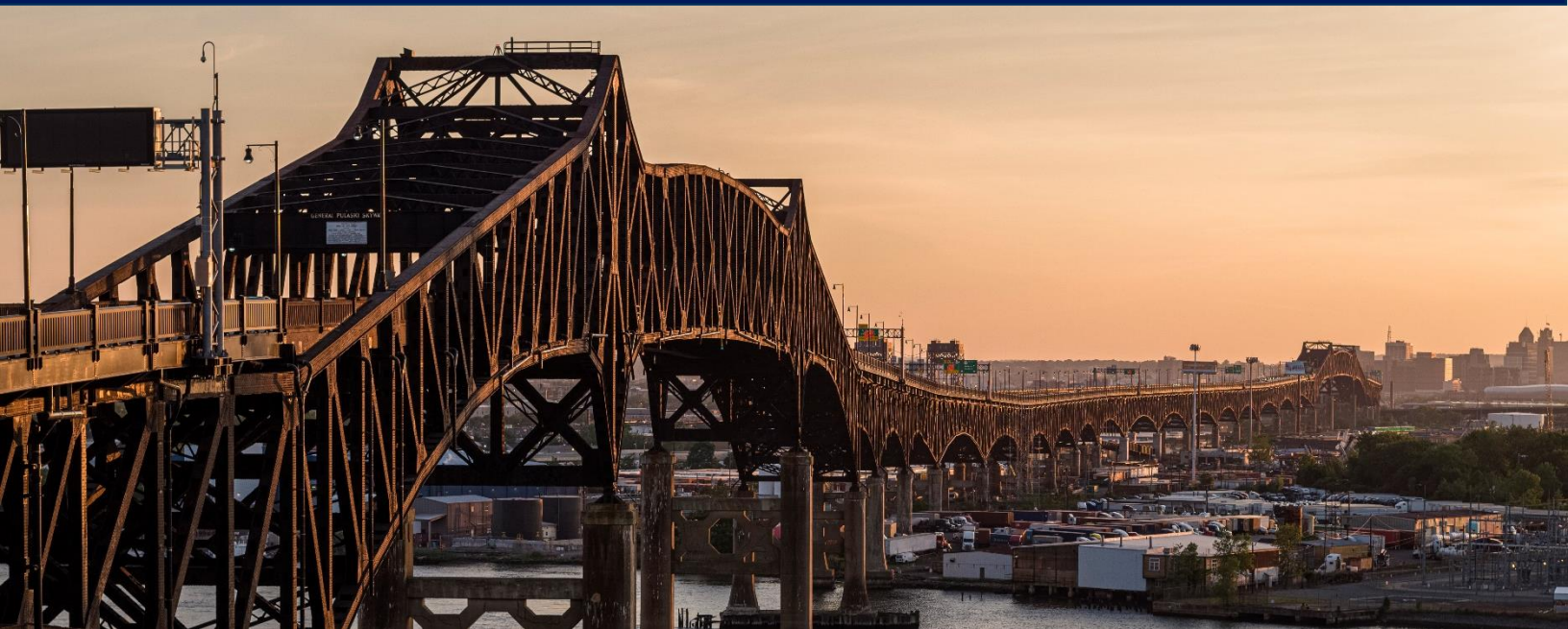

# New Jersey Office of the State Comptroller Fiscal Year 2023 Annual Report

## Improving the efficiency, transparency, and fiscal accountability of New Jersey government

November 2023

**Kevin D. Walsh, Acting State Comptroller**



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# Letter from the Acting State Comptroller

Dear Governor Murphy, Members of the State Legislature, and Residents of New Jersey:

This past fiscal year, the Office of the State Comptroller (OSC) continued to make strides in advancing our mission to make government throughout New Jersey more effective, transparent, and accountable.

OSC consists of the Audit, Investigations, Procurement, and Medicaid Fraud Divisions, the Police Accountability, COVID-19 Compliance and Oversight, and Survey Projects. Together during 2023, we investigated, audited, and reviewed the Executive Branch of the New Jersey government and shared reports that uncovered fraud, waste, and abuse at all levels of government.

OSC also has worked to optimize our resources and maximize our impact and presence – so that OSC is able to bring more transparency to more public entities throughout New Jersey. To that end, OSC conducted surveys and reviews, examining wasteful and improper practices across multiple municipalities and publishing those findings in our reports. OSC also continued to share best practices and alert elected and appointed officials that rigorous government oversight is a way to keep government effective. As a result, our work last fiscal year has saved millions in taxpayer dollars, prompted reforms and corrective actions, and inspired civic engagement.

One critical way to gauge OSC's impact is through the amount of tax dollars recovered. Through the efforts of OSC's Medicaid Fraud Division, we recovered more than $114 million in improperly spent Medicaid funds. As part of its anti-fraud efforts, we referred 18 cases to the Medicaid Fraud Control Unit within the state Office of the Attorney General and an additional 120 matters to other civil and criminal enforcement entities, including county prosecutors' offices and the state Department of Treasury, Division of Taxation. We also issued two follow-up reports on New Jersey's consistently low-rated nursing homes, which receive more than $100 million a year in Medicaid funds.

OSC's Audit Division released six reports that examined P-card practices, sick leave payments, health insurance procurements, and other fiscal and operating practices. In our follow-up reviews of earlier audits, we have seen that cost savings have been realized when our recommendations were implemented.

OSC continued to monitor the state's COVID-19 spending to ensure compliance with state and federal laws. Through the work of OSC's COVID-19 Compliance and Oversight Project, OSC found that as much

as 49 percent of federal COVID-19 funds paid out to New Jersey fisheries might be improper and need to be recovered. The New Jersey Department of Environmental Protection, which administered the funds, agreed to adopt our recommendations that it put in place new controls and take actions to review the payments and recoup any found to be improper – which could amount to about $7 million.

When appropriate, our OSC reports, reviews, and investigations created a roadmap for reform, pinpointing the policies and practices that posed systemic risks. During our investigation of New Jersey City University's (NJCU) financial crisis, we found that the University had faced years of declining student enrollment and tried to address its increasingly dire finances by improperly budgeting nearly $14 million in COVID-19 relief funds. Equally important, through the efforts of our Investigations Division and COVID-19 Project, we found the State did not possess the powers to effectively oversee state colleges and universities that were struggling financially. We also found that a lack of effective oversight by the University's Board of Trustees enabled poor decision-making to go undetected for many years. OSC made several recommendations, including that NJCU have an independent monitor to manage its operations and that the Legislature strengthen State oversight of higher education institutions. After the release of the report, the Legislature passed a law that provided for that, and more.

OSC also was successful at providing oversight on the local level, redoubling our impact through reports examining multiple municipalities, such as our survey of 60 municipalities' adherence to sick leave laws. Through the efforts of the Survey Project, OSC found that 57 of 60 municipalities surveyed were not following laws prohibiting expensive sick leave payouts. We also published a data dashboard and created a detailed roadmap for towns so that all, including those not mentioned in the report, could comply and end the wasteful practices.

Similarly, our Police Accountability Project reviewed 100 local police department websites and found that 80 failed to meet the Attorney General's Internal Affairs mandates, which are intended to encourage public reporting of police misconduct. In some cases, the departments were engaging in practices that could effectively deter the public from filing complaints. Soon after OSC sent out its findings, more than 50 of the departments responded immediately, saying they made the recommended changes or were in the process of doing so.

One of OSC's most important statutory functions is to review procurements from more than 1,900 public entities in the state. Our reviews often serve as a circuit breaker within government, preventing local governments and state entities from entering into contracts without following applicable laws. Last year, attorneys in our Procurement Division reviewed 191 proposed contracts valued at more than $12.5 million; we required changes in 68 percent of those cases.

OSC remains committed to educating people in government and the public at large, equipping them with the knowledge to make government work more effectively and efficiently. Overall, public interest in our work has grown. We frequently hear about residents attending local government meetings asking about an issue highlighted in one of our reports. The number of people signing up for our emails and

newsletter, visiting our website, and following us on social media has, overall, nearly doubled in the last year.

There is much more work to be done, but as you will see in this report, through our diligent, thorough investigations, audits, and reviews, we are helping to make government work better for everyone and giving New Jersey residents the confidence that their tax dollars are being well managed.

Sincerely,

Kevin D. Walsh, Acting State Comptroller

# Overview

Since its creation in January 2008, the Office of the State Comptroller (OSC) has served as an advocate for taxpayers and a leader in bringing about government reform. OSC reports have focused on bringing greater efficiency, transparency, and analysis to the operation of all levels of government in New Jersey.

OSC consists of four divisions – Audit, Investigations, Medicaid Fraud, and Procurement. OSC has also established three projects – the COVID-19 Compliance and Oversight Project, Police Accountability Project, and Survey Project. OSC's COVID-19 Project promotes accountability, transparency, and compliance in the spending of federal COVID-19 recovery funds in New Jersey, while the Police Accountability Project focuses on detecting fraud, waste, abuse, and misconduct in law enforcement agencies exercising Executive Branch authority. OSC's Survey Project seeks to determine through the issuance of targeted surveys whether there are any specific or systemic failures at the local or state government level that allow for fraud, waste, abuse, or non-compliance with state laws and regulations. Each of OSC's four divisions and its three projects have made significant contributions to OSC's accomplishments this past fiscal year.

Our Audit Division concluded its work on two performance audits in FY 2023. The audits examined selected fiscal and operating practices of two municipalities. In addition to these audits, the division completed four follow-up reviews of prior audits to determine whether the auditees had implemented OSC's recommendations.

Our Investigations Division issued three reports this past fiscal year. The first report, in collaboration with OSC's COVID-19 Compliance and Oversight Project, examined the declaration of a financial emergency by New Jersey City University in 2022. The division also issued OSC's Eighth Periodic Review on Law Enforcement Professional Standards examining aspects of the New Jersey State Police's training bureau and reported on the waste of taxpayer funds at the Mercer County Finance Department.

Our Medicaid Fraud Division continued its ongoing efforts to combat fraud, waste, and abuse in the Medicaid Program. The division recovered or facilitated the recovery of more than $114 million of taxpayer dollars in FY 2023. Its anti-fraud efforts also resulted in the exclusion of 234 ineligible providers from the Medicaid program.

Our Procurement Division reviewed 878 contracts this past fiscal year, 191 of which were valued at $12.5 million or more. Division

attorneys also reviewed hundreds of contracts under Executive Order 166 (Murphy) and Executive Order 125 (Christie). In all, Division attorneys pre-screened 364 contracts before advertisement or negotiation by the contracting unit.

OSC's COVID-19 Compliance and Oversight Project collaborated with OSC's Investigations Division to examine New Jersey City University's declaration of a financial emergency. Project staff also provided technical assistance and support to state and local government units to identify and mitigate risks of fraud, waste, and abuse in the use of COVID-19 recovery funds. The Project also completed a follow-up review of the state Department of Environmental Protection's administration of the Marine Fisheries Assistance Grant Program.

OSC's Police Accountability Project undertook investigative matters involving fraud, waste, abuse, and misconduct in policing and issued two public reports. One report concerned the state Department of Children and Families' change of its practices to limit access to child welfare services without notifying stakeholders. The second report reviewed municipal police department websites' compliance with Internal Affairs Policies and Procedures.

OSC's Survey Project issued a report concerning 60 municipalities' compliance with the 2007 and 2010 laws governing payouts of unused sick and vacation leave time.

The sections of this report that follow briefly explain the role of each division as well as OSC's COVID-19 Compliance and Oversight Project, Police Accountability Project, and Survey Project while setting forth highlights of OSC accomplishments from the past fiscal year of July 1, 2022 to June 30, 2023.

# Audit Division

OSC's Audit Division conducts audits and reviews the performance of New Jersey state government, public institutions of higher education, independent state authorities, local governments, and school districts.

The Audit Division is led by Director Christopher Jensen, who brings years of experience as an auditor and accounting executive to the position. The Audit Division staff includes individuals who possess certifications or professional designations such as Certified Public Accountant, Registered Municipal Accountant, and Certified Fraud Examiner.

Examples of the Audit Division's work in FY 2023 are set forth below. Audit reports can be viewed in their entirety on OSC's website.

