927, totaling \$65,325. This could result in the underpayment of contributions. Eleven employers reported more wages paid on the NJ-927 than on the WR-30, totaling \$205,120. An additional four employers never submitted a WR-30 or submitted it blank for a combined five quarters. The total amount of wages submitted on the NJ-927s for these employers and quarters was \$172,984. Differences where the NJ-927 wages are higher could result in an overpayment of contributions and an underpayment of unemployment benefits. One employer had more wages reported once on the WR-30 and once on the NJ-927 during two separate reporting periods.

In addition, we evaluated a sample from all employers, including governmental, for the reasonableness of excess wages reported on the NJ-927. For calendar year 2012, UI contributions are paid on wages up to \$30,300. Amounts remitted from employers consist of employee withholdings and employers contributions. Employers report the amount of excess wages (amounts over \$30,300) on their NJ-927. Utilizing the employers' WR-30 reports, we recalculated the excess wages and compared them to the NJ-927 amount for the 129 employers in our sample. We found 14 employers (10.85%) where one or more quarters did not match our calculation. One employer's excess wages differed from our calculation by \$1.8 million for calendar year 2012. We referred this matter to division personnel for investigation. The investigation noted that this employer has incorrectly calculated excess wages for 26 years. The division determined the miscalculation of excess wages for a four-year period for the worker contributions (employee withholdings) resulted in an underpayment totaling \$31,000 and interest of \$5,600. This employer has since corrected their reports and paid their contributions and interest.

We performed an additional comparison of wages reported on the NJ-927 and the WR-30 for employers where former employees filed for unemployment benefits through an affidavit of employment and wages. An individual filing for benefits can utilize an affidavit when their wages are not available or have not yet been reported on a WR-30. We noted a difference in total wages reported between the WR-30 and the NJ-927 for the 186 quarters tested which included affidavits of \$6.8 million.

**ACCOMPLISHMENTS AND RESULTS
OTHER REPORTS OF INTEREST**

**DEPARTMENT OF COMMUNITY AFFAIRS
DIVISION OF HOUSING AND COMMUNITY RESOURCES
SELECTED PROGRAMS**

Observation

LIHEAP Wage Match

The Low Income Home Energy Assistance Program (LIHEAP) provides a one-time energy benefit based on a matrix consisting of income and other factors. Verification of eligibility for the LIHEAP is complicated by the program's reliance on recipient income at a particular point in time. According to department policy, applicants for LIHEAP benefits are required to show proof of income only for the month prior to the application date in order to be eligible for energy assistance. Eligibility for the program is determined by non-profit agencies working for the division or is granted automatically to all recipients of Food Stamp benefits. The program does not verify all sources of income of LIHEAP applicants at the time of application. The division does not use a wage database to verify income eligibility of LIHEAP applicants at the time of application or subsequent to acceptance into the program.

Our data analysis of wage and hour reports and the energy assistance database at the Department of Community Affairs revealed 15,674 of 262,000 LIHEAP recipients may have underreported their income. This analysis was designed to assess the risk inherent in the LIHEAP income verification process. It was performed by taking a recipient's quarterly wages from the wage and hour report for the quarter ending September 30, 2012, annualizing them, and comparing them to 110 percent of the reported wages by the recipient. Any cases where the annualized wages were greater were considered to be instances of possible underreported income. As a result, it is possible the division provided LIHEAP recipients with greater benefits than they were entitled. An additional analysis showed that 192,000 (74%) of the 2013 heating season recipients had also received the benefit in the 2012 heating season.

The division should determine if it is more cost-effective to test for eligibility before or after LIHEAP benefits have been granted and implement an appropriate testing procedure. For example, consideration should be given to requiring additional documentation from those repeat applicants whose incomes exceed a particular threshold based on a match with the wage and hour report before eligibility is approved for the next program year.

**ACCOMPLISHMENTS AND RESULTS
OTHER REPORTS OF INTEREST**

**DEPARTMENT OF EDUCATION
MARIE H. KATZENBACH SCHOOL FOR THE DEAF**

Observation

Campus

Marie H. Katzenbach School for the Deaf was founded in 1883 and is currently located on approximately 110 acres of land. Until 1952, the facility was situated on approximately 70 acres of land when the school acquired an additional 40 acres to meet the needs of a student population that had grown to nearly 600. School enrollment, however, has declined steadily over the years, resulting in a facility that is too large and inefficient for its current population.

