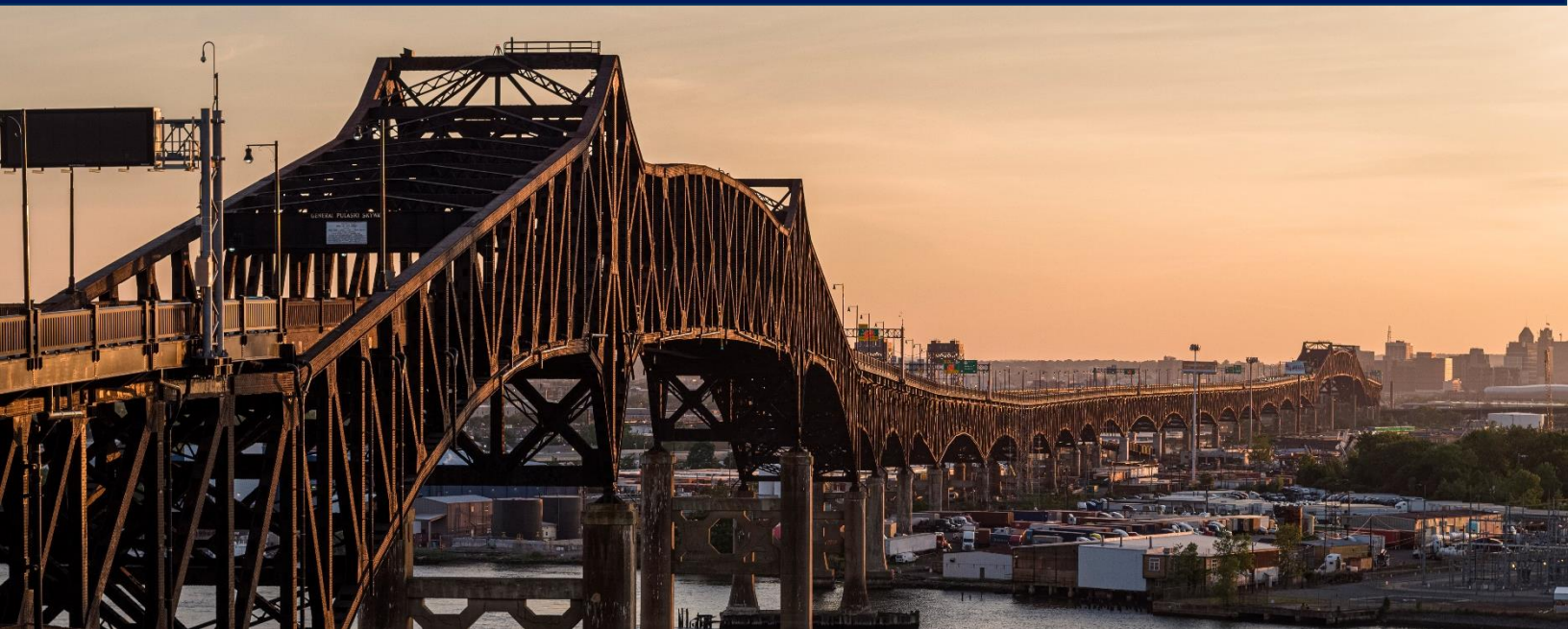
New Jersey Office of the State Comptroller Fiscal Year 2024 Annual Report

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

November 2024

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:

As I write this letter, I am nearing the end of my fifth year leading the Office of the State Comptroller, the independent watchdog agency focused on advancing transparency and accountability in government. Over that time, we have produced 89 audits, reviews, and investigations that examined 20 statewide issues, 21 counties, and more than 200 municipalities across the state.

But when I look back at OSC's work this past fiscal year, I am struck by not only the depth and breadth of our work but the impact it has had. As the local media has shrunk and transparency protections have weakened, OSC's ability to uncover fraud, waste, and abuse at all levels of government has become more critical than ever. In fiscal year 2024, OSC's Investigations Division received 2,009 tips, a nearly 100 percent increase from the 1,007 received in FY 2023. One of our key 2024 reports, prompted by a tip, was an investigation of a 2021 private police training conference in Atlantic City, attended by nearly 1,000 law enforcement officers across the country. OSC's Police Accountability Project found the conference – paid for largely with public funds – taught unconstitutional policing tactics, denigrated women and racial and ethnic minorities, and likely violated a myriad of state laws and policies.

After OSC published the report with video segments of the training, more than 100,000 people visited our website to read the report and watch the videos. New Jersey's Attorney General required all New Jersey officers who attended to be retrained. Nine states, in total, reportedly barred the company from training officers, and the report also sparked a much-needed national conversation around the importance of regulating private, post-academy police training.

The work of OSC's Medicaid Fraud Division also continues to reverberate across the state. In 2024, OSC reached a milestone, recovering $1 billion in Medicaid funds over ten years. We also sent a clear message that we will not tolerate irresponsible nursing home owners who put residents in harm's way.

OSC published a series of reports in 2022 and 2023 showing that chronically low-rated nursing homes receive millions in New Jersey Medicaid dollars, despite delivering poor quality care, year after year. In 2024, OSC moved to suspend and disqualify nursing home owners who were found to have committed Medicaid fraud or provided unsafe environments for residents. In response, some owners sold their interest, a few began the process of relinquishing ownership, and the Department of Health installed an independent receiver at two facilities. Protecting the integrity of Medicaid and vulnerable residents who depend on it remains a top priority.

Looking at our reports, some clear themes and lessons also emerge for policymakers and the public. A lack of oversight and an institutional resistance to accountability present a clear risk and challenge for New Jersey government. OSC released a report finding that policies and processes put in place to prevent discriminatory policing by the New Jersey State Police were largely performative and noted that the New Jersey State Police refused to respond to many of OSC's inquiries. OSC also found that Union County paid three top officials a total of $417,772 in extra stipends and tuition reimbursement, without following the public legislative process required by law. And when OSC directed the County to submit a corrective action plan to come into compliance with the law, the County refused and instead pushed for the passage of a bill that would change the law that OSC found the County violated.

Another theme that has emerged through our work: Procurement violations are still rife, and where they flourish, so do fraud, waste, and abuse. Our investigation of Essex County's $40 million COVID-19 vaccination program found multiple violations of federal, state, and local procurement rules. There were so few controls that one consultant received an identical $110,000 payment twice. Another worker was paid $130,000 over 11 months, yet the County did not know who that person was or what the person did. Some $17 million was spent on staffing costs, yet the County did not implement an effective time-tracking system to verify they worked the hours they logged. OSC made numerous referrals and required a corrective action plan from the State. The government's obligation to protect taxpayer funds does not go away during an emergency.

One of OSC's statutory functions is to review procurements from more than 1,900 public entities in the state. These reviews are an important line of defense against self-dealing, corruption, fraud, and waste. Last year, our attorneys in the Procurement Division pre-screened 392 proposed government contracts and required changes in 66 percent of the cases. But this year, OSC also encountered resistance and issued a rare public letter directing Hudson County not to proceed with a $13.5 million prison contract because the County used an improper process that lacked open competition and transparency. Litigation to enforce OSC's directive is pending as I write this letter. Taxpayer funds will not be protected in the way the Legislature intended if local governments are free to ignore OSC's directives.

OSC always follows up within three years of an audit to determine if recommendations have been followed. This past year, OSC went beyond that because of poor compliance with OSC's

recommendations. OSC's 2009 and 2011 reports on Irvington Township identified serious deficiencies in financial controls. Our 2024 report on Irvington found the Township spent nearly $1 million without approval from the town council and even paid to rent space from a business partly owned by a top town official. As a result, OSC recommended the State appoint a fiscal monitor and made seven recommendations to the Township.

Whenever OSC issues a report, we make recommendations for reforms and policy change that can fix the problems we uncovered. Sometimes, as with the private police training report, we see immediate action – but more often, we don't. Overcoming apathy and resistance to imposing government accountability can be challenging. But the first step is always transparency, and as the media shrinks, public faith in government may be weakened. OSC's responsibility to be a nonpartisan, objective source of transparency has never been more essential.

Sincerely,

Kevin D. Walsh, Acting State Comptroller

Overview

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

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

In FY 2024, our Audit Division issued a performance audit of selected fiscal and operating practices at the Hunterdon Central Regional High School District and completed four follow-up reviews of prior audits to determine whether the auditees had implemented OSC's recommendations.

Our Investigations Division issued two reports this past fiscal year. The first, a letter report, concerned Union County's violation of the State's Optional Charter Law with regard to compensation paid to three high-level County Officials. The second report examined aspects of the New Jersey Department of Corrections' Special Investigations Division.

Our Medicaid Fraud Division continued its ongoing efforts to combat fraud, waste, and abuse in the Medicaid Program. The division recovered or facilitated the recovery of more than $119.2 million of taxpayer dollars in FY 2024. Its anti-fraud efforts also resulted in the exclusion of 277 ineligible providers from the Medicaid program.

Our Procurement Division received notice of 901 contracts this past fiscal year, 233 of which were valued at $12.5 million or more. Division attorneys also reviewed hundreds of contracts under Executive Order 166 (Murphy) and Executive Order 125 (Christie). In all, Division attorneys pre-screened 364 contracts before advertisement or negotiation by the contracting unit.

This past fiscal year, OSC's COVID-19 Compliance and Oversight Project conducted an investigation into Essex County's $40 million COVID-19 vaccination program, uncovering significant shortcomings, including inadequate oversight of expenditures and multiple violations of procurement rules.

OSC's Police Accountability Project undertook investigative matters involving fraud, waste, abuse, and misconduct in policing and issued two public reports. One report concerned a 2021 police training conference held in Atlantic City that taught unconstitutional policing tactics, glorified violence, denigrated women and minorities, and likely violated state laws and policies. The second report, issued in accordance with OSC's mandate under the Law Enforcement Professional Standards Act (LEPSA), evaluated the effectiveness of the New Jersey State Police's (NJSP) risk management process, which includes the Risk Analysis Core Group (RACG), a team of civilian analysts, and the NJSP's Risk Management Advisory Panel. It also evaluated the effectiveness of the Attorney General's Office of Law Enforcement Professional Standards' (OLEPS) oversight of that process. In doing so, OSC identified areas of significant weakness, including that leaders never meaningfully grappled with certain data trends that indicated persistent, adverse treatment of racial and ethnic minority motorists. As a result of these findings, and a lack of cooperation in the review process by NJSP and OLEPS, OSC determined corrective action is required for LEPSA compliance.

