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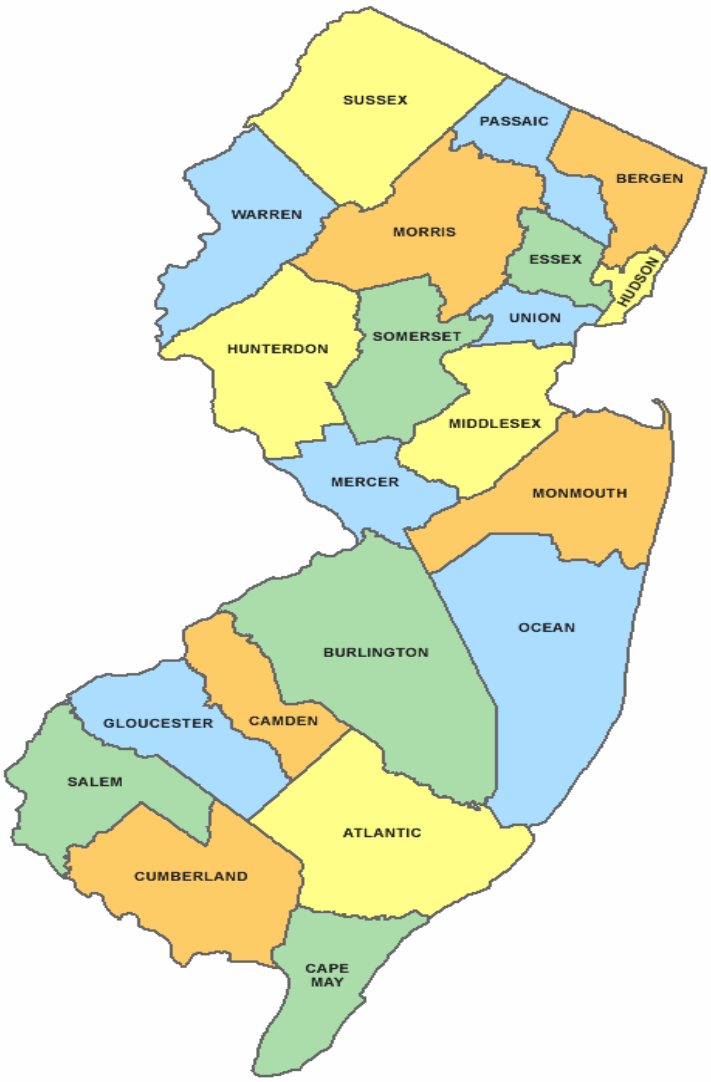
Annual Report of the New Jersey Office of Legislative Services Office of the State Auditor

For the Calendar Year Ended December 31, 2009



2009

2008 - 2009

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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 2009. 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 28 reports during 2009 which identified $59.0 million in potential cost savings/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 for 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 best 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 that we audit. We are committed to providing high quality audit reports. You may be assured that 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 9, 2010

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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 September 26, 1989, Mr. Richard L. Fair, CPA, was appointed State Auditor Designate and was confirmed by a joint session of the Legislature on March 15, 1990. He retired on June 30, 2008. As of December 31, 2009, no successor had been appointed (On February 11, 2010, Stephen M. Eells was confirmed by joint session of the Legislature).

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 Legislature, the Governor, 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 compliance with its recommendations. In addition, at the request of the legislative leadership or the Legislative Services Commission, the State Auditor conducts studies on the operation of state and state-supported agencies with respect to their economy, internal management control, and compliance with applicable laws and regulations.

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INTRODUCTION

MISSION STATEMENT

The State Auditor provides independent, unbiased, timely, and relevant information to the Legislature, agency management, and the citizens of New Jersey which 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.

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

ACCOMPLISHMENTS

During calendar year 2009 we identified $59.0 million in new cost savings or revenue enhancements. The schedule of cost savings is presented on page 3. The office provided training to over 120 participants from other governmental agencies in the area of governmental budgeting, accounting and financial reporting and through audio conferences in various topics for no charge. In addition, our compliance review on findings related to audit reports issued during the fiscal year ended June 30, 2008 disclosed that 86 percent of the recommendations have been complied with or management has taken steps to achieve compliance.

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OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF COST SAVINGS AND REVENUE ENHANCEMENTS
REPORTS ISSUED DURING CALENDAR YEAR 2009

REPORT	COST SAVINGS/ REVENUE ENHANCEMENTS (In Thousands)
City of Camden School District	$246
Department of Children and Families	
Division of Youth and Family Services	560
Department of Corrections	
Edna Mahan Correctional Facility for Women	434
New Jersey State Prison	667
Department of Health and Senior Services	
Division of Senior Benefits and Utilization Management	
Medical Services for the Aged, Nursing Homes	6,747
Department of Human Services	
Commission for the Blind and Visually Impaired	323
Division of Developmental Disabilities	
Woodbine Developmental Center	3,831
Division of Medical Assistance and Health Services	
Fee-for-Service Payments for Managed Care Beneficiaries	11,309
Managed Care Contract, Vaccines for Children Program	1,600
Managed Care Program, Third Party Liability Medical Coverage	7,051
Department of Environmental Protection	
Natural Resource Management	982
Department of the Treasury	
Division of Investment	5,000
New Jersey Comprehensive Annual Financial Report	20,000
Transportation Trust Fund Authority	
Appropriations	233
Total Cost Savings and Revenue Enhancements	$58,983

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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 opinion on the state's Comprehensive Annual Financial Report (CAFR) which is published by the Department of the Treasury. The CAFR engagement includes the audit of 194 funds and component units which had a total asset value of $155 billion at June 30, 2009 based on full accrual accounting. Two other financial audits were issued in calendar year 2009.

Agency 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 performed 22 of these audits in calendar year 2009. These audits encompassed $12.9 billion and $1.1 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 2009 we reported on the myNewJersey Portal.

During calendar year 2008 the office also started an integrated IT audit effort, where IT auditors are assigned to other types of audits and are responsible for the review of IT controls that are applicable to the scope of those audits. This allows for more frequent reviews of IT systems. Audit hours relating to this effort are reported in the other types of audits performed.

School District Audits

N.J.S.A. 18A:7A-57 authorizes the Office of the State Auditor to conduct a forensic audit of the fiscal operations of any school district which has a year-end general fund deficit and meets one other criteria of this act. We audited one such school district in calendar year 2009. We also audited the City of Camden School District.

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AUDIT REPORTS

Legislative Requests

From time to time the Legislative Services Commission requests the State Auditor to conduct special projects of the fiscal practices and procedures of the major departments and agencies of the State, and to report findings to the Commission.

