

New Jersey Office of the State Comptroller Fiscal Year 2021 Annual Report

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

November 2021

Kevin D. Walsh, Acting State Comptroller

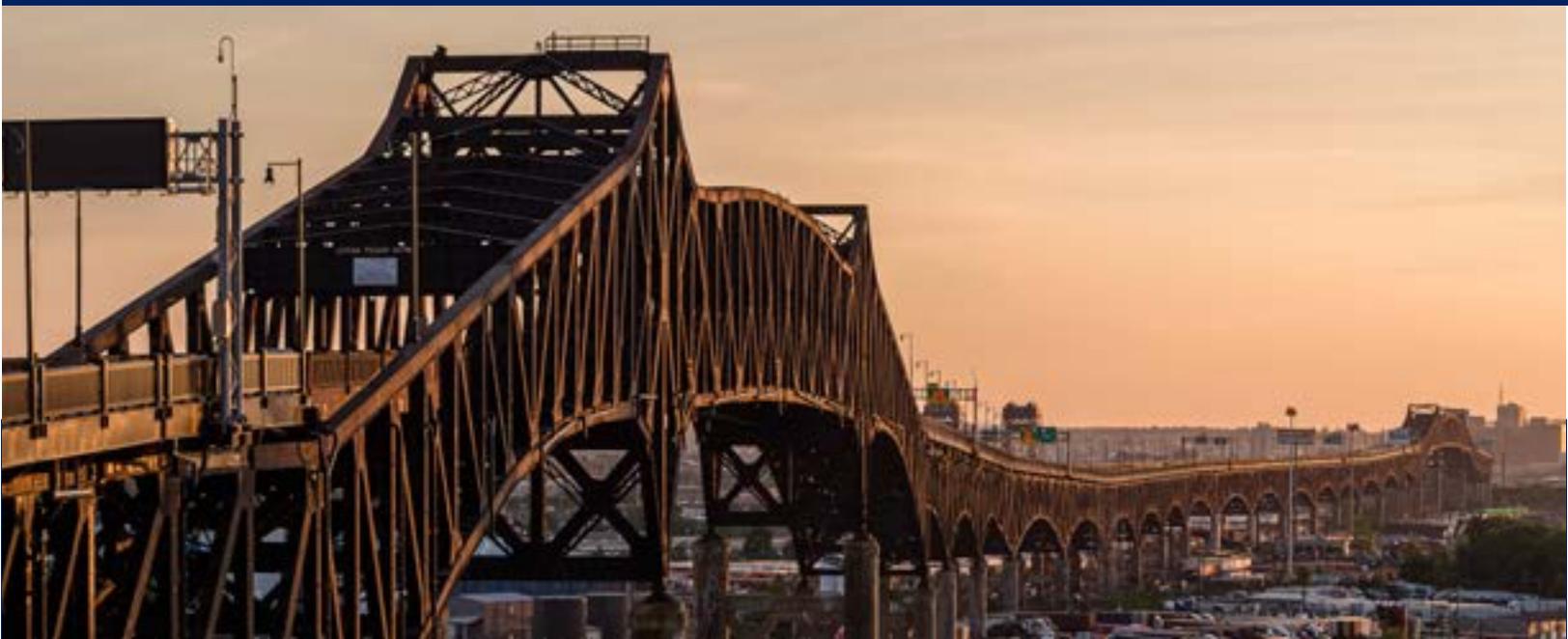




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Letter from the Acting State Comptroller

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

This past fiscal year was a productive one for the Office of the State Comptroller (OSC). It was also one marked with unprecedented challenges and exciting new initiatives advancing our mission to identify and eliminate fraud, waste and abuse in New Jersey government.

OSC occupies a singular role in state government. Since its founding in 2008, OSC's independent oversight has inspired a long list of positive reforms, uncovering inefficiencies and saving money for residents of our state. The work described in this Annual Report shows how wide-reaching our mandate is and, I am proud to share, how effective the employees of OSC have been in carrying out our duties during fiscal year 2021.

As Acting State Comptroller, my responsibility, first and foremost, is to advance accountability and transparency in New Jersey government. Practically, that means detecting and eliminating fraud, waste and abuse wherever we find it. It means making sure that public money is spent in the public's interest. It means reporting in

clear and objective ways when public entities and officials are not following the rules or when the people in charge are acting in their own self-interest.

“ Since its founding in 2008, OSC's independent oversight has inspired a long list of positive reforms, uncovering inefficiencies and saving money for residents of our state.

But OSC is not doing its job as a government watchdog if we are only calling out mismanagement after it occurs. That is why we take a proactive approach to prevent mismanagement before it happens by sharing resources and best practices. Taken together, OSC's four divisions – Audit, Investigations, Medicaid Fraud, and Procurement– implement a multi-pronged

strategy for making government in New Jersey run more efficiently and effectively by sharing our expertise and experience before waste, fraud, and abuse occur. As discussed in this report, we measure our work in reports issued, dollars recovered, contracts amended to comply with the law, issues identified, and recommendations implemented.

This past year, in view of the billions of federal recovery dollars headed to New Jersey and in order to implement an executive order issued by Governor Murphy, I formed OSC's new COVID-19 Compliance and Oversight Project to promote accountability and transparency in our recovery from the pandemic. Through trainings, resources, and ongoing oversight of the State's Accountability Officers and Integrity Monitors, the COVID Project is ensuring that recovery funds are spent transparently and in compliance with all state and federal laws.

A central part of our COVID oversight work is mitigating the risks of fraud, waste and abuse by helping state agencies and authorities and local governments stay one step ahead of those who may take advantage of an assistance program or use inside information for their own benefit. We welcome your help in this important work. Our hotline is taking calls about COVID fraud, and we encourage residents and public employees alike to reach out to us if they have information to share.

We are not fulfilling our mandate of making government more transparent if the public does not know how to access OSC's resources and reports. That is why this year, we overhauled OSC's website to include a comprehensive reports database allowing users to search our reports going back to our very first ones in 2009. We also streamlined resources for procurement professionals, Medicaid professionals, and local governments using COVID recovery funds. And we launched a new blog written by OSC employees to help educate the public on topics regarding government accountability.

“ All of these changes are part of our effort to create an ongoing dialogue with members of the public about what they're seeing on the ground, where government is falling short, and what OSC can do about it.

All of these changes are part of our effort to create an ongoing dialogue with members of the public about what they're seeing on the ground, where government is falling short, and what OSC can do about it. Releasing reports is the most prominent work that we do, but by no means should the conversation begin and end there. We encourage you to reach out to us on social media, through our website, or by calling our tip line with your thoughts and feedback on how we can better hold New Jersey government accountable.

There is much more work to be done, and, as you will see in this report, the employees of OSC take seriously our mission to search high and low for opportunities to make government run more honestly, efficiently and effectively for the people of New Jersey.

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. In FY 2021, OSC also established the COVID-19 Compliance and Oversight Project, which promotes accountability, transparency, and compliance in the spending of federal COVID-19 recovery funds in New Jersey. Each of OSC's four divisions and its COVID-19 Project made significant contributions to OSC's accomplishments this past fiscal year.

Our Audit Division concluded its work on six performance audits in FY 2021. The audits examined selected fiscal and operating practices of two school districts and two municipalities and the operating practices and internal controls for the management and administration of the workers' compensation program. Division auditors also examined compliance with procurement and P-card policies and procedures within the state Departments of Human Services, Corrections, and Environmental Protection. In addition to these audits, the division completed eight follow-up reviews of prior audits to determine whether the auditees had implemented OSC's recommendations.

