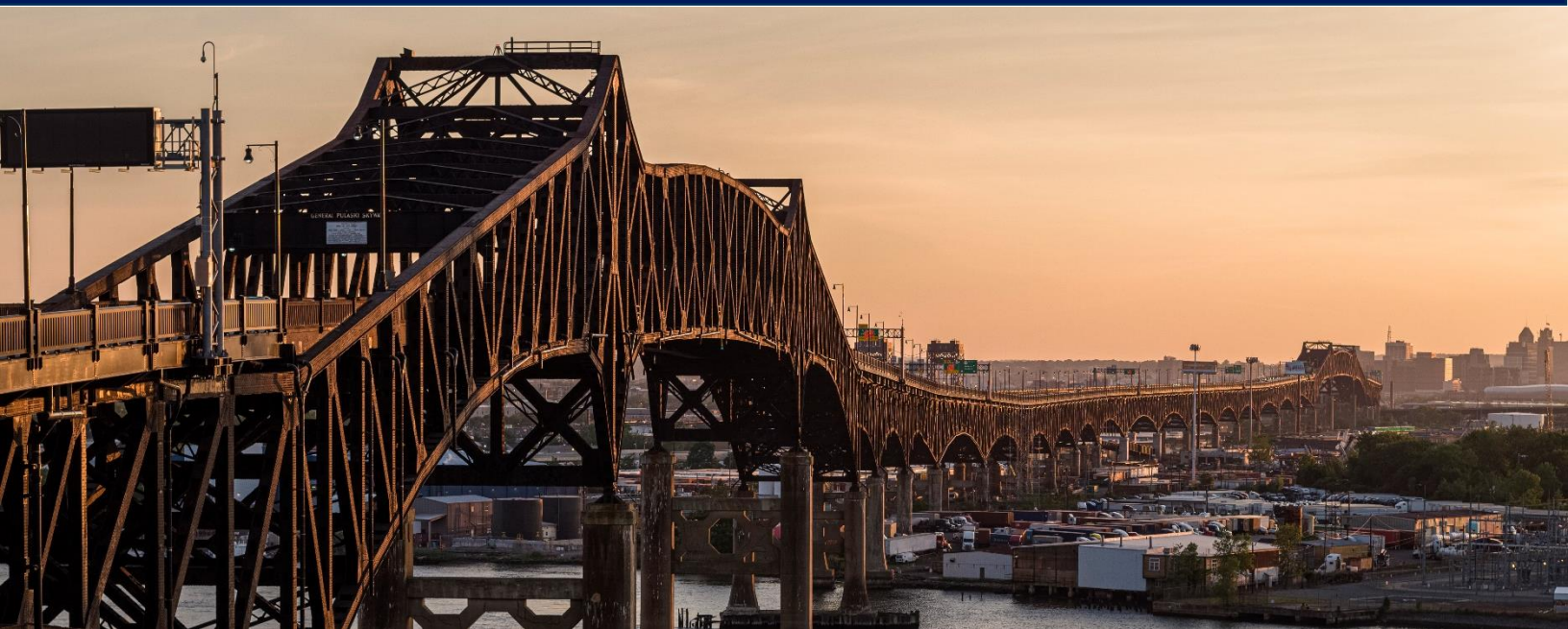
New Jersey Office of the State Comptroller Fiscal Year 2022 Annual Report

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

November 2022

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:

Nearly 15 years ago, the Office of the State Comptroller (OSC) was created with a clear mandate: To bring more transparency and financial accountability to government in New Jersey. Since then, OSC has uncovered government malfeasance, inspired policy reforms, and recovered many millions of taxpayer dollars.

This past fiscal year was a productive and impactful time for OSC. As you will see in our fiscal 2022 annual report, OSC effectively safeguarded public funds by exposing and reporting on fraud, waste, and abuse. As part of our commitment to keeping policymakers and the public informed about how tax dollars are being spent, we uncovered facts, shared findings, and developed recommendations – all with the goal of making New Jersey government more effective, transparent, and accountable.

OSC's four divisions continued to provide oversight through investigations, audits, and reviews. Our Medicaid Fraud Division (MFD) recovered or aided in the recovery of more than $141 million in taxpayer funds. MFD also published a major report revealing that 15 nursing homes, which together received more than $100 million a year in Medicaid funds, chronically received the lowest possible ratings. The report included a data dashboard showing many of the lowest-ranking nursing homes are for-profit and have been poorly rated for years. OSC made multiple recommendations to state agencies that oversee nursing homes and Medicaid. OSC will continue to track and report on whether those recommendations have been addressed.

As part of OSC's statutory obligation to scrutinize government spending, the Procurement Division reviewed 698 public contracts, 156 of which were valued at $12.5 million or more. These reviews protect taxpayer funds by ensuring that municipalities, school districts, state agencies, and other entities in the Executive Branch award their contracts in full compliance with procurement laws and regulations.

The Audit Division in FY 2022 issued reports involving a state college, a state agency, a municipality, and school districts. These audits provided transparency and identified ways to prevent fraud, waste,

and abuse. The division's report on the Economic Development Authority (EDA) found that EDA had made substantial progress in administering the State's tax incentive programs. OSC will continue to monitor its recommendations to provide greater assurance that businesses do not receive tax credits they have not earned.

Acting on tips and complaints from government workers and New Jersey residents, the Investigations Division probed and reported on procurement violations by a municipality, efforts to prevent fraud and abuse in the State's pension system, and raises given to county commissioners and the county sheriff without providing transparency to the public. These investigations found multiple violations of law and recommended changes to how state and local governments use taxpayer funds, all with the goal of providing more transparency to taxpayers.

OSC's COVID-19 Compliance and Oversight Project continued to oversee the billions of dollars in federal COVID-19 assistance provided to New Jersey by the federal government. The Project provided technical assistance and support to state and local government entities to identify and mitigate the risks of fraud, waste, and abuse in the use of COVID-19 recovery funds. The Project also reported on its review of the state Department of Environmental Protection's administration of the Marine Fisheries Assistance Grant Program and the state Department of Community Affairs' administration of the Emergency Rental Assistance Program.

Finally, this past year, OSC launched the Police Accountability Project, an initiative that is charged with uncovering and rectifying abuses and inefficiencies in law enforcement in New Jersey. Building on our work examining the New Jersey State Police's compliance with reforms designed to eliminate unlawful discrimination in policing, the Project is investigating and assisting with audits and reviews of law enforcement through the state.

I am proud to share this report with you and pledge to continue to provide independent and effective oversight on behalf of New Jersey residents.

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 two projects – the COVID-19 Compliance and Oversight Project and the Police Accountability 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. Each of OSC's four divisions and its two projects have made significant contributions to OSC's accomplishments this past fiscal year.

Our Audit Division concluded its work on four performance audits in FY 2022. The audits examined selected fiscal and operating practices of two school districts, one municipality, and a community college. In addition to these audits, the division completed two follow-up reviews of prior audits to determine whether the auditees had implemented OSC's recommendations.

Our Investigations Division issued two reports and one public letter this past fiscal year. The division's two reports examined the following: (1) the City of Newark's misapplication of the Adopt-a-Park statute to make renovations to a public ice rink; and (2) the state Department of the Treasury, Division of Pensions and Benefits' progress in overseeing the improper participation of private professional service providers in the Public Employees' Retirement System. In its public letter, the division found that the Monmouth County Board of Commissioners had failed to follow a statutorily required process when it approved salary increases for its members and the Monmouth County Sheriff.

