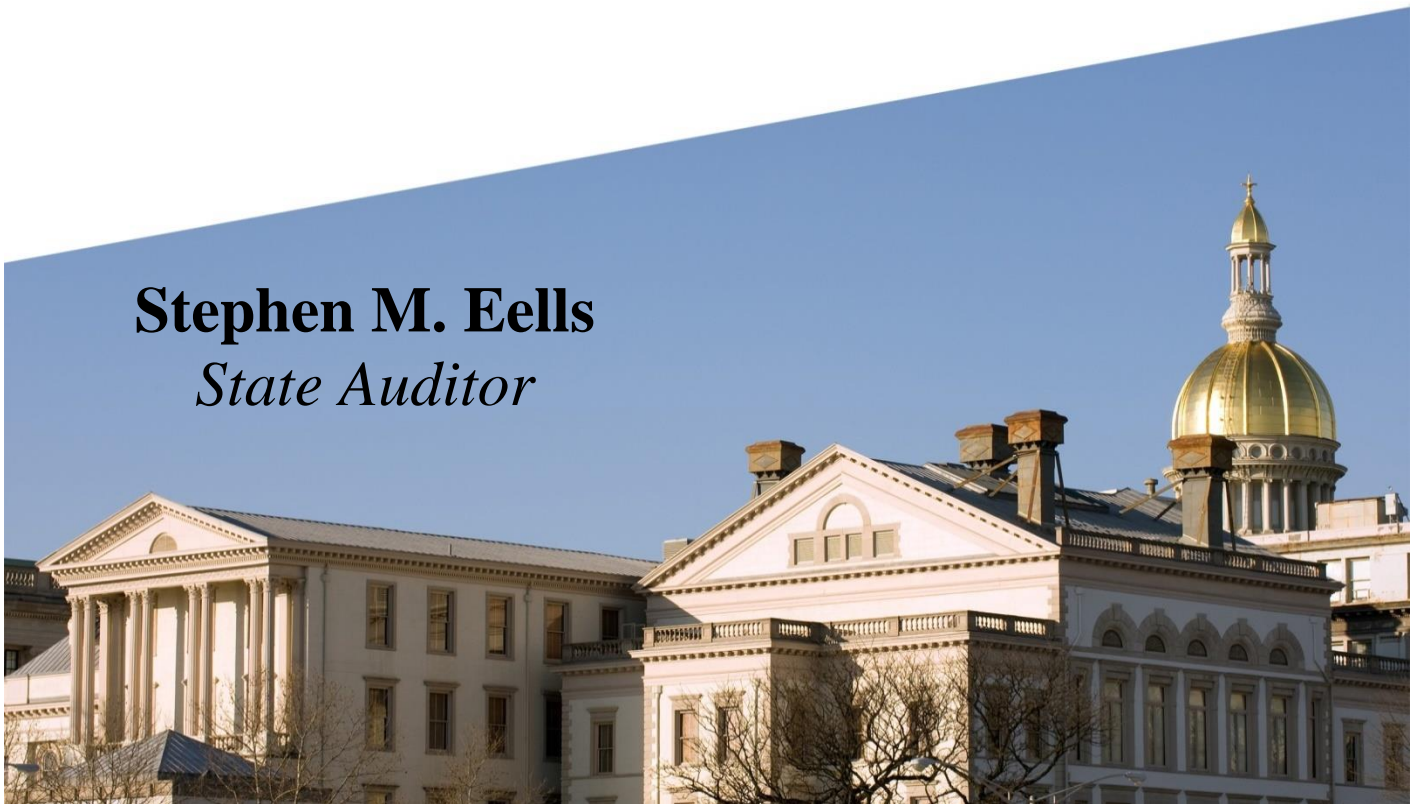


New Jersey Legislature
★ *Office of* LEGISLATIVE SERVICES ★
OFFICE OF THE STATE AUDITOR

Department of Human Services
Division of Mental Health and Addiction Services
Addiction Services

July 1, 2015 to September 30, 2018

Stephen M. Eells
State Auditor



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Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health and Addiction Services, Addiction Services for the period of July 1, 2015 to September 30, 2018. If you would like a personal briefing, please call me at (609) 847-3470.

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

Stephen M. Eells
State Auditor
January 17, 2019

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Scope

We have completed an audit of the Department of Human Services, Division of Mental Health and Addiction Services (division), Addiction Services for the period July 1, 2015, through September 30, 2018. Our audit included financial activities accounted for in the state's General Fund.

Chapter 35, P.L. 2010 formally merged the Division of Mental Health Services and the Division of Addiction Services into the Division of Mental Health and Addiction Services within the Department of Human Services. On October 1, 2017, the division was transferred to the Department of Health and was transferred back to the Department of Human Services as of October 1, 2018. Following the transfers, licensing responsibilities remained with the Department of Health under the Office of Licensing – Mental Health and Addiction Services. Our audit was confined to the division's addiction services activities.

The division contracts with approximately 230 licensed providers operating more than 400 sites to deliver substance abuse treatment and prevention services. Admissions to addiction treatment providers have increased from 69,477 in 2015 to 82,644 in 2017. The division expended \$88.1 million, \$93.7 million, and \$102.1 million in fiscal years 2016, 2017, and 2018, respectively.

Objectives

The objectives of our audit were to determine whether the division's procedures for monitoring programs and fee-for-service claims for individuals with substance use disorder were adequate and to determine the extent to which the division is measuring the effectiveness of its programs. An additional objective was to determine whether all licensed programs were complying with background check and drug screening requirements.

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. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied legislation, the administrative code, and policies of the agencies. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing. We interviewed

agency personnel to obtain an understanding of the internal control system, the licensing process, and monitoring procedures. We also reviewed employee files for a sample of addiction treatment providers and the electronic medical records maintained by providers for a sample of individuals receiving services.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions on our audit objectives, as well as on internal controls and compliance. Sample populations were judgmentally selected for testing.

Conclusions

We observed the state does not have a single coordinating entity to engage and coordinate all of New Jersey's efforts to prevent and treat substance abuse. We found the division's procedures for monitoring programs serving individuals with substance use disorder to be adequate, except for its monitoring of fee-for-service claims. In making this determination, we also noted the division can improve its monitoring of wait times, service capacity, and mobile medication unit contracts. In addition, we found the division can better determine the effectiveness of its programs and providers by increasing its use of performance measures. We also noted certain weaknesses regarding the monitoring of employees of addiction treatment providers meriting management's attention.

We also made observations regarding the use of naloxone, the limitations of the Opioid Overdose Recovery Program, and the consequences of income eligibility restrictions, as well as the effect of advertising on hotline call volume.

We found indications of fraud at three providers and referred them to the Division of Criminal Justice.

Background

According to the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, an estimated 30.5 million people ages 12 and older nationwide, or 11.2 percent of the population, were considered current users of illicit drugs in 2017. Additionally, 11.4 million people abused opioids, the vast majority of whom abused prescription pain relievers. While the number of people receiving treatment for substance abuse has increased, an estimated 16.7 million people needed treatment, but did not receive it. According to the Centers for Disease Control and Prevention estimates, more than 72,000 overdose deaths occurred in 2017, a 38 percent increase since 2015.