Our Investigations Division completed three reviews in FY 2021. First, the division examined the Division of Workers' Compensation's (DWC) approval of medical monitoring settlement agreements for public employees who received an accidental disability pension. This investigation determined that DWC's approval of these agreements encouraged employees to settle claims in a way that caused harm to the State's pension funds and provided windfalls to workers' compensation insurance providers. Second, the division completed an investigation into the fiscal operations of the Borough of Palisades Park. That investigation revealed troubling fiscal problems at the Borough, including unlawful sick leave payouts and a failure to adopt internal controls to prevent improper reimbursements and fuel card usage. Third, the division conducted its seventh in a series of OSC reviews of the New Jersey State Police (NJSP) and the Office of Law Enforcement Professional Standards (OLEPS). This year's review focused on internal affairs and disciplinary processes. OSC concluded that NJSP was generally compliant with governing disciplinary procedures, but that it deviated from those procedures in several ways. OSC also found that OLEPS was not using existing data to analyze race, gender, or rank and the influence of those factors, if any, on the imposition of Trooper discipline.

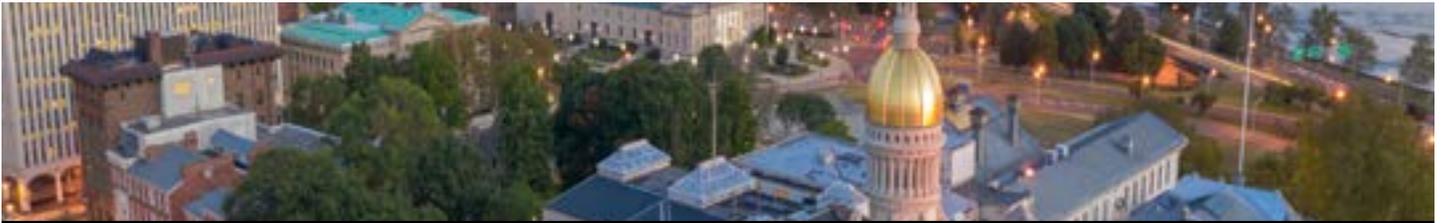
Our Medicaid Fraud Division's ongoing efforts to combat waste, fraud and abuse in the Medicaid

Program resulted in the recovery of more than \$72.6 million of taxpayer dollars in FY 2021. Its anti-fraud efforts also resulted in the exclusion of 79 ineligible providers from the Medicaid program.

Our Procurement Division reviewed 700 contracts this past fiscal year, 140 of which were valued at \$12.5 million or more. Division attorneys also reviewed 364 contracts valued between \$2.5 million and \$12.5 million.

OSC's newly-formed 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 COVID-19 Project worked to ensure that the billions of dollars of COVID-19 recovery funding allocated to New Jersey's state and local governments was spent effectively and efficiently by providing training, guidance documents, and ongoing oversight of the State's Accountability Officers and Integrity Monitors.

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 while setting forth highlights of OSC accomplishments from the past fiscal year of July 1, 2020 to June 30, 2021.



Audits

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 Yvonne Tierney, who brings more than 30 years of experience as an auditor and investigator to the position. The Audit Division staff includes individuals who possess certifications or professional designations such as Certified Public Accountant, Certified Internal Auditor, and Certified Fraud Examiner.

Examples of our Audit Division's work in FY 2021 are set forth below. OSC audit reports can be viewed in their entirety on our website.

Audits

Workers' Compensation Claim Management

OSC auditors examined the state Department of the Treasury, Division of Risk Management's operating practices and internal controls in the management and administration of the workers' compensation program. The audit found that the Division: (1) improperly processed workers' compensation benefits totaling \$54,605 contrary to the program limitations of the workers' compensation statutes

and its own policies and procedures; and (2) did not properly ensure that the vendor responsible for managing medical services satisfied all contract requirements.

Buena Regional School District

In this audit, OSC auditors examined certain fiscal and operating practices of the Buena Regional School District and found that the District had failed to comply with: (1) federal regulations for income verification in the school lunch program; (2) state regulations for the procurement of insurance brokers; (3) the District's own policies and procedures for procuring a broker; and (4) terms in employment contracts and collective bargaining agreements addressing health benefit opt-out waiver payments.

P-Card Practices

This audit reviewed certain purchasing card or P-Card practices by three state departments. Our auditors found that the state Departments of Human Services and Corrections failed to comply with P-Card Program regulations concerning: (1) the procurement of goods and services; (2) the maintenance of required documentation; and (3) the need to ensure adequate internal controls and segregation of duties. The audit also found that the Department of Environmental Protection failed to maintain required documentation concerning its P-Card transactions.

Salem County Special Services and Vo-Tech School Districts

In this audit, OSC examined selected fiscal and operating practices of the Salem County Special Services and Vocational Technical School Districts. The audit identified various weaknesses in the Districts' internal controls including inadequate accounting system security controls and a lack of appropriate segregation of duties.

Borough of Roselle

This audit examined, among other things, the adequacy of Roselle's internal controls over selected fiscal and operating practices and its compliance with applicable laws concerning procurements and employee benefits. The audit found that the Borough: (1) lacked adequate oversight and monitoring of its employee health insurance benefits and health benefit opt-out waiver payments that resulted in almost \$800,000 of improper payments; (2) failed to promptly investigate and resolve an employee disciplinary action that resulted in approximately \$611,000 of continued salary payments; (3) improperly awarded contracts for consulting services that did not comply with state laws; and (4) lacked adequate oversight, monitoring, and reporting of employees' use of Borough vehicles.

Borough of Keansburg

In this audit, OSC examined selected fiscal and operating practices of the Borough as well as its compliance with laws governing employee benefits. OSC's audit found that the Borough: (1) provided improper health benefit opt-out waiver payments of approximately \$22,000 to employees who received health insurance through the State Health Benefits Program; (2) failed to oversee the administration of employee benefits, which resulted in improper payments of approximately \$95,000 to the Chief of Police and Municipal Clerk for unused vacation and sick leave; (3) provided excessive employee benefits, including up to 55 days, or 11 weeks, of vaca-

tion to the Chief of Police; (4) failed to administer the Length of Service Award Program in compliance with state law and internal policies and procedures, resulting in improper contributions of \$7,650; and (5) failed to report the taxable fringe benefits of employees' personal use of Borough-assigned vehicles contrary to federal law.

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 our recommendations.

Follow-up Reviews

OSC obtains Corrective Action Plans from the 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 implements our recommendations.

We issued eight follow-up review reports in FY 2021.

College Fees

Our 2016 audit examined the controls over the collection, allocation and use of student fees at the College of New Jersey (TCNJ), William Paterson University (WPU), and Kean University (Kean). We discovered that, other than Board of Trustee bylaws and resolutions, none of the schools had written policies or procedures governing the development and management of their mandatory student fee process. We also found that two of the three schools (TCNJ and Kean) did not maintain separate funds for mandatory fees and did not provide documentation justifying increases to these fees. In addition, we noted that all three schools were not fully transparent with regard to their use of student fees.

We found that each of the schools has made progress in implementing the recommendations set

forth in our initial audit report. Of the three audit recommendations applicable to WPU, two were implemented and one was partially implemented. Of the four audit recommendations applicable to TCNJ, one was implemented, one was partially implemented, and two were not implemented. Of the seven recommendations applicable to Kean, six were implemented and one was partially implemented.

Prospect Park School District

OSC's 2019 audit identified weaknesses with certain District fiscal and operating practices and identified opportunities for potential cost savings. Specifically, Prospect Park lacked key internal controls for the management and administration of certain information technology functions, failed to comply with certain policies and state requirements, and lacked appropriate and necessary details in a substitute teacher staffing contract.

We found that Prospect Park has made progress in implementing the recommendations set forth in our initial audit report. Of the six audit recommendations, one was implemented and five were partially implemented.

Plainfield Municipal Utilities Authority

In our 2017 audit of the PMUA, we identified three areas for improvement: monitoring of indirect cost allocations, employee separation policies, and compliance with purchasing requirements.

The PMUA did not submit a formal corrective action plan as required by *N.J.A.C. 17:44-2.8(a)*. However, the PMUA's response to the initial report specified corrective actions it had taken. We found that the PMUA has made progress in implementing the recommendations set forth in our initial audit report. Of the five audit recommendations, one was implemented, two were partially implemented, and two were not implemented.