The school's enrollment has declined from 203 students in school year 2008-2009 to 168 in school year 2011-2012. The declining enrollment is partially attributable to higher functioning students as a result of medical advancements and earlier diagnosis. With the aide of cochlear implants and other medical innovations, many students can now be taught in their home school district. As a result of the declining enrollment, the school's facilities and grounds are vastly underutilized. The school offers a four night a week residential program and has eight dormitory buildings that can accommodate approximately 369 students. During school year 2011-2012, the residential student enrollment of 74 students represented only 20 percent of capacity. In addition, the campus has several buildings that are only partially used or not used at all. Also, although enrollments have decreased 17 percent over the last three years, the school's expenditures have increased 9.2 percent over the same period.

As of January 9, 2013, the Department of Education, in conjunction with the school's administration, was performing a study to determine a more cost-effective manner to meet the students' facility needs.

We recommend the department implement a plan that is both cost-effective and provides the flexibility to efficiently meet the future needs of the school's declining population. A change in location should be considered.

**ACCOMPLISHMENTS AND RESULTS
OTHER REPORTS OF INTEREST**

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF FAMILY DEVELOPMENT
CHILD SUPPORT PROGRAM**

Emancipation

New Jersey is one of only four states that do not have an established age of emancipation, resulting in additional costs to the state and to the custodial and non-custodial parents and increased child support arrearages. Parents are required to file a motion with the court to have their child declared emancipated. Otherwise, the child support order will continue in effect indefinitely unless the custodial parent agrees to the child's emancipation or a case worker issues a child status letter to both parents, which may trigger a court hearing. However, child status letters are only issued when the youngest child on the child support order turns 18 years old. If parents are not in agreement as to when their child should be emancipated, the non-custodial parent must then petition the courts for emancipation and termination of the child support order. A Family Court judge has sole discretion to determine when the child should be emancipated. Judges are allowed to vacate accrued child support charges only back to the date the petition was filed; they can vacate arrears back to the emancipation date for each child if the custodial parent agrees.

Not having established criteria or an age for emancipation can have a negative impact, financial and otherwise, on the parents and the state. The parents can incur unnecessary legal fees such as court filing and lawyer fees for representation. In addition, the non-custodial parents are still subject to all enforcement remedies available to the program to encourage collection of the child support debt, which includes reporting debt to credit reporting agencies, obtaining judgments, suspension of licenses, tax refund intercepts, bank levies, and bench warrants. The state is also negatively impacted with the increased administrative costs associated with mailings and scheduling of court hearings, as well as the potential loss of federal incentive dollars due to increased arrearages.

We performed an analysis to estimate the effect of not having a defined emancipation age on the accumulation of arrears. We selected age 23 for our analysis to provide a conservative estimation, because it is the oldest age suggested by program personnel for emancipation. As of September 2012, we noted there were 51,840 child support cases where at least one dependent was over the age of 23 and not emancipated. As a result of these dependents not being emancipated, we estimated arrears on these cases had a cumulative net increase from their 23rd birthday of \$20 million.

ACCOMPLISHMENTS AND RESULTS OTHER REPORTS OF INTEREST

DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT LOCAL OFFICE ONLINE PAYMENT SYSTEM (LOOPS)

Background

LOOPS is a 35-year-old legacy mainframe system used as the primary system for unemployment claims receipt and processing. This system is supplemented by a front-end claims receipt, web based self-service application utilized at all three call centers (Union City, Freehold, and Cumberland) with an Interactive Voice Response (IVR) for the Regional Call Center (RCC) that captures responses from customers. The RCC IVR system processes continued claims for benefits, as well as general and claim-specific information questions. In addition to the RCC IVR, there is a separate and distinct IVR system for claims filing for new customers. There are also two publicly accessed applications (Internet Claims and Continued Claims Certification) that interface with both the legacy and web based systems.

Business Continuity Plan and Disaster Recovery Test

Control Objectives for Information and related Technology (CobiT) states an Information Technology (IT) continuity plan should be developed and designed to reduce the impact of a major disruption in key business functions and processes. The plan should be based on an understanding of the risks of potential business impacts and address requirements for resilience, alternative processing, and recovery capability of all critical IT services. It should also cover usage guidelines, roles and responsibilities, procedures, communication processes, and the testing approach. The continuity plan needs to be periodically and thoroughly tested which is essential in determining whether it will function as intended in an emergency situation. Testing the IT continuity plan on a regular basis provides assurance that IT systems can be effectively recovered, deficiencies identified, and the plan remains relevant. The testing should involve recovery of single applications, inclusion of integrated scenarios, end-to-end tests, and integrated vendor tests.

