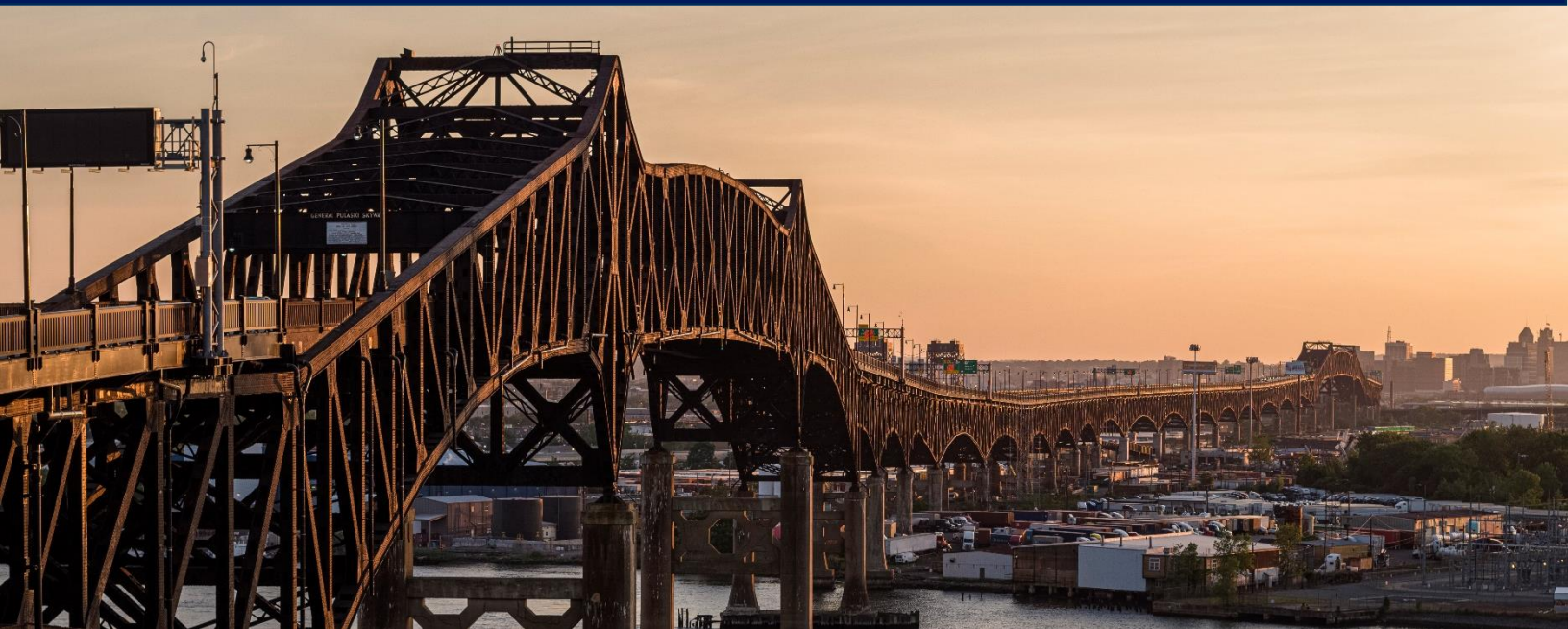
New Jersey Office of the State Comptroller Fiscal Year 2025 Annual Report

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

November 2025

Kevin D. Walsh, Acting State Comptroller



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Letter from the Acting State Comptroller

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

The Office of the State Comptroller (OSC) was created with a broad mandate: To bring transparency, accountability, and efficiency to government in New Jersey. As an independent watchdog agency, OSC is charged with auditing government finances, examining program efficiencies, investigating misconduct, scrutinizing public contracts, and overseeing the integrity of the New Jersey Medicaid Program.

Since early 2020, OSC has issued more than 100 audits, reviews, and reports uncovering fraud, waste, and abuse across government and has recovered or aided in the recovery of more than $670 million in Medicaid funds. In reviewing the last fiscal year, I am exceptionally proud of the work OSC has done to protect taxpayer funds and New Jersey residents.

In FY 2025, OSC's Medicaid Fraud Division recovered or facilitated in the recovery of $132.4 million in improperly paid Medicaid funds—the second highest recovery in at least a decade. OSC's Medicaid Fraud Division also excluded179 bad providers from New Jersey Medicaid. But these numbers don't tell the whole story. As an independent government watchdog, OSC is able to surface systemic weaknesses that enable fraud, waste, and abuse to flourish, not only in the Medicaid program. Whether in health care, local government spending, or policing, OSC's work this year showed that uncovering and addressing weaknesses ensures tax dollars are spent lawfully, efficiently, and in service of all residents, not just a favored few.

OSC issued a series of reports in 2022 and 2023 showing that New Jersey's lowest quality nursing homes received more than $100 million in Medicaid funds a year, despite delivering chronically poor care. That work highlighted a larger systemic issue: persistent oversight failures that allowed neglectful and exploitative operators to continue receiving taxpayer dollars with little consequence.

Last fiscal year, OSC's report on South Jersey Extended Care, the worst-rated nursing home in New Jersey, revealed the magnitude of the failures. OSC documented a financial scheme in which the owners and operators diverted tens of millions in Medicaid funds into personal accounts, related businesses, and affiliated charities over several years, leaving residents in a perpetually understaffed and deteriorating facility. The investigation also found gaps in state oversight systems that allowed the scheme to continue unchecked, to the detriment of residents.

OSC notified the owners/operators and affiliated businesses that they would be suspended from New Jersey Medicaid. The State also installed an independent monitor to supervise the nursing home finances and operations. OSC made numerous recommendations to state regulators and legislators to strengthen oversight of long-term care facilities and prevent similar abuses in the future.

OSC's work in other areas this past year showed similar failures in oversight and the consequences when they go unaddressed. This fiscal year marked OSC's first in-depth examination of how opioid settlement funds are being used. These funds—distributed to local governments as part of national agreements with pharmaceutical companies—are intended to support evidence-based opioid prevention, treatment, and recovery initiatives. Yet the State has provided only limited oversight and broad spending guidelines to municipalities, conditions that enabled the misuse OSC uncovered in Irvington Township.

OSC found that Irvington spent $632,000 on two opioid "awareness" concerts, without consulting public health officials, community groups, or residents directly affected by the opioid crisis. Significant amounts went toward event promotion, luxury trailers, catering, and popcorn machines. Businesses owned by a municipal employee's family also improperly received $368,000 in contracts.

It's worth noting that Irvington Township took extraordinary legal action to try to block the Office of the State Comptroller from releasing this report. OSC ultimately prevailed in court, and the public and policymakers benefitted as a result. The report detailed significant gaps in the State's oversight of local government spending of opioid funds and included 31 recommendations to Irvington Township, state agencies, the Legislature, and the public.

If Irvington reflected the risks of hidden spending abuses, our report on law enforcement's use of discretion during motor vehicle stops underscored a different risk: misconduct that has become so commonplace, it is normalized and tolerated. Reviewing body-worn camera footage of 501 non-enforcement stops by New Jersey State Police, OSC found troopers routinely gave preferential treatment to certain motorists who flashed a courtesy card or asserted a personal connection to law enforcement – even when motorists were suspected of dangerous offenses, such as drunk driving. The report reverberated across New Jersey and nationally. While the use of courtesy cards was an open secret in New Jersey, OSC's report showed how it was creating a two-tiered system of justice and increased risks to public safety.

As always, OSC followed up to ensure agencies and public entities implemented audit recommendations. When they did, the results were clear: programs saved money and operated more efficiently. This past fiscal year, OSC's second follow-up of its Economic Development Authority audit showed that implementing OSC's recommendations meant the entity reduced and recovered $3.4 million in improperly awarded tax breaks. Berlin Township also fully or partly implemented 12 of 13

recommendations from a prior OSC audit and generated $380,000 in revenue through the sale of municipally owned properties.

Another critical part of OSC's oversight is reviewing proposed major contracts to mitigate the risks of self-dealing, waste, cronyism, and improper procurements. OSC's Public Contracting Oversight Division reviewed 292 proposed government contracts this year and required changes in 66 percent of them—interventions that help ensure taxpayer dollars are protected at the outset. This front-end review is one of the most effective tools for preventing the kinds of systemic weaknesses OSC uncovers elsewhere.

At a time when budgets are tightening and public faith in government is weakening, the need for rigorous, independent oversight is urgent. OSC's work this past year demonstrates that when systemic failures go unaddressed, the costs fall on taxpayers and on some of the most vulnerable residents who rely on public programs. Uncovering fraud, waste, and abuse in government and pressing for reforms helps to ensure taxpayer funds are spent responsibly, public programs function efficiently, and the individuals who depend on them actually receive the care and support promised to them.

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 Public Contracting Oversight. OSC also has several specialized investigative units that conduct investigations and handle issues involving educational oversight, police accountability, COVID-19 spending, bi-state authorities, opioid settlement fund spending, and oversight of the Gateway Development Project, among other things. Of OSC's approximately 130 employees, about half are dedicated to the Medicaid Fraud Division.

The sections of this report that follow briefly explain the role of the various divisions and highlight OSC accomplishments in the past fiscal year.

If you suspect government fraud, waste, or abuse:

1-855-OSC-TIPS (1-855-672-8477)

comptrollertips@osc.nj.gov

Complaint Form

If you suspect Medicaid fraud, waste, or abuse:

1-888-9FRAUD5 (1-888-937-2835)

MedicaidFraud@osc.nj.gov

Complaint Form

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.

Risk/Priority Evaluation

OSC's enabling legislation requires OSC to "establish objective criteria for undertaking performance and other reviews" authorized by N.J.S.A. 52:15C. Accordingly, OSC developed a risk/priority evaluation matrix that considers a number of risk factors including, among others, the entity's past performance, size of budget, the frequency, scope, and quality of prior audits, and other credible information which suggests the necessity of a review. OSC's staff conducts research along these parameters and performs a risk assessment as an aid in determining audit priority.

Quality Control and Peer Review

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

In June 2023, OSC's Audit Division successfully passed its fifth peer review conducted by the National State Auditors Association. Audit organizations can receive a rating of "pass," "pass with deficiencies," or "fail." OSC received a peer review rating of "pass." OSC had received "pass" ratings in its prior peer reviews conducted in 2011, 2014, 2017, and 2020. As in those reviews, the 2023 review concluded that OSC's system for quality control has been "suitably designed" and complied with government auditing standards. The Division's next peer review is scheduled for 2026.

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.

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

Examples of the Audit Division's work in FY 2025, including reviews of prior recommendations, are set forth below. Audit reports can be viewed in their entirety on OSC's website.

Public Reports and Letters

Educational Services Commission of New Jersey

This audit examined certain fiscal and operating practices of the Educational Services Commission of New Jersey. The audit found that the Commission: (1) failed to properly procure health insurance coverage, health insurance brokerage services, and certain service contracts; (2) failed to comply with statutory requirements regarding notification of contracts valued in excess of $2.5 million to OSC; (3) failed to comply with statutory requirements as a lead agency for a cooperative pricing system; (4) failed to conduct annual cost-benefit analyses for health insurance costs leading to a potential missed opportunity to save millions of dollars in healthcare costs; (5) paid $343,000 more in medical claims than billed in FY 2023; and (6) maintained and continued to grow an unreasonably large general fund balance.

OSC made 12 recommendations to improve the Commission's operations and its compliance with applicable statutes and regulations. As required by law, OSC will conduct a follow-up review of the Commission to determine whether it has implemented the audit recommendations.

