

# Final Audit Report of Bonnie Brae's Compliance with Medicaid Requirements and Its Contracts with the Department of Children and Families

MEDICAID FRAUD DIVISION REPORT



**Shirley U. Emehelu**  
**Acting State Comptroller**

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## List of Abbreviations

BH/SU	Behavioral Health/Substance Use
DCF	Department of Children and Families
IOS	Intensity of Service
RTC	Residential Treatment Center
RTC-BH/SU	Residential Treatment Center Behavioral Health/Substance Use
SPEC	Specialty Residential Treatment Center

# I. Executive Summary

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As part of its oversight of the New Jersey Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) audited Bonnie Brae, a provider of out-of-home treatment services to youth, to determine whether it complied with Medicaid requirements and the terms of its contracts with the New Jersey Department of Children and Families (DCF). OSC found that Bonnie Brae violated Medicaid regulations and failed to satisfy provisions in its DCF contracts. Among other issues, OSC found that Bonnie Brae:

- Failed to maintain documentation that supported the contractually required service hours for clinical coordinators, with documented hours for clinical and case management services significantly exceeding those recorded on employees' timesheets;
- Claimed to provide on-site services to youth who, according to other Bonnie Brae documents, were off-site at the time;
- Failed to provide and/or document the amount or frequency of clinical therapy, psychiatric therapy, and case management services required by contract;
- Maintained duplicated progress notes, 93 in total, from two therapists that were nearly identical to one another and identical for all youth under their care over a span of seven weekly group therapy sessions; and
- Employed two unlicensed clinical coordinators.

Out-of-home treatment is intended to address identified behavior and underlying factors to enable vulnerable youth to safely return home or to a non-clinical setting. To meet those aims, Bonnie Brae provides clinical therapy, psychiatry, direct care, case management, nursing, and allied clinical services for youth through its contracts with DCF. During the audit period of July 1, 2019 through June 30, 2021, through these contracts, the Medicaid program paid Bonnie Brae per person rates that ranged from \$350 to more than \$670 per day, reflecting increases in per diem contract costs instituted over this period. In total, Medicaid paid Bonnie Brae \$34.4 million during this period. During the entire five-year period of the contracts under review, Medicaid paid Bonnie Brae approximately \$91.2 million.

Given the vulnerable youth population Bonnie Brae serves, the critical services that Bonnie Brae agreed to provide to them, and the considerable amount of Medicaid funds paid for these services, OSC found it concerning that Bonnie Brae did not maintain sufficient documentation to demonstrate compliance with Medicaid regulations and its DCF contracts. Equally concerning is that the documentation Bonnie Brae submitted to OSC after learning of OSC's initial findings did not reconcile with its initial submission, which further undermined the reliability of its documentation. In short, Bonnie Brae's unreliable and, at times, inconsistent documentation could not support the services it contracted to perform and for which it received Medicaid payments.

Based on the findings above, OSC determined that Bonnie Brae failed to maintain proper documentation that shows it provided contractually required services for which it received more than \$1.5 million in Medicaid payments. Accordingly, OSC found that Bonnie Brae must repay these funds to the Medicaid program. In addition, OSC found that in order for Bonnie Brae to meet

its Medicaid program and contractual obligations, it must significantly improve its record keeping and institute reforms.

## II. Background

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Founded in 1916 and incorporated as a nonprofit organization in 1953, Bonnie Brae specializes in delivering residential treatment services for emotionally disturbed adolescents. The organization's 100-acre main campus is located in Liberty Corner, within Bernard's Township, and includes a school, eight residential cottages, and recreational areas. Bonnie Brae also operates three community-based transitional living homes.

During the audit period of July 1, 2019 through June 30, 2021, the New Jersey Department of Children and Families (DCF) contracted with Bonnie Brae to provide out-of-home treatment services on behalf of the Children's System of Care (CSOC), DCF's division responsible for youth (under age 21) with emotional and mental health care needs, substance use challenges, and/or intellectual/developmental disabilities. The intensity, frequency, and duration of the out-of-home treatment varied based on a youth's clinical needs, age, and gender. Through two contracts, Bonnie Brae administered six programs, which provided the following levels of intensity: Residential Treatment Center (RTC) Intensity of Service (IOS); Residential Treatment Center Behavioral Health/Substance Use (RTC-BH/SU); and Specialty (SPEC) IOS.

The goal of an RTC is to establish a secure, well-rounded, stable, and therapeutically supportive environment. RTCs provide a range of services to help youth develop and enhance their behavioral, self-help, socialization, and adaptive skills. The overarching objective is to contribute to their improved physical, social, and emotional well-being and vocational potential. The therapeutic goal is to support the youth in reintegrating with their family/caregiver and community.

The RTC IOS and RTC-BH/SU programs provide 24-hour staff-supervised all-inclusive clinical services in a community-based therapeutic setting for youth with severe and persistent social, emotional, behavioral, and/or psychiatric challenges. Youth enrolled in the RTC-BH/SU program also present with co-occurring substance use treatment needs and receive specialized treatment. The SPEC program also provides 24-hour care for youth who manifest significant emotional and/or behavioral challenges that require specialized clinical intervention.

For the SPEC program, DCF and Bonnie Brae entered into a conditional five-year contract (Contract # 17BJZR) effective July 1, 2016 through June 30, 2021. The state conditioned the contract on Bonnie Brae hiring and training direct care staff to fill 11 vacancies. The state lifted the conditional status of the contract as of September 26, 2017. The contract's original terms required Bonnie Brae to provide up to 49 beds at a per diem rate of \$430 billed directly through Medicaid. Effective January 1, 2018, the State raised the per diem rate to \$445, and the parties extended the contract for six months to December 31, 2021. An additional increase, effective January 1, 2021, raised the per diem rate to \$670.70. Over the five-year term of the contract, the final maximum reimbursable ceiling for the SPEC program contract, after subsequent rate increases, was \$47,461,180. See Table I below.

**Table I: Contract # 17BJZR – Per Diem Rate Increases**

Program	Number of Beds	2017 per Diem Rate	2018 per Diem Rate	Percent Increase	2021-22 per Diem Rate	Percent Increase	Final Maximum Reimbursable Ceiling
SPEC	49	\$430	\$445	3%	\$670.70	34%	\$47,461,180

Similar to the SPEC program contract, for four RTC programs and one RTC-BH/SU program, DCF entered into a contract with Bonnie Brae effective July 1, 2017 for five years through June 2022 (Contract # 18FDZR). Pursuant to this contract, Bonnie Brae was required to provide up to 65 beds across the five programs at a per diem rate of \$350 for the four RTC programs and \$407 for the RTC BH/SU program. The parties modified this contract in June 2019, raising both rates retroactively, effective January 1, 2018, to \$365 and \$422, respectively. In October 2021, the parties again raised the per diem rates to \$611.13 for the four RTC programs and \$614.72 for the RTC BH/SU program, retroactively to the beginning of the calendar year through the termination of the contract in June 2022. The maximum reimbursable ceiling for the RTC programs contract was \$53,301,087. See Table II below.

**Table II: Contract # 18FDZR – Per Diem Rate Increases**

Program	Number of Beds	2017 per Diem Rate	2018 per Diem Rate	Percent Increase (2017-2018)	2021-22 per Diem Rate	Percent Increase (2018-2021)	Final Maximum Reimbursable Ceiling
RTC-Main Campus	25	\$350	\$365	4%	\$611.13	40%	\$19,952,925
RTC- BH/SU	19	\$407	\$422	4%	\$614.72	31%	\$16,587,705
RTC- New Brunswick	8	\$350	\$365	4%	\$611.13	40%	\$6,384,936
RTC-Bound Brook	8	\$350	\$365	4%	\$611.13	40%	\$6,384,936
RTC- Bridgewater	5	\$350	\$365	4%	\$611.13	40%	\$3,990,585
<b>Total</b>	<b>65</b>						<b>\$53,301,087</b>

RTC-BH/SU, RTC-Main Campus, and the SPEC program are located on Bonnie Brae’s main campus in Liberty Corner, Bernards Township. The RTC-BH/SU and RTC-Main Campus programs are co-located, with youth sharing residential cottages, case managers, and therapists. Youth enrolled in the SPEC program reside in separate cottages, distinct from those occupied by participants in the other two programs. The three remaining RTC programs are located in community-based transitional living homes in New Brunswick, Bound Brook, and Bridgewater.

The contracts with DCF required Bonnie Brae to submit to DCF Program Staffing Summary Reports (PSSR) showing assigned staff for each program at least once per year and at other times when Bonnie Brae made significant staffing changes. Among its staffing requirements, Bonnie Brae was required to have a director and a pediatrician on call 24 hours a day for all of its contracted programs. Bonnie Brae also was required to provide the following on-site services:

clinical therapy, psychiatry, direct care, case management, nursing, and allied clinical services. Table III below outlines the contractual minimum weekly service hours per youth, categorized by intensity and position.

**Table III: Minimum Staffing Requirements by Intensity per Week per Youth in 2020 and 2021 for Contract # 17BJZR and Contract # 18FDZR**

Position	Hours per Youth per Week: RTC	Hours per Youth Per Week: RTC-BH/SU	Hours per Youth per Week: SPEC
Psychiatrist or Advanced Practice Nurse	0.67	0.67	1.25
New Jersey Licensed Therapist (Clinician)/ Masters Level Therapist	6	6	8
Case Manager	5.5	5.5	5.5
Direct Care Staff	44	44	63
Allied Clinical Therapist	6	6	6
Nurse-Health Educator/Registered Nurse	2	2	1.5

Pursuant to the contracts, Bonnie Brae’s psychiatrists were responsible for conducting intake assessments, creating initial treatment and crisis plans, performing clinical visits, and managing medication. Licensed therapists, known as clinical coordinators, were responsible for delivering clinical services through individual, group, and family therapy. Both psychiatrists and clinical coordinators were required to allocate 75 percent of their clinical hours to face-to-face interactions with the youth. Case managers were responsible for administrative tasks related to each youth, including scheduling relevant appointments, providing financial oversight, and drafting incident reports/correspondence. A complete list of the minimum staffing credentials and requirements is provided in Exhibits 1-3 attached to this report.

DCF most recently audited Bonnie Brae’s SPEC Program in October 2015, covering the period from July 1, 2013 to June 30, 2015. DCF’s audit revealed several areas of non-compliance, including inadequate documentation for required therapy services and case management. The report recommended improvements in internal controls and documentation practices. In response to the 2015 audit, Bonnie Brae agreed to improve its documentation and internal controls for clinical therapy and case management, and to implement weekly audits for both.

### **III. Audit Objective, Scope, and Methodology**

The objective of OSC’s audit was to determine whether Bonnie Brae complied with applicable state regulations and certain provisions in its DCF contracts.

The audit scope was July 1, 2019 through June 30, 2021. OSC conducted this audit pursuant to its authority as set forth in N.J.S.A. 52:15C-23 and the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 to -64.

As part of the audit, to obtain an understanding of Bonnie Brae's controls and processes, OSC reviewed Bonnie Brae's contracts and contract modifications with DCF, PSSRs for Bonnie Brae's six programs, Bonnie Brae's 2020 and 2021 audited financial statements, and Bonnie Brae's 2020 Internal Revenue Service Form 990. OSC also conducted interviews and walkthroughs with Bonnie Brae personnel. In addition, OSC conducted a preliminary examination of progress notes for five selected youth to gain an understanding of Bonnie Brae's recordkeeping practices.

For substantive testing, OSC selected February 2020 as a sampled month because of heightened enrollment and because it predated the onset of the COVID-19 pandemic. To identify potential high-risk areas, OSC obtained staffing reports, timesheets, and payroll documents and compared the information contained in those documents to projected staffing requirements based on the number of youth enrolled at the time.

Based on its risk analysis, OSC found that clinical therapy, case management, and psychotherapy were high-risk areas and excluded RTC-New Brunswick, RTC-Bound Brook, and RTC-Bridgewater from further review. OSC obtained progress notes and documentation supporting case management, psychiatric services, and clinical therapy for each youth enrolled in the SPEC, BH/SU RTC, and RTC Main Campus programs for the substantive testing review period from February 1, 2020 through February 29, 2020. In addition, to determine whether any identified documentation deficiencies persisted after February 2020, OSC selected a smaller sample of two of eight cottages for review of case management, psychiatric services, and clinical therapy from February 1, 2021 through February 28, 2021.

Using the documents obtained from Bonnie Brae, OSC calculated the hours devoted to case management, psychiatric services, and clinical therapy for each youth and clinical coordinator to determine whether Bonnie Brae met the contracted minimum requirements. OSC also compared the number of hours recorded by clinical coordinators on supporting documentation to the number of hours worked on employee timesheets. To further test the reliability of the information received, OSC compared the following:

- Clinical coordinator absences on timesheets against dates and times recorded on progress notes;
- Medicaid billing records for youth who were recorded as absent against dates and times recorded on progress notes;
- Dates and times of individual therapy sessions by clinical coordinators to determine whether there was overlap; and
- Progress notes completed by different clinical coordinators.

Finally, OSC referenced the Division of Consumer Affairs' license verification system to assess Bonnie Brae's compliance with minimum requirements for clinical coordinators, psychiatrists, and Advanced Practice Nurses (APNs) identified within the audit samples.

## **IV. Discussion of Auditee Comments**

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The release of this Final Audit Report concludes a process during which OSC afforded Bonnie Brae multiple opportunities to provide input regarding OSC's audit findings. Specifically, OSC provided Bonnie Brae a Summary of Findings (SOF) and OSC and Bonnie Brae, represented by

counsel, held an exit conference during which the parties discussed the SOF. Following the exit conference, Bonnie Brae submitted additional records and a written response that disputed certain findings. After considering that submission, OSC provided Bonnie Brae a Draft Audit Report (DAR) and instructed Bonnie Brae to submit a formal response to the DAR including a Corrective Action Plan (CAP).

In response to the DAR, Bonnie Brae submitted a CAP to address OSC's findings (Appendix A). In its response, Bonnie Brae stated, "[w]hile we may not fully concur with all aspects of the findings, we acknowledge and respect the determinations made and will comply accordingly. Bonnie Brae remains firmly committed to maintaining full adherence to all contractual, fiscal, and documentation standards." The CAP advised that Bonnie Brae would hire additional clinicians, provide additional training, and implement updates to its procedures for completing service documentation. The CAP did not address whether Bonnie Brae would reimburse the Medicaid program the assessed overpayment of \$1,528,109.

OSC addresses Bonnie Brae's arguments in more detail in Appendix B. After reviewing Bonnie Brae's submission, OSC determined that the explanations provided did not resolve the deficiencies identified in the audit. OSC found that the inconsistencies across the entirety of the records OSC reviewed limited OSC's ability to verify that Bonnie Brae delivered the contractually required services. Accordingly, OSC concluded that despite its arguments and submissions, Bonnie Brae still could not rebut OSC's findings that it had failed to comply with Medicaid regulations and provisions in its DCF contracts.

## V. Audit Findings

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Based on a review of documentation for February 2020, OSC found that Bonnie Brae's documentation for services for which it billed and was paid by the Medicaid program was unreliable and inadequate. Specifically, OSC determined that it could not rely on Bonnie Brae's documentation to support the clinical therapy, case management, and psychiatric services for youth enrolled in SPEC, RTC-Main Campus, and RTC BH/SU (on-campus). Bonnie Brae's failure to support these services violated Medicaid requirements and its contracts with DCF. In addition, based on the deficient documentation Bonnie Brae provided, OSC found that Bonnie Brae failed to provide the required number of clinical therapy hours for 13 of the 101 youth enrolled in on-campus programs. OSC also found that Bonnie Brae failed to provide the minimum number of required hours for psychiatric services for the SPEC program. Finally, Bonnie Brae did not provide the required case management hours. These findings are set forth below in more detail.

For the two cottages sampled in February 2021, OSC found that nearly all of the issues that OSC identified with Bonnie Brae's documentation from February 2020, including the lack of adequate progress notes and case management documentation, persisted to varying degrees. Based on its review of February 2021 documentation, OSC determined that 8 of 26 youth did not receive the required number of therapy hours and that youth enrolled in the SPEC program did not receive the required number of hours for psychiatric services. Finally, OSC also identified two clinical coordinators, one in February 2020 and another in February 2021, who were not licensed during the periods when they provided services.

Taken as a whole, OSC determined that Bonnie Brae failed to adequately document clinical therapy, case management, and psychiatric services. As a result, Bonnie Brae could not demonstrate that it provided the minimum level of the services required by contract. OSC's other specific adverse findings, including its determination that Bonnie Brae failed to provide sufficient levels of clinical therapy, psychiatric services, and case management, and used unlicensed clinical coordinators, highlight serious internal control failures. Because of these material and widespread deficiencies, which may have adversely affected Medicaid beneficiaries' treatment, OSC determined that Bonnie Brae must return to the Medicaid program the full amount of Medicaid funds paid to Bonnie Brae for these services for February 2020 and for the two cottages reviewed in February 2021, which totals \$1,528,109.

## **A. Unreliable Documentation Supporting Clinical Therapy, Case Management, and Psychiatric Services**

OSC found that Bonnie Brae's records involving clinical therapy, case management, and psychiatric services were materially deficient. OSC identified multiple issues with these records, as detailed below.

### **1. Failure to Support Hours Documented by Cottage-Assigned Clinical Coordinators Demonstrates Deficient Recordkeeping**

OSC reviewed progress notes for clinical therapy and supporting documentation for case management services for February 2020 for the youth residing in all eight on-campus cottages. Bonnie Brae's contracts with DCF required it to provide at least eight hours of clinical therapy per youth per week for the SPEC program and six hours per week for the non-SPEC programs. The contracts required 75 percent of the hours to be face-to-face, which correlates to six hours for youth enrolled in SPEC and four and a half hours for youth enrolled in BH/SU and RTC-Main Campus. Bonnie Brae's contracts with DCF also required Bonnie Brae to provide five and a half hours of case management services for all youth in each program.

OSC found that certain clinical coordinators were also serving as case managers and documenting six hours of case management services per youth per week using a standardized summary form—on top of their clinical therapy responsibilities. (OSC identified significant reliability concerns with this summary form, which are addressed in finding A. 2. below.) The contracts allow clinicians to perform case management duties but explicitly state that these hours must be recorded separately from therapy hours.

When OSC examined the total hours logged for both clinical therapy and case management by the eight cottage-assigned clinical coordinators, it found that the reported service hours for February 2020 substantially exceeded the hours in a standard workweek, the clinical coordinators' logged timesheets, and the time plausibly available in their daily schedules. The documentation reflected workloads that were, in most cases, highly improbable and, in some cases, simply impossible. Table IV shows the total hours documented in progress notes by each cottage-assigned clinical coordinator in relation to the hours documented in their timesheets, and the difference between the two sets of documents.

**Table IV: Differences in Clinical Coordinators' Documented Case Management and Clinical Therapy Hours (Youth Progress Notes/Case Management Summary Forms vs. Timesheets - February 2020)**

Cottage (Clinical Coordinator Initials)	Hours Recorded by Clinical Coordinator on Youth Progress Notes/ Case Management Summary Forms			Clinical Coordinator Timesheet Hours	Difference
	Case Management Hours	Therapy (Individual, Family, Group) Hours (Rounded)	Total Hours Logged by Clinical Coordinator in February 2020 (Rounded)		
██████████	336	100	<b>436</b>	144	292
██████████	336	98	<b>434</b>	144	290
██████████	288	76	<b>364</b>	152	212
██████████	276	84	<b>360</b>	152	208
██████████	276	81	<b>357</b>	160	197
██████████	264	77	<b>341</b>	128	213
██████████	216	80	<b>296</b>	160	136
██████████	192	66	<b>258</b>	152	106
<b>Total</b>	<b>2,184</b>	<b>662</b>	<b>2,846</b>	<b>1,192</b>	<b>1,654</b>

The total hours documented by the cottage-assigned clinical coordinators in the month of February 2020 (leap year) ranged from a high of 436 to a low of 258 hours. Bonnie Brae claimed it did not possess clinician-staffing schedules for 2020, but its schedules for 2021 showed that therapists were scheduled to work a standard 40-hour workweek (8 hours per day). Employee timesheets for February 2020 also reflected a 40-hour workweek. OSC compared these hours to the hours listed on the employee timesheets. See Table IV for a comparison.

The large disparities between the hours recorded by Bonnie Brae's cottage-assigned clinical coordinators on progress notes and case management documentation, as compared to their timesheets, raise questions regarding the reliability of the documentation provided and whether Bonnie Brae retained sufficient staff to meet its contract requirements. Taking Bonnie Brae's documentation at face value, the aggregate hours reflected in the progress notes and case management summary form would have required approximately 10 additional clinicians to have provided these services. Specifically, the analysis of the data presented in Table IV reveals that for just eight clinical coordinators there is a collective difference of 1,654 hours for the month of February 2020 alone. To meet the claimed service hours provided to youth, as reflected in the progress notes, Bonnie Brae required an additional 10 full-time equivalent (FTE) (1,654/160 work month) positions to account for the difference in hours between what these clinicians

documented in their progress notes and case management summary forms and what Bonnie Brae’s timesheet records showed.<sup>1</sup>

OSC reviewed documentation from two of the eight cottages in February 2021. From this review, OSC identified patterns that mimicked what it found for February 2020. In February 2021, the cottage-assigned clinical coordinators continued to perform both clinical coordinator responsibilities and case management. See Table V below.

**Table V: Differences in Clinical Coordinators’ Documented Case Management and Clinical Therapy Hours (Youth Progress Notes/ Case Management Summary Forms vs. Timesheets - February 2021)**

Cottage (Clinical Coordinator Initials)	Hours Recorded by Clinical Coordinator on Youth Progress Notes/Case Management Summary Forms			Clinical Coordinator Timesheet Hours	Difference
	Case Management Hours	Therapy (Individual, Family, Group) Hours (Rounded)	Total Hours Logged by Clinical Coordinator in February 2021 (Rounded)		
██████████	282	68	350	128	222
██████████	204	37	241	88	153
<b>Total</b>	<b>486</b>	<b>105</b>	<b>591</b>	<b>216</b>	<b>375</b>

As shown in Table V above, OSC determined that the total documented hours for clinical coordinators/case managers assigned to the cottages exceeded the hours recorded on their timesheets by 375 hours in February 2021. To reconcile this discrepancy and provide the hours listed on progress notes for the two cottages reviewed, Bonnie Brae would have needed to fill an additional two FTE positions (375/160 work month), assuming each full-time position contributed 160 hours per month (40 hours per week \* 4 weeks).