OSC's Survey Initiative continued its work during the past fiscal year identifying matters at the state and local level that may give rise to fraud, waste, and abuse of taxpayer funds. The Survey Initiative reviewed and evaluated the corrective action plans for 57 municipalities identified in our previously published report titled *A Review of Sick and Vacation Leave Policies in New Jersey Municipalities*.

The sections of this report that follow briefly explain the role of each division as well as OSC's COVID-19 Compliance and Oversight Project, Police Accountability Project, and Survey Initiative while setting forth highlights of OSC accomplishments from the past fiscal year of July 1, 2023 to June 30, 2024.

Audit Division

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

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

Examples of the Audit Division's work in FY 2024 are set forth below. Audit reports can be viewed in their entirety on OSC's website.

Audits

Hunterdon Central Regional High School District

This audit examined employee benefits in the Hunterdon Central Regional High School District. The audit found that the District: (1) failed to procure health insurance coverage and health insurance brokerage services in accordance with the Public School Contracts Law; (2) could have saved up to approximately $2.3 million in fiscal year 2023 by obtaining health benefits coverage from the School Employees' Health Benefits Program; (3) paid $100,000 for health benefit waiver payments to eight employees who also received health insurance coverage paid for by the District through a family member employed with the District; (4) failed to adhere to its collective bargaining agreements or policies in processing and approving employees' leave of absence requests; and (5) issued improper payments to employees at separation of employment due to weaknesses in internal controls.

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

Follow-up Reviews

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

OSC issued four follow-up review reports in FY 2024.

Workers' Compensation Claim Management

OSC's 2020 audit identified weaknesses in the operating practices and internal controls for the management and administration of the workers' compensation program administered by the Division of Risk Management in the Department of the Treasury.

The follow-up review found that the Division had made limited progress in implementing the recommendations set forth in the initial audit report. Of the seven audit recommendations, four were partially implemented and three were not implemented. Unresolved issues included a lack of: (1) a formal policy to manage claimants or locations with multiple or excessive claims; (2) implementation of formal policies and procedures requiring more frequent case file reviews and monitoring of claimants' work status; and (3) revised policies and procedures to improve claim management with procedures establishing the criteria and protocols for authorizing the use of investigatory techniques, including the timing and frequency of site visits, witness interviews, and surveillance.

Of significant concern, the Division had not carried out its duties to prepare and distribute monthly accident reports or to convene state agency representatives quarterly to meet as a Risk Management Committee to review those reports and address issues related to worker safety and capital repairs that may prevent injuries. Additionally, OSC found that the Division implemented contract performance metrics that included accountability measures but did not sufficiently oversee performance and relied on the vendor's self-reporting.

Borough of Roselle

OSC's 2021 audit identified internal control weaknesses that resulted in noncompliance with statutory requirements and internal policies, and procedures related to the administration of employee payroll, health insurance benefits, personnel matters, and procurement of consulting services. These internal control deficiencies resulted in the improper use of Borough assets and improper expenditures totaling more than $1.4 million. It was also determined that Roselle would have saved approximately $1.9 million if the Borough participated in the State Health Benefits Program.

OSC's follow-up review found that Roselle had made progress in implementing the recommendations set forth in the initial audit report. Of the eight audit recommendations, two were implemented, three were partially implemented, and three were not implemented. Unresolved issues included: (1) failure to formally approve assignment of Borough vehicles; (2) no updated written policies and procedures to ensure compliance with the Local Public Contracts Law; and (3) failure to create new policies and procedures related to consulting services.

Of notable concern, Roselle continued to improperly pay for health insurance premiums and waiver payments for council members.

Borough of Keansburg

OSC's 2021 audit identified internal control weaknesses that resulted in noncompliance with statutory requirements and internal policies and procedures related to the administration of health insurance benefits, employee payroll, and personnel matters. These internal control deficiencies resulted in the improper use of Borough assets and improper payments totaling approximately $125,000. Additionally, our audit identified excessive employee benefits, including 55 annual vacation days for one employee and untaxed employee fringe benefits.

OSC's follow-up review found that the Borough had made limited progress in implementing the recommendations set forth in the initial audit report. Of the 13 audit recommendations, 2 were implemented, 3 were partially implemented, and 8 were not implemented. Unresolved issues included the Borough's failure to: (1) eliminate the provisions for health waiver benefit payments from future collective bargaining agreements in accordance with N.J.S.A. 40A:10-17.1; (2) implement procedures that enhance the administration and oversight of employee benefits, including appropriate approvals and authorizations; (3) develop standard employment contract templates with consistent and relevant contract terms and conditions, and details of employee benefits; (4) conduct a formal analysis of its stipends to ensure payments are reasonable; (5) modernize its record keeping for employee wage history and pay rate calculations; (6) draft and implement policies and procedures pertaining to the Borough's oversight of the Length of Service Award Program and verification of reported points; (7) draft formal policies and procedures pertaining to the use of Borough vehicles as well as expand the requirements of log books to include pertinent information; and (8) implement a process to assess taxable fringe benefits for employees' personal and commutation use of Borough-owned vehicles pursuant to Internal Revenue Service regulations.

Of significant concern, the Borough did not attempt to recover $95,000 in "gratuitous" vacation and sick leave payouts that were not required by employment contracts and continued to provide 55 annual vacation days or 11 weeks off a year to the Police Chief.

Township of Irvington

OSC's 2009 audit identified weaknesses in the Township's financial management practices. A follow-up review was conducted in 2011 and concluded that the Township had not fully implemented 13 of our 21 recommendations. After communicating with the Township and reviewing audit reports, OSC elected to perform an additional review of the Township's financial management practices as part of our monitoring process.

OSC's second follow-up review found that Irvington had made little progress in implementing the remaining recommendations. The review found the Township failed to: (1) maintain accounting records as required by N.J.A.C. 5:30-5.7; (2) implement adequate internal control policies and procedures for financial reporting; (3) conduct effective employee evaluations on a timely basis; (4) produce required financial information accurately and on a timely basis; (5) ensure that the Chief Financial Officer had an active Municipal Finance Officer Certificate as required by N.J.S.A. 40A:9-140.13; and (6) identify and prevent contractual relationships that create conflicts of interest between the Township and its officers and employees.

OSC made seven recommendations to improve the Township's operations and compliance with applicable statutes and regulations and directed the Township to submit written updates regarding its compliance with our recommendations every 90 days thereafter until further notice. In addition, OSC made a referral for possible ethics violations to the Local Finance Board within the Department of Community Affairs, Division of Local Government Services (DLGS) for their determination of any actions regarding violations of state ethics requirements. In addition to the recommendations and referral, and in accordance with N.J.S.A. 52:15C-11(b), OSC provided notification to the Governor, the President of the Senate, and the Speaker of the General Assembly of Irvington's failure to comply with a plan for corrective action. Lastly, in light of Irvington's continued failure to adhere

to the law and to implement measures to responsibly manage taxpayer funds, OSC recommended that the DLGS install a state fiscal monitor to ensure that Township officials come into compliance with corrective actions.

Policies and Procedures

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

Audit Manual

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

Audit Process Brochure

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

Risk/Priority Evaluation

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

Quality Control and Peer Review

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

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

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

Audit Coordination

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

Training

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

Investigations Division

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

Scott MacDougall is the Director of the Investigations Division and brings over 15 years of investigative experience to OSC. Prior to joining OSC in 2017, Mr. MacDougall worked as an attorney in the private sector representing clients in complex civil litigation and conducting investigations into suspected civil insurance fraud. The Division consists of a staff of investigators and attorneys—including former prosecutors and federal and state law enforcement professionals—whose diverse knowledge and skillsets bring added expertise and perspective. Staff members hold certifications such as Certified Inspector General, Certified Financial Crimes Investigator, and Certified Fraud Examiner.

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

Complaints and Referrals

In FY 2024, the Investigations Division fielded 2,009 tips. Tips fielded by the division resulted in referrals to a number of external agencies. In particular, the Investigations Division made 18 external referrals to other state, county, and federal agencies in FY 2024, among them were the United States Department of Justice, the New Jersey Department of Community Affairs, and the New Jersey Motor Vehicle Commission. The Investigations Division also referred matters to various units within the New Jersey Department of Law and Public Safety, including the Division of Criminal Justice, the Office of Public Integrity and Accountability, the Juvenile Justice Commission, and the Division on Civil Rights.

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

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

The Investigations Division also conducts inquiries based on incoming referrals from

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

Public Reports

The Investigations Division produced the following public reports in FY 2024:

The Approval Process for Compensation Paid to Three High-Level Union County Officials Violated the Plain Language of New Jersey's Optional Charter Law

OSC investigated Union County's processes for compensating its highest-paid officials and revealed that the County's methods violated state law. OSC's investigation found that three top Union County officials were compensated a total of $417,772 in extra stipends and/or tuition reimbursements, without following the public process required by the Optional County Charter Law (the OCCL), N.J.S.A. 40:41A-1 to 40:41A-149. OSC commenced this investigation following receipt of a confidential tip.

The OCCL required Union County to set the compensation of its top officials by way of ordinance, with public notice, hearing, and a vote. This investigation found that the County Manager and two department heads—the Director Finance and the Director of Public Works—received compensation above and beyond their base salaries that was not provided through the public process set forth in the OCCL. The County's failure to follow the process mandated by the OCCL and subject its compensation practices to public scrutiny may have undermined the public's trust in the operations of county government.

Emphasizing the importance of transparency in the compensation of public officials—particularly, highly compensated public employees—in preventing the misuse of taxpayer funds, OSC recommended that all counties subject to the OCCL, including Union County, strictly adhere to the requirements of the law by setting through ordinance all compensation paid to high-ranking officials and employees, whether the compensation is characterized as a base salary, stipend, bonus, benefit, fee, or tuition reimbursement. OSC also recommended that Union County update its internal policies, procedures, and memoranda related to compensation practices to make clear that all forms of compensation paid to commissioners, county executives, department heads, and other high-ranking county representatives must be approved by ordinance in advance.

As part of its investigation, OSC also directed Union County to create and submit a corrective action plan detailing how it would satisfy the OCCL's requirements for compensation previously paid to the high-level employees identified during the investigation. Despite OSC's clear directive, Union County failed to do so. Accordingly, pursuant to N.J.S.A. 52:15C-11(b), OSC provided notice to the Governor and legislative leadership of the County's refusal. As part of that notice, OSC recommended that the State withhold the expenditure of public funds that may be due to Union County. OSC also requested that the Department of Community Affairs direct Union County to seek approval from the Acting State Comptroller prior to issuing any payments to high-level county officials and employees in excess of their base salaries.