Economic Development Authority

OSC's 2019 audit identified significant deficiencies in the Authority's management and oversight of tax incentive programs. A follow-up review was conducted in 2022 and concluded that the Authority had not fully implemented 11 of our 21 recommendations. OSC conducted a second follow-up to evaluate the implementation status of the recommendations identified as not fully implemented or implemented with further action recommended. We also revisited previously identified exceptions from our 2019 Audit to determine whether they had been addressed and if EDA appropriately sought to recover for improper awards of tax credits.

OSC found that the Authority had made substantial progress in correcting issues identified in our 2019 Audit. Of the 11 recommendations that required our re-evaluation, this review found that 4 were implemented, 5 were partially implemented, 1 was not implemented, and 1 was not reviewed.

Specifically, OSC's 2025 Review found that EDA: (1) recovered funds or reduced awards in the amount of $3.4 million due to improperly awarded incentive awards; (2) performed annual reassessments of all awards certified since 2022 for two incentive programs; (3) established internal control policies and procedures to avoid double-counting of jobs when a recipient received awards from multiple incentive programs; (4) expanded its internal quality control operations to all incentive programs under this review; (5) implemented procedures to monitor fee payments; (6) did not track, report, or analyze information regarding the administrative costs directly related to the management of the five incentive programs identified in the 2019 Audit; and (7) did not consistently report on actual performance by award recipients.

There are multiple recommendations that EDA did not implement or did not fully implement. Many of these recommendations involve oversight, administration, and reporting requirements. We maintain these recommendations because they would enhance transparency and better safeguard public funds.

Hopatcong Borough School District

OSC's 2021 audit identified internal control weaknesses that resulted in noncompliance with statutory requirements and internal policies and procedures related to cash management and reporting, internal control over payroll processing, Extraordinary Aid applications, allocations of shared costs, ethics requirements, regulations on charge cards, and statutory requirements to submit contracts valued in excess of $2 million to OSC.

The follow-up review found that the district had made substantial progress in implementing the recommendations set forth in the initial audit report. Of the 11 audit recommendations, 10 were implemented and 1 was not implemented. As a result of improved procedures implemented to calculate Extraordinary Aid, we found the district increased the amount of aid it received from $238,000 in FY 2020 to approximately $696,300 in FY 2022. The only outstanding issue pertained to the lack of segregation between payroll and human resources functions, which did not comply with N.J.A.C. 6A:23A-6.5.

Pennsauken Public Schools District

OSC's 2021 audit identified internal control weaknesses that resulted in noncompliance with statutory requirements and internal policies and procedures related to: Pennsauken's procurement of its health insurance broker and health insurance coverage provider, health benefit opt-out waiver payments, the school lunch program, and procurement of food supplies. The District did not have adequate controls over its food supplies inventory, stipend and unused accrued leave payment processing, fueling operations, and fixed assets inventory. The District also failed to identify the opportunity to cut $1.6 million in health insurance benefit expenses and made approximately $95,000 in improper health benefit opt-out waiver, stipend, and unused accrued leave payments to employees.

OSC found that the District had made limited progress implementing the recommendations set forth in the initial audit report. Of the 11 audit recommendations, 1 was implemented, 5 were partially implemented, and 5 were not implemented. Unresolved issues included the District's: (1) lack of waiver payment policies; (2) failure to renegotiate terms of collective bargaining agreements to eliminate waiver payments for employees covered by District-provided health insurance; (3) failure to annually adopt its food purchasing policy; (4) failure to examine its food service inventory practices related to maintaining inventory records and monitoring physical inventory for improvement; and (5) failure to perform annual inventories of fixed assets.

Of notable concern, OSC found that the District agreed to vague provisions in its insurance broker's contract that may have allowed the broker to receive additional compensation. We also found the District paid $1.35 million in stipends to 173 employees who perform extra-curricular duties but lacked adequate controls that would ensure that these payments were proper.

Township of Berlin

OSC's 2021 audit identified internal control and oversight weaknesses that resulted in a failure to comply with various policies and laws, including unused sick leave, timekeeping, new hires, reimbursements, health benefits

eligibility, master plan requirements, and procurement laws. Additionally, we found Berlin did not have policies addressing the sale of municipal properties, personal use of municipal vehicles, and access to its accounting system.

OSC's follow-up review found that the Township had made progress in implementing the recommendations set forth in the initial audit report. Of the 13 audit recommendations, 6 were implemented, 6 were partially implemented, and 1 was not implemented. We found that Berlin, as a result of our recommendations, generated $380,000 in revenue through the sale of municipal-owned properties. However, we also found that the Township continued to improperly calculate waiver payments, did not comply with Township ordinances and procedures when processing employee reimbursements, and did not receive price quotes for its dental insurance contract.

Brookdale Community College

OSC's 2022 audit identified many internal control weaknesses. These weaknesses resulted in noncompliance with statutory requirements and internal policies and procedures related to overtime, expenditures, health benefit waivers, cell phone allowances, procurement of and compliance with a contract for its bookstore, information technology inventory, and employment after retirement.

OSC found that Brookdale had made substantial progress in implementing the recommendations set forth in the initial audit report. Of the 11 audit recommendations, 9 were implemented, 1 was partially implemented, and 1 was not implemented. The only outstanding issues concerned the College's failure to update its policies concerning the Fair Labor Standards Act and the New Jersey Wage and Hour Law.

Investigations

OSC's Investigations Division and specialized investigative units, including units focused on Police Accountability, COVID-19 funding, and Special Initiatives, work to detect and uncover fraud, waste, and misconduct involving the management of public funds and the performance of government officers, employees, and programs.

We conduct investigations, inspections, reviews, and evaluations pursuant to the standards set forth in the Association of Inspector General's Principles and Standards for Offices of Inspector General, i.e., the "Green Book."

OSC also manages the "Fraud, Waste, and Abuse Hotline" which fields tips and complaints from concerned residents, neighbors, public employees, insiders, vendors, and others. Each call, email, or online complaint is reviewed, analyzed, and triaged. Many of OSC's investigations begin with tips from the hotline.

In FY 2025, we fielded 2,383 tips and made 14 external referrals to other state, county, and federal agencies. Among them were the New Jersey Division of Community Affairs, New Jersey Department of Education, State Ethics Commission, and the New Jersey Department of Environmental Protection. We also referred matters to various units within the New Jersey Department of Law and Public Safety.

Public Reports

Examples of our investigative work are set forth below. Our public reports can be viewed in their entirety on OSC's website.

Parsippany-Troy Hills' Improper Emergency Contracting

OSC investigated the improper use of emergency contracting procedures by the Township of Parsippany-Troy Hills for renovations at the Knoll West County Club. OSC's investigation found the Township violated New Jersey procurement law when it paid a vendor nearly $1.3 million to repair and renovate a municipal-owned golf club without seeking competitive bids.

This investigation, which was initiated after receiving an anonymous tip, found that the Township improperly used an "emergency exception" to bypass public bidding requirements when there was no emergency. This occurred when it hired a general contractor to repair and renovate parts of a clubhouse at the township-owned Knoll Country Club in 2020 and 2021.

Under New Jersey's Local Public Contracts Law (LCPL), municipalities that have qualified purchasing agents, such as the Township, are

required to publicly advertise and solicit bids if the contracts are valued at over $44,000. Local governments are permitted to use "emergency" contracts, foregoing the public bidding process, only when addressing true emergencies involving imminent public health and safety threats.

Although the improvements to the clubhouse took place during the COVID-19 pandemic, OSC found that none of the repairs and renovations directly addressed imminent risks to public health and safety. Additionally, the Township failed to comply with state law and its own procurement rules requiring that it document the need for the emergency contract and have the emergency contract put before the Township Council for a public vote. It could not produce any written documentation showing the then-Business Administrator had ever even approved the renovation project, as legally required.

Based on its findings, OSC recommended the Township take corrective action, including updating its policies and procedures related to emergency procurement; ensuring proper documentation and staff training; strictly adhering to public bidding requirements to foster competition and achieve potential cost savings; and to obtain written emergency certifications and adopt public resolutions authorizing emergency contracts before paying any associated invoices. In turn, the Township acknowledged OSC's findings and recommendations, and committed to implementing robust policies, procedures, and training to prevent future violations.

Letter to State Leaders About Union County's Failure to Comply with Compensation Law

OSC sent a letter to the Governor and legislative leadership in July 2024 to follow up on a public letter it had sent to Union County in December 2023 about the County's compensation practices for high-level officials. In the December 2023 letter, OSC detailed its finding that the County violated the Optional County Charter Law (OCCL) by failing to set compensation for its highest-ranked officials by ordinance. Specifically, the County paid three top officials a total of $417,772 in extra stipends and tuition reimbursement, without following the required public legislative process. This process would have provided County residents with the information necessary to weigh in on the extra compensation.

To ensure transparency to the County's taxpayers through the County's compliance with the OCCL moving forward, OSC directed the County to submit a corrective action plan by March 2024. However, the County refused, pointing to its ongoing efforts to change the law it had violated and for which it remained in violation. In light of this continued refusal to comply with OSC's directive, OSC provided the statutorily required notice to the Governor and legislative leadership pursuant to N.J.S.A. 52:15C-11(b) to consider further action.

Supplemental Report on the High Price of Unregulated Private Police Training

A December 2023 report revealed that Street Cop Training's 2021 training conference, attended by nearly 1,000 officers, many from New Jersey, taught dangerous, improper, and likely illegal policing tactics. As a result, the New Jersey Attorney General required that all New Jersey attendees be retrained and said New Jersey officers should not attend any Street Cop Training courses and events in the future.

OSC released a supplemental report in January 2025 that was based on a review of thousands of documents, including many produced by Street Cop, after protracted litigation. OSC found that police departments from all 21 New Jersey counties, as well as from public

universities, and state-wide, county, and interstate agencies, spent more than $1 million in public funds on Street Cop Training courses and events from December 1, 2019 through March 13, 2023.

OSC also found at least 32 New Jersey police departments and agencies were repeat customers spending funds on Street Cop Training even after officers attended the 2021 Conference, where the presentations were riddled with discriminatory, harassing, and lewd remarks, among other problematic content. Street Cop Training's Chief Executive Officer had previously said that the 2021 conference was "standard fare" for the company; additional training materials reviewed by OSC further supported this assertion.

Internal company records indicated that Street Cop was willing to help officers hide their attendance at courses/events or their involvement as instructors. Internal records also showed multiple police departments and agencies, including an agency that operates in New Jersey, requested case law or other materials from Street Cop to help defend officers from lawsuits.

Overall, 2,721 government entities from 49 states, including New Jersey, paid for Street Cop Training courses and events. OSC published the list of entities as a public referral and also made additional referrals to the Attorney General based on its supplemental findings. In response, the Attorney General referred OSC's supplemental findings to the New Jersey Division on Civil Rights for additional consideration and to the employing law enforcement agencies to implement any additional retraining. Since the publication of these reports, the Attorney General has issued a Directive creating a statewide public safety Professional Development Institute that will, among other things, offer pre-approved elective courses on policing and leadership that are designed for officers throughout their careers.

Use and Abuse of Officer Discretion in Declining to Enforce Motor Vehicle Violations

OSC initiated this investigation in response to frequent reports that New Jersey law enforcement officers' exercise of discretion during motor vehicle stops is regularly influenced by improper factors, including courtesy cards given to and purchased by motorists. The investigation found that New Jersey State Police troopers routinely gave preferential treatment to certain motorists who presented a courtesy card or asserted a personal connection to law enforcement—even when motorists were suspected of dangerous offenses, like drunk driving.

