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

For the Calendar Year Ended December 31,



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**Richard L. Fair
State Auditor**

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New Jersey State Legislature

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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 2004. In conformance with our responsibilities to perform financial and compliance audits, all state agencies are audited periodically. During 2004, we issued 34 reports which identified \$101.4 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.

Richard L. Fair
State Auditor

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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 his 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.

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 1, 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 State Auditor also performs other similar or related duties as required of him by law.

The State Auditor shall personally or by any of his authorized assistants or by contract with independent public accounting firms, examine and post-audit all accounts, reports and statements and make independent verification of all assets, liabilities, revenues and expenditures of the state, its departments, institutions, boards, commissions, officers, and any and all other state agencies now in existence or subsequently created.

In addition, at the request of the Legislature 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.

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 2004 we identified \$101.4 million in new cost savings or revenue enhancements. The schedule of cost savings is presented on page 3. In addition, as required by state statute to report instances of malfeasance, misfeasance or nonfeasance, our audits resulted in three referrals being made to the Division of Criminal Justice for further investigation.

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF COST SAVINGS AND
REVENUE ENHANCEMENTS
REPORTS ISSUED DURING 2004**

<u>REPORT</u>	<u>COST SAVINGS/ REVENUE ENHANCEMENTS</u> (In Thousands)
Department of Environmental Protection	\$ 1,831
Natural Resource Management	
Department of Health and Senior Services	135
Division of Administration	
Office of Support Services to the Aged	
Pharmaceutical Assistance to the Aged and Disabled,	22,450
Senior Gold, Lifeline, and Hearing Aid Assistance	
Department of Human Services	
Division of Developmental Disabilities	127
Hunterdon Developmental Center	
Division of Family Development	15,745
Child Day Care Contract Administration	
Division of Medical Assistance and Health Services	
Health Benefits Coordinator Contract for Medicaid	43,786
Managed Care Programs	
Department of the Treasury	4,048
Bureau of Risk Management	
Division of Pensions and Benefits	6,882
Selected Pension Services	
Judiciary	
Administrative Office of the Courts	6,400
Probation Services Division	
Total Cost Savings and Revenue Enhancements	<u>\$ 101,404</u>

AUDIT REPORTS

TYPES OF AUDITS PERFORMED

Financial Audits

Financial audits are designed to provide reasonable assurance about whether the financial statements (or schedules) 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 197 funds and component units which had a total asset value of \$139 billion at June 30, 2004 based on full accrual accounting. Four other financial audits were issued in calendar year 2004.

Audits of Agencies

The objectives of this type audit are to determine whether financial transactions are related to an agency's programs, are reasonable, and are recorded properly in the accounting systems. 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 department-wide because of their size and complexity. We performed 26 of these audits in calendar year 2004. These audits encompassed \$13.5 billion and \$896.1 million of expenditures and revenues, respectively.

Information Technology Audits

The objectives of this type audit are to determine whether the financial data relating to a particular computer system are reliable, valid, safeguarded, and recorded properly. During calendar year 2004, we reported on the Department of Community Affairs, Information Technology Controls and the Department of Human Services, Information Systems Management.

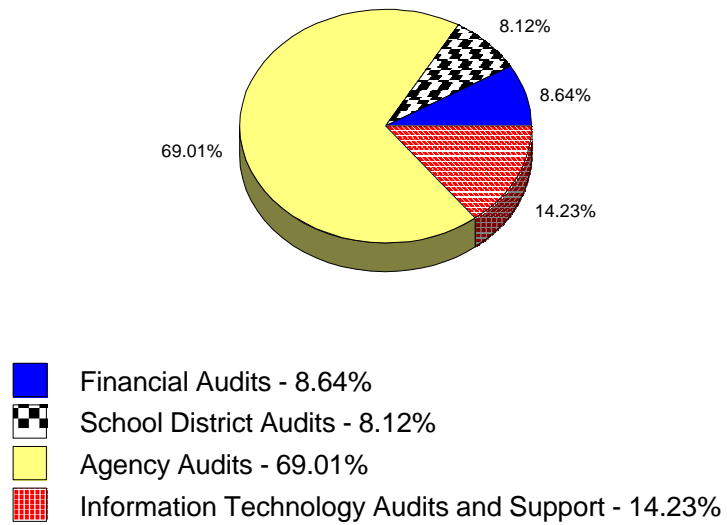
School District Audits

N.J.S.A. 18A:7F-6d authorizes the Office of the State Auditor to audit the accounts and financial transactions of any school district in which the state aid equals 80 percent or more of its net budget for the year. We audited the Plainfield Board of Education in calendar year 2004. This audit encompassed \$118.7 million and \$452,000 of expenditures and revenues, respectively.

AUDIT REPORTS

DISTRIBUTION OF AUDIT HOURS

The distribution of audit hours used in performing audits during calendar year 2004 is depicted on the following chart.



AUDIT REPORTS

HOW AND TO WHOM AUDIT REPORTS ARE ISSUED

The findings and recommendations in our reports are developed as a result of an independent objective audit and are intended to provide accountability to the legislature and recommendations for improvement of government operations. All reports issued are discussed with agency officials prior to finalizing the report. Modifications to the draft report are made if warranted. Agency 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 the report are routinely sent to:

- the chairs of the pertinent Senate and 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>

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 83 professionals and six support staff. All auditors must have a bachelors degree in accounting or a related field and a minimum of 24 credit hours in accounting. Forty-four staff members (53 percent of the professional staff) possess professional certifications or advanced degrees.

The office provides a minimum of 40 continuing professional education credits annually 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 of 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 eight active committees staffed by individuals in various titles to provide guidance in the areas of administration, communication, 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 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.

ORGANIZATION

ADMINISTRATIVE STAFF

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

**OFFICE OF THE STATE AUDITOR
STAFF ROSTER
As of December 31, 2004**

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Evelyn T. Richardson, Administrative Assistant

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ASSISTANT STATE AUDITOR

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Kurt Zadworney

ADMINISTRATIVE STAFF

Anthony Arena

Elizabeth H. Klingele

Camille E. Thomas-Day



ACCOMPLISHMENTS AND RESULTS

ACCOMPLISHMENTS AND RESULTS

Summary

This section highlights six of the more significant audits issued during the past year which individually contained cost savings/revenue enhancements greater than \$4 million and collectively totaled \$99.3 million. The Office also issued 3 reports with individual cost savings less than \$4 million totaling \$2.1 million. Our reports also contain findings addressing areas of noncompliance with laws or regulations, weaknesses in internal controls, and economies and efficiencies to improve operations, of which six of the more significant audits are included in this section. All reports issued in calendar year 2004 are identified on a schedule on pages 48 to 49 and are available for review on our internet website.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

Background

The Department of Human Services administers the Medicaid program which provides medical assistance to eligible low-income and disabled individuals. The department entered into a contract with a vendor for the period October 2000 to December 2004. The contract is part of the NJ Family Care Program which provides no cost or low-cost health insurance through managed care enrollment to uninsured parents and children with incomes up to 350 percent of the federal poverty level. Applicants become eligible for one of four NJ Family Care Plans identified as Plans A, B, C, and D dependent upon the family's income relative to the federal poverty level. The contract was expanded in January 2001 to include eligibility determinations and to provide education and enrollment services for the NJ Family Care program which evolved from the NJ Kid Care program. The vendor also inherited a large backlog of applications from the previous vendor. Currently, eligibility determinations for Plan A cases may be performed by either the county welfare agencies or by the vendor, while eligibility for Plans B, C, and D are determined by the vendor. Expenditures for Plan A are paid by Medicaid under Title XIX, while Plans B, C, and D are paid under Title XXI of the Social Security Act.

The following chart presents the income guidelines for program eligibility for the NJ Family Care program as of March 2003 and the number of beneficiaries enrolled in the program by the vendor. The federal poverty level for a family of four was \$5,367 in 2004.

Maximum Annual/Monthly Income	Premiums	Copayments	Total Participants
Plan A 133% Poverty Level	No Premium	No Copay	51,609
Plan B 134 - 150% Poverty Level	No Premium	No Copay	11,186
Plan C 151 - 200% Poverty Level	\$16.50 monthly per family	\$5 - \$35	33,834
Plan D 201 - 350% Poverty Level	\$33 - \$110 monthly per family	\$5 - \$35	55,320

Conclusions

We found the payments to the vendor were reasonable, were related to the department's programs, were in accordance with the contract, and were recorded properly in the accounting system. However, we identified several noncompliance issues with contractual performance terms because the division was prevented from administering and monitoring the contract properly. In making these determinations, we noted certain internal control weaknesses, matters of compliance with laws and regulations, and opportunities for cost savings meriting management's attention.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

It was the vendor's contractual obligation to administer and manage the programs under its control. Processing applications, processing missing information on pending applications, and reviewing renewals for benefits in a timely and accurate manner were essential requirements of the contract. The vendor's noncompliance with contractual obligations for processing applications timely jeopardized the state's efforts to provide medical benefits for a needy population. Moreover, the vendor's failure to process renewals or terminate benefits timely resulted in additional costs to the state because ineligible beneficiaries continued to receive benefits long after their eligibility should have been suspended. We also found numerous instances where program eligibility was not properly determined, the enrolled plan was incorrect, files were incomplete, premiums were not billed, and refunds were not processed timely. We found in general that vendor employees did not have the knowledge and experience required by the contract. This factor plus vendor work flow requirements may have had a negative impact on vendor performance.

An important aspect of eligibility and managed care plan designation is income determination and verification. Our tests and a division review disclosed error rates over 30 percent which impacts the propriety of the monthly capitation costs paid to managed care providers. A portion of these high error rates are due to the vendor's limited access to databases which would enable one to perform a thorough verification of income disclosed on the application. The state's county welfare agencies (CWAs), who in fact process a portion of the Plan A enrollments, have access to several additional databases. Whether the vendor or CWAs process enrollments, the division must establish procedures and monitor performance to ensure the integrity of the program.

In 2002, the department filed six complaints with the Department of the Treasury, Bureau of Contract Compliance against the vendor for unsatisfactory performance and not meeting contractual commitments. We found that the conditions that initiated the complaints are still in existence, there hasn't been any follow up on corrective action plans, and no subsequent complaints were filed until after our audit.