The Department of Corrections' Internal Affairs Unit Failed to Adequately Investigate Abuse Allegations

OSC's investigation into the Department of Correction's Special Investigations Division (SID)—a unit responsible for investigating and uncovering, among other things, allegations of

correctional police officer misconduct—revealed deficiencies in the thoroughness and objectivity of SID investigations. To conduct its investigation, OSC reviewed a 20 percent sampling of SID investigative case files from complaints involving allegations of assault, the use of excessive force, and violations of the Prison Rape Elimination Act by Department of Corrections (DOC) staff against incarcerated persons at three state correctional facilities—New Jersey State Prison, East Jersey State Prison, and Bayside State Prison (Bayside). The investigation was initiated upon receipt of multiple complaints asserting that SID's investigations and record-keeping practices were inadequate.

The investigation found that SID fell short in executing the basics of investigative practices. In 22 percent of the SID cases reviewed, the investigator failed to interview crucial witnesses, included incarcerated people who witnessed the incident under review and correctional police officers who were situated in close proximity to the subject officer at the time of the incident. In addition, many of the investigative files reviewed by OSC lacked recommended dispositions, increasing the risk that investigators failed to obtain the support necessary to justify their findings while simultaneously reducing the effectiveness of supervisory oversight. SID also engaged in inadequate evidence preservation. SID did not preserve key evidence, such as surveillance footage and records of interviews, in 13 percent of the files reviewed. It also struggled to locate evidence identified in investigative case files but not originally provided to OSC.

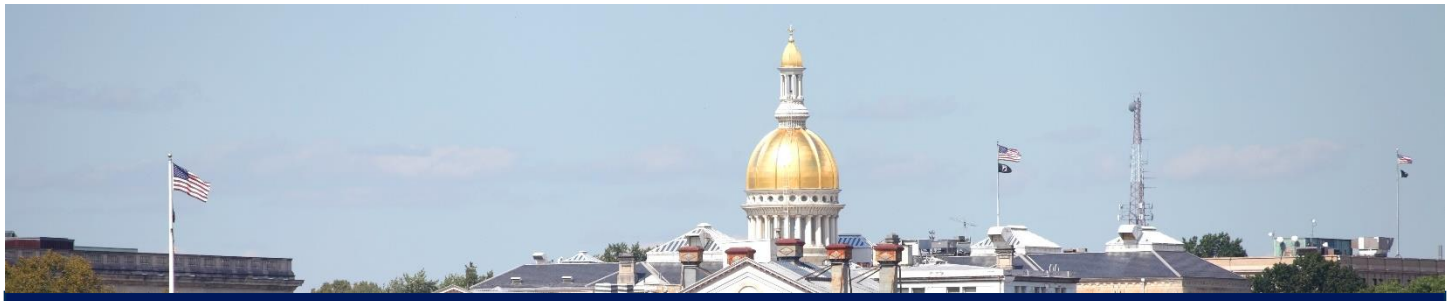
Two SID cases involving allegations of the use of excessive force highlighted the harms that result from the unit's inadequate investigations. In both cases, the available evidence strongly suggested that the correctional police officers' use of force was unjustified and that SID's investigation into those matters was deficient. In one incident, a correctional police officer struck an incarcerated person in the face multiple times and subsequently wrestled him to the ground, but surveillance video of the incident did not show any visible provocation or threat against the officer. The second incident involved a correctional police officer administering pepper spray on an inmate despite the absence of any provocation on the part of the inmate. Neither of these cases were thoroughly and objectively investigated. In fact, the investigator in the first case conducted an interview of the officer that appeared designed to exonerate him. The investigator in the second matter failed to interview a correctional police officer who was situated mere feet from the incident. As a result, the correctional police officers involved were not disciplined while the incarcerated persons were.

Through the course of its investigation, OSC identified three factors that contributed to SID's investigative deficiencies. First, law enforcement's code-of-silence culture—the tendency of officers to protect each other and the belief that they will not participate honestly in an investigation—very likely contributed to SID's failure to interview critical witnesses. Second, SID's policies and procedures governing investigative activity did not provide comprehensive direction on how to conduct investigations or maintain evidence, resulting in a grant of broad discretion in how each investigator conducted an investigation. Third, a lack of complete and regular training also contributed to the inadequacy of SID investigations.

At the conclusion of its report, OSC issued eleven recommendations to improve SID's operations and ensure public trust in its internal affairs process. Among other things, OSC recommended DOC: (1) re-open and re-examine the two incidents identified above and ensure that all witnesses are identified and interviewed; (2) formulate detailed policies and checklists to

standardize SID investigations and implement the New Jersey Attorney General's Internal Affairs Policies and Procedures (IAPP); (3) create and implement an objective and comprehensive oversight program that includes additional independent oversight from the Office of the Corrections Ombudsperson; (4) implement comprehensive training programs for new and current SID investigators; (5) increase public transparency about the complaint management process and outcomes of SID investigations by posting such metrics on DOC's website; and (6) engage in external recruitment by opening SID investigator positions to law enforcement officers outside DOC as a means to enhance objectivity. OSC also referred the findings from this investigation to the Office of the Corrections Ombudsperson so that it can monitor SID's compliance with its own internal policies and the IAPP, review SID files to ensure the investigations are adequate, and take any other action it deems warranted.

All told, the investigation underscored the need for comprehensive reforms in SID's processes and practices to ensure thorough, objective, and fair investigations into correctional police officer misconduct. These reforms are necessary to enhance oversight, accountability, and public trust in DOC's internal affairs operations.



Medicaid Fraud Division

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

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

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

- New Jersey's Medicaid program provides health insurance to qualifying parents and caretakers and their dependent children, along with pregnant 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 2024, 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 parties that contract with the Medicaid program to provide 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.

One example of MFD's oversight includes a review MFD conducted to identify adult medical day care (AMDC) providers who improperly billed the Medicaid program. Following this review, OSC published a report that identified 21 AMDCs that violated Medicaid regulations by (1) impermissibly billing for more than five days in a week; (2) billing for services supposedly provided to a beneficiary while that same beneficiary was actually receiving treatment in an inpatient facility such as a hospital; and/or (3) billing for services provided to a beneficiary while a different AMDC also billed for the same services to the same beneficiary on the same date. From this review, OSC identified approximately $1 million in improperly spent Medicaid funds, and thus far, has recovered almost all of these funds. The improprieties that MFD identified demonstrated that these AMDCs engaged in a pattern of conduct that ranged from careless mistakes to fraudulent billing errors. These errors also have potential implications for the quality of care provided by these AMDCs. OSC recommended systemic fixes to AMDCs and to the State Medicaid Agency and the Medicaid MCOs that paid these improper claims and is continuing to pursue recoveries for these improperly spent Medicaid funds. MFD continues to work with the MCOs and the Medicaid program to implement systemic fixes.

MFD's FY 2024 Statistics

In FY 2024, MFD recovered or facilitated in the recovery of more than $119.2 million in improperly paid Medicaid funds, with slightly more than $109.2 million of that attributable to third party liability (TPL) recoveries from third party insurance carriers and the remainder, more than $9.9 million, attributable to MFD's audits, investigations, and other data-based recovery efforts. Those funds were returned to both the state and federal budgets. MFD also excluded 277 providers from participating in the Medicaid program this past fiscal year.

MFD received 2,022 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 OSC resulted in some type of action, up to and including opening an investigation. Pursuant to its internal processes, MFD staff members reviewed the substance of the complaints to determine whether MFD should initiate an investigation or take other steps, including but not limited to referring a matter to a more 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, 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 109 high-risk provider applications and performed 582 individual background checks. In addition, the division referred 29 cases to the Medicaid Fraud Control Unit (MFCU) within the state Office of the Attorney General and an additional 143 matters to other civil and criminal enforcement entities, including county prosecutors' offices and the state Department of Treasury, Division of Taxation.

As part of its educational outreach program, MFD presents training programs to a wide variety of providers, including behavioral health, long-term care, medical day care, and other providers/practitioners.

In FY 2024, MFD collaborated with the Division of Consumer Affairs (DCA), DMAHS, the Medicaid MCOs, and MFCU to host a virtual educational training for New Jersey Pharmacy providers. This presentation was designed to educate Medicaid providers to be better equipped to identify and protect against fraud, waste, and abuse. Speakers underscored the importance of properly keeping and maintaining pharmacy records and invoices, reviewed responsible billing practices, discussed compliance with the Drug Supply Chain Security Act and the New Jersey Prescription Monitoring Program, and emphasized taking proactive steps to identify, prevent, and properly address Medicaid fraud, waste, and abuse.

MFD's oversight focuses on Medicaid health care providers, MCOs and Medicaid recipients, while coordinating oversight efforts among all state agencies that administer Medicaid program services. As part of these efforts and to fulfill a federal mandate, MFD ensures that entities that receive or make payments of $5 million or more in Medicaid funds assist in the prevention and detection of fraud, waste, and abuse within the program. Each year, applicable entities are required to certify compliance with Section 6032 of the federal Deficit Reduction Act by attesting that they have in place appropriate fraud, waste, and abuse policies and procedures. Using this information, MFD selects a sample of these entities to perform a documentation review. In calendar year 2024, MFD identified 223 parent entities (2,266 individual providers) that were required to certify through this process. Of those entities, 38 established Corrective Action Plans (CAPs) to address deficiencies.

What follows is an overview of MFD's work in FY 2024. A summary of all of MFD's individual settlements, notices of overpayments, and audits is included as an Appendix to this report.

Data and Fiscal Integrity Unit

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

Data Mining Unit

MFD's Data Mining Unit monitors Medicaid claims data and other information to detect fraud, waste, and abuse and, in collaboration with relevant Medicaid stakeholders, works to ensure that the data is sufficiently reliable for MFD to use in its audits and investigations. As such, the Data Mining Unit is involved in various stages of the process leading to the recovery of improperly paid Medicaid dollars. The Unit

employs numerous analytical techniques to detect atypical or unusual claims submitted by providers. In order to identify patterns of anomalous Medicaid reimbursements, MFD's data miners review Medicaid fraud reports and investigations from federal and state oversight bodies and analyze a range of additional resources to acquire pertinent data. The Data Mining Unit also monitors the Surveillance and Utilization Review System, a federally mandated exception reporting system, for indications of fraud, waste, and abuse and to detect duplicate, inconsistent, or excessive claim payments.