General Assistance Program

Our 2015 audit evaluated controls over the administration of the Work First New Jersey General Assistance Program at three selected county welfare agencies: Burlington County Board of Social Services (Burlington), Camden County Board of Social Services (Camden), and Passaic County Board of Social Services (Passaic). We identified control weaknesses in the areas of eligibility determination, enrollment in work activities, and support for Emergency Assistance payments.

None of the agencies submitted corrective action plans as required by *N.J.A.C. 17:44-2.8(a)*. During our review, we inquired about the corrective actions taken by the agencies and verified whether those actions were implemented. We found that each of the agencies has made significant progress in implementing the recommendations set forth in our initial audit report. Of the six audit recommendations applicable to Burlington, five were implemented and one was not implemented. Camden implemented all seven audit recommendations. Of the seven audit recommendations applicable to Passaic, six were implemented and one was not implemented.

Selected Fire Districts

Our 2014 audit evaluated fiscal and operating practices at three fire districts: Brick Fire District No. 1 (Brick No. 1), Cherry Hill Fire District No. 13 (Cherry Hill No. 13), and Woodbridge Fire District No. 1 (Woodbridge No. 1). The audit found that Cherry Hill No. 13 and Woodbridge No. 1 paid firefighters significantly more than the state average salary, as well as benefits that included longevity and terminal leave payments. We also found that Cherry Hill No. 13 failed to recruit volunteer firefighters. Given Brick No. 1's all volunteer fire department, we did not find any exceptions with regard to Brick No. 1's fiscal or operational practices concerning salaries and benefits. Lastly, we recommended that due to poor voter turnout in mid-February, fire district elections should coincide with general elections held in November.

Our follow-up engagement found that Cherry Hill No. 13 and Woodbridge No. 1 have each made progress in implementing the recommendations set forth in our initial audit report. Of the three recommendations applicable to Cherry Hill No. 13, two were implemented and one was partially implemented. All three recommendations applicable to Woodbridge No. 1 were implemented. We also found that although New Jersey enacted a law to allow fire districts to move elections to November, such a move is at the discretion of the fire district. Of the three fire districts, Cherry Hill No. 13 moved its elections to November. Brick No. 1 and Woodbridge No. 1 still hold elections in February.

Improper Temporary Disability Insurance Benefit Payments to Deceased Individuals

The Temporary Disability Insurance (TDI) program provides cash benefits to individuals who cannot work because of sickness or injury not caused by their job. The state Department of Labor and Workforce Development (LWD) administers the TDI program. Our 2014 audit identified TDI payments of \$168,764 improperly issued by LWD to 160 deceased individuals.

Our follow-up review found that LWD did not fully implement our audit recommendations. Of the two recommendations, LWD did not implement one and only partially implemented the other.

West New York School District Pre-school Program

In our 2015 audit, we identified various deficiencies, including internal control weaknesses involving payments to contracted preschool providers and the District's failure to ensure compliance by the providers with contract terms and state regulations.

Our follow-up review found that the District has made significant progress in implementing the recommendations set forth in our initial audit report. Of the four audit recommendations, three were implemented and one was partially implemented. Upon being notified that one of the recommendations was only partially implemented, the District took corrective action to address its compliance with that recommendation. The recommendation, however, is not considered fully implemented because the compliance was not timely.

Jersey City Municipal Utilities Authority

In our 2018 audit, we found weaknesses with controls over selected fiscal and operating practices and identified opportunities for potential cost savings. Specifically, JCMUA lacked key internal controls with regard to setting water and sewer user rates; monitoring bulk-water consumption and billing; procuring goods and services; and monitoring employee salary increases and other benefits.

We found that JCMUA has made progress implementing the recommendations set forth in the initial audit report. Of the ten audit recommendations, seven were implemented, two were partially implemented, and one was not implemented.

Policies and Procedures

Our efforts at OSC have included establishing policies and procedures that guide our audit process. The following are descriptions of some of the policies and procedures we have put into effect and have continued to refine over the past fiscal year.

Audit Manual

For professional audit organizations such as ours, it is essential that clearly defined policies be pro-

mulgated 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. Our 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 and is also posted on our website.

Risk/Priority Evaluation

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

Quality Control and Peer Review

Government auditing standards require audit organizations to establish an internal quality control system and to participate in an external quality control "peer review" program. The internal quality control system provides the organization with ongoing assurance that its policies, procedures and standards are adequate and are being followed. The external peer review, to be conducted once

every three years, is a professional benchmark that provides independent verification that the internal quality control system is in place and operating effectively, and that the organization is conducting its work in accordance with appropriate standards.

In June 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 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. We continue to work closely with both state and federal audit organizations and law enforcement officials in this regard.

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. OSC is recognized by the National Association of State Boards of Accountancy as a CPE sponsor. Annually, our staff receives formal training on topics such as governmental accounting, auditing and accounting, audit sampling, audit evidence, and internal controls. All staff members in the Audit Division have satisfied the biennial requirement of obtaining 80 CPE hours over the reporting period.



Investigations

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

Ravi Ramanathan joined OSC as Director of the Investigations Division in February 2021. Prior to joining OSC, Mr. Ramanathan worked as an attorney in the private sector representing individuals and corporations in criminal and civil enforcement matters, including internal investigations and compliance reviews, federal and state investigations, and monitorships of major financial institutions. 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 from government employees, and are received through OSC's toll-free Hotline, OSC's website, via email, or through the U.S. mail. The Hotline is also used as the official statewide tipline for any tips regarding the waste, fraud or abuse of Superstorm Sandy funds or federal COVID-19 recovery funds.

Complaints and Referrals

In FY 2021, the Investigations Division fielded 115 complaints, 5 of which related to Superstorm Sandy funds. The division referred an additional 10 matters to criminal investigators at both the state and federal levels.

The Investigations Division also made 35 external referrals to other state, county, and federal agencies in FY 2021, among them, the state Department of Community Affairs, the state Department of Children and Families, the state Department of Human Services, the state Department of Labor and Workforce Development, the state Department of the Treasury, and the Office of Inspector General for the U.S. Department of Housing and Urban Development.

The Investigations Division made other referrals in house to OSC's Audit, Procurement, and Medicaid Fraud Divisions, which are expected to result in future audits and investigations. The Investigations Division serves as a key resource to OSC's other divisions by providing investigative assistance, including helping to conduct witness interviews, identifying potential subjects for audits, and providing public record analyses. Conversely, the Investigations Division also conducts inquiries based on incoming referrals from other state agencies. Our joint efforts with these other agencies continue to build a synergy that has led to increasingly robust investigative efforts across state government.

Public Reports

The Investigations Division produced the following public reports in FY 2021:

An Examination into the Use of Medical Monitoring Settlements by the Division of Workers' Compensation within the State Department of Labor and Workforce Development and the Impact on the State's Pension Funds

This investigation examined the state Department of Labor and Workforce Development, Division of Workers' Compensation's (DWC) approval of medical monitoring settlement agreements for public employees who received an accidental disability pension. These agreements allowed the employee to avoid a mandatory pension offset and bypass a two-year limitation on the receipt of medical treatment.

OSC found that DWC's approval of these agreements encouraged employees to settle claims in a way that caused harm to the State's pension funds, provided windfalls to workers' compensation insurance providers, and permitted employees to receive medical monitoring and coverage without evaluating the necessity of those benefits.

OSC recommended that DWC (1) rescind its policies permitting medical monitoring settlement agreements and (2) in coordination with the Department of Treasury, Division of Pensions and Benefits, adopt regulations aimed at preventing windfalls to workers' compensation insurance providers and protecting the State's pension fund.

An Investigation into the Fiscal Operations of the Borough of Palisades Park

OSC's investigation found that the Borough of Palisades Park adopted and maintained policies and practices that violated state law. In particular, the

investigation revealed that the Borough entered into a contract with its Business Administrator that provided him with annual sick leave payments that were prohibited by a 2007 law. The investigation also found that the Borough contravened a 2010 state law by providing annual sick leave payments to employees hired after the effective date of that law.