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 $141 million of taxpayer dollars in FY 2022. Its anti-fraud efforts also resulted in the exclusion of 68 ineligible providers from the Medicaid program.

Our Procurement Division reviewed 698 contracts this past fiscal year, 156 of which were valued at $12.5 million or more. Division

attorneys also reviewed 375 contracts valued between $2.5 million and $12.5 million.

OSC's COVID-19 Compliance and Oversight Project 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 reported on its review of the state Department of Environmental Protection's administration of the Marine Fisheries Assistance Grant Program and the state Department of Community Affairs' administration of the Emergency Rental Assistance Program.

OSC's Police Accountability Project undertook investigative matters involving fraud, waste, abuse, and misconduct in policing.

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 and Police Accountability Project while setting forth highlights of OSC accomplishments from the past fiscal year of July 1, 2021 to June 30, 2022.

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 2022 are set forth below. Audit reports can be viewed in their entirety on OSC's website.

Audits

Hopatcong Borough School District

This audit examined selected fiscal and operating practices of the Hopatcong School District. The audit found that the District failed to comply with (1) proper procedures for cash management and reporting; (2) internal control requirements related to payroll processing; (3) Extraordinary Aid application guidelines; (4) proper allocation of shared costs between the District and a transportation co-op; (5) ethics requirements related to contracts with employee-owned vendors; (6) regulations regarding the use of charge cards; and (7) requirements to submit contracts to OSC for review pursuant to N.J.S.A. 52:15C-10.

Pennsauken Public Schools

In this audit, OSC reviewed Pennsauken's controls over selected fiscal and operating practices, compliance with applicable laws and regulations, and compliance with internal policies and procedures. OSC auditors found that the District failed to comply with (1) state statutes and regulations in procuring its health insurance broker and health insurance coverage provider; (2) its own policies and procedures, terms in employment contracts, and collective bargaining agreements addressing health benefit opt-out waiver payments; (3) federal regulations for income verification in the school lunch program; and (4) the Public School Contracts Law for its food supplies procurement. The District did not have adequate controls over its food supplies inventory, stipend and unused accrued leave payment processing, fueling operations, and fixed assets inventory. The District also failed to identify the opportunity to cut $1.6 million in health insurance benefit expenses and made approximately $95,000 in improper health benefit opt-out waiver, stipend, and unused accrued leave payments to employees.

Township of Berlin

This audit reviewed selected fiscal and operating practices and found that the Township failed to comply with (1) terms of its collective bargaining agreement related to unused sick leave; (2) its own policies and procedures addressing timekeeping, new hires, and employee reimbursements; (3) statutory requirements and its own policy regarding health benefits eligibility; (4) statutory requirements related to its master plan; and (5) the Local Public Contracts Law regarding the procurement of a prescription drug insurance contract. Berlin also lacked policies and procedures for its controls over municipal properties, municipal vehicle usage, and accounting system user access.

Brookdale Community College

In this audit of selected fiscal and operating practices, the audit found that Brookdale failed to (1) comply with applicable law for the procurement of its vendor for bookstore administration and management services, the processing and payment of overtime, and the calculation of health benefit opt-out waiver payments; (2) provide adequate monitoring and oversight of its bookstore vendor to ensure implementation of the agreement terms; (3) implement adequate policies and procedures addressing the processing of expenditures, cell phone allowances, and information technology asset recordkeeping and inventory; and (4) ensure retiring employees adhered to state regulations regarding post-employment separation, leading to a referral to the state Department of the Treasury, Division of Pension and Benefits, Pension Fraud and Abuse Unit.

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 two follow-up review reports in FY 2022.

Economic Development Authority (EDA)

OSC's 2019 audit identified deficiencies with EDA's management and administration of selected state tax incentive programs.

OSC's review found that EDA had made substantial progress in implementing the recommendations set forth in OSC's initial audit report. Of the 21 audit recommendations, 11 were implemented, 7 were partially implemented, and 3 were not implemented.

Department of Environmental Protection (DEP)

OSC's 2019 audit identified weaknesses in DEP's internal controls over its lease management and administration activities at three of New Jersey's most visited state parks – Island Beach State Park, Cheesequake State Park, and Liberty State Park. The audit also found weaknesses in DEP's internal controls for cash receipts and deposit operations.

OSC found that DEP had made progress in implementing the recommendations set forth in OSC's initial audit report. Of the nine audit

recommendations, two were implemented and seven were partially implemented.

Policies and Procedures

OSC's efforts have included establishing policies and procedures that guide OSC's 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 that 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, which is 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 2020, OSC's Audit Division successfully passed its fourth 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, and 2017. As in those reviews, the 2020 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 receives 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 Acting 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.

OSC's investigators field and review all tips, referrals, and allegations submitted to the office. Those tips come from both the general public and government employees and are received through OSC's toll-free hotline, OSC's website, email, or U.S. mail.

Complaints and Referrals

In FY 2022, the Investigations Division fielded 142 complaints. The division referred an additional eight matters to criminal investigators at both the state and federal levels.

The Investigations Division also made 24 external referrals to other state, county, and federal agencies in FY 2022, including to the state Department of the Treasury's Division of Taxation and the state Department of Health.

Other referrals were made in-house to OSC's Audit, Procurement, and Medicaid Fraud Divisions and are expected to result in future audits and/or investigations. The Investigations Division 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 reports and public letter in FY 2022:

Report: The City of Newark's Misapplication of the Adopt-a-Park Statute to Renovate a Public Ice Rink

OSC's investigation found that the City of Newark improperly entered into a $5.4 construction contract with a private business

entity in which Newark agreed to entirely fund the repair and renovation of an ice rink when it otherwise should have incurred little to no cost. Specifically, OSC found that Newark violated N.J.S.A. 40:12-20 *et seq.*, also referred to as New Jersey's Adopt-a-Park Statute, in two ways: (1) by entering into a contract violating the statute's requirement that such agreements come "at no cost" to a municipality; and (2) by drafting the contract in a way that permitted Newark to provide funding that exceeded what the city was authorized to provide under the statute. As a result, Newark incurred $5.2 million of municipal debt.

The investigation further revealed that because the contract was impermissible under the statute, Newark should have utilized the procurement process set forth in the Local Public Contracts Law (LPCL) to award the contract. Instead, Newark improperly entered into a no-bid construction contract, which created a risk of overpayment of construction services by failing to foster competition. The investigation also revealed at least two previous instances in which Newark entered into improper contracts for park improvements under the Adopt-a-Park statute.

OSC recommended that Newark (1) draft and update written policies regarding the LPCL; (2) adhere to the bidding requirements of the LPCL; (3) draft policies regarding the Adopt-a-Park statute so that taxpayer funds are not expended in connection with agreements under that law; and (4) ensure that all employees involved in procurements and all elected officials are educated about and understand their responsibilities under the LPCL and the Adopt-a-Park Statute. Newark agreed to implement these recommendations.

Report: The Division of Pension and Benefits' Oversight of Improper Participation in the Public Employees' Retirement System

In 2012, an OSC investigation found that a majority of municipalities and school districts had improperly enrolled private professional services providers (PSPs) in the Public Employees' Retirement System (PERS) in violation of N.J.S.A. 43:15A-7.2 (Section 7.2). Upon follow-up investigation, in 2021, OSC examined the state Department of the Treasury, Division of Pension and Benefits' (DPB) progress in eliminating improperly enrolled PSPs identified in OSC's 2012 report.