In total, MFD's Data Mining Unit referred 32 cases of anomalous claims behavior to the Audit/Investigation Units and generated 116 reports for use by these units in FY 2024. In addition, the Unit prepared 33 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 extrapolates the audit/investigative findings to calculate final overpayment amounts for recovery. This Unit also performs statistical analysis on a variety of projects including determining the widespread impact, and potential savings to the Medicaid program, of MFD's audits and investigations.

Audit Unit

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

MFD audited a spectrum of Medicaid providers, including durable medical equipment (DME) providers, independent clinical laboratories, and intensive in-community mental health providers. Two of these audits are particularly noteworthy.

MFD audited RDx BioScience, Inc. (RDx), an independent clinical laboratory provider located in Kenilworth. Clinical laboratory services are comprised of professional and technical laboratory services provided by an independent clinical laboratory performed in response to requests from physicians or other licensed practitioners. In this audit, MFD found that for 29 of the 120 episodes (24.2 percent) in one sample and 61 of the 104 claims (58.7 percent) in another sample, RDx billed for tests in violation of state regulations. OSC found that these deficient claims lacked required supporting documentation, lacked a physician or other licensed practitioner's signature, or referenced a referring physician who had ceased treating patients at the referring facility. Further, during the pendency of MFD's audit, MFD became aware of federal criminal and civil actions filed against RDx and its owner for an array of wire fraud and kickback charges. The federal civil action against RDx resulted in a settlement agreement with the federal government. MFD also reached a settlement with RDx, recovering all of the overpayments MFD had identified in its audit, $1,462,605, and a civil penalty of $1,472,372.

In its audit of Sokkyun Yi, LCSW, a children's mental health rehabilitation and behavioral assistance services provider located in Princeton, MFD found that Yi failed to support approximately 54 percent of his Medicaid

claims. As a result, MFD found that Yi overbilled the Medicaid program $1,795,277 and that he placed children at risk by not ensuring that his employees, who worked with children, had undergone required training, education, and criminal background checks. OSC found that Yi's records contained numerous other deficiencies such as, records that contained inaccurate or conflicting information, documentation for services that could not be substantiated, billing for more expensive care than was provided (upcoding), and claims for services that overlapped with other billed services.

Third Party Liability Unit

Under federal law, if a Medicaid recipient has other insurance coverage, Medicaid, as the payer of last resort, is responsible for paying the medical benefits only in cases in which the other coverage has been exhausted or does not cover the service at issue. Thus, a significant amount of the State's Medicaid recoveries are the result of the efforts of MFD and its contracted vendor to obtain payments from third-party insurers responsible for services that were inappropriately paid with Medicaid funds. MFD's Third Party Liability (TPL) Unit, working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and recovers money from private insurers or providers in cases where Medicaid has paid claims for which the private insurer was responsible. In addition, the TPL Unit also manages a daily hotline for the public and providers to call and update third-party commercial insurance information for Medicaid recipients and ensure that Medicaid recipients receive their benefits when improperly denied. MFD's TPL Unit reviews, oversees, and coordinates audit work performed by the State's TPL contractor. In FY 2024, MFD recovered more than $109.2 million from third parties.

In addition to overseeing TPL recoveries, the TPL Unit also handles the MFD hotline. MFD receives questions and allegations of fraud, waste, and abuse from many sources, including MFD's hotline and webpage as well as from other state and federal agencies. In total, MFD received 2,022 hotline intakes in FY 2024. 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. In FY 2024, the Investigations Unit opened 415 cases and made 172 referrals to other agencies such as the MFCU, state licensing boards, county prosecutors' offices, and various county boards and social services entities.

To ensure the integrity of Medicaid's enrollment process, the Investigations Unit also conducts background checks of high-risk providers applying to participate in the program. In FY 2024, the Investigations Unit reviewed 109 such applications from high-risk providers – DME, prosthetics and orthotics, and home healthcare agencies, for which MFD performed 582 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, 118 site visits in FY 2024. During the site visits, MFD investigators verify that the applying entity actually exists at the address listed, that it complies with state and federal requirements, and that the information supplied on the provider application is accurate. When the Investigations Unit uncovers patterns of fraud, waste, or abuse, in addition to addressing such actions by seeking to recover from the appropriate parties, it

recommends programmatic fixes to improve systemic oversight and thereby prevent such activity from reoccurring. In FY 2024, the work of the Investigations Unit resulted in the recovery of approximately $4.2 million in misspent Medicaid funds, which includes recoveries resulting from MFD investigations of providers and provider self-disclosures of their overpayments.

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. Regulatory and Exclusions may seek to exclude providers for numerous reasons, including 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 2024, MFD excluded 277 unique providers – including physicians, pharmacists, dentists, nursing home owners and administrators, social workers, and home care nurse's aides – for failing to meet the standards for integrity in the Medicaid program.

If you suspect Medicaid fraud, waste, or abuse:

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

Procurement Division

OSC's Procurement Division, staffed by attorneys specializing in public contract law, fulfills the office's statutory mandate to review public agency procurements from more than 1,900 public entities. In FY 2024, the Procurement Division received notice of 901 contracts, including 233 contracts that were valued at more than $12.5 million and pre-screened pursuant to OSC's statutory authority.

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

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

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

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

OSC's procurement reviews cover contracts awarded by municipalities, school districts, state colleges and 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.

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

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

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

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

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

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

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

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

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

federal reconstruction resources connected to Superstorm Sandy.

The division is also responsible for posting the procurements it reviewed pursuant to these executive orders on the state's COVID-19 Transparency website and OSC's Sandy Transparency website. As a result, in FY 2024, the Procurement Division reviewed a variety of purchasing practices that otherwise would have been below OSC's statutory monetary threshold for review.

The division reviews proposed procurements subject to Executive Orders 166 and 125 on an expedited basis, providing guidance and feedback to agencies to ensure compliance with public contracting laws without sacrificing expediency in the state's recovery process. In FY 2024, the division pre-screened 130 procurements pursuant to Executive Order 166 and took corrective action in 58 percent of those procurements. The division also pre-screened 29 procurements pursuant to Executive Order 125 and took corrective action in 38 percent of those procurements.

Of the 901 contracts submitted for review in FY 2024, 233 of them were valued at more than $12.5 million and were pre-screened pursuant to OSC's regular statutory authority. OSC attorneys took corrective action in 66 percent of those pre-screened contracts to ensure the legality of the procurement process. Altogether, the Division pre-screened 392 contracts for compliance with applicable law.

Some notable contracts reviewed include: the $140 million construction contract for the Shreiber School of Veterinary Medicine, New Jersey's first veterinary degree program at Rowan University. OSC also reviewed a construction contract for the Hudson County Community College's Center for Success. This $96.3 million project in Jersey City's Journal Square is partially funded by the federal American Rescue Plan Act of 2021. As part of the post-Superstorm Sandy resiliency program, OSC reviewed New Jersey Transit's $211 million Long Slip Fill and Rail Enhancement Project at the barge canal adjacent to the Hoboken Yard Terminal.

Contract reviews pursuant to Executive Order 166 covered a variety of goods and services including construction of a new visitor center at Washington Crossing State Park, public service announcements regarding access to COVD-19 vaccinations, and additional funding for suicide prevention, families, and at-risk youth made available through the Department of Children and Families.

The Procurement Division received 509 contracts valued between $2.5 million and $12.5 million. For these post-award reviews, OSC evaluates whether the contracting unit complied with the appropriate procurement process and provides guidance to assist the contracting unit with correcting errors in the future.

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

Public Letter

Hudson County's Procurement of Healthcare Management Services at the Hudson County Jail Violated State Procurement Law

In March 2024, the division issued a significant public letter directing Hudson County not to proceed with a contract award of $13.5 million to a prison healthcare management company because the County used an improper procurement process lacking open competition and transparency. OSC also found that the

County disregarded OSC's statutorily established oversight for pre-advertisement review of contracts with an expected value over $12.5 million. Disregarding important public bidding requirements, as the County did here, threatens to erode public confidence in public bidding laws.

Educational Outreach

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

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

COVID-19 Compliance and Oversight Project

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

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

The COVID-19 Project regularly interfaces with state and local government units on matters of oversight and compliance. This includes ongoing communication with the State's Accountability Officers – senior officials within agencies, departments, and authorities responsible for the oversight of COVID-19 recovery funding disbursement and administration. It also involves outreach to officials in municipalities and counties in New Jersey that have received COVID-19 recovery funds. In FY 2024, the COVID-19 Project has continued to provide state and local governments with timely reminders on compliance issues. The COVID-19 Project conducted a training for State agencies on avoiding duplication of benefits in public funding – a crucial requirement to ensure that federal funds are used efficiently and fairly. Additionally, in FY 2024, the COVID-19 Project provided training on compliance with federal grant requirements and reporting, specifically tailored for purchasing and procurement agents of local governments.

This fiscal year, the COVID-19 Project continued its work overseeing the State's contracted Integrity Oversight Monitors. Integrity Monitors are independent monitors deployed throughout the state to assist state entities with establishing programs, managing grants, or administering programs (Category 1 and 2 Integrity Monitors), or to oversee and monitor the use of COVID-19 recovery funds and check for non-compliance or fraud, waste, or abuse (Category 3 Integrity Monitors). The Integrity Oversight Monitoring program is integral to the State's accountability infrastructure and is intended to aid in a more transparent and effective recovery. The COVID-19 Project oversees these engagements, select deliverables, and the quarterly Integrity Monitor

reports to help maximize the value to the State and to identify or intervene in any issues requiring follow-up or corrective action. This work has led to follow-up reviews of agency programs and interfaces 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.

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

Through ongoing monitoring and targeted reviews, the COVID-19 Project has addressed issues involving reporting, proper internal controls, policies and procedures, duplication of benefits, the use of self-attestations and other fraud risks, documentation requirements, and more.

Public Reports

The COVID-19 Project produced the following public report in FY 2024:

An Investigation of Essex County's COVID-19 Vaccination Program

The COVID-19 Project conducted an investigation into Essex County's $40 million COVID-19 vaccination program, uncovering significant shortcomings, including inadequate oversight of expenditures and multiple violations of procurement rules. The investigation revealed that the County improperly awarded millions of dollars to vendors through emergency contracts without public bidding. These contracts were not properly procured under state law, the County's own procurement code, or in some cases under the federal procurement rules, potentially jeopardizing millions in federal grant funds. The County failed to properly oversee its contracts, leading to unsupported payments which likely increased overall costs for taxpayers. In one case, the County overpaid a vendor more than $100,000, which was only uncovered by the COVID-19 Project during its investigation. Compounding the error, and despite the clear overpayment, the County allowed the vendor to repay the money interest-free over a generous five-year term instead of demanding an immediate repayment.