The department lacks enforcement ability because, although the department withheld payments from the vendor for disputable billings that had been submitted, in October 2003 a settlement agreement was negotiated which ultimately resulted in limiting the vendor's liability for damages that the state could recover. By limiting the vendor's liability and accountability, there was little incentive for the vendor to take corrective actions or be held responsible for their noncompliance.

The department should immediately address the issues and weaknesses identified in this report. A new vendor will be in place beginning in January 2005 and to ensure the continuity of the program, will be transitioning with the current vendor until July 2005. If the existing problems are not corrected, the state and the new vendor will be starting out with the same problems that have plagued the current contract since its inception. More timely monitoring of contractual compliance and performance may help to minimize or eliminate the negative results experienced during the current contract.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

An additional consideration for the division is to remove eligibility determinations of Plan A cases from the vendor's contract and place the responsibility with the CWAs. The NJ Family Care Program eligibility criteria is extremely complex and requires an in-depth knowledge of Medicaid regulations for determining individuals into the appropriate benefits plans. There are 22 eligibility levels within the four plans. The CWAs are recognized as having an expertise in processing Medicaid eligibility. They have access to child support information and other databases which can be used to verify applicants' income. Additional potential benefits could include the following.

- Annual cost savings could be realized if the department removed the eligibility processing segment of Plan A cases from the vendor and place responsibility back with CWAs. The current 52,000 Plan A cases could be absorbed by the 21 counties, resulting in savings of up to \$1.6 million annually. This savings may be offset by some additional costs to the counties.
- The CWA case workers follow a case through the entire eligibility and redetermination process from receiving the application to its final determination. This process ensures accountability for each case and provides beneficiaries with direct access to the county worker for any inquiries regarding the case status. The current vendor's process did not include this level of accountability. Various employees could work on an individual case.

In addition, to improve the accuracy of eligibility determinations, we recommended the division increase its monitoring efforts over Plans B, C, and D. We also recommended the division require submission of federal tax returns for all applicants. Currently, this requirement applies only to self-employed applicants. Furthermore, we recommended the division match child support information with vendor files. These procedures would ensure the vendor's eligibility determinations are within acceptable levels as prescribed by federal requirements.

Additional details of performance deficiencies and other control weaknesses are presented in the following sections.

Eligibility and Application Processing

We found significant error rates in the determination of eligibility and accuracy of plan designations. We also found deficiencies in the timely processing of applications and follow up of missing or new information.

- We identified 8,900 beneficiaries with invalid social security numbers (SSNs) processed by the vendor. Federal social security regulations require, as a condition of eligibility for benefits under any program, that the beneficiary furnish their SSN. The department has stated that this practice of filling in improper social security numbers on the Medicaid eligibility file applies to newborns. Our review noted that approximately 7,600 of the 8,900 beneficiaries were over the age of one. The department should implement and enforce regulations to ensure that time limits are placed on securing proper SSNs. Additionally, income verification can not be effectively performed without proper SSNs.
- We randomly selected 193 cases processed by the vendor to test the propriety of eligibility

DEPARTMENT OF HUMAN SERVICES
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HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

determinations. Of the beneficiary files inspected, 43 percent did not contain the necessary supporting documentation to process the case. Supporting documentation includes proof of social security number, birth certificates or other documentation to verify date of birth, and proof of United States citizenship. The lack of proper documentation can have a negative or detrimental impact on program integrity.

- Of the 193 beneficiaries tested, 31 percent were placed in the wrong plan and seven percent should have been determined ineligible. If these errors are projected over the entire population, 49,800 individuals could have been enrolled in the wrong health plan and 11,600 individuals in the program may be ineligible. Based on this projection, the division could be paying \$1.9 million monthly in capitation for ineligible beneficiaries. Our results were supported by the 66 percent accuracy rate found by the Division of Medical Assistance and Health Services (DMAHS), Bureau of Quality Control in an April 2003 review of eligibility determinations for Plans B, C, and D. The review encompassed the period July 2002 through December 2002. In that report, the vendor was cited for a variety of mistakes and processing problems. Federal standards require a 95 percent accuracy rate.
- The Bureau of Quality Control's review also indicated that the complaint process needs to be monitored more closely. The vendor errors and processing delays resulted in a high volume of complaints. "There was evidence in the case records and computer system that the applicants complained repeatedly about the mistakes, without resolution. In some cases, the parents stopped paying the disputed amounts and were justly terminated for non-payment of premium. Other parents appeared to have withdrawn their applications because the mistakes they contested went uncorrected." A referral unit was established by the department to address the numerous complaints that were received because they were not addressed by the vendor. Our review of complaint logs from October 2003 through June 2004 found that the division received, on average, 105 of these complaints a month from various sources including the governor's office and legislators.
- The contract requires initial applications be reviewed and processed within five business days of receipt. Renewal applications are required to be redetermined within 30 days. Our review of 45 applications during the contract period found that 51 percent were not processed within the specified times.
- As of July 15, 2004, there were 22,000 renewal cases in missing information status, of which 10,700 cases were more than 60 days old. If the application is incomplete, the contractor is required to notify the applicant. After 60 days, if the request is not satisfied, the applicant should be disenrolled. The vendor's failure to terminate enrollments which were no longer valid caused the state to overpay capitation costs by \$1.6 million per month.

Approvals for Plan A Cases

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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

The DMAHS maintains a staff of 11 employees at the vendor's facility. They are required to provide final approval on the completion of all Plan A applications pursuant to federal regulations under Title XIX. Although all Plan A cases are forwarded to this state unit for final approval, the cases were initialed and returned to the vendor's employees for uploading to the state eligibility file. This process allows vendor employees to bypass the state's approvals. This weakness was exploited and resulted in a fraud in 2001 when several vendor employees inappropriately enrolled themselves into the NJ Family Care Program by creating fictitious applications. The division's investigation resulted in six employees being indicted and one convicted. This control weakness has not been corrected by the division.

Vendor's Data System

Weaknesses in the vendor's system have had a significant effect on the vendor's overall performance in meeting contractual obligations and are underlying reasons for other audit issues found in our review. The vendor's computer software system was developed in the 1970s as the means of processing beneficiaries' eligibility and managed care information. Our review noted the following.

- The vendor's system interfaces daily with the state's Medicaid eligibility file and uploads any changes to beneficiaries' eligibility segments. The vendor's system and the state's Medicaid eligibility file are not in agreement. Although the vendor performs weekly reconciliations to reconcile the two systems, there were 700 cases with differences. Most of the discrepancies involved plan codes which are essential in ensuring that beneficiaries are charged proper premiums and co-payments.
- Navigating the vendor's system for case information is cumbersome and often has conflicting information regarding beneficiaries' current eligibility status. Our review noted that calls were made by beneficiaries indicating changes in their current eligibility. These changes were logged on the system "action/call history" screen; however, the changes were never made to the eligibility screens. Two examples follow.

A beneficiary was determined eligible for the program in April 2001, two years after the date of death (February 1999). Several phone calls were made to the vendor regarding the beneficiary's death. The call history screens documented the telephone calls; however, no action was taken to terminate the individual's eligibility. Eligibility for the deceased continued until it was finally terminated on June 30, 2004. The state paid \$9,000 to the HMOs for health coverage for this deceased individual.

The vendor continued program eligibility for beneficiaries after mail was returned showing an out of state address or documentation of telephone calls indicating a new residence outside the state. The vendor did not terminate eligibility, causing the state to pay excess capitations of up to \$7,900.

- Historically, the division has not been able to verify the information on the vendor's computer

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS

system. The division had to rely on the vendor to supply accurate and timely managerial reports, limiting the division's ability to monitor program information. The division requested a diagnostic report in April 2004, identifying cases where parents might still be in the program after their children were no longer enrolled. These beneficiaries would no longer be eligible. There were 334 participants who were not terminated until three months later, resulting in the overpayments of capitation totaling \$162,000. The division assumed that the vendor terminated these individuals when they were first reported.

Premium Assessments / Refunds

Our review disclosed that the vendor is not in compliance with the contractual requirements for premium collections, and they did not refund premiums on a timely basis.

- There were 1,900 beneficiaries enrolled in the program who did not pay the required premium. We examined 125 of these cases and found that 49 percent of the beneficiaries did not remit premiums because the vendor never sent a letter indicating that payment was required. Additionally, 46 percent of the beneficiaries were notified of the required premium, but never remitted a payment. These beneficiaries were not disenrolled as required by procedure. The appropriate plan designation could not be ascertained for the remaining cases tested.

In one example, a family's eligibility became effective November 1, 2001. According to the vendor's computer system, the eligibility for this household should have never been made effective because the family never made a premium payment and they also never renewed their eligibility. The state paid capitation of \$6,700 for this family of four in error from November 2001 to September 2003.

- NJ Family Care beneficiaries, who by nature of their program participation often possess limited incomes, are entitled to have refunds processed within a reasonable period of time as intended by state regulations. Our test of 90 refunds processed during calendar year 2003 found that 90 percent of refund checks were not processed within 15 business days as specified by the contract. The average time between the termination date and the refund processing date was 286 days. The delays in processing could be attributed to the vendor's computer system lacking the capability to refund beneficiary premiums causing the vendor to manually input the refund information onto a retail accounting software. This increases the possibility of human error and duplicate work.
- The vendor's finance department initiated, processed, and mailed all of the refunds. This lack of segregation of duties increases the possibility of fraud, although our testing did not identify such fraud.

Qualifications of Vendor Employees

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
HEALTH BENEFITS COORDINATOR CONTRACT FOR MEDICAID MANAGED CARE PROGRAMS**

It is recognized that NJ Family Care is a complex program. The contract required a minimum level of experience and education for certain positions, in particular Eligibility Specialists and Health Benefit Coordinators. We reviewed personnel files for 30 employees in those titles as of June 2004 and found 80 percent lacked the required educational experience or the required experience in health care, social services, health maintenance organizations, and customer service.

DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF SUPPORT SERVICES TO THE AGED
PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED, SENIOR GOLD, LIFELINE,
AND HEARING AID ASSISTANCE

Accounts Receivable

As of March 9, 2004, a total of 7,444 beneficiaries owed \$15.8 million for benefits incorrectly paid on their behalf. This represents a dramatic increase from the prior audit in both dollars and number of beneficiaries as illustrated by the table below.

	As of <u>June 30, 1996</u>	As of <u>March 9, 2004</u>	Percentage <u>Increase</u>
Number of Beneficiaries	3,770	7,444	97.45%
Accounts Receivable	\$4,601,213	\$15,841,833	244.30%

Estimated current year income rather than actual income from the preceding year is used in determining eligibility. Other states with similar drug programs, such as New York and Pennsylvania, determine eligibility for their prescription drug programs based on the applicant's previous calendar year actual income. A policy utilizing actual income would significantly reduce the amount of receivables. For example, Pennsylvania, whose program costs totaled \$440 million, has a receivable balance of less than \$1 million.

Redetermination of beneficiaries' eligibility is usually conducted every one or two years when the beneficiary reapplies. During the redetermination process, the prior year's reported estimated income is compared with actual earnings from the Department of the Treasury, Division of Taxation files. If the actual income exceeds the eligibility income limits, the beneficiary is liable for repayment of benefits paid on their behalf from the beginning of their eligibility period.

If a beneficiary does not reapply, a redetermination is not performed and estimated and actual income is not compared. At our request, a match as of February 19, 2004 was performed by Pharmaceutical Assistance to the Aged and Disabled (PAAD) personnel and it was determined that 3,000 beneficiaries had not reapplied and had exceeded the income eligibility limits. During fiscal year 2003, PAAD paid \$3.6 million of prescription benefits for these individuals. Payments of this type are not included in the accounts receivable and the Office of Support Services to the Aged (Office) makes no effort to recover these benefits.

The Office collected \$3.5 million during fiscal year 2003 and has averaged \$3.3 million in collections over the past five years. Beneficiaries who received benefits incorrectly are asked to sign a monthly payment agreement. The Office allows beneficiaries to participate in the programs if they meet their eligibility requirements and continue to make their agreed upon monthly payments. Beneficiaries not making payments are referred to the state's Set Off of Individual Liability (SOIL) program and are not permitted to participate in the programs.

The Office receives payments from 6,300 beneficiaries. It is the Office's practice to accept a minimum payment of \$10 per month to avoid causing undue financial hardship on program participants. However, we noted 37 beneficiaries who were paying less than \$10 per month. Monthly

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payment agreements averaged \$30 for an average repayment period of 14 years. The following schedule summarizes the billing and payment information for the three beneficiaries with the longest repayment periods. These beneficiaries were billed \$80,000 and have repaid only \$724 as of March 17, 2004.

Beneficiary	#1	#2	#3	Totals
Benefit Period	1/1/99 - 12/31/99	1/1/00 - 12/31/00	1/1/98 - 8/27/99	
Monthly Payment Amount	\$1.00	\$5.00	\$10.00	
Total Repayment Period	1,311 Years	362 Years	354 Years	
Initial Amount Billed	\$15,732.88	\$21,742.43	\$42,473.76	\$79,949.07
Total Payments Received	39.00	125.00	560.00	724.00
Balance Due	\$15,693.88	\$21,617.43	\$41,913.76	\$79,225.07

The Office does not base its determination of the monthly payment amount on the income or assets of the beneficiary. We noted one beneficiary who was determined to be ineligible for having income of \$128,000 and who agreed to repay \$3,100 over the next 13 years at \$20 per month. This repayment period is very generous considering the beneficiary's income.

The Office has declared \$2.4 million as uncollectible during the last five years. These amounts are not included in the accounts receivable balance. The Office's collection policy does not use liens as a recovery method for delinquent accounts although it is legally permitted to use them. A lien is a legal claim that one person has on the property of another as security for debt. Liens would be an additional recovery tool, and if used, might lead to the recovery of otherwise uncollectible debt.

Dual Eligibility

The current system used to process prescriptions does not recognize beneficiaries with both PAAD and Medicaid eligibility. In these cases, Medicaid should pay for these prescriptions. At our request, a match was performed by the Office personnel which identified 3,000 individuals with dual eligibility.

Because of this system limitation, Medicaid has a process which identifies and converts over \$4 million in PAAD claims annually to Medicaid claims of which the state receives approximately \$1.75 million in federal reimbursements. Medicaid also pays \$200,000 annually to a vendor to assist them in this process.

Discount Rate

During fiscal year 2003, payments to pharmacies for prescription drugs were based on the average wholesale price less a ten percent discount. This discount rate increased to 12.5 percent effective July 1, 2003. However, the Office did not adjust claims paid to reflect the greater discount until July 8, 2003. As a result of this one week delay in re-programing the drug payment system, the Office incurred costs of \$250,000 unnecessarily.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF FAMILY DEVELOPMENT
CHILD DAY CARE CONTRACT ADMINISTRATION

Background

The division administers approximately 460 child day care contracts, which include Unified Child Care Agencies (UCCA), Center Based Care (CBC) providers, and Abbott school district providers. The UCCAs are contract providers who serve recipient clients with counseling and referral services for their child day care needs. The CBCs are direct contract child care centers who provide day care services. The division also contracts with day care providers who are located in the Abbott school districts.

Unified Child Care Agency Contract Monitoring

The division contracts with UCCAs to administer the child care programs in each of the 21 counties. During our audit period, the division expended \$466 million for these contracts. Our review of the division's closeout process for these contracts disclosed the following.

- In accordance with the contract terms, final UCCA expenditure reports are due 120 days following the end of the contract period. The final reports for the contracts ending September 30, 2002 were due January 31, 2003. Eighteen of the 21 UCCAs had not submitted their final expenditure reports as of the due date and as a result, the closeout process was delayed.
- The Unified Child Care Service Delivery System - Fiscal Manual states contract closeout should occur as promptly as is feasible after the end of the contract period. The 1998, 1999, 2000, and 2001 UCCA contracts were not closed out until April 2003 and resulted in the division requesting \$11.8 million in net overpayments from 13 UCCAs in April 2003. The division had collected \$998,000 as of August 22, 2003.
- UCCAs receive equal quarterly advances. The division does not adjust the final quarterly payment based on actual expenditure for the first three quarters and projected fourth quarter expenditures. Such action could avoid overpayments.

Emergency Payments

The division makes payments to CBC providers for emergency repairs or purchases. During our audit period, the division made 14 emergency payments totaling \$148,000 to 11 centers. The division has no formal written procedures concerning the review, approval, and monitoring of these payments. Our review of emergency payments disclosed:

- The division does not verify that all emergency funds requested were spent. As a result, three centers were able to underspend \$6,000 of their requested funds without returning the unused funds to the division.

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF FAMILY DEVELOPMENT
CHILD DAY CARE CONTRACT ADMINISTRATION**

- The division does not verify the urgency of the request. As a result, emergency expenditures totaling \$29,300 were incurred by five centers from three to nine months following the division's payment. We further noted two emergencies totaling \$4,300 were not completely addressed nine months after the receipt of the division's funds.
- Due to an oversight by the division, a provider received \$22,750 for an emergency, even though the request was only for \$2,561. The provider did not return the \$20,189 overpayment. The division was unaware of the overpayment until it was disclosed by the audit and the division subsequently recovered the overpayment.

Waiver of Overpayments

At the conclusion of the annual contract period, Center Based Care (CBC) providers are required to submit their final level of service reports. These final level of service reports serve as the basis for determining whether the providers earned the monies received during the contract period. The provider is required to refund any unearned payment should their level of service drop below 80 percent.

The following table is based on a reconstruction of the division's records as of the close of our field work.

Contract Year	Total Overpayment	Amount Recovered	Amount Unrecovered/ Waived
1999	\$ 1,288,000	\$ 558,000	\$ 730,000
2000	2,995,000	1,681,000	1,314,000
2001	2,994,000	1,119,000	1,875,000
Totals	\$ 7,277,000	\$ 3,358,000	\$ 3,919,000

Amounts owed can be completely or partially waived by the Contract Administration Unit. The authority to approve waivers rests with one individual without further review. The division does not have written procedures authorizing the processing and/or approval of waivers. In addition, the division does not have adequate accounting records and reports that would enable management to monitor the waivers authorized and the reasons supporting the waivers. As a result, we could not identify how much of the \$3.9 million has been waived.

DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
SELECTED PENSION SERVICES

Multiple Employer Pension Calculation

An employee is considered to be a multiple member if they are employed and reported to the retirement system by more than one participating employer. In calculating a retiree's pension for Public Employees' Retirement System (PERS), the plan utilizes years of service and salary amount. For most members, the formula to calculate the maximum annual pension is years of service divided by 55 multiplied by the average salary for the three highest years. For multiple members, all base salaries earned in a given year are combined and total years of service is used in calculating the pension. The utilization of combined salary amounts in the calculation is reasonable; however, applying total years of service to each salary component may lead to disproportionate pension benefits.

As an example, if a PERS employee was to complete 33 years of service with a final average salary of \$70,000, they would receive an annual pension of \$42,000. If during their last three years they were also employed in a PERS part-time position earning an additional \$10,000 per year, they would receive an annual pension of \$48,000. The part-time position at \$10,000 per year for three years would therefore result in an annual pension increase of \$6,000. If the part-time position was separately calculated based on the three years of service, it would yield a pension benefit of \$545 annually or \$5,455 less than the current methodology. Any provision to modify current practice would require legislative change.

For calendar year 2002, we determined that there were 1,414 PERS retirees whose pension calculations had included salaries earned from more than one employer. We randomly selected 60 of these retirees and performed the alternate calculation which would apply actual years of service to the corresponding salary components. Our analysis projected that the alternate calculation would have resulted in savings of \$6.4 million per year. The fact that there were 4,600 active PERS employees with multiple employer status as of the end of calendar year 2002 enhances the potential savings in future years if the alternate methodology was established.