These deficiencies, combined with the other deficiencies cited in the report, raise serious concerns that vulnerable youth may not have received the services to which they were contractually entitled. Further, based on these findings, OSC determined that Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which requires providers to certify that claim information is “true, accurate, and complete,” and N.J.A.C. 10:49-9.8(b)(1), which requires providers to “[k]eep such records as are necessary to disclose fully the extent of services provided.”

<sup>1</sup> The equivalent of 10 FTEs (1,654 hours/160-work month) was necessary to bridge the gap between the documented hours and the available staff, as each full-time position contributes 160 hours in a month (40 hours per week multiplied by 4 weeks) in February 2020. However, OSC cannot determine the full extent of the staffing shortage due to the unreliability of Bonnie Brae’s documentation and the presence of other clinical coordinators who were not assigned to specific cottages.

## 2. Case Management Summary Form Did Not Reconcile with Actual Services Delivered

In a prior stage of this audit, Bonnie Brae provided OSC case management summary forms that it used as a streamlined way to support its case management services. OSC found Bonnie Brae's approach inadequate because the forms contained unreliable information that could not be used to validate case management services. Specifically, in addition to finding that these forms contained improbable and impossible claims involving clinical coordinators, OSC found that the summary forms were nearly identical for all youth and cottages and, thus, lacked sufficient details to differentiate among individuals.

OSC found that therapists produced case management notes using templates, altering only the dates. All notes typically listed Fridays between 9:00 AM and 2:30 PM as the service times for all youth. Weekly activities are summarized in Table VI below, with a total of six hours documented per youth each week consistently for all youth in all cottages.

**Table VI: Weekly Activities per Case Management Notes**

<b>Tasks</b>	<b>Minutes per Youth</b>
Treatment Planning	60
Progress Notes	60
Correspondence	60
Weekend Projected Plan/Home Visits	30
Incident Report	30
Phone Calls	30
Transfer Meetings	30
Monthly Treatment Plan	30
Financial Oversight (W2's, Money Requests)	15
Cottage Staff Meetings	15
<b>Total</b>	<b>360 (6 hours)</b>

Based on its review of the case management notes for both the February 2020 and 2021 samples, OSC found that Bonnie Brae did not record specific times when activities occurred but instead routinely used a summary template with generalized time blocks (e.g., 9:00 AM to 2:30 PM every Friday) and predetermined tasks as illustrated in Table VI above. The absence of variation in tasks and times raised significant concern as to whether Bonnie Brae provided the listed services as documented on the form and, if so, the effectiveness of these services given the lack of specific information about what took place.

In response to OSC's Summary of Findings (SOF) and after holding an exit conference to discuss the SOF, Bonnie Brae submitted additional information that it stated bolstered its position that the previously submitted case management notes were reliable. Through counsel, Bonnie Brae argued that its use of case management summary forms was consistent with DCF guidance, stating "DCF approved Bonnie Brae's use of a summary Case Management Checklist with standardized times (even though the standardized times were just projections) as part of their 2015 action plan."

OSC found, however, that Bonnie Brae's position was not supported by the documentation, and that OSC's initial concerns regarding the unreliability of Bonnie Brae's case management notes remained valid. OSC notes that the 2015 action plan cited in counsel's letter was in response to a DCF audit that found that Bonnie Brae's case management records were insufficient to support the required five and a half hours per youth per week. Based on that finding, DCF recommended that Bonnie Brae institute a process through which its "[d]ocumentation should clearly represent case management provided for each youth. In addition, the duration and purpose of case management services should be noted. When minimum case management services are not being attained for a specific youth, the reasons should be documented and included in the youth's case file." In response to DCF, Bonnie Brae agreed that it would do so, stating that its "Case Management services summary form identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings and allows for documentation of discrete times spent delivering other Case Management services." Bonnie Brae also stated it would implement an internal control system that would allow for a weekly audit of all Case Management services delivered and documented for each youth. Specifically, it would institute audits by the Assistant Clinical Director and Medical Records Technician.

However, the documentation reviewed during the audit did not demonstrate that Bonnie Brae implemented these measures in a manner sufficient to meet the expectations outlined in the DCF action plan. Bonnie Brae's summary form did not clearly identify the actual case management activities performed for each youth, the duration of those activities, or otherwise provide sufficient detail to substantiate that it had provided required case management services. Specifically, Bonnie Brae relied on the same unvarying summary form for every youth, every week, without discrete time entries or individualized information. Further, OSC found that Bonnie Brae did not provide evidence that it performed any weekly audits of its case management services, despite having advised DCF that it would do so.

Importantly, nothing in the DCF action plan eliminated Bonnie Brae's requirement to demonstrate the actual delivery of the required case management services, and DCF's acceptance of the summary form did not relieve Bonnie Brae of its obligation to maintain documentation sufficient to substantiate that those services were provided. While Bonnie Brae asserted that case management is broad or difficult to quantify, it remained contractually obligated to provide a minimum level of services and maintain documentation demonstrating compliance with those requirements. In short, OSC's review of Bonnie Brae's case management documentation shows that Bonnie Brae failed to ensure that it properly documented that it had provided the contractually required five and a half hours per week of case management services to each youth.

By failing to maintain appropriate records, Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which states that "providers shall certify that the information furnished on the claim is true, accurate, and complete," and N.J.A.C. 10:49-9.8(b)(1), which states that providers are required "[t]o keep such records as are necessary to disclose fully the extent of services provided."

### **3. Case Management "Team-Based Approach" Did Not Substantiate Reported Weekly Summary Form Hours or Meet Contractual Requirements**

After reviewing Bonnie Brae's case management summary forms but prior to issuing the SOF, OSC requested that Bonnie Brae explain how the clinical coordinators could feasibly perform both

case management and clinical roles. Bonnie Brae initially failed to provide a substantive response to that inquiry. After OSC issued the SOF, which included findings regarding Bonnie Brae's impossible and improbable case management hours, Bonnie Brae provided supplemental documentation regarding its case management hours, claiming that these documents showed that it used a "team-based approach" to case management, with services collaboratively delivered by clinical, administrative, and program staff.<sup>2</sup>

In its supplemental submission, Bonnie Brae provided a chart identifying participating staff, estimated time allocations, and categories of case management activities. Additionally, Bonnie Brae provided documentation packets for six youth selected by Bonnie Brae from the February 2020 sample to illustrate the scope of case management services provided. Bonnie Brae asserted that tracking exactly five and a half hours of case management per youth per week was not feasible due to the integrated nature of service delivery. It further argued that activities such as administrative oversight should be considered part of case management, even though the contract did not specifically reference those services as being part of case management.

OSC reviewed the supplemental documentation and determined that, taken at face value, these documents still showed large discrepancies in service hours. Moreover, more than one-third of the documents lacked time durations, which prevented OSC from fully assessing the extent of services delivered. In several instances, Bonnie Brae included non-case management staff, such as direct care staff who typically performed routine duties, as having performed case management tasks. To quantify case management hours, OSC considered only records that included time durations but applied Bonnie Brae's broad definition of case management, counting hours documented not only by the assigned case managers but also by other individuals included in the supplemental documentation. The results are presented in Table VII below.

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<sup>2</sup> The "Supplemental Documentation" submitted by Bonnie Brae in support of its claimed "team-based approach" to case management included: team-meeting summaries, treatment plan entries, copies of medical and/or dental exams, leave or visits approvals, and incident reports, among other items. These documents were signed by various individuals, including direct care staff, nurses, administrative staff, and in some instances the assigned case managers/clinical coordinators. OSC summarized the hours reflected in this documentation but did not validate whether the individuals who signed the documents were employed at Bonnie Brae at the time of service, were qualified to perform these functions, or whether the "case management" tasks were in addition to their primary assigned duties, as required by the contract.

**Table VII: OSC’s Recalculation of Case Management Hours – Weekly Summary Form vs. “Team-Based Approach” – Based on Bonnie Brae’s Supplemental Documentation**

Youth Initials	Monthly Summary - February 2020			Weekly Summary - February 2020		
	Total Case Management Hours per Individual “Case Management – Checklist” per Youth	Case Management Hours per “Team-Based Approach” Supplemental Documents per Youth	Difference	Total Minimum Contractually Required Hours per Youth	Case Management Hours per “Team-Based Approach” Supplemental Documents per Youth	Difference
█	24.00	11.75	12.25	5.50	2.94	2.56
█	24.00	10.00	14.00	5.50	2.50	3.00
█	24.00	8.33	15.67	5.50	2.08	3.42
█	24.00	8.08	15.92	5.50	2.02	3.48
█	24.00	9.75	14.25	5.50	2.44	3.06
█	24.00	2.48	21.52	5.50	0.62	4.88
<b>Total</b>	<b>144.00</b>	<b>50.89</b>	<b>93.11</b>	<b>33.00</b>	<b>12.60</b>	<b>20.40</b>
<b>Percentage Difference (Summary Form vs. Team-Based) (144 – 50.90 = 93.10/144)</b>			<b>65%</b>	<b>Percentage Difference (Required vs. Team-Based) (33-12.60 = 20.4/33)</b>		<b>62%</b>
<b>Average Number of Hours per Month</b>			<b>8.4</b>	<b>Average Number of Hours per week</b>		<b>2.1</b>

OSC’s review identified significant discrepancies between the required and recorded hours. As highlighted in Table VII above, Bonnie Brae’s supplemental “team-based approach” documentation significantly differed from Bonnie Brae’s previously submitted case management documentation. Taking these supplemental documents at face value, OSC quantified the durations recorded and found that on a monthly basis there was a 65 percent discrepancy between the hours documented in the beneficiaries’ weekly case management summary form (signed by clinical coordinators/case managers) and the supplemental “team-based approach” documentation. According to Bonnie Brae’s supplemental “team-based approach” documents, on average, Bonnie Brae provided approximately 8.4 hours of case management per youth per month, compared to the combined 24 hours in a month (6 hours multiplied by 4 weeks) Bonnie Brae documented in the case management summary forms.

OSC also recalculated the contractually required weekly case management hours (5.5 hours per week per youth) and compared them to the hours reflected in the supplemental “team-based approach” documentation. This analysis revealed a similar discrepancy of 62 percent. On average, Bonnie Brae provided approximately 2.1 hours of case management per week per youth, far below the contractually required 5.5 hours per week. See Table VII. Bonnie Brae’s own documentation showed that Bonnie Brae failed to meet its contractual requirement here.

Taken together, Bonnie Brae provided OSC with two conflicting sets of records to substantiate its delivery of case management services. Given these conflicting and inadequate records, OSC found that Bonnie Brae could not support the services it contracted to perform. Combined with other deficiencies cited in this report, these failures possibly resulted in vulnerable youth not receiving the services DCF contracted and paid Bonnie Brae to provide. Furthermore, by failing to maintain appropriate records, OSC determined that Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which requires providers to certify that claim information is “true, accurate, and complete,” and N.J.A.C. 10:49-9.8(b)(1), which requires providers to “[k]eep such records as are necessary to disclose fully the extent of services provided.”

#### **4. Individual Therapy Sessions Overlap or Lacked Clear Documentation Specifying When Therapy Occurred**

DCF’s contracts required Bonnie Brae to perform weekly individual therapy sessions for each youth. OSC reviewed documentation for 408 contractually required weekly individual therapy sessions from February 2020. These sessions were comprised of 343 weekly individual sessions provided to youth across all programs and 65 weekly individual Mental Illness and Chemical Abuse (MICA) sessions for youth in the BH/SU program. Based on Bonnie Brae’s documentation, the same two clinical coordinators managed all of these MICA sessions.

OSC determined that Bonnie Brae’s records for the 343 weekly individual sessions for youth in all programs were unreliable. These records did not include the exact dates and times when the therapy occurred. The body of progress notes stated that the therapy sessions spanned the entire week and lasted for at least 60 minutes. However, that information contradicted the headers on the progress notes, which listed specific dates and times. This conflict in records raises the question of which portion of the record, if either, accurately reflected the therapy provided. In addition, OSC found that some of these individual therapy sessions overlapped with one another. For example, in ██████████ cottage, progress notes from February 7, 2020 stated that all eight youths received individual therapy sessions simultaneously from 9:00 AM to 10:30 AM by the same therapist, resulting in overlapping sessions on the same date and time. The body of each progress note, however, stated that the therapy took place for at least an hour over the course of the week, failing to specify exactly when or for how long the youth actively participated, or if the youth participated at all. Because these progress notes were internally inconsistent and the body of each note failed to state specifically when each session took place, OSC found that these notes were not reliable. Further, the progress notes frequently failed to discuss what transpired during these sessions. The absence of these details raises concerns about the quality, duration, and reliability of the documentation of individual therapy sessions.

With respect to the 65 individual MICA sessions, the documentation was equally deficient. The scheduled times listed for all 65 individual MICA sessions were in conflict because the identified coordinators purportedly conducted multiple individual therapy sessions simultaneously, which is not possible. There was no qualifier in the documentation to clarify that these sessions spanned different times throughout the entire week, which casts further doubt as to whether the reported sessions actually took place as recorded. For example, a MICA therapist documented individual therapy sessions from 9:00 AM to 10:30 AM on Friday, February 7, 2020 for all nine youth under her care. The other MICA therapist did the same with his seven assigned youth on Friday, February 7, 2020. This occurred every Friday. Their notes stated: “[y]outh was present for a 60-minute individual session” and “[w]riter met with youth for individual session.” These

statements are problematic as they imply that a single therapist was conducting individual therapy sessions for multiple youth simultaneously, which, by definition, is not an individual therapy session. The conflicting schedules and overlapping sessions cast doubt on the quality, duration, and reliability of the documentation.

OSC's limited review of two cottages during February 2021 identified similar issues. OSC found that 93 progress notes failed to disclose the exact dates and times when the therapy occurred and frequently failed to describe what transpired during the sessions. Separately, 16 progress notes involving individual MICA sessions reported overlapping dates and times for the same youth and clinical coordinator, as it did in February 2020.

According to Bonnie Brae, its Electronic Health Record (EHR) system contained a configuration flaw where service date and time fields automatically populated with pre-scheduled entries rather than the actual dates and times that services were provided. This resulted in inaccurate clinical documentation, an issue that Bonnie Brae asserted has since been corrected. As a result of this flaw, during the period at issue, Bonnie Brae failed to identify the actual dates, times, or durations of individual therapy sessions. Accordingly, OSC could not verify whether or for what duration Bonnie Brae delivered required therapy services. This further supports OSC's finding that Bonnie Brae's records were unreliable.

OSC found that Bonnie Brae improperly rendered overlapping sessions and failed to maintain true, accurate, and complete records. Accordingly, OSC found that Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which states that "providers shall certify that the information furnished on the claim is true, accurate, and complete," and N.J.A.C. 10:49-9.8(b)(1), which states that providers are required "[t]o keep such records as are necessary to disclose fully the extent of services provided." These violations demonstrate that Bonnie Brae failed to comply with regulatory requirements and raise doubts about the accuracy of its documentation and the quality and duration of services provided.

## **5. Discrepancies in Youth Attendance and Progress Notes Documentation**

Youth receiving treatment at Bonnie Brae may take therapeutic leave for 24 hours or more as a temporary absence from the facility for a variety of reasons, including visits with parents. Bonnie Brae's treatment team must approve this leave in advance. Bonnie Brae may request reimbursement from DCF for a maximum of 14 consecutive days of therapeutic leave. Similarly, Bonnie Brae may request from DCF a "missing days" payment authorization for youth who run away or are missing for up to five consecutive days.<sup>3</sup>

OSC cross-referenced Medicaid billing records with youth progress notes for clinical therapy and psychiatric services to determine whether Bonnie Brae billed for therapeutic leave in accordance with its contractual requirements. OSC found several troubling inconsistencies. In the February 2020 sample, out of 101 youth, 55 were on either therapeutic leave or missing for at least one day during the month. Of those 55 youth who were absent from the facility, 32 had at least one instance in their progress notes indicating their presence during therapy sessions, even though Bonnie Brae's own records showed they were on therapeutic leave. In total, OSC identified 109

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<sup>3</sup> Providers can request "missing days" authorization that covers up to a five-day period when a youth has left an out-of-home program. The authorization allows the provider to keep a bed open for that same youth to return within the five-day period.

instances when this occurred. To determine whether this continued, OSC reviewed these same documents for February 2021. From that information, OSC identified 13 instances when two youths were on therapeutic leave but their clinical documentation indicated that they were present.

The noted discrepancies between two sets of Bonnie Brae’s documentation—one showing youths absent from Bonnie Brae because they were either on leave or missing, and progress notes showing that these same youths were on site for services—is another example of Bonnie Brae’s deficient documentation. In one instance, a youth enrolled in the on-campus RTC program was on therapeutic leave in 2020 from February 7-8, 14-22, and 27-29 (14 days), but during those days, there were nine instances documented in progress notes stating that the youth was present for therapy sessions. The progress notes contained statements such as “[t]he youth attended group and provided his peer with feedback”; and “[y]outh joined peers for an RTR group session to discuss ways they could use sober leisure activities at home and on campus at Bonnie Brae to help reduce stress and to reduce triggers to relapse.” These inconsistencies again highlight Bonnie Brae’s failure to document accurately the services it provided. OSC can only conclude that one of the documents at issue—the leave documentation or session notes—is inaccurate.

In its response, Bonnie Brae attributed discrepancies between progress notes and attendance records to the same EHR system flaw previously described, explaining that pre-scheduled entries were not always updated to reflect cancellations or resident absences in the body of the note. Bonnie Brae also indicated that it has since taken corrective actions to address these issues.

By failing to maintain appropriate records, Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which states that “providers shall certify that the information furnished on the claim is true, accurate, and complete,” and N.J.A.C. 10:49-9.8(b)(1), which states that providers are required “[t]o keep such records as are necessary to disclose fully the extent of services provided.”

## **6. Discrepancies in Clinical Coordinator Attendance and Progress Notes Documentation**

OSC cross-referenced clinical coordinator timesheets with progress notes and identified 10 group therapy sessions that included a progress note stating that a clinical coordinator was in attendance during a period when the clinical coordinator was absent from work. For example, based on timesheets, OSC determined that a clinical coordinator used two personal days and one sick day from February 24-26, 2020. According to group therapy session notes, however, during this same three-day period, the clinical coordinator purportedly held a cottage group session and two specialized group sessions. The progress notes for the specialized group sessions stated, “[c]linician facilitated today’s group discussion.” The clinical coordinator signed each progress note for the three group sessions on March 5, 2020 within minutes of each other. In February 2021, OSC identified an additional three instances when, based on timesheets, a clinical coordinator was absent from work, and yet, according to group therapy notes, the same coordinator purportedly was present for therapy sessions. These inconsistencies cast doubt on the credibility of the reported group therapy sessions and raise concerns about Bonnie Brae’s oversight of its staff members.

By failing to maintain appropriate records, Bonnie Brae failed to comply with its DCF contracts and N.J.A.C. 10:49-9.8(b)(1), which states that providers are required “[t]o keep such records as are necessary to disclose fully the extent of services provided.”

## 7. Clinical Coordinators Duplicated Progress Notes

During the course of reviewing progress notes, OSC discovered that two cottage-assigned clinical coordinators generated identical group therapy notes for every youth and nearly every session within their respective cottages throughout the month of February 2020. The two clinical coordinators in question, assigned to [REDACTED] and [REDACTED] Cottages, were also the two coordinators who recorded in excess of 400 clinical hours on their progress notes for case management and clinical therapy.

The clinical coordinator for [REDACTED] Cottage held group therapy sessions on February 3, 10, 17 and 24. The progress notes were identical for all four sessions for every youth in [REDACTED]. The notes in part state:

All youth gathered to discuss the importance of boundary setting and treatment. There was also a discussion about accountability and it looks [sic]. Staff was able to provide each youth an opportunity to practice connecting feelings to words and sharing information with others in a way that has information examined for its content rather than its delivery. Residents were able to draw connections between interpersonal issues and treatment goals. Residents discussed the importance of respect and how to show this when change occurs.

Resident participated with minor issues and direction. Resident was able to debrief without any issues using appropriate communication skills.

Similarly, the clinical coordinator for [REDACTED] Cottage held group therapy sessions on February 6, 13, and 20. The progress notes for youth attending these sessions in part state:

All youth gathered to discuss the importance of respecting peers and staff. There was also a discussion about change. Staff was able to provide each youth an opportunity to practice connecting feelings to words and sharing information with others in a way that has information examined for its content rather than its delivery. Residents were able to draw connections between interpersonal issues and treatment goals. Residents discussed the importance of respect and how to show this when change occurs.

Resident participated with minor issues and direction. Resident was able to debrief without any issues using appropriate communication skills.

Given that youth in these group therapy sessions were not the same and that therapy sessions on different dates would not be identical, the therapy notes would be expected to vary to account for differences. The fact that progress notes from two clinical coordinators covering multiple sessions were nearly identical suggests that the clinical coordinators did not produce notes based on their specific sessions, but rather used a template that may not have been based on the actual therapy provided. Equally troubling, it appears that they duplicated one another's notes rather than documenting the unique observations of the youths in their respective cottages. This repetition, observed in clinical coordinators with the highest documented hours, raises alarms regarding what appears to be a lack of individualized care. This suggests there are systemic shortcomings in providing tailored therapy and support.

The duplicated notes fail to meet the requirements of N.J.A.C. 13:44G-12.1(b), which requires clinicians to maintain signed, dated, detailed, and accurate records that document the dates and nature of services provided, and support the necessity and the appropriateness of the services provided. In addition, these notes fail to satisfy N.J.A.C. 10:49-9.8(a), which states that "providers shall certify that the information furnished on the claim is true, accurate, and complete" and N.J.A.C. 10:49-9.8(b), which requires providers to "maintain records necessary to fully disclose the extent of services provided."

## **B. Clinical Therapy and Psychiatric Service Hours**

Although OSC determined that Bonnie Brae's progress notes for clinical therapy and psychiatric services were unreliable, OSC continued its audit testing using these same documents to assess the extent to which Bonnie Brae documented the required services. OSC accepted the recorded hours as accurate for purposes of calculating the total clinical therapy hours provided in the sample. OSC found that Bonnie Brae failed to provide minimally required services to multiple youths. These findings are discussed in more detail below.

### **1. Deficient Clinical Therapy Hours**

OSC calculated total hours of therapy provided on a weekly basis using the hours recorded on the progress notes. As previously stated, Bonnie Brae's contracts with DCF require it to provide at least eight hours of clinical therapy per week for the SPEC program and six hours per week for the non-SPEC programs, of which 75 percent must be face-to-face with the youth. This amounts to six hours for youth enrolled in SPEC and four and a half hours for youth enrolled in BH/SU and Main Campus RTC.