OSC found that DPB had effectively enforced Section 7.2, achieving significant savings from its investigations, totaling an estimated $59 million. However, OSC's investigation found that DPB had a backlog of PSPs identified by OSC in 2012 that still needed to be investigated to determine eligibility for enrollment in PERS. Given the substantial savings generated by these investigations, OSC found that the state would benefit from DPB being provided with additional resources and legislation providing DPB with additional powers that would enable it to work more effectively through its backlog.
OSC recommended that (1) the Legislature provide DPB with powers that enable it to respond to entities that fail to cooperate during Section 7.2 investigations; and (2) DPB perform a cost-benefit analysis and evaluate the appropriateness of allocating greater resources for hiring additional investigators.

Letter to Monmouth County Board of Commissioners Regarding Improper Salary Modifications for Monmouth County Board of Commissioners and Monmouth County Sheriff

OSC conducted an investigation into the processes by which the Monmouth County Board of Commissioners sets the salaries of commissioners and the Monmouth County Sheriff in response to numerous complaints alleging that the Board failed to follow statutory requirements for modifying those salaries. OSC's investigation found that the Board did not follow the statutorily required public process to approve a salary increase for its members in 2020, and it also failed to follow the proper process to increase the Sheriff's salary over the past five years.

The statutes governing salary modifications for public officials are designed to provide transparency and to prevent the misuse of taxpayer funds. Therefore, OSC recommended that the Board strictly adhere to the statutory processes when modifying commissioners and the Sheriff's salaries.

OSC's investigative reports can be viewed in their entirety on OSC's website.

Speaking Engagements and Outreach

In FY 2022, the Investigations Division continued outreach efforts to other government units across the state, including law enforcement agencies, as well as the public at large. These outreach efforts are intended to promote OSC's mission and encourage public employees and New Jersey residents to report instances of government fraud, waste, and abuse. Members of the Division have participated in and contributed to a variety of public-facing engagements, internal and external trainings, and blog posts on OSC's website.

GOVERNMENT WASTE & MISMANAGEMENT HOTLINE

TOLL FREE: 1-855-OSC-TIPS
(1-855-672-8477)

EMAIL: comptrollertips@osc.nj.gov

WEBSITE: www.nj.gov/comptroller

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, statisticians, and other professionals and para-professionals.

Josh Lichtblau joined the OSC as Director of the MFD in July 2015 after more than two decades serving the interests of New Jersey residents 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, the Medicaid and New Jersey FamilyCare programs serve more than 2.1 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 MCO contract changes designed 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. MFD also 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 report that identified 15 Long Term Care (LTC) facilities that provided services to Medicaid beneficiaries that consistently received the lowest CMS overall rating of one-star. The report found that these 15 LTCs provided services to approximately 1,850 Medicaid beneficiaries, which constituted 6.5% of the Medicaid population residing in LTCs in New Jersey, and that Medicaid annually paid these 15 LTCs an average of $103 million. The report 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. The report included a Data Dashboard that displayed the list of the 15 consistently lowest-ranked nursing homes in New Jersey, along with data on who owned these facilities, and how these facilities have been rated historically.

MFD's FY 2022 Statistics

In FY 2022, MFD recovered or facilitated in the recovery of slightly more than $141.5 million in improperly paid Medicaid funds, with $119.4 million of that attributable to third party liability (TPL) recoveries from third party insurance carriers and the remainder, $22 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 68 providers from participating in the Medicaid program this past fiscal year.

MFD received more than 1,173 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 state 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 93 high risk provider applications. In addition, the division referred 4 cases to the Medicaid Fraud Control Unit (MFCU) within the state Office of the Attorney General and an additional 12 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 2022, MFD hosted two virtual educational training sessions. In the first session, MFD collaborated with DMAHS, MCOs, and MFCU to provide a training focused on dental providers. The second presentation, in which MFD collaborated with DMAHS, the Department of Human Services, the Division of Mental Health and Addiction Services, MCOs, and MFCU, focused on Partial Care providers. 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 2022, MFD identified 268 parent entities (2,075 individual providers) that were required to certify. Of those entities, 58 established Corrective Action Plans (CAPs) to address deficiencies, with 40 entities currently remaining under CAPs.

What follows is an overview of the work performed by each unit in MFD in FY 2022. A summary of all of MFD's individual settlements and audits is included as an Appendix to this report.

Fiscal Integrity Unit

The Fiscal Integrity Unit focuses on data mining, audits, and liability of third parties for expenses improperly paid by the Medicaid program.

Data Mining Unit

MFD's data mining group 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 group 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 group 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 group referred 50 cases of anomalous claims behavior to the Audit/Investigation Units and generated 135 reports for use by these units in FY 2022.

Statistics Unit

The Statistics Unit selects random samples of medical records or other information based on Medicaid claims data that auditors and investigators then obtain to determine whether the provider being audited or investigated is meeting federal and state laws, rules, and guidance. In addition, this group applies statistically valid processes to extrapolate audit/investigative findings to calculate final overpayment amounts for recovery.

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 Independent Clinical Laboratories, Durable Medical Equipment (DME) providers, and Personal Care Service (PCS) providers. Two of these audits are particularly noteworthy.

In its audit of Truetox Laboratories, LLC (Truetox), an Independent Clinical Laboratory located in Garden City Park, New York, MFD found that for most of the audit period, Truetox charged Medicaid far more for its services than it charged other payers for identical services, which violated a Medicaid regulation that prohibits this practice. MFD also found that for almost 82 percent of the sample episodes reviewed, Truetox's documentation failed to comply with one or more regulatory requirements, including failing to provide a test requisition (an order from a referring provider) for drug tests that Truetox performed, and billing for tests that were not requested by the referring provider. Third, MFD found that Truetox impermissibly unbundled 39,531 specimen validity tests that it had performed in conjunction with presumptive and/or definitive drug tests for the same beneficiary on the same date of service. MFD calculated that Truetox received an overpayment of $24,089,938, which was comprised of an extrapolated amount of $23,895,319 and restitution of $194,619 for Truetox having improperly billed specimen validity claims separately from presumptive and/or definitive drug tests.

Finally, in addition to the monetary findings outlined above, MFD found that Truetox engaged in two other types of activities that harmed the Medicaid program. First, Truetox and drug treatment referring providers entered into "blanket" agreements in which the type of test (i.e., presumptive and/or definitive) and specific drugs to be tested for all of the referring provider's Medicaid beneficiaries were identical and more specific tests would be performed even if the underlying presumptive test was negative. MFD pointed out that this "one size fits all" approach to drug testing failed to take into account the individualized medical needs of the referring provider's patients and led to wasteful spending. DMAHS subsequently curbed this practice by proscribing the conditions when a laboratory could bill and be paid for definitive tests. Second, MFD found that Truetox provided benefits to referring providers that violated a Medicaid regulation that prohibits laboratories from offering consideration to other parties.

MFD also completed an audit of a personal care provider, Heart to Heart Home Care (HTH), which has locations in Paterson, Hackensack, East Orange, Lakewood, and Vineland, New Jersey, and Brooklyn, Flushing, and Bronx, New York. Personal care providers offer home health services to beneficiaries with functional impairments who need assistance with activities of daily living, such as dressing,

bathing, or feeding. In the HTH audit, MFD found that more than 16 percent of HTH's sampled claims failed to comply with relevant regulatory requirements and that the majority of these deficiencies were attributable to HTH having improperly billed and been paid for services despite having failed to have performed required supervisory evaluations at least once every 60 days. After extrapolating the dollars in error attributable to these deficient claims to the universe of claims, MFD calculated that HTH received an overpayment of slightly more than $2.38 million that it had to repay to the Medicaid program.