To conduct this investigation, OSC reviewed body-worn camera footage of 501 no-enforcement stops by New Jersey State Police—meaning stops where New Jersey State troopers did not issue tickets or make arrests. Reviewing more than 50 hours of body worn camera footage of the stops, which took place over ten days in December 2022, OSC found that troopers regularly decided not to enforce motor vehicle laws after receiving a courtesy card or being told the driver has ties to law enforcement.

For instance, one motorist, who was stopped for driving over 90 miles per hour, admitted to drinking alcohol but was let go without a sobriety test after he presented two cards. Another motorist was stopped for driving over 103 miles per hour and was released after she volunteered that her father was a lieutenant in a local police department. The most significant consequence the troopers imposed in these stops was advising the motorists that they had left a voicemail message for the law enforcement officer named on the courtesy

card or invoked as a friend or relative. With the written report, OSC released video excerpts of the footage.

Overall, close to half of the 501 non-enforcement stops reviewed by OSC involved speeding, many for more than 20 miles per hour over the speed limit. In three stops, drivers stopped for reckless driving, careless driving, and/or speeding, also admitted to drinking alcohol, yet were released without being asked to step out of the car for a field sobriety test. Both drunk driving and speeding are major causes of traffic fatalities. According to data compiled by the New Jersey State Police Fatal Accident Investigation Unit, in 2022, New Jersey recorded 646 fatal collisions that resulted in 689 deaths or 1.89 fatalities per day. This was among the highest number of traffic-related deaths in New Jersey in the past 15 years.

OSC's investigation found that courtesy cards are widely used and came from municipal police departments, county and state agencies, as well as inter-state and out-of-state law enforcement agencies. They all appeared to be treated as accepted courtesy, equally effective at getting motorists released without enforcement.

OSC also found that asserting a relationship with law enforcement appeared to carry equal weight. In 52 (10 percent) of the no-enforcement stops reviewed, the driver or passengers did not present a courtesy card but claimed a connection to law enforcement, and the trooper decided to let them go. In 29 of those stops, the motorist or passenger identified themselves as current, retired, or in-training law enforcement officers. Other stops resulted in no enforcement when the drivers or passengers claimed a relative, friend, or neighbor worked in a law enforcement agency.

In one stop, a trooper said he stopped a motorist for driving 97 miles per hour. After an extended conversation about the "friends" they had in common, the trooper told the driver to "stay safe" and let him go. In another stop, a trooper performed a computerized look-up of the driver's credentials and discovered the driver had an active warrant for his arrest. But when the driver's friend introduced himself, letting the trooper know that he was also an off-duty trooper, the stopping trooper walked back to the motorist, apologized for stopping him, and let him go without even mentioning the warrant. OSC was unable to determine the reason of the warrant from the footage.

Other findings included that providing preferential treatment to motorists who present courtesy cards or assert close personal relationships with law enforcement appears to have a discriminatory impact. Of the 87 courtesy cards observed in the sample, for instance, 69 were presented by White drivers. And even when courtesy cards were not present, racial disparities were observed in the sample. White and Asian drivers were less likely to have all three of their driving credentials requested and verified compared to Black and Hispanic/LatinX drivers. Additionally, troopers conducted computerized lookups of Hispanic/LatinX drivers 65 percent of the time, while looking up White drivers only 34 percent of the time.

OSC made 11 recommendations, including that New Jersey State Police regularly review no-enforcement stops to better understand racial/ethnic trends in motor vehicle data and determine if additional training is needed. OSC also recommended that the Attorney General consider issuing a directive that would explicitly prohibit law enforcement officers from giving preferential treatment to motorists because of their ties to law enforcement or possession of courtesy cards.

An Investigation of Irvington's Mismanagement of Opioid Settlement Funds

This report examined the use of opioid settlement funds by Irvington Township and sought to ensure that such funds are spent responsibly and in accordance with state law and the public interest.

New Jersey began receiving opioid settlement funds in 2023 as a result of national agreements with pharmaceutical companies. Under the Attorney General's memorandum of agreement with counties and municipalities and P.L. 2023, c.25 (the "2023 Opioid Law"), all expenditures must support evidence-based opioid prevention, treatment, and recovery initiatives and supplement—rather than replace—existing spending.

OSC's investigation found that Irvington Township, under then-Mayor Tony Vauss, spent approximately $632,000 in opioid funds to host two "Opioid Awareness" concerts. The Township did so without consulting public health officials, community groups, or residents directly affected by the opioid crisis. Of that amount, $368,500 went to businesses owned or controlled by a Township employee, and substantial funds were used for event promotion, luxury trailers, catering, and similar expenses rather than on addiction prevention or recovery services. After the report's completion, the Township sought to prevent its release through legal action. Following court proceedings, OSC was permitted to publish the report.

The investigation also revealed significant gaps in the State's oversight of local governments' expenditures of opioid settlement funds. While the Department of Human Services (DHS) serves as the lead agency responsible for ensuring compliance with settlement agreements and state law, there is no formal process through which counties and municipalities can seek guidance on allowable expenditures.

The Irvington report included 31 recommendations to Irvington Township, state agencies, the Legislature, and the public to strengthen oversight, transparency, and accountability. OSC referred its findings to several state agencies for further review, including the Office of the Attorney General, the Department of the Treasury's Divisions of Pensions and Benefits, Purchase and Property, and Taxation, and the Department of Community Affairs' Division of Local Government Services.

Beyond the Irvington report, OSC collaborates with DHS to ensure that counties and municipalities comply with annual reporting requirements for opioid settlement fund expenditures.

Local Government Compliance with Filing Requirements of the New Jersey Employer-Employee Relations Act

OSC released a review which revealed that a majority of school districts and more than a quarter of municipalities in New Jersey are not complying with the requirement to submit current union contracts to the Public Employment Relations Commission (PERC), with compliance rates plummeting since 2010. As of the end of 2021, 64 percent of school districts and 27 percent of municipalities had not submitted their contracts, a significant decline from 2010 when 97 percent of municipalities and over 80 percent of school districts were compliant. OSC recommended that municipalities and school districts establish internal protocols to ensure compliance and suggested that PERC coordinate with relevant state departments to improve notification and compliance measures, as well as enhance its website and data collection functionalities.

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.

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

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

- New Jersey FamilyCare is a Medicaid-type program for uninsured children whose family income is too high to qualify for traditional Medicaid but not high enough for the family to afford private health insurance. Combined, as of June 2025, the Medicaid and New Jersey FamilyCare programs served more than 1.8 million New Jersey residents.

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

As part of its oversight role, MFD audits and investigates health care providers, managed care organizations (MCOs), and other third-party contractors that provide Medicaid services to identify and recover improperly expended Medicaid funds; recommends Medicaid agency oversight improvements; recommends MCO Contract changes to improve program oversight; refers cases to other appropriate civil entities when the underlying conduct is outside of MFD's authority or more appropriately handled by such entities; refers cases of suspected criminal fraud to appropriate criminal prosecutors; and, investigates beneficiaries when there is a basis to suspect that they do not meet eligibility requirements, which helps ensure that only those who qualify are enrolled in Medicaid. In performing these functions, MFD considers the quality of care provided to Medicaid recipients and pursues civil and administrative enforcement actions against those who engage in fraud, waste, or abuse within the Medicaid program. MFD also excludes or terminates

ineligible health care providers from the Medicaid program when warranted and conducts educational programs for Medicaid providers and contractors. Finally, MFD identifies and collects payments from insurance carriers when Medicaid has paid for goods or services and there was third-party insurance coverage that should have paid for such claims.

MFD's FY 2025 Statistics

In FY 2025, MFD recovered or facilitated in the recovery of more than $132.4 million in improperly paid Medicaid funds, with slightly more than $125.3 million of that attributable to third party liability (TPL) recoveries from third party insurance carriers, Medicaid providers, or other parties liable for the overpayments. The remainder, more than $7.1 million, is attributable to MFD's audits, investigations, and other data-based recovery efforts. Those funds were returned to both the state and federal budgets. MFD also excluded 179 providers from participating in the Medicaid program this past fiscal year.

MFD received 1,523 complaints, tips, or other submissions (collectively "complaints") from a variety of intakes, including the MFD hotline, OSC website, referrals from other state and federal agencies, and correspondence from the public. All of the complaints received by MFD 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 suitable entity. From the complaints above, MFD opened full-scale cases when appropriate and referred the majority of the remaining complaints to more appropriate entities, including the New Jersey Department of Human Services (DHS), 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 124 high-risk provider applications and performed 818 individual background checks.

MFD referred 32 total cases to the Medicaid Fraud Control Unit (MFCU) within the State's Office of the Attorney General, of which 27 were accepted for criminal investigation. Of that figure, 18 stemmed from MCO referrals and 9 from MFD-generated matters. In addition, the Division reviewed a total of 93 referrals from MCOs, from which it found that 18 contained sufficient facts to support a credible allegation of fraud referral to MFCU.

MFD referred an additional 87 matters to other civil and criminal enforcement entities, including county prosecutors' offices and the State Department of Treasury, Division of Taxation, 50 of which were unique MFD cases.

As part of its educational outreach program, MFD presents training programs to a wide variety of providers, including behavioral health, long-term care, medical day care, and other providers/practitioners. In FY 2025, MFD organized two virtual educational training sessions. The first session was a collaboration with the Department of Health (DOH), DMAHS, MCOs, and MFCU, focusing on Adult Medical Day Care providers. The second session, which also involved collaboration with relevant state agencies and the Medicaid MCOs, addressed Durable Medical Equipment (DME) providers. Both sessions aimed to educate providers in the New Jersey Medicaid program on identifying and preventing fraud, waste, and abuse. The presentations highlighted the importance of accurately documenting medical and other records, submitting correct Medicaid claims,

disclosing any improperly received payments, and training employees to effectively identify, prevent, and address issues of 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 2025, MFD identified 232 parent entities (2,788 individual providers) that were required to certify through this process. Of those entities, 44 established Corrective Action Plans to address deficiencies.

What follows is an overview of MFD's substantive work in FY 2025. A summary of all of MFD's individual settlements, notices of overpayments, audits, investigations, and other actions is included as an Appendix to this report.

Data and Fiscal Integrity Unit

MFD's Data and Fiscal Integrity Unit monitors Medicaid claims data and other information from the fee-for-service (FFS) program and MCOs to detect fraud, waste, and abuse and, in collaboration with relevant Medicaid stakeholders, works to ensure that the data is complete, accurate, and sufficiently reliable for MFD to use in its audits and investigations. As such, this Unit is involved in various stages of the process leading to the recovery of improperly paid Medicaid dollars. The Unit employs numerous analytical techniques to detect atypical or unusual claims submitted by providers and refers its findings to the Audit or Investigations Units for additional action, and in some instances, performs desk reviews to pursue recoveries of misspent funds. 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 and Fiscal Integrity Unit also monitors the Surveillance and Utilization Review System, a federally mandated exception reporting system, for indications of fraud, waste, and abuse and to detect duplicate, inconsistent, or excessive claim payments. In addition, this Unit tracks MFD's receipt of overpayments, ensures that providers that have entered into settlement agreements to repay the Medicaid program do so in accordance with the terms of such agreements, and coordinates with DMAHS and its contractor to suspend, withhold, or refund payments to Medicaid providers as needed.