Oversight of the over 800 individuals who worked at the vaccination sites was similarly inadequate, leading to insufficient timekeeping and cost verification. The County spent $17 million on staffing costs alone, yet it did not have effective policies and controls to ensure that these expenditures were accurate. The COVID-19 Project found that workers were able to log their hours remotely from any device, and there was no enforcement of back-up controls to confirm whether workers were actually present on-site. Despite the County's early discovery that some workers were logging hours without being at the vaccination sites, it failed to make systemic changes to its timekeeping practices to address this loophole or initiate a broader investigation to discover if the abuse was more widespread. The COVID-19 Project itself conducted a limited review of these staffing costs and discovered hundreds of thousands of dollars of highly questionable payments and other irregularities. These included money paid to individuals despite adequate support for the time worked and the identification of individuals who worked for the vaccination program during hours that they held

full-time jobs for other employers. The County also failed to adequately evaluate whether the workers were correctly classified as independent contractors, which could lead to significant penalties for the County.

As a result of the investigation, OSC made referrals to the state Department of Labor and Workforce Development and other appropriate agencies to address the findings in the report.

Police Accountability Project

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

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

Public Reports

The Police Accountability Project produced the following investigative reports in FY 2024:

The High Price of Unregulated Private Police Training to New Jersey

OSC initiated an investigation into Street Cop Training (Street Cop or the Company) after receiving information that public funds were spent to send New Jersey police officers to a six-day conference in October 2021 in Atlantic City that trained officers on questionable policing tactics and contained offensive and discriminatory content (the Conference). At the time the Report was issued, Street Cop was a New Jersey-based company that billed itself as one of the country's largest police training companies.

Nearly 1,000 police officers attended the Conference, some 240 from New Jersey, the majority paying with public funds. Private, post-academy police training has virtually no regulation. Neither the Attorney General, Police Training Commission, nor any other public entity determines what private vendors like Street Cop can teach. Reviewing hours of Street

Cop video footage and internal documents, as well as conducting interviews with scores of witnesses, OSC's Police Accountability Project found the lack of oversight allowed for alarming deficiencies in the training, including:

- More than 100 discriminatory and harassing comments were made, with speakers discussing the size of their genitals, displaying lewd images, and making demeaning quips about women and minorities.

- Instructors, some of them active New Jersey police officers, advocated stopping motorists for no reason or illegally prolonging stops. If employed, these tactics could violate people's civil rights and be unconstitutional under both federal and New Jersey laws.

- Some instructors promoted a "warrior" approach to policing and dehumanized civilians, referring to certain groups as "the pieces of shit of society" and using offensive memes.

Street Cop, which described this event as "standard fare," produced records showing that the 240 New Jersey officers who attended the training came from 77 municipal police departments, 6 county agencies, 1 interstate agency, and 4 state agencies, including the New Jersey State Police. OSC independently confirmed that 3 county agencies, 48 municipal police departments, 1 interstate agency, and 2 state agencies (including the New Jersey State Police), spent public funds on the Conference.

More than $75,000 in public funds was spent, not including paid time off or paid training days, but the actual amount could not be determined. Street Cop records were incomplete and inaccurate. For instance, its records said it received roughly $320,000 from various New Jersey law enforcement agencies for other trainings held between 2019 and 2022, but OSC investigators found that the actual amount was at least double that.

The cost to New Jersey could be even higher, as Street Cop presenters promoted the kinds of tactics and behaviors that can prompt multi-million dollar lawsuits for excessive force, unlawful searches and seizures, and workplace harassment and discrimination.

The Conference was only one of many trainings conducted by Street Cop in New Jersey. At the time of OSC's investigation, the Company's founder reported that the Company annually conducted 40 to 45 courses in New Jersey, training more than 2,000 New Jersey State and local law enforcement officers every year.

OSC made nine recommendations and also sent referrals to the Attorney General, the Division on Civil Rights, and other agencies for further investigation.

OSC's recommendations included: (1) consideration by the Legislature of whether to establish a robust licensing regime for private police training in New Jersey; (2) consideration by the Attorney General of whether to issue law enforcement directives regarding re-training of officers who attended the Conference; (3) whether the fact of any officer's attendance at or involvement in the Conference may need to be disclosed to comply with any criminal discovery obligations; (4) or whether the Police Training Commission should oversee post-academy training, including establishing uniform standards and reviewing and approving training courses; (5) law enforcement agencies should scrutinizing training programs before spending public funds on them; (6) and should prohibit officers from using their agency name to bolster the credibility of an instructor, particularly when the agency has not reviewed the training materials or presentation; (7) law enforcement agencies that expended public

funds on the Conference should consider whether to issue a refund; (8) law enforcement agencies should require officers to report to their agencies any work-related training received, regardless of whether that training was self-paid or received during paid time off; and (9) law enforcement officers who attended the Conference should voluntarily self-report to their agencies and turn in any copies of Street Cop's reasonable suspicion checklist.

Ninth Review on Law Enforcement Professional Standards: New Jersey State Police, Office of Law Enforcement Professional Standards Failed to Comply with Key Reforms

The Law Enforcement Professional Standards Act of 2009 (LEPSA) directs OSC to conduct annual reviews of the NJSP and OLEPS to evaluate their compliance with the law. In July 2023, the Attorney General released an independent report by an outside expert, which found "strong empirical evidence" of discrimination against Black and Latinx/Hispanic motorists.

As a result, for its Ninth Review, OSC elected to delve deeper into the effectiveness of the NJSP's risk management process, which includes the Risk Analysis Core Group (RACG), a team of civilian analysts, and the NJSP's Risk Management Advisory Panel. Made up largely of high-level NJSP officials, the Panel is charged with examining RACG data analyses and determining if, when, and how to intervene to eliminate risks of biased policing.

Interviews and meeting minutes showed that for years, the Panel was repeatedly presented with detailed data-driven analyses showing trends similar to those flagged in the July 2023 report. An in-depth, 85-page December 2021 internal memorandum from OLEPS documented law enforcement patterns that reflected persistent and significant disparities across racial and ethnic groups in motor vehicle stop data over a ten-year period. OLEPS said it repeatedly requested the NJSP to offer any "organizational, environmental, or contextual" information to explain these trends, but most times, the NJSP "provide[d] little or limited responses."

Beyond that, OSC found NJSP leaders apparently never took a single vote or recommended a single initiative to address these ongoing, troubling, and well-documented trends. The NJSP also made clear its longstanding refusal to consider implicit bias as a possible explanation for such data trends even when unable to identify anything else that would credibly explain the data showing disparate treatment of ethnic and racial minority motorists.

OSC's review also identified several other deficiencies, including:

- In mid-2021, the NJSP's computer-aided dispatch and records management system was replaced, and the new system routinely failed to accurately record the race and ethnicity of drivers for more than two years. The RACG continued to analyze the data – even while acknowledging in documents that "the true increase or decrease in the race/ethnicity" was unknown. None of this was adequately communicated to the public. The failure of the NJSP to collect accurate data also meant that the NJSP and OLEPS could not conduct the analyses needed to evaluate whether discrimination was occurring.

- OLEPS was remarkably effective at identifying data trends that required examination and explanation from NJSP. But when NJSP failed repeatedly to respond to inquiries with reasonable explanations or at all in some cases,

OLEPS tended to acquiesce and did not raise the alarm to the Attorney General. OSC found OLEPS generally approached its role more as a collaborator, rather than an objective oversight entity with significant authority.

- The NJSP reported that since the Consent Decree, of the approximately 60 race-based complaints a year made against troopers, none was deemed substantiated. The NJSP denied OSC access to the investigative files related to complaints so OSC was unable to evaluate the effectiveness of this process.

Both OLEPS and the NJSP impeded OSC's ability to complete a comprehensive review in a variety of ways. To address this issue with cooperation and remedy the other problems identified through the review, OSC determined significant corrective action by NJSP and OLEPS was needed. Among other things, the recommended corrective action included both agencies working with the Attorney General to update the operational definition of unacceptable discrimination to explicitly include implicit bias; to update policies and processes for identifying and responding to data disparities in police-civilian encounters in which racial and ethnic minority motorists may be, and historically have been, disproportionally impacted; to adopt a policy that will ensure an "arms-length" relationship between NJSP and OLEPS; and to fully cooperate with OSC reviews as contemplated by LEPSA.

Survey Initiative

OSC's Survey Initiative is an interdisciplinary special project within OSC that works to detect fraud, waste, and abuse in local governments exercising Executive Branch authority. Using OSC's investigatory powers and authority to conduct performance reviews, the Survey Initiative surveys local governments as a data collection tool to examine local government policies and practices. The collection of such data allows OSC to determine if there are any specific or systemic failures at the local or state government level that allow for fraud, waste, or abuse, or non-compliance with state laws and regulations.

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

Conforming Sick and Vacation Leave Policies for New Jersey Municipalities

On July 7, 2022, OSC issued *A Review of Sick and Vacation Leave Policies in New Jersey Municipalities*, which examined the policies, ordinances, and contracts of 60 municipalities to determine if they implemented the cost-savings measures required by law.

As a result of the municipalities' significant failure to conform policies and practices to existing state law, OSC required that 57 municipalities provide a corrective action plan (CAP) to address those failures. Each municipality was to provide the specific course of action – whether to change the policy manual, to amend an ordinance, or to remove the provision from various employment contracts. The municipalities, as part of the CAP, were also to provide a timeframe in which such corrective actions were to be completed.

Of the CAPs received, 24 of 57 were satisfactory; 15 were initially deficient but corrected; 9 were in the process of correcting deficiencies and have since corrected them, and 9 failed to respond to OSC's directive to submit a CAP.

OSC made multiple attempts to obtain a CAP from the above-noted nine municipalities. After their refusal to do so, OSC notified the Governor and legislative leadership of those municipalities' lack of cooperation pursuant to N.J.S.A. 52:15C-11(b). Subsequent to the letter's submission, the nine municipalities provided corrective action plans that OSC deemed acceptable.

Appendix – MFD Settlements & Audits

Settlement Agreement/ Overpayment Letter Case Summaries

2nd Home Union City Operations, LLC
Settlement Agreement (7/7/2023)

MFD resolved a review of 2nd Home Union City Operations, LLC (2nd Home Union), located in Union City, New Jersey, with 2nd Home Union agreeing to repay the Medicaid program $43,905. MFD found that some claims that 2nd Home Union submitted from January 1, 2017 through May 31, 2022 were improper because they were for medical day care services rendered: (1) while the recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; (2) in excess of five days per week; and/or (3) while the recipients were receiving services from another adult medical day care (AMDC) provider, and in violation of the applicable regulatory requirements.