In both the Truetox and HTH audits, just as with all of its audits, MFD identified the Medicaid overpayment and recommended corrective actions to address the noted deficiencies. Both Truetox and HTH subsequently contested the assessed overpayments by seeking an administrative hearing.

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) group, 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 group 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 group, working with other MFD personnel, reviews, oversees, and coordinates audit work performed by the State's TPL contractor. In FY 2022, MFD recovered more than $119.4 million from third parties.

Investigations Unit

MFD's Investigations Unit investigates inappropriate conduct on the part of Medicaid, FamilyCare, and Charity Care providers and recipients. In FY 2022, the Investigations Unit opened 361 cases and made 16 referrals to other agencies such as MFCU, state licensing boards, county prosecutors' offices, and various county boards and social services entities. MFD investigators receive 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 1,173 telephone and other hotline tips in FY 2022.

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 2022, the Investigations Unit received 93 such applications from high-risk providers – DME, prosthetics and orthotics, and home healthcare agencies – for which MFD performed 486 individual background checks using several verification sources. The unit also confirmed 46 site visits on PECOS, a federal Medicare site. 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 2022, the work of the Investigations Unit resulted in the recovery of approximately $8.3 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.

Recovery and Exclusions Unit

The Recovery and Exclusions Unit (R&E) recovers overpayments identified by MFD's auditors and investigators and determines when to exclude a Medicaid provider from the Medicaid program. In cases of fraud, R&E may also assess additional penalties against a provider.

Once MFD identifies outstanding overpayments, R&E sends out appropriate notices, recovers the money from providers and recipients on behalf of the state, and works with federal authorities to ensure that the federal government receives its share of any recovery. In instances in which R&E cannot resolve an overpayment, MFD will take administrative action against the provider or recipient.

R&E also identifies providers who should be disqualified from participating in the Medicaid program. R&E 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 2022, MFD excluded 68 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.

Regulatory 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.

If you suspect Medicaid fraud, waste, or abuse:

Call 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 2022, the Procurement Division received notice of 698 contracts, including 156 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, and purchases of goods or services.

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 receipt of Disclosure of Investment Activities in Iran (now permitted to be received before contract award instead of at the time of proposal submission) as set forth in N.J.S.A. 52:32-58, requiring a business registration certificate at the time of proposal submission, failure to provide for "approved equals" in bid specifications, and inadequate descriptions of services in the scope of work.

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 2022, 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 2022, the division pre-screened 114 procurements pursuant to Executive Order 166 and 53 procurements pursuant to Executive Order 125.

In all, the Procurement Division received notice of 698 contracts for review in FY 2022. Of those contracts, 156 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 62 percent of those pre-screened contracts to ensure the legality of the procurement process.

Some notable contracts reviewed include a $22 million contract for the expansion of the Maplewood Public Library, partially funded under the New Jersey State Library Construction Bond Act; an $18.9 million construction contract awarded by Morris County for a shared five mile pedestrian-bike path; and a $17.7 million in contracts awarded by the Newark Board of Education for student transportation services.

The Procurement Division also reviewed 375 contracts valued between $2.5 million and $12.5 million. In these contracts, the Procurement Division found a 78 percent error rate. In each case, the division gave guidance to the contracting entity to ensure that the errors are not repeated.

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 Letters

The division also issued two significant public letters in FY 2022, both of which concerned public-private contracts related to public water assets.

Monmouth County – Leachate Pre-Treatment Plant

The Procurement Division issued a public letter to Monmouth County for its failure to comply with Local Public Contracts Law (LPCL) in awarding a contract for Modifications to the Leachate Pre-Treatment Plant at the Monmouth County Reclamation Center. Instead of issuing an invitation to bidders under the LPCL as would have been appropriate for this project, Monmouth County incorrectly issued a request for proposals under the New Jersey Wastewater Treatment Public Private Contracting Act (WTPPA). The WTPPA is appropriate for long-term (30+ years) contracts for the design, construction, or operation of waste water treatment facilities, not a discreet, time-limited project at a lump-sum price. This error was made worse by the County's failure to comply with the WTPPA's enhanced advertisement and notice requirements, including conducting a public hearing.

Egg Harbor City – Sale of Water and Wastewater Systems

The division issued a public letter to Egg Harbor City related to its failure to submit its solicitation to sell its water and waste water systems under the New Jersey Water Infrastructure Protection Act (WIPA) to OSC for pre-advertisement review. OSC also found that the City did not

comply with WIPA's requirement that it hire a financial advisor who was truly independent to value the water and waste water systems prior to the sale. Instead, the City allowed its municipal engineer to both assess the physical condition of the systems and prepare a report on their value. By doing so, the City ignored WIPA's requirement of hiring an independent financial advisor and denied both the governing body and the public from an opportunity to review a report from an expert in financial matters detached from the proposed sale of important public infrastructure.

Educational Outreach

In FY 2022, 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 redesigned Sandy Transparency website, http://nj.gov/comptroller/sandytransparency/, provides the public with a place to view the allotment and expenditure of federal Sandy funds, to research information about Sandy programs, and to examine detailed documents from Sandy-related contracts.

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 2022, the COVID-19 Project offered important and timely resources specific to local government units such as guidance documents, compliance alerts, and other reference materials to assist them in administering federal COVID-19 funding. The COVID-19 Project also partnered with OSC's other divisions to produce webinars and trainings for both state and local government units on various topics.

OSC is also responsible for overseeing the work of 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). Among other things, Integrity Monitors have completed risk assessments for state entities and programs and performed in-depth reviews that have identified a number of issues related to eligibility and processing, missing documentation, and incorrect or improper payments. Integrity Monitors have uncovered and avoided potentially fraudulent or improper payments and assisted State entities in their recovery. As of the end of FY 2022, Integrity Monitors reviewed over 200 State programs. In FY 2022 alone, there were 169 programs reviewed by Integrity Monitors, a significant increase from FY 2021.

The Integrity Oversight Monitoring program is a key part of 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. Integrity Monitor quarterly reports are public documents and are available for review on the state's COVID-19 Compliance and Transparency webpage. In FY 2022, 39 quarterly reports were made available to the public.

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. The COVID-19 Project assists the Taskforce in fulfilling its responsibilities under Executive Order 166, by helping to develop a statewide Compliance Plan and the development of the Integrity Monitor Guidelines.

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 2022 includes the following review and letter.

Review of Department of Environmental Protection's Administration of COVID-19 CARES Act Marine Fisheries Assistance Grant Program

OSC reviewed the state Department of Environmental Protection's (DEP) administration of its program to support New Jersey's COVID-19 impacted fishery-related businesses. OSC found that although DEP acted in accordance with federal guidance, DEP failed to address certain red flags that would have reduced the risk of fraud, waste, abuse, and improper payments in the program. OSC reviewed documentation of selected recipients and found that many lacked important information justifying an award and some grant recipients had been made "more than whole," resulting in $2.4 million in excess funding. OSC made several recommendations to DEP to improve its program, including enhancing internal controls and mitigating reliance on self-certifications. OSC recommends that DEP evaluate recoupment of any relief funds that should be returned.