To streamline the analysis, OSC focused on youth who were present in the facility for at least five of seven days each week. Since most youth taking therapeutic leave did so on weekends when official therapy sessions did not occur, OSC excluded from this review those who took extended therapeutic leave. Of the 274 weekly instances when a youth was present for five or more days, there were 94 instances when Bonnie Brae failed to meet the minimum weekly service hour requirements.

OSC also observed variations in the weekly therapy schedules, with some weeks exceeding the required therapy hours and others falling short. To assess whether Bonnie Brae compensated for

these shortfalls within the sampled month, OSC aggregated the total therapy hours for each youth present for more than 20 days, ensuring they were present for at least five days per week.

The analysis identified 13 of 101 youth (10 SPEC and 3 non-SPEC programs) who did not receive the required number of therapy hours over the course of the month. The deficiencies ranged from 0.5 hours to 8.25 hours, with an average shortfall of 3.73 hours in the month.

OSC performed a similar review for February 2021 that identified similar issues. Of the 89 weekly instances when a youth was present for five or more days, OSC found 41 instances in which Bonnie Brae did not provide the minimum number of therapy hours. During that month, the analysis identified 8 of 26 youth (5 SPEC and 3 non-SPEC programs) who did not receive the required minimum hours of service. The deficiencies ranged from 3.5 to 11.95 hours, with an average shortfall of 6.58 hours.

## 2. Deficient Psychiatric Hours

OSC also identified a shortfall in the psychiatric therapy hours offered to youth enrolled in the SPEC program because Bonnie Brae failed to schedule enough time for each youth. Bonnie Brae's contract with DCF required it to provide a minimum of 1.25 hours (75 minutes) per week per youth of psychiatric services by a licensed psychiatrist or Advanced Practice Nurse, of which 75 percent (56.25 minutes) were required to be face-to-face. According to Bonnie Brae's progress notes, however, Bonnie Brae only provided 45 minutes of face-to-face psychiatric services per week, which is 11.25 minutes or 20 percent less than required for each youth. While this gap may appear minimal on an individual basis, when applied across the 48 youth in the SPEC program for February 2020, it resulted in approximately 34 hours of contractually required psychiatric therapy services that Bonnie Brae did not deliver that month. If this monthly shortfall persisted throughout the year, it would equate to over 400 hours of face-to-face psychiatric services not delivered annually. OSC observed almost identical shortages in the February 2021 sample. The SPEC program provides services to youth who manifest significant emotional and/or behavioral challenges that require specialized clinical intervention, which means that even modest weekly service gaps could adversely impact the affected youth.

By failing to maintain appropriate records, Bonnie Brae violated N.J.A.C. 10:49-9.8(a), which states that "providers shall certify that the information furnished on the claim is true, accurate, and complete," and N.J.A.C. 10:49-9.8(b)(1), which states that providers are required "[t]o keep such records as are necessary to disclose fully the extent of services provided."

## C. Two Unlicensed Clinical Coordinators

OSC found that Bonnie Brae employed two clinical coordinators who were not licensed when they provided services to youth. DCF's contracts require clinical coordinators to be a Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Professional Counselor (LPC). Alternatively, the contracts allow Licensed Social Workers (LSW) and Licensed Associate Counselors (LAC) to work as clinical coordinators under the direct on-site supervision of a clinically licensed practitioner.

On September 9, 2019, Bonnie Brae conditionally hired an unlicensed clinical coordinator with the requirement that she pass the licensing exam to obtain LSW licensure within 90 days. Bonnie Brae representatives advised that they informed DCF's contract administrator of this arrangement on September 23, 2019 using the SPEC PSSR submission. When the clinical coordinator did not pass the exam, Bonnie Brae, without DCF's involvement, granted the clinician a one-time extension. On February 24, 2020, after the clinician again did not pass the exam and more than five months after hiring this individual, Bonnie Brae informed the unlicensed clinical coordinator that she would be reassigned immediately to a temporary case manager role.

Bonnie Brae's conduct undermined program integrity in multiple ways here. First, it was not clear that Bonnie Brae properly notified DCF because Bonnie Brae included the LSW designation in the licensing category of its PSSR, even though this person was not an LSW. Second, Bonnie Brae granted this individual a one-time extension, apparently without having first obtained DCF's approval. Third, this individual is the same [REDACTED] cottage-assigned clinical coordinator who documented more than 400 hours on progress notes and case management supporting documentation, while signing progress notes using the LSW designation. Finally, based on progress notes, this clinical coordinator continued to perform group therapy sessions on February 25, 2020 and February 27, 2020, despite Bonnie Brae advising DCF on February 24, 2020 that it would "immediately" reassign this person.

Separately, on November 16, 2020, Bonnie Brae hired a clinical coordinator with an expired LSW license. OSC reviewed the Division of Consumer Affairs' licensing database, which showed that this person's license expired on August 31, 2020. Progress notes from February 2021 reveal that this clinical coordinator conducted two hours of individual therapy, three hours of family therapy, and twelve hours of group therapy during that month. Bonnie Brae terminated this employee in March 2021. OSC further learned that this clinical coordinator entered into a Consent Order with the state licensing board in June 2022, in which she acknowledged engaging in professional misconduct prior to being employed at Bonnie Brae and further acknowledged working without a license while employed at Bonnie Brae. The Order mandated the clinical coordinator to "cease and desist from advertising, offering to engage in or engaging in the practice of social work, alcohol and drug counseling, mental health therapy and/or counseling, or the provision of social work services."

Bonnie Brae's failure to provide services using licensed clinical coordinators raises significant concerns. By failing to ensure that only licensed individuals provided services, Bonnie Brae violated N.J.A.C. 13:45B-14.4(a), which states that "[w]hen licensure to perform a health care service or function is required by law, an agency shall refer or place only those health care practitioners who are currently licensed or certified and in good standing with their respective New Jersey licensing or registration boards." These actions also violated N.J.A.C. 13:45B-14.4(c), which states that "[t]he agency shall, through its health care practitioner supervisor or other designated individual, verify the license status of each individual to be placed or referred prior to the referral or placement. Licensure shall be verified by obtaining a document, which verifies licensure from the Board or Committee that registers or licenses the individual and, within 45 days of obtaining the verification, by personally inspecting the current biennial registration or license or a copy of the current biennial registration or license."

## VI. Summary of Medicaid Overpayment

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OSC found that for services provided in February 2020 and February 2021, Bonnie Brae failed to maintain records that adequately documented the services that it was contractually required and paid to provide. These issues were widespread and significant. Taking Bonnie Brae's documentation at face value, OSC found that 13 youth in February 2020 and 8 youth in February 2021 did not receive the minimum required number of clinical therapy hours, and none of the participants in the SPEC program received the minimum number of required psychiatric hours in either February 2020 or February 2021, based on the documentation reviewed. Furthermore, the supplemental documentation submitted by Bonnie Brae after the issuance of the SOF confirmed that Bonnie Brae delivered case management services at levels significantly below the amounts indicated in the case management summary form and the contractually required minimums. Due to the unreliability and insufficiency of Bonnie Brae's documentation, OSC could not accurately quantify the full extent of this deficiency. Additionally, OSC found that two clinical coordinators delivered services despite not possessing appropriate licenses.

By failing to maintain accurate and reliable documentation and allowing unlicensed personnel to provide services, Bonnie Brae did not comply with N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:49-9.8(b), N.J.A.C. 10:49-9.8(b)(3), N.J.A.C. 13:45B-14.4(a), and N.J.A.C. 13:45B-14.4(c). Based on the widespread and significant failings noted above, OSC finds that Bonnie Brae must repay the Medicaid program for payments made to Bonnie Brae under the contracts for February 2020 and February 2021. Specifically, Bonnie Brae must repay a total of \$1,528,109, which is comprised of 2,656 claims totaling \$1,113,442 for services provided to youths enrolled in the SPEC, RTC, and BH/SU (on-campus) programs during the sampled month of February 2020 and \$414,667 for 646 claims for the youth sampled in February 2021.<sup>4</sup>

## VII. Recommendations

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Bonnie Brae shall:

1. Reimburse the Medicaid program \$1,528,109.
2. Revise its case management summary form to accurately reflect tasks performed, hours provided, and the individuals responsible. Any deviations from contractual requirements should be documented.
3. Ensure compliance with minimum required case management and clinical therapy hours.
4. In view of the similar findings in two successive audits (DCF and this one), retain and pay all costs/fees associated with an independent third-party monitor, who is approved by OSC and has no affiliation to Bonnie Brae, to conduct calendar year quarterly reviews of Bonnie Brae's case management, clinical, and psychiatric therapy documentation. The monitor shall have full access to all information needed to prepare such reports. The monitor shall prepare written reports bi-annually to OSC and DCF, which shall be submitted

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<sup>4</sup> OSC reserves the right to impose penalties based on the scope, scale, and materiality of the final findings.

no later than one month after the end of each six-month period. The monitor shall remain in place for no less than three bi-annual reports (18 months), subject to OSC extending this timeframe in its sole discretion for two more reporting periods (12 months) if it determines that Bonnie Brae has continued to provide inadequate documentation.

5. Ensure progress notes accurately document the actual time, date, and duration of individual therapy sessions.
6. Implement random weekly audits of progress notes to verify completeness, accuracy, and alignment with actual services rendered.
7. Ensure compliance with minimum required psychiatric hours to meet contractual face-to-face requirements.
8. Verify licensure by obtaining and maintaining copies of valid, non-expired licenses for all positions requiring licensure, and periodically confirming ongoing validity. The verification documentation should be dated to show the date on which verification occurred.
9. Provide regular staff training on accurate and comprehensive documentation practices, emphasizing the importance of recording all significant aspects of the therapy sessions.
10. Submit a CAP to OSC outlining the steps Bonnie Brae will take to address the deficiencies identified in this report.

OSC Note – Bonnie Brae submitted a CAP outlining steps it states it has taken and intends to take to address the identified deficiencies, but its CAP did not address repayment of the identified overpayment.

**Abstract of Minimum Staffing Credentials and Requirements for DCF-Contracted Providers of RTC IOS Services (Contract #18FDZR, Annex A)**

Position	Qualifications	Hours/Week/Youth
Psychiatrist or APN	MD, BC/BE/APN. Board-certified child psychiatrist or psychiatric APN in affiliation with a board-certified child psychiatrist	0.67 clinical hours
Pediatric APN or Pediatrician	MD, BC/BE/APN, NJ-licensed, board-certified	24/7 availability by contract
NJ Licensed Therapist (Clinician) or Masters Level Therapist (LSW, LAC)	LCSW, LMFT, LPC, NJ-licensed psychologist. Master's-level licensed practitioner under the direct on-site supervision of NJ clinically licensed practitioner with documented plan to achieve clinical licensure within 3 years	6 hours; 75 percent of which must be face-to-face time with youth and family
Allied Clinical Therapist	Professional (licensed where applicable)	6 hours per week per youth
Nurse-Health Educator/RN	Registered nurse (RN) or Pediatric Nurse Practitioner	2 hours
Psychologist or Psychiatrist	PhD, PsyD, and Ed.D, M.D.	At intake; as needed
Milieu Staff	Bachelor's-level or high school with 3 to 5 years' experience providing direct care to youth in a behavioral health agency or institutional setting	44 hours per week per youth
Case Manager – Bachelor's Level Practitioner	Bachelor's level with 3 to 5 years of relevant experience or unlicensed Master's-level with 1 year of related experience	5.5 hours per week per youth
Dietician		0.5 Hours at intake; as needed
Service Program Director	Master's degree and 3 years post M.A. experience; Minimum of 1 of the 3 years' experience must be in a supervisory capacity	FT dedicated; on-site

**Abstract of Minimum Staffing Credentials and Requirements for DCF Contracted Providers of BH/SU RTC IOS Services (Contract #18FDZR, Annex A)**

Position	Qualifications	Hours/Week/Youth
Psychiatrist or APN	MD, BC/BE/APN. Board-certified child psychiatrist or psychiatric APN in affiliation with a board-certified child psychiatrist	0.67 clinical hours. 75 percent of which must be face-to-face time with youth and/or family
Pediatric APN or Pediatrician	MD, BC/BE/APN, NJ-licensed, board-certified	24/7 availability by contract
NJ Licensed Therapist (Clinician) or Masters Level Therapist (LSW, LAC)	LCSW, LMFT, LPC, or NJ-licensed psychologist with LCADC licensure. Master's level Licensed Therapist under the direct on-site supervision of NJ clinically licensed practitioner with documented plan to achieve clinical licensure within 3 years	6 hours; 75 percent of which must be face-to-face time with youth and family
Allied Clinical Therapist	Professional (licensed where applicable)	6 hours per week per youth
Nurse-Health Educator/RN	Registered nurse (RN) or Pediatric Nurse Practitioner, with knowledge of substance use	2 hours
Psychologist or psychiatrist	PhD, PsyD, and Ed.D, M.D.	At intake; as needed
Direct Care Staff	Bachelor's-level or high school with 3 to 5 years' experience providing direct care to youth in a behavioral health agency or institutional setting	44 hours per week per youth
Case Manager – Bachelor's Level Practitioner	Bachelor's-level with 3 to 5 years of relevant experience or unlicensed Master's-level with 1 year of related experience	5.5 hours per week per youth
Dietician		0.5 Hours at intake; As needed
Service Program Director	Relevant Master's degree and 3 years post Master's experience working with youth with emotional behavioral challenges. Minimum of 1 of the 3 years' experience must be in a supervisory capacity	FT dedicated; on-site

**Abstract of Minimum Staffing Credentials and Requirements for DCF-Contracted Providers of SPEC Services (Contract #17BJZR, Annex A)**

Position	Qualifications	Hours/Week/Youth
Psychiatrist or APN	MD, BC/BE/APN. Board-certified child psychiatrist or psychiatric APN in affiliation with a board-certified child psychiatrist	1.25 clinical hours. 75 percent of which must be face-to-face time with youth and/or family
Pediatric APN or Pediatrician	MD, BC/BE/APN, NJ-licensed, board-certified	24/7 availability by contract
NJ Licensed Therapist (Clinician) or Masters Level Therapist (LSW, LAC)	LCSW, LMFT, LPC, NJ-licensed psychologist. Master's level licensed practitioner under the direct on-site supervision of NJ clinically licensed practitioner with documented plan to achieve clinical licensure within 3 years	8 hours; 75 percent of which must be face-to-face time with youth and family
Allied Clinical Therapist	Professional (licensed where applicable)	6 hours per week per youth
Nurse-Health Educator/RN	Registered nurse (RN) or Pediatric Nurse Practitioner	1.5 hours
Psychologist or psychiatrist	PhD, PsyD, and Ed.D, M.D.	At intake; as needed
Direct Care Staff	Bachelor's-level or high school with 3 to 5 years' experience providing direct care to youth in a behavioral health agency or institutional setting	63 hours per week per youth
Case Manager – Bachelor's Level Practitioner	Bachelor's level with 3 to 5 years of relevant experience or unlicensed Master's level with 1 year of related experience	5.5 hours per week per youth
Dietician		0.5 Hours at intake; As needed
Service Program Director	Master's degree and 3 years post M.A. experience; Minimum of 1 of the 3 years' experience must be in a supervisory capacity	FT dedicated; The hours provided are the number required to ensure that the needs of the youth are appropriately addressed in a manner consistent with DCF's requirements of the contracted provider



Ray A. Mateo, Partner



November 7, 2025

Via Email ([REDACTED])  
[REDACTED], Supervising Auditor  
Office of the State Comptroller  
Medicaid Fraud Division  
P.O. Box 025  
Trenton, NJ 08625-0025

**Re: Bonnie Brae**

Dear Mr. [REDACTED]:

This law firm represents Bonnie Brae in connection with the Office of the State Comptroller, Medicaid Fraud Division’s (“OSC”) audit of Bonnie Brae. Please accept this letter, and the additional documentation (BB-CK-2902 – 2913) submitted herewith, as Bonnie Brae’s response to the Draft Audit Report dated October 9, 2025 (“DAR”). Without waiving any defenses or objections to OSC’s findings, we have also attached a proposed Corrective Action Plan as Exhibit A hereto and incorporate by reference our previously submitted comments and objections in response to OSC’s Summary of Findings dated February 13, 2025 (“SOF”), including the expert report from [REDACTED], LCSW, the former Deputy Division Director and Manager of all Out-of-Home treatment (behavioral health, substance use, and developmental disabilities) within the New Jersey Department of Children and Families (“DCF”), Children's System of Care (“CSOC”) dated June 30, 2025 (the “[REDACTED] Expert Report”) (collectively the “Prior Submissions”).

Bonnie Brae appreciates the role of the OSC in ensuring accountability. However, the SOF and DAR misrepresent fundamental facts and paint a misleading picture of a respected non-profit’s century-long record of excellence. The findings rely on narrow interpretations of documentation standards that ignore both the complex realities of residential behavioral health care and the State’s own prior approvals of Bonnie Brae’s practices.

The DAR completely discounts the strong performance outcomes and transparency Bonnie Brae demonstrated throughout the audit process. Simply put, the DAR substitutes bureaucratic box-checking for meaningful evaluation – and in doing so, unfairly undermines the work of dedicated professionals who delivered high-quality, uninterrupted care to New Jersey’s most vulnerable youth under extraordinary circumstances.

Moreover, the OSC’s analysis fails to account for critical context. The DAR analyzes Bonnie Brae’s documentation practices from 2020 through 2021, the height of the COVID-19 pandemic. This was a time when residential care providers across New Jersey were adapting to unprecedented operational challenges and evolving state guidance. Since that time, Bonnie Brae has implemented and enforced policies and practices that render some of the points raised by the audit moot.

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### EXECUTIVE SUMMARY

Bonnie Brae is a non-profit corporation that was founded in 1915 by the Honorable Harry V. Osborne, an Essex County Court Judge. Its mission then, as it remains today, is to provide comprehensive care, education, and a safe place for historically underserved youth and families in crisis. Throughout its more than one-hundred-year existence, Bonnie Brae has transformed the lives of over 13,000 youth and families.

Bonnie Brae is Joint Commission accredited and has a long track record of compliance -- regularly passing the myriad of license inspections, surveys, and national accreditations that come with being a health care provider in the highly regulated residential treatment center industry.

Within this industry, Bonnie Brae handles the most challenging cases and is a “go-to agency when CSOC need[] assistance with a challenging youth.” [REDACTED] Expert Report at p. 2. At the time of their admission, 67% of Bonnie Brae residents had been abused, neglected, or witnessed violence inside or outside the home, 64% had been runaways, 70% were taking psychotropic medications, and 95% had school problems, including multiple suspensions, expulsions, and truancy. Despite handling such multi-faceted and complex cases, Bonnie Brae is “renowned for its exceptional track record in achieving positive outcomes.” *Id.* It regularly meets or exceeds the service outcome measures outlined in Annex A of its contracts with DCF. Indeed, for 2020, the focus of the audit, the average length of stay was 9.5 months; over 88% of residents were successfully discharged to a less restrictive setting; 97% of residents had a 90% or higher attendance rate at school; 100% of residents showed improvement on identified strength and needs domains from the time of admission to discharge; and 92% had no subsequent contact with the justice system. Bonnie Brae’s “campus is immaculate, the youth are engaged and satisfied, care managers are equally pleased, and youth are able to return home sooner.” *Id.* at p. 3. In a 2021 satisfaction survey of 75 DCF-contracted caseworkers assigned to Bonnie Brae residents, 99% or more agreed with the following statements:

- Overall, I am satisfied with the services the child receives
- The child's family gets the help they want for him
- The services the child and his family receive are right for them
- The people helping the child stick by the family no matter what
- I feel the child has someone to talk to when he is troubled

BB-CK-2904; see also BB-CK-2906 (similar satisfaction reported by DCF-contracted caseworkers in most recent survey available).

These are the “true measure[s]” of “contract compliance and programmatic success” and for which Bonnie Brae represents the “gold standard.” [REDACTED] Expert Report at p. 3.

Eschewing the true measures of contract compliance, OSC attempts to paint a different picture of Bonnie Brae. Indeed, the DAR is riddled with gratuitous language in its findings, including an unsupported theory of “impossible hours” by case managers. Despite OSC’s claims to the contrary, Bonnie Brae’s case managers did not misrepresent the number of case management hours they worked; rather, Bonnie Brae supplied the proper number of case manager

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full-time equivalents (FTEs) as set forth in its contracts. Bonnie Brae also did not provide overlapping therapy and did not maintain a second, “alternative” set of records as OSC suggests.

Bonnie Brae, as it has throughout the audit, acknowledges that its documentation practices and electronic health records system (EHR) have room for improvement, but objects to OSC’s findings that go beyond such documentation issues. It is important to note that Bonnie Brae has made great strides in its documentation practices since the audited time period. It has implemented rigorous quality controls, modernized its documentation systems, hired additional staff members, including a new Clinical Director, strengthened staffing oversight, and invested in compliance training across all levels of the organization. Going forward, Bonnie Brae looks forward to working with DCF on even further enhancements.

**Audit Finding - A(1)**

**Bonnie Brae’s Case Managers Never Represented to DCF That They Worked Upwards of 430 Hours a Month.**

As its lead point, OSC alleges that Bonnie Brae’s case managers represented that they worked a “highly improbable and, in some cases, simply impossible” number of hours. DAR at pp. 7, 11. That is simply not the case. This erroneous and highly inflammatory conclusion:

- (i) ignores that case management activities at Bonnie Brae are not performed exclusively by the designated case manager, but instead by a large, cross-departmental team,
- (ii) misreads and grossly mischaracterizes Bonnie Brae’s case management summary form – a one-page, internal document that was signed by the designated case manager as verification that Bonnie Brae collectively (and not the case manager individually) performed the required case management activities,
- (iii) disregards the contract between the parties, which specifically identified the number of case management FTEs that Bonnie Brae was required (and did) provide, and
- (iv) disregards the DCF-approved Program Staffing Summary Reports (“PSSRs”) – the *only* document submitted to DCF where Bonnie Brae represented the number of hours, and the percentage of time Bonnie Brae’s case managers were expected (and did) spend on case management activities.

*First*, as explained in our Prior Submissions and the Exit Conference, Bonnie Brae relies on a large, cross-departmental team to perform case management services. As the person with the closest and most direct relationship with the residents in his or her respective cottage, the designated case manager oversees this team and personally performs some of the case management services for his or her residents, but not all of them. This point should not be controversial.