Retiree Deaths

When a member of a pension system dies, a family member or survivor usually notifies the division and provides information necessary to determine the status of pension contributions, availability of pension benefits, and calculation of group life insurance proceeds. In regards to retiree deaths, the division reviews reports generated by the Department of the Treasury, Office of Information Technology (OIT) which match pension benefit records against death files provided by the Department of Health and Senior Services, Bureau of Vital Statistics for deaths that occur within the state and by an outside vendor for out-of-state deaths. When a match occurs, the division performs additional follow-up. If the division is able to obtain a member's death certificate, pension benefits are terminated or paid to a surviving beneficiary in accordance with terms of their retirement agreement. If the division is unable to verify the death of the member by obtaining the death certificate, they send signature requests to be signed by the pension member and notarized. If not returned, a second request is sent out. If this request is not returned, pension benefits are suspended.

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We contacted the outside vendor being utilized by the division during our audit period and supplied them with the names and social security numbers of three state employees who we knew were deceased. They responded that all three former employees were not deceased. This condition creates a heightened risk of ineligible pension payments.

We reviewed the reports generated by OIT and judgmentally selected matches to see if the division was adequately investigating cases. Our review of 37 cases disclosed the following.

- We located a death certificate from the Bureau of Vital Statistics for one member who died in September 1989, but whose pension checks continued for almost 14 years. Signature requests mailed by the division contained inconsistent signatures and were notarized by an individual who appears to be the member's son. The pension checks appeared to be endorsed by the same individual. This case has been referred to the Division of Criminal Justice.
- Another member who died in March 1998 had pension checks issued for another five years. Although an initial signature request and final signature request in 1999 were not returned, the division did not suspend payments. Based on the member's address and potential date of death, we located their obituary in a March 1998 edition of a local newspaper. Further review at the Bureau of Vital Statistics found the member to be deceased per their system, although a death certificate would have to be obtained from Pennsylvania since the member died in that state. We could not trace endorsements on checks since this member used direct deposit. This case has been referred to the Division of Criminal Justice.
- We identified another member who died in May 1997 but whose pension checks are still being issued more than six years later. The division did have a signature request returned in January 1998 both signed and notarized. The pension checks were therefore not suspended. Based on the member's address and potential date of death, we located their obituary in a May 1997 edition of a local newspaper. Further review at the Bureau of Vital Statistics found the member to be deceased per their system, although a death certificate would have to be obtained from Pennsylvania since the member died in that state. We determined the member's pension check dated October 1, 2003 had been cashed. This case has been referred to the Division of Criminal Justice.
- We identified a member who died in June 2001 but whose pension checks were not suspended until May 2002, a period of 11 months. Another member died in April 2002 and pension checks were not suspended until October 2002, a period of six months. Both of these deaths were supported by New Jersey Certificates of Death. Based on our review of these cases, no follow-up efforts have been made to recover the overpayments.

The three cases referred to the Division of Criminal Justice have a potential overpayment of \$107,000. The results of our testing indicate that the division's procedures should be improved to reduce erroneous payments.

Disability Retirees - Annual Employment Earnings

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According to N.J.A.C. 17:2-6.14, all disability retirees shall be required to file a report which shall include copies of their Internal Revenue Service 1040 forms, W-2 forms, and other proofs of employment indicating their gross earned income realized as of December 31 of each year. When a PERS or Teachers' Pension and Annuity Fund (TPAF) disability retiree's earned income for a calendar year is greater than the difference between their pension income and the annual salary they would have received had they not become disabled, such excess must be refunded to the appropriate pension fund. We found that the division does not monitor the disability retirees' income earnings.

For calendar year 2002, we matched wage reporting records obtained from the Department of Labor against disability retiree pension records which were adjusted for annual cost-of-living increases. We noted 50 cases where the disability retirees should have refunded \$330,000 to the pension funds due to excess earnings. This analysis was based on retirees employed within New Jersey. Additional excess amounts could exist for retirees employed out-of-state.

Unpaid Loans

Prior to retirement, members of PERS, TPAF, Police and Firemen's Retirement System (PFRS), and State Police Retirement System (SPRS) who have at least three years of service in the applicable pension fund may borrow up to 50 percent of the employee share of pension contributions. Members who retire with an outstanding loan balance have the option of paying the loan in full prior to receiving any pension benefits or continuing their monthly loan payment schedule into retirement. If a retiree dies before the loan balance is repaid, the division obtains the remaining balance from group life insurance proceeds.

The division has implemented an outstanding loan balance automated interface in order to identify loans which must be deducted from the pension benefits of retirees. While there are still instances where input errors or timing may result in the interface not identifying an outstanding loan, a quarterly report is generated to accumulate financial information which includes loan balances. Our test of controls revealed that this report is not being properly utilized as a monitoring tool. Our judgmental sample of 40 loan balances found that four loans totaling \$45,000 were not being deducted from the retirees' pension payments. We determined that the Office of Information Technology (OIT) is able to sort the quarterly report's loan balances by dollar value. However, additional system information is needed to identify payment activity.

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ADMINISTRATIVE OFFICE OF THE COURTS
PROBATION SERVICES DIVISION

Collection of Probation Fines, Penalties, and Restitution

We determined that the division's statewide average monthly collection rate was only 27 percent of the amount owed for those probationers with established payment plans for the period of July 1, 2002 through November 30, 2003. The division collected \$3 million of the \$11 million expected monthly. This low collection rate means that restitution to victims, as well as fines and penalties due to state and local agencies, are not being met. In our analysis of the Comprehensive Automated Probation System (CAPS) database we determined there were 180,000 probationers as of November 30, 2003 whose court imposed debt totaled \$296 million, comprised of \$198 million in restitution to victims and \$98 million in fines and penalties due to state agencies, local governments, and community groups.

We have determined that there are multiple reasons for this low collection rate. Additionally, we recognize the fact that the collection rate could be impacted by the 18 percent of probationers in bench warrant status at November 30, 2003. Existing collection policies need to be improved and enforced statewide. In addition, because the Administrative Office of the Courts (AOC) doesn't obtain and maintain information such as a probationer's social security number, the division is precluded from utilizing specialized computer database matches to enhance their collections. Details of these conditions follow.

Probationers Without Payment Plans

Pursuant to N.J.S.A. 2C:46-1, "...the court may grant permission for the payment to be made within a specified period of time or in specified installments. If no such permission is embodied in the sentence... the assessment, fine, penalty, fee or restitution shall be payable forthwith, and the court shall file a copy of the judgment of conviction with the Clerk of the Superior Court who shall enter the following information upon the record of docketed judgments..." To facilitate and enforce collection efforts, scheduled monthly payment plans should be established by the courts at sentencing based on the probationer's ability to pay. All payment plans, including voluntary consent orders, must be approved by a judge in a court order to be enforceable. We found 28,500 probationers owing \$65 million did not have an established payment plan and 18,200 or 64 percent had not made a single payment as of November 30, 2003. Further analysis revealed that 10,700 of these clients were initially entered into CAPS after December 31, 2000.

Invalid Social Security Numbers

Although CAPS provides a data field for the collection of social security numbers (SSNs), there were 25,800 probationers with invalid SSNs listed in the system whose outstanding debt totaled \$37 million. During our field visits we were informed that the lack of valid social security numbers was attributable to juvenile cases which had been transferred over to probation for collection, a large population of illegal aliens, or older cases which were back loaded into CAPS.

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~~We found that 12,200 (47 percent) of the 25,800 active probationers with invalid SSNs were juveniles~~
at the time of their first offense. The Tax Reform Act of 1986 required SSNs for dependents starting in 1987. The AOC did not require the Family Court to provide valid SSNs at the time these cases were entered into CAPS. In addition, there is no consistent identifier for illegal aliens. Not capturing valid SSNs prevents the division from using the Department of the Treasury's Set Off of Individual Liability (SOIL) program to enhance collection efforts and deters the division from identifying probationers who have achieved steady employment.

Match of Probationers with the Department of Labor's Wage & Hour Database

Our analysis of the CAPS payment types revealed that the use of income withholding/garnishments has steadily decreased over the past three years. Currently, collections in this form are done strictly on a voluntary basis since the division has not mandated income withholding/garnishments, although they have the legal authority to impose them pursuant to N.J.S.A. 2C:46-1 and 46-2(1)(d). We performed a database match between CAPS and the Department of Labor's Wage and Hour database covering reported earnings for the first three quarters of calendar year 2003. Utilizing a three-point match on social security number, last name, and first name we isolated those probationers with payment plans and earnings equal to or greater than \$5,000 in a quarter (annual income \$20,000). We determined if any of these probationers were not satisfying their financial obligations per their payment plan. On average, we identified 5,000 probationers owing \$26 million as of November 30, 2003 who could have paid an additional \$1.6 million per quarter. Two thousand four hundred probationers made no payment and 600 of these probationers had quarterly earnings of \$10,000 or more (\$40,000 annually). Access to the Department of Labor's Wage and Hour database could help identify earnings and the utilization of a wage garnishment sanction could improve the collection rate.

Match Probationers with the State's Death Records

A comparison of the CAPS database to the Department of Health and Senior Services, Bureau of Vital Statistics death records for calendar years 1998 through 2002 was done to determine which cases should be written off as truly uncollectible and removed from the CAPS system. Since these databases were not fully compatible we were unable to identify three point matches (SSN, last name, and first name). Our matches for this test were broken down into two populations.

Death Record Matches	Number of Probationers	Outstanding Debt
Two Point Matches (SSN and Last Name)	916	\$1.3 million
One point Matches (SSN Only)	291	\$1.0 million

Generally, the division learns of a probationer's death from a family member or from the obituaries listed in the newspaper. The probation officer will contact the family, funeral home, or county health

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~~department to locate a death certificate in order to close out the case. There is no standardized~~
method for researching the death of a probationer such as checking the Social Security Ancestry Death Index.

Low Dollar Balances within CAPS

We found that there were 6,000 probationers with balances under \$25. We believe the division should write off these balances for those probationers who are no longer supervised, once they confirm that the probationer has no quarterly earnings in accordance with the Comprehensive Enforcement Program (CEP) legislation. If this balance includes restitution, the division should obtain permission from the victim(s) prior to writing these funds off.