OSC's report further revealed that the Borough failed to adopt and implement internal controls that ensure accountability and prevent waste, fraud, and abuse. For instance, the Borough commonly approved and paid employee reimbursement requests without regard to the nature of the expenditure, the appropriateness of the receipts provided, or whether the request was supported by adequate documentation or required signatures. OSC also found that the Borough failed to monitor the use of fuel cards by its employees.

OSC recommended that the Borough adopt appropriate controls concerning, among other things, employee benefits, leave policies, and employee reimbursements. OSC also referred the findings from this investigation to the state Department of Community Affairs, Local Finance Board, to determine whether certain Borough employees engaged in conduct prohibited by the Local Government Ethics Law.

Seventh Periodic Report on Law Enforcement Professional Standards: Review of Motor Vehicle Stops and Post-Stop Enforcement Activities at the Division of New Jersey State Police and its monitoring by the Office of Law Enforcement Professional Standards

By statute, OSC is required to periodically review the performance of the New Jersey State Police (NJSP) with regard to its continuing efforts to prevent racial and other forms of discrimination in its policies, practices, and procedures. OSC is also tasked with reviewing the Office of Law Enforcement Professional Standards' (OLEPS) oversight of those efforts.

For FY 2021, OSC completed its seventh periodic review of NJSP and OLEPS, and publicly issued its findings and recommendations. The review focused on NJSP’s internal affairs and disciplinary processes. OSC’s report concluded that NJSP was generally compliant with governing procedures for classification and discipline, but that it deviated from those procedures in several ways. For example, the report identified a process NJSP used to administratively close some racial profiling and disparate treatments complaints that ran counter to governing policy. OSC also examined OLEPS’ oversight of NJSP on these matters and found that OLEPS was not using existing data to analyze race, gender, or rank and their influence, if any, on the imposition of discipline. OSC made recommendations for improvement to address these and other findings set forth in the report.

During this fiscal year, OSC also commenced its eighth periodic review. OSC expects to issue its findings in FY 2022.

Speaking Engagements and Outreach

In FY 2021, 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, including continuing legal education seminars, fraud symposiums, and blog posts on OSC’s website.

**GOVERNMENT WASTE AND
MISMANAGEMENT HOTLINE**

**Toll Free: 1-855-OSC-TIPS
(1-855-672-8477)**

Email: comptrollertips@osc.nj.gov

Website: www.nj.gov/comptroller



Medicaid Fraud

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

Josh Lichtblau joined OSC as Director of the MFD in July 2015 after more than two decades serving the interests of New Jersey citizens 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 which 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 which 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 1.7

million New Jersey residents.

- The New Jersey Hospital Care Payment Assistance Program, commonly known as Charity Care, which 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 where necessary and conducts educational programs for Medicaid providers and contractors. Finally, MFD oversees a contractor that 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.

FY 2021 Statistics

In FY 2021, MFD recovered or facilitated in the recovery of slightly more than \$72.6 million in improperly paid Medicaid funds, with \$59.6 million of that attributable to third party liability (TPL) recoveries from third party insurance carriers and the remainder, almost \$13 million, attributable to MFD's audits and investigations. Those funds were returned to both the state and federal budgets. MFD also excluded 79 ineligible providers from participating in the Medicaid program this past fiscal year.

MFD received more than 1,168 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 65 high-risk provider applications. In addition, the division referred 6 cases to the Medicaid Fraud Control Unit (MFCU) within the state Office of the Attorney General and an additional 14 matters to other civil and criminal enforcement entities, including county prosecutors' offices, the state Department of Treasury, Division of Taxation, and the Internal Revenue Service.

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 sole providers/ practitioners. MFD offered a virtual educational training session in coordination with the State Department of Human Services, Division of Developmental Disabilities (DDD), and MFCU titled "Steering Clear of Medicaid Fraud, Waste and Abuse" that was designed to help DDD 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 2021, MFD identified 180 parent entities (993 individual providers) that were required to certify. Of those entities, 85 established Corrective Action Plans (CAPs) to address deficiencies with 36 entities currently remaining under CAPs.

What follows is an overview of the work performed by each unit in MFD in FY 2021. 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

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

selects appropriate samples for audit/investigation purposes and, using statistically valid processes, extrapolates audit/investigative findings to determine the amount of overpayment (restitution) that should be pursued.

In total, MFD's data mining group referred 37 cases of anomalous claims behavior to the Audit/Investigation Units and generated 276 reports for use by these units in FY 2021.

Audit

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.

As part of MFD's fiscal integrity oversight, MFD launched audits in a number of areas, including durable medical equipment (DME) providers, hospitals, and partial care providers. MFD completed audits in two areas that are particularly noteworthy.

Medicaid Fraud Division by the Numbers



First, MFD initiated audits of several DME providers. In one such audit, Surgical Sock Shop, Inc. (Surgical Sock), MFD found that almost 72 percent of Surgical Sock's compression stocking claims failed to comply with Medicaid program requirements, which translates to a 34 percent error rate in terms of the Medicaid dollars paid for these items. Specifically, MFD found that Surgical Sock failed to maintain documentation from the prescribing practitioner (physician) and/or customer invoices to support the goods/services provided and/or failed to bill the accurate code for the item dispensed. These deficiencies resulted in improper Medicaid payments to Surgical Sock. MFD also found that Surgical Sock improperly billed for about 14 percent of its other DME claims that MFD tested. By extrapolating all of the deficient claims to the universe of claims/reimbursed amount, MFD calculated that Surgical Sock improperly billed and was paid by the Medicaid program a total of \$242,873 that it was required to repay to the Medicaid program.

MFD also completed audits of partial care providers. These providers offer group and individual outpatient therapy services. In one of these audits, Archway Programs, Inc. (Archway), MFD found that slightly more than 56 percent of Archway's sample claims failed to comply with relevant regulatory requirements. The majority of these deficient claims were attributable to Archway having billed and received Medicaid payments for active programming provided during meal time, which is not permitted by regulation. After extrapolating the net dollars in error attributable to these deficient claims to the universe of claims, MFD calculated that Archway received an overpayment of slightly more than \$1.3 million that it had to repay to the Medicaid program.

In both the Surgical Sock and Archway audits, MFD not only notified each provider of its Medicaid overpayment, but also recommended corrective steps each provider was required to implement to address the noted deficiencies.

Third Party Liability

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 where 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 2021, the state Medicaid program, through its outside TPL vendor, recovered more than \$59.6 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 2021, the Investigations Unit opened 198 cases and made referrals to other agencies such as the 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 Website as well as from other state and federal agencies. In total, MFD received 1,168 telephone Hotline tips in FY 2021. MFD, working in conjunction with the U.S. Social Security

Administration, provides resources to staff the Co-operative Disability Investigation Unit (CDIU). The CDIU investigates allegations of Social Security (SSI)/Disability fraud under Titles II and XVI of the Social Security Act, which may include Medicaid funds because recipients of SSI are automatically eligible for Medicaid coverage. During FY 2021, the CDIU realized total monetary recoveries and program savings totaling \$3,389,602 with \$32,228 of that amount attributable to Medicaid recoveries and \$777,440 to Medicaid savings.

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 2021, the Investigations Unit received 65 such applications from high-risk providers – DME, prosthetics and orthotics, and home healthcare agencies, for which MFD performed 517 individual background checks using several verification sources. The unit also confirmed 25 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 2021, the work of the Investigations Unit resulted in the recovery of approximately \$10.1 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 & 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 overpayments to be recovered, 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 where R&E cannot resolve an overpayment through a settlement, MFD will take administrative action against the provider or recipient.

Providers can be excluded from participating in the Medicaid program 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 2021, MFD excluded 79 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 identified 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 WASTE,
FRAUD, OR ABUSE:**

**CALL 1-888-937-2835
OR [FILE A COMPLAINT](#)**

Contract

Procurement

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 2021, the Procurement Division received notice of 700 contracts, including 140 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 OSC as an attorney in 2011.