## Audits

### City of Brigantine

This audit examined employee benefits in the City of Brigantine. The audit found that Brigantine failed to: (1) adhere to state laws and its own agreements regarding the payment and use of accrued sick and vacation leave; (2) follow its policies regarding overtime, compensatory time, and nepotism; (3) administer health benefit waiver payments appropriately, resulting in wasteful payments of approximately $64,500; (4) substantiate data received from its health insurance broker, resulting in the potential loss of $191,000 in healthcare savings; and (5) properly administer and fund its lifeguard pension plan, leading to a $4.5 million unfunded plan liability. OSC made 15 recommendations to improve Brigantine's operations and its compliance with applicable statutes and regulations.

### Rockaway Township

The audit of Rockaway Township identified weaknesses with certain fiscal and operating practices. Specifically, the audit found that the Township: (1) allowed employee leave payments of $167,093 in violation of state law or Township policy; (2) failed to properly procure health insurance coverage and health insurance brokerage services; (3) did not change to the State Health Benefits Program (SHBP) for prescription coverage, which cost taxpayers an estimated $4.5 million from January 1, 2019 to December 31, 2021 mostly because the Township paid twice for benefits for retirees; (4) failed to adhere to its policies and procedures or state law in its payment of overtime; and (5) had $10.1 million in unspent and unencumbered funds related to projects more than five years old and balances for local improvements of $2.1 million; these funds are eligible for use to offset future taxation.

Each of OSC's reports contained recommendations to address the deficiencies found in the audit. As required by law, OSC will conduct follow-up reviews of each auditee to determine whether they have implemented the recommendations.

## Follow-up Reviews

OSC obtains Corrective Action Plans from auditees to ensure that audit recommendations are properly implemented in an appropriate timeframe. OSC subsequently conducts follow-up reviews to determine whether the steps taken by the auditee effectively implement our recommendations.

OSC issued four follow-up review reports in FY 2023.

### North Bergen School District

OSC's 2019 audit identified weaknesses with the District's fiscal and operating practices and identified opportunities for potential cost savings.

The follow-up review found that North Bergen had made little progress in implementing the recommendations set forth in the initial audit report. Of the 15 audit recommendations, 2 were implemented, 6 were partially implemented, and 7 were not implemented.

### Salem Special Services & Vo-Tech School Districts

OSC's 2020 audit identified internal control weaknesses that resulted in unauthorized transactions and potentially lost revenue. The audit also found that VoTech lacked adequate internal controls for the billing and collection of payments for childcare services.

OSC found that Salem had made progress in implementing the recommendations set forth in the initial audit report. Of the eight audit recommendations, seven were implemented and one was partially implemented. Subsequent to the follow-up review, the Districts fully implemented the eighth recommendation.

### P-Card Practices

OSC's 2020 audit found that the Department of Human Services and the Department of Corrections failed to comply with Treasury circulars related to the procurement of goods and services, maintenance of supporting documentation, and required internal controls. Additionally, the audit found that the Department of Environmental Protection failed to comply with regulations requiring the maintenance of documentation.

OSC's follow-up review found that all three agencies had made significant progress in implementing the recommendations set forth in the 2020 audit. Of the three recommendations applicable to Human Services, all three were fully implemented. Of the three recommendations applicable to Corrections, all three were partially implemented. The one recommendation applicable to Environmental Protection was implemented.

### Buena Regional School District

The 2020 audit identified weaknesses with fiscal and operating practices. Specifically, the District had failed to comply with: (1) federal regulations for income verification in the school lunch program; (2) state regulations for the procurement of insurance brokers; (3) the District's own policies and procedures for procuring an insurance broker; and (4) terms in employment contracts and collective bargaining agreements addressing health benefit opt-out waiver payments.

OSC found that Buena had made progress in implementing the recommendations set forth in the initial audit. Of the five audit recommendations, four were implemented and one was partially implemented.

## Policies and Procedures

OSC's efforts have included establishing policies and procedures that guide the audit process. The following are descriptions of some of the policies and procedures OSC has put into effect and has continued to refine over the past year.

### Audit Manual

For professional audit organizations such as OSC, it is essential that clearly defined policies be promulgated to provide audit guidance and to ensure the quality and consistency of the audit work performed. To that end, OSC developed an Audit Manual to serve as the authoritative compilation of the professional auditing practices, policies, standards, and requirements for OSC's staff. OSC's Audit Manual is a constantly evolving document that is revised as standards are amended and other changes in the auditing profession occur.

### Audit Process Brochure

Open communication concerning the audit process lets the auditee know up front what to expect. With that in mind, OSC developed a brochure outlining the critical components of the audit process, from initiation to completion. This brochure is provided to the auditee prior to the start of an audit.

### Risk/Priority Evaluation

OSC's enabling legislation requires OSC to "establish objective criteria for undertaking performance and other reviews authorized by this act." Accordingly, OSC developed a risk/priority evaluation matrix that considers a number of risk factors including, among others, the entity's past performance, size of budget, the frequency, scope and quality of prior audits, and other credible information which suggests the necessity of a review. OSC's staff conducts research along these parameters and performs a risk assessment as an aid in determining audit priority.

### Quality Control and Peer Review

Government auditing standards require audit organizations to establish an internal quality control system and to participate in an external quality control "peer review" program. The internal quality control system provides the organization with ongoing assurance that its policies, procedures, and standards are adequate and are being followed. The external peer review, to be conducted once every three years, is a professional benchmark that provides independent verification that the internal quality control system is in place and operating effectively, and that the organization is conducting its work in accordance with appropriate standards.

In June 2023, OSC's Audit Division successfully passed its fifth peer review conducted by the National State Auditors Association. Audit organizations can receive a rating of "pass," "pass with deficiencies," or "fail." OSC received a peer review rating of "pass."

OSC had received "pass" ratings in its prior peer reviews conducted in 2011, 2014, 2017, and 2020. As in those reviews, the 2023 review concluded that OSC's system for quality control has been "suitably designed" and complied with government auditing standards.

## Audit Coordination

OSC's enabling legislation requires the State Comptroller to establish a system of coordination with other state entities responsible for conducting audits, investigations, and similar reviews. This system serves to avoid duplication and fragmentation of efforts while optimizing the use of resources, promoting effective working relationships, and avoiding the unnecessary expenditure of public funds.

## Training

Audits conducted by OSC's Audit Division comply with Generally Accepted Government Auditing Standards (GAGAS). Auditors performing work under GAGAS are required to maintain their professional competence through Continuing Professional Education (CPE). Specifically, every two years, each auditor must complete at least 80 hours of CPE, 24 of which must directly relate to government auditing, the government environment, or the specific or unique environment in which the audited entity operates. Annually, OSC staff receive formal training on topics such as governmental accounting, auditing and accounting, audit sampling, audit evidence, and internal controls.

# Investigations Division

OSC's Investigations Division works to detect and uncover fraud, waste, and misconduct involving the management of public funds and the performance of government officers, employees, and programs.

Scott MacDougall is the Director of the Investigations Division. Prior to joining OSC in 2017, Mr. MacDougall worked as an attorney in the private sector representing clients in complex matters involving insurance coverage and conducting investigations into suspected insurance fraud. The division consists of a staff of investigators and attorneys, including former federal and state law enforcement professionals. Staff members hold certifications such as Certified Financial Crimes Investigator and Certified Fraud Examiner.

Investigations Division staff accept and review all tips, referrals, and allegations submitted to the office. The tips, referrals, and allegations originate from both the general public and governmental employees and officers, and can be submitted through OSC's toll-free hotline, a portal on OSC's website, email, or the U.S. mail. The hotline is also used as the official statewide tipline for any tips regarding the fraud, waste, or abuse of federal COVID-19 recovery funds.

## Complaints and Referrals

In FY 2023, the Investigations Division fielded 1,007 tips. Tips fielded by the division resulted in referrals to a number of external agencies. In particular, the Investigations Division made 15 external referrals to other state, county, and federal agencies in FY 2023, among them were, the United States Department of Education, the New Jersey Department of Treasury, and the New Jersey Election Law Enforcement Commission. The Investigations Division also referred matters to various units within the New Jersey Department of Law and Public Safety, including the Division of Criminal Justice, the Office of Public Integrity and Accountability, the Division of Consumer Affairs, and the Division on Civil Rights.

The division also referred matters internally to other OSC divisions and projects. These referrals may result in future audits and investigations.

The Investigations Division also serves as a key resource to OSC's other divisions by conducting witness interviews, consulting on investigative techniques and methods, and identifying potential subjects for audits.

The Investigations Division also conducts inquiries based on incoming referrals from

other state agencies. Our joint efforts with these other agencies continue to build a synergy that has led to increasingly robust investigative efforts across state government.

## Public Reports

The Investigations Division produced the following public reports in FY 2023:

### An Investigation into New Jersey City University's Financial Emergency

On June 27, 2022, New Jersey City University (NJCU) declared a financial emergency and adopted an interim 90-day budget, citing a lack of funding and declining enrollment. On August 5, 2023, Governor Philip D. Murphy requested that OSC investigate the circumstances leading to NJCU's declaration of financial emergency. The Investigations Division collaborated with OSC's COVID-19 Compliance and Oversight Project to conduct the investigation.

OSC's investigation revealed a multitude of factors that contributed to NJCU's financial distress, and, ultimately, its decision to declare a financial emergency. OSC found that from 2016 through 2022, NJCU experienced an ongoing decline in student enrollment, causing a concomitant decrease in NJCU's revenues during that same period. NJCU took various measures to reverse this trend, such as retaining marketing consultants to expand the university's presence and improve its appeal, increasing student scholarships, expanding the number of graduate and undergraduate programs, enhancing its student service offerings, and investing heavily in real estate expansion projects. None of these efforts, however, were successful in reversing NJCU's enrollment trend. Instead, they served to dramatically increase NJCU's expenses and place the University in an unstable financial position.

The actions of NJCU's senior administrators were an immediate cause of NJCU's decision to declare a financial emergency. With the University in an unstable financial position caused by declining enrollment and increasing expenses, NJCU senior administrators submitted a fiscal year 2022 budget for approval by its Board of Trustees that proposed using nearly $14 million in COVID-19 relief monies made available through the federal Higher Education Emergency Relief Fund (HEERF) to pay for an existing scholarship program, despite knowing that the funds could not be used for that specific purpose. The University ultimately did not apply HEERF funds to the scholarship program. Nevertheless, the budget gap created by the senior administrators' actions forced NJCU to apply a significant portion of its cash reserves to fund the scholarship program, leaving the University with just 25.5 days of operating cash on hand at the end of the fiscal year. Senior administrators did not disclose to the Board of Trustees the risks of using the HEERF funds as budgeted until a new interim Chief Financial Officer was hired ten months after the budget was submitted.

OSC's investigation also found that the Board of Trustees failed to exercise adequate oversight. In particular, the Board of Trustees failed to conduct contractually required annual written performance evaluations of the President. The Board of Trustees also chose not to probe the causes of the financial crises once the budget deficit became known.

OSC made recommendations to NJCU and the Legislature. OSC recommended NJCU: (1) establish and implement robust policies, procedures, and internal controls related to budgeting and the accountability of the administration to the Board of Trustees, including requirements that budgetary assumptions and risks be disclosed; (2) commission an independent external review to

determine whether the University would benefit from adjustments to its Board of Trustees, such as the addition of new board members or the creation of additional committees, to ensure that the Board is equipped to provide effective governance of the University; (3) review training practices and institute a formal training program for board members; (4) ensure its Board of Trustees conducts and documents, in writing, annual performance evaluations of its President, whether required by contract or not; (5) engage an independent financial monitor with expertise in overseeing the finances of a public institution of higher education to ensure the administration and Board are discharging their duties in accordance with established policies, procedures, and internal controls and with the highest standards of integrity and transparency; and (6) adopt a program that regularly reviews the University's academic program portfolio.

OSC recommended that the Legislature: (1) evaluate whether powers currently provided to the Office of the Secretary of Higher Education (OSHE) adequately guard against poor decisions made by the administrations or boards of public colleges and universities and whether existing reporting and other requirements adequately protect the interests of taxpayers and students of public colleges and universities as well as the institutions themselves and (2) authorize and direct OSHE through legislation to institute requirements related to reporting by chief financial officers to boards of trustees, audit committees, and OSHE, including with regard to the validity of the preparation of budgets, accuracy of financial reports, and duties to protect public funds.

Following publication of its report and findings, the Legislature passed P.L. 2023, Chapter 115, a law that, among other things, requires public institutions of higher education to submit annual fiscal monitoring reports, authorizes the Secretary of Higher Education to appoint a State monitor at certain institutions, and requires chief financial officers to complete training.