2nd Home Sweet Home Operations, LLC
Settlement Agreement (7/7/2023)

MFD resolved a review of 2nd Home Sweet Home Operations, LLC (Home Sweet Home), located in Elizabeth, New Jersey, with Home Sweet Home agreeing to repay the Medicaid program $9,173. MFD found that some claims that Home Sweet Home submitted from January 1, 2017 through May 31, 2022 were improper because they were for medical day care services rendered: (1) while the recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; (2) in excess of five days per week; and/or (3) while the recipients were receiving services from another AMDC provider, in violation of the applicable regulatory requirements.

2nd Home Newark Operations, LLC
Settlement Agreement (7/7/2023)

MFD resolved a review of 2nd Home Newark Operations, LLC (2nd Home Newark), located in Newark, New Jersey, with 2nd Home Newark agreeing to repay the Medicaid program $15,584. MFD found that some claims that 2nd Home Newark submitted from January 1, 2017 through May 31, 2022 were improper because they were for medical day care services rendered: (1) while the recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; (2) in excess of five days per week; and/or (3) while the recipients were receiving services from another AMDC provider, in violation of the applicable regulatory requirements.

Greenwood House Home for the Jewish Aged
Settlement Agreement (7/19/2023)

MFD resolved a review, conducted by its TPL vendor, Health Management Systems, Inc. (HMS), of Greenwood House Home for the Jewish Aged (Greenwood House), located in Ewing, New Jersey. Through this review, HMS determined that Greenwood House improperly received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments between February 1, 2018 and July 31, 2021 to which Greenwood House was not entitled. Greenwood House agreed to repay the Medicaid program $181,932.

The Care Factory, Inc.
Overpayment Letter (7/19/2023)

MFD reviewed claims submitted by The Care Factory, Inc. (TCF), located in Haledon, New Jersey. MFD identified three categories of claims in which TCF improperly submitted claims and received Medicaid overpayments that it must repay: (1) claims submitted while recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; (2) claims that exceeded five days per week; and (3) claims while the recipients were receiving services from another AMDC provider. TCF repaid $17,597 to the Medicaid program.

Jefferson Cherry Hill Hospital
Settlement Agreement (7/20/2023)

MFD resolved an investigation of Jefferson Cherry Hill Hospital (Jefferson Cherry Hill), located in Cherry Hill, New Jersey. Through this investigation, MFD found that, between January 1, 2016 and April 25, 2021, Jefferson Cherry Hill improperly billed and was reimbursed by both Medicaid Fee for Service and a Medicaid Managed Care for claims for the same services for the same patients on the same service dates. Jefferson Cherry Hill agreed to repay the Medicaid program $206,659.

Trucare Adult Medical Day Care
Overpayment Letter (7/20/2023)

MFD reviewed claims submitted by Trucare Adult Medical Day Care, located in Clifton, New Jersey. MFD determined that, from March 18, 2020 through October 31, 2021, Trucare Adult Medical Day Care improperly submitted claims for AMDC services for beneficiaries who were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center. Trucare Adult Medical Day Care repaid the Medicaid program $1,230.

Always Caring Health Care Services, LLC
Overpayment Letter (7/21/2023)

MFD reviewed claims submitted by Always Caring Health Care Services, LLC (Always Care), located in West New York, New Jersey. MFD determined that, during the review period of July 1, 2018 through March 31, 2023, Always Care improperly submitted at-home based claims using code T1019 for services provided to beneficiaries while these beneficiaries had in-patient status in a hospital setting, nursing facility, residential health care facility, or an assisted living facility. Always Care repaid the Medicaid program $11,758.

Garbis Baydar, MD
Overpayment Letter (7/25/2023)

MFD reviewed claims submitted by Garbis Baydar, MD, a physician located in Englewood, New Jersey. MFD determined that, from April 1, 2018 through April 6, 2023, Dr. Baydar improperly billed and received payments totaling $1,064 for improperly billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative

medicine services. Dr. Baydar repaid the Medicaid program $1,064.

All About Care, LLC
Overpayment Letter (8/8/2023)

MFD reviewed New Jersey Medicaid claims submitted by All About Care, LLC (About Care), located in Brick, New Jersey, during the review period of July 1, 2018 through March 31, 2023. MFD found that About Care improperly submitted at-home based claims using code T1019 for services provided to beneficiaries while these beneficiaries had in-patient status in a hospital setting, nursing facility, residential health care facility, or an assisted living facility. About Care repaid the Medicaid program $17,988.

Sunshine Adult Day Health Care Center
Overpayment Letter (8/10/2023)

MFD reviewed claims submitted by Sunshine Adult Day Health Care Center (Sunshine), located in Bergenfield, New Jersey. MFD identified three categories of claims in which Sunshine improperly submitted claims for which it received Medicaid overpayments: (1) billing for medical day care while recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center; (2) billing for more than five days per week; and (3) billing while the recipients were receiving services from another AMDC provider. Sunshine repaid the Medicaid program $14,573.

Green Acres Rehab and Nursing LLC
Settlement Agreement (8/10/2023)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Green Acres Rehab and Nursing LLC d/b/a Complete Care at Green Acres (Green Acres), located in Toms River, New Jersey. Through this review, HMS determined that, for the period between February 1, 2018 and July 31, 2021, Green Acres improperly received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments to which Green Acres was not entitled. Green Acres agreed to repay the Medicaid program $183,028.

Women Physician LLC / Gehan Ibrahim, MD
Overpayment Letter (8/23/2023)

MFD reviewed claims submitted by Women Physician LLC/ Gehan Ibrahim, MD (Dr. Ibrahim), a physician located in Jersey City, New Jersey. MFD determined that, from April 1, 2018 through April 13, 2023, Dr. Ibrahim improperly billed and received payments for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Dr. Ibrahim repaid the Medicaid program $563.

New Beginnings Adult Day Care
Overpayment Letter (8/23/2023)

MFD reviewed claims submitted by Manav LLC d/b/a New Beginnings Adult Day Care (New Beginnings), located in Hamilton, New Jersey. During the review period of March 18, 2020 through October 31, 2021, MFD found that New Beginnings improperly submitted claims for medical day care services while recipients were admitted to an inpatient facility, such as a hospital or skilled nursing/long term care center, in violation of N.J.A.C. 10:164-1.5. New Beginnings repaid the Medicaid program $220.

Walter J Lewit Drugs
Overpayment Letter (9/5/2023)

MFD completed a review of Medicaid claims submitted by RMN Inc. d/b/a Walter J Lewit Drugs (RMN), located in Newark, New Jersey, for the period of January 1, 2018 through December 31, 2019. Through this review, MFD identified claims submitted by RMN that were not supported by pharmaceutical wholesaler/

supplier invoices or transfer records. RMN repaid the Medicaid program $23,978.

Bergen Pharmacy - Siddhi Priya
Overpayment Letter (9/5/2023)

MFD completed a review of Medicaid claims submitted by Siddhi Priya d/b/a Bergen Pharmacy (Siddhi Priya), located in Elizabeth, New Jersey, between January 1, 2018 through December 31, 2019. MFD's review identified claims submitted by Siddhi Priya that were not supplied by pharmaceutical wholesaler/ supplier invoices or transfer records. Siddhi Priya repaid the Medicaid program $5,943.

Bergen Pharmacy – Vakratunda
Overpayment Letter (9/5/2023)

MFD completed a review of Medicaid claims submitted by Vakratunda Inc. d/b/a Bergen Pharmacy (Vakratunda), located in Newark, New Jersey, for the period of January 1, 2018 through December 31, 2019. MFD identified claims submitted by Vakratunda that were not supported by pharmaceutical wholesaler/ supplier invoices or transfer records. Vakratunda repaid the Medicaid program $2,926.

Bergen Pharmacy – Siddhi Vinayak
Overpayment Letter (9/5/2023)

MFD completed a review of Medicaid claims submitted by Siddhi Vinayak d/b/a Bergen Pharmacy (Siddhi Vinayak), located in Newark, New Jersey, for the period of January 1, 2018 through December 31, 2019. MFD's review identified claims submitted by Siddhi Vinayak that were not supported by pharmaceutical wholesaler/supplier invoices or transfer records. Siddhi Vinayak repaid the Medicaid program $15,579.

Cellvio Biomedical LLC
Overpayment Letter (9/7/2023)

MFD reviewed claims submitted by Cellvio Biomedical LLC, a laboratory located in Raritan, New Jersey. MFD determined that, from July 30, 2021 through April 30, 2023, Cellvio Biomedical LLC improperly billed and received payments totaling $11,422 for billing COVID-19 add-on codes without any COVID-19 high-throughput claims in the previous month to qualify for this add-on payment. Cellvio Biomedical LLC repaid the Medicaid program $11,422.

Charles Uzoaru, MD
Overpayment Letter (10/23/2023)

MFD reviewed claims submitted by Charles Uzoaru, MD, a physician located in East Orange, New Jersey. MFD determined that, from June 1, 2018 through February 13, 2020, Dr. Uzoaru improperly billed and received payments for preventative medicine, individual counseling and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Dr. Uzoaru repaid the Medicaid program $1,077.

Med 4 Kids, PA
Overpayment Letter (11/9/2023)

MFD reviewed claims submitted by Med 4 Kids, PA a physicians group located in Somers Point, New Jersey. MFD determined that, from June 1, 2018 through October 7, 2021, Med 4 Kids, PA improperly billed and received payments for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Med 4 Kids, PA repaid the Medicaid program $9,105.

Archway Programs, Inc.
Settlement Agreement (11/9/2023)

MFD resolved an audit of Archway Programs Inc. (Archway), located in Atco, New Jersey. Through this audit, MFD determined that, for the period from August 1, 2014 through March 31, 2019, Archway incorrectly billed and received payment from the Medicaid program for claims for partial care services for which Archway lacked supporting documentation, in violation of applicable regulatory requirements. Archway agreed to repay the Medicaid program $500,000.

Legacy Life Solutions, LLC
Overpayment Letter (11/17/2023)

MFD reviewed claims submitted by Legacy Life Solutions LLC, a provider located in East Brunswick, New Jersey. MFD determined that, from February 1, 2021 through May 1, 2022, Legacy Life Solutions LLC improperly billed and received payments for lack of documentation on 49 claims. Legacy Life Solutions LLC submitted additional documentation, and, after reviewing that documentation, MFD determined that there were still 5 claims for which Legacy Life Solutions LLC lacked documentation and 19 instances where the information given was not sufficient, resulting in a revised overpayment amount. Legacy Life Solutions LLC repaid the Medicaid program the revised amount identified, $1,915.