In addition to reviewing contracts, the attorneys in 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)*, effective July 1, 2020, OSC's statutory review thresholds were adjusted. Accordingly, all contracting units now are required to submit contracts involving consideration or an expenditure of \$12.5 million (formerly \$10 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 (formerly \$2 million) but less than \$12.5 million, contracting units must notify OSC no later than 20 business days after the contract award.

Procurement Division by the Numbers



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 achieve procurements that 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 in need of 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 receive 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 con-

“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?”

tracting 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*, vague or confusing evaluation criteria 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. As a result, in FY 2021, the Procurement Division reviewed a variety of purchasing practices that otherwise would have been below OSC's statutory monetary threshold for review.

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.

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 2021 the division pre-screened 156 procurements pursuant to Exec-

utive Order 166 and 40 procurements pursuant to Executive Order 125.

In all, the Procurement Division received notice of 700 contracts for review in FY 2021. Of those contracts, 140 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 59 percent of those pre-screened contracts to ensure the legality of the procurement process.

Some notable contracts reviewed include: a \$1.5 billion contract for New Jersey Transit for the reconstruction of the Portal North Bridge; two contracts for the state Department of Transportation valued at \$161.4 million and \$75.7 million for improvements and repairs to two stretches of the Pulaski Skyway; and a \$107 million contract for Monmouth County for the reconstruction of a bridge over the Shrewsbury River.

The Procurement Division also reviewed 364 contracts valued between \$2.5 million and \$12.5 million. In these contracts, the Procurement Division found a 49 percent error rate. In each case, the division provided guidance to the contracting entity to ensure that the errors are not repeated.

Educational Outreach

In FY 2021, 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. OSC's Procurement Director 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.



COVID-19 Compliance and Oversight Project

The COVID-19 Compliance and Oversight Project (COVID 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 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.

As Director of the COVID-19 Compliance and Oversight Project, Jillian Holmes draws from nearly a decade of experience safeguarding public funding as an attorney in OSC's Procurement, Investigations, and Medicaid Fraud Divisions. The COVID Project is staffed by a dedicated team with expertise in investigations, fraud, auditing, accounting, and legal and regulatory compliance. The COVID Project also regularly collaborates with OSC's other divisions to take a comprehensive approach to oversight.

The COVID Project was formally created in April of 2021 and has issued several guidance documents, compliance alerts, and other reference materials aimed at improving compliance and transparency among state and local government units. These resources include:

- A checklist for evaluating internal controls
- A template for conducting a risk assessment

- Tips for working with integrity monitors and writing a clear scope of work; and
- Best practices for local governments using Local Fiscal Recovery Funds

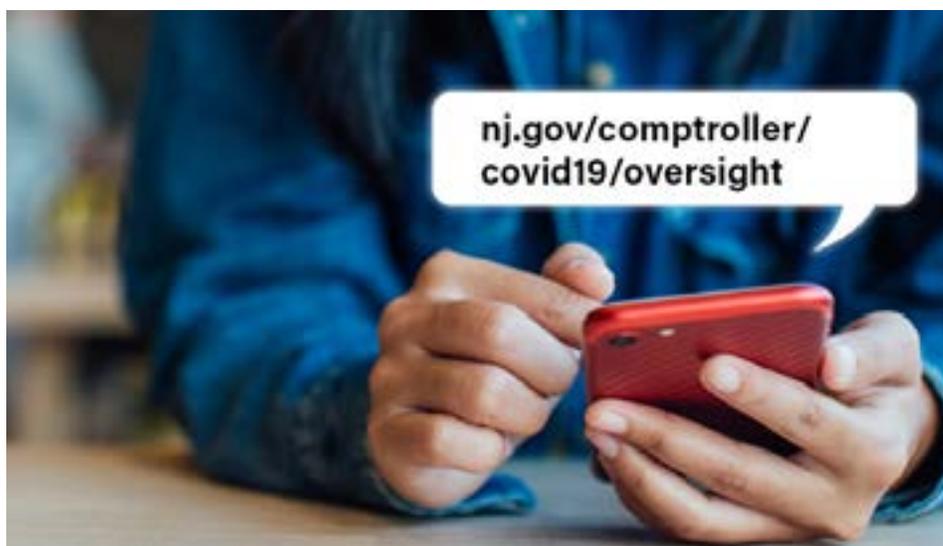
The COVID Project has also partnered with OSC's other divisions to produce webinars and trainings for state and local government units. Collectively, these trainings have reached over 400 individuals at all levels of New Jersey government, to instruct them on best practices for procurement, internal controls, compliance, and reporting. These resources and webinars are available on the newly-created COVID-19 section of OSC's website.

The COVID Project also regularly communicates with state and local government units on matters of oversight and compliance. This includes communications with the State's 29 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 at the 565 municipalities and 21 counties in New Jersey that have received COVID-19 recovery funds. Through ongoing monitoring and more targeted reviews, the COVID 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.

As an additional layer of oversight, OSC is also responsible for overseeing the work of the state's contracted Integrity Monitors. Integrity Monitors are independent monitors deployed throughout the state to either proactively assist a state entity with grants management or administration, or to oversee and monitor the use of COVID-19 recovery funds and checking for non-compliance or fraud, waste, or abuse. Among other things, the Integrity Monitors have completed risk assessments for state entities and programs and performed in-depth reviews that have identified various issues related to eligibility and processing, missing documentation, and incorrect or improper payments. As of June 30, 2021, four different Integrity Monitors were hired to oversee and assess compliance for 10 departments/agencies for 44 programs funded with COVID-19 recovery funds. Collectively, the programs under review by Integrity

Monitors account for over \$2 billion of New Jersey's COVID-19 recovery funding. The Integrity Monitors produced 16 reports, which are available for review by the public here. The COVID Project oversees these engagements and the quarterly Integrity Monitor reports to identify or intervene in any issues requiring additional follow-up or corrective action.

OSC and the COVID Project also support the work of the COVID-19 Compliance and Oversight Taskforce. The Taskforce was established pursuant to Executive Order 166 (Murphy, 2020) and is chaired by the Acting State Comptroller. The COVID Project assisted the Taskforce in fulfilling its responsibilities under Executive Order 166, by assisting with the development of a statewide Compliance Plan and the development of the Integrity Monitor Guidelines.





Appendix - MFD Settlements & Audits

FY 2021 Settlements

• **[JFK Pharmacy Settlement Agreement](#)** – MFD resolved an investigation of JFK Pharmacy, located in Jersey City, New Jersey, with JFK Pharmacy agreeing to repay the Medicaid program \$7,000. Through this investigation, MFD determined that JFK Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that JFK Pharmacy dispensed during the period from November 1, 2016 through October 31, 2018. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

• **[Value Plus Pharmacy Settlement Agreement](#)** – MFD resolved an investigation of Value Plus Pharmacy, located in Newark, New Jersey, with Value Plus Pharmacy agreeing to repay the Medicaid program \$843,000. Through this investigation, MFD determined that Value Plus Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Value Plus Pharmacy dispensed during the period from May 1, 2012 through March 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.

• **[Goethals Pharmacy Settlement Agreement](#)** – MFD resolved an investigation of Goethals Pharmacy, located in Elizabeth, New Jersey, with Goethals Pharmacy agreeing to repay the Medicaid program \$16,563. Through this investigation, MFD determined that Goethals Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Goethals Pharmacy dispensed during the period from March 5, 2014 through December 31, 2018. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

• **[Sunrise Care Settlement Agreement](#)** – MFD resolved an audit of Sunrise Care, located in Newark, New Jersey, with Sunrise Care agreeing to repay the Medicaid program \$182,637. Through this audit, MFD determined that Sunrise Care incorrectly billed the Medicaid program and was subsequently paid for a greater number of units for partial care services than what was authorized during the period from January 1, 2015 through September 30, 2019.