On August 30, 2023, the Secretary of Higher Education appointed a monitor to oversee NJCU's operations.

## The Eighth Periodic Review on Law Enforcement Professional Standards - A Review of the New Jersey State Police Training Bureau

OSC's review of the New Jersey State Police (NJSP) Training Bureau, a unit that plays a critical role in NJSP's efforts to maintain non-discriminatory practices through the delivery of training to new recruits and experienced troopers, identified weaknesses in the Training Bureau's oversight and implementation of training programs and policies.

Through the course of this review, Investigations Division staff observed several training courses in which full-time and temporary instructors deviated significantly from the approved curriculum on topics stemming from the Consent Decree entered into between the State of New Jersey and the United States Department of Justice and the New Jersey Attorney General's Use of Force Policy.

OSC further found that NJSP training could be improved through the implementation of teaching methods that aim to ensure troopers possess a deep understanding of course materials and the incorporation of additional performance objectives to improve its course materials, such as those developed by the New Jersey Police Training Commission (PTC), an entity responsible for the development and certification of basic training courses for county and municipal law enforcement officers.

OSC's review also identified concerns with the Training Bureau's practices for assigning temporary instructors to teach new recruits,

selecting applicants for a Trooper mentorship program, and ensuring promoted troopers attend required leadership training.

At the conclusion of its report, OSC issued eleven recommendations to NJSP to improve its compliance with applicable laws and best practices. Among others things, OSC recommended: (1) NJSP should deliver mandated trainings in accordance with the requirements of the training materials and should not deviate by shortening training times or removing exercises; (2) NJSP should interview all instructor candidates, including detached instructors; (3) NJSP should formally document the decision-making process for candidates seeking to become Trooper Coaches; (4) NJSP should revise its training materials to include best practices for adult learning, curricula development, and proficiency assessment; and (5) NJSP should adopt a policy requiring lesson plans to be reviewed annually to ensure lesson plans contain the most current training practices, changes to New Jersey law, Attorney General Directives, and law enforcement best practices.

## Has the Government Records Council Decided Public Records Complaints as Expeditiously as Possible?

This investigation examined the operations of the Government Records Council (GRC) to determine the cause of the GRC's ongoing backlog of denial of access complaints. To perform this review, OSC conducted interviews with two GRC representatives, and a representative from the Department of Community Affairs (DCA). OSC also reviewed governing statutes, regulations, case law, a sampling of GRC complaint files, and various GRC internal reports. OSC also attended multiple monthly GRC meetings and examined a GRC database that tracks the current statutes of all complaints received from July 1, 2011 to December 31, 2021.

OSC found that the GRC failed to accomplish the goal of the Open Public Records Act (OPRA) to resolve complaints as expeditiously as possible. Specifically, the investigation revealed that the average complaint took GRC 21 months to process from receipt to adjudication, compared to the state judiciary who resolves denial of access complaints in only 7 months. The investigation identified GRC's minimal staff, staffing structure, and decreased budget as contributing factors to its inability to process complaints expeditiously.

OSC recommended that GRC establish by rule what it considered an expeditious resolution of complaints to commit itself to more timely resolutions and adopt a process that permits the GRC to conduct its own fact-finding using staff attorneys as hearing officers. DCA declined to accept these two recommendations. OSC also recommended that DCA hire additional attorneys to exclusively handle complaints, to which DCA agreed. Lastly, OSC recommended to the Legislature to evaluate whether amendments to OPRA are appropriate that would allow staff attorneys, as opposed to the full Council, to issue decisions.

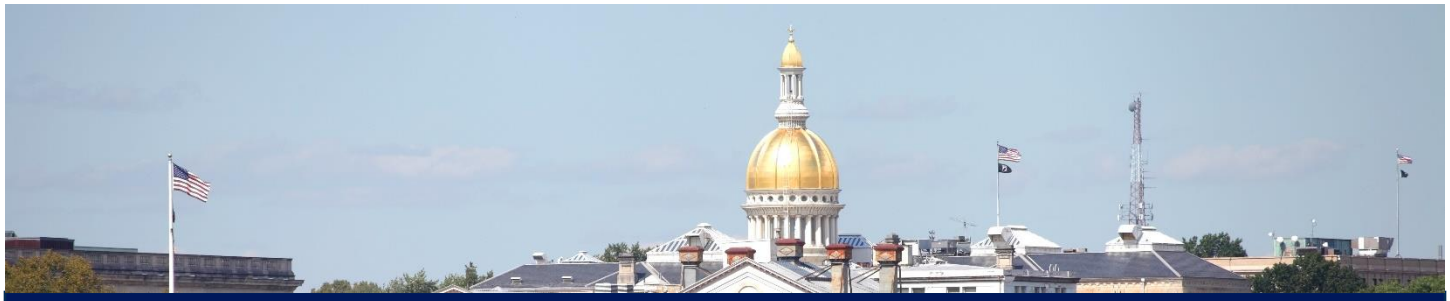
## Investigation of Waste at the Mercer County Finance Department

OSC conducted an investigation into the Mercer County Finance Department's failure to timely file and pay its federal and state payroll taxes. This investigation found that Mercer County incurred and paid nearly $4.5 million in penalties and interest for delinquent tax filings and payments to the Internal Revenue Service and the New Jersey Division of Taxation between 2018 and 2021, resulting in waste that was ultimately paid by Mercer County taxpayers.

OSC's investigation also found that the Chief Financial Officer (CFO) for the County lacked the statutorily required certificate to serve as CFO.

By statute, an individual must hold a county finance officer certificate issued by the Division of Local Government Services, a unit within the Department of Community Affairs, to serve as a County CFO. OSC's investigation revealed that the County's CFO during the relevant time period did not possess the requisite certificate for the entirety of his tenure, a period of over 10 years. OSC also found that the Finance Department's operations contravened best practices for the management and operation of a public entity's finance department, creating additional risk for fraud, waste, and abuse.

OSC recommended that Mercer County: (1) ensure that it files all taxes, including payroll taxes, in a timely manner and pays the amounts due within the timeframe required by taxing authorities; (2) adopt written policies and procedures directing the County Office of Personnel to annually verify that employees possess and maintain in good standing the credentials necessary to perform their respective job duties; (3) develop an accounting procedures manual that establishes a clear segregation of duties and a system of checks and balances to ensure financial systems are properly managed; (4) establish a committee to oversee the Finance Department, including its financial reporting practices, internal department controls, and compliance with laws and regulations affecting the department; and (5) through the Office of the County Executive and the County Board of Commissioners, conduct a periodic review of the Finance Department.



# Medicaid Fraud Division

OSC's Medicaid Fraud Division (MFD) serves as the State's independent watchdog for New Jersey's Medicaid, FamilyCare, and Charity Care programs and works to ensure that the State's Medicaid dollars are being spent effectively and efficiently. MFD is comprised of trained auditors, investigators, analysts, attorneys, and other professionals and para-professionals.

Josh Lichtblau joined OSC as Director of the MFD in July 2015 after more than two decades as a Deputy Attorney General, Assistant Attorney General, and as Director of a major state regulatory agency.

Operating under the authority of the Medicaid Program Integrity and Protection Act, MFD provides oversight concerning the following programs:

- New Jersey's Medicaid program provides health insurance to qualifying parents and caretakers and their dependent children, along with pregnant women and individuals who are aged, blind, or disabled. For example, the program pays for hospital services, doctor visits, prescriptions, nursing home care, and other health care needs.

- New Jersey FamilyCare is a Medicaid-type program for uninsured children whose family income is too high to qualify for traditional Medicaid but not high enough for the family to afford private health insurance. Combined, as of June 2023, the Medicaid and New Jersey FamilyCare programs served more than 2.3 million New Jersey residents.

- The New Jersey Hospital Care Payment Assistance Program, commonly known as Charity Care, provides free or reduced-charge services to patients who require care at New Jersey hospitals.

As part of its oversight role, MFD audits and investigates health care providers, managed care organizations (MCOs), and Medicaid beneficiaries to identify and recover improperly expended Medicaid funds; recommends Medicaid agency oversight improvements; recommends MCO Contract changes to improve programmatic oversight; refers cases to other appropriate civil entities when the underlying conduct is outside of MFD's authority or more appropriately handled by such entities; refers cases of suspected criminal fraud to appropriate criminal prosecutors; and, investigates beneficiaries when there is a basis to suspect that they do not meet eligibility requirements, which helps ensure that only those who qualify are enrolled in Medicaid. In

performing these functions, MFD considers the quality of care provided to Medicaid recipients and pursues civil and administrative enforcement actions against those who engage in fraud, waste, or abuse within the Medicaid program. MFD also excludes or terminates ineligible health care providers from the Medicaid program when necessary and conducts educational programs for Medicaid providers and contractors. Finally, MFD identifies and collects payments from insurance carriers when Medicaid has paid for goods or services and there was third-party insurance coverage that should have paid for such claims.

The office released a significant follow-up report that identified 12 Long Term Care (LTC) facilities that provided services to Medicaid beneficiaries that consistently received the lowest federal Centers for Medicare and Medicaid Services (CMS) overall rating of one-star. The report found that these 12 LTCs provided services to approximately 1,835 Medicaid beneficiaries, and that Medicaid annually paid these 12 LTCs an average of $107 million. The report, like the prior two reports that OSC issued on this topic, recommended that the Department of Health and the Medicaid program institute a phased approach through which these oversight bodies should impose increasing levels of restrictions on these facilities while affording them an opportunity to improve their ratings before imposing more serious restrictions.

This report gained widespread national attention and fueled a rigorous public conversation on how to improve the care people receive in nursing homes.

## MFD's FY 2023 Statistics

In FY 2023, MFD recovered or facilitated in the recovery of slightly more than $114.5 million in improperly paid Medicaid funds, with $105.2 million of that attributable to third party liability (TPL) recoveries from third party insurance carriers and the remainder, $9.3 million, attributable to MFD's audits, investigations, and other data-based recovery efforts. Those funds were returned to both the state and federal budgets. MFD also excluded 234 providers from participating in the Medicaid program this past fiscal year.

MFD received 2,144 complaints, tips, or other submissions (collectively "complaints") from a variety of outlets, including the MFD hotline, OSC website, referrals from other state and federal agencies, and correspondence from the public. All of the complaints received by OSC resulted in some type of action, up to and including opening an investigation. Pursuant to its internal processes, MFD staff members reviewed the substance of the complaints to determine whether MFD should initiate an investigation or take other steps, including but not limited to referring a matter to a more appropriate entity for handling. From the complaints above, OSC opened full-scale cases when appropriate and referred the majority of the remaining complaints to other more appropriate entities for handling, including the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS); professional licensing boards; county welfare agencies; and appropriate state vendors responsible for providing services related to the Medicaid program at issue.

MFD also received and reviewed a total of 130 high-risk provider applications and performed 887 individual background checks. In addition, the division referred 18 cases to the Medicaid Fraud Control Unit (MFCU) within the state Office of the Attorney General and an additional 120 matters to other civil and criminal enforcement entities, including county prosecutors' offices and the state Department of Treasury, Division of Taxation.

As part of its educational outreach program, MFD presents training programs to a wide variety of providers, including behavioral health, long-term care, medical day care, and other providers/practitioners. In FY 2023, MFD hosted two virtual educational training sessions. In the first session, MFD collaborated with the Department of Children & Families (DCF), DMAHS, MCOs, and MFCU to provide a training focused on Intensive In-Community Providers. The second presentation, in which MFD collaborated with DMAHS, MCOs, and MFCU, focused on Personal Care Agencies. Both presentations were designed to educate providers who participate in the New Jersey Medicaid program to identify and protect against fraud, waste, and abuse. Speakers emphasized the importance of properly documenting medical and other records, submitting accurate Medicaid claims, disclosing improperly received payments, and proactively taking steps to train employees in ways to identify, prevent, and properly address Medicaid fraud, waste, and abuse.

MFD's oversight focuses on Medicaid health care providers, MCOs and Medicaid recipients, while coordinating oversight efforts among all state agencies that administer Medicaid program services. As part of these efforts and to fulfill a federal mandate, MFD ensures that entities that receive or make payments of $5 million or more in Medicaid funds assist in the prevention and detection of fraud, waste, and abuse within the program. Each year, applicable entities are required to certify compliance with Section 6032 of the federal Deficit Reduction Act, by attesting that they have in place appropriate fraud, waste, and abuse policies and procedures. Using this information, MFD selects a sample of these entities to perform a documentation review. In calendar year 2023, MFD identified 225 parent entities (2,043 individual providers) that were required to certify. Of those entities, 43 established Corrective Action Plans (CAPs) to address deficiencies.