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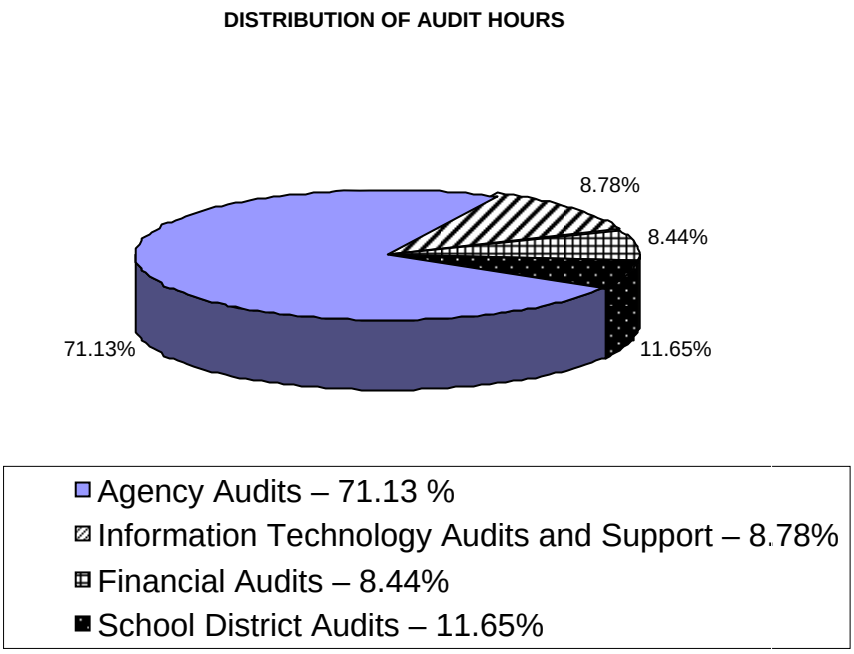
AUDIT REPORTS

DISTRIBUTION OF AUDIT HOURS

The distribution of audit hours used in performing audits during calendar year 2009 is depicted on the following chart.



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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 since 1996 are available on the Internet through the New Jersey Legislature's Home Page.

Reports are statutorily required to be sent to:

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

In addition, copies of reports are routinely sent to:

- the chairs of the pertinent Senate and the General Assembly committees,
- the Executive Directors of partisan staff,
- the management of the audited entity,
- the State Treasurer, and
- the State Library.

Finally, reports are placed on the Internet at:

http://www.njleg.state.nj.us/legislativepub/auditreports.asp

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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 six 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. Forty-nine staff members, 55 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 participated 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 staff.

The office maintains six active committees staffed by individuals in various titles to provide guidance in the areas of information technology, 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 which the audit staff can access through their computers.

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

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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 maintenance of the audit working papers and the office library, purchasing and maintaining office supplies, and other general administrative functions.

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OFFICE OF THE STATE AUDITOR
STAFF ROSTER
As of December 31, 2009

STATE AUDITOR
Vacant
Evelyn T. Richardson, Administrative Assistant

ASSISTANT STATE AUDITOR
Stephen M. Eells, CPA
Jean Horner, Secretary

ASSISTANT STATE AUDITOR
Thomas R. Meseroll, CPA, CGFM
Deborah S. Tucker, Secretary

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J. Robert Malone, MBA
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ACCOMPLISHMENTS AND RESULTS

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ACCOMPLISHMENTS AND RESULTS

SUMMARY

This section highlights seven of the more significant audits issued during the past year which individually contained cost savings/revenue enhancements greater than $1.0 million and collectively totaled $55.5 million. Information on these reports is presented on pages 14 through 31. The office issued seven other reports with individual cost savings totaling $3.5 million. This section also contains the significant findings from ten audits on pages 33 through 47 which address information technology, public safety, and other issues.

All reports issued in calendar year 2009 are identified on a schedule on pages 48 to 49 and are available for review on our internet website.

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SIGNIFICANT COST SAVINGS/REVENUE ENHANCEMENTS

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Acuity Audits

Additional nursing services, commonly referred to as acuities, are provided when a patient requires trachea tubes, intravenous therapy, wound care, oxygen therapy, and tube feeding or additional care due to head trauma or respiratory condition. The numbers of acuities for a calendar year are reported to the Division of Senior Benefits and Utilization Management (division) and ultimately are reflected in the nursing home's subsequent year per diem calculation. In the past, audits of a nursing home's reported acuity services had been performed by the professional nursing staff of the Department of Health and Senior Services (department) as part of a cost report audit. Agency personnel stated that these audits had resulted in the greatest amounts recovered due to overstatement of acuities. Due to the vacancy in the nursing staff position these audits have not been performed by the department since 2005. The only records the division could provide were from fiscal year 2005 when eight acuity audits were performed. Four of these audits identified overpayments totaling $424,000 for an average of $53,000 per audit.

We performed two acuity tests at 11 nursing homes. The first test consisted of reviewing the support for all acuities for one month. The second test involved selecting individuals that had started and then completed the acuity treatment during a subsequent month. Our objective was to verify that the nursing homes had followed the regulations (N.J.A.C. 8:85-3.9) for inclusion of an acuity on their cost report. We found a seven percent error rate on our first test and a 26 percent error rate on the second. If the department had a nursing professional on staff performing these same tests, the error rates may even be higher because their expertise could identify and disallow additional services. We had the rate setting unit perform a recalculation on the two nursing homes with the largest error rates using our sample results which resulted in overpayments of $114,000 and $48,000. Based on the department's information and our current acuity tests, it is important to resume the acuity audits since it is likely that they will result in significant recoveries.

Cost Recoveries

Each year there are 40 full and 100 focus audits performed on nursing homes by a contract vendor. Audit adjustments may result in a reduction in a facility's per diem reimbursement rate. A recalculation of the per diem rate and the recovery calculation is performed by the rate setting unit and forwarded to the financial unit for recovery. Our review noted that due to a vacancy that existed in the unit there was a backlog in performing these per diem and recovery recalculations. The unit has begun the process of calculating recoveries, but as of December 2008 there were 125 to be completed. We estimate this to be a six to nine month backlog at the current processing rate. The average recovery from the last eight months of recalculations is $29,000. Applying this average to the remaining 125 to be recalculated would result in $3.5 million in recoveries.

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Our examination of the recovery process also disclosed internal control weaknesses. One individual is responsible for notifying the nursing home of their overpayment and maintaining a manual log of the notices. This person is also responsible for maintaining documentation to offset subsequent payments on the state's Medicaid fiscal agent system to recover the overpayment or receive checks if the nursing home chooses this method of repayment. A report is prepared by this individual that identifies those homes which have satisfied their overpayment. The unit supervisor uses this report to relieve an informal accounts receivable report. However, during our review we noted that the accounts receivable report is incomplete. In addition, there is no independent reconciliation of the amount received to the calculated recovery.

Rate Setting

New Jersey reimburses nursing homes based on annual facility specific prospective per diem rates. In accordance with N.J.A.C. 8:85-3.2, nursing homes submit annual cost reports to the department's rate setting unit. These reports provide the information necessary to establish per diem rates. The fiscal year 2008 rates were calculated using calendar year 2006 cost reports. We did not perform a test of the rate calculation, although we did evaluate access and system controls.

The rate setting unit developed an Excel spreadsheet entitled the Excel Nursing Home Cost Report Workbook (ENHCRW) to perform the calculation beginning in fiscal year 2007. Our review disclosed that no supporting explanatory documentation as to how the formulas were developed or changed exists. This lack of documentation increases the risk that necessary changes to the ENHCRW or recovery of the application due to a disaster could not be accomplished if the one individual currently responsible for the application was unavailable. Control Objectives for Information and Related Technology (CobiT) requires detailed system documentation be created during the development and maintenance process for all applications. The additional time and resources that would be needed to replace or upgrade an undocumented application could be greater than the time spent documenting the system.

Our audit noted several errors in the rate calculation that need to be corrected. The rate calculation includes an evaluation of the occupancy level of a nursing home to determine if they achieved 85 percent Medicaid occupancy. If the nursing home was below this occupancy level it would fall into a penalty phase which may result in a lower per diem rate. The ENHCRW did not correctly apply this penalty phase to the per diem rate calculation. Upon discovery of this problem, the rate setting unit recalculated the rates of those nursing homes affected resulting in a $1.2 million recovery for fiscal year 2008. The division should review fiscal year 2007 and recalculate the effect of the penalty phase for those calculations.