As New Jersey's Office of the Attorney General reports, almost 8,600 people died from a drug overdose from January 2015 through August 2018, with 2018 projected to see more than 3,000 deaths. According to the division, almost 38,000 New Jersey residents who needed treatment for substance abuse in 2017 did not receive it.

Observation

No Single Coordinating Entity

The state should have a single entity to engage and coordinate New Jersey's efforts to prevent and treat substance abuse.

According to the legislation establishing the Governor's Council on Alcoholism and Drug Abuse (council), substance abuse is a major health problem facing the residents of New Jersey, with aspects of these problems extending into many areas of almost every state department. The state does not have a single coordinating entity to synchronize the efforts of the various state departments in the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of substance abuse in order to avoid duplications and inconsistencies in these efforts, and to ensure one consistent state vision is observed by all departments.

The council was established in 1989 by state law to be an independent body that would review and coordinate New Jersey's efforts regarding the education, prevention, treatment, research and evaluation for, and public awareness of, alcoholism and drug abuse. Per N.J.S.A. 26:2BB, the council was placed in, but not of, the Department of the Treasury. This was deemed to be the most logical and appropriate location for focusing a coordinated planning and review effort to ameliorate the problems associated with substance abuse. The council's bylaws, last adopted in 2012, confirm the statute's authorization and powers. However, the council does not exercise the statutory powers granted to it.

In fiscal year 2018, the division spent \$100.5 million in state funds on substance abuse prevention, treatment, and recovery activities, while the council has an annual budget of about \$13 million. However, New Jersey's total spending on substance abuse prevention, treatment, and recovery activities is not fully known because an inventory identifying all efforts by the various state departments in addressing substance abuse does not exist. The council is required to submit to the governor and the legislature an annual Comprehensive Statewide Alcoholism and Drug Abuse Master Plan, which shall include recommended allocations of all state and federal funds for the treatment, prevention, research, evaluation, education, and public awareness of substance abuse, and shall incorporate and unify all state, county, local, and private substance abuse initiatives. The last plan was released in February 2011 and included a summary of various, but not all, state efforts. We identified efforts in more than half of the state departments, but we could not determine with certainty that these constitute all state efforts for the treatment of substance abuse.

The division is the single state authority for substance abuse in New Jersey, which, in accordance with federal law, is the state government organization responsible for planning, organizing, delivering, and monitoring critical substance use disorder services in the state.

One way other states have implemented a single coordinating entity has been to elevate their single state authority to a cabinet-level department. Nine states have cabinet-level departments as

their single state authority. For example, the Commonwealth of Pennsylvania's Department of Drug and Alcohol Programs is the single state authority and coordinates the activities of all of Pennsylvania's agencies in all aspects of the state's efforts to combat substance abuse. It reviews the administration, operation, and effectiveness of programs and reports its findings in an annual report that also summarizes the efforts of other departments. It also includes a strategic plan outlining the state's strategy for various substance abuse issues and develops model control plans for local government.

Other states have created a state drug control policy office to coordinate efforts to address substance abuse. These offices are modeled after the federal Office of National Drug Control Policy, with some strategically placed in the governor's office. With the imprimatur of the governor's office, these offices coordinate prevention, treatment, recovery, and law enforcement efforts throughout their states.

The designation of a single coordinating entity could unify policy efforts and integrate those efforts throughout agencies across state government. This would help avoid duplication and inconsistencies and help ensure the state's vision is consistently observed by all departments. To this end, the role of the council needs to be clarified. If the council is not going to act as the coordinating entity, other options should be considered.

Although the decision to designate a single coordinating entity is beyond the division's control, the division is a significant contributor to the state's overall response to combat the problem of substance abuse. As such, the division could help with this endeavor by communicating its support to the governor's office, the legislature, and the council and by providing whatever assistance it can.



Findings

Performance Measures

The division measures performance in many areas. However, it can improve its monitoring by utilizing them more to evaluate programs and providers.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has identified certain performance measures to be used in evaluating the effectiveness of various treatment protocols and providers. The division utilizes these national outcome measures (NOMs), derived using data from the New Jersey Substance Abuse Monitoring System (NJSAMS), as its central means of measuring the effectiveness of its programs. The NOMs help the division monitor client outcomes, direct system improvements, and achieve better accountability. The division releases an annual statewide performance report that presents these outcomes summarized by the different levels of care, and includes the following measures.

- Percentage of clients abstinent from alcohol at admission and at discharge
- Percentage of clients abstinent from drugs at admission and at discharge
- Percentage of clients employed at admission and at discharge
- Percentage of clients enrolled in school or a job training program at admission and at discharge
- Percentage of clients who are homeless at admission and at discharge
- Average length of client treatment
- Percentage of clients arrested in prior 30 days at admission and at discharge

The division uses the NOMs to illustrate the level of effectiveness of treatment at different levels of care, but it can improve monitoring by using these measures, and others, to evaluate provider performance. The division releases the Substance Abuse Treatment Provider Performance Report annually that compares all providers using the above measures (excluding the arrest measure); however, the report is not used to monitor and evaluate providers. Its purpose is to provide information to help consumers make informed decisions about choosing a provider and allow providers to compare themselves to their peers in order to identify areas that might need improvement.

The NJSAMS includes data relating to a client's length of stay, whether or not a client has completed treatment, and the reasons for disenrollment. However, the division does not use this type of data to evaluate the performance of providers or their effectiveness at delivering treatment. The division should be using metrics such as these to determine which providers are more effective at retaining individuals and the reasons. According to the National Institute on Drug Abuse, individuals who remain in treatment longer have better post-treatment outcomes.

The division could also use various measures to establish relevant performance benchmarks in provider contracts and consider ways to incentivize providers who achieve these standards and penalize those who do not. For example, one state has set standards for the timeliness of receiving services. Providers are required to have no more than five percent of their clients wait longer than seven days for a level of care assessment and no more than seven percent wait more than fourteen days to be admitted into the recommended level of care. Other states have set performance benchmarks related to the completion of treatment and have tied incentives and disincentives to various outcomes, such as the percentage of clients who remain in treatment to completion, the percentage of clients who leave treatment against professional advice, and the percentage of clients who remain in certain levels of care for a targeted number of days.

The outcome measures reported by the division generally indicate the programs are achieving positive results from admission to discharge, but the division does not measure the effectiveness

of treatment beyond discharge. To determine the overall effectiveness of treatment programs in the long run, as well as the effectiveness of individual providers, it is important to measure performance over time, including after clients leave treatment.

Measuring the effectiveness of addiction treatment programs is difficult. The National Center on Addiction and Substance Abuse states that the challenges associated with measuring effectiveness of treatment initiatives include that no specific treatment is the right treatment – what works for some does not work for others. In addition, the population being served is difficult to monitor and track, particularly after leaving treatment. However, developing additional ways to measure the performance of the program and its providers could help ensure taxpayer dollars spent on substance abuse prevention, treatment, and recovery efforts are spent efficiently and effectively.