What follows is an overview of MFD's work in FY 2023. A summary of all of MFD's individual settlements, notices of overpayments, and audits is included as an Appendix to this report.

## Data and Fiscal Integrity Unit

The Data and Fiscal Integrity Unit monitors the Medicaid data from the fee-for-service program and MCOs in an effort to ensure that this data is complete and accurate. This Unit uses Medicaid data to identify anomalous activity and prepares referrals to investigate, audit, or review such activity. In addition, this Unit tracks MFD's receipt of overpayments and ensures that providers that have entered into settlement agreements to repay the Medicaid program do so in accordance with the terms of such agreements.

### Data Mining Unit

MFD's Data Mining Unit monitors Medicaid claims and other data used to detect fraud, waste, and abuse and, in collaboration with relevant Medicaid stakeholders, works to ensure that the data is sufficiently reliable for MFD to use in its audits and investigations. As such, the Data Mining Unit is involved in various stages of the process leading to the recovery of improperly paid Medicaid dollars. The Unit employs numerous analytical techniques to detect anomalous claims submitted by providers. In order to identify patterns of anomalous Medicaid reimbursements, MFD's data miners review Medicaid fraud reports and investigations from federal and state oversight bodies and analyze a range of additional resources to acquire pertinent data. The Data Mining Unit also monitors the Surveillance and Utilization Review System, a federally mandated exception reporting system, for indications of

fraud, waste, and abuse and to detect duplicate, inconsistent, or excessive claim payments.

In total, MFD's Data Mining Unit referred 39 cases of anomalous claims behavior to the Audit/Investigation Units and generated 134 reports for use by these units in FY 2023. In addition, this Unit prepared 25 overpayment letters based on data-based desk reviews.

## Statistics Unit

A primary responsibility of the Statistics Unit is to select random samples of medical records or other information, based on Medicaid claims data. Auditors and investigators then obtain records or documentation to determine whether the provider being audited or investigated is meeting federal and state laws, rules, and guidance. If applicable, the Statistics Unit then extrapolates the audit/ investigative findings to calculate final overpayment amounts for recovery. This Unit also performs statistical analysis on a variety of projects including determining the widespread impact, and potential savings to the Medicaid program, of MFD's audits and investigations.

## Audit Unit

MFD conducts audits to ensure that Medicaid providers comply with program requirements, to identify improper billings submitted by Medicaid providers, and to deter fraud, waste, and abuse in the Medicaid program.

MFD audited a spectrum of Medicaid providers, including Partial Care, Durable Medical Equipment (DME) providers, and Intensive In-Community Mental Health providers. Two of these audits are particularly noteworthy.

In its audit of John Gore, a children's mental health rehabilitation and behavioral assistance services provider located in South Plainfield, MFD found that Gore failed to support approximately 34 percent of his Medicaid claims. As a result, MFD found that Gore overbilled the Medicaid program $1.1 million and that he placed children at risk by not subjecting his employees, who worked with children, to criminal background checks. This audit, along with other important work from the Audit Unit in MFD, revealed a systemic issue that created risk to children. In conjunction with issuing this report, MFD released correspondence it had sent to DMAHS prior to the Gore report urging DMAHS to implement improved background check requirements that would ensure that employers like Gore background checked their employees before allowing them to work one-on-one with children. DMAHS later issued a Newsletter and regulation to address this oversight deficiency.

MFD audited Community Care, a psychiatric partial care provider with locations in Freehold, Piscataway, and Morris Plains. Partial care providers offer outpatient clinical services, such as group and individual therapy services. From this audit, MFD determined that in 76 of 292 sampled claims (approximately 26 percent) of Community Care's documentation did not support the claims billed. From this audit finding, MFD calculated that Community Care had received an overpayment of $816,280 that it had to repay to the Medicaid program.

In both Gore and Community Care, just as with all of its audits, MFD identified the Medicaid overpayment and recommended that the providers take corrective actions to address the noted deficiencies.

## Third Party Liability Unit

Under federal law, if a Medicaid recipient has other insurance coverage, Medicaid, as the payer of last resort, is responsible for paying the medical benefits only in cases in which the other coverage has been exhausted or does not cover the service at issue. Thus, a significant

amount of the State's Medicaid recoveries are the result of the efforts of MFD and its contracted vendor to obtain payments from third-party insurers responsible for services that were inappropriately paid with Medicaid funds. MFD's Third Party Liability (TPL) Unit, working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and recovers money from private insurers or providers in cases where Medicaid has paid claims for which the private insurer was responsible. In addition, the TPL Unit also manages a daily hotline for the public and providers to call and update third-party commercial insurance information for Medicaid recipients and ensure that Medicaid recipients receive their benefits when improperly denied. MFD's TPL Unit reviews, oversees, and coordinates audit work performed by the State's TPL contractor. In FY 2023, MFD recovered more than $105.2 million from third parties.

In addition to overseeing TPL recoveries, the TPL Unit also handles the MFD hotline. MFD receives questions and allegations of fraud, waste, and abuse from many sources, including MFD's hotline and webpage as well as from other state and federal agencies. In total, MFD received 2,144 hotline intakes in FY 2023. As part of this role, the TPL Unit tracks and refers to the appropriate body all hotline communications received.

## Investigations Unit

MFD's Investigations Unit investigates inappropriate conduct on the part of Medicaid, FamilyCare, and Charity Care providers and recipients. In FY 2023, the Investigations Unit opened 407 cases and made 138 referrals to other agencies such as the MFCU, state licensing boards, county prosecutors' offices, and various county boards and social services entities.

To ensure the integrity of Medicaid's enrollment process, the Investigations Unit also conducts background checks of high-risk providers applying to participate in the program. In FY 2023, the Investigations Unit reviewed 130 such applications from high-risk providers – DME, prosthetics and orthotics, and home healthcare agencies, for which MFD performed 887 individual background checks using several verification sources. The Unit also performed or confirmed through PECOS, an online database showing site visits performed by Medicare oversight bodies, 108 site visits in FY 2023. During the site visits, MFD investigators verify that the applying entity actually exists at the address listed, that it complies with state and federal requirements, and that the information supplied on the provider application is accurate. When the Investigations Unit uncovers patterns of fraud, waste, or abuse, in addition to addressing such actions by seeking to recover from the appropriate parties, it recommends programmatic fixes to improve systemic oversight and thereby prevent such activity from reoccurring. In FY 2023, the work of the Investigations Unit resulted in the recovery of approximately $6.3 million in misspent Medicaid funds, which includes recoveries resulting from MFD investigations of providers, provider self-disclosures of their overpayments, and civil recoveries from Medicaid beneficiaries who MFD determined received benefits when they were not eligible for the same.

## Regulatory and Exclusions Unit

MFD's Regulatory Officers are licensed attorneys who handle MFD-initiated fraud, waste, and abuse cases from initiation of a Notice of Claim through the administrative law process, including settlement negotiations, the discovery process, and Office of Administrative Law Fair Hearings as State Agency Representatives. The Regulatory Officers also represent the Medicaid program's interest in pursuing overpayments, whether identified

internally or by the State's outside vendors, including its TPL contractor. The Regulatory Unit provides guidance to the other units of the division, including advice regarding the legal sufficiency of an audit/investigation, and assessments regarding a provider's legal basis for objecting to an overpayment demand. MFD's Regulatory Officers also work with other state departments to propose new Medicaid program regulations and guidance designed to improve program integrity and strengthen the State's oversight of the Medicaid program.

The Regulatory and Exclusions Unit also identifies providers who should be disqualified from participating in the Medicaid program. Regulatory and Exclusions may seek to exclude providers for numerous reasons, including criminal convictions or exclusions issued by a New Jersey licensing board or by the federal government. Adverse action taken by MFD against these individuals are part of an ongoing OSC effort to ensure that only those medical providers who maintain the highest integrity participate in the Medicaid program. In FY 2023, MFD excluded 234 providers – including physicians, pharmacists, dentists, social workers, and home care nurse's aides – for failing to meet the standards for integrity in the Medicaid program.

**If you suspect Medicaid fraud, waste, or abuse:**

**Call** 1-888-9FRAUD5
(1-888-937-2835)
**or** File a Complaint.

# Procurement Division

OSC's Procurement Division, staffed by attorneys specializing in public contract law, fulfills the office's statutory mandate to review public agency procurements from more than 1,900 public entities. In FY 2023, the Procurement Division received notice of 878 contracts, including 191 contracts that were valued at more than $12.5 million and pre-screened pursuant to OSC's statutory authority.

Barbara Geary is the Director of the Procurement Division. She has more than 20 years of contracting experience in both the public and private sectors. She became Director in June 2015 after joining the OSC as an attorney in 2011.

In addition to reviewing contracts, the attorneys of the Procurement Division work with OSC's audit teams and provide guidance concerning the many legal issues that arise during the course of an audit. Division attorneys also assist in investigations and other projects.

Pursuant to N.J.S.A. 52:15C-10(d), all contracting units are required to submit contracts involving consideration or an expenditure of $12.5 million not less than 30 days prior to the expected advertisement date or issuance of the solicitation. For contracts valued at more than $2.5 million but less than $12.5 million, contracting units must notify OSC no later than 20 business days after the contract award.

As prescribed by statute, the Procurement Division pre-screens the legality of the proposed vendor selection process for all government contracts exceeding $12.5 million and has post-award oversight responsibilities for contracts exceeding $2.5 million.

OSC's procurement reviews cover contracts awarded by municipalities, school districts, state colleges, and state authorities and departments, as well as other public boards and commissions with contracting authority. Regulations promulgated by OSC assist public entities in determining whether OSC review is required for a particular contract and provide guidance as to how OSC reviews are conducted.

Procurements subject to OSC review cover a wide range of contracts, including land sales, leases, purchases of goods and services, and building and road construction.

For contracts exceeding $12.5 million, the Procurement Division works closely with government entities as they formulate specifications, intervening when necessary to ensure procurements comply with all applicable laws, regulations, and rules. Errors are corrected before the contract advertisement takes place.

The review of contracts valued at more than $12.5 million begins with judging the appropriateness of the vendor selection process proposed by the contracting unit. The reviewing attorney assesses, for example, whether the procurement requires sealed bids or whether other contracting procedures are appropriate. The reviewer further determines whether the government unit has followed all other statutes, rules, and regulations applicable to the procurement. Additional questions asked include: Has the governing body, department, or authority approved the procurement? Are the specifications designed to ensure a competitive process? Is the method of advertisement appropriate?

For contracts exceeding $12.5 million, the contracting unit must submit notification to OSC 30 days before advertisement or otherwise entering into a contract. On occasion, contracting units request flexibility in that time period. Accordingly, OSC has set forth a procedure through which government entities can seek a waiver of the 30-day time period. OSC works closely with contracting units needing such a waiver to ensure that contract solicitations can be made in a timely manner.

Contracts exceeding $2.5 million, including contracts previously submitted for pre-approval, are examined post-award. The focus post-award remains on compliance with laws and regulations. In addition, a determination is made as to whether the award followed the guidelines set forth in the solicitation. For example: Did the lowest bidder get the award in a sealed bid determination that appropriately considered alternates? Did the governing body approve and certify funding for the contract? Are the records submitted sufficient to justify the governing body's action? Is there any evidence of collusion or bid rigging?

To ensure that OSC's contract reviews result in a better contracting process in both the short and long terms, the Procurement Division consults directly with contracting units during and following reviews. Depending upon the nature of the review and any deficiency noted, the Procurement Division might hold an exit interview, prepare a written determination, or simply provide oral guidance to the contracting unit. In cases involving serious deficiencies, OSC may refer contracts for audit review or further civil or administrative action, such as actions to recover monies expended. Criminal activity is referred to appropriate law enforcement authorities.

Among the most frequent errors OSC encountered were the misstatement of the timing requirement for statutorily required bidder forms and certifications such as, the Disclosure of Investment Activities in Iran business registration certificate, public works contractor registration certificate, and evidence of compliance with equal employment opportunity, and affirmative action laws. Substantively, OSC also corrects the inclusion of propriety items in bid specifications and ensures that contracting units are allowing for "approved equals." Importantly, OSC works with contracting units to adequately describe the services desired and the deliverables needed to assure it is getting the services it needs.