Letter to Department of Community Affairs – Administration of the Emergency Rental Assistance Program

OSC also issued a public letter regarding the state Department of Community Affairs' (DCA) administration of the Emergency Rental Assistance Program. As part of its ongoing oversight of the State's contracted Integrity Monitors, OSC reviewed the June 30, 2021 Integrity Monitor report related to that program. Among other activities, the Integrity Monitor reviewed a sample of rental assistance files to determine compliance with documentation and other program requirements. The Integrity Monitor found that many files were missing critical information, and although DCA had suggested that the missing documents could be provided to the Integrity Monitor for review, DCA failed to submit them in a timely manner. OSC undertook a review of the documentation provided by DCA to determine whether it addressed the deficiencies noted by the Integrity Monitor. Based on its review, OSC found that there was still missing or incomplete documentation in many files that it reviewed. OSC also found DCA's documentation policies conflicted with each other or with DCA's response to the Integrity Monitor's findings. Finally, OSC found that DCA relied heavily on

self-certifications to establish program requirements, but lacked sufficient additional controls to properly mitigate the risk of fraud, waste, and abuse. OSC issued a public letter noting these findings and making several recommendations to DCA to improve its processes.

Visit
https://nj.gov/comptroller/covid19/oversight/
for more information.

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 is also actively investigating whether there are policing practices that expose the state to significant civil liability. Among other things, the Project will review and report 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. And the Project will 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.

Appendix – MFD Settlements & Audits

Settlement Agreement/ Overpayment Letter Case Summaries

HMH Residential Care, Inc. (Final Findings Letter)

MFD, through its Uniform Program Integrity Contractor (UPIC), SafeGuard Services, LLC, issued a Final Findings Report, which determined that HMH Residential Care, Inc. (Residential), located in Neptune, New Jersey, received a Medicaid overpayment of $1,087 for the review period of January 1, 2017 through September 30, 2019. The overpayment was a result of Medicaid paying Residential for hospice charges for dates after patients had been discharged from hospice. Residential paid the overpayment amount in full.

Wellness Direct, LLC (Settlement Agreement)

MFD resolved an investigation of Wellness Direct, LLC (Wellness Direct), a mental health provider located in Cedar Grove, New Jersey, with Wellness Direct agreeing to repay the Medicaid program $300,000. Through this investigation, MFD determined that Wellness Direct's documentation did not support the claims it billed for the review period of March 10, 2018 through November 28, 2020.

Anita Vaughn, M.D. (Settlement Agreement)

MFD resolved an investigation of Anita Vaughn, M.D. (Vaughn), located in Newark, New Jersey, with Vaughn agreeing to repay the Medicaid program $98,351. Through this investigation, MFD determined that for the period from September 15, 2007 through September 15, 2012, Vaughn submitted group medical psychotherapy claims for payment that were not compensable because the services were provided by a person who lacked appropriate licensure and the documentation underlying the claims failed to support the claims. The total payment amount was comprised of an assessed overpayment amount of $92,784 and interest of $5,567 based on the extended repayment term.

Prime Healthcare – St. Michael's, LLC (Settlement Agreement)

MFD, through its Recovery Audit Contractor, Health Management Services, LLC (HMS), resolved an audit of Prime Healthcare Services - St. Michaels, LLC (St. Michaels), located in Newark, New Jersey, with St. Michael's agreeing to repay the Medicaid program $53,002. Through this review, HMS determined that for the period from April 1, 2017 through November 26, 2017, St. Michael's billed and received payment for inpatient claims that were not

supported by the underlying medical records and other documentation.

Prime Healthcare – St. Clare's, LLC (Settlement Agreement)

MFD, through its Recovery Audit Contractor, Health Management Services, LLC (HMS), resolved an audit of Prime Healthcare Services - St. Clare's, LLC (St. Clare's), located in Denville and Dover, New Jersey, with St. Clare's agreeing to repay the Medicaid program $81,477. Through this review, HMS determined that for the period from March 31, 2017 through February 20, 2018, St. Clare's billed and received payment for inpatient claims that were not supported by the underlying medical records and other documentation.

Health Care Pharmacy (Settlement Agreement)

MFD resolved an investigation of Health Care Pharmacy, located in Passaic, New Jersey, with Health Care Pharmacy agreeing to repay the Medicaid program $56,814. Through this investigation, MFD determined that Health Care Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Health Care Pharmacy dispensed during the period from February 1, 2014 through November 30, 2018. This inventory "shortage" constituted a Medicaid overpayment, because the pharmacy could not provide documentation to support the claims it submitted for these medications.

Social Clubhouse (Notice of Overpayment)

MFD reviewed claims submitted by Social Clubhouse Inc. (Social Clubhouse), a mental health and substance abuse provider located in Springfield, New Jersey, to determine whether Social Clubhouse appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2017 through February 29, 2020, Social Clubhouse billed and received $58,813 in payment for units of services in excess of the pre-approved authorized number of units, in violation of the applicable regulatory requirement. As such, MFD found that Social Clubhouse received an overpayment of $58,813 that it had to repay to the Medicaid program. Social Clubhouse paid the full amount identified in MFD's review.

Family Pediatrics (Settlement Agreement)

MFD resolved an investigation of Family Pediatrics, LLC, located in Wayne, New Jersey, with Family Pediatrics agreeing to repay the Medicaid program $127,495. Through this investigation, MFD determined that Family Pediatrics was reimbursed for claims that failed to have supporting documentation for certain counseling and testing services during the period from January 1, 2017 through January 20, 2021.

VNA Health Group (Final Findings Letter)

MFD, through its Uniform Program Integrity Contractor (UPIC), SafeGuard Services, LLC, issued a Revised Final Findings Report, which determined that VNA (VNA) Health Group, located in West Orange, New Jersey, received a Medicaid overpayment of $95,053 for the review period of January 1, 2017 through September 30, 2019. The overpayment was a result of Medicaid paying VNA for hospice charges for dates after patients had been discharged from hospice. VNA paid the overpayment amount in full.

Integrated Therapy (Settlement Agreement)

MFD resolved its review of Integrated Therapy, Inc., located in Lakewood, New Jersey, with Integrated Therapy agreeing to repay the Medicaid program $88,000. Through its review, MFD determined that Integrated Therapy was reimbursed for claims that received Medicaid

payments for billing certain combinations of codes that were not in compliance with applicable coding policies during the period January 1, 2014 through December 31, 2018.

My First Dentist (Settlement Agreement)

MFD resolved its investigation of My First Dentist, located in Englishtown, New Jersey, with My First Dentist agreeing to repay the Medicaid program $66,494.74. Through this investigation, MFD determined that My First Dentist did not have sufficient documentation to support certain dental claims for which it was reimbursed by the Medicaid program during the period January 1, 2014 through May 19, 2019.

Seashore Gardens (Settlement Agreement)

MFD resolved a review, conducted by its Recovery Audit Contractor, Health Management Systems, of Seashore Gardens Living Center, a long term care facility, located in Galloway, New Jersey, with Seashore Gardens Living Center agreeing to repay the Medicaid program $234,863.77. Through this review, HMS determined that, from April 1, 2016 through September 30, 2019, Seashore Gardens Living Center improperly received Medicaid managed care patient liability and claim overpayments to which it was not entitled.

Odyssey Healthcare (Final Findings Letter)

MFD, through its Uniform Program Integrity Contractor (UPIC), SafeGuard Services, LLC (SGS), determined that Odyssey Healthcare, a hospice care provider located in Piscataway, New Jersey, received an overpayment of $20,835 for the review period of January 1, 2017 through September 30, 2019. The overpayment was the result of Medicaid paying Odyssey Healthcare for hospice charges for dates after patients had been discharged from hospice. Odyssey Healthcare paid the overpayment amount in full.