The Department of Labor and Workforce Development has drafted a business continuity plan, titled “Unemployment Insurance Division of Information Technology (D.I.T.) Contingency Plan,” which includes LOOPS; however, it has not been finalized and approved. Testing has been limited to tabletop exercises and no comprehensive disaster recovery test has been performed on LOOPS, nor is one part of the department’s current plans. The Office of Information Technology (OIT) administers the LOOPS application and has two contingency plans, the Continuity of Operations Plan and the Disaster Recovery Plan, that only address the IBM mainframe on which LOOPS resides. The OIT plans do not specifically address a recovery of LOOPS. Without a finalized contingency plan that has been properly tested through a complete disaster recovery test, management may not have properly identified deficiencies with either their Unemployment Insurance D.I.T. Contingency Plan or OIT’s plans. Any service outages as a result of an insufficient and untested plan could greatly impact the ability of individuals to file for and collect unemployment insurance.

**ACCOMPLISHMENTS AND RESULTS
OTHER REPORTS OF INTEREST**

**JUDICIARY
ADULT DRUG COURT PROGRAM**

Observation

The Judiciary has partnered with the Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) to administer the program. There is no process by which the Division of Mental Health and Addiction Services uses participants' own health insurance to cover program costs. According to a report, "A Model for Success: A Report on New Jersey's Drug Courts October 2010", upon entry into the program, 17 percent of participants have health insurance. While not all health insurers will cover all treatments or services, the potential exists for savings through the use or reimbursement of rehabilitation services from these insurers. Program personnel state there are impediments to the use of participant health insurers.

The Judiciary and the Division of Mental Health and Addiction Services should evaluate the cost benefit versus program issues in regards to using participant health insurance to defray state costs.

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF REPORTS ISSUED DURING CALENDAR YEAR 2013**

TYPES OF FINDINGS

<u>REPORT</u>	<u>COMPLIANCE</u>	<u>CONTROLS</u>	<u>ECONOMY/ EFFICIENCY</u>	<u>NONE</u>
Casino Control Fund		Opinion Report		X
Department of Children and Families				
Division of Children Protection and Permanency Contracted Foster Care and Related Services	X	X	X	
Department of Community Affairs				
American Recovery and Reinvestment Act Weatherization Assistance Program Multi-Family Buildings	X	X	X	
Division of Housing and Community Resources Selected Programs		X		
Department of Education				
Marie H. Katzenbach School for the Deaf Office of Special Education Programs	X X	X X	X X	
Department of Environmental Protection				
Land Use Management and Selected Programs of Compliance and Enforcement		X	X	
Department of Human Services				
Division of Aging Services Office of the Public Guardian for Elderly Adults	X	X	X	
Division of Developmental Disabilities Community Programs	X	X	X	
Division of Family Development Child Support Program		X	X	
Division of Mental Health and Addiction Services Greystone Park Psychiatric Hospital	X	X	X	
Department of Human Services and Office of the State Comptroller				
Division of Medical Assistance and Health Services and Office of the State Comptroller – Medicaid Fraud Division Medicaid Third Party Liability (TPL) Recovery Services	X	X	X	
Department of Labor and Workforce Development				
Local Office Online Payment System (LOOPS) Unemployment Insurance Contribution Revenue	X	X	X	
Department of Military and Veterans' Affairs				
New Jersey Veterans Memorial Home at Menlo Park New Jersey Veterans Memorial Home at Paramus	X X	X X	X X	
Department of Transportation				
Administration	X	X		
Department of the Treasury				
Division of Property Management and Construction Office of Public Finance		X X	X	

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF REPORTS ISSUED DURING CALENDAR YEAR 2013**

TYPES OF FINDINGS

<u>REPORT</u>	<u>COMPLIANCE</u>	<u>CONTROLS</u>	<u>ECONOMY/ EFFICIENCY</u>	<u>NONE</u>
Judiciary				
Adult Drug Court Program		X	X	
Motor Vehicle Commission				
Payroll Expenditures	X	X	X	
Pleasantville Board of Education	X	X	X	
Pinelands Commission		Opinion Report		X
State of New Jersey				
Comprehensive Annual Financial Report For the Fiscal Year Ended June 30, 2012		Opinion Report		
Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards				X