In total, in FY 2025, MFD's Data and Fiscal Unit referred 43 cases of anomalous claims behavior to the Audit/Investigation Units and generated 156 reports for use by these units. In addition, the Unit prepared 24 overpayment letters based on data-based desk reviews.

Statistics Unit

A primary responsibility of the Statistics Unit is to select random samples using Medicaid claims data for use in audits, investigations, and other reviews. Based on these samples, auditors and investigators obtain records or documentation to determine whether the provider being audited or investigated met federal and state laws, rules, and guidance. If

applicable, the Statistics Unit then performs a statistically valid extrapolation of the audit/investigative findings to calculate final overpayment amounts for recovery. This Unit also performs statistical analysis on a variety of projects, including determining the widespread impact of MFD's audits and investigations and potential savings to the Medicaid program. The Unit's staff serve as experts in administrative proceedings to explain the validity of its processes and, as appropriate, rebut challenges to the sufficiency of MFD's findings.

Audit Unit

MFD conducts audits and reviews 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. The Unit also uses its findings to recommend that providers and, as appropriate, the Medicaid program and MCOs, institute systemic actions to address identified deficiencies and thereby prevent these deficiencies from recurring.

During FY 2025, MFD audited a spectrum of Medicaid providers, including independent clinical laboratories and intensive in-community mental health providers, and conducted reviews of the staffing ratios of three nursing homes.

MFD audited claims submitted by Atlantic Diagnostic Laboratory, LLC (ADL), an independent clinical laboratory provider located in Bensalem, Pennsylvania. Clinical laboratory services consist of professional and technical testing performed in response to requests from physicians or other licensed practitioners. The audit found that for 88 of the 261 sample episodes (33.7 percent), ADL either billed for tests that were not ordered either by a physician or licensed practitioner, or billed for tests lacking required documentation or signatures. In 71 of these exceptions, ADL billed and was paid for a higher level of definitive testing than ordered, or used an incorrect procedure code. For these documentation deficiencies, MFD calculated that ADL received an extrapolated overpayment of $2,943,586. The audit also found that ADL improperly unbundled 231,091 claims for specimen validity testing from presumptive and definitive drug testing performed for the same beneficiary on the same date of service. For these unbundled claims, MFD determined that ADL received an overpayment of $1,140,043. Finally, MFD assessed a civil penalty of $3,269,332 for the 261 episodes that violated Medicaid "Basis of Reimbursement" regulations by charging other groups or individuals a lower charge than the Medicaid program during the audit period. In total, MFD calculated that ADL received a total overpayment of $7,352,961 that it had to repay to the Medicaid program.

In its audit of Star Laboratory Corporation (Star), an independent clinical laboratory provider located in Piscataway, New Jersey, MFD reviewed claims submitted by Star to determine whether Star complied with applicable requirements. The audit found that, for 81 of 148 sampled episodes (54.7 percent), Star's documentation failed to comply with legal requirements. Specifically, in 79 episodes, Star performed and billed for drug tests without the required signatures from the referring physician or licensed practitioner. In five episodes, Star performed and billed for a higher level of testing than what was included on the testing requisition, and three of those episodes contained both deficiencies. By performing and billing for drug tests in these instances, Star lacked assurance that the referring providers had authorized the tests or that they were medically necessary. This resulted in potentially unnecessary drug testing and waste and abuse of Medicaid program resources. MFD calculated that Star improperly received an extrapolated overpayment of at least $3,332,626 and an additional non-extrapolated

overpayment of $1,208, which must be repaid to the Medicaid program.

In its audit of Greater New Jersey Creative Counseling, Inc. (Greater New Jersey) an intensive in-community mental health rehabilitation and behavioral assistance provider, located in Palmyra, New Jersey, MFD reviewed claims submitted by Greater New Jersey to determine whether services were billed in accordance with state regulations. The audit found that, in more than twenty-three percent of the claims reviewed, Greater New Jersey failed to meet Medicaid program requirements, including those intended to safeguard beneficiaries' health and safety. MFD found that 44 of the 188 sampled claims, contained 53 exceptions. Specifically, Greater New Jersey did not maintain required background checks for 5 behavioral assistants (BAs), representing 11 claims. For 14 of 97 servicing providers, which accounted for 17 claims, Greater New Jersey failed to maintain a copy of the servicing provider's current and valid driver's license. For 4 of the 29 BAs, which accounted for 7 claims, Greater New Jersey rendered services without the required certifications. For 14 claims, Greater New Jersey billed for services without adequate documentation; for 3 claims, Greater New Jersey upcoded services; and for 1 claim, Greater New Jersey failed to document services in a progress note. Based on the failures, MFD calculated that Greater New Jersey improperly received overpayments totaling $2,711,289 (an extrapolated overpayment of $2,709,266 plus a direct recovery of $2,023).

During the year, the Audit Unit conducted reviews of the statutorily required direct care staff-to-resident ratio of three nursing home facilities: Barnegat Rehabilitation and Nursing Center (Barnegat), Belle Care Nursing and Rehabilitation Center (Belle Care), and Barclays Rehabilitation and Healthcare Center, LLC (Barclays) for the period July 1, 2023 through July 31, 2023. The reviews found pervasive noncompliance at all three facilities.

At Barnegat, for at least two shifts every day of the month, the facility maintained staffing levels that were below the minimum required to ensure resident health and safety. Belle Care showed similar deficiencies, with at least two shifts each day failing short of the requirements, while Barclays failed to meet the standard during at least one shift every day. Across the 93 shifts, three shifts per day for 31 days in a month reviewed at each facility, Barnegat failed to meet the ratio in 86 shifts (92 percent), Belle Care in 83 shifts (89 percent), and Barclays in 85 shifts (91 percent).

Based on its findings, MFD determined that all three nursing homes had improperly billed Medicaid for days when they failed to meet minimum staffing levels. MFD also assessed civil monetary penalties reflecting the seriousness and pervasiveness of the deficiencies. Specifically, MFD found that Barnegat improperly billed $395,690 and MFD assessed a penalty of $395,690, which resulted in a total overpayment of $791,380. For Belle Care, MFD found that it improperly billed $215,768 and MFD assessed a penalty of $431,536, which resulted in a total overpayment of $647,304. Finally, for Barclays, MFD found that it improperly billed $367,590 and MFD assessed a penalty of $367,590, which resulted in a total overpayment of $735,180. In total, the three nursing homes must repay $2,173,864 to the Medicaid program.

Third Party Liability Unit

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

the result of the efforts of MFD and its contracted vendor to obtain payments from third-party insurers responsible for services that were inappropriately paid with Medicaid funds. MFD's Third Party Liability (TPL) Unit, working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and recovers money from private insurers or providers in cases where Medicaid has paid claims for which the private insurer was responsible. The TPL Unit also manages the State's PARIS Match program, which is a state and federal partnership that identifies Medicaid recipients who may be receiving benefits in more than one state, due to agency error, client error, or fraud. The program allows the State to recover capitation funds paid to MCOs on behalf of ineligible beneficiaries. In FY 2025, MFD recovered total overpayments of more than $125.4 million from third party insurance carriers, Medicaid providers, or other parties liable for the overpayments.

In addition to reviewing, overseeing, and coordinating work performed by the State's TPL vendor, the TPL Unit also manages two daily hotlines: (1) the TPL 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 and (2) the Medicaid Fraud, Waste, and Abuse Hotline. MFD receives questions and allegations of fraud, waste, and abuse from many sources, including MFD's hotline and complaint form as well as from other state and federal agencies. In total, MFD received 1,523 hotline intakes in FY 2025. As part of this role, the TPL Unit tracks and refers all hotline communications received to the appropriate entity.

Investigations Unit

MFD's Investigations Unit investigates inappropriate conduct on the part of Medicaid, FamilyCare, and Charity Care providers and recipients. The Unit receives allegations of fraud, waste, and abuse from a variety of internal and external sources, including provider self-disclosures, tips from the hotline, and referrals. The Investigations Unit also handles referrals of potential beneficiary fraud to and from county offices and investigates designated high-risk providers who are seeking to participate in Medicaid, which may include ownership financial reviews, interviews, and on-site visits. In FY 2025, the Investigations Unit opened 324 cases and made 12 referrals to county boards and social services entities.

To ensure the integrity of Medicaid's enrollment process, the Investigations Unit conducts background checks of high-risk providers applying to participate in the program. In FY 2025, the Investigations Unit reviewed 124 such applications from high-risk providers – DME, prosthetics and orthotics, and home healthcare agencies, for which MFD performed 818 individual background checks using several verification sources. The Unit also performed or confirmed through the Provider Enrollment, Chain, and Ownership System, an online database showing site visits performed by Medicare oversight bodies, 111 site visits in FY 2025. 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 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 2025, the work of the Investigations Unit resulted in the recovery of approximately $3.5 million in misspent Medicaid funds, which includes recoveries resulting from MFD investigations of providers and provider self-disclosures.

Regulatory and Exclusions Unit

MFD's Regulatory Officers are licensed attorneys who handle MFD-initiated fraud, waste, and abuse cases from initiation of a Notice of Claim through the administrative law process, including settlement negotiations, the discovery process, and Office of Administrative Law Fair Hearings as State Agency Representatives. The Regulatory Officers also represent the Medicaid program's interest in pursuing overpayments, whether identified internally or by the State's outside vendors, including its TPL contractor. The Regulatory Unit provides guidance to the other units of the Division, including advice regarding the legal sufficiency of audits/ investigations and assessments regarding a provider's legal basis for objecting to an overpayment demand. MFD's Regulatory Officers also work with other state departments to propose new Medicaid program regulations and guidance designed to improve program integrity and strengthen the State's oversight of the Medicaid program.

The Regulatory and Exclusions Unit also identifies providers who should be disqualified from participating in the Medicaid program. The Unit may seek to exclude providers for numerous reasons, such as criminal indictment, conviction, or exclusion/ professional discipline imposed 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 2025, MFD excluded 179 unique providers – including physicians, pharmacists, dentists, nursing home owners and administrators, social workers, and home care nurse aides – for failing to meet the standards for integrity in the Medicaid program.

Special Investigations Unit

MFD's Special Investigations Unit specializes in complex, deep-dive investigations, often involving an in-depth financial review into complex corporate structures. In addition to conducting complex investigations and issuing related public reports, the Unit assists with high-risk provider reviews.

This Unit conducted an investigation of South Jersey Extended Care (SJEC), a nursing home in Bridgeton, NJ. MFD exposed a massive scam by the owners/operators of SJEC. MFD found that the owners/operators funneled millions of dollars in Medicaid funds out of the nursing home into their personal accounts, businesses, and charities over several years, leaving residents to live in inadequate and understaffed conditions. MFD, with the support of the Attorney General and in coordination with DOH and DHS, suspended SJEC's related entities and partners including Sterling Manor Nursing Center, Michael Konig, and Steven Krausman from the Medicaid program and is holding in abeyance the suspensions for SJEC and Mordechay "Mark" Weisz while the State and court-appointed receiver consider next steps for this facility.

Public Contracting Oversight

OSC's Public Contracting Oversight Division (PCO), staffed by attorneys, paralegals, and administrative assistants 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 2025, OSC received notice of 1,064 contracts, including 292 contracts that were valued at more than $12.5 million / $15.2 million[1] and pre-screened pursuant to OSC's statutory authority.

In addition to reviewing contracts, division attorneys 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 with investigations and other projects.