Bonnie Brae is a large residential treatment provider. It is not a five-bed residential home where a single person may handle all the home’s case management activities. Rather, Bonnie Brae

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employs 316 people and, over the years, has built a significant organizational infrastructure. Unlike smaller facilities, Bonnie Brae possesses multiple specialized departments, such as a clinical department, admissions department, transition specialists, finance department, medical records department, health office, residential department, and quality department, among others. When a case management activity involves one of these functions, a staff member in the appropriate department performs the service. Thus, dozens of Bonnie Brae employees contribute to Bonnie Brae's case management service hours and deliverables –not just the designated case manager.

Besides this being completely logical, this should come as no surprise as DCF recognized during its 2015 audit that Bonnie Brae's case management "involve various functions." *See* 2015 Audit at p. 15. Indeed, Mr. ██████████ – the person who co-led the project to develop the staffing grid and rates for the contracts at issue and oversaw contract compliance – acknowledged that "[i]n a large residential facility like Bonnie Brae, case management activities are typically performed by a team of staff, rather than placing all responsibilities on a single individual, which would be inefficient, impractical, and costly." *See* ██████████ Expert Report at p.3. Mr. ██████████ also explained that "[f]rom DCF's perspective, residential treatment facilities were afforded the flexibility to develop a system and infrastructure that worked best for their particular organization so long as adequate personnel were available to meet the diverse case management needs of the youth." *Id.* at p. 4. It should be plain that at Bonnie Brae, an organization with 316 employees, case management services were not solely performed by its case managers and that DCF understood and approved of this approach.<sup>1</sup>

*Second*, OSC bases its "impossible hour" theory on its incorrect reading of Bonnie Brae's one-page case management summary form. As will be discussed more herein, Bonnie Brae, with the approval of DCF, "developed a weekly Case Management services summary documentation form to be completed by the Clinical staff." The "summary form is a one-page, checklist" with "standardized times" for common case management activities. *See* 2015 audit at p. 16. The summary form was just that – a summary document. It was maintained for internal verification purposes only and was not, and was never intended to be, a formal claim form submitted to a payor for payment as OSC seems to treat it. In fact, the weekly-signed case management summary forms were never submitted to DCF at all.

Moreover, nowhere on the form does the case manager expressly represent or certify that all case management activities referenced were personally performed. By electronically signing the summary sheet, the case manager did not, and never intended to, indicate that he/she personally performed all of the listed case management services, let alone make such a representation to DCF,

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<sup>1</sup> Further to this point, during the 2015 audit, DCF, after acknowledging Bonnie Brae's case management services involved "various functions," recommended that Bonnie Brae institute a "system of internal controls [which] *may* include the assignment of a Case Manager to insure that each youth receives the required 5.5 hours per week of case management." *See* DCF 2015 Audit at p. 15 (emphasis added). Thus, DCF did not even require Bonnie Brae to assign case managers to a youth's file and within the context of this recommendation clearly envisioned the role of a case manager, if one was assigned, as overseeing the organization's various functions and confirming that case management activities were performed.

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as OSC maintains. Rather, as the person responsible for overseeing cross-departmental case management activities, the designated case manager merely signed the form to confirm that the requisite services and hours were performed by the case management team – this is exactly what Bonnie Brae proposed in its 2015 corrective plan by stating that the form would be “completed by the Clinical staff.” See 2015 audit at p. 16. The fact that Bonnie Brae did not require each staff member in its 316-person organization who assisted with a resident’s case management to sign an internal one-page summary form does not mean that the case manager was the only individual providing case management services. Contrary to OSC's claim, the internal summary form does not reveal the number of case management hours personally performed by the designated case manager. Instead, the annual PSSRs, which OSC did not consider in this analysis, indicate the amount of time the designated case manager was expected to spend on such activities. If this information had been taken into consideration, it would have demonstrated that the designated case managers had sufficient capacity to fulfill their allotted case management hours and that Bonnie Brae provided the contractually required number of case manager FTEs.

*Third*, despite OSC’s claim that Bonnie Brae was plagued by “significant staffing deficiencies,” Bonnie Brae complied with the contract and supplied the agreed-upon case management resources. Though not referenced in the DAR, each of the contracts at issue contained a staffing grid, which specified the number of FTEs required for different positions. As Mr. [REDACTED] explained, the staffing grid was “used as a mechanism to determine an inclusive rate for providers to have particular staff on hand” – i.e., providers were compensated for having an “appropriate mix of staff ... to achieve ... program directives;” and requiring *more* FTEs would have thus necessarily resulted in *higher* reimbursement rates. [REDACTED] Expert Report at p. 4. For case management, the contracts collectively called for 4.2 case manager FTEs (which equates to 170 total per week by the designated case managers) to service 93 children, as the contract excerpts below demonstrate.

**SPECIALTY BEDS (2.2 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BRAE, BONNIE .  
Contract Number: 17BJZR Program Type: SPEC  
Contract Start Date: 07/01/2016 Contract End Date: 06/30/2021

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	2.20	88.00	49	5.50

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**RTC (1.2 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BONNIE BRAE  
Contract Number: 18FDZR Program Type: RTC  
Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	1.20	47.00	25	5.50

**RTC – Behavioral Health/Substance Use (.86 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BONNIE BRAE- CO-OCCURRING RTC  
Contract Number: 18FDZR Program Type: RTC-BH/SU  
Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	0.86	35.00	19	5.50

At 5.5 hours per child per week, the contracts require a total of 511.5 weekly case management hours (93 x 5.5) but only provide for (and base the reimbursement schedule on) 170 weekly case manager hours. Thus, on their face, the contracts seemingly created a significant staffing shortage of 341.5 hours per week, equivalent to 8.5 FTEs. Put differently, under a strict mathematical approach that treats case management activities as an individualized service, a residential treatment center would need to source 300% more case management hours and FTEs than specified in the contract (and for which they were paid) to meet the service requirements. The contract, however, was not intended to be interpreted in this manner, and the parties did not intend to create such an obvious discrepancy. Nevertheless, this is exactly how OSC interprets the contract when it claims that Bonnie Brae needed 10 *additional* FTEs (for a total of 14.2 FTEs) to perform the work indicated on the case management summary forms, even though the contract itself only called for 4.2 FTEs. See DAR at p. 8.

The flaw in OSC’s approach can be explained by two main points:

- (i) the staffing grid accounted for the fact that others at Bonnie Brae, besides the case managers, would perform case management services -- as we’ve explained, Bonnie Brae case managers oversee the delivery of case management services but do not personally perform all such services. As the staffing grid demonstrates, the

dedicated case managers were expected to perform 170 of the required 511.5 weekly case management hours; and

- (ii) some case management activities are performed at the group level rather than on an individualized basis; therefore, an approach that strictly equates one hour of staff member time to one hour of case management service misses the mark. From a mathematical perspective, if, for example, one hour of service is delivered in a group format of five youth, five hours of service have been delivered. In fact, we shared with OSC communications with DCF that showed an agreement between the parties that case management services were performed 25% on an individual basis and 75% on a group basis. In the email thread with DCF, Bonnie Brae explained that a portion of case management services are “delivered in a group format,” such as “transportation coordination, daily scheduling, organizing family visits, group social/educational appointments and outings, clothing inventory and shopping, etc.” See BB-CK-2408 – 2411.

Understanding these two points is essential in reconciling the contracts’ staffing requirements with the required service hours. OSC, however, improperly neglected these points and calculated case management service hours in a way that conflicted with the contracts’ express terms and staffing ratios as well as the parties’ long-established course of dealing. This led to their faulty conclusion that Bonnie Brae needed 10 additional FTEs to deliver the services outlined in its case management summary forms.

Lastly, OSC’s approach to case management service hours also conflicts with the DCF-approved PSSRs. On an annual basis, Bonnie Brae submitted PSSRs for DCF’s review and approval, which specifically identified the percentage of time and number of hours each designated case manager was required to devote to case management activities. This was the only document submitted by Bonnie Brae to DCF that specifically represented how many hours each of its case managers would dedicate to case management activities.

As the relevant sections of the approved 2020 PSSRs show (copied below), Bonnie Brae’s designated case managers were generally expected to spend between 14.50 and 20 hours per week in a standard 40-hour work week (or 36.2% and 50% of their time) on case management activities for the 93 beds/residents covered by the contracts.

**CONTRACT - 17BJZR**

CASE MANAGEMENT																								
[REDACTED]	Case Management	MA	Psych Studies	LSW	Case Management. Delivery of service hours will vary.	FT(40)	37.50%	RTC, Co-Occurring RTC			9:30 AM	11:00 AM	9:30 AM	11:30 AM	9:30 AM	10:30 AM	9:30 AM	11:30 AM	9:30 AM	10:00 AM			7.00	
[REDACTED]	Case Management	MSW	Social Work	IAC, LCADC, LPC	Case Management. Delivery of service	FT(40)	36.20%				1:00 PM	3:00 PM	10:00 AM	12:30 PM	10:00 AM	2:00 PM	10:00 AM	2:00 PM	10:00 AM	12:00 PM				14.50
[REDACTED]	Case Management	MA	Mental Health Counseling	IAC, LCADC, LPC	Case Management. Delivery of service	FT(40)	36.20%				12:00 PM	2:00 PM	9:00 AM	11:30 AM	9:00 AM	1:00 PM	1:00 PM	5:00 PM	1:00 PM	3:00 PM				14.50
[REDACTED]	Case Management	MA	Counseling	IAC	Case Management. Delivery of service	FT(40)	36.20%				1:00 PM	3:00 PM	9:00 AM	11:30 AM	9:00 AM	1:00 PM	11:00 AM	3:00 PM	9:00 AM	11:00 AM				14.50
[REDACTED]	Case Management	MA	Social Work	LAC. 6 yrs exp	Case Management. Delivery of service	FT(40)	36.20%				8:00 AM	10:00 AM	12:00 PM	2:30 PM	11:00 AM	3:00 PM	10:00 AM	2:00 PM	9:00 AM	11:00 AM				14.50
[REDACTED]	Case Management	MSW	Social Work	LSW <1 year	Case Management. Delivery of service	FT(40)	36.20%				12:00 PM	2:00 PM	11:00 AM	1:30 PM	8:30 AM	12:30 PM	1:00 PM	5:00 PM	9:00 AM	11:00 AM				14.50



**Table I: Case Manager Capacity to Perform Contractually Required Case Management Hours (February 2020)**

Cottage/ Case Manager	Hours Worked (Actual)	Percentage of time to be devoted to Case Management Activities per PSSR	Expected Case Management Hours Based on Total Hours Worked	Therapy Hours Worked (Actual)	Available Hours for Case Management Activities (Hours worked – therapy hours worked)
██████████	144	36.2%	52	100	44
██████████	144	36.2%	52	98	46
██████████	152	50%	76	76	76
██████████	152	36.2%	55	84	68
██████████	160	50%	80	81	79
██████████	128	50%	64	77	51
██████████	160	36.2%	58	80	80
██████████	152	50%	76	66	86
<b>TOTAL</b>			<b>513</b>		<b>530</b>

Based on the foregoing points above, we respectfully request that OSC remove section A(1) from the final audit report. Consistent with the contract and PSSRs, Bonnie Brae assigned the proper number of FTEs to perform the contractual case management services. It was not required to supply an additional 10 FTEs (a 333% increase) to meet its contractual obligations. Rather, the assigned case managers had sufficient capacity to perform their expected number of weekly case management hours as defined by the staffing grid and PSSRs. Moreover, the notion that Bonnie Brae was plagued with staffing shortages and its case managers compensated by falsely claiming to work upwards of 436 hours per month fails to recognize that case management activities are performed by a large, cross-departmental team and do not reside exclusively in the designated case managers. It is also based on a flawed reading of Bonnie Brae’s case management summary form, which was nothing more than an internal, one-page, summary verification form and not a representation by the case manager of personal hours worked, as well as a plainly incorrect approach to calculating case management service hours, which diverged dramatically from the staffing grid and PSSRs. As such, this section, which is superfluous to OSC’s overall finding regarding Bonnie Brae’s purported documentation deficiencies, should be excised from the final report.

**Audit Finding - A(2)  
Bonnie Brae Used Its Case Management Summary Form in a Manner Reasonably Believed to Be Acceptable to DCF**

As OSC observes, the case management summary form did not “record specific times when [case management] activities occurred.” DAR at p. 10. Bonnie Brae does not contest this finding. The case management summary form, however, was never intended to track time with such

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precision. Rather, Bonnie Brae used the form in the way it believed in good faith was approved and acceptable to DCF.

The case management summary form, as noted in the DAR, was developed in response to Bonnie Brae's 2015 DCF audit. As a way to better document and confirm Bonnie Brae's weekly performance of case management activities, DCF accepted Bonnie Brae's proposed corrective action of utilizing a summary form that "identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings and allows for documentation of discrete times spent delivering *other* Case Management services." 2015 Audit at p. 16 (emphasis added).

As shown below, the summary form developed as part of the 2015 audit corrective action plan lists twelve separate categories of activities with a conservative standardized projection of the weekly time spent throughout the organization across the tasks.

### **Case Management - Weekly Activities**

TASK & Hours/Minutes per resident
TX planning - 1 hour
Transfer Meetings (AM, PM) - 30 minutes
Cottage staff meetings - 15 minutes
Weekend Projected Plan/ Home Visits (Planning & Debriefing) - 30 minutes
Incident report (review & signature) - 30 minutes
Phone calls - 30 minutes
Progress Notes Documentation - 1 hour
Correspondence - 1 hour
*(Routine: e-mails, Contact/Visitors list, Invite and cover letters for treatment team)
*(External Correspondence: Letters for court, DCP, Medicaid, SSI, etc.)
Monthly Treatment Plan - 30 min/wk
Financial Oversight - 15 minutes
*(WEP, W2's, money requests, transportation vouchers, etc.)
<b>Total number of weekly case management hours provided: 6.0 hours</b>
<b>Total number of contracted weekly case management hours required: 5.5 hours</b>
<b>Community Program - Additional Weekly Case Management Activities, School registration and coordination: 45 minutes</b>
<b>Total number of weekly case management hours provided by the Community Programs: 6 hours and 45 minutes</b>

To understand why Bonnie Brae proposed, and DCF approved, this approach requires an appreciation of the broad scope of case management services performed at large residential treatment centers like Bonnie Brae. Case management services, by their nature, are difficult to define. The contract does not define the term and, in fact, offers scant details regarding the expected services. More specifically, as can be seen in the contract excerpt below, the only case management services identified in the contracts are family orientation, admission documentation,

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participation in monthly treatment team meetings, and ad hoc psycho educational activities. See Contracts at Exhibit E, Part A – Minimum Staffing Requirements Grid.

Position	Qualifications	Other Requirements	Hours/youth/week
Case Manager- Bachelors Level Practitioner	Bachelor's level with 3-5 years of relevant experience or unlicensed Master's level with 1 year of related experience	-Family orientation (within 1 <sup>st</sup> 24 hours) -Review and signature of all required paperwork (within 48 hours) -On-site family psycho educational activities consistent w/ comprehensive treatment & discharge plan (as needed/monthly) -Attend treatment team meetings (monthly)	5.5 hours per week per youth;

Besides the monthly treatment team meeting, the specific activities identified in the contracts either occur on admission or an as-needed basis and plainly do not lend themselves to predictable scheduling, consistent hour tracking, or collectively comprise anything close to 5.5 hours per week per youth.

As Mr. ██████████ explained in his report and based on his role in developing and enforcing the contract, the contract's lack of detail was intentional:

The Contract defines case management services very generally... The Contract was structured this way because case management services cover a broad range of activities designed to offer individualized support and assist youth in gaining access to needed medical, social, educational, and other services that address their unique circumstances. It involves a wide variety of everyday activities, like ensuring that residents attend school, receive medical care, and have their daily needs met, as well as coordinating transportation for family visits, court hearings, and medical appointments. It also involves coordination and communication, as applicable, with families, foster families, child welfare workers, probation officers, court officials, family support organizations, care management organizations, medical providers, and schools. For example, case management services could entail spending a day in court with a resident or something more routine like making sure a resident has clean and seasonally appropriate clothes or their preferred toothpaste or soap. In short, case management services cover hard to define ancillary activities that help individuals navigate the treatment process, connect with necessary resources, and ultimately achieve positive and lasting recovery.

██████████ Expert Report at p. 3.

Mr. ██████████'s description of the intended scope of the contract's case management services is consistent with common regulatory definitions of the term in other contexts. See, e.g., N.J.A.C. 10:73-1.2 (defining case management services as "services which assist a beneficiary of Medicaid/NJ Family Care or a child, youth, or young adult receiving services from the Children's

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System of Care (CSOC) in gaining access to needed medical, social, educational, and other services.”); 42 C.F.R. §440.169 (“Case management services means services furnished to assist individuals...in gaining access to needed medical, social, educational, and other services.”). Bonnie Brae’s delivery of case management services followed this standard definition. To help OSC appreciate the wide range of case management activities it performs on a regular basis, Bonnie Brae prepared a detailed case management chart that identified the different activities, the department/person responsible for the task, and a more precise approximation of the average time spent on those activities. Overall, the chart spans 23 pages and lists 93 discrete activities ranging from coordination of visitations and medical/legal appointments to activities associated with Joint Care Reviews to more routine scheduling, documentation, and communications.

Once the sheer breadth and *ad hoc* nature of these activities at a large residential treatment center like Bonnie Brae is recognized, the use of a summary form with standardized time projections becomes more understandable. DCF indeed appreciated the “impracticality of rigidly documenting case management activities” and logging “numerous every day, routine tasks that independently may not be very time-consuming, such as obtaining toothpaste or procuring a permission slip for the youth.” ██████████ Expert Report at p. 4. Mr. ██████████ explained that:

these types of ad hoc activities are impractical to track on a minute-by-minute basis. In my experience, if an agency was adequately staffed and residents were progressing in their treatment, like at Bonnie Brae, the residents were undoubtedly receiving the necessary case management services. Otherwise, the residents would not be in a position to achieve such positive outcomes. In other words, documenting every minute of staff time is nearly impossible due to the ad hoc nature of case management activities and communications with stakeholders (including family, physicians, courts, and probation officers) and was not the focus of DCF. DCF’s focus was on the residents having the necessary case management support, as much or as little as needed, to allow the residents to return home or transition to a lower-intensity service with the shortest feasible length of stay.

From DCF’s perspective, meeting service outcomes – which Bonnie Brae regularly accomplished – was the primary goal of the contract and served as *prima facie* evidence that the residents were receiving the necessary case management services. These outcomes could not have been achieved without a residential treatment center performing the “hard to define ancillary activities that help individuals navigate the treatment process, [and] connect with necessary resources.” *Id.* at p.3.

Because “DCF’s focus, was on achieving qualitative outcomes that are not measured by counting minutes” and “[d]ue to the impracticality of documenting this type of ad hoc support, DCF approved Bonnie Brae’s use of a summary Case Management Checklist with standardized times (even though the standardized times were just projections) as part of their 2015 action plan.” *Id.* at pp. 2, 4. OSC misattributes Mr. ██████████’s personal knowledge to counsel, dismissively labeling that insight as “not tenable.” DAR at p. 10. However, Mr. ██████████, the former Deputy Director of DCF who was instrumental in creating the contract and overseeing its compliance during the 2015 audit, is far better positioned to comment on DCF’s actions during his tenure than OSC, which lacks firsthand knowledge or a credible basis to opine on DCF’s decisions in 2015.

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Moreover, OSC's finding that "Bonnie Brae did not use [the case management summary] form in the manner as approved by DCF and as Bonnie Brae proposed to do in response to the 2015 audit" because the form "lacked discrete time entries or individualized information" is also misplaced. DAR at p. 11. As the 2015 audit report states, Bonnie Brae proposed using a "Case Management services summary form [which] identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings, and allows for documentation of discrete times spent delivering other Case Management services." 2015 Audit at p. 16. The weekly case management summary form is structured exactly as written. It enumerates Bonnie Brae's twelve most common case management activities with standardized times for each category. Bonnie Brae could have supplemented this form by adding discrete times spent on "*other* Case Management services" (i.e., services that are not already on the standard one-page summary checklist). However, such supplementation of other services was not required in the action plan, and Bonnie Brae relied in good faith on the fact that DCF found the summary form with standardized times acceptable. Additionally, as represented in its 2015 corrective action plan, Bonnie Brae's medical records and clinical teams conducted weekly audits. As the case management activities chart indicates, the Medical Records team devotes approximately 2.5 hours per week to auditing clinical and psychiatric charts, and the Medical Records team, Clinical Team, and Quality Department spend another approximately 2.5 hours per week auditing EHR records. Documents reflecting near daily audits of clinical and case management notes were produced to OSC at BB-CK-2235 – 2257 despite OSC's claim that "Bonnie Brae did not produce evidence that it performed any weekly audits of its case management services." DAR at p. 11. As such, Bonnie Brae complied with its 2015 audit action plan, which did not require the "discrete time entries" that OSC seeks to impose ten years after the fact.

### **Audit Finding - A(3)**

#### **The Case Management Materials Produced During the Audit Demonstrate That Bonnie Brae Performed the Activities Listed on the Case Management Summary Form**

In response to OSC's audit request for case management documentation, Bonnie Brae produced the relevant case management summary forms as it reasonably believed such forms were sufficient per the 2015 audit. As a result, Bonnie Brae did not believe it was necessary to produce, and OSC did not specifically request, the supporting documentation to the summary form. While Bonnie Brae would have complied with any request, providing such documentation for each of the 93 residents enrolled in on-campus programs would have been an extremely cumbersome and time-consuming task. This process would have required gathering thousands of pages of documents related to routine daily activities from multiple departments and employees, as well as conducting an extensive email review, since much of the staff's work and coordination occurs via email.

Against this backdrop and having only received the case management summary forms from Bonnie Brae, OSC expressed "significant concern" in its SOF "as to whether Bonnie Brae provided the listed [case management] services and, if so, the effectiveness of these services given the lack of specific information about what took place." DAR at p. 10. To address this purported concern and disabuse the misimpression that residents were not receiving case management services,

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Bonnie Brae assembled case management packets for 6 residents and offered to go through the burdensome exercise for the other 87 residents if OSC wanted to review such information.