In addition, we noted an input error in which the acuities were vastly over-recorded for one facility. This error resulted in a higher per diem rate which caused an overpayment of $485,000. If there were edit checks for reasonableness in the ENHCRW the over-recorded acuities would have been identified.

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Potential Cost Savings Therapeutic Leave

Therapeutic leave, as per N.J.A.C. 8:85-1.14, is therapeutic or rehabilitative home and community visits with relatives and friends. Residents are permitted to take up to 24 days per year of therapy leave for which Medicaid pays the full per diem rate to the nursing home. During our field visits we found one facility was not recording the therapy days on the system billing documents. Their rationale was that they are paid at the same full daily rate anyway. Other facilities may be underreporting as well. Bed hold days, per appropriations language, are paid at 50 percent of the per diem rate if the facility meets the 90 percent Medicaid occupancy level. The therapy day payment could be reduced by $1.4 million annually if they were paid at the same 50 percent rate.

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Revenue

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

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

Medical Rehabilitation Cottage

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

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Respites

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

Medicare Part B Billings

The center can recover partial costs for covered services when a consumer with Medicare Part B sees a doctor. Doctor visits and procedures performed on consumers are recorded in each consumer's binder. A billing clerk reviews these binders regularly and records billable visits on a Medicare Part B billing log sheet. Billable visits on the log sheet are coded and entered into the Division of Developmental Disabilities' Meditrak billing system. Claims are then submitted for reimbursement under the Medicare Part B program. When reimbursements are received, the Division of Developmental Disabilities (division) prepares a cash receipt document and enters the information into the state's accounting system to the credit of the center. Neither the center's billing unit nor the business office are notified of the status of submitted claims. It is the division's responsibility to submit claims for reimbursement and process rejected claims. The division's records showed it processed an average of 4,813 paid claims on behalf of the center and revenues averaged $187,609 per year. Our review disclosed the following.

- Three hundred forty-six consumers living in the center are enrolled in Medicare Part B. The Meditrak billing system did not list Medicare Part B numbers for 12 eligible consumers. No billing histories were found for these consumers.

- Five consumers' Medicare Part B number was incorrectly listed in the Meditrak system. Claims for two consumers were affected. One consumer, admitted in 2007, had 45 claims from calendar year 2007 to June 2009 and none of the claims were paid. The other consumer, admitted in 2005, had 61 unpaid claims during the same time period.

- We reviewed five consumers' binders and identified 105 billable medical visits in calendar year 2008. The calendar year 2008 billing summary report from the division only identified 42 visits had been processed.

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Welfare Fund

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

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Managed Care Beneficiaries with Multiple Recipient Numbers

The Division of Medical Assistance and Health Services (division) administers the state's Medicaid and NJ FamilyCare programs, which provide medical assistance to needy or uninsured individuals. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for every Medicaid eligible service rendered to the beneficiary; or the capitation method, in which a Managed Care Organization (MCO) receives a monthly payment for each Medicaid beneficiary enrolled in the plan and in return is responsible for ensuring enrollees have access to quality health care and needed medical services.

The division's automated claims payment system has edits to identify and prevent fee-for-service payments for services for beneficiaries covered under managed care. Through an intricate multi-stepped computerized data match and manual analysis, we identified 505 fee-for-service inpatient hospital claims totaling $4.8 million for the period January 2007 through March 2009 for beneficiaries with managed care enrollment at the date of service. We tested 278 of these claims totaling $4.3 million and found 101 totaling $1.1 million that should have been paid by the MCO. These claims were paid because the beneficiaries had both a fee-for-service and a managed care recipient number open simultaneously. Hospitals may have knowledge of both numbers enabling them to circumvent managed care by billing the fee-for-service number. Included in the 101 claims were the following examples.

- A $231,000 inpatient claim for a liver transplant was inappropriately paid as fee-for-service when the procedure should have been paid by the MCO. The beneficiary had two active identification numbers: one fee-for-service and the other managed care. The hospital was paid by billing the fee-for-service number.

- A beneficiary had two active recipient numbers for one month with one being fee-for-service and the other managed care. A hospital was paid $78,000 using the fee-for-service number when the services should have been paid by the MCO.

County welfare agencies and the state's contracted enrollment broker are responsible for determining and terminating program eligibility. The county welfare agencies and the broker are not always adequately screening individuals for currently assigned recipient numbers. Often an individual's eligibility was established under one program and the individual re-entered under another program and a new recipient number was assigned without termination of the previous recipient number. Also, when a newborn's birth weight is less than 1200 grams (2.6 pounds), the infant may be determined eligible for Supplemental Security Income (SSI), by the Social Security Administration, which results in a new recipient number being issued.

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This weakness was noted in our audit report issued August 2, 2001. The division is aware of the multiple numbers and is trying to address the issue. As of April 2009, the division estimated there were 75,000 multiple numbers.

Separate from the data match noted above, we performed additional analysis of high dollar out-of-state inpatient hospital claims and found the following claim for a beneficiary with multiple recipient numbers inappropriately paid as a fee-for-service claim.

An MCO inappropriately denied an inpatient hospital claim for a newborn maintaining the child was not their member when, in fact, the child was enrolled in the MCO at the time of service. Despite the MCO claiming that the newborn was not a member, it paid approximately 280 claims totaling $38,000 throughout the newborn's three month inpatient stay including physician services, radiology, and the cost to transport the newborn to the hospital via helicopter. The hospital resubmitted the denied claim and was paid $658,000 as a fee-for-service claim using the second recipient number. The numbers were not linked in the system due to the misspelling of the beneficiary's last name on one of the numbers. Had the numbers been linked, the fee-for-service claim would have been denied.

Timely Enrollment of Newborns in Managed Care

The division inappropriately paid fee-for-service hospital payments for infants born to mothers enrolled in managed care. In addition to the monthly capitation, the division pays the Managed Care Organization (MCO) a supplemental payment following a pregnancy outcome. This single lump sum payment reimburses the MCO for its inpatient hospital/birthing center, antepartum (prenatal), and postpartum costs in connection with the delivery. This payment also covers the care of the baby for the first 60 days after the birth plus through the end of the month in which the 60th day occurs. During this post-partum period, the newborn is covered under the mother's recipient number.

Our review found the division does not have adequate procedures to identify all infants born to beneficiaries enrolled in managed care. We identified $748,000 in fee-for-service payments for hospital services that should have been covered by an MCO. These inappropriate payments occurred because the division could not properly link the newborn to the mother's recipient number indicating coverage by an MCO. Had the link been properly made, the hospital fee-for-service claim would have been denied by the Medicaid Management Information System.

Our review found that if a county does not update the eligibility file in a timely manner, or if a mother of the newborn does not report the birth to her county welfare agency as required, the child will not be enrolled and will lose coverage under managed care.

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In one situation, an MCO received a lump sum maternity payment but the child was not enrolled in managed care until 4½ months after the date of birth because the mother failed to notify the county in a timely manner. This resulted in a $314,000 fee-for-service inpatient claim that should have been the responsibility of the MCO. As a result of our inquiries, the division recovered the $314,000 from the MCO.

Procedural Disenrollment from Managed Care

The division needs to be more conscious of maintaining managed care enrollment in certain situations such as pregnancy. Our review also found that procedural disenrollment from managed care for reasons such as a change in program status, transferring to another Managed Care Organization (MCO), or moving to another county can result in significant fee-for-service claims as noted in the following examples.