Brighton Pediatrics (Notice of Overpayment)

MFD reviewed claims submitted by Brighton Pediatrics, a pediatrician provider located in Egg Harbor Township, New Jersey, to determine whether Brighton Pediatrics billed for services in accordance with applicable requirements. MFD determined that, from October 1, 2016 through July 29, 2021, Brighton Pediatrics inappropriately billed five claims in error. As such, MFD found that Brighton Pediatrics received an overpayment of $266.16 that it had to repay to the Medicaid program. Brighton Pediatrics paid the full amount identified in MFD's review.

Atrium/Park Ridge (Settlement Agreement)

MFD resolved a review, conducted by its Recovery Audit Contractor, HMS, of Atrium Post Acute Care of Park Ridge, a long term care facility, located in Park Ridge, New Jersey, with Atrium Post Acute Care of Park Ridge agreeing to repay the Medicaid program $347,768.50. Through this review, HMS determined that, from June 1, 2015 through November 30, 2017, Atrium Post Acute Care of Park Ridge improperly received Medicaid managed care patient liability and claim overpayments to which it was not entitled.

Leo Hopp (Settlement Agreement)

MFD resolved an investigation of Leo Hopp Pharmacy, located in Newark, New Jersey, with Leo Hopp Pharmacy agreeing to repay the Medicaid program $103,000, comprised of a principal amount of $81,997.46 and a civil penalty of $21,002.54. Through this investigation, MFD determined that Leo Hopp Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Leo Hopp Pharmacy dispensed during the period from November 1, 2012 through October 31, 2017. This inventory

"shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

Say It Right (Settlement Agreement)

MFD reviewed claims submitted by Say It Right Speech and Language Services, LLC (Say It Right), a speech language provider located in Lakewood, New Jersey, to determine whether Say It Right appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2014 through December 31, 2018, Say It Right billed and received $25,388 in payment for claims for Current Procedural Terminology ("CPT") codes 97532 and/or 97533 billed in conjunction with CPT code 92507, in violation of the applicable regulatory requirement. As such, MFD found that Say It Right received an overpayment of $25,388 that it had to repay to the Medicaid program. Say It Right paid the full amount identified in MFD's review.

Vinnakota (Settlement Agreement)

MFD reviewed claims submitted by Radha Vinnakota (Vinnakota), an otolaryngology provider located in South Plainfield, New Jersey, to determine whether Vinnakota appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2015 through May 28, 2020, Vinnakota billed and received $60,333 in payment for claims which failed to have necessary supporting documentation for Current Procedural Terminology ("CPT") code 95024, in violation of the applicable regulatory requirement. As such, MFD found that Vinnakota received an overpayment of $60,333 that it had to repay to the Medicaid program. Vinnakota paid the full amount identified in MFD's review.

Healthcare Pharmacy (Settlement Agreement)

MFD resolved an investigation of Health Care Pharmacy, Inc. (Health Care Pharmacy) located in Trenton, New Jersey, with Health Care Pharmacy agreeing to repay the Medicaid program $281,808. Through this investigation, MFD determined that Health Care Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Health Care Pharmacy dispensed during the period from February 11, 2012 through September 30, 2016. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

Intervention Specialist (Settlement Agreement)

MFD reviewed claims submitted by Enterprise Alliance Group, Inc. d/b/a Intervention Specialist (Intervention Specialist), an otolaryngology provider located in Elizabeth, New Jersey, to determine whether Intervention Specialist appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2014 through March 11, 2019, Intervention Specialist billed and received $75,000 in payment for claims which failed to have necessary supporting documentation, in violation of the applicable regulatory requirement. As such, MFD found that Intervention Specialist received an overpayment of $75,000 that it had to repay to the Medicaid program. Intervention Specialist paid the full amount identified in MFD's review.

Affinity Care (Settlement Agreement)

MFD reviewed claims submitted by VC Services LLC d/b/a Affinity Care of NJ (Affinity Care), an home health provider located in Metuchen, New Jersey, to determine whether Affinity Care appropriately billed for services in accordance with applicable requirements. MFD determined

that, from January 1, 2015 through June 30, 2020, Affinity Care billed and received $14,745 in payment for claims for personal care services which failed to have necessary supporting documentation, in violation of the applicable regulatory requirement. As such, MFD found that Affinity Care received an overpayment of $24,835 which includes a civil penalty of $10,089 (based upon the fact that it did not provide MFD with any documentation for 189 claims pursuant to N.J.S.A 30:4D-17(e)(3)), that it had to repay to the Medicaid program. Affinity Care paid the full amount identified in MFD's review.

Medlabs Diagnostics (Settlement Agreement)

MFD resolved an investigation of Medlabs Diagnostics (Medlabs), located in West Orange, New Jersey, with Medlabs agreeing to repay the Medicaid program $325,000. Through this investigation, MFD determined that from January 1, 2015 through March 6, 2020, Medlabs improperly billed for and received payment from the Medicaid program for claims for which Medlabs failed to have the necessary supporting documentation.

Virtua Health, Inc. (Settlement Agreement)

MFD through its Recovery Audit Contractor, Health Management Systems, Inc., resolved an audit of two Virtua Health branch offices located in Mount Holly and Marlton, New Jersey, with Virtua Health, Inc. agreeing to repay the Medicaid program $2,500. Through this audit, Health Management Systems determined Virtua Health Inc. billed and was reimbursed by Medicaid Fee For-Service and/or the Managed Care Organizations for certain in-patient hospital admissions from 2017 that could not be supported by the medical records and other supporting documentation.

Aveanna Health Care (Notice of Overpayment)

MFD resolved an investigation of Aveanna Health Care, located in Hamilton, New Jersey, with Aveanna Health Care agreeing to repay the Medicaid program $2,026.26. Through this investigation, MFD determined that from December 1, 2016 through May 25, 2021, Aveanna Health Care improperly billed for and received payment from the Medicaid program for claims for which Aveanna Health Care failed to have the necessary supporting documentation.

Beverly Taitt (Settlement Agreement)

MFD resolved an investigation of Beverly Taitt, located in East Orange, New Jersey, with Beverly Taitt agreeing to repay the Medicaid program $113,419.56. Through this investigation, MFD determined that from July 2, 2013 through March 8, 2016, a practice improperly owned by non-physicians billed for and received payment from the Medicaid program under Dr. Taitt's Medicaid number.

Jersey City Medical Center (Notice of Overpayment)

MFD resolved an investigation of Jersey City Medical Center, located in Jersey City, New Jersey, with Jersey City Medical Center agreeing to repay the Medicaid program $129,177.60. Through this investigation, MFD determined that from January 1, 2016 through June 30, 2021, Jersey City Medical Center billed both a Medicaid Managed Care claim and a Fee-for-Service claim for the same service provided to the same recipient on the same date of service.

Jersey Shore University Medical Center (Overpayment Letter)

MFD's Investigations Unit reviewed claims submitted by Jersey Shore University Medical

Center (JSUMC), a hospital located in Neptune, New Jersey, to determine whether JSUMC billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2016 through June 26, 2020, JSUMC billed and received $117,758.12 in payment for units of psychiatric emergency services in excess of the amount of time supported by the submitted documentation, in violation of the applicable regulatory requirement. As such, MFD found that JSUMC received an overpayment of $117,758.12 that it had to repay to the Medicaid program. JSUMC paid the full amount identified in MFD's review.