Recommendation

We recommend the division develop additional measures to help determine the effectiveness of its treatment programs, including for time periods after participants have left treatment. These measures, as well as existing measures, should also be used to monitor and evaluate providers.

In an effort to improve treatment outcomes, the division should establish performance benchmarks for providers related to retention and treatment completion, and consider ways to incentivize providers to meet these measures. In doing so, the division should consider the potential for unintended consequences, such as providers retaining clients unnecessarily, and take steps to ensure the benchmarks achieve their desired goals.



Monitoring of Treatment Wait Times

The division should improve its monitoring of substance abuse treatment wait times.

It is important for the division to sufficiently monitor substance abuse treatment programs to make sure treatment is effectively and efficiently delivered. The division manages its budget and develops programs and initiatives to help individuals seeking treatment for addiction. However, our review disclosed that the division can improve its monitoring of substance abuse treatment programs.

In July 2015, the division implemented an interim managing entity (IME) for addiction services. The IME was created, as the division's website notes, to be the central point of access for individuals seeking treatment through its 24/7 call center. Individuals who call the IME seeking treatment are screened and referred to an appropriate provider. If the IME determines the call is an emergency, the IME will call 911 or contact local authorities.

When an individual seeking treatment contacts the IME, its coordination of care staff tracks the case from when the IME receives the call to when the individual is admitted into treatment. However, the division does not monitor the coordination of care data. Spreadsheets we reviewed were created by an IME employee for her own tracking purposes, but the information was not forwarded to the division. Furthermore, the division estimates only about 20-25 percent of clients admitted to treatment do so through the IME. The majority contact providers directly or are referred to providers by other parties. For those individuals, there is no process in place to effectively monitor the time it takes to get them into treatment.

In NJSAMS, the division's data collection system, providers are required to enter the total number of days between the client's first contact and first day of treatment. This number is self-reported by the providers and the division has not attempted to evaluate its accuracy. Nevertheless, using NJSAMS, we noted that from January 2017 through September 12, 2018, the average number of days it took an individual to be admitted after first contact was reported to be 4.5 days, with wait times ranging from 0 to 99 days. The division does not use this information to evaluate providers or determine how wait times could be improved. In addition, NJSAMS does not include information regarding the reasons an individual may be waiting for treatment; therefore, the division could not evaluate the reasons if it attempted to do so.

Recommendation

We recommend the division develop a method for monitoring wait times on a regular basis in order to determine if individuals are receiving treatment promptly and identify those who are not.



Service Capacity Management System

The division should require providers to update treatment availability more frequently.

The division's Service Capacity Management System (SCMS) is a portion of the interim managing entity's (IME's) computer application that allows providers to update their availability for all licensed levels of care. Providers, however, are only required to update their availability each morning and the information is not in real time. While a system like this is beneficial, having the information in real time would be a significant improvement because the IME needs to have the most up-to-date information when trying to make the correct referral. By having up-to-date information, the time it takes for an individual to receive necessary treatment could be reduced.

Furthermore, the SCMS is only available for the IME to use when making referrals. As mentioned before, it is estimated that only 20-25 percent of the individuals admitted for treatment have been referred through the IME. Sometimes an individual comes to a provider seeking treatment, but cannot be admitted. This often happens when either the provider has no more capacity or does not offer the level of service that the individual needs. Based on the providers we interviewed, when this occurs the provider will contact other nearby providers they are familiar with, but it

can sometimes be difficult to find a match. Having access to the SCMS could help providers in these instances.

Recommendation

We recommend the division develop a system that would allow for the real-time availability of service capacity. In the absence of such a system, the division should require providers to update SCMS more frequently than each morning to keep availability more up to date. In addition, the division should make SCMS available to providers. In the meantime, providers should be reminded that the IME can assist them when they need to find a referral to another provider.



Monitoring of Fee-For-Service Claims

The division does not adequately monitor fee-for-services claims.

We found a significant number of claims lacking the required documentation to support payment. The division contracts with a fiscal agent to process fee-for-service (FFS) claims submitted for reimbursement by providers. The claims are subjected to a series of system edits to ensure all required information has been included, and the claims have met billing requirements. In addition, the division's FFS unit performs data analytics of FFS claims in an effort to monitor provider claims. Furthermore, the FFS contract requires providers to maintain medical records and attendance sheets; however, the division does not review FFS claims for supporting documentation to ensure the payment is warranted.

Based on geographic proximities and services provided, we judgmentally selected 10 providers and tested FFS claims paid to them from July 1, 2017, through February 22, 2018. These 10 providers had 62,687 FFS claims totaling \$3.9 million during that period, and we sampled 1,261 of them totaling \$91,377. We reviewed the clients' electronic medical records (EMR) maintained by the providers, attendance sheets, and other documentation to determine if each claim's payment was adequately supported and found the following issues.

- 557 claims for therapy (44 percent) were not supported by an attendance sheet. Providers are required to have all clients sign in when attending therapy sessions.
- 124 claims for therapy (10 percent) were not supported by an EMR for the therapy session. In fact, in 19 instances, the medical record indicated the client did not show for the therapy session. A medical record is critical to support this type of FFS claim.

In addition, for the same 10 providers, there were 171 instances where a client had only one FFS claim during fiscal years 2017 and 2018. We tested 94 of them and found 10 (11 percent) were not supported by an EMR.

Recommendation

The division needs to improve its monitoring of fee-for-service claims by including reviews of supporting documentation, such as medical records and sign-in sheets.



Monitoring of Mobile Medication Units

The division should improve its monitoring of mobile medication unit providers and re-assess the use of these units.

The division paid \$4.3 million per year to five providers to operate mobile medication units (MMU) as part of its Medication-Assisted Treatment Initiative (MATI). The MATI funds medication-assisted and other treatment services for indigent New Jersey residents with an opiate addiction. The goal is to provide medication-assisted treatment in the form of methadone and buprenorphine dispensed to individuals in areas with limited or no access to medication-assisted treatment, as well as to individuals referred through the Syringe Access Program administered by the Department of Health. An individual receiving medication through an MMU is required to receive counseling and other services either at the MMU or at the provider's office-based facility.

Levels of Service

The providers are contractually required to serve at least 200 clients daily and must go out into the community six days each week. For a provider to receive full contract funding it must maintain a utilization rate of 95 percent. Failure to meet that level of service may result in the recoupment of funds by the division. Each provider submits signed monthly rosters to the division listing all clients receiving services from the MMUs. However, that information is not communicated to the division's contract administrators who monitor the MMU contracts. Our review of the 2017 monthly rosters disclosed that two of the providers failed to meet the level of service requirement. When we brought this to the attention of the contract administrators, they were unaware of the level of service requirement. In addition, the MMUs are required to go out into the community 312 days per year, but none did so in 2017. In fact, the five MMUs went into the community an average of only 60 percent of the number of days required, with only two exceeding 90 percent, as shown below.