- A woman enrolled in managed care for nine months while pregnant had her eligibility and managed care terminated, per regulation, six days prior to giving birth after failing to respond to her annual eligibility redetermination. The newborn was immediately transferred to a hospital for approximately six months resulting in a fee-for-service claim of $1.1 million. After reapplying, both mother and child were re-enrolled in the same MCO less than two months after the birth.

- A child was procedurally disenrolled from managed care after a change in household composition resulted in increased income triggering a change in the child's program status code. Although the child never lost Medicaid eligibility, her managed care was systematically terminated. Twenty-seven days after being disenrolled from managed care, the child was admitted to a hospital for approximately eight months resulting in a fee-for-service claim of $1.1 million that would have been the responsibility of the MCO had the division and the county maintained continuous managed care coverage during the change. The child was subsequently re-enrolled in a different MCO twelve days after leaving the hospital.

- A beneficiary transferring from one MCO to another can result in a gap in their managed care coverage. A beneficiary requested to switch MCOs the day before giving birth. Her enrollment in her old MCO ended the last day of the month she gave birth and began with her new MCO the first day of the next month. Despite the original MCO receiving the lump sum maternity payment, the post-partum period was shortened by the switching of MCOs resulting in a $208,000 fee-for-service inpatient claim that should have been the responsibility of her MCO at birth. The process of transferring from one MCO to another should be seamless and not result in a gap in managed care coverage.

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- A woman enrolled in an MCO for seven years lost her managed care eligibility for one month because she moved to a different county. The month before the lapse in coverage she gave birth and the MCO received a lump sum payment to cover the newborn during the post-partum period. The lapse in managed care resulted in a $50,000 fee-for-service inpatient claim for the newborn which should have been paid by the MCO. The mother and child were subsequently re-enrolled in the MCO.

Maternity Claims and Newborn Drug Withdrawal Syndrome

An infant whose mother is enrolled in managed care at the time of the infant's birth is covered by the mother's managed care plan. When a baby is born to a mother who is enrolled in managed care, the division makes a supplemental payment to the Managed Care Organization (MCO) to reimburse them for the cost of the newborn's delivery, inpatient hospital, and post-partum costs. The following contract references pertain to the MCO's responsibility.

"Coverage of newborn infants shall be the responsibility of the contractor that covered the mother on the date of birth from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the contractor's responsibility until discharge as well as for any hospital readmissions within forty-eight (48) hours of discharge for the same diagnosis…"

"The contractor shall be responsible for inpatient hospital costs of enrollees with a dual diagnosis (physical plus mental health/substance abuse condition) whose primary diagnosis is not mental health or substance abuse related."

We found the division manually processed fee-for-service hospital claims for neonatal services provided to newborns covered under the managed care contract. The claims were manually processed by the division by overriding an existing Medicaid Management Information System edit preventing the payment of such claims for beneficiaries covered under managed care. These claims were denied by MCOs because services were provided to a newborn of a substance abuse mother.

In a July 26, 2007 letter to a children's rehabilitation hospital, the division stated that services provided by this hospital for infants diagnosed with newborn drug withdrawal syndrome were to be reimbursed fee-for-service. Some of the MCOs used this letter to deny hospital claims for intensive care services for newborns born to a substance abuse mother. For example, an MCO received the maternity payment from the division in the amount of $9,400 for a birth. The hospital claim shows charges for the delivery and hospitalization of the

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newborn in a neonatal intensive care unit for 52 days. The MCO paid the hospital $3,000 for only two days of the infant's hospitalization. The hospital submitted the claim to the division. The division made a $101,000 payment to the hospital for the 50 days not covered by the MCO. A review of the diagnosis codes on the claim indicated that the newborn drug withdrawal syndrome diagnosis was neither the primary nor secondary diagnosis on the claim.

By overriding these types of claims, the division increased the risk of MCOs improperly splitting and denying claims for hospital days for newborns in neonatal intensive care units that should be covered by the managed care contract.

Encounter Based Supplemental Payments

Various services are carved out of the monthly capitation to the Managed Care Organizations (MCOs) and reimbursed separately. These services include maternity outcomes, certain blood clotting drugs, HIV/AIDS drugs, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) incentive payments. The MCOs are reimbursed for these services based on approved encounter claims submitted to the division.

MCOs received numerous duplicate payments for these encounters since 2005. The division became aware of duplicate payments for blood clotting drugs in 2006 and requested an audit be performed by the department's internal auditors. In 2007, the auditors confirmed that a duplicate payment issue existed and also included maternity payments, HIV/AIDS drugs, and EPSDT incentive payments. According to the division, one MCO told the auditors that it had a $2.6 million liability on its books for unearned payments. A June 2008 letter from the MCO to the department indicated that it had previously sought guidance from the division on how to remedy the unearned supplemental payments.

In September 2008 the division's Encounter Data Monitoring Unit began a reconciliation of the supplemental payments with the encounter claims to determine the scope and cause of the duplicate payments. In July 2009 the division recouped $3.8 million from five MCOs for 6700 duplicate payments during the period January 2005 through December 2008. Most duplicate payments were the result of MCOs voiding and resubmitting encounter claims for various reasons. We found no evidence that MCOs intentionally submitted duplicate claims. The division plans to perform a second reconciliation and recoupment after addressing the following weaknesses in the encounter processing system which contributed to the duplicate payments.

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Voided encounter claims were not always processed correctly. MCOs received duplicate supplemental payments after properly voiding and resubmitting an encounter claim; however, the voided claim was not reflected on the payment system. After this processing error was disclosed by our audit, the division identified an additional $1.4 million in supplemental payments that should have been voided since January 2005. The division anticipates recouping these payments. In addition, the division discovered that MCOs may have received maternity payments for encounter claims that were not actual deliveries as well as the possibility that MCOs may not have received payments for some legitimate maternity claims. The net effect of any potential over/underpayments to the MCOs has not been determined by the division at this time.

The division did not have a timely filing rule which allowed MCOs to receive duplicate payments for older services. Prior to July 2009 the division made a supplemental payment to the MCO regardless of the encounter's date of service. Beginning July 2009 the division, while still accepting all encounter claims, stopped making supplemental payments on claims with service dates older than one year.

Due to the limited two year retention of claims history on the payment system, when an MCO resubmitted an encounter claim with a date of service greater than two years, it failed to deny the claim as a duplicate because the original encounter and payment was archived off the system. As a result, the resubmitted encounter was approved a second time and a duplicate supplemental payment was issued. The timely filing rule should eliminate this problem going forward.

Pharmacy Claims for Contraceptives

Our review of encounter data noted that Managed Care Organizations (MCOs) paid claims totaling $5.4 million for contraceptives from January 2008 through March 2009. Family planning drugs such as contraceptives are covered under the managed care contract. We identified an additional $900,000 in claims paid as fee-for-service for contraceptives for beneficiaries covered under managed care. Most beneficiaries enrolled in managed care obtain care and services from managed care providers affiliated with their plans. A federal statute makes an exception for family planning services and supplies. Beneficiaries have the right to choose any family planning provider regardless of whether the provider is participating in their MCO.

In New Jersey's managed care contract, family planning services may or may not be covered by the contract depending on whether the provider is in or outside of the MCO's provider network. The contract allows family planning services and supplies to remain in the fee-for-service program when furnished by a non-participating provider. Our review found that at least 86 percent of the fee-for-service claims for contraceptives should have been paid by the

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MCO because the pharmacies were participating in all five MCO provider networks. This occurred because the state's Medicaid Management Information System (MMIS) managed care edit is bypassed for family planning drugs and instead allows these claims to be paid as fee-for-service. Beneficiaries would still be able to retain their freedom of choice even if the division denied these fee-for-service claims and directed the pharmacy to submit the claims to the MCO.