The Procurement Division also has added oversight responsibilities pursuant to two gubernatorial executive orders: Executive Order 166 (Murphy, 2020) concerning the expenditure of COVID-19 related funding and Executive Order 125 (Christie, 2013) concerning expenditures related to Superstorm Sandy.

Pursuant to Executive Order 166, the Procurement Division conducts pre-screening reviews of state procurements utilizing $150,000 or more in COVID-19 related federal funding. Pursuant to Executive Order 125, the division conducts equivalent reviews of all state procurements that involve the expenditure of

federal reconstruction resources connected to Superstorm Sandy.

The division is also responsible for posting the procurements it reviewed pursuant to these executive orders on the state's COVID-19 Transparency website and OSC's Sandy Transparency website. As a result, in FY 2023, the Procurement Division reviewed a variety of purchasing practices that otherwise would have been below OSC's statutory monetary threshold for review.

The division reviews proposed procurements subject to Executive Orders 166 and 125 on an expedited basis, providing guidance and feedback to agencies to ensure compliance with public contracting laws without sacrificing expediency in the state's recovery process. In FY 2023, the division pre-screened 144 procurements pursuant to Executive Order 166 and took corrective action in 51 percent of those procurements. The division also pre-screened 29 procurements pursuant to Executive Order 125 and took corrective action in 59 percent of those procurements.

Of the 878 contracts submitted for review in FY 2023, 191 of them were valued at more than $12.5 million and were pre-screened pursuant to OSC's regular statutory authority. OSC attorneys took corrective action in 68 percent of those pre-screened contracts to ensure the legality of the procurement process. Altogether, the Division pre-screened 364 contracts for compliance with applicable law.

Some notable contracts reviewed include: the construction contract for the Rebuild By Design Hudson River Coastal Defense project, a $250 million contract to address sea level rise and coastal flooding in Hoboken, Jersey City, and Weehawken and the agreement and plan of merger between Montclair State University and Bloomfield College. Contract reviews pursuant to Executive Order 166 covered a variety of goods and services including air purifiers for school districts, COVD-19 vaccinations, additional funding for family and domestic violence prevention, and reagents for testing new COVID-19 variants.

The Procurement Division received 514 contracts valued between $2.5 million and $12.5 million. For these post-award reviews, OSC evaluates whether the contracting unit complied with the appropriate procurement process and provides guidance to assist the contracting unit with correcting errors in the future.

In addition to its pre- and post-review powers, the Procurement Division is statutorily authorized to monitor procurements undertaken by all Executive Branch entities.

## Public Letter

### Gloucester County's Unlawful Award of Emergency Contract

In April 2023, the division issued a significant public letter to Gloucester County for its failure to comply with Local Public Contracts Law. OSC found that Gloucester County impermissibly relied on Governor Murphy's COVID-19 emergency declaration to award a previously planned road construction project in the amount of $4.9 million. OSC found that there was no nexus between the emergency road work and the COVID-19 emergency and that the project should have been publicly advertised and competitively bid. OSC also found that the County failed to follow proper procedures when it allowed the low bidder to withdraw its bid resulting in a lack of transparency and accountability to the public. Disregarding important public bidding requirements, as here, threatens to erode confidence in the public bidding laws and their use by local officials.

## Educational Outreach

In FY 2023, the division continued its extensive outreach to government contracting units across the state to review their procurement processes and specific compliance issues identified by OSC. Division attorneys also participated on various government-related panels and webinars discussing the procurement requirements for the expenditure of federal COVID-19 related funds and other matters concerning OSC's statutory authority to review public procurements.

**Our COVID-19 Recovery Contracts website, https://nj.gov/covid19oversight/transparency/contracts/reports.shtml, is a great resource to view contracts funded by federal COVID-19 Recovery Funds. The posted contracts include expenditures from the beginning of the pandemic and continue through the recovery period.**

# COVID-19 Compliance and Oversight Project

The COVID-19 Compliance and Oversight Project (COVID-19 Project) is a special project within OSC that promotes accountability, transparency, and compliance in the spending of billions of COVID-19 federal recovery funds in New Jersey. The COVID-19 Project accomplishes this through ongoing monitoring and oversight, special projects and targeted reviews, and by offering technical assistance and training to state and local government units.

Caroline Jones joined the COVID-19 Project as Director in May 2022, bringing over a decade of New Jersey public sector experience to the position. The COVID-19 Project is staffed by a dedicated team with expertise in investigations, fraud, accounting, auditing, and legal and regulatory compliance.

The COVID-19 Project regularly interfaces with state and local government units on matters of oversight and compliance. This includes ongoing communication with the State's Accountability Officers – senior officials within agencies, departments, and authorities responsible for the oversight of COVID-19 recovery funding disbursement and administration. It also involves outreach to officials in municipalities and counties in New Jersey that have received COVID-19 recovery funds. In FY 2023, the COVID-19 Project provided state and local governments with timely reminders on compliance issues.

This fiscal year, the COVID-19 Project continued its work overseeing the State's contracted Integrity Oversight Monitors. Integrity Monitors are independent monitors deployed throughout the state to assist state entities with establishing programs, managing grants, or administering programs (Category 1 and 2 Integrity Monitors), or to oversee and monitor the use of COVID-19 recovery funds and check for non-compliance or fraud, waste, or abuse (Category 3 Integrity Monitors). The Integrity Oversight Monitoring program is integral to the State's accountability infrastructure and is intended to aid in a more transparent and effective recovery. The COVID-19 Project oversees these engagements, select deliverables, and the quarterly Integrity Monitor reports to help maximize the value to the State and to identify or intervene in any issues requiring follow-up or corrective action. This work has led to follow-up reviews of agency programs including the New Jersey Department of Environmental Protection's Marine Fisheries Program, highlighted below, to ensure that State agencies are implementing the recommendations suggested by their monitors. Integrity Monitor quarterly reports are public documents and are available for review on the state's COVID-19 Compliance and Transparency webpage.

OSC and the COVID-19 Project also support the work of the COVID-19 Compliance and Oversight Taskforce. The Taskforce was established by Executive Order 166 (Murphy, 2020) and is chaired by the Acting State Comptroller.

Through ongoing monitoring and more targeted reviews, the COVID-19 Project has addressed issues involving reporting, proper internal controls, policies and procedures, duplication of benefits, the use of self-attestations, fraud risks, documentation requirements, and more. Public reporting by the COVID-19 Project in FY 2023 includes a follow up review of the Department of Environmental Protection's implementation of the CARES Act Fisheries Program and a joint investigation into New Jersey City University's Financial Emergency (also highlighted above).

## Public Reports

The COVID-19 Project produced the following public reports in FY 2023:

### Follow-Up Review of COVID-19 CARES Act Marine Fisheries Assistance Grant Program

In late FY 2022, OSC issued a report in connection with its review of the Department of Environmental Protection's (DEP) administration of the New Jersey COVID-19 CARES Act Marine fisheries Assistance Grant Program. Also that year, DEP contracted with an independent Integrity Monitor to review the same program. OSC's March 2022 report and the Integrity Monitor's September 2022 report reached substantially similar conclusions about the program. Both reviews found significant deficiencies in the financial records and documents provided by the program applicants and that many recipients of the federal grants where made "more than whole" subjecting their awards to potential recoupment.

OSC reviewed the Integrity Monitor's findings alongside its own findings to understand the total impact to the program. Collectively, OSC and the Integrity Monitor reviewed 52 out of 117 total applications to the Fisheries Program, which accounted for $12.6 million of the $14.4 million awarded (88 percent) by DEP. OSC found that up to 49 percent, $14.4 million of the COVID-19 funds awarded to fisheries may need to be returned to that state for failing to meet program guidelines.

Because both OSC and the Integrity Monitor made recommendations, OSC also followed up with DEP regarding what steps it has taken to address the findings in OSC's and the Integrity Monitor's reports. In response to OSC's follow up, DEP stated it has begun to review the $7 million in awards identified as inappropriate by OSC and the Integrity Monitor and seek recoupment of funds, where appropriate, pursuant to its program guidance. DEP also advised that it has instituted additional controls for the distribution of federal funds in other COVID-19 programs that it administers to reduce the opportunity for fraud, waste, or abuse.

### An Investigation into New Jersey City University's Financial Emergency

In collaboration with OSC's Investigations Division, the COVID-19 Project investigated New Jersey City University's financial emergency which the University declared in June 2023. As outlined above in a previous section, this investigation revealed several important factors that lead to NJCU's financial crisis. Among those factors, OSC found that an immediate cause of the financial emergency was that the University planned to improperly fund around eight percent of the expenses in its 2022 budget—nearly $14 million—using federal COVID-19 relief funding from the Higher Education Emergency Relief Fund (HEERF). HEERF is a $76 billion federal program designed

to help alleviate the impacts of the COVID-19 pandemic to institutions of higher education across the country. NJCU's planned to use a large portion of its HEERF grant to fund non-pandemic-related institutional scholarship expenses, an improper use that violated restrictions on the use of the funds. While ultimately the funds were not used for that purpose, OSC concluded that NJCU's administrators knew that federal law likely prohibited them from using the funds in that way yet failed to correct the significant budget gap created as a result leading to the financial emergency.

# Police Accountability Project

The Police Accountability Project is a special project within OSC that is working to detect fraud, waste, abuse, and misconduct in law enforcement agencies exercising Executive Branch authority. Using OSC's full investigatory powers and oversight over the expenditure of government funds, the Project is actively engaged in multiple investigations into how public funds are used for different aspects of policing. The Project's mission includes investigating whether there are policing practices that expose the state to significant civil liability and reviewing and reporting to the general public on how taxpayer funds are used for policing so taxpayers can understand what public safety services they are actually paying for. The Project seeks to identify areas in which there are wasteful inefficiencies, or in which funds may be lacking to fully implement police reform efforts and realize the stated goals of legislation and directives.

The Project is led by Senior Advisor Jane Schuster, who brings to OSC nearly a decade of experience on policing issues, including the legality and propriety of police encounters, internal affairs and disciplinary processes, and various aspects of police training. The Project is staffed by a dedicated team, whose wealth of diverse skills and experience bring added expertise and perspective. The Project also regularly collaborates with other OSC divisions on investigations, reviews, and audits that intersect with policing issues.

## Public Reports

The Police Accountability Project produced the following investigative reports in FY 2023:

### The Department of Children and Families Changed its Practices to Limit Access to Child Welfare Services Without Notifying Stakeholders

OSC initiated this investigation in February 2022, in response to numerous complaints alleging that the Department of Children and Families (DCF or the Department) had changed its policies or practices on how it responds to allegations of child-on-child sexual activity and child sexual abuse by non-caregivers. The complainants alleged that DCF had stopped accepting these cases for intake and services by the Division of Child Protection and Permanency (DCPP), the division within DCF charged with child protection and child welfare, and that it did so without providing notice to law enforcement and multi-disciplinary teams (MDTs) that had previously coordinated their response to these types of cases. The complainants further alleged that as a result of these changes, and because of the lack of

coordination and notice, the children involved in these cases were not receiving appropriate services and interventions.

Through its investigation, OSC obtained internal DCF documents corroborating that in early 2020, DCF changed its practices with regard to how it handled allegations of child-on-child sexual activity (including sexual assault) and child sexual abuse by non-caregivers. These changes to the intake and screening process were not communicated to law enforcement or DCF's other MDT partners, creating confusion and concern among stakeholders about how to handle these cases. As a result of DCF's new practices, OSC found that a significant number of children did not receive services and interventions that had previously been provided by DCPP.

Given its findings, OSC made six recommendations to ensure greater transparency about DCF's current policies and practices and help ensure any impacted children and families receive appropriate services. The recommendations to DCF included: (1) complying with current written policies and only changing policies after adequate notice to all stakeholders and time to prepare for such changes; (2) engaging cooperatively with law enforcement and other members of the MDTs regarding the appropriateness of changes in policy and practices and the capability of law enforcement to engage in areas in which DCPP previously engaged; (3) being transparent with law enforcement, other members of the MDTs, and the public about the decision to limit the number of child welfare assessments performed by DCPP caseworkers in cases that involve child-on-child inappropriate sexual activity and non-caregiver sexual abuse in contravention of current published policy; (4) complying with its own administrative directive requiring the issuance of Department-wide updates informing staff of changes and placing updated policies on the Department's webpage; (5) ensuring the children identified as the subject of reports of child-on-child inappropriate sexual activity who needed services were connected with services and that the services were appropriate to meet the needs of the children; and (6) providing transparency, going forward, about changes to policies and practices that will have a direct impact on members of the MDTs and the public.