Union County Pediatrics Group (Settlement Agreement)

MFD resolved an investigation of Union County Pediatrics Group, located in Elizabeth, New Jersey, with Union County Pediatrics Group agreeing to repay the Medicaid program $38,982.37. Through this investigation, MFD determined that, for the period from January 1, 2015 through October 18, 2019, Union County Pediatrics Group incorrectly billed and received payment from the Medicaid program for claims for which Union County Pediatrics Group lacked supporting documentation.

Empathy Care, LLC (Settlement Agreement)

MFD resolved an audit of Empathy Care, LLC, located in Somerset, New Jersey, with Empathy Care, LLC agreeing to repay the Medicaid program $36,635.97. Through this audit, MFD determined that, for the period from August 1, 2016 through July 31, 2021, Empathy Care, LLC incorrectly billed and received payment from the Medicaid program for home based personal care service claims for services rendered while recipients had inpatient status in a hospital setting.

Metropolitan Anesthesia Group, LLC (Settlement Agreement)

MFD resolved an investigation of Metropolitan Anesthesia Group, LLC located in Englewood, New Jersey, with Metropolitan Anesthesia Group, LLC agreeing to repay the Medicaid program $590,018.18. Through this investigation, MFD determined that Metropolitan Anesthesia Group, LLC incorrectly billed the Medicaid program and was subsequently paid for claims for that could not be supported by documentation during the period from July 1, 2015 through March 31, 2020.

Chrill Care Inc. (Settlement Agreement)

MFD resolved an audit of Chrill Care Inc., located in Verona, New Jersey, with Chrill Care Inc. agreeing to repay the Medicaid program $159,878. Through this audit, MFD determined that Chrill Care Inc. incorrectly billed the Medicaid program for and was subsequently paid for claims for personal care services that were not supported by documentation in violation of the applicable regulatory requirement during the period from August 1, 2014 through July 31, 2019.

First Aid RX Pharmacy (Settlement Agreement)

MFD resolved an investigation of First Aid RX Pharmacy, located in Haledon, New Jersey, with First Aid RX Pharmacy agreeing to repay the Medicaid program $489,507.48. Through this investigation, MFD determined that, from August 1, 2013 through April 30, 2018, First Aid RX Pharmacy's inventory for selected medications was insufficient to account for the quantity of medications that First Aid RX 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.

Atlantic Gastroenterology Associates, P.A. (Settlement Agreement)

MFD resolved an investigation of Atlantic Gastroenterology Associates, P.A., located in Egg Harbor Township, New Jersey, with Atlantic Gastroenterology Associates agreeing to repay the Medicaid program $126,050.67. Through this investigation, MFD determined that, from January 1, 2015 through November 15, 2019, Atlantic Gastroenterology Associates improperly billed for and received payments from the Medicaid program for claims involving various procedure codes for which Atlantic Gastroenterology Associates failed to have necessary supporting documentation.

American Habitare and Counseling, Inc. (Settlement Agreement)

MFD resolved an investigation of American Habitare and Counseling, Inc., located in Newark, New Jersey, with American Habitare and Counseling agreeing to repay the Medicaid program $1,485,420.00. Through this investigation, MFD determined that, from June 2, 2014 through February 9, 2019, American Habitare and Counseling improperly billed for and received payments from the Medicaid program for claims for which American Habitare and Counseling failed to have necessary supporting documentation. MFD also determined that, from November 7, 2016 through February 9, 2019, American Habitare and Counseling double billed the Medicaid program for two American Medical Association Current Procedural Terminology codes.

Surgical Step, Inc. (Settlement Agreement)

MFD resolved an investigation of Surgical Step, Inc., located in Lakewood, New Jersey, with Surgical Step agreeing to repay the Medicaid program $1,339.87. Through this investigation, MFD determined that, from September 1, 2013 through October 4, 2018, Surgical Step improperly billed for and received payments from the Medicaid program for claims for which Surgical Step failed to have necessary supporting documentation.

A Best Home Care, LLC (Notice of Overpayment)

MFD reviewed claims submitted by A Best Home Care, Inc. (Best Home) a personnel care service (PCS) provider located in Jersey City, New Jersey. MFD determined that, from January 1, 2015 through June 30, 2020, Best Home improperly billed and received payments totaling $7,758 for home-based services rendered to beneficiaries while these beneficiaries had inpatient status in a hospital setting. Best Home paid the Medicaid program the full amount identified, $7,758.

Sunrise Clinical Services, LLC D/B/A Oasis Clinical Services (Settlement Agreement)

MFD resolved an investigation of Sunrise Clinical Services, LLC D/B/A Oasis Clinical Services, located in Irvington, New Jersey, with Oasis Clinical Services agreeing to repay the Medicaid program $2,438,967.49, comprised of a principal amount of $2,237,700.49 plus a civil penalty of $201,267.00. Through this investigation, MFD determined that, from January 1, 2012 through July 27, 2017, Oasis Clinical Services improperly billed for and received payments from the Medicaid program for claims involving various procedure codes for which Oasis Clinical Services failed to have necessary supporting documentation.

Phoenix Behavioral Health (Settlement Agreement)

MFD resolved a review of Phoenix Behavioral Health, LLC, (Phoenix) located in Ewing, New Jersey, with Phoenix agreeing to repay the Medicaid program $33,618.14. Through its review, MFD determined that, from March 1,

2015 through February 29, 2020, Phoenix submitted claims and received payment for units of service that were greater than the pre-approved number of authorized units, in violation of state regulation.

Cooper Hospital University (Settlement Agreement)

MFD resolved a review, conducted by its Recovery Audit Contractor, Health Management Systems (HMS), of Cooper Hospital University Medical Center (Cooper Hospital), located in Camden, New Jersey, with Cooper Hospital agreeing to repay the Medicaid program $7,500. Through this review, HMS determined that Cooper Hospital billed and was reimbursed for certain inpatient hospital admissions that could not be supported by the medical records and other supporting documentation, in violation of applicable regulatory requirement.

St. Peter's Hospital (Settlement Agreement)

MFD resolved a review, conducted by its Recovery Audit Contractor, Health Management Systems (HMS), of St. Peter's University Hospital (St. Peter's Hospital) located in Passaic, New Jersey, with St. Peter's Hospital agreeing to repay the Medicaid program $50,000. Through this review, HMS determined that Health Care Pharmacy billed and was reimbursed for certain inpatient hospital admissions during the years from 2014 through 2018 that could not be supported by the medical records and other supporting documentation, in violation of the applicable regulatory requirement.

Mental Health Association of Essex and Morris (Notice of Overpayment)

MFD reviewed claims submitted by Mental Health Association of Essex and Morris, Inc. (MHAEM), a mental health and substance abuse provider located in Montclair, New Jersey, to determine whether MHAEM appropriately billed for services in accordance with applicable requirements. MFD determined that, from March 1, 2015 through February 29, 2020, MHAEM billed and received $12,480 in payment for units of services in excess of the pre-approved authorized number of units, in violation of the applicable regulatory requirement. As such, MFD found that MHAEM received an overpayment of $12,480 that it had to repay to the Medicaid program. MHAEM paid the full amount identified in MFD's review.

Eatontown Primary Care (Settlement Agreement)

MFD resolved its review of Eatontown Primary Care (Eatontown), located in Eatontown, New Jersey, with Eatontown agreeing to repay the Medicaid program $235,304. Through it review, MFD determined that, from January 4, 2017 through September 17, 2020, Eatontown submitted claims for reimbursement that unbundled certain codes which should have been billed under one code per proper coding guidelines.