By continuing to allow pharmacy claims for these drugs to be paid as fee-for-service when a beneficiary is covered by managed care, the risk of fraud and abuse is increased. We found 281 pharmacies submitted claims totaling $21,000 where both the MCO and the program were billed for the same prescription. Some of these claims were partially billed and $12,000 in claims appeared to be double billed. These claims will be referred to the Medicaid Inspector General for further review. In addition, we found the division paid 198 fee-for-service claims for prescriptions totaling $10,000 for female contraceptives billed to male beneficiaries.

Inappropriate Managed Care Enrollments of Beneficiaries in Psychiatric Hospitals

During our review of fee-for-service claims for beneficiaries in managed care, we found twelve beneficiaries in one inpatient psychiatric hospital facility that were enrolled in managed care. Beneficiaries who are institutionalized in an inpatient psychiatric facility are excluded from managed care enrollment. Their enrollment and continued coverage in managed care results in the overpayment of services since their medical care is provided by the psychiatric facility. The managed care contract states the following.

"Capitation payments for a full-month of coverage shall be recovered from the contractor (MCO) on a prorated basis when an enrollee is admitted to a nursing facility for long term care services, psychiatric care facility or other institution including incarceration and the individual is disenrolled from the contractor's plan on the day prior to such admission."

The twelve beneficiaries had capitation payments totaling $144,000 that were improperly paid by the division. In one example, a beneficiary enrolled in the managed care program since July 2001 entered a psychiatric hospital in May 2004. The division has continued to pay capitation premiums for the beneficiary for the last 67 months. Overpayments for this beneficiary totaled $32,000. It was unclear whether the MCO was aware that their member was in a psychiatric hospital.

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DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
MANAGED CARE CONTRACT
VACCINES FOR CHILDREN PROGRAM

The Department of Health and Senior Services' Vaccines for Children (VFC) program is a federally funded, state operated vaccine supply program that began nationally in October 1994. The program supplies vaccines at no cost to all public providers and private care providers who agree to administer federally purchased vaccines. The VFC program was created to meet the vaccination needs of children from birth through 18 years of age. Children enrolled in Medicaid or the Medicaid expansion portion of NJ FamilyCare are eligible to receive VFC provided vaccines. Under the program, providers are eligible to receive a fee of $11.50 per injection from managed care organizations (MCO).

We found that MCOs were not in compliance with the Managed Care contract as it relates to the use of the VFC program resulting in claims paid by the MCOs to providers for vaccines from July 1, 2005 through November 25, 2008 that should have been free under the program. The Division of Medical Assistance and Health Services (division) did not effectively monitor the contract to ensure that MCOs did not receive any reimbursement for the costs of VFC covered vaccines.

The division contracts with five MCOs to provide comprehensive health care services to eligible beneficiaries. The contract requires that MCO providers enroll in the VFC program and use the free vaccines for its enrollees if the vaccine is covered by the program. The contract further states that MCOs shall not receive any reimbursement from the division for the costs of VFC covered vaccines.

During the audit period, of the 1.3 million claims for vaccines that should have been free under the program MCOs paid 78,400 claims totaling $1.6 million to 997 providers. These inappropriate claims are included in the annual rate setting calculation (50 percent federally funded).

Our review disclosed that the division does not have adequate procedures in place to verify that all MCO providers are enrolled in the VFC program. Instead, it relies on the MCOs to develop their own in-house edits to ensure that their providers are enrolled in the VFC program and that they do not pay for any VFC covered vaccines. Our review of 20 providers with the highest dollars in claims for VFC covered vaccines, totaling $792,000, disclosed that five providers with claims totaling $116,000 were not enrolled in the VFC program. The remaining 15 providers were enrolled in the VFC program but still submitted claims totaling $676,000 for VFC covered vaccines. We conclude that the MCO edits are lacking and additional monitoring needs to be undertaken by the division.

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Third Party Liability

Medicare and other private health insurers may pay for a substantial portion of the cost of health care services provided to beneficiaries with third party liability (TPL). Because of this comprehensive primary coverage, the Division of Medical Assistance and Health Services' (division) regulations prohibit most of these beneficiaries from enrollment in NJ FamilyCare or Medicaid managed care. Allowing their enrollment would make the division reliant on the managed care organization (MCO) to enforce cost avoidance requirements, and capitation premiums could result in overpaying for services.

Over 120,000 beneficiaries with comprehensive TPL coverage were properly denied managed care enrollment and were covered by the fee-for-service method. However, our review of the division's June 2008 eligibility data files found:

- 2,800 Medicaid beneficiaries enrolled in managed care that also have comprehensive TPL coverage. They should have been disenrolled and placed in the Medicaid fee-for-service program. The Medicaid program paid $513,000 in capitation premiums for these beneficiaries for June 2008. If this result was consistent throughout the year, capitation premiums for these beneficiaries would have totaled $6.2 million (50 percent federal). The coverage change of these beneficiaries may result in cost savings, depending on the impact on capitation rate calculations and resulting fee-for-service costs.

- 1,150 beneficiaries with comprehensive TPL coverage that should have precluded them from enrollment in the NJ FamilyCare program. The capitation payments for these beneficiaries totaled $150,000 (50 percent federal) for June 2008. The removal of these beneficiaries may result in cost savings, depending on the impact on capitation rate calculations.

Most third party liability information is obtained at the time of application or redetermination for Medicaid services. Various sources have the ability to update the TPL resource file. The division employs a vendor that actively looks for beneficiaries that have TPL and provides update information for entry into the Medicaid Management Information System (MMIS). However, there are no coordinated procedures that would process changes in eligibility resulting from TPL coverage so that the proper actions could be taken to disenroll these beneficiaries from the program.

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Duplicated Health Coverage

The health and medical care provided under the Medicaid program and NJ FamilyCare are considered to be last resort benefits. Last resort benefits means that these programs only pay benefits after all other resources of funding are exhausted. The division, pursuant to N.J.A.C. 10:74-8.3, allows individuals already enrolled in or covered by either a Medicare or commercial MCO to also be covered by New Jersey Medicaid managed care as long as the two plans are with the same MCO. This policy results in duplicate coverage and results in a managed care organization receiving two capitation payments for the same individual. Furthermore, this practice weakens the division's monitoring controls by making them overly reliant on the MCO to ensure the proper allocation of medical costs to these two managed care plans and the MCO's compliance with cost avoidance requirements. Our review of June 2008 files identified 3,700 beneficiaries that had been covered by the Medicaid Managed Care program and had other insurance with the same MCO. The Medicaid program paid monthly capitation premiums totaling $701,000 for these individuals. Disenrolling these individuals would minimize the efforts required by the division to ensure that MCO plans were properly following cost avoidance procedures. In addition to a more efficient process, the removal of these enrollees may result in some cost savings, depending on the impact on capitation rate calculations.

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External Investment Advisor Fees

The State Investment Council, which sets the Division of Investment's (division) long-term investment policy and strategy, expanded the universe of permissible investments in 2006 to include emerging international markets. Although the division already managed its international developed portfolio internally, current staffing levels were not sufficient to actively manage emerging markets. The division therefore retains external investment advisors to perform research, make recommendations, and initiate trade orders while maintaining final approval authority for all trades.