More specifically, Bonnie Brae produced the following categories of documents and explained the effort, coordination, and process that is involved with each activity: (1) comprehensive monthly treatment plans, (2) therapeutic leave documents, (3) weekend projected schedules, (4) incident reports, (5) memos to chart reflecting calls, (6) correspondence with guardians and other stakeholders, (7) PerformCare notes capturing interactions between the case management organization and Bonnie Brae, (8) treatment discharge plans, (9) nursing notes, (10) child satisfaction surveys, (11) mental health assessments, (12) youth appointment calendars, (13) visitor sign-in sheets, (14) van shuttle schedules, (15) financial oversight tracker, and (16) chart audits. This production for just six of the 93 residents was approximately 2500 pages. Bonnie Brae also offered to pull staff member emails to show the extensive internal and external case management communications occurring on a regular basis.

These documents are not in any way “alternative records” as OSC pejoratively and recklessly calls them, as if trying to suggest that Bonnie Brae maintained a secret, second set of books or otherwise concocted records to respond to the SOF. DAR at p.1. That notion is absurd. The records were maintained in the normal course of business and made at or near the time of the event by, or from information transmitted by, a person with knowledge of the matter. The documents were not created after the fact or for the purposes of the audit, and nothing on the face of the documents suggests anything to the contrary.

They are also not “conflicting” records and do not contradict the case management summary form. The documents were *not* produced as a proxy to count case management minutes, as OSC attempts to do, because many of the documents do not quantify the amount of time spent on an activity. The documents, rather, were produced to show that the activities on the case management summary form – and other unlisted case management activities that were identified on the case management chart – were occurring on a regular basis. As such, the documents are supportive and do not in any way contradict or conflict with the case management summary form.

For example, the case management summary form lists treatment planning and the monthly treatment plan as two of the standard weekly activities and assigns a “standardized time” of 1.5 hours per week for the activities – the same standardized time DCF credited Bonnie Brae for these activities in the 2015 audit, but for which OSC provides no credit. *See* 2015 Audit at p. 15. To show that this work was performed, Bonnie Brae produced a copy of the thorough monthly treatment plan and other documents showing the scheduling/participation by Bonnie Brae resources in the monthly treatment plan meeting. As explained in our Prior Submissions and Exit Conference and as should have been evident from the document itself, the treatment plan is constantly updated throughout the month and tracks the residents’ progress on clinical, medical, school, social/recreational, and work experience matters. It also reflects the treatment team’s current recommendations for an appropriate treatment regimen. Creating this comprehensive document requires treatment team interactions and discourse, along with frequent updates and interactions between the case manager and clinical, medical, school, and cottage resources.

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DCF, as experts in the field with familiarity of the treatment plan process and the significant amount of time, resources, and coordination it requires, credited Bonnie Brae with 1.5 hours per week for such activities in 2015 along with another hour per week for preparation and completion of Joint Care Reviews, and Bonnie Brae incorporated such standardized times in its case management summary form. Lacking a similar background, OSC did not credit Bonnie Brae for any treatment plan-related time despite being presented with proof that the treatment plan tasks listed on the case management summary form were, in fact, performed. While the treatment plan and related scheduling documents may not help OSC quantify the precise time spent on these activities, it does not logically track that the production of these materials conflicts with the case management summary form. To the contrary, the documents support the form as they show the activity took place.

Along these same lines, and as another example, Bonnie Brae produced weekend projected schedules in support of the line item on the case management summary form regarding “weekend projected plan/home visits (planning & debriefing) – 30 minutes.” As explained in the Prior Submissions and the Exit Conference, this schedule is updated every weekend to reflect which residents are going home for the weekend and which residents are remaining on campus. To create the schedule, Bonnie Brae confirms the resident’s eligibility to go home based on a level of supervision review, confirms the visit with the resident’s guardian along with the time of departure and method of travel, ensures the resident’s departure is consistent with the agreed upon travel plan, makes appropriate staffing arrangements for the residents remaining on campus, and then debriefs with the guardian and residents during and/or after the visit. Again, OSC did not credit Bonnie Brae for any time for this activity although it undoubtedly occurred presumably because Bonnie Brae did not track the date and time each of these different steps was accomplished. OSC took the same approach for the other categories of backup documentation produced by Bonnie Brae – only crediting those activities that were documented with a time component. *See* DAR at pp. 11-12.

While we understand (though do not agree with) OSC’s approach and finding that Bonnie Brae did not “properly document[] that [it] had provided the contractually required five and a half hours per week of case management services to each youth” because it did not log the time spent on every activity, we strongly object to OSC’s speculative and erroneous suggestions throughout the DAR that based on this perceived documentation deficiency residents did not receive proper care or were somehow “adversely affected.” DAR at pages 6, 11, 12. OSC simply has no basis or expertise to make such sweeping conclusions regarding treatment, which happen to be contrary to Bonnie Brae’s positive service outcome metrics, sterling industry reputation, glowing caseworker satisfaction surveys, and Mr. [REDACTED]’s first-hand observations regarding Bonnie Brae’s “gold standard” quality of care. *See* [REDACTED] Expert Report at pp. 2-3; *see also* BB-CK-2902 – 2907.

#### **Audit Finding - A(4)**

#### **Bonnie Brae’s Clinicians Did Not Improperly Render Overlapping Individual Therapy Sessions.**

In this section, OSC, focusing on the header of the EHR records, claims that “Bonnie Brae improperly rendered overlapping [individual therapy] sessions.” DAR at pp. 13-14. Based on its

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EHR records, Bonnie Brae understands why it may appear that its clinicians performed overlapping services. That, however, was not the case.

As OSC notes, the Service Date/Time fields for weekly individual therapy in the EHR records often overlapped across cottage members. In contrast, the body of the note typically indicated something different, such as individual therapy taking place over the course of the week or the session being rescheduled or canceled. We provided additional context during the Exit Conference to explain this apparent conflict.

Specifically, as previously explained, the audit helped Bonnie Brae discover a flaw in the setup of its EHR system, which has since been remedied. Based on the way the EHR platform was structured, an activity needed to be scheduled in advance in the system before an electronic note could be generated. To facilitate this process, the EHR team scheduled upcoming events in the system, which allowed clinicians or case managers to go into the system and create an electronic note after the event took place. As it turned out, this approach was flawed because the Service Date/Time fields in the note automatically populated with the date and time scheduled in the system by the EHR team. For group therapy sessions, which took place on recurring dates and times, this did not pose a problem as the Service Date/Time fields reflected the actual date and time of the service. However, for activities that did not take place on a set schedule, like individual therapy or case management, this structure presented a challenge. The EHR team addressed this challenge by programming events without a fixed or routine schedule in the EHR system for Fridays. As a result, at the end of each week, the clinician or case manager would receive a scheduling reminder to create a note memorializing the weekly activity. Based on the way the system was structured, the Service Date/Time fields in the note for such non-fixed events were automatically populated with the Friday control date. Clinicians were not trained on how to change these fields, as it was a convoluted, complex, and time-consuming process. Instead, they were instructed to reflect any changes to the scheduled date and time in the body of the note.

Because individual therapy usually does not take place during a set block of time, this approach often led clinicians to insert a statement in the body of the individual therapy notes indicating that therapy occurred throughout the course of the week. From decades of experience and best practices, Bonnie Brae learned that its patient population generally does not tolerate lengthy one-hour blocks of individual therapy well. Rather, individual therapy for at-risk youth is most effective in smaller intervals, which allows the clinicians to be more flexible and respond to issues as they arise in the moment. This approach is referred to as life space therapy and is a well-established therapeutic technique. As Mr. [REDACTED] explained:

in the context of a residential treatment facility working with at-risk youth, it is challenging for youth with behavioral issues to engage in extended therapy sessions. Facilities like Bonnie Brae focus on a therapeutic approach known as Life Space Counseling, using everyday situations and interactions to help youth learn from challenging behaviors and build positive relationships. This approach allows for shorter therapy sessions (sometimes only 10-15 minutes) as needed, rather than scheduled one-hour sessions.

[REDACTED] Expert Report at p. 5.

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During the audit period, the progress notes did not reflect the date and times of these 10- and 15-minute increments but only generally stated that therapy was performed throughout the week.<sup>3</sup> This is no longer the case. As part of its corrective action, Bonnie Brae has implemented changes to better track the date/times during the week the clinician interacts with a resident, along with the substance of each such incremental meeting.

Prior to the audit, Bonnie Brae prioritized the resident's individualized monthly treatment plan over documenting every interaction. The monthly treatment plan is a live document that is updated regularly throughout the course of the month and tracks, among many other things, the residents' clinical progress against emotional, behavioral, family, and discharge goals. This process acts as a safeguard and check and balance to ensure that the contractual services are being provided, and the residents are progressing through their treatment goals. Mr. [REDACTED] described the critical importance of the treatment plan process in evaluating clinical progress and contract compliance:

DCF monitored facilities' compliance by reviewing treatment plans and often attending Child and Family Team (CFT) meetings. The treatment plans and CFT meetings are essential in developing the array of interventions a youth may need. ... Clinicians are not required to document every interaction; instead, they rely on weekly documentation in treatment plans to track progress. The use of treatment plans, outcomes of CFT meetings, and other diagnostic information are fundamental to providing effective care. While DCF values routine documentation by clinicians and staff, the emphasis on metrics is secondary to clinical oversight by qualified staff and detailed treatment plan documentation.

[REDACTED] Expert Report at p. 5.

Bonnie Brae thus rightfully placed its focus on the treatment plan over "document[ing] every interaction." Nevertheless, Bonnie Brae understands OSC's findings regarding its EHR flaw that led to inaccurate date/time fields and the lack of detail in its progress notes and has implemented appropriate corrective actions. Bonnie Brae, however, objects to the various gratuitous comments sprinkled throughout this section, questioning the "quality of care" delivered even though OSC never evaluated Bonnie Brae's performance under the contracts' service outcome metrics and lacks the foundation to make such claims. *Id.* Mr. [REDACTED], who has treatment expertise and a foundation to opine on this issue as the former Deputy Director of DCF, has a very different view of Bonnie Brae. In his professional judgment, "Bonnie Brae's outcomes represent the gold standard." [REDACTED] Expert Report at p. 3. Stated differently, "it is the treatment outcomes that truly matter, which was an area where Bonnie Brae excelled." *Id.* at p. 2. This sentiment is echoed by the DCF-contracted caseworkers who universally are "satisfied with the services the child receives" and find residents are "doing better in school and/or work," "get[] along better with peers and other people," and are "able to cope when things go wrong." BB-CK-2907. As such, we respectfully request that such unnecessary and unfounded comments be removed from the final audit report.

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<sup>3</sup> We acknowledge the MICA notes lacked similar language but note that life space counseling was practiced with MICA residents.

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**Audit Findings – A(5) and (6)  
Alleged Discrepancies in Youth and Clinical Coordinator Attendance and Progress Note Documentation.**

These findings reference purported discrepancies between the date/time fields of progress notes and the attendance records for clinical coordinators and residents. Both of these issues are largely driven by the flawed EHR system discussed in our response to Section A(4).

Regarding the resident attendance discrepancy, as stated above, upcoming therapy sessions were scheduled in the EHR system in advance. This often took place before Bonnie Brae received notice that a resident would be going home on therapeutic leave. In these situations, because the date/time field was pre-populated with the scheduled date and time, the clinician was supposed to indicate the resident's absence in the body of the note. Some of the clinicians, however, were not as diligent as they should have been about indicating absences. The issue, however, has been fixed as the EHR settings have been changed, and clinicians are now required to keep signed attendance sheets for therapy sessions.

Moreover, we also note that calculating therapeutic leave is nuanced, which may not have been completely factored into OSC's analysis. A resident is considered to be on therapeutic leave based on their location at 11:59 pm. Thus, a resident may still attend a therapy session on days they are listed as being on therapeutic leave – it would depend on the time of the therapy session as compared to the time the resident leaves the facility. And, from an economic perspective, Bonnie Brae is paid the same rate whether the resident is classified as being on leave or present, meaning there is no financial incentive to classify a resident one way or the other. Any mistakes were clearly of an administrative nature.

As for the ten instances of a clinical coordinator being absent on days when the date/time field of the progress note indicated that group therapy was performed, this too relates to the prior settings in the EHR. If a session was rescheduled or canceled altogether, the clinician was supposed to indicate such information in the body of the note. This did not occur on the ten occasions identified by OSC. The issue has since been fixed. Bonnie Brae has also put in place more robust weekly audits by the quality assurance and clinical supervisory team to ensure compliance with the contract and to confirm that the progress notes are consistent with attendance sheets.

**Audit Finding – (A)(7)  
Alleged Cloned Progress Notes**

OSC alleges that two clinical coordinators generated identical group therapy notes for four group sessions in February 2020 and three group sessions in February 2021. Bonnie Brae does not condone the copying of notes from week to week, however we object to the statement in the DAR that the clinician "used a template that was not based on the actual therapy provided." As explained during the Exit Conference and in our Prior Submissions, it is common for group therapy sessions to address the same topics in back-to-back sessions or for one cottage to cover a similar group topic as another cottage, especially for important subjects like boundaries and

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accountability, which were covered by [REDACTED] in February 2020, and respecting peers and staff, which was covered by [REDACTED] in February 2021.

Bonnie Brae recognizes that the clinician should have provided more session-specific details in the progress notes, should not have copied a model from another clinician, and should have clearly included a notation that the group was continuing its discussion from a prior session. However, the lack of such detail in the progress notes does not in any way mean, as OSC maintains, that the notes do not reflect the actual therapy provided or the topics covered by the group. To avoid this issue from reoccurring, Bonnie Brae has implemented processes to ensure that group therapy notes are more robust going forward, including the establishment of an internal committee to audit a sampling of group therapy notes, track findings, and respond accordingly.

## **SECTION B**

### **Audit Finding – B(1)**

#### **Bonnie Brae Generally Made the Required Minimum Therapy Hours Available to its Residents and Their Families**

OSC contends that Bonnie Brae failed to provide the required clinical therapy hours for some of its residents – 13 of 101 residents in February 2020 and 8 of 26 residents in February 2021. Bonnie Brae conducted its own independent analysis and arrived at a different calculation for most of the residents in question. As outlined in our Prior Submissions, the majority of these residents met the required clinical therapy hours. In fact, several of the residents far exceeded the minimum requirements.

In reviewing the supporting documentation, we note that OSC continues to not give Bonnie Brae credit in some instances for scheduled Family Group Therapy sessions that did not take place because the family did not attend the scheduled event, and that OSC reversed credit for some sessions previously credited in the SOF. First, the family therapy time should be credited to Bonnie Brae. The organization made efforts to arrange and staff the service, but for reasons outside of Bonnie Brae's control, the session did not take place. The DAR implies that these services were not rendered due to Bonnie Brae's shortcomings; however, the fact is that the services were made available, but the families in these instances failed to attend their scheduled session.

As the treatment plans indicate, the treatment team plots a course of monthly therapy for each resident. This is done with complete transparency to the resident, the resident's guardian(s), and the State's care management organization and unified case management worker. In fact, one hundred percent of surveyed DCF-contracted caseworkers indicated that they help decide the child's treatment goals and participate in the child's treatment. *See* BB-CK-2907; *See also* BB-CK-00020 (excerpted below for an example of treatment plan course of treatment); BB-CK-00025 (showing resident, resident's mother, and CMO/UCM worker signature on treatment plan).

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<b>Treatment Recommendations:</b>	Treatment team recommends Emotional Management group 2x per week and individual therapy to address emotional management issues. Team recommends family therapy 2x per month to address family issues. Team would like to address ██████████ academic issues through participation in on campus school program. In addition, the team recommends trauma survivor group, psychosexual education and extra-curricular activities.
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Where a family is unwilling to engage in family therapy, it is not clinically appropriate to alter the individualized and thoroughly vetted treatment plan and substitute the family therapy hours with another form of therapy. As Mr. ██████████ observed, “[f]orcing residents to participate in inappropriate services or undergo lengthy therapy sessions can be clinically harmful.” ██████████ Expert Report at p. 5. Thus, Bonnie Brae should not be penalized for refusing to add clinically inappropriate services that would conflict with a resident’s treatment plan to compensate for a family’s lack of attendance.

Second, it is unclear why OSC reversed credit for certain therapy sessions. We have resubmitted documentation for those sessions and ask that OSC reconsider its reversal. *See* BB-CK-2908 – 2913.

On a separate note, as referenced in our Prior Submission, there are three residents in February 2021—specifically ██████████, ██████████, and ██████████—who fell short of their respective clinical hours because they were admitted to Bonnie Brae during that particular month. As we explained in the Prior Submissions, as part of Bonnie Brae’s COVID protocols in effect in February 2021, new residents started off in quarantine in a separate cottage until they were cleared to move into the milieu, which delayed the start of full therapy services. Moreover, new admittees undergo an onboarding process, including orientation, completion of admission paperwork, and clinical evaluations for group assignments. The treatment team must first make an “individualized, needs driven assessment” before therapy starts in full as a “one-sized fits all approach” is clinically inappropriate. ██████████ Expert Report at 2. Consequently, during the pandemic, it took a week or longer after admission for a resident to be assigned and fully integrated into therapy groups. The circumstances surrounding these three residents were isolated incidents related to their admission dates and should not be counted against Bonnie Brae’s contract compliance.

**Audit Finding – B(2)**  
**Residents Met the Required Minimum Psychiatric Hours**

OSC claims that residents in the SPEC program received 11.25 minutes less face-to-face psychiatric services per week than contractually required. More specifically, OSC contends that Bonnie Brae provided 45 minutes of face-to-face psychiatric care per week to SPEC residents rather than the contractually allotted 56.25 minutes. That is not so.

During the audited time period, psychiatric services consisted of two separate activities: psychiatric care group therapy and current mental status check.<sup>4</sup> As the progress notes indicate,

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<sup>4</sup> As discussed during the Exit Conference, Bonnie Brae changed its clinical model for delivering psychiatric services in 2023 and stopped performing group psychiatric therapy in favor of individualized therapy.

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the weekly group therapy sessions spanned 45 minutes. The current mental status check was a separate activity of at least 15 minutes where the psychiatric staff reviewed and logged the resident's appearance, motor activity, attitude, speech, mood, affect, thought process, thought content, concentration, and assessed whether the resident possessed any suicidal or homicidal ideations. The individual checks were sometimes performed before or after the group sessions and sometimes on different dates altogether.

Because the current mental status check did not regularly occur at a scheduled time, the EHR team scheduled the mental status check within the EHR system for the same time as the psychiatric group session. This was done as a reminder to the psychiatric staff to perform such checks and, as stated above, the event needed to be scheduled in the system before an electronic note could be generated. This approach led to the date/time field for the current mental status electronic record to automatically populate with the same date and time as the group therapy session. Although the records show that the current mental status checks were performed, OSC gave Bonnie Brae no credit for the activity. Consequently, the purported shortfall is attributable to the flawed setup in the EHR system and is not indicative of a lack of service.

### **Audit Finding - SECTION C**

#### **The Two Unlicensed Coordinators Were Promptly Addressed**

Bonnie Brae acknowledges that it briefly employed two unlicensed clinical coordinators. The DAR, however, lacks context and does not set forth the reasons for the issues or Bonnie Brae's prompt corrective actions.

The first unlicensed clinician, ██████████, was conditionally hired as a clinical coordinator on September 9, 2019, subject to her receiving an LCSW license within 90 days and she worked under the direct supervision of Bonnie Brae's then-Clinical Director. Bonnie Brae disclosed ██████████'s hiring to DCF in its September 30, 2019, SPEC PSSR. When ██████████ did not earn her license within the allotted time, she was granted a short extension to pass the licensing exam. OSC asserts that Bonnie Brae did not disclose this extension to DCF, but as documents produced during the audit demonstrate, Bonnie Brae was encouraged by its contract administrator to provide interim staffing updates and changes via email or telephonically rather than through the formal PSSR process. Consistent with Bonnie Brae's practices and strong rapport with its contract administrator, it is far more likely that the one-time extension was vetted with the contract administrator rather than unilaterally granted by Bonnie Brae.

In any event, on February 24, 2020, after ██████████ notified Bonnie Brae that she failed the exam, she was reassigned to a temporary case manager role on that same date and DCF was contemporaneously notified of the change. Following ██████████'s reassignment, OSC alleges that she provided clinical services for two additional days: February 25, 2020, and February 27, 2020. However, as OSC noted in Section A(6), ██████████ was absent on February 27, 2020, and did not perform any services on that day. A note was incorrectly generated for that date due to the aforementioned EHR system flaw, as the session was scheduled in the system prior to ██████████'s reassignment. Thus, at most, there may have been a one-day lag time in the implementation of ██████████'s reassignment.

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The second unlicensed clinician, [REDACTED], was hired as a clinical coordinator on November 16, 2020. In accordance with its onboarding diligence process, Bonnie Brae conducted a license status search on the Division of Consumer Affairs (“DCA”) website prior to hiring [REDACTED]. DCA’s database indicated that [REDACTED]’s license was “active” and that she was not subject to any board actions. See BB-CK-2407. Bonnie Brae relied on the search result in allowing [REDACTED] to begin employment four days later.

11/12/2020

Details



The State of New Jersey NJHome Services A-Z Departments/Agencies



Office of the Attorney General OAGHome Agencies/Pro



## NEW JERSEY DIVISION OF CONSUMER AFFAIRS

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License Information

Accurate as of November 12, 2020 1:09 PM

[Return to Search Results](#)

Name: [REDACTED]

Address: Woodbridge, NJ

Profession/License Type: Social Work Examiners, Licensed Social Worker

License No: [REDACTED]

License Status: Active

Status Change Reason: License Issuance

Issue Date: 6/14/2017

Expiration Date: 8/31/2020

NO Board Actions. For more information contact New Jersey State Board of Social Work Examiners at (973) 504-6495

OSC contends that Bonnie Brae failed to properly verify [REDACTED]’s license because, at the bottom of the search page, and inconsistent with the “active” classification, the site also indicated a license expiration date of August 31, 2020. [REDACTED] however, was hired in the middle of the COVID-19 pandemic. During this public health emergency, the State and regulators were frequently providing grace periods and relaxing deadlines across various sectors and legal systems. Under these circumstances, it was not unreasonable for Bonnie Brae to accept DCA’s public display of the active status of [REDACTED]’s license. Once Bonnie Brae learned that [REDACTED]’s license was, in fact, expired, it promptly terminated her employment. That said, Bonnie Brae has since implemented a new license verification policy to ensure this type of situation does not occur again.

Lastly, it is important to note that both circumstances involving [REDACTED] and [REDACTED] were temporal in scope, predated OSC’s audit, and were rectified through Bonnie Brae’s internal system. Indeed, Bonnie Brae has already implemented robust processes to verify credentials for newly licensed professionals and requires monthly verification for all professional licenses for existing staff. Accordingly, Bonnie Brae’s new verification policy will prevent any administrative oversight regarding its employees’ licenses.