	Days In Community	Percentage In Community
Provider A	294	94%
Provider B	203	65%
Provider C	120	38%
Provider D	25	8%
Provider E	292	94%
Average		60%

When an MMU does not go into the community, the provider notifies the division, but the division does not track the days MMUs are not in operation. When we asked the division for the number of days the MMUs were not in operation, it contacted the providers for that information. In addition, no efforts were made by the division to recoup any contract costs from the providers not achieving the required levels of service.

We sent questionnaires to the five providers and visited two of them. Three of the five stated the MMU program was inefficient and that the money would be better spent on other programs or methods of treatment delivery. The reasons given included:

- Too expensive for them to operate and maintain;
- Community resistance;
- Limited space on the unit; and
- Makes services too fragmented for clients.

In addition, three of the MMUs travel less than two miles away from the provider's fixed site when they go into the community. Some of the providers noted it would be easier and more efficient to pick clients up in company vans and transport them to and from the fixed site for their medication. One provider utilizes the MMU at the county jail. Other providers stated they would also be interested in using a mobile unit for that purpose.

Contract Monitoring

It is the division's responsibility to scrutinize MMU provider budgets and expenditures and to implement controls that allow for the equitable reimbursement for services delivered under each provider's contract. The division's contract administrators monitor the expenditures submitted by providers, who are paid in equal monthly installments based on approved budgets.

We reviewed the contracts and expenditures for four providers with approved budgets totaling \$3.5 million and found the following weaknesses.

- Certain costs may be allocated between a provider's MMU and a provider's other programs. One provider stated it allocated 23 percent of its expenses to the MMU for most budget categories, but could not explain how the allocation figure was determined. This provider allocated 23 percent of its medication expenses to the MMU. We expected medication to be charged as an actual expense, as medication is directly related to the program.
- The same provider's 2016-2017 audited financial report noted concern for the lack of adequate supporting documentation with respect to its MATI grant. The financial auditor also expressed concern regarding the provider's methodology used for allocating costs as direct or indirect because it was not adequately defined and documented.

- One provider stated it owed the division about \$1.2 million for the 2016 and 2017 contract years, but the division had not asked for payment because a contract closeout had not been performed. The provider indicated that it intended to pay, but had not received any requests from the division. After we notified the division, a preliminary and final closeout was completed, and the \$1.2 million was collected. The same provider was also overpaid more than \$28,000 for the 2010 grant year, but the division failed to seek recovery.
- This same provider also paid \$44,000 for the construction of a parking lot without going through a bidding process. When we asked the contract administrator if bidding was needed in this instance, she said she was not familiar with the issue.
- The division does not request supporting documentation, such as receipts or payroll information to verify the expenditures reported by the providers.

Provider expenditures are reported quarterly and at the end of the contract year. For each quarter of the contract year and during the preliminary contract closeouts, contract administrators evaluate expenditure levels to make sure they are within approved budgeted amounts, but they generally do not ask for any documentation supporting the reported expenditures until final closeouts are done, if at all.

Recommendation

The division should improve its monitoring of the levels of service of the mobile medication units. It should also reassess the use of the units. In addition, the division should strengthen its monitoring of contracts by requiring contract administrators to test and trace expenditures to source documents during the contract year, as well as during the contract closeouts.



Methadone Outpatient Treatment

Providers are billing the division for bundled services without providing the required counseling services.

Methadone Outpatient Treatment (MOP) is a weekly bundled service that includes case management, medication monitoring, medication and dispensing, and counseling services; none of which may be claimed separately for payment. An individual in MOP is assigned to one of six phases, which determines how much counseling is needed and in what timeframe.

During our testing of FFS claims, there were three providers in our sample who had a total of 410 claims for MOP. Of those 410 claims, 266 (65 percent) lacked the required counseling services within the specified timeframe.

Providers are able to bill for these weekly bundled rates without providing the counseling services because the minimum billing requirements allow for it. The minimum billing requirements implemented by the division use encounters as a basis for billing and each treatment phase has a minimum number of encounters needed. An encounter is a face-to-face interaction between a client and a provider for the purpose of providing services. An encounter consists of any of the services included in the bundle (medication monitoring, medication and dispensing, and counseling services) with the exception of case management. Therefore, as long as the individuals are dispensed their daily medication, the provider meets the required number of encounters for reimbursement without ever needing to provide the needed counseling services.

Recommendation

We recommend the division reassess its billing requirements for Methadone Outpatient Treatment claims. In addition, the division should monitor these claims to determine if individuals are receiving the treatment they need.



Contract Closeouts

The division needs to improve its monitoring of all contracts by completing preliminary and final closeouts annually.

The division contracts annually with providers to render services to individuals seeking addiction treatment and determines, through a required closeout process, any overpayments or underpayments in order to make financial settlement. This process requires a preliminary and final closeout, or in some cases only a final closeout. However, the division has not even completed a preliminary closeout for more than half of its contracts since 2012. According to the division, the reason these closeouts have not been performed is insufficient staffing and allocation of resources.

For contract years 2012 through 2017, the division had 813 contracts with addiction treatment providers with an aggregate value of approximately \$535 million. The division has completed a preliminary contract closeout on 389 of these contracts, with a total contract value of \$302 million. Furthermore, as of August 10, 2018, the division completed only 30 final closeouts and began completing them earlier this year. The 30 final closeouts have identified possible recoveries of over \$2.1 million. If the division performs closeouts on the remaining contracts and identifies possible recoveries at the same level, we estimate the division could recover an additional \$18.4 million from providers.

In addition, the recovery and outstanding receivable information was not kept up to date by the division, and it was unable to provide us the actual recovery amounts or the outstanding receivable balances. Based on the records the division did keep for preliminary closeouts prior to

June 30, 2016, and then after December 2017, we estimate the total outstanding receivable is \$1.9 million dating back to contract year 2012.

The division has decided that final closeouts will not be performed for the 127 contracts from contract year 2011 because they are too old, illustrating the need for timely closeouts prospectively. The following are two additional examples.

- In September 2017, a provider was experiencing financial and operating issues that resulted in it forming an affiliation with another company. The division had not performed any closeouts on nine of the provider's contracts dating back to 2006. As a condition of approving the affiliation, the division performed the final closeouts on the contracts and identified a recovery amount more than \$1.2 million. To prevent the provider from closing, the division agreed to accept \$300,000 to satisfy the recovery. While the decision to accept less than the full recovery amount was reasonable given the circumstances, the division recovered \$900,000 less than it could have if closeouts had been completed timely.
- A provider had a preliminary closeout performed showing an outstanding receivable of \$700,000. This provider has not contracted with the division since 2015, making any recovery less likely.

By not performing preliminary and final closeouts timely, the division could be forgoing money owed to it.

Recommendation

The division should perform preliminary and final closeouts on all contracts in a timely manner. In addition, preliminary and final closeouts should be tracked so receivable amounts are easily identified and collected.



Drug Screenings and Criminal Background Checks

Monitoring of drug screenings and criminal history background checks for employees of licensed addiction treatment providers should be improved.