The division paid approximately $6.4 million in fiscal year 2009 to the emerging markets advisors. If provided with adequate staffing and travel resources, the division could have actively managed the entire emerging markets portfolio for an estimated $5 million less than it paid the advisors in fiscal year 2009. The advisors' fees are based on a percentage of the amount invested; therefore the savings could grow to an estimated $20 million a year if the division increases its emerging markets allocation to its maximum target level. Since the administrative costs of the division are paid from the same funding source as the advisors' fees, the state pension funds, these savings would be reinvested and compounded.

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Sales Tax Dedication to Property Tax Relief Fund Relating to Enterprise Zone Sales

In fiscal year 2007 the state constitution was amended to designate a tax rate of 0.5 percent on sales subject to the Sales and Use Tax Act exclusively for property tax reform. The amount is to be credited annually from the General Fund to a special account in the Property Tax Relief Fund (PTRF).

New Jersey statutes grant an exemption to the extent of 50 percent of the tax imposed under the Sales and Use Tax Act for qualifying municipalities designated enterprise zones (EZ). The reduced tax collected in these zones is allocated between the Enterprise Zone Assistance Fund (EZAF) and the General Fund at annually determined percentages. The amounts deposited into the EZAF are made available to municipalities for various approved revitalization projects. When the general sales tax rate was increased from 6 percent to 7 percent, the tax rate for enterprise zones increased from 3 percent to 3.5 percent.

In our audit of the New Jersey Comprehensive Annual Financial Report a management letter was issued noting that the Office of Management and Budget (OMB) made year end calculations of the amount to be credited to the PTRF from the General Fund based on 0.5 percent of gross sales subject to the sales and use tax. In doing so, they included the sales occurring in the EZs as part of the calculations. Meanwhile, the EZAF retained the additional revenue derived from the sales tax increase based on the predetermined allocation percentages. Therefore, the General Fund paid the EZAF's share of the PTRF dedication. The new legislation was not specific as to the treatment of the sales tax dedication in respect to sales tax collected in EZs and any liability thereon to the EZAF. Subsequent to our inquiry of the allocation procedure, the Department of the Treasury has requested $20 million be returned to the General Fund from the EZAF.

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INFORMATION TECHNOLOGY ISSUES

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Monitoring of Applications Accessed Through the Portal

The myNewJersey Portal is an identity enabled portal server solution. It provides all the user, policy, and identity management to enforce security, single sign-on, and access capabilities to end user communities while combining key portal services such as personalization, aggregation, security, integration, and search capabilities. Unique capabilities that enable secure remote access to internal applications round out a complete portal platform for deploying robust government-to-employee, government-to-government, and government-to-business applications.

The myNewJersey Portal requires users to be authenticated and authorized. Through authentication, a user identifies himself by logging into the portal. Authorization indicates that the user has the proper role for a given application. The web application being accessed calls the portal to determine if the user has been authenticated and if the user is authorized to use the application. It is through the use of roles that access to portal applications is accomplished for authorized users. Some roles may be configured to limit access to specific information. The permissions to perform certain operations are controlled by the resource being accessed. The granting of roles is delegated to Role Managers designated by the resource owner. Management of individual user access requires the assignment of the appropriate role to each user.

Portal staff is not always made aware of changes to the applications and access allowed through the portal, since privileges and access are granted by the security staff of the owners of the applications. This may impact the myNewJersey Portal's efficiency by increasing the demand created by the addition of an application. This may also result in more access being granted than originally intended. Testing could not be performed to verify these potential risks. There are 110 roles providing access to resources residing on agency owned and administered servers. This represents 25.7 percent of the roles maintained by the portal which are not monitored by the Office of Information Technology.

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PUBLIC SAFETY ISSUES

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Dam Inspections

One of the primary duties of Natural Resources Engineering is to monitor dam inspections required by the Dam Safety Standards, N.J.A.C. 7:20. The Bureau of Dam Safety and Flood Control (bureau) has identified 1,724 dams that are classified into various categories.

Dam Classification	Inspection Cycle	Number of Dams
High Hazard-Large	1 year	33
High Hazard	2 years	182
Significant Hazard	2 years	345
Subtotal		**560**
Low Hazard	4 years	1164
Total		**1724**

Based on classification the owner is required to have a periodic inspection performed by a licensed New Jersey professional engineer. Our prior audit noted 48 percent of the high and significant hazard dams were past due on their inspections. We noted improvement in this area as 32 percent of the high and significant hazard dams were past due on their inspections. Seventy-four of these dams were more than one year past due on their inspection. These dams are required to be inspected at least every two years. The absence of timely inspections prevents the bureau from assessing the extent of damaged dams in the state. These inspections would note problems that dam owners may need to address to prevent issues from arising which could pose a risk to property and public safety. The bureau can and has issued administrative orders in order to encourage dam owners to comply with the inspection requirements; however, there does not appear to be a definitive procedure to determine which dam owners will be issued these orders. The bureau has informed us that future procedures will include the use of a notice of violation and offer of settlement (NVOS). The NVOS will require the noncompliant dam owner to submit an inspection report within 60 days of receipt. If the owner fails to comply with the NVOS, the bureau will have the authority to initiate further action against the owner, and as a last resort, the issue will be forwarded to the Office of the Attorney General for resolution.

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Fire Safety Code Violations

The New Jersey Division of Fire Safety, Bureau of Fire Code Enforcement in the Department of Community Affairs is responsible for compliance with the New Jersey Uniform Fire Safety Act in all state buildings. The Department of Military and Veterans' Affairs (department) administrative building has several code violations. Per the Notice of Violations and Order to Correct dated October 28, 2008, the department was cited for three violations of the code. Two items were previously reported in May 2005 and one was reported in August 2006.

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Criminal History Background Checks

Governing legislation has given the responsibility for criminal history background checks for individuals in the health care industry to the Department of Health and Senior Services (DHSS) and the Department of Law and Public Safety, Division of Consumer Affairs (DCA). N.J.A.C. 8:43I requires that all prospective individuals seeking certification in a long term care facility as a nurse's aide, personal care assistant and/or certified assisted living administrator submit to a criminal history background check as a condition of certification through the DHSS. The Health Care Professional Responsibility and Reporting Enhancement Act requires that a criminal history background check be undertaken for all health care professionals licensed or certified by the Division of Consumer Affairs. Examples of the professionals licensed/certified by DCA are doctors, nurses, home health aides, pharmacists, and physical therapists. Other individuals having direct one-on-one contact with patients provide companionship, housekeeping, meal preparation, shopping, laundry, and transportation services.

Both oversight organizations require applicants to submit to fingerprints at the state-authorized vendor for fingerprint screening. This process determines whether the individual has a disqualifying criminal history on the Federal Bureau of Investigation, Identification Division or the State Bureau of Identification database at the Division of State Police. The comprehensive criminal history background check transcends state lines and jurisdictions and provides current updates of criminal activity. This process is also used for all employees at State facilities within the Department of Human Services.

DHSS and DCA maintain records of those individuals that have completed the criminal history background check and are licensed, certified, or disqualified. DHSS also maintains a record of those individuals in the health care industry accused of abuse, neglect, or misappropriation of nursing home resident property. In addition, both organizations maintain records on the licensed health care industries overseen by their particular organization.

Our field visits to three health care facilities overseen by DHSS noted that there are individuals employed at facilities who have direct one-on-one contact with patients, who are not required by legislation to have criminal history background checks. It is the responsibility of the management of the facility to determine if a background check is to be done for these individuals, the type of background check to be performed, and whether or not they decide to hire the individual based on the results of the background check. Our review noted that the background checks for these employees are not as comprehensive as those required for licensing/certification from DHSS. Typically these background checks are not done by fingerprint screening, do not provide current updates of criminal activity, and do not always transcend state lines or current jurisdictions. One facility only had a background check performed by name, social security number, and date of birth in the county the prospective employee resided.