An additional 20,000 probationers owing \$1 million had an outstanding balance between \$25 and \$100. For this population, the division should require those under active supervision to pay off this debt prior to the conclusion of their probation term. For those classified as “collection only”, the division could issue more aggressive collection letters such as notifying them that their driver’s license will be automatically suspended unless they make a payment within 30 days of the notice or scheduling special CEP hearings for these clients to promote the prompt collection of these low balance accounts.

Pretrial Intervention (PTI) and Conditional Discharge (CD)

Those eligible for PTI and CD are either first time offenders or perpetrators of relatively minor crimes. Participants are supervised by probation officers and the level of this supervision is dependent upon their crime. Participants’ cases are reviewed by the assignment judge every six months and enrollment in the program can be extended to a maximum term of three years. The PTI program represents Superior Court cases, while CD cases are municipal court cases which are supervised at the state level by the Probation Services Division. In both instances, the division is responsible for the collection of all fees, fines, restitution, and penalties imposed by the program.

If the client does not violate the conditions of PTI, their charges will be dismissed at the end of the term, even if the client has failed to pay off their financial obligations or even made a good faith effort to do so. Once the charges are dismissed, the division indicated that they have no legal authority to pursue collection efforts because clients are not required to sign a statement or consent order acknowledging their financial obligation as a condition of acceptance into the program. This acknowledgment would facilitate the filing of a civil judgment, thus protecting the financial interests of the victim(s) and the state.

We determined that there are 9,400 probationers owing \$21.2 million statewide that have a disposition type of either PTI or CD. Assuming that all the PTI and CD cases are extended to the maximum term and that the probationers make all of their scheduled payments, we project that 4,500 of these cases will not fully satisfy their assessments, leaving a balance of \$13.9 million that would become uncollectible.

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Civil Judgments on Uncollectible Cases

N.J.S.A. 2B:19-8 makes CEP the only avenue for declaring a case uncollectible. After the division has exhausted all search efforts to locate the person, they may declare the case uncollectible provided that the following three conditions are met: the case is within 60 days of the termination date or the date has passed, a Bench Warrant has been issued, and a Civil Judgment has been docketed for the total amount outstanding.

There were 10,300 probationers labeled as uncollectible as of November 30, 2003 who had a total outstanding debt of \$14 million. There were no entries in CAPS stating that a civil judgment had been docketed in Superior Court for 54 percent of these probationers. When we compared this population of uncollectible probationers with the Department of Labor's Wage and Hour database for the first three quarters of calendar year 2003, we found 1,200 probationers with earnings totaling \$10.2 million who had an uncollectible outstanding balance in CAPS totaling \$1.6 million.

When a case is declared uncollectible, the vicinages/counties no longer consider the case a part of their receivable, therefore the case gets very little, if any, attention with regard to collections. If civil judgments are not docketed for these cases before they are declared uncollectible, as required by the Judiciary's CEP policy, there is little or no chance that the money will ever be collected.

Coordination of Benefits

The Bureau of Risk Management (BRM) Workers' Compensation program is governed by N.J.S.A. 34:15-1 et. seq. and provides medical treatment for all state employees injured while working and nontaxable compensation to those who are eligible. Through Workers' Compensation, employees may receive temporary compensation (TC) and/or permanent awards. The bureau receives approximately 6,000 new cases per year. The cost of the program for fiscal year 2004 totaled \$52.8 million. TC is awarded at a rate of 70 percent of the employee's salary up to a weekly maximum as determined by the Commissioner of Labor (\$650 weekly for calendar year 2004) and is limited to 450 weeks. Medical providers in coordination with bureau investigators establish the length of leave time and the amount of TC to be paid. Permanent awards are determined by a workers' compensation court judgment.

State employees injured or who become ill while working may be eligible for the Sick Leave Injury (SLI) program. This program, established by N.J.S.A. 11A:6-8 and defined in N.J.A.C. 4A:6-1.6 et. seq., provides continuation of pay, limited to a period beginning on the initial date of injury and ending one year from that date. Eligibility differs from workers' compensation because benefits are not available for workers who lose time because of a pre-existing illness or condition which is aggravated in a work related accident when such aggravation was reasonably foreseeable, when the employee is injured through gross negligence or for injuries occurring during the employees' commute, lunch, or break period. All of these situations may be compensable under the workers' compensation law. Compensability determinations are made by the human resources or administrative sections within state agencies. An employee may appeal the denial of a claim to the Department of Personnel's Merit Board. Approved SLI claims are paid to the injured employee by his employing agency and these payments appear as regular, taxable payroll.

Employees receive TC while SLI is on hold, or denied and under appeal. There were 1164 employees who received TC payments with a due date between July 1, 2001 and April 30, 2004. If SLI is later approved for the same TC period, the employing agency is responsible to reimburse the BRM for TC paid during the approved SLI period and to pay the employee for the difference between the nontaxable TC and taxable SLI. We found agencies which did not reimburse the BRM, and reimbursements owed to the BRM that were miscalculated. We sampled 111 employees where an overlap in benefit payments appeared likely and noted the following exceptions.

- We noted 50 occurrences, totaling \$151,925, where agencies owe the BRM for TC payments made when SLI was approved after the commencement of TC. These cases did not go through the appellate process and the BRM was therefore not aware of any reimbursement due.
- There were 33 occurrences, totaling \$196,717, where BRM has requested reimbursement from the employing agency for the TC payments made during an approved SLI period, which remain unpaid. All of these SLI claims were approved via the Merit System Boards' appellate process.

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- We found 21 requests for reimbursements which were miscalculated due to lack of SLI information provided by agency human resource personnel.
- We found 47 claimants who received \$47,809 of TC for the same period that regular payroll was processed by their employing state agency and paid to the claimant.
- We found 19 employees who were not paid the difference between TC and SLI by their employing agency.

Ninety-three percent (57 of 61 tested) of the employees who did receive the difference between SLI and TC were paid the improper amount because of the taxability differences between the two programs. SLI is fully taxable, while TC is a tax-free benefit. The total SLI amount must be shown on the employees' payroll records. Agencies would improperly compensate the employee for the difference between SLI and TC and withhold taxes based only on the difference instead of the full SLI amount. Thus, the employees' W-2 income and payroll taxes are understated.

Caseload Management

The BRM Claims Investigators are responsible for determining compensability on a work related injury. In making this determination, the investigator may be required to interview any and all parties involved, visit accident scenes and make sketches or take photos, obtain all medical and police reports which may be necessary in litigated claims, attend hearings, and have ongoing interaction with injured workers, state agencies, Horizon Casualty Services, and attorneys. In addition to these duties, the investigators are required by BRM to make bi-weekly visits to agencies within their territory to train agency human resources personnel on workers' compensation procedures. As of July 2004, the bureau employed 14 claims investigators.

According to BRM management, each investigator carries a caseload which averages 751 cases. A recent Wyoming Legislative Audit report notes private industry standard caseload is 150 to 175 cases per investigator. Staffing practices within an organization are widely understood to have a profound impact on efficiency and productivity. BRM investigators interviewed agree that their caseloads are unmanageable due to present staffing levels. Thorough documentation provides evidence for internal review and also supports the decisions made when cases go to court. Investigators are unable to perform their titled duties, they simply process claims after minimal screening and have little time to investigate.

Internal Controls over Subrogation Functions

The bureau's subrogation unit is responsible for the administration and recovery of claims on behalf of the state against others responsible for damages to the state, its employees, and property. Over the past six fiscal years the subrogation unit has compiled \$4 million in outstanding open and closed claims with no payments. The following factors contribute to the loss of potential revenue for the bureau.

DEPARTMENT OF THE TREASURY
BUREAU OF RISK MANAGEMENT

- The subrogation unit has an outdated computer system that does not provide management the ability to monitor and track open and closed claims properly. Furthermore, the computer system can not handle multiple users at one time, slowing down the overall efficiency of the unit. This condition was noted in our previous report dated December 1999.
- There are no formal procedures or written policies for claims investigators to follow regarding the collection process. Claims investigators have no clear understanding of when uncollected claims greater than \$1,000 should be handed over to the Division of Law for investigation. Currently, unresolved cases are not being handed over at all. Additionally, cases under \$1,000 that are deemed uncollectible are not being forwarded to the Division of Revenue for possible collection through the Set-Off of Individual Liability (SOIL) program, as noted in our previous report. Furthermore, the unit wastes valuable time by waiting too long between claim notices. After a first notice is mailed, the investigators wait eight weeks before sending out a follow-up notice and wait another eight weeks for a response.
- The bureau/unit does not have a reconciliation process established for incoming claims. Currently, management does not reconcile how many claims come into each investigator to ensure that all claims are accounted for appropriately. Without a reconciliation process, the risk of losing claims increases.
- There is a lengthy time lapse from when an accident occurs to when the bureau/unit receives a report from the applicable state agency. We reviewed 20 claims and found, on average, it takes 7 ½ months before the proper documentation is submitted to the subrogation unit.
- The unit did not maintain adequate records. We sampled ten closed cases with no payments and found seven had unacceptable supporting documentation. Five of the seven cases had no support on file.
- The bureau/unit does not have direct access to motor vehicle records/files that could be matched against the bureau's records in order to find new addresses for individuals with outstanding claims. They rely on other divisions for assistance; however, this process is burdensome, time consuming, and often not productive.

In addition, as was noted in our previous report dated December 1999, the bureau is not complying with Circular Letter 94-24 OMB, which states, "Agencies are to ensure that all money's are deposited on the same day received." A cash count of the bureau's subrogation unit discovered that 47 checks totaling \$140,000 were on hand ranging between 3 to 20 days after receipt. The unit is holding onto checks in order to determine what agency will be reimbursed for the payment received. Furthermore, there is no segregation of duties regarding the deposit process. The same individual receives, inputs, and deposits checks for the subrogation unit. Without strong internal controls, the bureau is more vulnerable for misappropriation of state funds.

Charter School Monitoring

The Office of Innovative Programs and Schools (OIPS) oversees the application, monitoring and evaluation process for charter schools. Monitoring consists of the on-site review at a charter school to corroborate and augment the annual reports and to verify compliance with statutes, regulations and the terms of the charter. We noted weaknesses in the monitoring of the charter schools.