The division's fee-for-service contract requires providers to conduct full background checks for all staff. In addition, employees of licensed addiction treatment providers are required by the New Jersey administrative code to be drug-screened and submit to a state-level criminal background check supported by fingerprints prior to employment. Per the division, it is recognized that there are counselors in the field of addiction recovery who may have a history of substance abuse and may be in recovery themselves, or even have a criminal history. Having such a history does not preclude an individual from being hired by a provider. A staff member with such a history may better empathize with the clients receiving treatment, lend credibility to the program, and act as

a role model. However, being in contact with individuals who are currently abusing illegal substances or who have a disqualifying criminal history, may put these clients at risk. Therefore, it is important to ensure all employees have completed the required pre-employment drug screening and criminal background check.

We reviewed 86 employee files at five providers, and found 40 percent of the files we reviewed lacked evidence of compliance with these requirements. Of the 86 employee files we reviewed, 20 lacked any documentation of a criminal background check, while another 16 had a criminal background check performed by a private vendor that was supported by the employee's social security number and date of birth, but not the employee's fingerprint. In addition, 35 lacked any evidence of a pre-employment drug screening.

Per the administrative code, and in the contract with the division, providers are responsible for not hiring staff that have been convicted of a crime that adversely affects the person's ability to provide care or interact with clients and families. Such crimes include, but are not limited to, "drug-related offenses, homicide, aggravated assault, kidnapping, sexual offenses, robbery and crimes against the family, children or incompetents," unless rehabilitation has been demonstrated. The administrative code allows the provider to make this determination.

During inspections by the Department of Health's Office of Licensing – Mental Health and Addiction Services (OOL), inspectors check for evidence of a state-level background check supported by fingerprints, but do not look at the results of the background check. In addition, the OOL does not verify all staff have obtained the required background check. Instead, the OOL reviews the records for a small sample of employees. Without knowing the results of an individual's criminal background check, the division is unaware if any employees have a disqualifying criminal history, which employees need to have demonstrated rehabilitation, or if applicable, whether rehabilitation has been demonstrated. This increases the risk of an individual with a disqualifying record being hired by a provider.

In addition, it is important for these providers to obtain as much information regarding a potential employee's criminal history as reasonably possible. By not requiring a national criminal background check, providers could unknowingly hire individuals with a disqualifying criminal history, thereby putting clients at risk and in an unsafe environment.

Recommendation

The division should collaborate with the Department of Health's Office of Licensing – Mental Health and Addiction Services to ensure all provider employee files are reviewed and determine whether there are any disqualifying offenses, and if so, whether rehabilitation has been properly demonstrated and documented. Furthermore, all employees should be subject to a national background check.



Additional Observations

Naloxone Use and the Opioid Overdose Recovery Program

The Opioid Overdose Recovery Program is effective at getting individuals into treatment, but there are limitations that prevent it from reaching others in need.

Naloxone Use

In 2013, the Overdose Prevention Act was signed into law to promote the wider prescription and distribution of naloxone. Better known by its commercial name Narcan, naloxone is an easily administered medication designed to quickly reverse the effects of an opioid overdose. The law recognizes that overdose deaths can be prevented by making naloxone more readily available to those at risk of an opioid overdose, and to their families, friends, and loved ones. Every state has now passed a law that facilitates widespread distribution and use of naloxone.

In New Jersey, naloxone is most often administered by law enforcement and emergency medical personnel, who are required to document and report administrations of naloxone. The depersonalized information is collected and made available to the public by the Department of Law and Public Safety, Office of the New Jersey Coordinator of Addiction Response and Enforcement Strategies. The number of administrations by first responders has increased significantly, from 5,174 in 2014 to 14,356 in 2017; however, hospitals do not report naloxone administrations to state officials. The Department of Health could require hospitals to do so in order to provide a more accurate figure of naloxone administrations.

Opioid Overdose Recovery Program

The administration of naloxone is a critical step needed to save a person who is suffering from an opioid overdose. However, the administration of naloxone is not enough to accomplish the division's goal of obtaining appropriate treatment or recovery support for those who need it. According to the division, detoxification without follow-up treatment is usually ineffective, and "[r]epeated episodes of detoxification followed by inadequate treatment or no treatment at all do not make sense, not only from a healthcare perspective, but also from a humanitarian and an economic perspective." Survivors of an opioid overdose are at significant risk to overdose again without treatment for their addiction. To help address this issue, the division started the Opioid Overdose Recovery Program (OORP).

The OORP provides recovery support services and other assistance to individuals who have been reversed from opioid overdoses and are treated at participating hospital emergency departments. The program's goal is to link individuals reversed from an opioid overdose to withdrawal management, substance use disorder treatment, continued recovery support services, and follow-up. The program was initiated in 2016 with three providers operating in the five counties demonstrating the most need. Since then, the program has grown to include 14 providers

operating in all 21 counties. The OORP began as a two-year project, but the division estimates federal grant money should keep the program funded for an additional two years.

When a naloxone-reversed patient is admitted to a participating hospital, a recovery specialist is deployed to engage the patient and offer non-clinical assistance and recovery supports. Most programs have a specialist on call 24 hours a day, 7 days a week. The OORP providers also maintain follow-up contact with these individuals for a minimum of eight weeks after the initial contact. Since its implementation on January 1, 2016, the OORP providers have engaged with over 6,600 individuals who were reversed from an opioid overdose and taken to a participating hospital emergency department, with over 60 percent accepting withdrawal management, substance abuse treatment, or recovery support services.

The program has been effective at assisting reversed patients, but we noted some limitations. The division monitors the program by receiving data indicating the number of patients who have accepted or declined assistance. However, the numbers are reported by the OORP providers and only include individuals the providers were able to engage. Not all reversed patients agree to meet with an OORP recovery specialist and some patients leave the hospital against medical advice before seeing the specialist. One emergency department supervisor we interviewed stated she maintains records on all opioid overdose patients that could be shared with state officials, as long as the data is depersonalized for individuals who did not agree to meet with an OORP specialist.

Individuals who have been naloxone-reversed by first responders are not even required to go to the hospital. If the individual is awake and alert, he or she can refuse treatment against medical advice and be released without ever being offered the opportunity to meet with a specialist. The ability for a naloxone-reversed patient to leave the hospital against medical advice before being seen by a specialist, or not even go to the emergency department at all, limits the program's ability to get treatment for those who need it.

Additionally, not all hospital emergency departments participate in the program. As of April 30, 2018, the OORP providers are operating in 53 hospital emergency departments throughout New Jersey, or about 70 percent of all emergency departments in the state. The hospitals not participating in the OORP may have their own similar program. However, they are not monitored by the division, and the division would not know how many overdose cases go through those emergency departments.

These issues highlight the need to collect data on all opioid overdoses, not just those seen by the OORP specialists. Currently, the state does not know the number of individuals this represents. However, the total naloxone administrations reported by law enforcement and emergency medical services first responders in 2017 was 14,356, far exceeding the 3,744 reversed patients seen by the OORP specialists. It is therefore likely there are a significant number of naloxone-reversed individuals who are not being offered the help they need for their addiction.

By working with relevant stakeholders to develop a way to monitor the number of naloxone-reversed patients from all emergency departments, as well as from law enforcement and emergency medical services first responders, the division should be able to determine the extent

to which the OORP program is not able to address its target population and whether additional measures are warranted.