We also noted that individuals disqualified by DHSS or DCA for specific licensed or certified positions that require background checks are working at facilities in another capacity. Our field visits disclosed that four employees who can have direct one-on-one

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contact with patients were on the DHSS disqualified database and one additional employee who also can have direct one-on-one contact with patients was on the Abuse, Neglect, and Misappropriation of Nursing Home Resident Property database.

Our field visit to one health care service firm licensed by DCA noted criminal history background checks are not as comprehensive as the background checks done for those employees licensed/certified by DCA, nor do they provide current updates of criminal activity. Our review noted one individual who had a clean background check based on the firm's review, but this individual had a criminal record per the DHSS database. Seven employees at this firm were on the DHSS disqualified database. In addition, our review noted that the employees of the firm perform functions of a DCA certified health care position yet employees were not certified because they were classified by the firm in a different title thus circumventing the comprehensive background checks performed by DCA. A review of one county's website noted 5 of 47 health care service firms listed were not on the DCA license list.

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Security

Our review of human resources noted two of seven employees sampled did not return their identification badges and red alert cards upon separation. The New Jersey Office of Homeland Security and Preparedness (OHSP) has a checklist that instructs individuals conducting an exit interview as to what items need to be obtained from the departing employee such as identification badges and office assigned equipment. Although the checklist was present in each folder sampled, it was not always complete. A letter was sent in November 2008 to one of the separated employees requesting confirmation of non-possession of the OHSP identification badge; the red alert card was not addressed. This individual confirmed non-possession of the identification badge. As a result of our audit work, letters were sent to two additional separated individuals requesting the return of their identification badges and red alert cards. One of the individuals signed and returned the letter stating they were not in possession of the identification badge or red alert card, and the other individual responded and returned them by mail. Subsequently, one of the two missing identification badges and red alert cards was located by OHSP personnel. The identification badge, which is separate from an OHSP building access card, may allow an individual to gain inappropriate access to buildings, information, and individuals. The red alert card in conjunction with the identification badge will permit an individual access to a roadway in a red threat level declaration. Access cards to the OHSP buildings were electronically terminated within 14 days of separation. Identification badges and red alert cards need to be returned and destroyed.

In addition, OHSP employees are assigned computers. Our review of data security noted their computers are password protected. A higher level of protection such as encryption software is not utilized by the OHSP. There is an unwritten policy that all information must be saved to the shared network drive. Any information saved to a hard drive would be vulnerable when the computer is unattended, lost, or stolen. In the past, laptop computers have been stolen and all the information stored on the hard drive was lost. Encryption software would provide needed security over the sensitive information handled and retained by the OHSP.

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OTHER ISSUES

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Cost Savings

Ewing, Woodbridge, and Vineland Residential Treatment Centers are state-operated facilities. Their staffs are responsible for the care of approximately 90 adolescents with intensive behavioral health needs. The adolescents are placed in the centers on both an emergency and planned basis. The average stay is 105 days.

To address the safety and welfare of the residents and staff, while providing for the needs of specific youths, the centers provide one-on-one supervision of some residents. While staff overtime can be used for this purpose, additional staffing is sometimes required. Currently, the Division of Youth and Family Services (DYFS) has contracted with a private agency to provide the one-on-one services. However, management indicates these contracted individuals do not receive the same training as the DYFS staff and are not allowed to resolve conflicts when the residents become aggressive. Additionally, they are not subject to criminal background checks, and therefore, cannot be left alone with the residents. Furthermore, the same contracted individuals are not consistently assigned to the residential centers and, consequently, the individuals may lack the proper knowledge necessary for the one-on-one supervision. The contracted hourly rate for the vendor's services is $20.86.

As an alternative to address these issues, DYFS has proposed to eliminate the contracted workers and use the state's Temporary Employment Services (TES) at a total cost rate of $16.28 per hour including employee benefit costs. A TES is a temporary state employee that can be trained and held accountable in the same manner as a permanent DYFS employee. Each TES could work up to 944 hours per year (approximately 18 hours per week). The temporary employees would perform the basic duties of the more experienced permanent youth workers who could then perform the more demanding one-on-one supervision previously assigned to the independent contractor. Discontinuing the use of contracted workers and replacing their hours with temporary employees at the residential centers could save the division approximately $65,000 annually.

The temporary employees could also be used to decrease the amount of overtime charged by the full-time youth workers at the centers. During fiscal year 2008 the youth workers, not including supervisors, charged 36,000 hours of overtime at a cost of $1 million. If temporary employees were used for those hours, annual cost savings could be $495,000. It is management's responsibility to decrease costs when possible without compromising the care of the residents. This can be done by hiring, training, and utilizing the services of temporary employees.

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Food Waste Disposal

During fiscal year 2007 Edna Mahan Correctional Facility for Women prepared 1.3 million meals for inmates and staff and an additional 2.6 million meals for three other institutions. Our prior audit reported that the facility disposed a significant amount of food waste daily and that only 30 percent of meal serving logs, used to adjust the daily meal production so as not to overproduce meals, were completed. We recommended that the facility improve their record keeping on the meal serving logs and use them to reduce the meal production to an acceptable level. The facility did not follow our recommendation. Meal logs were not completed for about a year.

Food waste generated from meals was disposed by a contract vendor at a cost of $21,500 in fiscal year 2007 and $22,000 in 2008. We reviewed 23 months of vendor invoices. The vendor picks up an average of 22 tons of food waste monthly, down from 77 tons in 2001 when we conducted our last audit. The decrease in food waste hauled away was partly due to the facility purchasing and utilizing two insinkerators at a cost of $11,000 each. An insinkerator is a garbage disposal grinder. Liquid and solid food waste is placed into the food waste disposer, where it is ground and then, according to the manufacturer, reduced by up to 85 percent of its original volume. We observed performance of one working insinkerator and it seemed to process food waste quite efficiently.

Department of Corrections and other state agencies have been using farmers for food waste disposal for over 20 years. Originally the state sold the food waste to the farmers for profit. Gradually however, fees were eliminated and food waste was donated to the farmers at no charge. Eventually farmers started charging their own hauling fees. In 1997 the Department of Corrections made a request to the Department of the Treasury, Purchase Bureau for a term contract due to the extreme increase in the farmer's fees. The contract expired on May 31, 2008. Purchase Bureau management made the decision not to extend or rebid the contract making agencies responsible for determining the most efficient way to dispose of food waste. Justification for the decision included escalating costs, limited competition, and lack of reporting and oversight. Also, the decision was made whereby the state would not pay for a vendor to remove edible plate waste since it was benefiting the vendor by providing food for their hog farms. Despite the Purchase Bureau's decision, agencies are still paying the farmers for waste removal using a Direct Purchase Authority (DPA). During fiscal year 2006 through 2008, the Department of Corrections and eight other state facilities have spent over one million dollars disposing of food waste with farmers.

According to a second quarter 2008 article in Choices, a publication of the American Agriculture Economics Association, "Feed is the largest single cost item for livestock production, accounting for 60 - 70 % of the total cost in most years. Although energy, labor, and other inputs have increased, feed cost have increased anywhere from 40 - 60 %... in the last two years... rising costs have largely been absorbed by livestock and poultry producers, often with significant financial loss." Although recycling food waste may be an environmentally sound cause, state facilities should not pay farmers over $400,000 annually

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for the disposal. The rise in commercial feed prices should serve as an incentive for farmers to accept free food waste donations at no or minimal cost to the state.