Pursuant to N.J.S.A. 52:15C-10(b), all contracting units are required to submit contracts involving consideration or an expenditure of $12.5 million / $15.2 million not less than 30 days prior to the expected advertisement date or issuance of the solicitation. Pursuant to N.J.S.A. 52:15C-10(a), for contracts valued at more than $2.5 million / $3 million,[2] but less than $12.5 million / $15.2 million, contracting units must notify OSC no later than 20 business days after the contract award. The Division pre-screens the legality of the proposed vendor selection process for all government contracts pursuant to N.J.S.A. 52:15C-10(b), and it has post-award oversight responsibilities for contracts pursuant to N.J.S.A. 52:15C-10(a).

OSC's procurement reviews cover contracts awarded by municipalities, school districts, county colleges, state colleges and universities, 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. OSC's Public Contracting Oversight Division regulations were updated in February 2025 to clarify contracting unit notice and submission obligations.

Procurements subject to OSC review cover a wide range of contracts, including real property transactions such as land sales and leases, concession agreements, third-party contracts, purchases of goods and services, and building and road construction.

For contracts subject to N.J.S.A. 52:15C-10(b) review, the Division works closely with government entities as they formulate

[1] As of July 1, 2020, the statutory threshold for N.J.S.A. 52:15C-10(b) became $12.5 million. On July 1, 2025, the statutory threshold was increased to $15.2 million.

[2] As of July 1, 2020, the statutory threshold for N.J.S.A. 52:15C-10(a) became $2.5 million. On July 1, 2025, the statutory threshold was increased to $3 million.

specifications, intervening when necessary to ensure procurements comply with all applicable laws, regulations, and rules. Errors are corrected before the contract advertisement takes place.

The review of contracts valued at more than the 10(b) threshold 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; whether the government unit has followed all statutes, rules, and regulations applicable to the procurement; whether specifications are designed to ensure a fair and competitive process; and whether the method of soliciting potential vendors is appropriate.

For contracts exceeding the 10(b) threshold, the contracting unit must submit notification to OSC at least 30 days before the proposed advertisement or other method of soliciting the contract. On occasion, contracting units request flexibility in that time period. Accordingly, OSC has set forth a procedure by which government entities can seek a waiver of the 30-day period. OSC works closely with contracting units needing such a waiver to ensure that contract solicitations can be made in a timely manner.

Contracts meeting the 10(a) thresholds, including contracts previously submitted for pre-approval, are examined post-award. The post-award focus remains on compliance with laws and regulations. In addition, OSC determines whether the award followed the guidelines set forth in the solicitation. For example, attorneys review whether the lowest bidder got the award in a sealed bid procurement; whether an award determination appropriately considered alternates; whether the governing body approved and certified funding for the contract; whether records submitted to OSC sufficiently justify the governing body's action; and whether there is 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, division attorneys consult directly with contracting units during and following reviews. Depending upon the nature of the review and any deficiency noted, the 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 submission requirements for statutorily required bidder forms and certifications such as, the Disclosure of Investment Activities in Iran business registration certificate, public works contractor registration certificate, and evidence of compliance with equal employment opportunity, and affirmative action laws. Substantively, OSC also corrects the inclusion of propriety items in bid specifications and ensures that contracting units are allowing for "approved equals." Importantly, OSC works with contracting units to adequately describe the services desired and the deliverables needed to assure it is getting the services it needs.

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

Pursuant to Executive Order 166, OSC conducts pre-screening reviews of state procurements utilizing $150,000 or more in Executive Order 166 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 Executive Order 125.

The Division is also responsible for posting the procurements it reviewed pursuant to these executive orders on the State's COVID-19 Transparency website and OSC's Sandy Transparency website. As a result, in FY 2025, PCO reviewed a variety of purchasing practices that otherwise would have been below OSC's statutory monetary threshold for review.

OSC 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 2025, OSC received 131 procurements pursuant to Executive Order 166 and took corrective action in 69.1 percent of those procurements. We also pre-screened 15 procurements pursuant to Executive Order 125 and took corrective action in 66.6 percent of those procurements.

Of the 1,064 contracts submitted for review in FY 2025, 292 of them were valued above the 10(b) threshold and were pre-screened pursuant to OSC's regular statutory authority. OSC attorneys took corrective action in 66.4 percent of those pre-screened contracts to ensure the legality of the procurement process.

Some notable contracts reviewed include: the $34.6 million federally funded construction contract for Rutgers University, for the Cooper Street Gateway Project. We also reviewed two construction contracts for Middlesex County's parks, improving the athletic fields and college arts and student services. These two projects, totaling over $203.9 million combined, were partially funded by the federal American Rescue Plan Act of 2021. OSC also reviewed the construction contract of Rowan University's Schreiber School of Veterinary Medicine. Additionally, pursuant to Executive Order 166, OSC reviewed the New Jersey Sports and Exposition Authority's $37.5 million contract for the Meadowlands Pedestrian Bridge Design/Build project.

OSC received 626 contracts valued for 10(a) review. For these post-award reviews, OSC evaluates whether the contracting unit complied with the appropriate procurement process and provides guidance to assist the contracting unit with correcting errors in the future.

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

Educational Outreach

In FY 2025, OSC continued its extensive outreach to government contracting units across the state to review their procurement processes and specific compliance issues identified by OSC. Our attorneys also participated on various government-related panels and webinars discussing the procurement requirements for the expenditure of federal COVID-19-related funds and other matters concerning OSC's statutory authority to review public procurements. We made presentations to the New Jersey State League of Municipalities, New Jersey Association of School Business Officials, and New Jersey Association of County Purchasing Officials. We also offered a guidance webinar in FY 2025, with more scheduled and planned in the future.

COVID-19 Oversight

OSC continues to oversee the State's contracted Integrity Oversight Monitors. Integrity Monitors are independent monitors deployed throughout the state to assist state entities with establishing programs, managing grants, or administering programs (Category 1 and 2 Integrity Monitors), or to oversee and monitor the use of COVID-19 recovery funds and check for non-compliance or fraud, waste, or abuse (Category 3 Integrity Monitors). The Integrity Oversight Monitoring program is integral to the State's accountability infrastructure and is intended to aid in a more transparent and effective recovery.

OSC oversees these engagements, select deliverables, and the quarterly Integrity Monitor reports to help maximize the value to the State and to identify or intervene in any issues requiring follow-up or corrective action. This work has led to follow-up reviews of agency programs and coordination with State officials to ensure that State recipients of federal funds are implementing the recommendations suggested by their monitors. Integrity Monitor quarterly reports are public documents and are available for review on the state's COVID-19 Compliance and Transparency webpage.

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

The COVID-19 Recovery Contracts website, is a great resource to view contracts funded by federal COVID-19 Recovery Funds. The posted contracts include expenditures from the beginning of the pandemic and continue through the recovery period.

Appendix – MFD Settlements & Audits

Settlement Agreement/ Overpayment Letter Case Summaries

North Wayne Pediatrics LLC
Overpayment Letter (7/8/2024)

MFD reviewed claims submitted by North Wayne Pediatrics, LLC, located in Wayne, New Jersey. MFD determined that, from January 1, 2019 through October 11, 2021, North Wayne improperly billed and received payments totaling $3,129 for preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. North Wayne repaid the Medicaid program the full amount identified, $3,129.

Dewi Sudjono-Santoso, MD
Overpayment Letter (7/9/2024)

MFD reviewed claims submitted by Dewi Sudjono-Santoso, MD, a physician located in Cranbury, New Jersey. MFD determined that, from January 1, 2019 through August 25, 2022, Dewi Sudjono-Santoso, MD, improperly billed and received payments totaling $3,800 for preventative medicine, individual counseling and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Dewi Sudjono-Santoso, MD paid the Medicaid program the full amount identified, $3,800.

Monroe Adult Day Care
Overpayment Letter (7/25/2024)

MFD reviewed claims submitted by Monroe Adult Day Care, an adult day health services provider located in Millstone, New Jersey. MFD determined that, from January 1, 2019 through June 19, 2023, Monroe Adult Day Care improperly billed and received payments totaling $3,734 for services provided to beneficiaries who were also inpatient at a facility and billing in excess of five days of service in a week for an individual beneficiary. Monroe Adult Day Care paid the Medicaid program the full revised amount identified, $3,734.

Complete Care at Arbors, LLC
Settlement Agreement (8/2/2024)

MFD resolved a review conducted by its third-party liability recovery services contractor, Health Management Systems, Inc. (HMS), of Complete Care at Arbors, LLC, located in Toms River, New Jersey. Through this review, HMS determined that Complete Care at Arbors improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from September 1, 2019 through

March 31, 2022 to which Complete Care at Arbors was not entitled. Complete Care at Arbors agreed to repay the Medicaid program $326,976.

Providence Nursing and Rehabilitation Center
Settlement Agreement (8/14/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Providence Nursing and Rehabilitation Center, located in Trenton, New Jersey. Through this review, HMS determined that Providence Nursing and Rehabilitation Center improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from November 1, 2018 through December 31, 2021 to which Providence Nursing and Rehabilitation Center was not entitled. Providence Nursing and Rehabilitation Center agreed to repay the Medicaid program $164,681.

Breathe Rite Medical and Surgical Equipment, LLC
Overpayment Letter (8/21/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Breathe Rite Medical and Surgical Equipment, LLC, located in Trenton, New Jersey. Through this review, HMS determined that Breathe Rite improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from May 16, 2014 to May 15, 2019 to which Breathe Rite was not entitled. Breathe Rite agreed to repay the Medicaid program $167,846.

Northeastern Professional Nurses Registry, Inc.
Overpayment Letter (8/23/2024)

MFD reviewed claims submitted by Northeastern Professional Nurses Registry, Inc. a personal care service (PCS) provider. MFD determined that from July 1, 2019 through March 31, 2024 Northeastern improperly billed and received payments totaling $29,932 for home-based services rendered to beneficiaries while these beneficiaries had in-patient status in a hospital setting. Northeastern paid the Medicaid program the full amount of $29,932.

Peace Care Saint Joseph's
Settlement Agreement (8/28/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Peace Care Saint Joseph's, located in Jersey City, New Jersey. Through this review, HMS determined that Peace Care Saint Joseph's improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from January 1, 2019 through June 30, 2022 to which Peace Care Saint Joseph's was not entitled. Peace Care Saint Joseph's agreed to repay the Medicaid program $480,087.

Cooper Surgical Associates, PA (Ortho)
Overpayment Letter (8/30/2024)

MFD reviewed claims submitted by Cooper Surgical Associates, PA (Ortho), a physician group located in Camden, New Jersey. MFD determined that, from March 1, 2018 through February 28, 2023, Cooper Surgical Associates, PA (Ortho), improperly billed and received payments totaling $10,163 for billing an excessive number of units of service that is not permissible for hyaluronic injections. Cooper Surgical Associates, PA (Ortho) paid the Medicaid program the full amount identified, $10,163.

Xanadu Adult Medical Day Care
Overpayment Letter (9/10/2024)

MFD reviewed claims submitted by Xanadu Adult Medical Day Care, an adult day health services provider located in Passaic, New Jersey. MFD determined that, from January 1, 2017 through May 31, 2022, Xanadu Adult Medical Day Care improperly billed and received

payments totaling $24,385 for services provided to beneficiaries who were also inpatient at a facility, billing in excess of five days of service in a week for an individual beneficiary, and billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Xanadu Adult Medical Day Care paid the Medicaid program the full revised amount identified, $24,385.