High Point Partial Care (Notice of Overpayment)

MFD reviewed claims submitted by High Point Partial Care, LLC (High Point), a mental health and substance abuse provider located in Flemington, New Jersey, to determine whether High Point appropriately billed for services in accordance with applicable requirements. MFD determined that, from March 1, 2015 through February 29, 2020, High Point billed and received $13,660 in payment for units of services in excess of the pre-approved authorized number of units, in violation of the applicable regulatory requirement. As such, MFD found that High Point received an overpayment of $13,660 that it had to repay to the Medicaid program. High Point paid the full amount identified in MFD's review.

CRP Behavioral Health/Possemato (Settlement Agreement)

MFD resolved an investigation of CRP Behavioral Health, LLC and Christine Possemato, A.P.N, a mental health provider (collectively referred to as CRP Behavioral Health) located in Long Branch, New Jersey, with CRP Behavioral Health agreeing to repay the Medicaid program $172,372. Through this investigation, MFD determined that, from February 5, 2017 through February 21, 2019, CRP Behavioral Health submitted claims for mental health but failed to possess the necessary supporting documentation for these claims.

Crest Haven (Settlement Agreement)

MFD resolved an Investigation of Cape May County Crest Haven Nursing & Rehabilitation Center (Crest Haven), a skilled nursing provider located in Cape May Court House, New Jersey, with Crest Haven agreeing to pay $60,582 in restitution to the Medicaid program. Through its investigation, MFD determined that, from January 7, 2013 through September 27, 2018, Crest Haven, a period during which Crest Haven submitted claims and received payment from the Medicaid program, it employed a licensed practical nurse who was excluded from Medicaid, which violated Medicaid requirements.

Medallion Behavioral Health (Notice of Overpayment)

MFD reviewed claims submitted by Medallion Behavioral Health, LLC (Medallion), a mental health and substance abuse provider located in Paterson, New Jersey, to determine whether Medallion appropriately billed for services in accordance with applicable requirements. MFD determined that, from March 1, 2015 through February 29, 2020, Medallion billed and received $32,769 in payment for units of services in excess of the pre-approved authorized number of units, in violation of the applicable regulatory requirement. As such, MFD found that Medallion received an overpayment of $32,769 that it had to repay to the Medicaid program. Medallion paid the full amount identified in MFD's review.

Final Audit Reports

Ramos Foot and Ankle Center, LLC (Final Audit Report)

MFD audited claims submitted by Ramos Foot and Ankle Center, LLC (RFAC), a podiatric medicine provider located in Perth Amboy, New Jersey, to determine whether RFAC billed in accordance with applicable requirements. MFD found that for 27 out of 324 sample claims, RFAC failed to possess documentation that fully supported the claims. After extrapolating the net dollars in error over the audit universe, MFD calculated that RFAC improperly received an overpayment of $128,719 that it had to repay to the Medicaid program.

Breathe Rite Medical and Surgical Equipment, LLC (Final Audit Report)

MFD audited claims submitted by Breathe Rite Medical and Surgical Equipment, LLC (Breathe Rite), a durable medical equipment provider located in Trenton, New Jersey, to determine whether Breathe Rite billed in accordance with applicable requirements. MFD found that for 144 out of 303 sample claims, Breathe Rite failed to possess documentation that fully supported the claims. After extrapolating the net dollars in error over the audit universe, MFD calculated that Breathe Rite improperly received an overpayment of $411,277 that it had to repay to the Medicaid program.

Heart to Heart Health Care Services, LLC (Final Audit Report)

MFD audited claims submitted by Heart to Heart Health Care Services, LLC, d/b/a Heart to Heart Home Care (HTH), a Personal Care Services (PCS) provider with locations in New Jersey (Paterson, Hackensack, East Orange, Lakewood, and Vineland) and New York (Brooklyn, Flushing, and Bronx), to determine whether HTH billed for home-based PCS in accordance with applicable requirements. MFD found that for 19 of the 118 sample claims, HTH failed to possess documentation that fully supported the claims. After extrapolating the sample dollars in error to the total dollars in the audit universe, MFD calculated that HTH received an overpayment of $2,384,132. Additionally, MFD determined that HTH improperly billed and received payment for 46 other claims, totaling $2,155, which overlapped with hospital claims for the same beneficiary and for the same date of service. In total, MFD determined that HTH received an overpayment of $2,386,287 ($2,384,132 plus $2,155) that it had to repay to the Medicaid program.

Chrill Care, Inc. (Final Audit Report)

MFD audited claims submitted by Chrill Care, Inc. (Chrill), a Personal Care Services (PCS) provider, located in Verona, New Jersey, to determine whether Chrill billed Medicaid for home-based PCS in accordance with applicable requirements. MFD found that for 8 of the 125 sampled claims, Chrill failed to possess documentation that fully supported the claims. After extrapolating the sample dollars in error to the total dollars in the audit universe, MFD calculated that Chrill received an overpayment of $599,036. Additionally, MFD determined that Chrill improperly billed and received payment for 7 other claims, totaling $178, which overlapped with hospital claims for the same beneficiary and for the same date of service. In total, MFD determined that Chrill received an overpayment of $599,214 ($599,036 plus $178) that it had to repay to the Medicaid program.

Truetox Laboratories, LLC (Final Audit Report)

MFD audited Truetox Laboratories, LLC (Truetox), an independent clinical laboratory, located in Garden City Park, New York, to determine whether Truetox appropriately billed Medicaid for drug tests in accordance with applicable requirements. MFD found that for most of the audit period, Truetox charged Medicaid far more for its services than it charged other payers for identical services, which violated a Medicaid regulation that prohibits this practice. MFD also found that for almost 82 percent of the sample episodes reviewed, Truetox's documentation failed to comply with one or more regulatory requirements, including failing to provide a test requisition (an order from a referring provider) for drug tests that Truetox performed and billing for tests that were not requested by the referring provider. Third, MFD found that Truetox impermissibly unbundled 39,531 specimen validity tests that it had performed in conjunction with presumptive and/or definitive drug tests for the same beneficiary on the same date of service. MFD calculated that Truetox received an overpayment of $24,089,938, which was comprised of an extrapolated amount of $23,895,319 and restitution of $194,619 for Truetox having improperly billed specimen validity claims separately from presumptive and/or definitive drug tests.

In addition to the monetary findings outlined above, MFD found that Truetox engaged in two other types of activities that harmed the Medicaid program. First, Truetox and drug treatment referring providers entered into "blanket" agreements in which the type of test (i.e., presumptive and/or definitive) and specific drugs to be tested for all of the referring provider's Medicaid beneficiaries were identical and more specific tests would be performed

even if the underlying presumptive test was negative. MFD pointed out that this "one size fits all" approach to drug testing failed to take into account the individualized medical needs of the referring provider's patients and led to wasteful spending. DMAHS subsequently curbed this practice by proscribing the conditions when a laboratory could bill and be paid for definitive tests. Second, MFD found that Truetox provided benefits to referring providers that violated a Medicaid regulation that prohibits laboratories from offering consideration to other parties.

Closing Reports

Clarity Laboratories, LLC (Closing Report)

MFD audited Clarity Laboratories, LLC (Clarity), an independent clinical laboratory, located in Somerset, New Jersey, to determine whether Clarity appropriately billed for drug testing services in accordance with applicable requirements. MFD found that Clarity generally complied with applicable regulations and guidance, including the requirement that Clarity not charge Medicaid more for drug testing services than it charged other payers for identical drug testing services. Based on its determination, MFD closed the audit without any adverse findings.