All classroom teachers, principals, and professional support staff employed by the board of trustees of a charter school shall hold appropriate New Jersey certification in accordance with N.J.A.C. 6A:11-5.1. Documentation of this certification and criminal history background checks for employees of the charter schools is required to be submitted to the OIPS for review.

We reviewed the teacher certification database at the Department of Education (DOE) and documents submitted from nine charter schools for evidence of certification. We could not substantiate proper certification for 66 of the 360 professionals examined. Teachers with no provisional certificates, expired provisional certificates, or no certificates were teaching classes. This included 12 school nurses of which six did not have the proper certification documentation. One school employed a nurse for eight months before terminating that employee due to lack of a license. At another school, the principal and vice principal did not hold the required certification. The condition was a result of charter schools hiring employees without proper certification, provisional certificates or renewing expired certificates. Although we noted a backlog in the licensing unit, there are alternate procedures available to schools to obtain certification. We further noted the OIPS is not adequately verifying and monitoring for proper certification.

We also examined employee files at the charter schools and records at the department for evidence that all employees that come into contact with children under the age of eighteen had undergone a criminal history background check as required by N.J.S.A. 18A:6-7.1. The review included 592 employees from nine charter schools and found that 166 of these files contained no evidence of the background check. This situation is a result of insufficient monitoring for compliance by the charter schools and OIPS. This condition could put children at risk and result in potential liability to the charter schools and the state.

Other deficiencies found during our school visits included:

- three schools not having fire inspection certificates;
- one school utilizing a new modular building for high school classes without the department being aware of the building;
- three charter schools not being able to provide board approved school policies and procedures manuals; and
- substitutes being used as full-time teachers at one school in subjects where they are not certified.

We noted that the OIPS / Charter Schools unit does not have a policies manual, although they are in the process of developing one.

Charter School Aid Calculation

Charter school aid is calculated by the DOE, Office of School Funding / Charter Schools based on the formulas established by N.J.S.A. 18A:36A-12 and N.J.S.A. 18A:7F. Charter school aid distributed through the local school districts includes a per pupil amount and categorical aid. Aid distributed by direct payments from the state consists of local mandate, nonpublic, and Abbott Kindergarten aid. Aid calculations are performed quarterly based on enrollment counts. The computer software which calculates the aid was developed internally in 1997 and has been continually updated with new calculations in response to changes in legislation. As a result, the system has become cumbersome and unreliable. The unit spends the majority of their time reviewing calculations and correcting errors. Some errors are not caught and result in incorrect payments of aid. Although we did not detect material incorrect payments, our testing identified system errors including an error in the computer program logic, an error where a category of aid was not calculated, and errors where the aid amount was improperly calculated. We also noted instances where the amount paid differed from the aid calculation and the support documentation was not available. The DOE is aware of the need to correct these deficiencies and is in the process of developing a new program to accurately calculate charter school aid.

Average Daily Enrollment Errors

The Department of Education Network (DOEnet) tracks and maintains enrollment counts for charter school students. Enrollment counts are converted to average daily enrollment (ADE) which is used in the calculation of charter school aid. ADE is determined by dividing the total days a student is enrolled in the school by the total days a school is in session. Each student can have a maximum ADE of one if enrolled for the entire school year. If a student transfers in or out during the school year, the school must manually compute the number of days enrolled and enter the number in the DOEnet. We tested enrollments at eight schools for 413 students who had less than one ADE in a sending district. We noted that the ADE for 32 students was incorrect based on the transfer in or out dates, the ADE for nine students totaled more than one, and the ADE for 24 students could not be verified at one charter school due to missing student files. Charter schools are responsible for the accuracy of the information. Inaccurate ADEs can result in incorrect charter school aid payments. We further noted that the system lacks a specific identifier for each student which can result in aid for a student being paid to two districts simultaneously.

Medical Security Officers Staffing and Overtime

In order to maintain federal medicaid eligibility by allowing patients' room doors to remain unlocked at night, the center hired 46 additional medical security officers (MSOs) in November 2002 at a cost of approximately \$2.3 million. However, the center subsequently decided not to unlock the patients' room doors at night, and voluntarily withdrew from the Medicaid program in June 2003. Despite their withdrawal from the program, the center retained the extra MSOs on the payroll. Throughout fiscal year 2004, normal attrition reduced the number of extra MSOs from 46 to 30 above the budgeted position level. Funded by transfers from the division, these additional 30 MSOs continue to cost approximately \$1.5 million annually.

Overtime becomes necessary when daily staff levels fall below the operational standards level set by the center. The hiring of the additional MSOs at a cost of \$2.3 million resulted in the reduction of overtime by \$800,000 during calendar year 2003. With the availability of 30 extra MSOs, it would be expected that the \$1.1 million in overtime incurred by the MSOs during calendar year 2003 would continue to decline in calendar year 2004. However, our projections indicate overtime payments for MSOs in calendar year 2004 will continue at calendar year 2003 levels. Management's assertion that overtime costs are primarily driven by an increase in patient supervision could not be confirmed. Instead, our review suggests the primary cause of overtime is the high number of call-outs by the MSOs.

Our observations and review of the causes of MSOs' overtime noted several control weaknesses and practices that management should address to further control or reduce overtime. A scheduling unit was formed in early 2003 to maintain the scheduling functions of both the nursing and MSO staff. During our fieldwork, we noted the use of the scheduling software known as "Inovar" was not utilized in scheduling MSO staff. Management cited a shortage of one person, as well as software problems with the application, as the reason for not using the scheduling software. During our review, our tests further noted routinely undocumented overtime caused by missing logs used to support call-outs, and as recently as April 2004, confusion by the MSO supervisors regarding daily minimum staffing requirements.

Some employees who have sustained injuries and are medically cleared to return to work are placed on adjusted work duty (light duty) status by attending physicians. Historically, the center has assigned these employees to the loading dock area, where they do not contribute to the minimum staffing requirements. Management has decided there are not positions in which these employees can safely work and be counted towards operational standards. Because the state continues to be liable for these employees while at work, management may consider not allowing these employees to return to work until fully capable and medically cleared to do so. During the 13-month period ending March 2004, over 7,100 hours were lost due to employees on adjusted duty status. In April 2004, the single monthly total increased to 1,592 hours. Those 14 months of lost productivity equate to approximately \$217,000 or four full-time unproductive employees.

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
ANN KLEIN FORENSIC CENTER**

A management practice allows MSO supervisors to unofficially report to duty one-half hour before their scheduled starting time and stay one-half hour after the end of their shifts for organizational purposes. These same employees were allowed to work through their lunch giving them, in effect, two hours of daily overtime “built-in” to their schedules. In response to our observations, management began requiring supervisors to take one-half hour lunch breaks, but still allows the organizational one hour of overtime during their shifts. Based upon statistics provided by management, the potential annual overtime costs for this practice is between \$50,000 and \$140,000.

Overview

To achieve strong information technology (IT) management, the National Association of State Chief Information Officers (NASCIO) recommends an enterprise resource management and architecture approach. This approach requires comprehensive, documented and continual IT planning for an entire organization. It is applicable to the state as a whole, and is also applicable at the departmental level, especially for a department as large as the Department of Human Services (DHS).

The Information Systems Audit and Control Foundation, in its IT control publication COBIT, states “In placing the information services function in the overall organization structure, senior management should ensure authority, critical mass and independence from user departments”. The federal Government Accountability Office (GAO) has also advocated these centralized control approaches for federal technology management.

For the state, Executive Order #87, issued in 1998, was an attempt to address the reality of the need for strong centralized management. This order required the creation of the Office of Information Technology (OIT) in recognition of the need for statewide management, and mandated the appointment of a chief information officer (CIO) by the Governor, who develops and implements the Statewide Strategic Plan for Information Technology. The CIO “shall lead, coordinate, and integrate statewide information technology policies and activities.” In addition, per NJ Circular Letter No. 00-03-DPP, all IT procurements must conform with approved Departmental IT Strategic Plans, regardless of dollar amount.

The State of New Jersey’s “Shared IT Architecture” document, issued by OIT, states that “The Shared Server Infrastructure (SSI) is located at the HUB and River Road data centers. It is an area in each computer room where servers are being centralized to offer a common location to manage the distributed environment.” It further states that “Optimizing key server resources through common logical and physical environments positions the State to properly plan, manage and control a growing server infrastructure.” In addition, this document also states that “The State manages two Storage Area Networks (SAN), one at River Road and one at the HUB. A SAN is a network whose primary purpose is the transfer of data between computer systems and storage elements.”

Therefore, any attempt by a department to isolate development and processing efforts from OIT can be counter-productive, inefficient, and contrary to state guidelines. However, this condition is what we found at the DHS.

Information Technology Planning and Development

DHS, through its Office of Information Services (OIS), is in the process of overseeing an ambitious initiative in support of the department. This new technology initiative involves the modernization of systems used by DHS and moving of applications away from the state’s legacy mainframe environment. In support of this initiative, the department has been making decisions and purchases to build their own data processing capabilities separate from OIT. They intend to house applications

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INFORMATION SYSTEMS MANAGEMENT**

at a data center they have created at the central office instead of at the OIT data center, and were moving ahead without a comprehensive strategic plan, until one was developed in July 2004 to guide them.

The department is to be commended for their recent creation of a comprehensive IT strategic plan. However, it was not in place during the development discussed in this report. In addition, the strategic plan makes no mention of working in conjunction with OIT, which would provide the appropriate level of control that is necessary for these significant technology enhancements.

The most significant modernization effort currently being implemented is the Division of Youth and Family Services' new case management system, SACWIS, which is expected to cost \$30 million, including implementation and verification over a five-year period. The contract awarded was for a version of SACWIS designed to run on a Sun Solaris platform housed at OIT. However, DHS has insisted on having SACWIS run on IBM servers, requiring system modification. This modification is estimated by OIT's management to require an additional three full-time technical support staff.

OIS has incurred approximately \$10 million of DHS' \$60 million in IT expenditures over the last two fiscal years. Much of this was expended for the purchase and installation of servers at their main office. OIS has individual plans for which it has hired nine contractors to aid in the in-house development of 23 applications in addition to the SACWIS development. Until recently, these efforts have been undertaken without a department-wide strategic plan.