Campus Pharmacy
Settlement Agreement (12/4/2023)

MFD completed a review of select pharmacy claims of Hemschem, Inc. d/b/a Campus Pharmacy (Campus Pharmacy) for the period from October 1, 2015 through April 30, 2018. MFD found that Campus Pharmacy failed to provide adequate support for some of these claims. Campus Pharmacy agreed to repay the Medicaid program $390,483.

Heal and Care Pediatrics, PA
Overpayment Letter (12/7/2023)

MFD reviewed claims submitted by Heal and Care Pediatrics, PA/Vrinda Shah, MD, a physicians group located in Freehold, New Jersey. MFD determined that, from June 1, 2018 through March 12, 2021, Heal and Care Pediatrics, PA/Vrinda Shah, MD improperly billed and received payments for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Heal and Care Pediatrics, PA/Vrinda Shah, MD repaid the Medicaid program $6,127.

Pine Acres Convalescent Center
Settlement Agreement (12/21/2023)

MFD resolved a review, conducted by its TPL vendor, HMS, of Hallmark Healthcare, LLC d/b/a Pine Acres Convalescent Center (Pine Acres), a long term care facility located in Madison, New Jersey. Through this review, HMS determined that, from March 1, 2018 through August 31, 2021, Pine Acres improperly received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments to which it was not entitled. Pine Acres agreed to repay the Medicaid program $356,305.

Castillo & Castillo MD, PA
Overpayment Letter (12/28/2023)

MFD reviewed claims submitted by Castillo & Castillo MD, PA, a physician group located in West New York, New Jersey. MFD determined that, from April 1, 2018 through December 31, 2022, Castillo & Castillo MD, PA improperly billed and received payments for exercise classes. Castillo & Castillo MD, PA repaid the Medicaid program $31,834.

Sana Obaid, MD/ Sana Obaid MD Obstetrics Gynecology Inc.
Overpayment Letter (12/29/2023)

MFD reviewed claims submitted by Sana Obaid, MD/Sana Obaid MD Obstetrics Gynecology Inc., a physicians group located in Woodland Park, New Jersey. MFD determined that, from August 1, 2018 through August 28, 2023, Sana Obaid, MD/Sana Obaid MD Obstetrics Gynecology Inc. improperly billed and received payments for preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Sana Obaid, MD/Sana Obaid MD Obstetrics Gynecology Inc. repaid the Medicaid program $5,558.

RDx Bioscience Inc. (Eric Leykin)
Settlement Agreement (1/8/2024)

MFD conducted an audit of Medicaid claims submitted by RDx BioScience, Inc., an independent clinical laboratory located in Kenilworth, New Jersey for the period from September 30, 2016 through August 31, 2019. During the pendency of MFD's audit, MFD became aware that the federal government had filed civil and criminal charges, including wire fraud and paying impermissible kickbacks, against RDx BioScience, Inc., and its owner. The civil charges resulted in an agreement with the federal government. In parallel to that settlement, MFD reached a settlement resolving its audit findings through which MFD recovered $2,934,977 in overpayments that MFD had identified in its audit. This amount was comprised of claims for improperly billed drug tests that lacked sufficient documentation, inappropriately unbundled drug test claims, and civil penalties. RDx BioScience, Inc. is no longer a part of the Medicaid program and its owner is suspended from the Medicaid program and prohibited from owning, operating, or holding a position related to submission of Medicaid claims for 3 years.

Golden Era, LLC
Overpayment Letter (1/9/2024)

MFD reviewed claims submitted by Golden Era LLC, an adult day health services provider located in Edison, New Jersey. MFD determined that, from September 1, 2018 through June 19, 2023, Golden Era LLC improperly billed and received payments for: (1) billing for medical day care services for beneficiaries who were inpatient at a facility; (2) billing in excess of five days of service in a week for an individual beneficiary; and (3) billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Golden Era LLC, NJ repaid the Medicaid program $8,571.

Genetworx
Overpayment Letter (1/11/2024)

MFD reviewed claims submitted by Genetworx, a laboratory located in Glen Allen, Virginia. MFD determined that, from February 8, 2018 through August 31, 2022, Genetworx improperly billed and received payments for presumptive urine drug tests performed in conjunction with specimen validity tests and for billing definitive urine drug tests in conjunction with specimen validity testing. Genetworx repaid the Medicaid program $56,083.

Big Oak Rehabilitation and Heath Care Center
Settlement Agreement (1/23/2024)

MFD resolved a review, conducted by its TPL vendor, HMS, of Gardens Operator, LLC, d/b/a Big Oak Rehabilitation and Heath Care Center (Big Oak), a long term care facility located in Pittsgrove, New Jersey. Through this review, HMS determined that, from May 1, 2022 through December 31, 2022, Big Oak improperly received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments to which it was not entitled. Big

Oak agreed to repay the Medicaid program $136,797.

Elite Caring AMDC
Overpayment Letter (1/30/2024)

MFD reviewed claims submitted by Elite Caring, an adult day health services provider located in Ewing, New Jersey. MFD determined that, from September 1, 2018 through June 19, 2023, Elite Caring improperly billed and received payments for medical day care services provided to beneficiaries who were inpatient at a facility and billing in excess of five days of service in a week for an individual beneficiary. Elite Caring repaid the Medicaid program $8,092.

Manhattanview Center for Rehabilitation and Healthcare
Settlement Agreement (2/1/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Manhattanview Center for Rehabilitation and Healthcare, a provider located in Union City, New Jersey. Through this review, HMS determined that, from April 1, 2022 through December 31, 2022, Manhattanview Center for Rehabilitation improperly billed and received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments. Manhattanview Center for Rehabilitation and Healthcare agreed to repay the Medicaid program $96,873.

Lakeview Pediatrics Inc.
Settlement Agreement (2/12/2024)

MFD reviewed claims submitted by Lakeview Pediatrics, Inc., a pediatric provider located in Clifton, New Jersey. MFD determined that, from January 1, 2017 through November 30, 2021, Lakeview Pediatrics improperly received payments for billing counseling codes in conjunction with evaluation and management codes that already included payment for the counseling charges. Lakeview Pediatrics agreed to repay the Medicaid program $60,118.

Springfield Pediatrics, P.A.
Settlement Agreement (2/23/2024)

MFD reviewed claims submitted by Springfield Pediatrics, a pediatric provider located in Springfield, Plainfield, and Elizabeth, New Jersey. MFD determined that, from January 1, 2015 through April 27, 2020, Springfield Pediatrics improperly received payments for hearing test claims that lacked the clinical documentation needed to support such claims. Springfield Pediatrics agreed to repay the Medicaid program $198,801.

Roses Home Care Services, Inc.
Overpayment Letter (2/23/2024)

MFD reviewed claims submitted by Roses Home Care Services, Inc. (Roses) a personal care service (PCS) provider located in Orange, New Jersey. MFD determined, from November 1, 2018 through October 31, 2023, Roses improperly billed and received payments for at-home services rendered to beneficiaries while these beneficiaries had inpatient status in a hospital setting. In addition, MFD imposed a civil penalty totaling $4,380 since these deficient claims related to the same underlying conduct for which MFD and Roses entered into the November 26, 2019 Settlement Agreement. In total Roses repaid the Medicaid program $10,678.

Concord Healthcare and Rehabilitation Center
Settlement Agreement (2/28/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Concord Healthcare, LLC d/b/a Concord Healthcare and Rehabilitation Center, a provider located in Lakewood, New Jersey. HMS determined that, from March 1, 2018 through August 31, 2021, Concord Healthcare, LLC improperly billed and received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim

overpayments. Concord Healthcare, LLC agreed to repay the Medicaid program $309,384.

Garden State Healthcare Associates
Settlement Agreement (2/28/2024)

MFD conducted an investigation of claims billed by Garden State Healthcare (Garden State), a provider located in Bayonne, New Jersey, for the period from January 1, 2015 and February 28, 2020. MFD determined that Garden State submitted claims for reimbursement that inappropriately appended a modifier to claims for emergency room services that were not supported by documentation. Garden State agreed to repay the Medicaid program $5,277.

Complete Care at Bey Lea
Settlement Agreement (3/14/2024)

MFD resolved a review, conducted by its TPL vendor, HMS, of Complete Care at Bey Lea, LLC, a long-term care facility, located in Toms River, New Jersey. Through this review, HMS determined that, from August 8, 2018 through January 31, 2022, Complete Care at Bey Lea, LLC improperly received Medicaid Managed Care patient liability and claim overpayments to which it was not entitled. Complete Care at Bey Lea, LLC agreed to repay the Medicaid program $164,975.

Sewell Senior Citizen Ctr. LLC
Overpayment Letter (3/26/2024)

MFD reviewed claims submitted by Sewell Senior Citizen Ctr., an adult day health services provider located in Sewell, New Jersey. MFD determined that, from January 1, 2019 through July 19, 2023, Sewell Senior Citizen Ctr. improperly billed and received payments for: (1) billing for medical day care services provided to beneficiaries who were admitted at an inpatient facility; (2) billing in excess of five days of service in a week for an individual; and, (3) billing for services for the same day, same service, and same beneficiary as another AMDC. Sewell Senior Citizen Ctr. repaid the Medicaid program $9,072.

Meridian Medical Group Faculty
Overpayment Letter (4/4/2024)

MFD reviewed claims submitted by Meridian Medical Group Faculty Practice, a physician group located in Neptune, New Jersey. MFD determined that, from January 1, 2017 through April 25, 2022, Meridian Medical Group Faculty Practice improperly billed and received payments for duplicate billings, and Fee for Service and Managed Care claims for the same beneficiary, on the same day. Meridian Medical Group Faculty Practice repaid the Medicaid program $35,922.

Manhattanview Operations, LLC
Settlement Agreement (4/4/2024)

MFD resolved a review, conducted by its TPL vendor, HMS, of Manhattanview Operations, LLC, a long-term care facility, located in Union City, New Jersey. Through this review, HMS determined that, from February 1, 2018 through March 31, 2022, Manhattanview Operations, LLC improperly received Medicaid Managed Care patient liability and claim overpayments to which it was not entitled. Manhattanview Operations, LLC agreed to repay the Medicaid program $510,438.