## A Review of Municipal Police Websites' Compliance with Internal Affairs Policies & Procedures

OSC's Police Accountability Project conducted a review of 100 randomly selected municipal police departments' websites for compliance with the current internal affairs policies and procedures. Specifically, OSC reviewed the websites for availability of the standardized internal affairs report form and complaint information sheet, along with other markers of an electronically accessible internal affairs complaint process.

OSC found that the majority of municipal police departments were not following all of the relevant mandates with respect to the information they were making available online about the internal affairs complaint process. OSC also found that many of the departments were engaging in practices either intended to discourage complaints or that could have a chilling effect, especially with regard to complaints made by undocumented persons, non-English speakers, and anonymous sources. The high degree of non-compliance uncovered by OSC in this review signals a potential statewide issue with law enforcement agencies failing to adhere to Attorney General mandates governing the intake of complaints online. This lack of compliance has the potential to undermine at least one of the overarching goals of the Attorney General's Policing Initiative — building and maintaining public trust in police —

and may impede the efficacy of the internal police disciplinary process overall.

Based on its findings, OSC made recommendations to ensure compliance with mandatory internal affairs policies and procedures by law enforcement statewide and to encourage reporting of police misconduct from all New Jersey residents. These recommendations included: (1) recommending that all local departments and law enforcement agencies review the information they make available to the public online to ensure that the information is updated to be compliant with the most recent version of the Internal Affairs Policies and Procedures (IAPP); (2) recommending that the Attorney General conduct a full review of compliance with the IAPP with regard to acceptance of complaints to ensure that the internal affairs complaint process remains as accessible as possible; and (3) recommending that the Attorney General and/or County Prosecutors investigate police departments in their jurisdiction that do not comply with the basic mandates of the IAPP as discussed in the report.

# Survey Project

OSC's Survey Project is an interdisciplinary special project within OSC that works to detect fraud, waste, and abuse in local governments exercising Executive Branch authority. Using OSC's investigatory powers and authority to conduct performance reviews, the Survey Project surveys state or local government units collecting data on policies and practices. The collection and analysis of such data allows OSC to determine if state or local government units comply with applicable laws and regulations, or if there are any specific or systemic failures that allow for fraud, waste, or abuse.

The Survey Project is led by Legal Affairs and Audit Specialist David Bender, bringing years of New Jersey public sector experience to the position. The Survey Project is staffed by a dedicated team with expertise in investigations, accounting, and legal and regulatory compliance. The Survey Project also regularly collaborates with other OSC divisions on investigations, reviews, and audits that intersect with local government policy issues.

## Public Report

The Survey Project produced the following report in FY 2023:

### A Review of Sick and Vacation Leave Policies in New Jersey Municipalities

OSC initiated this review in 2021 as a result of the same lack of compliance with state law occurring in previous audits and a recent investigation of Palisades Park Borough. Multiple independent government agencies had reported on sick leave abuse in the past. In 2005 to 2006, three different reports came to the same conclusion: extravagant sick and vacation leave payouts were driving up property taxes in New Jersey and reforms were needed to end it.

The Legislature enacted laws in 2007 and 2010 to reform such practices. In 2007, the state limited senior management local government employees to payments for accumulated unused sick leave to $15,000, or the amount accrued as of the effective date of the law or when the employee is hired to the senior position, if more than $15,000. The law only allowed payment at the time of retirement. In 2010, the state expanded the limitation to all employees hired after May 21, 2010 or at the expiration of current collective bargaining agreements. The 2010 law capped payment for unused sick leave to $15,000, and only at retirement. Both the 2007 and 2010 laws also capped the accrual of vacation leave to two

years, unless there was a state-declared emergency that would prevent the employees use.

OSC selected 60 municipalities to evaluate compliance with state law that had intended to curb large payments for unused sick and vacation leave to employees. Through the use of surveys, document reviews, and analysis of publicly available data, OSC was able to examine payments made, policies, employee handbooks, ordinances, and employment contracts to determine compliance with state law.

OSC found that 95 percent of the municipalities surveyed did not have policies and procedures or employment contracts that complied with the law. OSC also found that 60 percent allowed payments over the statutory cap of $15,000. OSC further found that 48 percent continued the policy of paying employees annually for unused sick leave regardless of when the person had been hired. OSC also found that 27 percent of the municipalities had policies that allowed for more than two years' worth of vacation leave.

Based on the findings, OSC made recommendations to ensure compliance with state sick and vacation leave laws, including: requiring municipalities to address and correct the identified policies, ordinance or contracts found to be non-compliant; requesting a legal review and amend contracts, personnel policies, and ordinances; providing transparency and prevent improper payments through an independent assessment; and developing an effective system of internal controls for all supplemental payments. OSC continues to evaluate and oversee the corrective action plans submitted by those municipalities.

OSC also recommended that all local governments examine their policies and contracts to determine if they are compliant with state law. OSC further recommended that the New Jersey Legislature review the sick and vacation laws to amend or supplement them to ensure compliance.

Subsequent to the publication of OSC's report, the State revised regulations to clarify eligibility and timing of sick and vacation leave, and to require, as part of a municipality's annual audit, that payments for unused sick and vacation leave be sampled for examination by the auditor to oversee eligibility and amount of such payments.

# Appendix – MFD Settlements & Audits

## Settlement Agreement/ Overpayment Letter Case Summaries

Ramos Foot and Ankle Center
Settlement Agreement (7/6/22)

MFD resolved an audit of Ramos Foot and Ankle Center (RFAC), located in Perth Amboy, New Jersey, with Ramos agreeing to repay the Medicaid program $70,000. Through this audit, MFD determined that, for the period from July 1, 2014 through June 30, 2019, RFAC incorrectly billed and received payment from the Medicaid program for claims that failed to have necessary supporting documentation for services rendered and for the provision of durable medical equipment.

Dignity Nursing Solutions
Settlement Agreement (7/11/22)

MFD resolved an investigation of BKT High Quality Healthcare Agency, d/b/a Dignity Nursing Solutions, located in Bridgeton, New Jersey, with Dignity Nursing Solutions agreeing to repay the Medicaid program $465,059.47, comprised of a principal amount of $425,744.57, plus a civil penalty in the amount of $34,818.27, plus an interest payment of $4,496.63. From this investigation, MFD determined that, from March 17, 2016 through August 2, 2019, Dignity Nursing Solutions improperly billed for and received payments from the Medicaid program for claims for personal care services for which Dignity Nursing Solutions failed to possess necessary supporting documentation. Additionally, MFD determined that Dignity Nursing Solutions submitted inconsistent documentation relating to 440 claims, which resulted in the imposition of a civil penalty in the amount of $34,818.27.

Royal Homecare, LLC
Settlement Agreement (7/12/22)

MFD resolved a self-disclosure by Royal Homecare, LLC, located in Newark, New Jersey, with Royal Homecare, LLC agreeing to repay the Medicaid program $6,107.40. Royal Homecare, LLC disclosed and MFD verified that between November 1, 2021 and January 7, 2022, Royal Homecare, LLC improperly billed for and received payments from the Medicaid program for Community-Based Wrap-Around Services that were not rendered.

Atrium Post Acute of Wayneview
Settlement Agreement (7/13/22)

MFD resolved a review, conducted by its Third Party Liability (TPL) Contractor, Health Management Systems, Inc. (HMS), of Atrium Post Acute of Wayneview, a long-term care facility, located in Wayne, New Jersey, with Atrium Post Acute of Wayneview agreeing to repay the Medicaid program $356,217.22. Through this review, HMS determined that, from August 1, 2016 through January 30, 2020, Atrium Post Acute of Wayneview improperly received Medicaid managed care patient liability and claim overpayments to which it was not entitled.

Dr. Haim Cohen
Notice of Overpayment (7/14/22)

MFD resolved a review of Dr. Haim Cohen (Cohen) located in Howell, New Jersey, with Cohen agreeing to repay the Medicaid program $21,072.20. Through its review, MFD determined that, from July 1, 2016 through April 1, 2021, Cohen submitted claims and received payment in some instances for services for which he did not maintain sufficient documentation to support those services or for services for which he utilized incorrect billing codes when billing and receiving payment from the Medicaid program, in violation of state regulation.

Somerset Woods Rehabilitation
Settlement Agreement (7/14/22)

MFD resolved a review, conducted by its TPL Recovery Services Contractor, HMS, of Somerset Woods Rehabilitation (Somerset Woods), a long-term care facility, located in Somerset, New Jersey, with Somerset Woods agreeing to repay the Medicaid program $444,797.84. Through this review, HMS determined that, from August 1, 2016 through January 31, 2020, Somerset Woods Rehabilitation improperly received Medicaid managed care patient liability and claim overpayments to which it was not entitled.

ADV Counseling Services, LLC
Settlement Agreement (7/15/22)

MFD resolved an audit of ADV Counseling Services, LLC, located in Northfield, New Jersey, with ADV Counseling Services, LLC agreeing to repay the Medicaid program $62,000. Through this audit, MFD determined that ADV Counseling Services, LLC incorrectly billed the Medicaid program for claims that failed to comply with the minimum standards for individuals providing behavioral assistance services and for claims that failed to have necessary supporting documentation for intensive in-community and behavioral assistance services in violation of the applicable regulatory requirement during the period March 1, 2014 through February 15, 2019.

West Broadway Dental, PA
Settlement Agreement (7/21/22)

MFD resolved an investigation of West Broadway Dental, PA (West Broadway), located in Paterson, New Jersey, with West Broadway agreeing to repay the Medicaid program $145,000. Through this investigation, MFD determined that for the period from July 1, 2015 through May 31, 2020, West Broadway submitted claims that failed to have necessary supporting documentation for dental services.

Pediatricare Associates
Settlement Agreement (8/5/22)

MFD resolved an investigation of Pediatricare Associates (Pediatricare) located in Fairlawn, New Jersey, with Pediatricare agreeing to repay

the Medicaid program $153,000. Through this investigation, MFD determined that, for the period from September 1, 2015 through August 31, 2020, Pediatricare submitted claims that failed to have the necessary clinical supporting documentation.

Joseph DeMeyer PhD
Notice of Overpayment (8/8/22)

MFD resolved a review of Joseph DeMeyer PhD (DeMeyer), a skilled nursing provider located in Wayne, New Jersey, with DeMeyer agreeing to pay $60,439.75 in restitution to the Medicaid program. Through its review, MFD determined that, from January 1, 2017 through November 9, 2021, DeMeyer did not submit documentation to support the services for which it billed and received reimbursement from the Medicaid program, in violation of the applicable regulatory requirement.

Mercy Home Care
Notice of Overpayment (8/12/22)

MFD resolved its review of Mercy Home Care (Mercy), located in Cherry Hill, New Jersey, with Mercy agreeing to repay the Medicaid program $87,115.63. Through this review, MFD determined that, from January 1, 2017 through December 31, 2021, Mercy billed and was reimbursed for Personal Care Services claims for certain beneficiaries while these beneficiaries were in-patient in a hospital, in violation of applicable regulatory requirements.

Rainbow Home Adult Medical Day Care
Notice of Overpayment (8/16/22)

MFD reviewed claims submitted by Rainbow Home Adult Medical Day Care (Rainbow), an adult medical day care (AMDC) provider located in Somerset, New Jersey, to determine whether Rainbow billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2016 through December 31, 2021, Rainbow violated Medicaid regulations by submitting claims and receiving Medicaid payments of $12,050.10 for services in excess of five days per week, while beneficiaries were admitted to an inpatient facility, and while beneficiaries received services from another AMDC on the same date of service. Accordingly, MFD found that Rainbow received an overpayment of $12,050.10 that it had to repay to the Medicaid program. Rainbow paid the full amount identified in MFD's review.

Stars Adult Medical Day Care Center
Notice of Overpayment (8/16/22)

MFD reviewed claims submitted by Stars Adult Medical Day Care Center (Stars), an AMDC located in Camden, New Jersey, to determine whether Stars billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2016 through December 31, 2021, Stars violated Medicaid regulations by submitting claims and receiving Medicaid payments of $9,235.60 for services in excess of five days per week, while beneficiaries were admitted to an inpatient facility, and while beneficiaries received services from another AMDC on the same date of service. Accordingly, MFD found that Stars received an overpayment of $9,235.60 that it had to repay to the Medicaid program. Stars paid the full amount identified in MFD's review.