Complete Care at Westfield, LLC
Settlement Agreement (9/12/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Complete Care at Westfield, LLC, located in Westfield, New Jersey. Through this review, HMS determined that Complete Care at Westfield improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from July 1, 2021 through April 30, 2022 to which Complete Care at Westfield was not entitled. Complete Care at Westfield agreed to repay the Medicaid program $125,432.

Warren Haven Rehab and Nursing Center
Settlement Agreement (9/13/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Warren Haven Rehab and Nursing Center, located in Oxford, New Jersey. Through this review, HMS determined that Warren Haven improperly received Medicaid Managed Care and Medicaid FFS patient liability and claim overpayments from October 1, 2018 through March 31, 2022 to which Warren Haven was not entitled. Warren Haven agreed to repay the Medicaid program $258,797.

Advanced Subacute Rehabilitation Center at Sewell, LLC
Settlement Agreement (9/24/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Advanced Subacute Rehabilitation Center at Sewell, LLC, located in Sewell, New Jersey. Through this review, HMS determined that Advanced Subacute improperly received Medicaid managed care and Medicaid FFS patient liability and claim overpayments from December 1, 2018 through May 31, 2022 to which Advanced Subacute was not entitled. Advanced Subacute agreed to repay the Medicaid program $470,678.

Trinitas Regional Medical Center
Overpayment Letter (9/25/2024)

MFD reviewed claims submitted by Trinitas Regional Medical Center, a physician group located in Elizabeth, New Jersey. MFD determined that, from June 1, 2019 through June 5, 2024, Trinitas Regional Medical Center, improperly received duplicate payments from encounter (ENC) or FFS claims totaling $59,742. Trinitas Regional Medical Center paid the Medicaid program the full amount identified, $59,742.

Diamond Years Adult Medical Day Care Ctr.
Overpayment Letter (10/4/2024)

MFD reviewed claims submitted by Diamond Adult Day Care Center, an adult day health services provider located in Haledon, New Jersey. MFD determined that, from July 1, 2019 through July 19, 2023, Diamond Adult Day Care Center improperly billed and received payments totaling $22,046 for services provided to beneficiaries who were also inpatient at a facility, billing in excess of five days of service in a week for an individual beneficiary, and billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Diamond Adult Day Care Center paid the Medicaid program the full revised amount identified, $22,046.

Recovery Centers of America
Settlement Agreement (11/4/2024)

MFD resolved an investigation of Recovery Centers of America (RCA), located in South Amboy, New Jersey. MFD found that from January 1, 2020 through December 8, 2023, RCA was reimbursed by DMAHS and/or its fiscal agent and/or the MCOs for overpayment amounts attributable to a failure on the part of counselors to provide weekly individual counseling sessions, which is required for an intensive outpatient treatment program (IOP) to receive the IOP-bundled reimbursement rate, in violation of N.J.A.C. 10:161B-10.1. RCA agreed to settle this matter for $449,334.

NJ Memory and Behavioral Care
Overpayment Letter (11/8/2024)

MFD reviewed claims submitted by NJ Memory and Behavioral Care, a physician group located in Cedar Knolls, New Jersey. MFD determined that, from January 1, 2020 through March 20, 2024, NJ Memory and Behavioral Care improperly received duplicate payments from ENC or FFS claims totaling $62,269. NJ Memory and Behavioral Care paid the Medicaid program the full amount identified, $62,269. NJ Memory and Behavioral Care also provided a corrective action plan to avoid any future incorrect payments being furnished to the provider on behalf of the New Jersey Medicaid Program.

Our Home Adult Day Care LLC
Overpayment Letter (11/19/2024)

MFD reviewed claims submitted by Our Home Adult Day Care LLC, an adult day health services provider located in Englewood, New Jersey. MFD determined that, from July 1, 2019 through July 19, 2023, Our Home Adult Day Care LLC improperly billed and received payments totaling $15,175 for services provided to beneficiaries who were also inpatient at a facility, billing in excess of five days of service in a week for an individual beneficiary, and billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Our Home Adult Day Care paid the Medicaid program the full revised amount identified, $15,175.

NYNJ Psychiatric Associates
Overpayment Letter (11/21/2024)

MFD reviewed claims submitted by NYNJ Psychiatric Associates, a physician group located in Short Knolls, New Jersey. MFD determined that, from September 1, 2019 through May 16, 2024, NYNJ Psychiatric Associates improperly received duplicate payments from ENC or FFS claims totaling $65,792. NYNJ Psychiatric Associates paid the Medicaid program the full amount identified, $65,792, and reported that the MCO reprocessed previously denied charges without its request resulting in the duplicate payments. NYNJ Psychiatric Associates also provided a corrective action plan to avoid any future incorrect payments being furnished to the provider on behalf of the New Jersey Medicaid Program.

CMC Department of Medicine Group, PA
Overpayment Letter (11/21/2024)

MFD reviewed claims submitted by CMC Department of Medicine Group, PA, a physician group located in Camden, New Jersey. MFD determined that, from June 1, 2019 through June 19, 2024, CMC Department of Medicine Group, PA, improperly received duplicate payments from ENC or FFS claims totaling $122,666. CMC Department of Medicine Group, PA paid the Medicaid program the full amount identified, $122,666.

CMC Psychiatric Associates
Overpayment Letter (11/21/2024)

MFD reviewed claims submitted by CMC Psychiatric Associates, a physician group located in Camden, New Jersey. MFD determined that, from June 1, 2019 through June 25, 2024, CMC Psychiatric Associates, improperly received duplicate payments from ENC or FFS claims totaling $91,013. CMC Psychiatric Associates paid the Medicaid program the full amount identified, $91,013.

Family of Caring Healthcare at Ridgewood
Settlement Agreement (12/10/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Family of Caring Healthcare at Ridgewood, LLC, a long-term care facility located in Ridgewood, New Jersey, with Family of Caring Healthcare at Ridgewood, LLC agreeing to repay the Medicaid program $102,418. Through this review, HMS determined that, from May 1, 2019 through October 31, 2022, Family of Caring Healthcare at Ridgewood, LLC improperly received Medicaid managed care patient liability and claim overpayments to which it was not entitled.

Complete Care at Linwood, LLC
Settlement Agreement (12/26/2024)

MFD resolved a review conducted by its TPL vendor, HMS, of Complete Care at Linwood, LLC, located in Linwood, New Jersey. Through this review, HMS determined that Complete Care at Linwood, LLC improperly received MCO and FFS patient liability and claim overpayments between December 1, 2018 and May 31, 2022, to which Complete Care at Linwood, LLC was not entitled. Complete Care at Linwood, LLC agreed to repay the Medicaid program $267,920.

Project Live Incorporated
Overpayment Letter (1/8/2025)

MFD reviewed claims submitted by Project Live Incorporated, a community care facility located in Newark, New Jersey. MFD determined that, from November 14, 2021 through May 22, 2022, Project Live Incorporated improperly received duplicate payments from ENC or FFS claims totaling $34,950. Project Live Incorporated paid the Medicaid program the full amount identified, $34,950.

Barnabas Health Medical Group PC
Overpayment Letter (1/9/2025)

MFD reviewed claims submitted by Barnabas Health Medical Group PC, a physician group located in West Orange, New Jersey. MFD determined that, from June 1, 2020 through June 30, 2024, Barnabas Health Medical Group PC improperly billed and received payments for excessive units of service for knee injection ENC or FFS claims totaling $17,771. Barnabas Health Medical Group PC paid the Medicaid program the full amount identified, $17,771.

Morris View Healthcare Center
Settlement Agreement (1/17/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Morris View Management CO, LLC, located in Morris Plains, New Jersey. Through this review, HMS determined that Morris View Management CO, LLC improperly received MCO and FFS patient liability and claim overpayments between December 1, 2018 and May 31, 2024, to which Morris View Management CO, LLC was not entitled. Morris View Management CO, LLC agreed to repay the Medicaid program $952,682.

Aristacare at Cherry Hill, LLC
Settlement Agreement (1/21/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Aristacare at Cherry Hill, LLC, located in Cherry Hill, New Jersey. Through this review, HMS determined that Aristacare at Cherry Hill, LLC improperly received MCO and FFS patient liability and claim overpayments between January 1, 2019 and June 30, 2022, to which Aristacare at Cherry Hill, LLC was not entitled. Aristacare at Cherry Hill, LLC agreed to repay the Medicaid program $384,570.

Lakeview Medical Center and Dr. Ifeoma Iwelumo
Overpayment Letter (1/23/2025)

MFD reviewed claims submitted by Lakeview Medical Center and Dr. Ifeoma Iwelumo, a physician located in Clifton, New Jersey. MFD determined that, from January 1, 2019 through December 31, 2023, Lakeview Medical Center and Dr. Ifeoma Iwelumo improperly billed and received payments totaling $3,440 for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Lakeview Medical Center and Dr. Ifeoma Iwelumo paid the Medicaid program the full amount identified, $3,440.

Magdy Basta, MD
Overpayment Letter (1/30/2025)

MFD reviewed claims submitted Magdy Basta, MD a physician located in Clifton, New Jersey. MFD determined that, from June 1, 2018 through September 7, 2023, Magdy Basta, MD improperly billed and received payments totaling $5,010 for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Magdy Basta, MD paid the Medicaid program the full amount identified, $5,010.

Family of Caring Healthcare at Montclair LLC
Settlement Agreement (1/30/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Family of Caring Healthcare at Montclair LLC, located in Montclair, New Jersey. Through this review, HMS determined that Family of Caring Healthcare at Montclair LLC improperly received MCO and FFS patient liability and claim overpayments between May 1, 2019 and October 31, 2022, to which Family of Caring Healthcare at Montclair LLC was not entitled. Family of Caring Healthcare at Montclair LLC agreed to repay the Medicaid program $229,767.

Dellridge Care Center
Settlement Agreement (1/30/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Dellridge Care Facility, located in Paramus, New Jersey. Through this review, HMS determined that Dellridge Care Center improperly received MCO and FFS patient liability and claim overpayments between April 1, 2019 and September 30, 2022, to which Dellridge Care Center was not entitled. Dellridge Care Center agreed to repay the Medicaid program $101,926.

Sunny Days Adult Day Care
Overpayment Letter (1/30/2025)

MFD reviewed claims submitted by Sunny Days Adult Day Care, an adult day health services provider located in Edison, New Jersey. MFD determined that, from January 1, 2020 through July 19, 2023, Sunny Days Adult Day Care improperly billed and received payments totaling $3,644 for services provided to beneficiaries who were also inpatient at a facility, billing in excess of five days of service in a week for an individual beneficiary, and billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Sunny Days Adult Day

Care paid the Medicaid program the full revised amount identified, $3,644.

Jersey Shore University Medical Center
Overpayment Letter (2/18/2025)

MFD reviewed claims submitted by Jersey Shore University Medical Center, a hospital located in Neptune, New Jersey. MFD determined that, from October 9, 2020 through November 9, 2020, Jersey Shore University Medical Center improperly received payments totaling $4,843 for billing wound repair codes in conjunction with excisions of benign lesions with an excised diameter of 0.5 cm or less. Jersey Shore University Medical Center paid the New Jersey Medicaid program the full amount identified, $4,843.

Advance Services International
Overpayment Letter (2/18/2025)

MFD reviewed claims submitted by Advance Services International, an adult day health services provider located in Jersey City, New Jersey. MFD determined that, from January 1, 2020 through July 19, 2023, Advance Services International improperly billed and received payments totaling $6,399 with the number of deficient claims noted for billing for services provided to beneficiaries who were also inpatient at a facility and billing in excess of five days of service in a week for an individual beneficiary. Advance Services International paid the New Jersey Medicaid program the full amount identified, $6,399.