Tony's Pharmacy II
Settlement Agreement (5/2/2024)

MFD investigated 21st Avenue Pharmacy, Inc., d/b/a Tony's Pharmacy in Passaic, New Jersey. The investigation found, from December 1, 2014 through October 31, 2019, Tony's Pharmacy submitted 893 claims that were not supported by wholesaler invoices. MFD also assessed civil penalties because the provider had previously committed the same violations. The provider agreed to repay the Medicaid program $264,484

(comprised of $100,837 for the overpayment and $163,646 for penalties).

Tony's Pharmacy III
Settlement Agreement (5/2/2024)

MFD investigated Tony's Pharmacy, Inc., d/b/a Tony's Pharmacy in Paterson, New Jersey. The investigation found, from December 1, 2014 through October 31, 2019, Tony's Pharmacy submitted 856 claims that could not be supported by wholesaler invoices. MFD also assessed civil penalties because the provider had previously committed the same violations. The provider agreed to repay the Medicaid program $309,190 (comprised of $133,633 for the overpayment and $175,557 in penalties).

Mi Casa Es Su Casa II, Inc.
Overpayment Letter (5/7/2024)

MFD reviewed claims submitted by Mi Casa Es Su Casa II, an adult day health services provider located in West New York, New Jersey. MFD determined that, from June 1, 2018 through October 7, 2021, Mi Casa Es Su Casa II improperly billed and received payments for: (1) billing for services provided to beneficiaries who were also inpatient at a facility; (2) billing in excess of five days of service in a week for an individual beneficiary; and, (3) billing for services for the same day, same service, and same beneficiary as another adult medical day provider. Mi Casa Es Su Casa II repaid the Medicaid program $14,031.

Complete Care at Woodlands, LLC
Settlement Agreement (5/14/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Complete Care at Woodlands, LLC, a provider located in Plainfield, New Jersey. HMS determined that, from April 1, 2020 through March 31, 2022, Complete Care at Woodlands, LLC improperly billed and received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments. Complete Care at Woodlands, LLC agreed to repay the Medicaid program $101,652.

Complete Care at Hamilton, LLC
Settlement Agreement (5/15/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Complete Care at Hamilton, LLC, a provider located in Passaic, New Jersey. HMS determined that, from September 1, 2018 through February 28, 2022, Complete Care at Hamilton, LLC improperly billed and received Medicaid Managed Care and Medicaid Fee for Service patient liability and claim overpayments. Complete Care at Hamilton, LLC agreed to repay the Medicaid program $294,345.

Cedar Oaks Healthcare, LLC d/b/a Aristacare at Cedar Oaks
Settlement Agreement (5/24/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Cedar Oaks Healthcare, LLC, a provider located in South Plainfield, New Jersey. HMS determined that, from April 1, 2018 through September 30, 2021, Cedar Oaks Healthcare, LLC improperly billed and received Medicaid Managed Care and Fee for Service patient liability and claim overpayments. Cedar Healthcare, LLC agreed to repay the Medicaid program $339,832.

Complete Care at Laurelton, LLC
Settlement Agreement (5/29/2024)

MFD, through its TPL vendor, HMS, reviewed claims submitted by Complete Care at Laurelton, LLC, a provider located in Brick, New Jersey. HMS determined that, from October 1, 2018 through March 31, 2022, Complete Care at Laurelton, LLC billed and received Medicaid Managed Care and Medicaid Fee for Service patient liability and claims overpayments.

Complete Care at Laurelton, LLC agreed to repay the Medicaid program $238,095.

Barnabas Health Medical Group
Overpayment Letter (5/31/2024)

MFD reviewed claims submitted by Barnabas Health Medical Group, a physician group located in West Orange, New Jersey. MFD determined that, from March 1, 2019 through January 1, 2024, Barnabas Health Medical Group improperly billed and received overpayments for various evaluation and management codes, individual psychiatric evaluations, and/or inpatient/outpatient hospital services. Barnabas Health Medical Group repaid the Medicaid program $275,731.

Esther Bursztyn
Settlement Agreement (6/5/2024)

MFD reviewed claims submitted by Esther Bursztyn, a speech language pathologist (SLP) provider located in Lakewood, New Jersey. MFD found that, from January 1, 2017 through December 31, 2018, Bursztyn submitted claims to Medicaid through MCOs for services rendered on the same day for the same beneficiary. MFD concluded that Bursztyn had improperly unbundled claims and received an overpayment. Bursztyn agreed to repay the Medicaid program $14,994.

2nd Home Totowa LLC
Overpayment Letter (6/11/2024)

MFD reviewed claims submitted by 2nd Home Totowa, an adult day health services provider located in Totowa, New Jersey. MFD determined that, from January 1, 2019 through June 19, 2023, 2nd Home Totowa improperly billed and received payments for: (1) billing for at-home services provided to beneficiaries who were inpatient at a facility; (2) billing in excess of five days of service in a week for an individual beneficiary; and, (3) billing for services for the same day, same service, and same beneficiary as another adult medical day provider. 2nd Home Totowa repaid the Medicaid program $7,945.

Jersey Behavioral Care, LLC
Settlement Agreement (6/24/2024)

MFD completed a review of Medicaid claims submitted by Jersey Behavioral Care during the review period of January 1, 2017 through February 11, 2021. MFD's review identified 135 claims submitted by Jersey Behavioral Care that were deficient and 485 claims that were inappropriately billed. Jersey Behavioral Care agreed to repay the Medicaid program $166,001.

Eye Centers of America, LLC
Settlement Agreement (6/24/2024)

MFD completed a review of Medicaid claims submitted by Eye Centers of America, LLC (Eye Centers), an ophthalmology practice located in Bloomfield, New Jersey for claims submitted between August 1, 2015 through July 31, 2020. MFD's review identified claims that Eye Centers' documentation did not adequately support. Eye Centers agreed to repay the Medicaid program $184,603.

Community Care Behavioral Health Inc.
Settlement Agreement (6/26/2024)

MFD resolved an audit of Community Care Behavioral Health Inc. (Community Care), located in Freehold, Piscataway, and Morris Plains, New Jersey. Through this audit, MFD determined that, for the audit period from January 1, 2015 through September 30, 2019, Community Care billed and received payment from the Medicaid program for partial care claims for which Community Care lacked sufficient documentation. Community Care agreed to repay the Medicaid program $631,853.

Mona Ayoub, MD
Overpayment Letter (6/28/2024)

MFD reviewed claims submitted by Dr. Mona Ayoub, a physician located in Bayonne, New Jersey. MFD determined that, from January 1, 2019 through September 14, 2021, Dr. Ayoub improperly billed and received payments totaling $4,690 for billing preventative medicine, individual counseling, and/or risk factor reduction intervention in conjunction with comprehensive preventative medicine services. Dr. Ayoub repaid the Medicaid program $4,690.

Summaries of Final Audit Reports and Closing Letters

Tri County Foot and Ankle Center
Final Audit Report (7/17/2023)

The Office of the State Comptroller, Medicaid Fraud Division (OSC), reviewed a statistically valid sample of 130 dates of service, comprised of 291 Medicaid claims submitted by and paid to Tri County Foot and Ankle Center (Tri County), a durable medical equipment provider located in Bayonne, New Jersey. The reviewed claims, which Tri County submitted between May 22, 2014 and May 21, 2019, totaled $40,427. OSC determined that Tri County failed to bill properly 130 of the 291 claims. OSC found monetary errors in 67 of the 291 claims, totaling $5,824 out of $40,427 in paid claims (14.4 percent). With respect to these 67 claims, Tri County violated N.J.A.C. 10:49-9.8 by not maintaining records that fully documented the services provided and by inaccurately billing the submitted claim codes. For purposes of ascertaining a final recovery amount, OSC extrapolated the error dollars for dates of service that failed to comply with state regulations to the total dollars in the universe from which the sample of dates of service was drawn, which in this case was 9,437 dates of service, comprised of 14,895 claims with a total payment of $1,644,179.00. By extrapolating the dollars in error over the entire audit universe, OSC calculated that Tri County improperly received an overpayment of at least $168,878 that it must repay to the Medicaid program.

Sokkyun Yi
Final Audit Report (8/24/2023)

OSC reviewed claims submitted by Sokkyun Yi, a licensed clinical social worker, located in Princeton, New Jersey. OSC determined that, from September 21, 2016 through March 2, 2020 (audit period), Sokkyun Yi improperly billed intensive in-community mental health rehabilitation and behavioral assistance services. During the audit period, OSC found that Yi's records contained numerous deficiencies such as, records that contained inaccurate or conflicting information, services that Yi could not substantiate, upcoded services, and claims submitted for overlapping services. OSC found that, in total, Sokkyun Yi improperly billed and received Medicaid payments totaling $1,795,277 that Yi had to repay to the Medicaid program.

Adult Medical Day Care Providers Improperly Billed NJ Medicaid
Report (10/31/2023)

The Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted this review to identify AMDC providers who improperly billed the Medicaid program for duplicative services or who billed for services that exceeded program limits. Through this review, OSC identified 21 AMDCs that violated Medicaid regulations by (1) impermissibly billing for more than five days in a week; (2) billing for services to a beneficiary while that beneficiary was actually in an inpatient facility such as a hospital; and (3) billing for services provided to a beneficiary when in fact another AMDC also billed for the same services to the same beneficiary on the same date. As a result of this

review, OSC identified approximately $1 million in improperly spent Medicaid funds. These problems show a pattern of improper billing by AMDCs that could range from careless mistakes to fraudulent billing errors. These errors also have potential implications for the quality of care provided by the AMDC. OSC recommended systemic fixes to address the problems identified above and continues to pursue recoveries for these improperly spent Medicaid funds.

RDx BioScience, Inc.
Closing Report (4/5/2024)

MFD conducted an audit of Medicaid claims submitted by RDx BioScience, Inc. (RDx), an independent clinical laboratory located in Kenilworth, New Jersey. OSC's audit was for the period from September 30, 2016 through August 31, 2019, and sought to determine whether RDx properly billed for drug testing claims. During the pendency of MFD's audit, MFD became aware of federal criminal and civil actions involving RDx and its ownership for an array of wire fraud and kickback charges. The federal civil claims resulted in a settlement agreement between RDx, and the federal government. In parallel to that federal settlement, OSC entered into a settlement through which it recovered $2,934,977 for overpayments and penalties that OSC had identified in its audit. RDx is no longer a part of the Medicaid program and its owner is subject to a suspension from the Medicaid program that prohibits him from owning, operating, or holding a position related to submission of Medicaid claims for 3 years.