Canterbury at Cedar Grove and Rehabilitation Center, LLC
Settlement Agreement (8/16/22)

MFD, through its TPL Contractor, HMS, resolved a review of Canterbury at Cedar Grove and Rehabilitation Center, LLC (Canterbury), a long-term care facility, located in Cedar Grove, New

Jersey, with Canterbury agreeing to repay the Medicaid program $309,541.20. Through this review, HMS determined that, for the period from October 1, 2016 through March 31, 2020, Canterbury improperly received Medicaid Managed Care Organization and Medicaid fee-for-service patient liability and claim overpayments to which it was not entitled.

Windsor Gardens Care Center
Settlement Agreement (8/16/22)

MFD, through its TPL Contractor, HMS, resolved a review of Windsor Gardens Care Center (Windsor Gardens), a long-term care facility, located in East Orange, New Jersey, with Windsor Gardens agreeing to repay the Medicaid program $442,950.86. Through this review, HMS determined that, for the period from September 1, 2016 through September 30, 2021, Windsor Gardens improperly received Medicaid Managed Care Organization and Medicaid fee-for-service patient liability and claim overpayments to which it was not entitled.

Broadway Respite and Home Care LLC
Notice of Overpayment (8/18/22)

MFD resolved a review of Broadway Respite and Home Care LLC (Broadway) located in Fair Lawn, New Jersey, with Broadway agreeing to repay the Medicaid program $41,925.45. Through this review, MFD determined that Broadway billed and was reimbursed for Personal Care Services during its review period of June 1, 2017 through December 31, 2021 for certain beneficiaries who had in-patient status in a hospital, nursing facility, residential health care facility, or assisted living facility, in violation of the applicable regulatory requirement.

Town Square Medical Day Care
Settlement Agreement (8/29/22)

MFD resolved a review of Town Square Medical Day Care (Town Square), an AMDC located in Elizabeth, New Jersey, with Town Square agreeing to repay the Medicaid program $36,956. Through this review, MFD determined that, from January 1, 2016 through December 31, 2021, Town Square violated Medicaid regulations by submitting claims and receiving Medicaid payments for services in excess of five days per week, while beneficiaries were admitted to an inpatient facility, and while beneficiaries received services from another AMDC on the same date of service.

P & C Medical Group, LLC
Settlement Agreement (9/7/22)

MFD resolved an investigation of P&C Medical Group, LLC (P&C), a family medicine practice located in Elizabeth, New Jersey, with P&C agreeing to repay the Medicaid program $308,589.93. Through this investigation, MFD determined that, between July 1, 2013 and June 30, 2018, P&C's documentation did not support its billings and subsequent reimbursements by Medicaid fee-for-service and the Managed Care Organizations.

Garden State Healthcare Associates
Settlement Agreement (9/9/22)

MFD resolved an investigation of Garden State Healthcare Associates (GSHA), a physician group located in Bayonne, New Jersey, with GSHA agreeing to repay the Medicaid program $58,129.00. Through this investigation, MFD determined that, between January 1, 2016 and July 31, 2021, GSHA incorrectly received payment from both Medicaid fee-for-service and Medicaid Managed Care Organizations (MCO) for the same patient(s), for the same

date(s) of service, for the same service(s), when the MCO was the responsible payer.

New Life Adult Day Care
Notice of Overpayment (9/12/22)

MFD reviewed claims submitted by New Life Adult Day Care (New Life), an AMDC located in Paramus, New Jersey, to determine whether New Life billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2017 through May 31, 2022, New Life violated Medicaid regulations by submitting claims and receiving Medicaid payments for services in excess of five days per week, while beneficiaries were admitted to an inpatient facility, and while beneficiaries received services from another AMDC on the same date of service. Accordingly, MFD found that New Life received an overpayment of $173,461.90 that it had to repay to the Medicaid program. New Life paid the full amount identified in MFD's review.

Golden Path Adult Day Care
Settlement Agreement (9/14/22)

MFD resolved its review of Golden Path Adult Day Care (Golden Path), located in New Brunswick, New Jersey, with Golden Path agreeing to repay the Medicaid program $126,782.20. Through its review, MFD determined that, from January 1, 2017 through May 31, 2022, Golden Path violated Medicaid regulations by submitting claims and receiving Medicaid payments for services provided while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long-term care center, in excess of five days per week, and while the recipients were receiving services from another AMDC provider on the same date of service.

Let's Talk Therapies Speech and Language Services, LLC
Notice of Overpayment (9/16/22)

MFD resolved a review of claims submitted by Let's Talk Therapies Speech and Language Services, LLC (Let's Talk), based in Jackson, New Jersey, with Let's Talk repaying the Medicaid program $13,357. Through this review, MFD determined that, for the period from January 1, 2017 through December 31, 2018, Let's Talk improperly unbundled speech language therapy claims related to 637 episodes of care.

Compassionate Care Hospice of Northern New Jersey, LLC
Final Findings Report (9/30/22)

MFD resolved a review performed by the Northeastern Unified Program Integrity Review Contractor, Safeguard Services, LLC (SGS), involving hospice claims submitted by Compassionate Care Hospice of Northern New Jersey, LLC (Compassionate Care), based in Budd Lake, New Jersey, with Compassionate Care repaying the Medicaid program $2,236. Through this review, MFD, working in coordination with SGS, determined that, for the period from January 1, 2017 through September 30, 2019, Compassionate Care improperly billed the Medicaid program for 12 hospice service claims for beneficiaries who had been discharged from hospice and, thus, had not received such care.

Peaceful Adult Day Care
Notice of Overpayment (10/3/22)

MFD reviewed claims submitted by Peaceful Adult Day Care (Peaceful), located in Little Ferry, New Jersey, to determine whether Peaceful appropriately billed for services in accordance with applicable requirements. Through its

review, MFD determined that, from January 1, 2017 through May 31, 2022, Peaceful violated Medicaid regulations by submitting claims and receiving Medicaid payments for services provided while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center, in excess of five days per week, and while the beneficiaries were receiving services from another AMDC provider on the same date of service. Accordingly, MFD found that Peaceful received an overpayment of $130,141.60 that it had to repay to the Medicaid program. Peaceful paid the full amount identified in MFD's review.

Atmiya Adult Day Care
Notice of Overpayment (10/18/22)

MFD reviewed claims submitted by Atmiya Adult Day Care (Atmiya), located in Elmwood Park, New Jersey, to determine whether Atmiya appropriately billed for services in accordance with applicable requirements. Through its review, MFD determined that, from January 1, 2017 through May 31, 2022, Atmiya violated Medicaid regulations by submitting claims and receiving Medicaid payments for services provided while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long-term care center, in excess of five days per week, and while beneficiaries were receiving services from another AMDC provider on the same date of service. Accordingly, MFD found that Atmiya received an overpayment of $60,367.80 that it had to repay to the Medicaid program. Atmiya paid the full amount identified in MFD's review.

Five Star Adult Daycare
Settlement Agreement (10/31/22)

MFD resolved its review of Five Star Adult Medical Day Care Center (Five Star), located in Linden, New Jersey, with Five Star agreeing to repay the Medicaid program $52,115.30. Through its review, MFD determined that, from January 1, 2016 through December 31, 2021, Five Star violated Medicaid regulations by submitting claims and receiving Medicaid payments for services provided while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long-term care center, in excess of five days per week, and while beneficiaries were receiving services from another AMDC provider on the same date of service.

Mount Carmel Guild Behavioral Health
Notice of Overpayment (11/1/22)

MFD resolved a review of claims submitted by Mount Carmel Guild Behavioral Health (Mount Carmel), based in Newark, New Jersey, with Mount Carmel repaying the Medicaid program $11,934. Through this review, MFD determined that, for the period from January 1, 2017 through February 29, 2020, Mount Carmel improperly billed for 662 units of partial care services that exceeded Mount Carmel's pre-approved number of authorized units.

Pediatrics Morristown and Essex Pediatrics
Settlement Agreement (11/3/22)

MFD resolved an investigation of Pediatrics Morristown and Essex Pediatrics, and owner Rosario Zambrano, MD (collectively referred to as Pediatrics), located in East Orange, New Jersey, with Pediatrics agreeing to repay the Medicaid program $392,200. Through this investigation, MFD determined that Pediatrics did not have sufficient documentation to support certain claims for which it was reimbursed by the Medicaid program during the period from June 1, 2015 to May 5, 2020.

White House Healthcare and Rehabilitation Center, Inc.
Settlement Agreement (11/9/22)

MFD resolved a review, conducted by its TPL Contractor, HMS, of White House Healthcare and Rehabilitation Center, Inc. (White House), a long-term care facility located in Orange, New Jersey, with White House agreeing to repay the Medicaid program $493,667.37. Through this review, HMS determined that, from October 1, 2016 through March 31, 2020, White House improperly received Medicaid Managed Care Organization patient liability and claim overpayments to which it was not entitled.

Golden Years Adult Day Care Center, LLC
Notice of Overpayment (12/14/22)

MFD resolved a review of claims submitted by Golden Years Adult Day Care Services, LLC (Golden Years), based in Woodland Park, New Jersey, with Golden Years repaying the Medicaid program $20,984, which was later adjusted to $20,247, with the difference refunded to Golden Years. Through this review, MFD determined that, for the period from January 1, 2017 through May 31, 2017, Golden Years improperly billed the Medicaid program 86 claims for at-home services while the beneficiary was actually in an in-patient facility such as a hospital, 168 claims that exceeded the five consecutive days in a week requirement, and 5 claims that overlapped with another provider's claims for services for the same beneficiary on the same date.

Heart to Heart Health Care Services, LLC
Settlement Agreement (12/28/22)

MFD resolved an audit of Heart to Heart Health Care Services, LLC. (HTH), located in East Orange, New Jersey, with HTH agreeing to repay the Medicaid program $1,506,618. Through this audit, MFD determined that HTH was paid for claims for personal care services that were not supported by clinical documentation, in violation of the applicable regulatory requirement during the period from August 1, 2014 to July 31, 2019.

Variety Drug Pharmacy
Settlement Agreement (1/4/23)

MFD resolved an investigation of Variety Drug Pharmacy, located in Garfield, New Jersey, with Variety Drug Pharmacy agreeing to repay the Medicaid program $37,399.01, comprised of a principal amount of $24,932.67 plus a civil penalty of $12,466.34 against the pharmacy's owners. Through this investigation, MFD determined that, from January 1, 2019 through March 1, 2020, Variety Drug Pharmacy's inventory for selected medications was insufficient to account for the quantity of medications that Variety Drug Pharmacy dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

Surgical Sock, Inc.
Settlement Agreement (1/4/23)

MFD's Audit unit reviewed claims submitted by Surgical Sock, Inc. (Surgical Sock), a durable medical equipment (DME) provider located in Lakewood, New Jersey, to determine whether Surgical Sock appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2014 through December 31, 2018, Surgical Sock was reimbursed for certain claims for DME, including compression stockings, breast pumps, walking boots, supportive devices, blood pressure monitors, enuresis alarms, respiratory devices,

and for orthotics management and training, that MFD determined lacked necessary supporting documentation, in violation of the applicable regulatory requirements. As such, MFD found that Surgical Sock received an overpayment of $175,000 and Surgical Sock agreed to repay the Medicaid program this amount.

Physiologic Assessment Services, LLC
Settlement Agreement (1/31/23)

MFD's Investigation Unit reviewed claims submitted by Physiologic Assessment Services, LLC (Physiologic Assessment Services), an otolaryngology provider located in Teaneck, New Jersey, to determine whether Physiologic Assessment Services appropriately billed for services in accordance with applicable requirements. MFD determined that, from July 1, 2016 through April 30, 2021, Physiologic Assessment Services was reimbursed for claims that failed to have necessary supporting documentation for American Medical Association's Current Procedural Terminology (CPT) code 95941, in violation of the applicable regulatory requirement. As such, MFD found that Physiologic Assessment Services received an overpayment of $149,900 and Physiologic Assessment Services agreed to repay the Medicaid program this amount.