We asked the Pennsylvania Department of Corrections about food waste disposal at its institutions. We were informed that some facilities use composting while others use pulping machines and insinkerators and then dispose of the processed waste with the regular garbage. A number of facilities also use pig farmers; however they are moving away from this method due to its increasing cost.

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Payroll – Shift Overlap

Shift overlap is required to assure proper post coverage and a smooth transition of duties necessary to maintain security during shift changes. Shift overlap was completely eliminated in 2001, but was reinstated in the beginning of fiscal year 2007 at 15 minute increments to improve the safety of staff and inmates. It was reduced to 10 minute increments in the beginning of fiscal year 2009. Shift overlap costs the prison approximately $500,000 annually in overtime for each 5 minute increment.

It is management's responsibility to implement cost effective procedures to reduce and control overtime. During our analyses of shift overlap we noticed two alternative methods in which shift overlap costs could be significantly reduced.

- First, as recommended in our prior audit reports, the shift start and end times could be adjusted so that all posts and shifts would overlap and overtime would only be incurred on the third shift, where staffing levels are significantly lower when compared to the first and second shifts.

Shift	Start	End	Shift Length	Overtime Total	Average Posts
1st	6:00 AM	2:00 PM	8 hrs	0	224
2nd	1:50 PM	9:50 PM	8 hrs	0	176
3rd	9:40 PM	6:10 AM	8:30 hrs	30 minutes	75

This schedule change would have no effect on security or staff communication. This alternate method of shift overlap scheduling would have saved $380,000 for calendar year 2007 in comparison to the current ten minute overlap practice.

- Second, shift overlap is only necessary for job posts which require relief for the next shift. During calendar year 2007 we determined that 74 overlap posts did not require an officer for the following shift. The majority of these posts fall within the second shift due to the decrease in officers required during the third (night) shift. If these unnecessary overlap posts were eliminated the New Jersey State Prison could have saved an estimated $230,000 in calendar year 2007.

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Collection Efforts

Uninsured Employers Fund

The Uninsured Employers Fund (UEF) provides temporary disability benefits and covers medical expenses for those injured while working for an employer who does not provide the required coverage and fails to provide those benefit payments awarded by the Division of Workers' Compensation. In addition to these individual cases, the Division of Special Compensation (division) periodically matches Department of Labor and Workforce Development files of registered employers against the Department of Banking and Insurance files of insured employers in order to identify those businesses without required workers' compensation insurance coverage. If proof of insurance coverage is not provided or obtained by the uninsured employers, cases proceed through the court system. Judgments are docketed and liens are filed against the uninsured employer. Although the division attempts to collect the docketed judgments, we found their efforts were not in compliance with state regulations.

A Department of the Treasury circular letter, which has recently been enacted into law, requires state agencies to use the Department of the Treasury, Division of Revenue in the recovery and resolution of non-tax debt if the agency is unable to collect the debt within 90 days. The Division of Special Compensation has not turned over any receivable records to the Division of Revenue. The UEF has an accounts receivable balance of $63 million as of July 2008. The amounts eventually collected are subject to negotiation and could be significantly reduced. Since 1979 the division has collected only $3.2 million from uninsured employers, including $1.8 million through a collection agency it used beginning in 1997.

Second Injury Fund

The Second Injury Fund (SIF) limits the liability of employers and their insurance carriers in cases where a worker with disabilities experiences further injury. Once the employee has been adjudicated to be permanently and totally disabled, the employer's payments would eventually cease and the SIF would continue such payments until the death of the beneficiary or gainful employment.

Although the division requires beneficiaries to submit an annual certification and performs cross-matches against death and wage files, benefit overpayments may still occur. We found that the division has not established satisfactory procedures to investigate these benefit overpayments and arrange for their immediate repayment. The division does initially notify the beneficiaries or their estates of the overpayments and makes attempts to recoup these funds. It is currently collecting on benefit overpayments of approximately $150,000 where the recipients have agreed to repay their debt on a periodic basis. When terms of repayment are not agreed upon, cases have been transferred to the Department of Law and Public Safety, Division of Law, but only if they exceed $2,000. In 2002, the division sent 78 cases of benefit overpayments to the Division of Law which totaled $606,000 and occurred from

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1981 through 2002. Only two of these cases totaling $7,700 were being collected by the Division of Law as of August 2008. The division recently forwarded another $524,000 in benefit overpayments from 2002 to July 2008 to the Division of Law but no action has been taken. Most of these SIF benefit overpayments totaling $1.3 million have not been brought to the attention of the Department of Law and Public Safety, Division of Criminal Justice or transferred to the Division of Revenue for collection.

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Opportunity for Cost Savings

Partial Return to Work Program

In New Jersey, claimants deemed eligible for temporary disability benefits receive full benefits up until the day they return to work. Our review disclosed another state uses a partial return to work program which transitions employees back into the workplace. This results in employers providing wages for hours worked in a given week, which reduces payments made by the disability program. According to a progress report prepared by the other state, $480,000 was paid to partial return to work program participants from September 1, 2006 to August 31, 2007. This is substantially less than the projected $1.2 million of payments had they collected the full amount of disability benefits during this time period.

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OFFICE OF LEGISLATIVE SERVICES
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SCHEDULE OF REPORTS ISSUED DURING CALENDAR YEAR 2009

	TYPES OF FINDINGS		
REPORT	**COMPLIANCE**	**CONTROLS**	**ECONOMY/ EFFICIENCY**
Borough of Woodbine School District		X	
Casino Control Fund		Opinion Report No Findings	
City of Camden School District	X	X	
Department of Children and Families			
Division of Youth and Family Services		X	X
Department of Corrections			
Edna Mahan Correctional Facility for Women	X	X	X
New Jersey State Prison	X	X	X
Department of Environmental Protection			
Natural Resource Management	X	X	X
Department of Health and Senior Services			
Division of Senior Benefits and Utilization Management			
Medical Services for the Aged, Nursing Homes		X	X
Department of Human Services			
Commission for the Blind and Visually Impaired	X	X	
Division of Developmental Disabilities			
Woodbine Developmental Center		X	X
Division of Medical Assistance and Health Services			
Fee-for-Service Payments for Managed Care Beneficiaries		X	X
Managed Care Contract, Vaccines for Children Program	X	X	X
Managed Care Program, Third Party Liability Medical Coverage			X
New Jersey Council on Developmental Disabilities	X	X	
Department of Labor and Workforce Development			
Division of Special Compensation and Departmental Payroll Expenditures	X	X	
Temporary Disability Benefit Payments	X	X	X
Department of Law and Public Safety			
Division of Consumer Affairs	X		
Department of Military and Veterans' Affairs		X	X
Department of the Treasury			
Division of Investment			X
Employment of Teachers' Pension and Annuity Fund Retirees	X		

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	TYPES OF FINDINGS		
REPORT	**COMPLIANCE**	**CONTROLS**	**ECONOMY/ EFFICIENCY**
Health Care – Background Checks		X	
New Jersey Commission on Science and Technology		X	
New Jersey Comprehensive Annual Financial Report		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	
New Jersey Office of Homeland Security and Preparedness	X	X	X
Office of Information Technology			
myNewJersey Portal		X	
Pinelands Commission		Opinion Report Single Audit Report No Findings	
Transportation Trust Fund Authority			
Appropriations			X