Contributing to the condition is DHS' creation of their own internal data center. OIS created this data center through the installation of several IBM servers and a storage area network in the central office's network control room over the last four years. The basis for this action is to support the development of cross-divisional application systems. Currently, a portion of the capacity of two of three servers purchased for this reason have actually been used in support of two separate divisional application systems, General Assistance and Document Imaging. One cross-divisional application, the Unusual Incident Reporting System (UIRS), is in production and uses a portion of the capacity of these servers.

Half of the capacity of these two servers remains unutilized. The third server primarily supports various system management software products.

Our review of acquisitions for development of this central office data center identified contracted personnel costs to compensate for the lack of sufficient departmental staff to properly undertake this project. The cost of these services was \$1.3 million. If the servers were placed at OIT data centers, the need for consultants could be reduced.

In addition, this central office data center has insufficient backup cooling and no alternative processing facility to provide adequate business continuity and disaster recovery capabilities. A current information technology continuity plan identifying infrastructure requirements, an alternative processing facility and recovery procedures is not documented and regularly updated. Although data

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INFORMATION SYSTEMS MANAGEMENT

and system software backup tapes are produced and moved off site, insufficient periodic tests have been performed and documented to ensure the reliability and effectiveness of this process.

According to the *Federal Information System Controls Audit Manual*, published by the GAO, procedures should be in place to protect information resources and minimize the risk of unplanned interruptions and a plan to recover critical operations should be maintained in the event interruptions occur. These plans should be fully tested periodically to determine whether procedures will work as intended.

Operating System Security Administration

OIS has not developed and documented a computer security policy addressing the following areas: the assignment of privileges and the authorization of access to system resources; the review and resolution of unauthorized use or attempted use of system resources; and the request, review and authorization of system software installation and modification. We tested and found implementation of system security (for IBM's AIX operating system) has been performed using incomplete and unapproved procedures and guidelines. The AIX servers process among other items, confidential information for the General Assistance program. Our evaluation revealed deficiencies in defining user account attributes, removing unnecessary system services, and implementing system configuration options. The account attributes omitted are critical in assuring proper user account administration and effective user account identification and authentication. For instance, blank passwords were allowed. The services remaining and options omitted increase the risk associated with providing access. Our tests further indicated noncompliance with the procedures and guidelines that were established.

A complete computer security policy identifies security objectives and operational security rules that support the derivation of appropriate implementation procedures and guidelines. According to the *Federal Information System Controls Audit Manual*, a comprehensive policy for security planning provides the basis for the control structure which defines procedures for assessing risk, developing and implementing effective controls to reduce risk, and monitoring the effectiveness of these controls to reduce risk.

Server and Associated Product Acquisitions

Our review of selected server and associated product acquisitions with a total cost of \$3.8 million, identified services costing \$447,000 improperly coded under the contract. The desired consulting services should have been identified as "work station conversion services".

DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
GROUP LIFE INSURANCE

Life Insurance Plan Administration

Upon the death of a retiree or active member, a group life insurance benefit is paid to the designated beneficiary through the state's insurance carrier. The total amount of life insurance payments made to the insurance carrier, including premium and administrative costs, is \$185 million annually. We identified issues involving the review of year-end billings, beneficiary payment options, bidding for services, and benefit reconciliations which are disclosed in the following paragraphs.

Insurance Carrier Billings

The division calculates the beneficiaries' entitlements and notifies the insurance carrier of the amounts to be paid. Death benefit claims paid by the insurance carrier along with administrative costs are billed to the division on a monthly basis for reimbursement. At year-end, the insurance carrier analyzes actual costs and informs the division of the final payment or refund amount due. The division has no written procedures and may not have the level of expertise necessary to perform a detailed review of the year-end experience analysis provided by the insurance carrier. The information currently obtained from the insurance carrier is not sufficient for the division to verify that the final billing is accurate. The division relies on the insurance carrier for the accuracy of the bill.

Beneficiary Payment Options

Beneficiaries have the option of receiving one lump-sum payment, an annuity over a period of years, or a life annuity. Both lump-sum payments and annuities are funded by the state and administered by the insurance carrier. According to N.J.S.A. 43:16A-60 (Police and Firemen's Retirement System) and 18A:66-81 (Teachers' Pension and Annuity Fund), the current interest rate to be used for annuities is 8.75 percent. Although not required by law, this rate is also being utilized by other pension systems. The current annuity interest rate of 8.75 percent greatly exceeds the prevailing market rate and is therefore more costly to the pension funds. In addition, the cost of providing the annuity becomes part of the insurance carrier's annual billing which further complicates the year-end experience analysis. An alternative could have beneficiaries dealing directly with the insurance carrier if an annuity is desired.

Contract Bidding

The same insurance carrier has been the sole provider of the group life insurance plans since the 1950's with automatic renewal and no competitive bids. Although the division is not required by law to seek competitive bids, this is a standard government procurement practice which could be beneficial in determining if the current group life insurance plans could be provided at a lower cost. In addition, the most recent study of group life insurance plans administered by the division was performed by an outside consultant in 1982. This type of study could analyze the current plans, describe the benefits of other plans available, and suggest which alternatives would be most beneficial. This information could be used by the division in selecting criteria to be utilized in awarding a contract.

DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
GROUP LIFE INSURANCE

Benefit Reconciliations

Our prior audit recommended the division reconcile death benefits initiated by the division to the monthly billings of death benefit claims paid by the insurance carrier. The division, in conjunction with the Office of Information and Technology and the insurance carrier, has developed an interface between the division's Death Information Benefits System and the data transmitted by the insurance carrier. A report is generated which summarizes these individual payments and identifies any differences. We were informed that the division's Financial Services personnel are to review this report and present any questionable items to the Claims Bureau for investigation. This computerized comparison has reached its operational stage but no standard procedures have yet been implemented to investigate any differences on a regular basis. The possibility of overpayment therefore still exists.

JUDICIARY
ADMINISTRATIVE OFFICE OF THE COURTS
JUDICIARY BAIL FUND

Negotiated Bail Forfeitures

A bail bond is a written document provided by an insurance company (surety) that guarantees a defendant's appearance in court and holds the surety liable for the amount of the bond if the defendant fails to appear. Failure to appear in court results in a forfeiture of the bail and a bench warrant being issued for the defendant's arrest. The County Counsel is responsible for the collection of forfeited bail.

Typically, most sureties file a motion to vacate a forfeiture when a defendant has been apprehended. After the motion is filed, the court schedules a hearing in which the judge determines a settlement amount. Prior to the hearing, however, County Counsel can choose to resolve the matter by negotiating a settlement with the surety and having the results agreed upon by the judge. Effective November 26, 2003, the Office of the Attorney General must approve all settlements. Negotiated settlements are typically much less than the original bond amount.

An ad hoc committee of presiding judges in 1997 advised that seven criteria should be considered in negotiating bail. The criteria include the costs incurred by the state and county, the bondsman's efforts to return the fugitive, and the length of time the defendant was a fugitive and the resulting harm to the public.

Currently, there are no approved procedures to ensure the above criteria are considered when determining a settlement. At an absolute minimum, negotiated settlements should recoup county and state costs. Our review of 8,632 negotiated settlements for ten sample counties reported on Central Automated Bail System (CABS) disclosed the average negotiated settlement was approximately ten percent of the bond amount. Average settlements by county ranged from 1.83 percent to 20.36 percent of the bond amount. In addition, 275 of 4,156 cases involving bonds with a face value of at least \$10,000 were settled for \$300 or less.

There have been recent court decisions involving the remission of forfeited bail to surety companies that address the percentage of the bail amount to be returned and the factors including the level of supervision over a defendant. Standard procedures incorporating the results of the court decisions could be developed and distributed to County Counsel to ensure a consistent and fair negotiation process statewide.

Collection of Forfeited Bail from Surety Companies

As of September 3, 2003, CABS reported 28 surety companies with a total of 2,845 default judgment cases amounting to \$71.5 million in uncollected corporate surety bonds. Of this amount, \$23.9 million is due from companies that are now insolvent. Collection procedures that include a course of action for the refusal of payment by a surety company have not been established to ensure County Counsels initiate a thorough and timely collection effort.

JUDICIARY
ADMINISTRATIVE OFFICE OF THE COURTS
JUDICIARY BAIL FUND

Collection of Forfeited Bail from Individuals

The County Counsel is responsible for the collection of forfeited bail with oversight by the Office of the Attorney General. As of September 3, 2003, forfeited bail judgments against individuals totaled \$98.2 million. County Counsels are not proactive in their approach to collecting forfeited bail from individuals because standard procedures providing guidance have not been established. One source not used is the state's Set-off of Individual Liability (SOIL) program which withholds tax refunds as payment against outstanding debts. Other state resources that could also be used to locate and initiate collection proceedings are the Department of Labor (DOL) wage reporting and unemployment systems. We compared 129 individuals in default from CABS to the above DOL systems. We identified 40 individuals who collected unemployment, earned wages or both after forfeiting their bail. In addition, four of these 40 individuals are still fugitives. After identification, collections could be processed through garnishment or through the Comprehensive Automated Probation System (CAPS). CAPS is the primary system used by the Judiciary to account for the collection and disbursement of court ordered fines, penalties, and restitutions.

Purchasing Controls and Documentation

During fiscal year 2004, the Commission expended \$9 million for the purchase of goods and services which were not approved or recorded by the Controller's Office prior to the receipt of goods or services being rendered. Paperwork involving requests and approvals were prepared after delivery. As a result, the Controller's Office did not know what the obligations of the Commission were and each of the Commission's 28 units had the ability to knowingly or unknowingly overspend their budget without the knowledge of the Controller's Office. We tested \$7.5 million of the purchases for fiscal year 2004. Our review disclosed that the documentation to support the transactions was often vague or inadequate. Examples of the types of exceptions noted during our testing follows.