Letter to [REDACTED], Friday, November 7, 2025  
Page 23 of 23

\* \* \* \*

As set forth above, Bonnie Brae faithfully complied with the true measure of contract compliance and programmatic success – it regularly met or exceeded the service outcome measures in its contracts with DCF. As Mr. [REDACTED] explained, “the real purpose of the Contract, and DCF's focus, was on achieving qualitative outcomes that are not measured by counting minutes. The Contract goals were, as they should be, focused on providing the best treatment with the shortest feasible length of stay, allowing youths to return home or transition to a lower-intensity service.” [REDACTED] Expert Report at p. 2. Having met these qualitative metrics, DCF and residents received the benefit of the contracts. As such, we respectfully maintain that OSC's request of a full refund for all monies paid for the February 2020 and 2021 audited services is excessive.

Thank you for your consideration. Please contact us if you have any questions or have difficulty accessing any of the referenced documents.

Very truly yours,



---

Ray A. Mateo, Partner  
Calcagni & Kanefsky LLP

# Exhibit A



# Bonnie Brae

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November 7, 2025

Office of the State Comptroller (OSC)  
State of New Jersey  
New Jersey Department of Children and Families (DCF)

**Re: Submission of Bonnie Brae Corrective Action Plan**

Dear OSC and DCF Representatives,

On behalf of Bonnie Brae, I respectfully submit the organization's Corrective Action Plan in response to the recent audit findings issued by the Office of the State Comptroller and the Department of Children and Families.

While we may not fully concur with all aspects of the findings, we acknowledge and respect the determinations made and will comply accordingly. Bonnie Brae remains firmly committed to maintaining full adherence to all contractual, fiscal, and documentation standards. The attached plan outlines the corrective measures we are implementing to strengthen systems, ensure sustained compliance, and promote continuous quality improvement.

This plan reflects our values of transparency, accountability, and collaboration. It also establishes an Internal Audit and Compliance Oversight Committee, reporting directly to the Chief Executive Officer and the Board Finance Committee, to ensure long-term monitoring and execution.

We appreciate the guidance and oversight provided by OSC and DCF and look forward to ongoing partnership as we implement these actions. Please do not hesitate to contact me directly should additional information or documentation be required.

Sincerely,

Paul D. Rieger, MSW  
*Chief Executive Officer*



# Bonnie Brae

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## *Bonnie Brae – Audit Response and Corrective Action Plan*

Date: November 7, 2025

Submitted to: Office of the State Comptroller (OSC) and New Jersey Department of Children and Families (DCF)

Prepared by: Paul D. Rieger, Chief Executive Officer – Bonnie Brae

In coordination with:

- Chief Financial Officer: [REDACTED]
- Chief Operating Officer: [REDACTED]
- Clinical Director: [REDACTED]
- Director of Quality Assurance and Improvement: [REDACTED]

### SUMMARY STATEMENT

*Bonnie Brae acknowledges receipt of the audit findings and recommendations and is fully committed to addressing each item in a transparent and compliant manner. Prior to the audit findings, Bonnie Brae proactively sought to address and innovate solutions for some of the issues identified in the audit. Specifically, our leadership team has initiated a corrective action process aimed at improving cross-departmental collaboration, independent consultation, strengthening internal controls, and ensuring sustainability.*

*The following corrective action plan outlines: (i) the work that Bonnie Brae has undertaken since 2021, (ii) the work performed since we were contacted in January 2025 regarding the Summary of Findings, and (iii) our responses to the Draft Audit Report recommendations.*

### CORRECTIVE ACTION PLAN

#### **I. Enhancements Made Prior to the Issuance of the SOF (June 20, 2021 – January 2025)**

- On rare occasions prior to the last quarter of calendar year 2022, Bonnie Brae hired Clinical Coordinators pending waivers or documentation from the NJ Boards, limiting their responsibilities strictly to case management and non-clinical duties. To further ensure that no individual inadvertently provides services beyond the scope of their license, Bonnie Brae has since discontinued this practice. All clinical staff now begin employment only after full licensure verification and Board documentation are confirmed.
- A second Assistant Clinical Director was added to the clinical department in July 2022 to lower the supervisory load, provide coverage in absences and enhance auditing of clinical documentation.
- A ‘float’ clinician position was approved and hired in March 2022 to enhance coverage in the clinical department.
- Psychiatric deliverables - The psychiatric staffing and contract deliverables were modified in the Spring of 2023. This was done in collaboration with the clinical



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- department at CSOC/DCF. This work culminated in Bonnie Brae increasing staffing (adding 1.5 FTE, psychiatric APNs) and a contract modification.
- In February 2023, Bonnie Brae purchased iCentrix a software solution to add auditing and dashboard functionality to the Carelogic platform prioritizing an audit tracking system for the contract deliverables.
  - In November 2023, the clinical department enhanced the Superuser training for our EHR platform, Carelogic, to include audit tracking through iCentrix. This evolved into weekly audit meetings starting in early 2024.
  - In mid-2024 due to the delay in the iCentrix project an IT consultant was hired to develop audit reports from Carelogic by youth and clinician as well as reports on deliverable completion.
  - Upgraded clinical department IT equipment to include laptops and signature pads.
  - Focused on recruitment and retention of clinicians through training and compensation (periodically throughout the time period).

## II. Enhancements from the receipt of the SOF to present:

### January 2025

- Jan 22: Comptroller's preliminary audit feedback received — triggered corrective planning process.
- Jan 23: Leadership engaged legal and external audit consultants — established foundation for systematic corrective action.

### February 2025

- Feb 14 & 19: Audit review meetings identified compliance and documentation potential areas of improvement.
- Feb 21: Updated policy for verifying licenses.
- Feb 24: Benchmarked documentation and staffing strategies with other providers.

### March 2025

- Mar 10–11: Contract deliverables reviewed; clarifying questions sent to DCF.
- Mar 13: Executive Committee of Bonnie Brae's Board briefed on audit issues — ensured governance oversight.
- Mar 20: DAP note format implemented (this is a known clinical documentation note structure, implemented for consistency)

### April 2025

- Apr 3–4: Two new clinical positions approved; SPEC deliverables plan developed — compliance roadmap established.
- Apr 9: Engaged external consultant [REDACTED] (Lean Six Sigma) — enhanced compliance expertise
- Apr 15: Phased Compliance Plan developed — structured approach to align deliverables.

### May 2025

- May 6: Group schedule designed for SPEC implementation.
- May 20: SPEC staffing increased from 7 to 8 clinicians.



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- May 2025: Benchmarked practices with peer provider [REDACTED] — expanded creative therapy modalities.

## June 2025

- Jun 2: New SPEC Clinical Coordinator hired
- Jun 2025: Two additional clinical positions approved — increased bandwidth.

## July 2025

- Jul 21: [REDACTED] group structure realigned.
- Jul 22: SPEC Clinical Deliverables Workgroup established — instituted weekly cross-departmental oversight.
- Jul 2025: State initiated review of contract deliverables — informed next phase of planning. Bonnie Brae is part of the state workgroup for reviewing and updating contract deliverables.

## August 2025

- Aug 18: Assistant Clinical Director appointed; two new SPEC clinicians hired — ensured continuity and expansion.
- Aug 18: Draft *Clinical Handbook* and *Vacancy Coverage Plan* developed — formalized sustainability framework.
- Aug 25: New Clinical Director hired (start date October 6).

## September 2025

- Sep 4–5: Clinical Focus Group schedule finalized in CareLogic.
- Sep 8–9: Documentation audit completed and reviewed; staff-specific corrective timelines established.
- Sep 15: Focus and Track groups implemented in multiple cottages.
- Sep 18–19: HR accountability meetings initiated; Performance Improvement Plan implemented.
- Sep 28: Per-diem clinician job description developed for flexible coverage.

## October 2025

- Oct 2: Supervised Hours Policy issued — linked documentation completion to accrual of hours.
- Oct 6: New Clinical Director began — unified leadership and accountability.
- Oct 6: Documentation Compliance Assistant position posted.
- Oct 20: Temporary Case Coverage Policy drafted — ensured deliverables maintained during vacancies.
- Oct 28: Clinical temp agency engaged as contingency staffing measure.

## November 2025

- Nov 3: Recruitment/retention recommendations
- Nov 5: Clinical Director reported full compliance for face-to-face deliverables under SPEC.



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### III. Enhancements in Progress/Response to OSC Recommendations

#### 1. Case Management Summary Form Revision

Audit Recommendation: Revise the Case Management Summary Form to accurately reflect tasks performed, hours provided, and responsible staff.

Actions:

- Going forward, each designated clinician or case manager will be required to write a narrative summary of individualized case management activities.
- The QA Department will oversee the development of the new case management section and the COO and Clinical Director will develop and implement staff training on proper use.
- Monitoring and Accountability:  
QA will oversee staff training completion. The Director of Quality Assurance, COO, and Clinical Director will develop and facilitate training, which will also be incorporated into the Clinical Handbook. A signed attendance sheet will be maintained in the corrective action file.
- Responsible Party: COO, Clinical and Director of Quality Assurance and Improvement

#### 2. Compliance with Required Case Management and Clinical Hours

Audit Recommendation: Ensure compliance with the minimum required case management and clinical therapy hours.

Actions:

- Develop a new model and staffing complement for delivering case management: Bonnie Brae has developed an integrated case management framework designed to provide a more unified and sustainable approach to coordinating admissions, treatment planning, medical services, discharge, and aftercare. The model is intended to align with contract case-management expectations and includes provisions to help maintain continuity of services during vacancies, absences, or documentation delays.
- Each youth will participate in weekly case-management groups led by designated case managers, representing approximately one-third of required service hours, with the remainder covered through individualized, group, and collateral activities across specialized roles.
- The continuum integrates existing, repurposed, and new case management positions—including Medical, Education, Quality, and Discharge Planning Case Managers—supported by clinicians and medical records staff.
- Case Management Oversight: Case management documentation reports will be generated by the QAI Department and presented to the Clinical Director and COO for review and follow-up. Supervisors will utilize an audit tool during regular supervision to review content accuracy. Weekly compliance audits and cross-program quality



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reviews will verify that required case-management hours are met and documentation is completed accurately and on time.

- Clinical Therapy Enhancement: Four new clinician positions have been added to our 93-bed main campus. Three are assigned to the SPEC program—which requires the most clinical hours and represents 52.7% of campus beds—reducing caseloads from up to 14 to 7 (a 50% decrease). The fourth clinician is added to RTC BH/SU services, where caseloads are smaller and require about 25% fewer hours. The first two positions were approved 4/1/25 and the second 2 were added 6/1/25
- This expansion increased clinical capacity by 60% for SPEC, 14.3% for RTC and RTC BH/SU, and 33.3% overall across campus contracts.
- To prevent service interruptions, clinical vacancies are now covered collaboratively, with cases distributed among multiple clinicians. Combined with enhanced case management resources, this provides greater flexibility and consistency
- Expanded the number of clinical track and focus groups and standardized approach to documentation to ensure accurate service records.
- Clinical Service Oversight: Clinical documentation completion and service delivery are tracked weekly through compliance audits. A dedicated position has been established to conduct routine compliance audits across all programs. The Clinical Director and QAI Department review these findings to verify that required clinical hours are met and documentation is completed accurately and on time.
- Responsible Party: COO, Clinical Director and QAI Director

### **3. Independent Third-Party Monitor**

Audit Recommendation: Retain an independent third-party monitor approved by OSC to review case management, clinical, and psychiatric documentation.

Actions:

- As part of a negotiated resolution and subject to agreement on the scope and duration of the monitorship, Bonnie Brae will consider retaining an independent monitor to review case management, clinical, and psychiatric documentation.
- Responsible Party: CEO with Legal Counsel

### **4. Documentation of Therapy Sessions**

Audit Recommendation: Ensure progress notes document actual time, date, and duration of sessions.

Actions:

- The EHR system will be updated to ensure all notes reflect actual time, date, and session duration.
- Clinical Director and QAI Department will develop and facilitate training on new documentation standards and retain attendance records.



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- Time has been scheduled on the master calendar each week for all clinicians to complete documentation.
- **Monitoring and Accountability:** A pilot audit tool has been developed for use by the Clinical Director and Assistant Clinical Directors during supervision to review sample notes and confirm that required elements—including time, date, and session duration—are accurate. Accountability expectations for clinicians will be reinforced through supervision, performance evaluation, and corrective action processes. Clinicians must be current on documentation to accrue hours toward independent licensure.
- **Responsible Party:** COO, Clinical and Director of Quality Assurance and Improvement

## **5. Weekly Audits of Progress Notes**

**Audit Recommendation:** Implement random weekly audits of progress notes.

**Actions:**

- Weekly compliance audits now track clinical documentation and service delivery to confirm accuracy and timely completion of all required hours
- Quality audit of random sample of progress notes weekly.
- An internal committee has been established to operationalize these audits, document policies and procedures and track/respond to the audits
- **Monitoring and Accountability:** An internal committee has been established to operationalize audits, track findings, and respond. Audit results will be reviewed monthly in Leadership Meetings to ensure follow-through
- **Responsible Party:** COO, Clinical and Director of Quality Assurance and Improvement

## **6. Psychiatric Session Scheduling**

**Audit Recommendation:** Ensure sufficient time is allocated for psychiatric sessions.

**Actions:**

- Scheduling and documentation processes will be reviewed to ensure adequate time is allocated for all psychiatric sessions.
- Conduct workload and scheduling review.
- Adjust psychiatric coverage if necessary to meet face-to-face requirements.
- Enhanced in Spring 2023 through collaboration with CSOC clinical and contracting departments. CSOC approved enhancements and modified contract.
- When sessions are shorter than scheduled, the reason and clinical justification will be documented.
- **Monitoring and Accountability:** QAI will report on completion of notes for the Medical Director's review and follow-up. The Medical Director will conduct and/or review monthly sample audits to verify session duration, documentation completeness, and clinical justification.
- **Responsible Party:** Medical Director, CEO, COO and Director of QAI



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## 7. Licensure Verification and Documentation

Audit Recommendation: Verify and maintain current licensure documentation.

Actions:

- Human Resources has enhanced verification processes.
- Updated the process for verifying licensed professionals at Bonnie Brae (Policy Updated 2/21/25)
- Monitoring and Accountability: HR will maintain a licensure tracking log. Random file audits will be conducted biannually to confirm valid licensure documentation.
- Responsible Party: HR and Director of Quality Assurance and Improvement.

## 8. Staff Training on Documentation Practices

Audit Recommendation: Provide regular staff training on documentation practices.

Actions:

- Comprehensive documentation training will be embedded in professional development processes.
- Develop and deliver annual Documentation Accuracy Training.
- Require completion by all licensed and clinical staff.
- Monitoring and Accountability: Compliance will be included as a performance evaluation metric.
- Responsible Party: COO, Clinical Director, HR Director

**OSC Note** - Supporting documentation (pages 33 to 44) attached to the provider's response has been omitted to maintain confidentiality.

### **Bonnie Brae's Comments and OSC's Responses**

In response to the Draft Audit Report (DAR) issued by the Office of the State Comptroller, Medicaid Fraud Division (OSC), Bonnie Brae, through counsel, submitted a response that takes issue with OSC's audit findings. After reviewing Bonnie Brae's response, OSC determined that it did not contain information that would change OSC's findings.

As part of its response, Bonnie Brae provided a Corrective Action Plan (CAP) stating "[w]hile we may not fully concur with all aspects of the findings, we acknowledge and respect the determinations made and will comply accordingly. Bonnie Brae remains firmly committed to maintaining full adherence to all contractual, fiscal, and documentation standards." The CAP states that Bonnie Brae hired additional clinical and management staff, approved hiring additional staff, provides additional training, and updated procedures for completing service documentation. However, the CAP does not address whether Bonnie Brae will reimburse the Medicaid program the identified overpayment of \$1,528,109.

Set forth below are Bonnie Brae's specific objections to the audit findings and OSC's responses. Bonnie Brae's full response is attached to the Final Audit Report as Appendix A.

#### **Failure to Support Hours Documented by Cottage-Assigned Clinical Coordinators Demonstrates Deficient Recordkeeping**

##### **Excerpt of Bonnie Brae's Objections**

###### **Audit Finding - A(1)**

###### **Bonnie Brae's Case Managers Never Represented to DCF That They Worked Upwards of 430 Hours a Month.**

As its lead point, OSC alleges that Bonnie Brae's case managers represented that they worked a "highly improbable and, in some cases, simply impossible" number of hours. DAR at pp. 7, 11. That is simply not the case. This erroneous and highly inflammatory conclusion:

- (i) ignores that case management activities at Bonnie Brae are not performed exclusively by the designated case manager, but instead by a large, cross-departmental team,
- (ii) misreads and grossly mischaracterizes Bonnie Brae's case management summary form – a one-page, internal document that was signed by the designated case manager as verification that Bonnie Brae collectively (and not the case manager individually) performed the required case management activities,
- (iii) disregards the contract between the parties, which specifically identified the number of case management FTEs that Bonnie Brae was required (and did) provide, and
- (iv) disregards the DCF-approved Program Staffing Summary Reports ("PSSRs") – the **only** document submitted to DCF where Bonnie Brae represented the number of hours, and the percentage of time Bonnie Brae's case managers were expected (and did) spend on case management activities.

*First*, as explained in our Prior Submissions and the Exit Conference, Bonnie Brae relies on a large, cross-departmental team to perform case management services. As the person with the closest and most direct relationship with the residents in his or her respective cottage, the designated case manager oversees this team and personally performs some of the case management services for his or her residents, but not all of them. This point should not be controversial.

Bonnie Brae is a large residential treatment provider. It is not a five-bed residential home where a single person may handle all the home's case management activities. Rather, Bonnie Brae employs 316 people and, over the years, has built a significant organizational infrastructure. Unlike smaller facilities, Bonnie Brae possesses multiple specialized departments, such as a clinical department, admissions department, transition specialists, finance department, medical records department, health office, residential department, and quality department, among others. When a case management activity involves one of these functions, a staff member in the appropriate department performs the service. Thus, dozens of Bonnie Brae employees contribute to Bonnie Brae's case management service hours and deliverables –not just the designated case manager.

Besides this being completely logical, this should come as no surprise as DCF recognized during its 2015 audit that Bonnie Brae's case management "involve various functions." *See* 2015 Audit at p. 15. Indeed, Mr. ██████ – the person who co-led the project to develop the staffing grid and rates for the contracts at issue and oversaw contract compliance – acknowledged that "[i]n a large residential facility like Bonnie Brae, case management activities are typically performed by a team of staff, rather than placing all responsibilities on a single individual, which would be inefficient, impractical, and costly." *See* ██████ Expert Report at p.3. Mr. ██████ also explained that "[f]rom DCF's perspective, residential treatment facilities were afforded the flexibility to develop a system and infrastructure that worked best for their particular organization so long as adequate personnel were available to meet the diverse case management needs of the youth." *Id.* at p. 4. It should be plain that at Bonnie Brae, an organization with 316 employees, case management services were not solely performed by its case managers and that DCF understood and approved of this approach.<sup>1</sup>

*Second*, OSC bases its "impossible hour" theory on its incorrect reading of Bonnie Brae's one-page case management summary form. As will be discussed more herein, Bonnie Brae, with the approval of DCF, "developed a weekly Case Management services summary documentation form to be completed by the Clinical staff." The "summary form is a one-page, checklist" with "standardized times" for common case management activities. *See* 2015 audit at p. 16. The summary form was just that – a summary document. It was maintained for internal verification purposes only and was not, and was never intended to be, a formal claim form submitted to a payor for payment as OSC seems to treat it. In fact, the weekly-signed case management summary forms were never submitted to DCF at all.

Moreover, nowhere on the form does the case manager expressly represent or certify that all case management activities referenced were personally performed. By electronically signing the summary

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<sup>1</sup> Further to this point, during the 2015 audit, DCF, after acknowledging Bonnie Brae's case management services involved "various functions," recommended that Bonnie Brae institute a "system of internal controls [which] *may* include the assignment of a Case Manager to insure that each youth receives the required 5.5 hours per week of case management." *See* DCF 2015 Audit at p. 15 (emphasis added). Thus, DCF did not even require Bonnie Brae to assign case managers to a youth's file and within the context of this recommendation clearly envisioned the role of a case manager, if one was assigned, as overseeing the organization's various functions and confirming that case management activities were performed.

sheet, the case manager did not, and never intended to, indicate that he/she personally performed all of the listed case management services, let alone make such a representation to DCF, as OSC maintains. Rather, as the person responsible for overseeing cross-departmental case management activities, the designated case manager merely signed the form to confirm that the requisite services and hours were performed by the case management team – this is exactly what Bonnie Brae proposed in its 2015 corrective plan by stating that the form would be “completed by the Clinical staff.” See 2015 audit at p. 16. The fact that Bonnie Brae did not require each staff member in its 316-person organization who assisted with a resident’s case management to sign an internal one-page summary form does not mean that the case manager was the only individual providing case management services. Contrary to OSC’s claim, the internal summary form does not reveal the number of case management hours personally performed by the designated case manager. Instead, the annual PSSRs, which OSC did not consider in this analysis, indicate the amount of time the designated case manager was expected to spend on such activities. If this information had been taken into consideration, it would have demonstrated that the designated case managers had sufficient capacity to fulfill their allotted case management hours and that Bonnie Brae provided the contractually required number of case manager FTEs.

*Third*, despite OSC’s claim that Bonnie Brae was plagued by “significant staffing deficiencies,” Bonnie Brae complied with the contract and supplied the agreed-upon case management resources. Though not referenced in the DAR, each of the contracts at issue contained a staffing grid, which specified the number of FTEs required for different positions. As Mr. [REDACTED] explained, the staffing grid was “used as a mechanism to determine an inclusive rate for providers to have particular staff on hand” – i.e., providers were compensated for having an “appropriate mix of staff ... to achieve ... program directives;” and requiring *more* FTEs would have thus necessarily resulted in *higher* reimbursement rates. [REDACTED] Expert Report at p. 4. For case management, the contracts collectively called for 4.2 case manager FTEs (which equates to 170 total per week by the designated case managers) to service 93 children, as the contract excerpts below demonstrate.