• **[Ammon Analytical Laboratories Settlement Agreement](#)** – MFD resolved a self-disclosure submitted by Ammon Analytical Laboratories, located in Linden, New Jersey, with Ammon Analytical Laboratories agreeing to repay the Medicaid program \$207,837. Through this self-disclosure and MFD's subsequent investigation, MFD determined that Ammon Analytical

Laboratories incorrectly billed the Medicaid program and was subsequently paid for claims that should have been submitted to a third-party payer during the period from January 1, 2019 through December 31, 2019.

• **Caliber Home Health Care Settlement Agreement**

– MFD resolved an investigation of Caliber Home Health Care, located in Rutherford, New Jersey, with Caliber Home Health Care agreeing to repay the Medicaid program \$21,116. Through this investigation, MFD determined that Caliber Home Health Care incorrectly billed the Medicaid program and was subsequently paid for claims for personal care services that could not be supported by documentation during the period from January 1, 2015 through June 30, 2020.

• **Lakewood Speech and Language Solutions Settlement Agreement**

– MFD resolved an audit of Lakewood Speech and Language Solutions, located in Lakewood, New Jersey, with Lakewood Speech and Language Solutions agreeing to repay the Medicaid program \$145,000. Through this audit, MFD determined that Lakewood Speech and Language Solutions incorrectly billed the Medicaid program and was subsequently paid for claims that were not in compliance with the Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual during the period from January 1, 2014 through December 31, 2018.

• **Tanya Leykin, MD Settlement Agreement** – MFD resolved an investigation of Tanya Leykin, MD, a pediatrician located in Cliffside Park, New Jersey, with Dr. Leykin agreeing to repay the Medicaid program \$120,710. Through this investigation, MFD determined that, from January 1, 2015 through October 10, 2019, Tanya Leykin improperly billed for and received Medicaid payments for claims for which she failed to unbundle preventive maintenance Evaluation and Management services and/or failed to have necessary supporting documentation.

• **Total Care Nursing Settlement Agreement** – MFD resolved an investigation of Total Care Nursing

Registry, located in Rochelle Park, New Jersey, with Total Care agreeing to repay the Medicaid program a total of \$76,000. Through its investigation, MFD determined that, from January 1, 2014 through February 13, 2019, Total Care Nursing improperly billed for and received Medicaid payments for claims involving various codes that Total Care did not support through its clinical documentation.

• **Steven Weissman (Ocean Dermatology) Settlement Agreement**

– MFD resolved an investigation of Dr. Weissman/Ocean Dermatology, located in Jackson, New Jersey, with the provider agreeing to repay the Medicaid program a total of \$103,586. Through this investigation, MFD determined that, from January 1, 2015 through July 8, 2019, Ocean Dermatology improperly billed for and received payments from the Medicaid program for claims involving various codes for which Ocean Dermatology failed to have necessary supporting documentation.

• **Curemed Pharmacy Settlement Agreement** – MFD resolved an investigation of Curemed Pharmacy, located in Clifton, New Jersey, with Curemed agreeing to pay \$62,563. Through this investigation, MFD determined that, from May 1, 2015 through December 1, 2017, Curemed's inventory for selected medications was not sufficient to account for the quantity of these medications that Curemed dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

• **Adult Family Health Services Settlement Agreement** – MFD resolved an investigation of Adult Family Health Services, located in Clifton, New Jersey, with the provider agreeing to pay \$45,828. Through this investigation, MFD determined that, from March 1, 2015 through December 31, 2019, Adult Family Health improperly billed and received payments from the Medicaid program for claims in excess of the pre-approved number of authorized units associated with the medical code billed.

- **New Essecare Settlement Agreement** – MFD resolved an audit of New Essecare of NJ, LLC, located in Orange, New Jersey, with New Essecare agreeing to pay \$1,061,933. Through its audit, MFD determined that, from January 1, 2015 through December 31, 2017, New Essecare improperly billed and received payments from the Medicaid program for which New Essecare failed to have supporting documentation.

- **Refua Pharmacy Settlement Agreement** – MFD resolved an investigation of Refua Pharmacy, located in Lakewood, New Jersey, with Refua agreeing to pay \$304,380. Through this investigation, MFD determined that, from July 1, 2013 through April 30, 2018, Refua’s inventory for selected medications was not sufficient to account for the quantity of these medications that Refua dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Goethals Pharmacy Settlement Agreement** – MFD resolved an investigation of Goethals Pharmacy, located in Elizabeth, New Jersey, with Goethals agreeing to repay the Medicaid program \$6,593. Through this investigation, MFD determined that, from March 1, 2016 through January 2, 2017, Goethals’ inventory for selected medications was not sufficient to account for the quantity of medications that Goethals dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Behavioral Crossroads, LLC Settlement Agreement** – MFD resolved an investigation of Behavioral Crossroads, LLC, located in Egg Harbor Township, New Jersey, with Behavioral Crossroads agreeing to repay the Medicaid program \$277,612. Through this investigation, MFD determined that, from September 1, 2013 through September 1, 2018, Behavioral Crossroads improperly billed and received payments from Medicaid for claims for which Behavioral Crossroads lacked adequate documentation.

- **RWJ Barnabas Settlement Agreement** – MFD resolved an audit performed by its recovery audit contractor, HMS, of Robert Wood Johnson Barnabas Hospitals (collectively referred to as RWJ Barnabas Hospitals), with various locations throughout the state, with RWJ Barnabas Hospitals agreeing to repay the Medicaid program \$1,000,000. Through this audit, HMS, on behalf of MFD, found that from May 16, 2014 through July 12, 2018, RWJ Hospitals failed to possess necessary supporting documentation for inpatient services that HMS determined could have been performed in a less expensive, outpatient setting.

- **John Brooks Recovery Center Settlement Agreement** – MFD resolved a self-disclosure received from John Brooks Recovery Center, located in Pleasantville, New Jersey, with John Brooks agreeing to repay the Medicaid program \$955,075. Through this self-disclosure and the ensuing MFD review and analysis of relevant information, MFD determined that, from July 1, 2016 through April 30, 2020, John Brooks Recovery Center had inappropriately billed and received payments from Medicaid for bundled intensive outpatient program and/or opioid treatment services without having provided the required individual counseling sessions.

- **Mirian Lugo Settlement Agreement** – MFD resolved an investigation of Mirian Lugo and L & L Pediatrics (collectively referred to as Dr. Lugo), located in Clifton, New Jersey, with Dr. Lugo agreeing to repay the Medicaid program \$287,440, comprised of a principle amount of \$271,170 and interest of \$16,270. Through this investigation, MFD determined that, from January 1, 2013 through June 20, 2018, Dr. Lugo submitted claims for the same patients and same dates of service that Lugo did not support with required documentation.

- **Morning Glory Settlement Agreement** – MFD resolved a desk audit of Morning Glory Behavioral Health Partial Care Program, LLC (Morning Glory), located in Neptune, New Jersey, with Morning Glory agreeing to repay the Medicaid program \$77,276. Through this desk audit, MFD determined that, from

September 1, 2015 through February 29, 2020, Morning Glory submitted claims for partial care services that exceeded prior authorized limits and, thus, were not supported by documentation.

- **Steven Dorfman Settlement Agreement** – MFD resolved an investigation of Steven Dorfman, located in Vineland, New Jersey, with Steven Dorfman agreeing to repay the Medicaid program \$24,937, comprised of a principal amount of \$8,312 and a penalty of double that amount, or \$16,625. Through this investigation, MFD determined that, from October 1, 2017 through March 9, 2018, Steven Dorfman submitted claims to the Medicaid program while his chiropractic license was expired.

- **New Future Dreams Settlement Agreement** – MFD resolved a desk audit of new Future Dreams, LLC (New Future), located in Lakewood, New Jersey, with New Future agreeing to repay the Medicaid program \$134,646. Through this desk audit, MFD determined that, from March 1, 2015 through December 31, 2019, New Future submitted claims for partial care services that exceeded prior authorized limits and, thus, were not supported by documentation.