Involuntary Commitment

As of 2016, 37 other states and the District of Columbia had statutes allowing for the involuntary commitment of individuals suffering from substance abuse disorder and/or alcoholism. Yet, according to The Pew Charitable Trusts, most state commitment laws have rarely been used to detain people with opioid addictions, for a variety of reasons. However, many states have revised, or are considering revising, their involuntary commitment statutes to make it easier to do so in cases involving individuals suffering from substance abuse.

Research shows involuntary treatment can be as effective as or more effective than voluntary treatment. Approximately one-third of the adults receiving treatment in New Jersey are doing so through compulsory court programs. In 2010, New Jersey's Drug Court reported that the rates at which drug court graduates are re-arrested for a new indictable offense or reconvicted were much lower than the rates for drug offenders released from prison. According to the National Institute on Drug Abuse, "sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions." For example, more than two-thirds of the people involuntarily committed in Tampa, Florida completed their treatment programs, according to The Pew Charitable Trusts. This exceeds the 50 percent threshold generally considered to indicate a program is successful.

As previously stated, one limitation we identified in the OORP is that individuals are not required to meet with a recovery specialist when admitted into the emergency department, while others may refuse to even be taken to the hospital. The Overdose Prevention Act may unintentionally contribute to this. The law contains a "Good Samaritan" component that provides legal protections to not only the person seeking medical assistance for the victim of an opioid overdose, but the overdose victim as well. We were advised by emergency medical services at a local hospital that the law has definitely saved lives, but it also prevents law enforcement from detaining the individual who overdosed.

There are minimal health risks associated with the use of naloxone. However, these risks are amplified when the reversed individual either does not go to the hospital or leaves the hospital too soon. The effects of naloxone often wear off before the effects of the opioid. When this happens, the individual can begin overdosing again, or go through withdrawal and begin using again right away. This illustrates the state's interest in getting these individuals into treatment, or at least providing information on the availability of treatment.

The following is a list of some approaches to involuntary commitment other state and local governments are considering or have implemented.

- Anyone administered an opioid antagonist (e.g., naloxone) by first responders are subject to involuntary commitment and taken to a treatment facility.
- Anyone believed to be experiencing a drug overdose may be placed in protective custody and taken to a treatment facility. The individual is not considered under arrest or charged with a crime.
- First responders are authorized to sign a 72-hour noncriminal detention order that requires an overdose victim to be transported to a hospital or treatment facility and held until an addiction assessment is completed and a treatment plan developed.
- Use of federal and state grants to create secure triage centers in areas where there is limited access to hospital emergency departments or treatment facilities.
- The ability to petition the courts to have an individual committed for substance abuse similar to commitment laws designed to protect individuals with a mental illness. The standards and conditions that must be met to commit someone vary by state.

We acknowledge there are significant legal and practical issues that would need to be addressed before any action similar to the above examples is taken. The civil rights of the individual must be considered against the interests of the state, and appropriate treatment must be readily available for any form of involuntary commitment to be effective. The effects on emergency departments, emergency medical services, law enforcement, treatment facilities, and others must be carefully considered as well.

State resources used to reverse drug overdoses have the obvious immediate benefit of saving lives. However, naloxone-reversed individuals are especially susceptible to another overdose, or in some cases death, if they do not enter a treatment program. Various involuntary commitment alternatives may support the state's efforts in helping those suffering from addiction but are not getting the help they need.



Eligibility Restrictions

While eligibility restrictions help manage limited state resources, some ineligible individuals may not be able to afford to get the treatment they need.

In order for an individual to be eligible to receive division-funded services, the individual's household income must be at or below 350 percent of the federal poverty level. With limited state funds, eligibility restrictions are necessary to provide treatment to those individuals who would otherwise not have access to it. However, eligibility restrictions also may prevent certain segments of the population from getting needed care.

While all state health insurance providers are now required by law to cover substance abuse treatment, health benefits plan premium costs, coverage, and deductible and co-pay amounts vary. Some lower income individuals, while ineligible for division-funded services because of household income levels, may not be able to afford health insurance. Others who have health insurance may not be able to afford the deductibles associated with substance abuse treatment. These individuals may not be eligible for division-funded services.

The division conducts a household survey to, among other things, identify barriers to treatment for those with dependence issues. The most recent survey was conducted in 2016, and results are still in draft form. Results indicate that 12 percent of New Jersey residents met the diagnostic criteria for past-year substance abuse or dependence, and only 10 percent of those individuals actually received treatment in the preceding 12 months. The survey also disclosed 41 percent of respondents indicated costs were a barrier to treatment. It is important to note that the survey was conducted prior to the legislation expanding insurance coverage.

It is also possible for individuals to be eligible for division-funded services at the onset of treatment because they are unemployed, but they become ineligible for services during treatment. For example, according to the division's 2016 Substance Abuse Treatment State Performance Report, over 24,000 individuals receiving treatment in calendar year 2016 were employed at admittance, while nearly 28,000 were employed at discharge. In addition, it is common for individuals who have completed treatment to relapse. Those who relapse after gaining employment that makes them ineligible for services may not be able to afford follow-up treatment while employed, even if their employer provides health insurance.

The development of a cost-sharing program to fund, in whole or in part, the deductibles of individuals whose household income exceed current eligibility limits could assist these at-risk individuals. Another possibility would be to have variable eligibility levels that would provide less aid as income increases. This would provide a safety net for individuals who need treatment, but are, or become, ineligible for treatment under current rules.