**SPECIALTY BEDS (2.2 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BRAE, BONNIE .  
 Contract Number: 17BJZR Program Type: SPEC  
 Contract Start Date: 07/01/2016 Contract End Date: 06/30/2021

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	2.20	88.00	49	5.50

**RTC (1.2 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BONNIE BRAE  
 Contract Number: 18FDZR Program Type: RTC  
 Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	1.20	47.00	25	5.50

**RTC – Behavioral Health/Substance Use (.86 FTEs)**

Medicaid Provider #: [REDACTED] Agency Name: BONNIE BRAE- CO-OCCURRING RTC  
 Contract Number: 18FDZR Program Type: RTC-BH/SU  
 Contract Start Date: 07/01/2017 Contract End Date: 06/30/2022

**TREATMENT TEAM MEMBERS TO CHILD RATIOS**

Position	Credentials	FTE	Total Hours Per Week	# Children Served	Hours Per Child/Week
Case Management	BA with 3-5 years experience or unlicensed MA with 1 year experience	0.86	35.00	19	5.50

At 5.5 hours per child per week, the contracts require a total of 511.5 weekly case management hours (93 x 5.5) but only provide for (and base the reimbursement schedule on) 170 weekly case manager hours. Thus, on their face, the contracts seemingly created a significant staffing shortage of 341.5 hours per week, equivalent to 8.5 FTEs. Put differently, under a strict mathematical approach that treats case management activities as an individualized service, a residential treatment center would need to source 300% more case management hours and FTEs than specified in the contract (and for which they were paid) to meet the service requirements. The contract, however, was not intended to be interpreted in this manner, and the parties did not intend to create such an obvious discrepancy. Nevertheless, this is exactly how OSC interprets the contract when it claims that Bonnie Brae needed 10 *additional* FTEs (for a total of 14.2 FTEs) to perform the work indicated on the case management summary forms, even though the contract itself only called for 4.2 FTEs. See DAR at p. 8.

The flaw in OSC’s approach can be explained by two main points:

- (i) the staffing grid accounted for the fact that others at Bonnie Brae, besides the case managers, would perform case management services – as we’ve explained, Bonnie Brae case managers oversee the delivery of case management services but do not personally perform all such services. As the staffing grid demonstrates, the dedicated case managers were expected to perform 170 of the required 511.5 weekly case management hours; and



**CONTRACT - 18 FDZR**

CASE MANAGEMENT																						
Case Management	MA	Psych Studies	LSW Supervision by J. [redacted] 2 year plan to	Case Management. Delivery of service hours will vary.	FT (40)	20%	RTC MICA, SPEC					2:00 PM	4:00 PM	2:00 PM	4:00 PM	2:00 PM	4:00 PM	12:30 PM	2:30 PM	1:00 PM	2:00 PM	9.00
Case Management	MSW	Social Work	LSW. LCSW within 2 years under clinical supervision of LCSW.	Case Management. Delivery of service hours will vary.	FT (40)	50%						1:00 PM	5:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM	9:00 AM	1:00 PM	20.00
Case Management	MSW	Social Work	LSW. LCSW within 2 years under clinical supervision of LCSW. 6 yrs. exp	Case Management. Delivery of service hours will vary.	FT (40)	50%						1:00 PM	5:00 PM	9:00 AM	1:00 PM	9:00 AM	12:30 PM	9:00 AM	2:00 PM	9:00 AM	12:30 PM	20.00
Case Management	MSW	Social Work	LSW. 2 year plan for LCSW licensure supervised by [redacted] CSW. 11/2 yrs. exp	Case Management. Delivery of service hours will vary.	FT (40)	50%						12:00 PM	4:00 PM	11:00 AM	3:00 PM	8:30 AM	12:30 PM	1:00 PM	5:00 PM	9:00 AM	1:00 PM	20.00
Case Management	MSW	Social Work	LSW. 2 year plan to obtain LCSW under supervision of LCSW 5 years exp	Case Management. Delivery of service hours will vary.	FT (40)	50%						11:00 AM	4:00 PM	11:00 AM	3:00 PM	11:00 AM	3:30 PM	9:00 AM	12:30 PM	9:00 AM	12:00 PM	20.00

Pursuant to the 2020 approved PSSRs, the parties agreed that Bonnie Brae’s designated case managers would collectively allocate 168.5 hours per week (the equivalent of 4.2 FTEs) on case management activities to service 93 residents. As such, the weekly hour/FTE commitments in the approved PSSRs tracked the contract staffing grid requirements outlined above – the PSSRs in the contracts’ other years similarly aligned with the staffing grid as well. Thus, each year the parties reaffirmed the number of case management hours Bonnie Brae’s designated case managers were expected to perform and, by doing so, reinforced that the calculation of case management service hours is more nuanced than OSC’s approach.

And, despite OSC’s view that Bonnie Brae had a “significant staffing shortage” and needed 10 more FTEs (or a total of more than 14 FTEs even though the contract called for 4.2 FTEs) to perform the case management services enumerated on the case management summary forms, Bonnie Brae’s designated case managers had sufficient capacity to perform the expected number of case management service hours per the staffing grid and PSSRs.

Table I below shows, for February 2020, the total number of hours worked by each case manager, the percentage of those hours that were expected to be spent on case management services per the applicable PSSR and then calculates the expected number of case management hours to be performed during the month based on such percentages. Using the data from Table IV of the DAR, the fifth column shows the number of therapy hours worked (actual) by the case manager and then lastly calculates each case manager’s capacity to perform case management services by subtracting their respective number of therapy hours from their total hours worked. As the table shows, the case managers assigned to cottages<sup>2</sup> were collectively expected to perform 513 hours of case management services under the contracts and PSSRs and had the capacity to perform 530 hours of case management services. Thus, Bonnie Brae’s case managers had ample bandwidth to perform their contractually expected share of case management services.

<sup>2</sup> The chart does not reflect any floater case managers who were not assigned to any particular cottage but filled in where needed due to employee absences or service-related reasons.

**Table I: Case Manager Capacity to Perform Contractually Required Case Management Hours (February 2020)**

Cottage/ Case Manager	Hours Worked (Actual)	Percentage of time to be devoted to Case Management Activities per PSSR	Expected Case Management Hours Based on Total Hours Worked	Therapy Hours Worked (Actual)	Available Hours for Case Management Activities ( <i>Hours worked – therapy hours worked</i> )
██████████	144	36.2%	52	100	44
██████████	144	36.2%	52	98	46
██████████	152	50%	76	76	76
██████████	152	36.2%	55	84	68
██████████	160	50%	80	81	79
██████████	128	50%	64	77	51
██████████	160	36.2%	58	80	80
██████████	152	50%	76	66	86
<b>TOTAL</b>			<b>513</b>		<b>530</b>

Based on the foregoing points above, we respectfully request that OSC remove section A(1) from the final audit report. Consistent with the contract and PSSRs, Bonnie Brae assigned the proper number of FTEs to perform the contractual case management services. It was not required to supply an additional 10 FTEs (a 333% increase) to meet its contractual obligations. Rather, the assigned case managers had sufficient capacity to perform their expected number of weekly case management hours as defined by the staffing grid and PSSRs. Moreover, the notion that Bonnie Brae was plagued with staffing shortages and its case managers compensated by falsely claiming to work upwards of 436 hours per month fails to recognize that case management activities are performed by a large, cross-departmental team and do not reside exclusively in the designated case managers. It is also based on a flawed reading of Bonnie Brae’s case management summary form, which was nothing more than an internal, one-page, summary verification form and not a representation by the case manager of personal hours worked, as well as a plainly incorrect approach to calculating case management service hours, which diverged dramatically from the staffing grid and PSSRs. As such, this section, which is superfluous to OSC’s overall finding regarding Bonnie Brae’s purported documentation deficiencies, should be excised from the final report.

**OSC’s Response**

Bonnie Brae misconstrues OSC’s finding. OSC found that Bonnie Brae failed to maintain reliable, contemporaneous documentation to demonstrate that its cottage-assigned clinical coordinators worked the number of hours that the State contracted with Bonnie Brae to provide. OSC did not find that Bonnie Brae’s case managers worked an impossible number of hours. OSC’s use of the terms “improbable” or “impossible” in relation to the hours is a factual depiction of the case manager hours recorded on the progress notes and signed by case managers. The fact that this documentation contained conflicting information and varied from one submission to another illustrates the

unreliability of the documentation that Bonnie Brae submitted. Bonnie Brae's explanation that case management activities were performed by a large, cross-departmental team underscores the unreliability of the documentation: since the progress notes were signed by case managers, rather than the individuals who Bonnie Brae later purported to have performed the work, OSC was unable to reconcile case management hours and allocate them to respective individuals providing services to youth.

Bonnie Brae's varying explanations for the conflicts and variability of its own documentation is echoed in its changing explanations for how it provided case management services. During the initial phase of the audit, Bonnie Brae provided documentation showing that cottage-assigned clinical coordinators alone performed case management functions. That explanation comports with the Department of Children and Families (DCF)-approved Program Staffing Summary Reports (PSSRs) that list specific individuals as case managers with defined time allocations. When OSC asked how cottage-assigned clinical coordinators could perform both therapy services and the large volume of case management hours reflected on the summary forms, Bonnie Brae's officials suggested that other non-cottage assigned clinical staff "may help." After OSC issued the Summary of Findings (SOF), however, Bonnie Brae asserted that "dozens" of staff across multiple departments "collectively" performed this function and designated case managers verified this work. Bonnie Brae's inconsistent explanations regarding how it delivered case management services and the conflicting and varying documentation that Bonnie Brae provided to support its position undermines OSC's confidence in the reliability of Bonnie Brae's documentation.

Based on the entirety of Bonnie Brae's submitted documentation, OSC concluded that none of the documentation Bonnie Brae provided supported the contractually required 5.5 case management hours per week per youth. For example, Bonnie Brae's weekly Case Management Summary Forms showed six hours per week per youth, with each signed by individuals designated as case managers. However, when OSC added the hours reflected on these forms to the progress notes documenting clinical therapy, the totals attributed to certain cottage-assigned clinical coordinators were so excessive that they underscored the unreliability of the summary forms. This does not mean OSC believed these individuals actually worked hundreds of hours in a month; rather, the inconsistency shows that Bonnie Brae's documentation is not a reliable basis for determining whether Bonnie Brae delivered all contractually required services. Despite multiple opportunities to give OSC supplemental information, Bonnie Brae did not produce documentation that reconciled its summary forms to the underlying case management records.

Bonnie Brae's additional arguments disputing OSC's case management findings rely on the staffing grid, full-time equivalent (FTE) counts, and "capacity." These arguments are unpersuasive. The staffing grid and PSSRs are prospectively generated documents that identify expected staffing levels and time allocations; they are not documentation of services actually delivered. Capacity to perform services does not equate to evidence of service delivery. Nothing in the contracts substitutes FTE staffing or theoretical time availability for the requirement to maintain adequate and contemporaneous service records. The fact that Bonnie Brae's underlying documentation does not come close to demonstrating that youth received their contractually required 5.5 hours of case management services per week—despite Bonnie Brae's alleged capacity to do so—supports OSC's concerns regarding Bonnie Brae's documentation and staffing sufficiency. OSC did not require 14.2 FTEs; rather, OSC observed that if one takes Bonnie Brae's own summary forms at face value, the implied workload far exceeds what the staffing grid and PSSRs reflect, confirming that the summary forms are unreliable.

Bonnie Brae next contends that OSC failed to consider that its staff performed case management activities “at the group level rather than on an individualized basis” and the fact that case management “involves various functions.” OSC does not dispute that Bonnie Brae may have delivered case management services at the group level or that case management touches multiple functional areas. However, those arguments do not address Bonnie Brae’s failure to document properly who performed these services, which youth participated, the duration of the services, and whether staff who performed case management services met the minimum qualifications to provide these services. Bonnie Brae provided almost no documentation that correlates group services to individual youth or the required service hours, nor did it provide evidence that employees who allegedly performed case management services possessed the required qualifications.

Finally, Bonnie Brae’s explanation raises significant concerns as whether staff that performed case management possessed the minimum qualifications. If dozens of different staff across various departments were performing case management, as Bonnie Brae now states, Bonnie Brae did not demonstrate that these individuals were qualified to do so, nor did it produce the required internal audits or verification records showing how case managers supposedly supervised this distributed work. Minimum qualification requirements exist precisely to ensure that qualified personnel deliver and document case management services. Treating case management as an activity spread across unidentified staff who did not document their work undermines the purpose of these requirements and reinforces OSC’s finding that Bonnie Brae failed to maintain reliable, contemporaneous documentation to demonstrate that it satisfied contractual requirements for case management.

In sum, OSC found that Bonnie Brae failed to maintain reliable documentation that it provided the required 5.5 hours of weekly case management per youth. Bonnie Brae’s evolving explanations, including its collective-service explanation, reliance on theoretical capacity rather than service records, inability to reconcile summary forms to underlying documentation (even after being afforded the opportunity to supplement the record), and its lack of transparent or verifiable documentation provide further support for OSC finding.

### **Case Management Summary Form Did Not Reflect Actual Services Delivered**

#### **Excerpt of Bonnie Brae’s Objections**

##### **Audit Finding - A(2)**

##### **Bonnie Brae Used Its Case Management Summary Form in a Manner Reasonably Believed to Be Acceptable to DCF**

As OSC observes, the case management summary form did not “record specific times when [case management] activities occurred.” DAR at p. 10. Bonnie Brae does not contest this finding. The case management summary form, however, was never intended to track time with such precision. Rather, Bonnie Brae used the form in the way it believed in good faith was approved and acceptable to DCF.

The case management summary form, as noted in the DAR, was developed in response to Bonnie Brae’s 2015 DCF audit. As a way to better document and confirm Bonnie Brae’s weekly performance of case management activities, DCF accepted Bonnie Brae’s proposed corrective action of utilizing a summary form that “identifies all Case Management services that are delivered with standardized times, when applicable, such as the times identified for preparation of treatment plans and treatment

team meetings and allows for documentation of discrete times spent delivering *other* Case Management services.” 2015 Audit at p. 16 (emphasis added).

As shown below, the summary form developed as part of the 2015 audit corrective action plan lists twelve separate categories of activities with a conservative standardized projection of the weekly time spent throughout the organization across the tasks.

### **Case Management - Weekly Activities**

<b>TASK &amp; Hours/Minutes per resident</b>
TX planning - 1 hour
Transfer Meetings (AM, PM) - 30 minutes
Cottage staff meetings - 15 minutes
Weekend Projected Plan/ Home Visits (Planning & Debriefing) - 30 minutes
Incident report (review & signature) - 30 minutes
Phone calls - 30 minutes
Progress Notes Documentation - 1 hour
Correspondence - 1 hour
*(Routine: e-mails, Contact/Visitors list, Invite and cover letters for treatment team)
*(External Correspondence: Letters for court, DCP, Medicaid, SSI, etc.)
Monthly Treatment Plan - 30 min/wk
Financial Oversight - 15 minutes
*(WEP, W2's, money requests, transportation vouchers, etc.)
<b>Total number of weekly case management hours provided: 6.0 hours</b>
<b>Total number of contracted weekly case management hours required: 5.5 hours</b>
<b>Community Program - Additional Weekly Case Management Activities, School registration and coordination: 45 minutes</b>
<b>Total number of weekly case management hours provided by the Community Programs: 6 hours and 45 minutes</b>

To understand why Bonnie Brae proposed, and DCF approved, this approach requires an appreciation of the broad scope of case management services performed at large residential treatment centers like Bonnie Brae. Case management services, by their nature, are difficult to define. The contract does not define the term and, in fact, offers scant details regarding the expected services. More specifically, as can be seen in the contract excerpt below, the only case management services identified in the contracts are family orientation, admission documentation, participation in monthly treatment team meetings, and ad hoc psycho educational activities. See Contracts at Exhibit E, Part A – Minimum Staffing Requirements Grid.

Position	Qualifications	Other Requirements	Hours/youth/week
Case Manager- Bachelors Level Practitioner	Bachelor's level with 3-5 years of relevant experience or unlicensed Master's level with 1 year of related experience	-Family orientation (within 1 <sup>st</sup> 24 hours) -Review and signature of all required paperwork (within 48 hours) -On-site family psycho educational activities consistent w/ comprehensive treatment & discharge plan (as needed/monthly) -Attend treatment team meetings (monthly)	5.5 hours per week per youth;

Besides the monthly treatment team meeting, the specific activities identified in the contracts either occur on admission or an as-needed basis and plainly do not lend themselves to predictable scheduling, consistent hour tracking, or collectively comprise anything close to 5.5 hours per week per youth.

As Mr. [REDACTED] explained in his report and based on his role in developing and enforcing the contract, the contract's lack of detail was intentional:

The Contract defines case management services very generally...The Contract was structured this way because case management services cover a broad range of activities designed to offer individualized support and assist youth in gaining access to needed medical, social, educational, and other services that address their unique circumstances. It involves a wide variety of everyday activities, like ensuring that residents attend school, receive medical care, and have their daily needs met, as well as coordinating transportation for family visits, court hearings, and medical appointments. It also involves coordination and communication, as applicable, with families, foster families, child welfare workers, probation officers, court officials, family support organizations, care management organizations, medical providers, and schools. For example, case management services could entail spending a day in court with a resident or something more routine like making sure a resident has clean and seasonally appropriate clothes or their preferred toothpaste or soap. In short, case management services cover hard to define ancillary activities that help individuals navigate the treatment process, connect with necessary resources, and ultimately achieve positive and lasting recovery.

[REDACTED] Expert Report at p. 3.

Mr. [REDACTED]'s description of the intended scope of the contract's case management services is consistent with common regulatory definitions of the term in other contexts. *See, e.g.*, N.J.A.C. 10:73-1.2 (defining case management services as "services which assist a beneficiary of Medicaid/NJ Family Care or a child, youth, or young adult receiving services from the Children's System of Care (CSOC) in gaining access to needed medical, social, educational, and other services."); 42 C.F.R. §440.169 ("Case management services means services furnished to assist individuals...in gaining access to needed medical, social, educational, and other services."). Bonnie Brae's delivery of case

management services followed this standard definition. To help OSC appreciate the wide range of case management activities it performs on a regular basis, Bonnie Brae prepared a detailed case management chart that identified the different activities, the department/person responsible for the task, and a more precise approximation of the average time spent on those activities. Overall, the chart spans 23 pages and lists 93 discrete activities ranging from coordination of visitations and medical/legal appointments to activities associated with Joint Care Reviews to more routine scheduling, documentation, and communications.

Once the sheer breadth and *ad hoc* nature of these activities at a large residential treatment center like Bonnie Brae is recognized, the use of a summary form with standardized time projections becomes more understandable. DCF indeed appreciated the “impracticality of rigidly documenting case management activities” and logging “numerous every day, routine tasks that independently may not be very time-consuming, such as obtaining toothpaste or procuring a permission slip for the youth.” ██████ Expert Report at p. 4. Mr. ██████ explained that:

these types of ad hoc activities are impractical to track on a minute-by-minute basis. In my experience, if an agency was adequately staffed and residents were progressing in their treatment, like at Bonnie Brae, the residents were undoubtedly receiving the necessary case management services. Otherwise, the residents would not be in a position to achieve such positive outcomes. In other words, documenting every minute of staff time is nearly impossible due to the ad hoc nature of case management activities and communications with stakeholders (including family, physicians, courts, and probation officers) and was not the focus of DCF. DCF's focus was on the residents having the necessary case management support, as much or as little as needed, to allow the residents to return home or transition to a lower-intensity service with the shortest feasible length of stay.

From DCF's perspective, meeting service outcomes – which Bonnie Brae regularly accomplished – was the primary goal of the contract and served as *prima facie* evidence that the residents were receiving the necessary case management services. These outcomes could not have been achieved without a residential treatment center performing the “hard to define ancillary activities that help individuals navigate the treatment process, [and] connect with necessary resources.” *Id.* at p.3.

Because “DCF's focus, was on achieving qualitative outcomes that are not measured by counting minutes” and “[d]ue to the impracticality of documenting this type of ad hoc support, DCF approved Bonnie Brae's use of a summary Case Management Checklist with standardized times (even though the standardized times were just projections) as part of their 2015 action plan.” *Id.* at pp. 2, 4. OSC misattributes Mr. ██████'s personal knowledge to counsel, dismissively labeling that insight as “not tenable.” DAR at p. 10. However, Mr. ██████, the former Deputy Director of DCF who was instrumental in creating the contract and overseeing its compliance during the 2015 audit, is far better positioned to comment on DCF's actions during his tenure than OSC, which lacks firsthand knowledge or a credible basis to opine on DCF's decisions in 2015.

Moreover, OSC's finding that “Bonnie Brae did not use [the case management summary] form in the manner as approved by DCF and as Bonnie Brae proposed to do in response to the 2015 audit” because the form “lacked discrete time entries or individualized information” is also misplaced. DAR at p. 11. As the 2015 audit report states, Bonnie Brae proposed using a “Case Management services summary form [which] identifies all Case Management services that are delivered with standardized

times, when applicable, such as the times identified for preparation of treatment plans and treatment team meetings, and allows for documentation of discrete times spent delivering other Case Management services.” 2015 Audit at p. 16. The weekly case management summary form is structured exactly as written. It enumerates Bonnie Brae’s twelve most common case management activities with standardized times for each category. Bonnie Brae could have supplemented this form by adding discrete times spent on “other Case Management services” (i.e., services that are not already on the standard one-page summary checklist). However, such supplementation of other services was not required in the action plan, and Bonnie Brae relied in good faith on the fact that DCF found the summary form with standardized times acceptable. Additionally, as represented in its 2015 corrective action plan, Bonnie Brae’s medical records and clinical teams conducted weekly audits. As the case management activities chart indicates, the Medical Records team devotes approximately 2.5 hours per week to auditing clinical and psychiatric charts, and the Medical Records team, Clinical Team, and Quality Department spend another approximately 2.5 hours per week auditing EHR records. Documents reflecting near daily audits of clinical and case management notes were produced to OSC at BB-CK-2235 – 2257 despite OSC’s claim that “Bonnie Brae did not produce evidence that it performed any weekly audits of its case management services.” DAR at p. 11. As such, Bonnie Brae complied with its 2015 audit action plan, which did not require the “discrete time entries” that OSC seeks to impose ten years after the fact.