Teaneck Nursing Center
Settlement Agreement (3/12/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of M.R. of Teaneck, LLC, located in Morris Plains, New Jersey. Through this review, HMS determined that M.R. of Teaneck, LLC improperly received MCO and FFS patient liability and claim overpayments between November 1, 2018 and October 31, 2021, to which M.R. of Teaneck, LLC was not entitled. M.R. of Teaneck, LLC agreed to repay the Medicaid program $228,901.

Ammon Analytical Laboratories LLC
Settlement Agreement (3/26/2025)

MFD resolved an investigation of Ammon Analytical Laboratories LLC located in Linden, New Jersey with Ammon Analytical agreeing to repay the Medicaid program $11,511. Through this investigation, MFD found that Ammon Analytical billed and was reimbursed by the MCO and FFS for claims for which it failed to provide sufficient documentation to support some of the services claimed, including claims that contained COVID-19 specimen collection without the required COVID-19 testing code(s).

Amboy Care Center
Settlement Agreement (3/31/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of M.R. of Amboy, LLC, located in Perth Amboy, New Jersey. Through this review, HMS determined that M.R. of Amboy, LLC improperly received MCO and FFS patient liability and claim overpayments between March 1, 2019 and November 29, 2021, to which M.R. of Amboy, LLC was not entitled. M.R. of Amboy, LLC agreed to repay the Medicaid program $209,336.

Shore Meadows Rehabilitation and Nursing Center
Settlement Agreement (3/31/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Shore Meadows Operations, LLC, located in Toms River, New Jersey. Through this review, HMS determined that Shore Meadows Operations, LLC improperly received MCO and FFS patient liability and claim overpayments between April 1, 2019 and August 2, 2021, to which Shore Meadows

Operations, LLC was not entitled. Shore Meadows Operations, LLC agreed to repay the Medicaid program $232,028.

Family of Caring at Teaneck
Settlement Agreement (4/2/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Family of Caring at Teaneck, LLC, located in Teaneck, New Jersey. Through this review, HMS determined that Family of Caring at Teaneck, LLC improperly received MCO and FFS patient liability and claim overpayments between November 1, 2021 and December 31, 2022, to which Family of Caring at Teaneck, LLC was not entitled. Family of Caring at Teaneck, LLC agreed to repay the Medicaid program $122,753.

Family of Caring at Tenafly
Settlement Agreement (4/3/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Family of Caring at Tenafly, LLC, located in Tenafly, New Jersey. Through this review, HMS determined that Family of Caring at Tenafly, LLC improperly received MCO and FFS patient liability and claim overpayments between December 1, 2020 and November 30, 2022, to which Family of Caring at Tenafly, LLC was not entitled. Family of Caring at Tenafly, LLC agreed to repay the Medicaid program $127,922.

Ammon Analytical Laboratories LLC
Overpayment Letter (4/4/2025)

MFD reviewed claims submitted by Ammon Analytical Labs, a laboratory located in Linden, New Jersey. MFD determined that, from March 1, 2020 through September 30, 2023, Ammon Analytical Labs improperly billed and received payments totaling $11,511 for billing specimen collection codes without any COVID-19 testing codes. Ammon Analytical Labs paid the New Jersey Medicaid program the full amount identified, $11,511.

St. Joseph's Healthcare
Overpayment Letter (4/7/2025)

MFD reviewed claims submitted by St. Joseph's Healthcare, located in Paterson, New Jersey. MFD determined that, from February 1, 2020 through November 15, 2024, St. Joseph's Healthcare was paid for duplicate FFS and ENC claims and received excess payments totaling $43,855. St. Joseph's Healthcare paid the Medicaid program the full amount identified.

Morristown Post Acute Rehab and Nursing
Settlement Agreement (4/9/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Morristown Post Acute Rehabilitation and Nursing Center, LLC, located in Morristown, New Jersey. Through this review, HMS determined that Morristown Post Acute Rehabilitation and Nursing Center, LLC improperly received MCO and FFS patient liability and claim overpayments between December 1, 2019 and July 31, 2022, to which Morristown Post Acute Rehabilitation and Nursing Center, LLC was not entitled. Morristown Post Acute Rehabilitation and Nursing Center, LLC agreed to repay the Medicaid program $503,111.

SERV Centers of New Jersey
Overpayment Letter (4/11/2025)

MFD reviewed claims submitted by SERV Centers of New Jersey located in Ewing, New Jersey. MFD determined that, from July 1, 2019 through May 14, 2022, SERV Centers of New Jersey was paid for duplicate FFS and ENC claims and received excess payments totaling $37,346. SERV Centers of New Jersey paid the Medicaid program $37,346.

Elizabeth Pharmacy
Settlement Agreement (4/14/2025)

MFD resolved an investigation of Saadiya Health LLC d/b/a Elizabeth Pharmacy and its owner, Meghna Doshi, located in Elizabeth, New Jersey, with Elizabeth Pharmacy agreeing to repay the Medicaid program $129,622. Through this investigation, MFD found that Elizabeth Pharmacy billed and was reimbursed by the MCO and FFS for claims that could not be supported by wholesaler invoices. Elizabeth Pharmacy agreed to pay MFD a total of $129,622, which is comprised of $43,207 in overpayment, $43,207 in civil penalties against Elizabeth Pharmacy, and $43,207 in civil penalties against owner Meghna Doshi.

Milford Manor Nursing and Rehabilitation
Settlement Agreement (4/22/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of 69 Maple Ave., Inc. d/b/a Milford Manor Nursing & Rehabilitation located in West Milford, New Jersey. Through this review, HMS determined that Milford Manor Nursing & Rehabilitation improperly received MCO and FFS patient liability and claim overpayments between October 1, 2019 and December 26, 2021, to which Milford Manor Nursing & Rehabilitation was not entitled. Milford Manor Nursing & Rehabilitation agreed to repay the Medicaid program $250,746.

Complete Care at Whiting
Settlement Agreement (4/25/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Complete Care at Whiting, LLC, located in Whiting, New Jersey. Through this review, HMS determined that Complete Care at Whiting, LLC improperly received MCO and FFS patient liability and claim overpayments between October 1, 2019 and October 17, 2023, to which Complete Care at Whiting, LLC was not entitled. Complete Care at Whiting, LLC agreed to repay the Medicaid program $850,271.

Senior Care Therapy
Overpayment Letter (5/2/2025)

MFD reviewed claims submitted by Senior Care Therapy located in Passaic, New Jersey. MFD determined that, from October 1, 2019 through October 1, 2024, Senior Care Therapy was paid for duplicate FFS and ENC claims and received excess payments totaling $23,139. Senior Care Therapy paid the Medicaid program $23,139.

Carnegie Post Acute Care at Princeton
Settlement Agreement (5/2/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Carnegie Post Acute Care at Princeton, LLC, located in Princeton, New Jersey. Through this review, HMS determined that Carnegie Post Acute Care at Princeton, LLC improperly received MCO and FFS patient liability and claim overpayments between April 1, 2022 and June 13, 2023, to which Carnegie Post Acute Care at Princeton, LLC was not entitled. Carnegie Post Acute Care at Princeton, LLC agreed to repay the Medicaid program $247,103.

New Caring of Prospect
Overpayment Letter (5/6/2025)

MFD reviewed claims submitted by New Caring of Prospect, an adult day health services provider located in Prospect Park, New Jersey. MFD determined that, from January 1, 2020 through July 19, 2023, New Caring of Prospect improperly billed and received payments totaling $5,153 with the number of deficient claims noted for billing for services provided to beneficiaries who were also inpatient at a facility and billing for services for the same day, same service, and same beneficiary as another adult medical day provider. New Caring of

Prospect paid the Medicaid program the full revised amount identified, $5,153.

Cranford Rehab & Nursing Center
Settlement Agreement (5/14/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of CRNC Operating, LLC, located in Cranford, New Jersey. Through this review, HMS determined that CRNC Operating, LLC improperly received MCO and FFS patient liability and claim overpayments between April 1, 2019 and April 30, 2021, to which CRNC Operating, LLC was not entitled. CRNC Operating, LLC agreed to repay the Medicaid program $381,152.

Clover Meadows Healthcare and Rehabilitation Center
Settlement Agreement (5/20/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Clover Meadows Healthcare and Rehabilitation Center, LLC, located in Lawrence Township, New Jersey. Through this review, HMS determined that Clover Meadows Healthcare and Rehabilitation Center, LLC improperly received MCO and FFS patient liability and claim overpayments between June 1, 2019 and November 30, 2022, to which Clover Meadows Healthcare and Rehabilitation Center, LLC was not entitled. Clover Meadows Healthcare and Rehabilitation Center, LLC agreed to repay the Medicaid program $264,572.

Grove Park Healthcare and Rehabilitation
Settlement Agreement (5/21/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Park Grove Healthcare & Rehabilitation Center, LLC, located in East Orange, New Jersey. Through this review, HMS determined that Park Grove Healthcare & Rehabilitation Center, LLC improperly received MCO and FFS patient liability and claim overpayments between January 1, 2021 and December 31, 2022, to which Park Grove Healthcare & Rehabilitation Center, LLC was not entitled. Park Grove Healthcare & Rehabilitation Center, LLC agreed to repay the Medicaid program $426,433.

Atlantic Emergency Associates
Overpayment Letter (5/22/2025)

MFD reviewed claims submitted by Atlantic Emergency Associates, located in Atlantic City, New Jersey. MFD determined that, from February 1, 2020 through October 1, 2024, Atlantic Emergency Associates was paid for duplicate FFS and ENC claims and received excess payments totaling $20,837. Atlantic Emergency Associates repaid the Medicaid program the total identified overpayment amount.

Avista Care at Cherry Hill
Settlement Agreement (5/27/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Avista Healthcare, LLC, located in Cherry Hill, New Jersey. Through this review, HMS determined that Avista Healthcare, LLC improperly received MCO and FFS patient liability and claim overpayments between December 1, 2018 and October 31, 2021, to which Avista Healthcare, LLC was not entitled. Avista Healthcare, LLC agreed to repay the Medicaid program $239,787.

Kindcare Pediatrics
Settlement Agreement (6/5/2025)

MFD resolved an audit of Kindcare Pediatrics and its owner, Yocasta Fernandez, MD, located in Passaic, New Jersey, with Kindcare Pediatrics agreeing to repay the Medicaid program $62,318. Through this audit, MFD found that Kindcare Pediatrics improperly billed the MCOs and FFS for Transition Care Management and preventive medicine

counseling claims. Kindcare Pediatrics agreed to repay the Medicaid program $62,318.

Doctors Subacute Healthcare
Settlement Agreement (6/10/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Doctors Subacute Healthcare, LLC, located in Paterson, New Jersey. Through this review, HMS determined that Doctors Subacute Healthcare, LLC improperly received MCO and FFS patient liability and claim overpayments between September 1, 2019 and February 28, 2023, to which Doctors Subacute Healthcare, LLC was not entitled. Doctors Subacute Healthcare, LLC agreed to repay the Medicaid program $274,664.