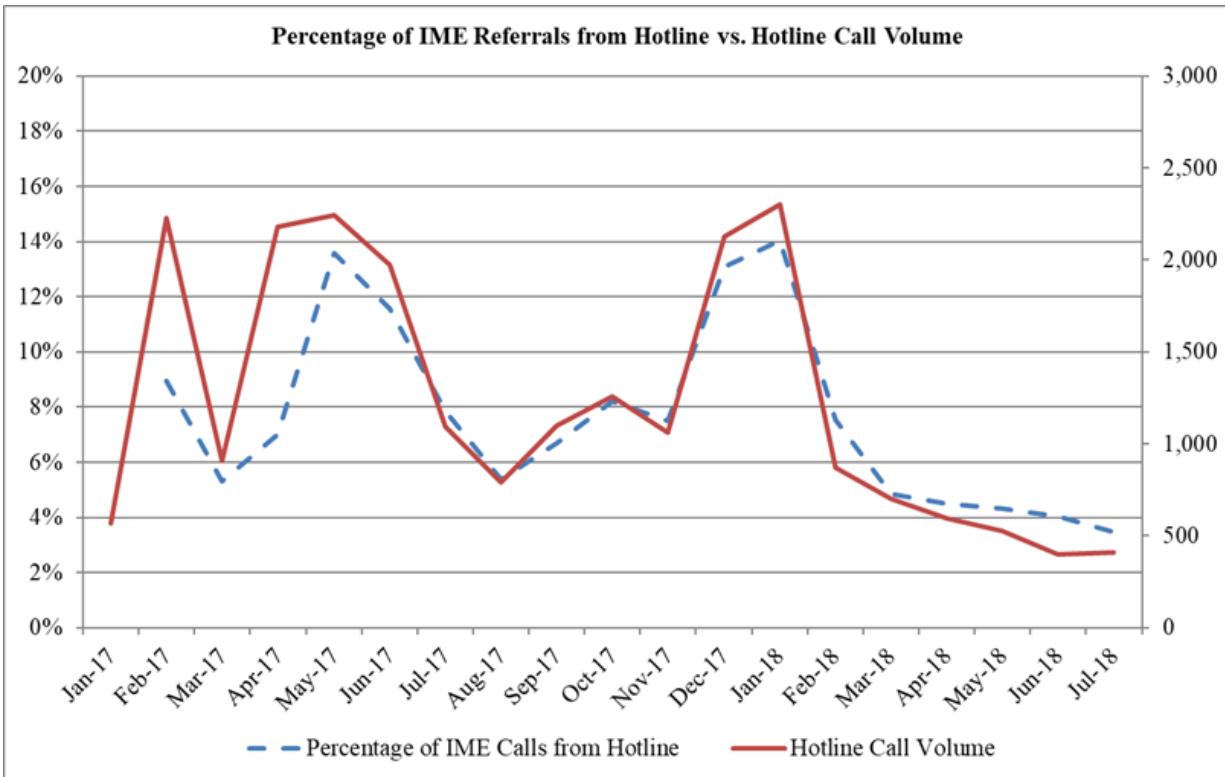
Addiction Hotline Advertising

There is a direct correlation between advertising, hotline call volume, and IME referrals.

In an effort to make treatment for addiction easier to find and more accessible to families and individuals, the state launched a “one-stop” website and hotline in January 2017. The hotline is powered by NJ 2-1-1, which is an information and referral service that connects individuals with addiction recovery and support services available throughout New Jersey. When an individual seeking help calls the hotline, a specialist asks the caller a series of questions to determine the caller's needs. Using a “warm handoff” by direct line, the caller is transferred to one of the following appropriate hotlines.

- Children and parents of children are referred to PerformCare and the Children’s System of Care.
- Families are referred to NJConnect for Recovery.
- Adults without insurance are referred to the Interim Managing Entity (IME) Addictions Access Center, which refers individuals seeking treatment to appropriate treatment providers.
- Individuals with private insurance are transferred to the Benefits Verification Hotline, which helps the caller navigate their insurance.

The hotline and website are funded by the division, with an annual budget totaling \$340,000. Approximately \$42 million was spent from January 2017 through January 2018 on an advertising campaign for the hotline, with the reported goal of raising awareness. Advertising ended in January 2018. While \$42 million on advertising is a significant media buy, it did increase call volume to the call center. As shown below, the call volume has dropped significantly since January 2018, decreasing from more than 2,300 calls to just 400 in July 2018. In addition, the percentage of calls to the IME Addictions Access Center that are transferred through the hotline correlate with the hotline’s call volume.



The increases and decreases in the 2017 monthly call volume are also in line with the changes in monthly advertising levels. Finally, the percentage of callers who cited billboards, radio, or television advertising for how they learned of the hotline has dropped from 56 percent in January 2018 to just 14 percent in July.





State of New Jersey
Department of Human Services

P.O. BOX 700
TRENTON NJ 08625-0700

PHILIP D. MURPHY
Governor

Carole Johnson
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Sheila Y. Oliver
Lt. Governor

January 10, 2019

John J. Termyna
Assistant State Auditor
Office of the State Auditor
125 South Warren Street
PO Box 067
Trenton, NJ 08625

Dear Mr. Termyna:

The Department of Human Services (the Department) is in receipt of a draft audit report issued by your office entitled "*Department of Human Services' Division of Mental Health and Addiction Services, Addiction Services*" for the period of July 1, 2015 through September 30, 2018. The objectives of the audit were to determine whether the Division of Mental Health and Addiction Services' (DMHAS or the Division) procedures for monitoring programs and fee-for-service claims for individuals with substance use disorder were adequate and to determine the extent to which the Division is monitoring the effectiveness of its programs. The audit also sought to determine whether all licensed programs were complying with background check and drug screening requirements. Thank you for the opportunity to comment on the draft report.

Please accept the following responses to the draft audit findings:

OSA Observation

"The state should have a single entity to engage and coordinate New Jersey's efforts to prevent and treat substance abuse."

Response

The Department acknowledges OSA's observation related to a single state coordinating entity as well as its recognition that the designation of such an entity is beyond the control of DMHAS. We note that United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes DMHAS as the Single State Authority for Substance Abuse Services, including prevention, early intervention, and treatment. Further, DMHAS engages in ongoing collaboration and coordination with departments and agencies across state government on substance use issues under the leadership and direction of

the Governor's office, including the development and implementation of the Governor's \$100 million plan to address the opioid epidemic.

OSA Recommendation

"We recommend the division develop additional measures to help determine the effectiveness of its treatment programs, including for time periods after participants have left treatment. These measures, as well as existing measures, should also be used to monitor and evaluate providers.

"In an effort to improve treatment outcomes, the division should establish performance benchmarks for providers related to retention and treatment completion and consider ways to incentivize providers to meet these measures. In doing so, the division should consider the potential for unintended consequences, such as providers retaining clients unnecessarily, and take steps to ensure the benchmarks achieve their desired goals."

Response

The Division strongly believes in using performance metrics to measure and evaluate programs and providers. As OSA notes, the Division collects a variety of performance measures including state measures and National Outcome Measures (NOMS) required by SAMHSA and releases an annual statewide performance report based on this data. The monitoring system used to collect these measures has been in place for more than ten years, providing the Division with many years of performance data with which to review provider performance over time.

We note OSA's recommendation regarding the development of additional measures to assess performance post-treatment discharge. We also note OSA's acknowledgement of the challenges of tracking individuals after leaving treatment. Nonetheless, the Division intends to explore potential data collection and other approaches to track post-discharge performance. Options the Division will explore include the use of data monitoring repeat admissions to care and continued care after discharge from withdrawal management (detox). Admission to treatment after discharge from withdrawal management is a strong predictor of successful recovery in clients served.

The Division will also explore how other states and programs have developed retention and treatment completion benchmarks in light of the OSA caveat that designs must take into account the potential for negative unintended consequences. The Division will look at indicators such as treatment retention, treatment completion, re-admissions to care and continued care after discharge from withdrawal management. As data is developed, the Division will consider incentive strategies.

OSA Recommendation

"We recommend the division develop a method for monitoring wait times on a regular basis in order to determine if individuals are receiving treatment promptly and identify those who are not."

Response

The Division strongly agrees that it is important to effectively monitor substance use disorder treatment programs and with the OSA recommendation to develop an enhanced method for monitoring wait times for individuals who are seeking treatment. The Division will revise provider reporting requirements in the New Jersey Substance Abuse Monitoring System (NJSAMS), which currently track days from first contact to first treatment to also include the reason for the wait times to allow the Division to better conduct gap analysis and identify other barriers to care such as transportation or child care. The Division will use this information to track individual provider wait times.