- **Aelia Pediatric Center Settlement Agreement** – MFD resolved a desk audit of Aelia Pediatric Center, located in Clifton, New Jersey, with Aelia Pediatric Center agreeing to repay the Medicaid program \$28,529. Through this desk audit, MFD determined that, from January 1, 2015 through September 30, 2019, Aelia Pediatric Center submitted to and was paid by the Medicaid program for claims that Aelia Pediatric Center had improperly unbundled.

- **Unity Place, Inc. Settlement Agreement** – MFD resolved an audit of Unity Place, Inc., located in Cherry Hill, New Jersey, with Unity Place agreeing to repay the Medicaid program \$45,254. Through this audit, MFD determined that Unity Place incorrectly billed the Medicaid program and was paid for a greater number of units for partial care services than authorized during the period from January 1, 2015 through September 30, 2019.

- **Washington Shop Pharmacy Settlement Agreement** – MFD resolved an investigation of Washing-

ton Shop Pharmacy, located in East Orange, New Jersey, with Washington Shop Pharmacy agreeing to repay the Medicaid program \$103,296. Through this investigation, MFD determined that from April 1, 2013 through March 1, 2016, Washington Shop's inventory for selected medications was not sufficient to account for the quantity of these medications that it dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Mike's Pharmacy Settlement Agreement** – MFD resolved an investigation of Mike's Pharmacy, located in East Orange, New Jersey, with Mike's Pharmacy agreeing to repay the Medicaid program \$44,400. Through this investigation, MFD determined that, from February 1, 2018 through May 1, 2019, Mike's Pharmacy's inventory for selected medications was insufficient to account for the quantity of medications that it dispensed and billed Medicaid. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Shumet Inc. d/b/a Keansburg Drugs Settlement Agreement** – MFD resolved an investigation of Keansburg Drugs, located in Keansburg, New Jersey, with Keansburg Drugs, and its owners George Grumet and Howard Shulman, agreeing to repay the Medicaid program \$20,154. Through this investigation, MFD determined that from February 1, 2014 through November 30, 2018, Keansburg Drugs's inventory for selected medications was insufficient to account for the quantity of medications that it billed Medicaid. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Autumn Lake Health Care at Oceanview, formerly known as Oceanview Center for Rehabilitation ("Oceanview") Settlement Agreement** – MFD resolved a Recovery Audit Contractor (RAC) long term care audit of Oceanview, located in Oceanview, New Jersey, with Oceanview and its owners, Aryeh Stern and Morris Meisels, agreeing to repay the Medicaid

program \$13,020. Through a RAC audit, MFD determined that Oceanview failed to repay the Medicaid program for payments it had already collected during the period from April 1, 2015 through January 31, 2017. Through this investigation, MFD determined that from February 1, 2014 through November 30, 2018, Keansburg Drugs' inventory for selected medications was insufficient to account for the quantity of medications that it billed Medicaid. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- [Secaucus Health Care Center LLC d/b/a Alaris Health at the Fountains d/b/a/ The Manor \("The Fountains\) Settlement Agreement](#) – MFD resolved a Recovery Audit Contractor (RAC) long term care audit of The Fountains, located in Secaucus, New Jersey, with The Fountains and its owner Avery Eisenreich agreeing to repay the Medicaid program \$18,464. Through a RAC audit, MFD determined that The Fountain failed to repay the Medicaid program for payments it had already collected during the period from July 1, 2013 through October 31, 2015.

- [Tri-State Healthcare Management, LLC d/b/a/ Lakeview Rehabilitation and Care Center/Vent, LLC- \("Lakeview Rehab"\) Settlement Agreement](#) – MFD resolved a Recovery Audit Contractor (RAC) long term care audit of Lakeview Rehab, located in Secaucus, New Jersey, with Lakeview Rehab and its owners Joel Lefer and David Oberlender agreeing to repay the Medicaid program \$1,305. Through a RAC audit, MFD determined that Lakeview Rehab failed to repay the Medicaid program for payments it had already collected during the period from November 1, 2013 through March 31, 2016.

- [RMC Pharmacy Settlement Agreement](#) - MFD resolved an investigation of RMC Pharmacy, located in Newark, New Jersey, with RMC Pharmacy agreeing to repay the Medicaid Program \$60,000. Through this investigation, MFD determined that, for the period from October 1, 2013 through May 1, 2018, RMC Pharmacy's inventory for selected

medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- [Olshins Pharmacy Settlement Agreement](#) – MFD resolved an investigation of Olshins Pharmacy, located in Newark, New Jersey, with Olshins agreeing to repay the Medicaid program \$23,383.43. Through this investigation, MFD determined that, for the period from December 1, 2011 through December 1, 2016, Olshins' inventory for selected medications was not sufficient to account for the quantity of these medications that Olshins dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- [Nour Pharmacy Settlement Agreement](#) – MFD resolved an investigation of Nour Pharmacy, located in Clifton, New Jersey, with Nour Pharmacy agreeing to repay the Medicaid program \$130,279. Through this investigation, MFD determined that, for the period from March 1, 2012 through March 1, 2017, Nour's inventory for selected medications was not sufficient to account for the quantity of these medications that Nour dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- [Matthew's Sable Settlement Agreement](#) – MFD resolved an audit of Matthew Sable, an intensive in-community mental health rehabilitation services provider located in Flemington, New Jersey, with Sable agreeing to repay the Medicaid program \$159,592. Through this audit, MFD determined that, for the period from July 1, 2014 through December 31, 2018, Sable billed for claims that were not supported by documentation, including claims for services provided to multiple (two) beneficiaries provided at the same or overlapping times.

- **Colonia Pharmacy Settlement Agreement** – MFD resolved an investigation of Colonia Pharmacy, located in Colonia, New Jersey, with Colonia Pharmacy agreeing to repay the Medicaid program \$47,508. Through this investigation, MFD determined that, from March 1, 2012 through January 1, 2017, Colonia’s inventory for selected medications was not sufficient to account for the quantity of these medications that Colonia dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **S&H Speech Therapy Settlement Agreement** – MFD resolved an audit of S&H Speech Therapy, located in Lakewood, New Jersey, with S&H agreeing to repay the Medicaid program \$56,530. Through this audit, MFD determined that, from January 1, 2014 through December 31, 2018, S&H improperly billed for a combination of speech language pathology codes that were not supported by S&H’s documentation.

- **Broadway Discount Pharmacy Settlement Agreement** –MFD resolved an investigation of Broadway Discount Pharmacy, located in Camden, New Jersey, with Broadway Discount Pharmacy agreeing to repay the Medicaid program \$56,210. Through this investigation, MFD determined that, from September 1, 2015 through November 30, 2018, Broadway’s inventory for selected medications was not sufficient to account for the quantity of these medications that Broadway Discount 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.

- **Cutrite Settlement Agreement** – MFD resolved an investigation of Cutrite, located in Edison, New Jersey, with Cutrite agreeing to repay the Medicaid program \$120,000. Through this investigation, MFD determined that, from January 1, 2014 through December 31, 2018, Cutrite billed for claims for which

Cutrite lacked supporting documentation.

Notices/Overpayment Letters

- **CareFinders (Notice of Overpayment)** – MFD’s Audit unit reviewed claims submitted by CareFinders Inc. (CareFinders), a mental health and substance abuse provider located in Hackensack, New Jersey, to determine whether CareFinders appropriately billed for services in accordance with applicable requirements. MFD determined that, from January 1, 2015 through May 31, 2019, CareFinders billed and received \$24,178 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 CareFinders received an overpayment of \$24,178 that it had to repay to the Medicaid program. CareFinders paid the full amount identified in MFD’s review.

- **Wiley Christian Behavioral Management Services (Overpayment Letter)** – MFD’s Audit unit reviewed claims submitted by Wiley Christian Behavioral Management Services (Wiley Christian), a mental health and substance abuse provider located in Pennsauken, New Jersey. MFD found that, from September 1, 2015 through February 29, 2020, Wiley Christian billed and received payment for units of services totaling \$44,918 in excess of the pre-approved authorized number of units. As such, MFD found that Wiley Christian received an overpayment of \$44,918 that it had to repay to the Medicaid program. Wiley Christian paid the full amount identified in MFD’s review.