- The Commission paid five consultants more than \$30,000 without having an adequate contract to define the services to be provided or detailed invoices which itemized the services performed. Four of these vendors were related party transactions that were not disclosed to us.
- The Commission paid a Georgia-based travel agent a total of \$75,000 during fiscal year 2004 without requiring the submission of detailed documentation to support the billings. Furthermore, we could not determine why the Commission was using an out of state travel agent since it seemed contrary to their mission of promoting business in New Jersey.
- The Commission paid \$14,500 during fiscal year 2004 to a consultant living in New Jersey to promote bilateral trade and investment in China. The Commission had already retained a consultant in China performing these functions. We found no other duplication of effort for other countries with whom they are seeking to do trade.
- We were not provided with any documentation to support the payment of \$3,000 to a speaker at the Economic Development Conference for Non-profits. Seven of the other conference speakers were not paid.

Travel Controls and Documentation

In accordance with the Commission's Interim Procedure Manual, "an employee of the Commission is responsible for the proper preparation of documents necessary to obtain approval for authorized travel and reimbursement for travel expenses." All requests for travel must be approved in advance of the travel. A travel voucher with itemized receipts must be submitted within 15 working days of the completed travel. Employees are expected to use the most direct and most economical travel route. Excessive and unnecessary travel and other expenses will not be reimbursed.

Our review of travel advances and reimbursements noted that the current travel policy was not effective nor being enforced. We noted that advances often appeared to be for unnecessarily large amounts, settlements were not completed timely, and final review of documents was not adequate. For example:

NEW JERSEY COMMERCE AND ECONOMIC GROWTH COMMISSION

- In April 2004 an employee received a travel advance of \$35,947 and returned \$28,472, while another employee received \$19,636 and returned \$17,961 for the same trip.
- In one instance an inadequate review was evidenced by a \$7,150 payment to a travel agent to arrange for airfare and hotel for two employees. These same employees also received advances that included amounts for the same airfare and hotel costs. The two employees did reimburse the Commission for this duplication.
- An employee did not adjust for the Mexican exchange rate on their travel voucher. The employee sought reimbursements of \$2,000 when they were only entitled to \$200. When we brought this to the attention of management, final settlement was adjusted.
- Travel expenses of \$416 described as “business meeting service fees” were supported by receipts from a clothing store and gift shop without any further support.

We further noted that cash advances were often not settled timely or not at all, as illustrated by the chart below. As of May 2004, the Commission had outstanding travel advances totaling \$141,000 which exceeded the 15 working day settlement policy.

OUTSTANDING TRAVEL ADVANCES

Days Outstanding	Amount	Number
16 to 45 days	\$ 47,000	3
46 to 105 days	\$ 15,000	3
106 days to 1 year	\$ 23,000	10
Over 1 year	\$ 23,000	9
Total	\$ 108,000	25

In addition, there are five unsettled advances totaling \$33,000 to four employees who no longer work for the Commission.

Our review of documentation to support travel reimbursements found that adequate documentation was often not provided or expenses may have been in violation of the policy. In two instances employees were reimbursed for airfares totaling \$1,700 without detail as to the reasons for the trips or documentation detailing the specifics of the flights. Employees were reimbursed for telephone charges, personal cell phones, EZ Pass, and credit card fees without documentation that they were business related.

We also noted charges that appeared to be excessive or unnecessary. Specific examples were over \$1,000 for phone charges on a single trip and \$375 for two employees to travel to Atlantic City by train or limousine even though each had state vehicles assigned to them.

Revenue

The Office of Business Services collects a \$100 fee for registration as a Small Business Enterprise (SBE) for State of New Jersey Small Business contracts and Set-Aside Program and a \$75 fee for certification as a Minority and/or Women Business Enterprise. The registration and certification fee also allows the business to be listed in the New Jersey Selective Assistance Vendor Information (NJSAVI) database for an annual fee of \$100. The Commission collected \$460,000 in revenues for these programs during fiscal year 2003.

Prior to our audit, the Office had no standard written procedures to outline duties and methods concerning revenue collection and recording. Mail logs were not maintained and checks were not restrictively endorsed when received or safeguarded until deposits were made. Deposits were untimely and no reconciliations were performed to verify proper collection, depositing and recording of the revenue. There are still no follow-up procedures for the collection of non-sufficient fund checks received from businesses.

Based on our recommendations, the Office started maintaining a mail and check log in March 2004. Our review of the April 2004 collections showed that check logs were incomplete because 48 checks provided to us in support of deposits could not be traced to the logs. We also found that receipts were not being deposited timely. One hundred sixty-seven of 354 checks listed in the April 2004 check logs were deposited from three to six days after collection. Our reconciliation of the registration and annual fees noted an unreconciled difference of \$40,000 between fee revenue reported by the Office during fiscal year 2003 and the NJSAVI database.

Petty Cash

The Commission's Interim Procedure Manual required that proper accountability and safekeeping of petty cash funds be maintained at all times. It also specified that custodial functions for petty cash funds were the responsibility of each unit's respective Office Manager. The Manager was required to routinely count petty cash, check sales receipts, and prepare a monthly reconciliation. Petty cash funds were to be subject to surprise counts, reviewed periodically, and replenished based on an authorization submitted to the Controller's Office by the unit's Director/Vice President.

Our count and reconciliation of the petty cash funds revealed that the Commission was not in compliance with its internal policies for operation and custody of petty cash funds. There were nine \$500 petty cash funds established for the total amount of \$4,500. Three complete funds were missing, five had either a deficit or overage, and only one fund reconciled. The total amount of the petty cash funds unaccounted for was \$1,400. We further noted that there were no guidelines established regarding the types of expenditures allowed to be made from petty cash funds, and some of the receipts supporting the funds expended were questionable.

Independent Contractor vs. Employee

The Commission adopted a practice of engaging individuals for performance of services and compensating them as independent contractors rather than employees. Six individuals were hired by the Commission and misclassified as independent contractors in spite of the Commission's intention to eventually offer these individuals permanent employment. These employees were under the control of the Commission and should have been hired as employees and subject to state and federal withholding taxes.

In accordance with Internal Revenue Service Regulations, the Commission is required to issue statements of miscellaneous income (form 1099-Misc) for payments to individuals other than employees who have rendered a service or have received rent from the Commission in excess of \$600. Our review of calendar year 2003 payments to individuals showed that the Commission did not issue the required 1099 forms to 12 individuals. Noncompliance with Internal Revenue Service Regulations may result in monetary penalties imposed on the Commission.

Payroll

The Commission paid \$6 million during fiscal year 2004 in payroll costs. The Commission recorded employees' leave time on an exception basis and did not require any form of time reporting. The leave time taken is recorded on Absence Time Sheets which are completed by one of the seven timekeepers. Our review further disclosed that the timekeepers were also responsible for recording their own time; in three cases, supervisors were approving their own time; and in one case, the preparer was also an approving supervisor. This current method of timekeeping could lead to discrepancies not being detected. We noted that errors had occurred and were approved since verification reports were changed to reflect absences which had been initially omitted. We could not determine the number of omissions that have not been corrected.

The Commission recognized that the lack of timekeeping records may result in leave time being either under-reported or not reported, and they have developed and started utilizing sign-in sheets.

Reporting

The Secretary of the Commission is required to report semi-annually on the expenditure of state funds and private contributions during the preceding six months for the Advertising and Promotion Program, Travel and Tourism, and the Advertising and Promotion - Cooperative Marketing Program. The reports are to be submitted to the Governor and the Joint Budget Oversight Committee.

The Commission has not complied with the law since December 1999. As a result of our inquiries about the reporting requirement, the Commission submitted their first report covering the period of July 1 through December 31, 2003 as of April 2004. Noncompliance with the law weakens reporting and oversight controls of these programs.

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF REPORTS ISSUED DURING 2004**

<u>REPORT</u>	<u>TYPES OF FINDINGS</u>			
	<u>COMPLIANCE</u>	<u>CONTROLS</u>	<u>ECONOMY/ EFFICIENCY</u>	<u>NONE</u>
Casino Control Fund		OPINION ONLY		
Department of Banking and Insurance	X	X		
Department of Community Affairs Information Technology Controls		X		
Department of Education Office of Innovative Programs and Schools Charter Schools Plainfield Board of Education	X	X	X	
Department of Environmental Protection Natural Resource Management	X	X	X	
Department of Health and Senior Services Division of Administration Office of Support Services to the Aged Pharmaceutical Assistance to the Aged and Disabled, Senior Gold, Lifeline, and Hearing Aid Assistance Public Health Preparedness and Response for Bioterrorism Federal Program	X	X	X	X
Department of Human Services Developmental Disabilities Council Division of Developmental Disabilities Administrative Support Services Greenbrook Regional Center Hunterdon Developmental Center Division of Family Development Child Day Care Contract Administration Division of Medical Assistance and Health Services Health Benefits Coordinator Contract for Medicaid Managed Care Programs Division of Mental Health Services Ann Klein Forensic Center Information Systems Management	X	X	X	

**OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
SCHEDULE OF REPORTS ISSUED DURING 2004**

REPORT	TYPES OF FINDINGS			
	COMPLIANCE	CONTROLS	ECONOMY/ EFFICIENCY	NONE
Department of Law and Public Safety				
Division of Criminal Justice and the Office of the State Medical Examiner		X		
Office of the Attorney General and Selected Organizations		X	X	
Office of Counter-Terrorism				X
Department of State				
Commission on Higher Education				X
Department of the Treasury				
Bureau of Risk Management	X	X	X	
Division of Administration		X		
Division of Pensions and Benefits				
Group Life Insurance		X	X	
Selected Pension Services		X	X	
Interstate Environmental Commission		SINGLE AUDIT REPORT		
Judiciary				
Administrative Office of the Courts				
Judiciary Bail Fund		X		
Probation Services Division	X	X	X	
Superior Court of New Jersey				
Passaic Vicinage				X
New Jersey Commerce and Economic Growth Commission		X	X	
New Jersey Comprehensive Annual Financial Report		OPINION ONLY		
Office of Information Technology				
Administration	X			
Pinelands Commission		SINGLE AUDIT REPORT		
State of New Jersey				
Report on Compliance and on Internal Control Related to Our Audit of the State's Comprehensive Annual Financial Report				X