Nimisha Shukla, M.D
Settlement Agreement (6/11/2025)

MFD reviewed claims submitted by Nimisha Shukla, MD, a Medicaid provider located in Edison, New Jersey. MFD found that from May 1, 2018 through September 30, 2022, Nimisha Shukla, MD submitted claims to Medicaid through MCOs, FFS, or both for Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes 99381-99385, 99391-99395, 92587, 96110, 97801, G0477 in violation of N.J.S.A 30:4D-12, N.J.A.C. 10:49-9.8, and N.J.A.C. 10:49-5.5. MFD concluded that Nimisha Shukla, M.D.'s clinical documentation did not support billings and subsequent reimbursements and received an overpayment. Nimisha Shukla, M.D. agreed to repay the Medicaid program $40,665.

Complete Care at Holiday City
Settlement Agreement (6/17/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Complete Care at Holiday, LLC, located in Toms River, New Jersey. Through this review, HMS determined that Complete Care at Holiday, LLC improperly received MCO and FFS patient liability and claim overpayments between September 1, 2019 and November 30, 2022, to which Complete Care at Holiday, LLC was not entitled. Complete Care at Holiday, LLC agreed to repay the Medicaid program $395,960.

Complete Care at Court House
Settlement Agreement (6/19/2025)

MFD resolved a review conducted by its TPL vendor, HMS, of Complete Care at Court House, LLC, located in Cape May Court House, New Jersey. Through this review, HMS determined that Complete Care at Court House, LLC improperly received MCO and FFS patient liability and claim overpayments between April 1, 2021 and January 31, 2023, to which Complete Care at Court House, LLC was not entitled. Complete Care at Court House, LLC agreed to repay the Medicaid program $117,295.

Summaries of Final Reports, Court Decisions, and Other Medicaid Actions

Atlantic Diagnostics Laboratories
Final Audit Report (10/3/2024)

MFD audited claims submitted by Atlantic Diagnostic Laboratory, LLC (ADL), an independent clinical laboratory provider located in Bensalem, Pennsylvania, to determine whether ADL billed in accordance with applicable requirements. MFD found that for 88 of the 261 sample episodes, ADL either billed for tests that the physician or licensed practitioner had not ordered or billed for tests that lacked required documentation or signatures. For these documentation deficiencies, MFD calculated that ADL received an extrapolated overpayment of $2,943,586. ADL also improperly unbundled 231,091

specimen validity testing claims from presumptive and definitive drug testing. For these unbundled claims, MFD determined that ADL received an overpayment totaling $1,140,043. MFD also assessed a civil penalty of $3,269,332 for the 261 episodes in the audit sample that violated Medicaid basis of reimbursement regulations by charging other groups or individuals a lower charge than the Medicaid program in the audit period.

South Jersey Extended Care
Final Investigative Report (12/12/2024)

MFD investigated South Jersey Extended Care (SJEC), a nursing home in Bridgeton, NJ. MFD exposed a massive scam by the owners/operators of SJEC. MFD found that the owners/operators funneled millions of dollars in Medicaid funds out of the nursing home into their personal accounts, businesses, and charities over several years, leaving residents to live in inadequate and understaffed conditions. MFD, with the support of the Attorney General and in coordination with DOH and DHS, notified SJEC and its related entities and partners including Sterling Manor Nursing Center, Michael Konig, Steven Krausman, and Mordechay "Mark" Weisz that they will be suspended from the Medicaid program.

Star Laboratory Corporation
Final Audit Report (3/19/2025)

MFD audited claims submitted by Star Laboratory Corporation (Star), an independent clinical laboratory provider located in Piscataway, New Jersey, to determine whether Star billed in accordance with applicable requirements. MFD found that for 81 of 148 sample episodes, Star's documentation failed to comply with legal requirements. Specifically, MFD found that in 79 episodes, Star performed and billed for drug tests that lacked required signatures from the referring physician or licensed practitioner. MFD also found that in five episodes, Star performed and billed for a higher level of testing than what was included on the test requisition, with three of these episodes having both deficiencies. MFD calculated that Star improperly received an extrapolated overpayment of $3,332,626 that it had to repay to the Medicaid program.

Barclays Rehabilitation and Healthcare Center
Review Findings (3/25/2025)

MFD conducted a review of the statutorily required direct care staff-to-resident ratio of Barclays Rehabilitation and Healthcare Center, LLC (Barclays) for the period from July 1, 2023 through July 31, 2023. MFD found that for each of the 31 days in July 2023, for at least one shift every day, Barclays failed to provide the minimum number of direct care staff to appropriately render services to its residents. Of the 93 shifts that constituted the three shifts (day, evening, and night) for the 31 days in July 2023, Barclays did not adequately staff 85 shifts (91 percent). Furthermore, for the day shift, on average, Barclays staffed its facility 23 percent below the minimum legal requirement; during the evening shift, on average, Barclays staffed its facility 16 percent below the minimum legal requirement; and during the night shift, on average, Barclays staffed its facility 31 percent below the minimum legal requirement. Based on the March 2025 review findings, MFD is seeking to recover from Barclays the payments that the Medicaid program paid to Barclays for each day in July 2023, which is $367,590. In addition, given Barclays knowledge of its deficiencies, as well as the pervasiveness and seriousness of the findings, MFD imposed a notice of claim in June 2025 for a civil monetary penalty of $367,590. In total, Barclays must repay the Medicaid program $735,180.

Barnegat Nursing and Rehabilitation Center
Review Findings (3/25/2025)

MFD conducted a review of the statutorily

required direct care staff-to-resident ratio of Barnegat Rehabilitation and Nursing Center (Barnegat) for the period from July 1, 2023 through July 31, 2023. MFD found that for each of the 31 days in July 2023, for at least two shifts every day, Barnegat failed to provide the minimum number of direct care staff to appropriately render services to its residents. Out of the 93 shifts that constituted the three shifts (day, evening, and night) for the 31 days in July 2023, Barnegat did not adequately staff 86 shifts (92 percent). Furthermore, for the day shift, on average, Barnegat staffed its facility 29 percent below the minimum legal requirement; during the evening shift, on average, Barnegat staffed its facility 15 percent below the minimum legal requirement; and during the night shift, on average, Barnegat staffed its facility 41 percent below the minimum legal requirement. Based on the March 2025 review findings, MFD is seeking to recover from Barnegat the payments that the Medicaid program paid to Barnegat for each day in July 2023, which is $395,690. In addition, given Barnegat's knowledge of its deficiencies, as well as the pervasiveness and seriousness of the findings, MFD imposed a notice of claim in June 2025 for a civil monetary penalty of $395,690. In total, Barnegat must repay the Medicaid program $791,380.

Belle Care Nursing and Rehabilitation Center
Review Findings (3/25/2025)

MFD conducted a review of the statutorily required direct care staff-to-resident ratio of Belle Care Nursing and Rehabilitation Center (Belle Care) for the period from July 1, 2023 through July 31, 2023. MFD found that for each of the 31 days in July 2023, for at least two shifts every day, Belle Care failed to provide the minimum number of direct care staff to appropriately render services to its residents. Out of the 93 shifts that constituted the three shifts (day, evening, and night) for the 31 days in July 2023, Belle Care did not adequately staff 83 shifts (89 percent). Furthermore, for the day shift, on average, Belle Care staffed its facility 57 percent below the minimum legal requirement; during the evening shift, on average, Belle Care staffed its facility 36 percent below the minimum legal requirement; and during the night shift, on average, Belle Care staffed its facility 51 percent below the minimum legal requirement. Based on the March 2025 review findings, MFD is seeking to recover from Belle Care the payments that the Medicaid program paid to Belle Care for each day in July 2023, which is $215,768. In addition, given Belle Care's knowledge of its deficiencies, as well as the pervasiveness and seriousness of the findings, MFD imposed a notice of claim in June 2025 for a civil monetary penalty of $431,536. In total, Belle Care must repay the Medicaid program $647,304.

Oscar E. Sandoval
Court Decision (5/19/2025)

MFD won a Final Agency Decision against Oscar Sandoval, MD, in the amount of $238,215. Dr. Sandoval was ordered to repay the Medicaid program for improperly prescribing the medication Nudexta where he failed to document the requisite underlying medical diagnosis in patient records. The OAL's Initial Decision and DMAHS' Final Agency Decision found that Dr. Sandoval, as the prescriber, was liable for Medicaid payments made for the prescriptions even though he did not personally receive the payments for the prescriptions.

Alps Rehabilitation Center LLC
Medicaid Enrollment Denial Letter (5/27/2025)

MFD denied the Alps Rehabilitation Center LLC d/b/a Alps at Wayne Rehab Care Center Medicaid provider application, finding that there is good cause for denial in accordance with N.J.A.C 10:49-11.1(d)(20), (22), and (23), and finding that this denial is in the best interests of the Medicaid program.

Avalon Garden Group LLC
Medicaid Enrollment Denial Letter (5/27/2025)

MFD denied the Avalon Garden Group LLC d/b/a Accela Rehab and Care Center at Wayne Medicaid Provider application, finding that there is good cause for denial in accordance with N.J.A.C 10:49-11.1(d)(20), (22), and (23), and finding that this denial is in the best interests of the Medicaid program.

OSC Recommendations Yield Over $100 Million in Medicaid Savings
Alert (6/10/2025)

In MFD's audit of Ammon Analytical Laboratory (Ammon), MFD found that Ammon used "blanket" or one-size-fits-all drug test requisition forms, subjecting all patients to the same battery of drug tests regardless of their individual medical needs. Additionally, MFD found that Ammon and the substance use treatment providers who used Ammon's services had agreed upon a practice in which the providers would commonly request a medically unnecessary "definitive" test as the initial test, bypassing the lower cost "presumptive" test. Industry standard practice, however, recommends using the more expensive definitive tests only after an initial, lower cost presumptive test has indicated the presence of a substance. MFD found that these medically suspect practices significantly increased Medicaid costs and did not improve patient care.

Based on its findings, MFD made a series of recommendations to DMAHS to reform its oversight of and payment for independent clinical laboratory services. DMAHS subsequently implemented a number of MFD's recommendations. To determine how much money DMAHS's programmatic changes saved the Medicaid program, MFD forecasted the amount that would have been billed had DMAHS not made these changes. Based on this analysis, MFD estimated that the Medicaid program has saved approximately $64.7 million, with savings continuing to accrue. In addition, MFD estimated that savings attributable to a decline in billing for a definitive testing code saved the program more than $37 million to date.

Greater New Jersey Creative Counseling
Final Audit Report (6/12/2025)

MFD audited Medicaid claims submitted by Greater New Jersey Creative Counseling, Inc. (Greater NJ) an intensive in-community mental health rehabilitation and behavioral assistance provider, located in Palmyra, New Jersey. MFD found that, for the period of August 1, 2017 through April 30, 2022, Greater NJ failed to maintain documentation showing that it performed required criminal background checks and other required screening for multiple employees. In essence, Greater NJ did not consistently comply with regulations requiring providers to conduct qualifications and background checks, which caused unnecessary risk for Medicaid beneficiaries. MFD also found that Greater NJ failed to follow proper billing practices by billing for unsubstantiated services and maintaining inaccurate and incomplete documentation. For example, MFD found multiple instances for which Greater NJ failed to provide documentation that would support the claims it billed and for which it was paid, and the documentation it provided conflicted with the hours billed and paid. Additionally, Greater NJ billed for upcoded services. MFD found 39 of 177 sampled claims failed for the reasons mentioned above. MFD extrapolated the error dollars for the sampled claims to the total population from which the sample was drawn and calculated that Greater NJ received an overpayment of $2,709,266 plus a direct recovery of $2,023. In total, MFD found that Greater NJ received an overpayment of at least $2,711,289.