- **A Better Home Care, LLC (Audit Letter - Notice of Overpayment)** – MFD audited A Better Home Care, LLC (Better Home) a personnel care service (PCS) provider with locations in Egg Harbor Township, Brick and Vineland, New Jersey. MFD determined that, from August 1, 2014 through July 31, 2019, Better Home improperly billed and received payments totaling \$4,106 for home-based services rendered to

beneficiaries while these beneficiaries had inpatient status in a hospital setting. In addition, MFD found that Better Home's documentation did not support the services billed for three other claims totaling \$144. Better Home paid the Medicaid program the full amount identified, \$4,250.

- **Care Plus NJ, Inc. (Overpayment Letter)** – MFD's Audit unit reviewed claims submitted by Care Plus NJ, Inc. (Care Plus), a mental health and substance abuse provider located in Paramus, New Jersey, to determine whether Care Plus appropriately billed for services in accordance with applicable requirements. MFD determined that, from September 1, 2015 through February 29, 2020, Care Plus billed and received \$6,731 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 Care Plus received an overpayment of \$6,731 that it had to repay to the Medicaid program. Care Plus paid the full amount identified in MFD's review.

- **Health Care Commons Inc. (Overpayment Letter)** – MFD's Audit unit reviewed claims submitted by Health Care Commons Inc. (Health Care Commons) a mental health and substance abuse provider located in Carney's Point, New Jersey, to determine whether Health Care Commons appropriately billed for services in accordance with applicable requirements. MFD determined that, from September 1, 2015 through February 29, 2020, Health Care Commons billed and received \$52,397 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 Health Care Commons received an overpayment of \$52,397 that it had to repay to the Medicaid program. Health Care Commons paid the full amount identified in MFD's review.

- **Advanced Behavioral Care Services (Overpayment Letter)** – MFD's Audit unit reviewed claims submitted by Advanced Behavioral Care Services (Advanced Behavioral) a mental health and substance abuse provider located in Lakewood, New

Jersey, to determine whether Advanced Behavioral appropriately billed for services in accordance with applicable requirements. MFD determined that, from September 1, 2015 through February 29, 2020, Advanced Behavioral billed and received \$16,489 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 Advanced Behavioral received an overpayment of \$16,489 that it had to repay to the Medicaid program. Advanced Behavioral paid the full amount identified in MFD's review.

- **Bridgeway Rehabilitation Services Inc. (Overpayment Letter)** – MFD's Audit Unit reviewed claims submitted by Bridgeway Rehabilitation Services Inc. (Bridgeway), a mental health and substance abuse provider located in Elizabeth, New Jersey, to determine whether Bridgeway billed for services in accordance with applicable requirements. MFD determined that, from March 1, 2015 through December 31, 2019, Bridgeway billed and received \$17,400 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 Bridgeway received an overpayment of \$17,400 that it had to repay to the Medicaid program. Bridgeway paid the full amount identified in MFD's review.

- **Bridges Day Treatment Program (Overpayment Letter)** – MFD's Audit unit reviewed claims submitted by Bridges Day Treatment Program (Bridges Day), a mental health and substance abuse provider located in Ocean Township, New Jersey, to determine whether Bridges Day appropriately billed for services in accordance with applicable requirements. MFD determined that, from September 1, 2015 through February 29, 2020, Bridges Day billed and received \$64,028 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 Bridges Day received an overpayment of \$64,028 that it had to repay to the Medicaid program. Bridges Day paid the full amount identified in MFD's review. As such,

MFD found that Taylor received an overpayment of \$17,265.76 that it had to repay to the Medicaid program. Taylor paid the full amount identified in MFD's review.

• **[Diabest Inc. \(Audit Letter - Notice of Overpayment\)](#)**

– MFD audited claims submitted by Diabest Inc., (Diabest) an orthopedic shoe and durable medical equipment (DME) provider located in Perth Amboy, New Jersey, to determine whether Diabest correctly billed for DME in accordance with applicable requirements. MFD determined that, from July 1, 2014 through June 30, 2019, Diabest's documentation supported the vast majority of its claims. MFD did find, however, that Diabest improperly billed three sample claims for which Diabest received Medicaid payments totaling \$528. These three improperly billed claims constitute overpayments that Diabest had to repay to the Medicaid program. Given MFD's findings, specifically that Diabest's documentation was generally compliant with applicable requirements, MFD closed out this audit upon receipt of Diabest's payment of the identified overpayment amount, \$528.

Final Audit Reports

• **[Bergen New Bridge Medical Center \(Final Audit Report\)](#)**

– MFD audited Bergen New Bridge Medical Center (Bergen), located in Paramus, New Jersey, to determine whether Bergen billed for certain inpatient services in accordance with applicable requirements for the period from January 1, 2013 through December 31, 2017. MFD found that Bergen improperly billed and was paid for 171 of the 564 claims, totaling \$1,126,983. After Bergen agreed with the overpayment, it adjusted and resubmitted these claims. Through the resubmission process, the state voided all of the claims and determined that of the \$1,126,983 in voided claims, Bergen was entitled to receive payment of \$813,681, which was then paid to Bergen, with the Medicaid program retaining the remaining amount, \$313,302.

• **[Archway Programs, Inc. \(Final Audit Report\)](#)**– MFD audited claims submitted by Archway Programs, Inc.

(Archway), a mental health and substance abuse provider located in Atco, New Jersey, to determine whether Archway billed for partial care services in accordance with applicable requirements for the period from August 1, 2014 through March 31, 2019. MFD found that 108 of the 192 claims it reviewed failed to comply with one or more of the applicable requirements. After extrapolating this finding to the universe of claims from which the sample was drawn, MFD calculated that Archway received an overpayment totaling \$1,311,001 that it had to repay to the Medicaid program.

• **[ADV Counseling Services, LLC \(Final Audit Report\)](#)**

– MFD audited ADV Counseling Services, LLC (ADV), a mental health rehabilitation and behavioral assistance services provider located in Northfield, New Jersey, to determine whether ADV billed for services in accordance with applicable requirements. MFD found that, from March 1, 2014 through February 15, 2019, ADV billed 47 of 523 sampled claims in error. After extrapolating the sample dollars in error to the universe of claims from which the sample was drawn, MFD calculated that ADV received an overpayment of \$76,663 that it had to repay to the Medicaid program.

• **[Surgical Sock Shop, Inc. \(Final Audit Report\)](#)**

– MFD audited Surgical Sock Shop Inc. (Surgical Shop), a durable medical equipment (DME) with four locations: Monsey, New York (headquarters); Brooklyn, New York; Monroe, New York; and Lakewood, New Jersey, to determine whether Surgical Sock correctly billed for compression stockings and other items. MFD found that, for the sample of claims selected from the period from January 1, 2014 through December 31, 2018, Surgical Sock failed to bill correctly for 52 of the 135 sample claims. Specifically, MFD found that Surgical Sock failed to disclose fully the services provided, and/or used inaccurate billing codes. After extrapolating the dollars in error to the universe of claims from which the sample was drawn, MFD calculated that Surgical Sock improperly received an overpayment of \$242,873 that it had to repay to the Medicaid program.

Closing Reports

• [Daybreak Treatment Center \(Closing Report\)](#) – MFD audited Daybreak Treatment Center (Daybreak), a mental health and substance abuse provider located in Atco, New Jersey, to determine whether Daybreak billed for partial care services in accordance with applicable requirements. MFD determined that, from September 1, 2015 through March 15, 2020, Daybreak’s documentation supported the vast majority of its claims. OSC did find, however, that Daybreak improperly billed four units associated with four claims for which Daybreak received Medicaid payments totaling \$64.94 that it had to repay to the Medicaid program. Based on its determination that it had reasonable assurance that Daybreak’s claims comported with relevant requirements, MFD closed the audit without any adverse material findings.

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