OSA also notes the Division's use of an interim managing entity (IME) for addiction services to provide a 24-hour a day, seven day a week call center staffed with addiction treatment experts and access to information about treatment program availability. The IME facilitates connecting individuals to treatment and tracks individuals from call to connection to treatment. The Division is currently reviewing and updating its expectations of the IME function and will revise its requirements to ensure the Division receives direct and timely data on wait times.

The Division also requires providers that receive funding from the federal substance use disorder block grant to provide interim services to priority populations awaiting treatment. Interim services assist individuals in immediate distress, keep individuals engaged in services until they are able to be connected to treatment, and educate individuals on risks associated with continued misuse of substances.

OSA Recommendation

“We recommend the division develop a system that would allow for the real-time availability of service capacity. In the absence of such a system, the division should require providers to update SCMS more frequently than each morning to keep availability more up to date. In addition, the division should make SCMS available to providers. In the meantime, providers should be reminded that the IME can assist them when they need to find a referral to another provider”

Response

The Division agrees with OSA's recommendation to require more frequent updates of treatment availability. The Division will work with the IME to revise the Service Capacity Management System (SCMS) to more effectively monitor substance use disorder (SUD) provider capacity so that targeted referrals may be made to providers. Changes will include amending the IME requirements and requiring all substance use disorder treatment providers to update capacity on the SCMS twice daily and to direct providers to contact the IME when referral to another provider is needed. Providers are already able to contact the IME directly to receive real time treatment availability options, but the Division will continue to provide education to providers about this IME function. Additionally, the Division will engage SUD providers to develop a plan to implement input into SCMS two-times per day.

The Division will provide treatment agencies technical assistance on these changes and monitor compliance.

OSA Recommendation

“The division needs to improve its monitoring of fee-for-service claims by including reviews of supporting documentation, such as medical records and sign-in sheets.”

Response

The Division appreciates OSA’s recommendation and will enhance its monitoring of fee-for-service claims through the implementation of an on-site monitoring plan for substance use disorder providers similar to the monitoring process used for mental health providers. This plan includes the review of supporting documentation for SUD service claims that have been paid through the Division’s fiscal agent as well as claims paid through direct payment voucher reimbursement.

The on-site monitoring plan of SUD fee-for-service claims will be similar to the process the Division utilizes for monitoring mental health fee-for-service claims. The Division has recognized the value of coordinating its monitoring efforts across mental health and addictions programs and has already changed its organizational structure to support this collaborative effort. As a result, the Addictions Fee-for-Service Unit has been moved to be managed by and report to the Division Chief of Staff where the Mental Health Fee-for-Service Units currently report.

The Division will provide notice and technical assistance to providers in advance of the monitoring process commencing. All contracted fee-for-service provider agencies will be subject to on-site review of claims during their contract term based on scope determined by the monitoring unit. The Division’s fee-for-service staff, the Monitoring Units, and Program Managers will be responsible for on-site monitoring of providers to review supporting documentation such as medical records and attendance sheets to confirm the delivery of services for which the claims were submitted for payments.

OSA Recommendation

“The division should improve its monitoring of the levels of service of the mobile medication units. It should also reassess the use of the units. In addition, the division should strengthen its monitoring of contracts by requiring contract administrators to test and trace expenditures to source documents during the contract year, as well as during the contract closeouts.”

Response

The Division contracted for the mobile medication units (MMU) to increase availability and access to medication-assisted treatment (MAT); however, challenges beset providers in meeting this intended goal. The most notable challenges include community resistance to siting vans in areas where consumers could readily have reached them and aging vehicles requiring significant and frequent repairs.

Moving forward, the Division will reassess the use of the mobile medication units, including exploring alternate uses for the units. In 2017, the Division worked with a mobile medication provider to repurpose the mobile unit to provide MAT to inmates at a county jail. Such innovative approaches will be explored with the other mobile units. The Division will meet with

the other providers and review how these units can be most effectively utilized moving forward. Plans will be implemented for either continuing the use of a mobile medication unit with enhanced oversight and accountability or for repurposing the mobile units to provide MAT in a different manner. Plans may differ based on each provider's situation or the conditions of the area served or the condition of the vehicle.

The Division's Program Monitoring Unit also will continue to collect monthly rosters from the six Medication Assisted Treatment Initiative (MATI) contract agencies. On a quarterly basis, the Division's Contract Monitoring Unit will review MATI contract utilization charts which indicate monthly utilization rates and average utilization rates for each quarter. From these reports, the Contract Monitoring Unit will assess whether agencies are meeting contractual requirements of at least 95 percent utilization rate. If agencies do not meet the contractual requirements, the Division will either reduce individual agency contract ceilings or seek recoupment of funds.

With respect to contract monitoring, the Division will ensure that contract administrators request cost allocation plans from the MMU providers at the renewal of their contracts and ensure that medication costs are not allocated as indirect costs. The six mobile medication unit providers will be required to submit receipts for medication charged to the contract on quarterly and final ROEs and for review in contract closeouts. The Division will require contract administrators to test and trace expenditures to source documents during the contract year, as well as during the contract closeouts.

OSA Recommendation

"We recommend the division reassess its billing requirements for Methadone Outpatient Treatment claims. In addition, the division should monitor these claims to determine if individuals are receiving the treatment they need."

Response

The Division is reviewing the bundled rate billing requirements, particularly with respect to minimum billing requirements. The Division will collect the information necessary to assure that clients are receiving the appropriate treatment through reviewing of clinical documentation of encounters and will revise the billing requirements as necessary. The Division will conduct education and outreach as needed to ensure that providers understand the clinical and fiscal expectations of any bundled rate changes.

OSA Recommendation

"The division should perform preliminary and final closeouts on all contracts in a timely manner. In addition, preliminary and final closeouts should be tracked so receivable amounts are easily identified and collected."

Response

The Division has begun closing out prior year contracts and seeking recovery of amounts owed by providers as appropriate. The Division is also developing a centralized accounts receivable system to record, track, follow-up, and collect outstanding receivables.

OSA Recommendation

“The division should collaborate with Department of Health’s Office of Licensing-Mental Health and Addiction Services to ensure all provider employee files are reviewed and determine whether there are any disqualifying offenses, and if so, whether rehabilitation has been properly demonstrated and documented. Furthermore, all employees should be subject to a national background check.”


Response

The Division is working collaboratively with the Department of Health (DOH) to ensure that providers are reviewing background check results to determine fitness for employment. In November 2018, DOH inspectors began reviewing records of all employees to verify that they have received the required background checks. The Department regulations require all potential employees to have a state-level background check supported by fingerprinting prior to hiring. The Department will consider subjecting employees to national background checks, but such checks generally require an authorizing State statute which has been approved by the Federal Bureau of Investigation. See Public Law 92-544; 28 CFR 50.12(a).

Finally, the Division appreciates the observations offered by the OSA and will continue to review them.

Thank you again for the opportunity to review and respond to OSA’s draft audit report.

Sincerely,



Carole Johnson
Commissioner

c: Valerie Mielke, Assistant Commissioner
Daniel Prupis
Mark Talbot