Cooper University Health Care
Settlement Agreement (2/16/23)

MFD resolved an investigation of Cooper University Health Care d/b/a Cooper University Hospital (Cooper Hospital) located in Camden, New Jersey, with Cooper Hospital agreeing to repay the Medicaid program $551,304.89. Through this investigation, MFD determined that Cooper Hospital's clinical documentation did not support its billings from August 1, 2018 through December 32, 2020 and subsequent reimbursements by Medicaid fee-for-service, the New Jersey Hospital Care Payment Assistance Program (Charity Care), and the Managed Care Organizations for the claims for Healthcare Common Procedure Coding System (HCPCS) G0378, hospital observation services, in violation of the applicable regulatory requirement.

Delaire Nursing and Rehabilitation Company, LLC
Settlement Agreement (3/14/23)

MFD, through its TPL Contractor, HMS, determined that, from September 30, 2016 through September 30, 2017, Delaire Nursing and Rehabilitation Company, LLC (Delaire Nursing) improperly received Medicaid Manage Care Organization claim overpayments in the amount of $20,000 to which Delaire Nursing was not entitled. Delaire agreed to repay the Medicaid program this amount.

Alliance Adult Medical Day Care Services, LLC
Settlement Agreement (3/16/23)

MFD conducted a review and found that, between January 1, 2017 through May 31, 2022, Alliance Adult Medical Day Care Services, LLC (Alliance) was reimbursed for claims while the recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center, in violation of the applicable regulatory requirement. As such, MFD found that Alliance received an overpayment of $21,409, and Alliance agreed to repay the Medicaid program this amount.

Signature Medical Daycare
Notice of Overpayment (4/6/23)

MFD reviewed claims submitted by Signature Medical Daycare (Signature), an AMDC provider located in Montclair, New Jersey. MFD

determined that, from January 1, 2017 through May 31, 2022, Signature violated Medicaid regulations by submitting claims and receiving Medicaid payments for services provided while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long-term care center, in excess of five days per week, and while beneficiaries were receiving services from another AMDC provider on the same date of service. Accordingly, MFD found that Signature received an overpayment totaling $79,079 that it had to repay the Medicaid program. Signature paid the Medicaid program the full amount identified in MFD's review.

### Mercer-Bucks Orthopaedics, P.C.
Settlement Agreement (4/28/23)

MFD's Investigation Unit reviewed claims submitted by Mercer-Bucks Orthopaedics P.C., d/b/a Mercer Bucks Orthopaedics (Mercer Bucks Orthopaedics), an orthopaedic provider located in Hamilton, New Jersey, to determine whether Mercer Bucks Orthopaedics appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2015 through March 30, 2019, Mercer Bucks Orthopaedics was reimbursed for claims which failed to have necessary supporting documentation for American Medical Association's Current Procedural Terminology (CPT) code(s) 99202 through 99215, 99242 through 99245, 20600 through 20610, and 98926 through 98928, in violation of the applicable regulatory requirement. As such, MFD found that Mercer Bucks Orthopaedics received an overpayment of $102,987, and Mercer Bucks Orthopaedics agreed to repay the Medicaid program this amount.

### Home Away from Home Adult Day Care of Nutley
Settlement Agreement (5/2/23)

MFD reviewed claims submitted by Essex Medical Day Care Center of Nutley, LLC d/b/a/ Home Away from Home Adult Day Care of Nutley (Home Away), an AMDC located in Nutley, New Jersey. MFD determined that, from January 1, 2017 through May 31, 2022, Home Away violated Medicaid regulations by submitting claims and receiving Medicaid payments for services rendered while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center, in excess of five days per week, and while the beneficiaries were receiving services from another AMDC provider on the same date of service. Accordingly, MFD found that Home Away received an overpayment of $43,356.20, and Home Away agreed to repay the Medicaid program this amount.

### Jersey Shore Medical Day Care
Notice of Overpayment (5/15/23)

MFD reviewed claims submitted by Jersey Shore Medical Day Care (Jersey Shore), an AMDC located in Asbury Park, New Jersey. MFD determined that, from January 1, 2016 through December 31, 2021, Jersey Shore violated Medicaid regulations by submitting claims and receiving Medicaid payments for services rendered while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center, in excess of five days per week, and while the patients were receiving services from another AMDC provider on the same date of service. Jersey Shore paid the Medicaid program the full amount identified in MFD's review.

Elizabeth Primary Care, LLC
Notice of Overpayment (5/19/23)

MFD resolved a review of claims submitted by Elizabeth Primary Care, LLC, located in Elizabeth, New Jersey, with Elizabeth Primary Care repaying the Medicaid program $40,425. Through this review, MFD determined that, for the period from March 1, 2018 through February 28, 2023, Elizabeth Primary Care improperly submitted 4,282 claims for procedures that were not supposed to be submitted in conjunction with other billed procedures.

Mejia Pediatrics, LLC
Settlement Agreement (5/26/23)

MFD's Investigation Unit reviewed claims submitted by Mejia Pediatrics, LLC (Mejia Pediatrics), a pediatric provider located in Elizabeth, New Jersey, to determine whether Mejia Pediatrics appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2017 through July 15, 2021, Mejia Pediatrics was reimbursed for claims for which Mejia lacked the necessary supporting documentation for American Medical Association's Current Procedural Terminology (CPT) modifier 25 when billed with an evaluation and management service, in violation of the applicable regulatory requirement. As such, MFD found that Mejia Pediatrics received an overpayment of $78,269.06, and Mejia Pediatrics agreed to repay the Medicaid program this amount.

Diane Mustafa, MD and Living Springs Women's Care
Notice of Overpayment (5/30/23)

MFD resolved a review of claims submitted by Diane Mustafa, MD, and Living Springs Women's Care, located in Passaic, New Jersey, with Dr. Mustafa/Living Springs Women's Care repaying the Medicaid program $11,125. Through this review, MFD determined that, for the period from April 1, 2018 through June 9, 2021, Dr. Mustafa/Living Springs Women's Care improperly unbundled 360 claims by submitting claims for services separately when such services were subsumed within other billed services.

All 4 Kidz Pediatrics, LLC
Settlement Agreement (6/8/23)

MFD resolved its review of All 4 Kidz Pediatrics, LLC (All 4 Kidz), located in North Bergen, New Jersey, with All 4 Kidz agreeing to repay $35,804.13. MFD determined that, from January 1, 2018 through December 31, 2020, All 4 Kidz inappropriately billed preventative medicine counseling services in conjunction with preventative medicine evaluation and management services for recipients on the same date of service.

Sayed Aly, MD
Notice of Overpayment (6/19/23)

MFD resolved a review of claims submitted by Sayed Aly, MD, located in Bayonne, New Jersey, with Dr. Aly repaying the Medicaid program $9,181. Through this review, MFD determined that, for the period from April 1, 2018 through March 15, 2023, Dr. Aly improperly unbundled 425 claims by submitting claims for services separately when such services were subsumed within other billed services.

South Amboy Adult Day Healthcare Center
Notice of Overpayment (6/23/23)

MFD reviewed claims submitted by South Amboy Adult Day Healthcare Center (South Amboy), an AMDC provider located in South Amboy, New Jersey. MFD determined that, from January 1, 2017 through May 31, 2022, South

Amboy violated Medicaid regulations by submitting claims and receiving Medicaid payments for services rendered while beneficiaries were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; in excess of five days per week, and while beneficiaries were receiving services from another AMDC provider on the same date of service. Accordingly, MFD found that South Amboy received an overpayment of $12,283 that it had to repay the Medicaid program. South Amboy paid the full amount identified in MFD's review.

## Summaries of Final Audit Reports and Closing Letters

An Examination of the Lowest-Rated Long Term Care Facilities Participating in New Jersey's Medicaid Program
Update Report (9/8/22)

OSC issued its second report regarding New Jersey's lowest performing nursing homes that continued to receive Medicaid funds. In its first report on this topic, issued in February 2022, OSC found that 15 nursing homes in New Jersey's Medicaid program performed poorly year after year without facing any consequences. To address that, OSC made recommendations to DMAHS, which oversees Medicaid providers, and to the New Jersey Department of Health (DOH), which oversees nursing homes. OSC recommended that DMAHS institute a phased approach to tie quality of care to admissions, including curtailing and/or capping admissions to nursing homes that consistently perform poorly and, in some cases, removing existing Medicaid beneficiaries from nursing homes that fail to improve. OSC further recommended that DMAHS eliminate or reduce the amount of the quality incentive program payments (QIPP) made to these poor-performing nursing homes. OSC also recommended that DMAHS and DOH collaborate to bar owners of the consistently lowest performing nursing homes from obtaining interests in or contracts with additional nursing homes.

In this updated report, OSC found that 12 nursing homes in New Jersey's Medicaid program, which provided services to approximately 1,835 Medicaid beneficiaries and received an average of $107 million annually in Medicaid funds, received the lowest-possible quality rating from CMS. Since the February 2022 report was issued, six LTCs moved off the list and three new LTCs joined the list. Nine LTCs were on both lists. One of the nine LTCs on both lists was shut down.

Edward Montoya, Doctor of Podiatric Medicine
Final Audit Report (9/28/22)

MFD audited claims submitted by Edward Montoya (Dr. Montoya), a podiatric medicine provider with locations in Elizabeth; Passaic; Perth Amboy; and Avenel, New Jersey, to determine whether Dr. Montoya billed in accordance with applicable requirements. MFD found that, for 114 out of 180 sample claims, Dr. Montoya failed to possess documentation that fully supported the claims and/or inaccurately billed HCPCS/CPT codes. After extrapolating the net dollars in error over the audit universe, MFD calculated that Dr. Montoya improperly received an overpayment of $333,408 that it had to repay to the Medicaid program.

Community Care Behavioral Health
Final Audit Report (2/21/23)

MFD audited claims submitted by Community Care Behavioral Health (Community Care), with

locations in Freehold; Piscataway; and Morris Plains, New Jersey, to determine whether Community Care billed for partial care services in accordance with applicable state and federal laws, regulations, and guidance. MFD found that 76 of the 292 claims (26 percent) failed to possess documentation that fully supported the number of units billed for partial care services. After extrapolating the net dollars in error over the audit universe, MFD calculated that Community Care improperly received an overpayment of $816,280 that it had to repay to the Medicaid program.

New Jersey Medicaid Continues to Fund Poor Quality Care for Nursing Home Residents
Update Report (3/31/23)

OSC issued its third report regarding New Jersey's lowest performing nursing homes that continued to receive Medicaid funds. In this updated report, OSC found that 12 nursing homes received the lowest-possible quality rating but continued to be paid tens of millions of dollars in Medicaid funds.

OSC found that despite having first issued recommendations to DMAHS more than a year prior to this report, with one exception, DMAHS disregarded OSC's recommendations. DMAHS followed OSC's recommendation to stop paying QIPPs to the lowest-performing nursing homes. Otherwise, DMAHS elected to continue the policies criticized in OSC's prior two reports.

OSC noted that its overall findings in the March 2023 report were almost identical to the original report—the consistently lowest-rated nursing homes continued to provide poor-quality care while continuing to be financed with public funds. OSC also noted that over a year after OSC first sounded the alarm, more than 1,500 Medicaid beneficiaries continued to receive care in these persistently lowest-rated nursing homes—facilities that have been consistently cited for serious failings in patient care, medical management, nutritional services, and overall environment. And New Jersey continued to pay an average of more than $102 million a year for this poor-quality service. Based on these poor outcomes, OSC reiterated the recommendations it made in its February 2022 report.

John Gore
Final Audit Report (2/23/23)

MFD audited claims submitted by John Gore, a Licensed Clinical Alcohol and Drug Counselor (Gore), located in South Plainfield, New Jersey, to determine whether Gore billed for intensive in-community mental-health rehabilitation and behavioral assistance services in accordance with applicable state regulations. MFD found that 280 of the 818 claims (34 percent) failed to comply with state regulations. After extrapolating the error dollars to the audit universe, MFD calculated that Gore improperly received an overpayment of $1,160,371 that it had to repay to the Medicaid program.

AtHome Medical, Inc.
Closing Report (5/5/23)

MFD audited AtHome Medical, Inc. (AtHome), a durable medical equipment and medical supplies provider located in Morris Plains and South Hackensack, New Jersey, to determine whether AtHome billed for items such as enteral formula, feeding supplies, and non-invasive ventilators in accordance with applicable requirements. MFD found that AtHome generally complied with applicable regulations and guidance. Based on its determination, MFD closed the audit without any adverse findings.