### **OSC’s Response**

Bonnie Brae contests OSC’s finding that its summary form did not reliably document the hours or substance of its contractually required case management services first by acknowledging that its case management summary form did not record specific times. It then points to unrelated factors to excuse this failure. First, it references the 2015 DCF corrective action to justify the unreliability of its summary forms. The 2015 DCF corrective action allowed Bonnie Brae to use a summary form with standardized times when applicable, but it did not authorize Bonnie Brae to rely on projected time estimates in place of individualized, contemporaneous service documentation. Nothing in the DCF plan eliminated Bonnie Brae’s requirement to demonstrate the actual delivery of 5.5 hours of case management per youth per week, and DCF’s acceptance of the summary form did not relieve Bonnie Brae of its responsibility to maintain documentation demonstrating that it delivered those services.

Bonnie Brae then maintains that because case management is broad, ad hoc, or hard to define, OSC should not use the summary forms to determine whether Bonnie Brae complied with its contractual and legal obligations but rather OSC should look to qualitative outcomes. That is not the case. Bonnie Brae was contractually obligated to perform a minimum amount of case management services on a weekly basis, and, pursuant to its contracts and Medicaid regulations, Bonnie Brae was required to maintain documentation showing that it satisfied these requirements. Bonnie Brae’s summary forms, by its own admission, failed to meet these requirements. In fact, these forms, which repeated the same standardized time blocks each week, conflicted with other records Bonnie Brae produced during the audit. As a result, OSC found that Bonnie Brae’s documentation was not sufficiently reliable to verify required services.

The assertion that DCF focused on “qualitative outcomes” rather than documentation is also unsupported. The 2015 plan approved the use of a standardized summary form; it did not permit the substitution of projected times for actual documentation. Bonnie Brae’s argument that it obtained positive outcomes does not establish that it delivered required services in accordance with contractual terms. The retrospective documentation Bonnie Brae provided after the SOF does not

resolve the deficiencies identified during the audit. While the documentation submitted does reflect certain activities, it does not reconcile with the hours recorded on the case management summary forms or otherwise validate that Bonnie Brae delivered the required services as documented, particularly given the absence of contemporaneous records, time-specific records needed to substantiate service delivery in accordance with contractual requirements.

Finally, the materials Bonnie Brae cites as “weekly audits” do not show that case management services were reviewed or verified. Rather, they reflect general chart checks (e.g., notes were signed)—not audits reconciling the case management summary forms to individualized service records demonstrating that required services were delivered.

In short, Bonnie Brae’s good-faith belief in its use of the summary form does not change the fact that the underlying documentation it maintained failed to demonstrate that it provided the required case management services.

### **Case Management “Team-Based Approach” Did Not Substantiate Reported Weekly Summary Form Hours or Meet Contractual Requirements**

#### **Excerpt of Bonnie Brae’s Objections**

#### **Audit Finding - A(3)**

#### **The Case Management Materials Produced During the Audit Demonstrate That Bonnie Brae Performed the Activities Listed on the Case Management Summary Form**

In response to OSC’s audit request for case management documentation, Bonnie Brae produced the relevant case management summary forms as it reasonably believed such forms were sufficient per the 2015 audit. As a result, Bonnie Brae did not believe it was necessary to produce, and OSC did not specifically request, the supporting documentation to the summary form. While Bonnie Brae would have complied with any request, providing such documentation for each of the 93 residents enrolled in on-campus programs would have been an extremely cumbersome and time-consuming task. This process would have required gathering thousands of pages of documents related to routine daily activities from multiple departments and employees, as well as conducting an extensive email review, since much of the staff’s work and coordination occurs via email.

Against this backdrop and having only received the case management summary forms from Bonnie Brae, OSC expressed “significant concern” in its SOF “as to whether Bonnie Brae provided the listed [case management] services and, if so, the effectiveness of these services given the lack of specific information about what took place.” DAR at p. 10. To address this purported concern and disabuse the misimpression that residents were not receiving case management services, Bonnie Brae assembled case management packets for 6 residents and offered to go through the burdensome exercise for the other 87 residents if OSC wanted to review such information.

More specifically, Bonnie Brae produced the following categories of documents and explained the effort, coordination, and process that is involved with each activity: (1) comprehensive monthly treatment plans, (2) therapeutic leave documents, (3) weekend projected schedules, (4) incident reports, (5) memos to chart reflecting calls, (6) correspondence with guardians and other stakeholders, (7) PerformCare notes capturing interactions between the case management organization and Bonnie Brae, (8) treatment discharge plans, (9) nursing notes, (10) child satisfaction

surveys, (11) mental health assessments, (12) youth appointment calendars, (13) visitor sign-in sheets, (14) van shuttle schedules, (15) financial oversight tracker, and (16) chart audits. This production for just six of the 93 residents was approximately 2500 pages. Bonnie Brae also offered to pull staff member emails to show the extensive internal and external case management communications occurring on a regular basis.

These documents are not in any way “alternative records” as OSC pejoratively and recklessly calls them, as if trying to suggest that Bonnie Brae maintained a secret, second set of books or otherwise concocted records to respond to the SOF. DAR at p.1. That notion is absurd. The records were maintained in the normal course of business and made at or near the time of the event by, or from information transmitted by, a person with knowledge of the matter. The documents were not created after the fact or for the purposes of the audit, and nothing on the face of the documents suggests anything to the contrary.

They are also not “conflicting” records and do not contradict the case management summary form. The documents were *not* produced as a proxy to count case management minutes, as OSC attempts to do, because many of the documents do not quantify the amount of time spent on an activity. The documents, rather, were produced to show that the activities on the case management summary form – and other unlisted case management activities that were identified on the case management chart – were occurring on a regular basis. As such, the documents are supportive and do not in any way contradict or conflict with the case management summary form.

For example, the case management summary form lists treatment planning and the monthly treatment plan as two of the standard weekly activities and assigns a “standardized time” of 1.5 hours per week for the activities – the same standardized time DCF credited Bonnie Brae for these activities in the 2015 audit, but for which OSC provides no credit. *See* 2015 Audit at p. 15. To show that this work was performed, Bonnie Brae produced a copy of the thorough monthly treatment plan and other documents showing the scheduling/participation by Bonnie Brae resources in the monthly treatment plan meeting. As explained in our Prior Submissions and Exit Conference and as should have been evident from the document itself, the treatment plan is constantly updated throughout the month and tracks the residents’ progress on clinical, medical, school, social/recreational, and work experience matters. It also reflects the treatment team’s current recommendations for an appropriate treatment regimen. Creating this comprehensive document requires treatment team interactions and discourse, along with frequent updates and interactions between the case manager and clinical, medical, school, and cottage resources.

DCF, as experts in the field with familiarity of the treatment plan process and the significant amount of time, resources, and coordination it requires, credited Bonnie Brae with 1.5 hours per week for such activities in 2015 along with another hour per week for preparation and completion of Joint Care Reviews, and Bonnie Brae incorporated such standardized times in its case management summary form. Lacking a similar background, OSC did not credit Bonnie Brae for any treatment plan-related time despite being presented with proof that the treatment plan tasks listed on the case management summary form were, in fact, performed. While the treatment plan and related scheduling documents may not help OSC quantify the precise time spent on these activities, it does not logically track that the production of these materials conflicts with the case management summary form. To the contrary, the documents support the form as they show the activity took place.

Along these same lines, and as another example, Bonnie Brae produced weekend projected schedules in support of the line item on the case management summary form regarding “weekend projected plan/home visits (planning & debriefing) – 30 minutes.” As explained in the Prior Submissions and the Exit Conference, this schedule is updated every weekend to reflect which residents are going home for the weekend and which residents are remaining on campus. To create the schedule, Bonnie Brae confirms the resident’s eligibility to go home based on a level of supervision review, confirms the visit with the resident’s guardian along with the time of departure and method of travel, ensures the resident’s departure is consistent with the agreed upon travel plan, makes appropriate staffing arrangements for the residents remaining on campus, and then debriefs with the guardian and residents during and/or after the visit. Again, OSC did not credit Bonnie Brae for any time for this activity although it undoubtedly occurred presumably because Bonnie Brae did not track the date and time each of these different steps was accomplished. OSC took the same approach for the other categories of backup documentation produced by Bonnie Brae – only crediting those activities that were documented with a time component. *See* DAR at pp. 11-12.

While we understand (though do not agree with) OSC’s approach and finding that Bonnie Brae did not “properly document[] that [it] had provided the contractually required five and a half hours per week of case management services to each youth” because it did not log the time spent on every activity, we strongly object to OSC’s speculative and erroneous suggestions throughout the DAR that based on this perceived documentation deficiency residents did not receive proper care or were somehow “adversely affected.” DAR at pages 6, 11, 12. OSC simply has no basis or expertise to make such sweeping conclusions regarding treatment, which happen to be contrary to Bonnie Brae’s positive service outcome metrics, sterling industry reputation, glowing caseworker satisfaction surveys, and Mr. ██████’s first-hand observations regarding Bonnie Brae’s “gold standard” quality of care. *See* ██████ Expert Report at pp. 2-3; *see also* BB-CK-2902 – 2907.

### **OSC’s Response**

Bonnie Brae’s argument that the case management materials produced during the audit “demonstrate” the activities on the summary form does not resolve the documentation deficiencies identified in the audit. To support required case management services, Bonnie Brae initially produced only the weekly summary forms—forms that listed standardized projected times, not actual service information. Nothing in the 2015 DCF corrective action authorized Bonnie Brae to rely exclusively on these standardized projections without contemporaneous, individualized documentation. Bonnie Brae’s belief that it was not necessary to provide supporting records does not overcome its contractual and legal requirements to do so.

After OSC expressed concern about the lack of detailed information, Bonnie Brae produced case management packets for only six self-selected residents, totaling roughly 2,500 pages. These records were largely general business documents—schedules, incident reports, calendars, emails, and similar materials. These documents reflected the day-to-day operations of the facility, but they did not demonstrate that Bonnie Brae delivered the required 5.5 hours of case management per youth per week, nor did they reconcile with the standardized weekly time shown in the summary forms. Most records contained no time component at all, and some did not identify the staff member who performed the activity or whether the staff member met the minimum qualifications for case management. These documents showed that certain tasks occurred, but they did not show that Bonnie Brae provided the required case management hours.

OSC did not characterize these materials as “alternative records” to imply wrongdoing. OSC characterized these records in that manner to distinguish them from the summary forms, which was the first set of records that Bonnie Brae provided to justify its case management services. OSC carefully reviewed these documents and found that they did not substantiate the hours reported on the summary forms. Without individualized, contemporaneous time-based documentation, OSC could not verify that the activities corresponded to the 5.5-hour requirement or that they aligned with the standardized time blocks Bonnie Brae assigned each week. DCF’s 2015 acceptance of a summary form with standardized times did not eliminate Bonnie Brae’s requirement to maintain adequate documentation of actual services delivered, nor did it authorize Bonnie Brae to replace individualized records with broad operational documents that lack time or attribution.

Finally, OSC did not conclude that residents were harmed or denied necessary services. Rather, OSC raised concern that because Bonnie Brae’s documentation was unreliable, OSC could not confirm whether Bonnie Brae provided required services, which, then raises concern that vulnerable youth may not have received the services to which they were contractually entitled.

### **Individual Therapy Sessions Overlap or Lacked Clear Documentation Specifying When Therapy Occurred**

#### **Excerpt of Bonnie Brae’s Objections**

#### **Audit Finding - A(4)**

#### **Bonnie Brae’s Clinicians Did Not Improperly Render Overlapping Individual Therapy Sessions.**

In this section, OSC, focusing on the header of the EHR records, claims that “Bonnie Brae improperly rendered overlapping [individual therapy] sessions.” DAR at pp. 13-14. Based on its EHR records, Bonnie Brae understands why it may appear that its clinicians performed overlapping services. That, however, was not the case.

As OSC notes, the Service Date/Time fields for weekly individual therapy in the EHR records often overlapped across cottage members. In contrast, the body of the note typically indicated something different, such as individual therapy taking place over the course of the week or the session being rescheduled or canceled. We provided additional context during the Exit Conference to explain this apparent conflict.

Specifically, as previously explained, the audit helped Bonnie Brae discover a flaw in the setup of its EHR system, which has since been remedied. Based on the way the EHR platform was structured, an activity needed to be scheduled in advance in the system before an electronic note could be generated. To facilitate this process, the EHR team scheduled upcoming events in the system, which allowed clinicians or case managers to go into the system and create an electronic note after the event took place. As it turned out, this approach was flawed because the Service Date/Time fields in the note automatically populated with the date and time scheduled in the system by the EHR team. For group therapy sessions, which took place on recurring dates and times, this did not pose a problem as the Service Date/Time fields reflected the actual date and time of the service. However, for activities that did not take place on a set schedule, like individual therapy or case management, this structure presented a challenge. The EHR team addressed this challenge by programming events without a fixed or routine schedule in the EHR system for Fridays. As a result, at the end of each week, the clinician or case manager would receive a scheduling reminder to create a note memorializing

the weekly activity. Based on the way the system was structured, the Service Date/Time fields in the note for such non-fixed events were automatically populated with the Friday control date. Clinicians were not trained on how to change these fields, as it was a convoluted, complex, and time-consuming process. Instead, they were instructed to reflect any changes to the scheduled date and time in the body of the note.

Because individual therapy usually does not take place during a set block of time, this approach often led clinicians to insert a statement in the body of the individual therapy notes indicating that therapy occurred throughout the course of the week. From decades of experience and best practices, Bonnie Brae learned that its patient population generally does not tolerate lengthy one-hour blocks of individual therapy well. Rather, individual therapy for at-risk youth is most effective in smaller intervals, which allows the clinicians to be more flexible and respond to issues as they arise in the moment. This approach is referred to as life space therapy and is a well-established therapeutic technique. As Mr. [REDACTED] explained:

in the context of a residential treatment facility working with at-risk youth, it is challenging for youth with behavioral issues to engage in extended therapy sessions. Facilities like Bonnie Brae focus on a therapeutic approach known as Life Space Counseling, using everyday situations and interactions to help youth learn from challenging behaviors and build positive relationships. This approach allows for shorter therapy sessions (sometimes only 10-15 minutes) as needed, rather than scheduled one-hour sessions.

[REDACTED] Expert Report at p. 5.

During the audit period, the progress notes did not reflect the date and times of these 10- and 15-minute increments but only generally stated that therapy was performed throughout the week.<sup>3</sup> This is no longer the case. As part of its corrective action, Bonnie Brae has implemented changes to better track the date/times during the week the clinician interacts with a resident, along with the substance of each such incremental meeting.

Prior to the audit, Bonnie Brae prioritized the resident's individualized monthly treatment plan over documenting every interaction. The monthly treatment plan is a live document that is updated regularly throughout the course of the month and tracks, among many other things, the residents' clinical progress against emotional, behavioral, family, and discharge goals. This process acts as a safeguard and check and balance to ensure that the contractual services are being provided, and the residents are progressing through their treatment goals. Mr. [REDACTED] described the critical importance of the treatment plan process in evaluating clinical progress and contract compliance:

DCF monitored facilities' compliance by reviewing treatment plans and often attending Child and Family Team (CFT) meetings. The treatment plans and CFT meetings are essential in developing the array of interventions a youth may need...Clinicians are not required to document every interaction; instead, they rely on weekly documentation in treatment plans to track progress. The use of treatment plans, outcomes of CFT meetings, and other diagnostic

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<sup>3</sup> We acknowledge the MICA notes lacked similar language but note that life space counseling was practiced with MICA residents.

information are fundamental to providing effective care. While DCF values routine documentation by clinicians and staff, the emphasis on metrics is secondary to clinical oversight by qualified staff and detailed treatment plan documentation.

██████ Expert Report at p. 5.

Bonnie Brae thus rightfully placed its focus on the treatment plan over “document[ing] every interaction.” Nevertheless, Bonnie Brae understands OSC’s findings regarding its EHR flaw that led to inaccurate date/time fields and the lack of detail in its progress notes and has implemented appropriate corrective actions. Bonnie Brae, however, objects to the various gratuitous comments sprinkled throughout this section, questioning the “quality of care” delivered even though OSC never evaluated Bonnie Brae’s performance under the contracts’ service outcome metrics and lacks the foundation to make such claims. Id. Mr. ██████, who has treatment expertise and a foundation to opine on this issue as the former Deputy Director of DCF, has a very different view of Bonnie Brae. In his professional judgment, “Bonnie Brae’s outcomes represent the gold standard.” ██████ Expert Report at p. 3. Stated differently, “it is the treatment outcomes that truly matter, which was an area where Bonnie Brae excelled.” Id. at p. 2. This sentiment is echoed by the DCF-contracted caseworkers who universally are “satisfied with the services the child receives” and find residents are “doing better in school and/or work,” “get[] along better with peers and other people,” and are “able to cope when things go wrong.” BB-CK-2907. As such, we respectfully request that such unnecessary and unfounded comments be removed from the final audit report.

### **OSC’s Response**

Bonnie Brae acknowledges that its Electronic Health Record (EHR) reflected overlapping individual therapy sessions but asserts that this resulted from a scheduling flaw and that clinicians provided therapy “throughout the week” in short intervals. Regardless of the therapeutic model used or how clinicians delivered services, OSC found fault with Bonnie Brae’s documentation, not its clinical approach. By its contracts and the Medicaid regulations, Bonnie Brae was required to maintain contemporaneous, accurate documentation of services. Bonnie Brae’s progress notes routinely listed the same default date and time for multiple youth and failed to identify the actual dates, times, or durations of the individual therapy encounters. Accordingly, OSC could not verify whether Bonnie Brae delivered required therapy services, to whom, or for what duration.

Bonnie Brae states that clinicians relied on monthly treatment plans and life-space counseling rather than documenting each interaction. However, treatment plans are not a substitute for required service documentation, nor do they establish that weekly therapy sessions occurred as contractually required. The EHR flaw Bonnie Brae describes, where staff created notes using pre-populated dates, may explain why at least some of Bonnie Brae’s documentation was unreliable. While Bonnie Brae asserts that it implemented corrective actions to address these deficiencies, such subsequent changes do not lead OSC to modify its findings.

Finally, Bonnie Brae’s argument about “quality of care” and resident outcomes is not relevant to this finding. OSC found that Bonnie Brae’s documentation was deficient; it did not evaluate Bonnie Brae’s clinical effectiveness. Accordingly, OSC did not modify this finding.

## **Discrepancies in Youth Attendance and Progress Notes Documentation and Discrepancies in Clinical Coordinator Attendance and Progress Notes Documentation**

### **Excerpt of Bonnie Brae's Objections**

#### **Audit Findings - A(5 and 6)**

#### **Alleged Discrepancies in Youth and Clinical Coordinator Attendance and Progress Note Documentation.**

These findings reference purported discrepancies between the date/time fields of progress notes and the attendance records for clinical coordinators and residents. Both of these issues are largely driven by the flawed EHR system discussed in our response to Section A(4).

Regarding the resident attendance discrepancy, as stated above, upcoming therapy sessions were scheduled in the EHR system in advance. This often took place before Bonnie Brae received notice that a resident would be going home on therapeutic leave. In these situations, because the date/time field was pre-populated with the scheduled date and time, the clinician was supposed to indicate the resident's absence in the body of the note. Some of the clinicians, however, were not as diligent as they should have been about indicating absences. The issue, however, has been fixed as the EHR settings have been changed, and clinicians are now required to keep signed attendance sheets for therapy sessions.

Moreover, we also note that calculating therapeutic leave is nuanced, which may not have been completely factored into OSC's analysis. A resident is considered to be on therapeutic leave based on their location at 11:59 pm. Thus, a resident may still attend a therapy session on days they are listed as being on therapeutic leave – it would depend on the time of the therapy session as compared to the time the resident leaves the facility. And, from an economic perspective, Bonnie Brae is paid the same rate whether the resident is classified as being on leave or present, meaning there is no financial incentive to classify a resident one way or the other. Any mistakes were clearly of an administrative nature.

As for the ten instances of a clinical coordinator being absent on days when the date/time field of the progress note indicated that group therapy was performed, this too relates to the prior settings in the EHR. If a session was rescheduled or canceled altogether, the clinician was supposed to indicate such information in the body of the note. This did not occur on the ten occasions identified by OSC. The issue has since been fixed. Bonnie Brae has also put in place more robust weekly audits by the quality assurance and clinical supervisory team to ensure compliance with the contract and to confirm that the progress notes are consistent with attendance sheets.

### **OSC's Response**

Bonnie Brae maintains that OSC's findings regarding material inconsistencies in Bonnie Brae's records were "largely driven" by its flawed electronic health records system. That acknowledgement does not excuse or provide a basis for OSC to modify the underlying findings, but rather bolsters OSC's finding here.

Bonnie Brae next claims that OSC's findings may contain some errors because OSC failed to recognize that leave is based on a resident's location at 11:59 P.M. Bonnie Brae's reliance on this

definition is misplaced. Many of the discrepancies OSC identified involved youths who were documented as being on therapeutic leave for multiple consecutive days, not isolated overnight absences. Specifically, 78 of the 109 instances identified in February 2020 occurred after the first day the youths were on therapeutic leave. In those circumstances, Bonnie Brae's timing explanation is irrelevant. A youth who is not present on campus for an entire multi-day period cannot have attended therapy sessions that Bonnie Brae documented as occurring during that same timeframe. These conflicts are not minor administrative errors. They directly undermine the credibility of the progress notes and raise legitimate concerns about the accuracy of the service documentation.

The argument that Bonnie Brae had no "financial incentive" to misclassify attendance is likewise irrelevant. Compliance with Medicaid documentation requirements does not hinge on financial motive; it hinges on maintaining accurate, contemporaneous records that substantiate billed services. In addition, the ten instances in which a clinical coordinator was recorded as absent on days when group therapy was nevertheless documented further illustrate systemic weaknesses in Bonnie Brae's internal controls. The fact that Bonnie Brae only addressed these issues after OSC identified them confirms that its documentation practices during the audit period were insufficient. Accordingly, Bonnie Brae has not provided a basis for OSC to modify these findings.

### **Clinical Coordinators Cloned Progress Notes**

#### **Excerpt of Bonnie Brae's Objections**

##### **Audit Finding - A(7)**

##### **Alleged Cloned Progress Notes**

OSC alleges that two clinical coordinators generated identical group therapy notes for four group sessions in February 2020 and three group sessions in February 2021. Bonnie Brae does not condone the copying of notes from week to week, however we object to the statement in the DAR that the clinician "used a template that was not based on the actual therapy provided." As explained during the Exit Conference and in our Prior Submissions, it is common for group therapy sessions to address the same topics in back-to-back sessions or for one cottage to cover a similar group topic as another cottage, especially for important subjects like boundaries and accountability, which were covered by █████ in February 2020, and respecting peers and staff, which was covered by █████ in February 2021.

Bonnie Brae recognizes that the clinician should have provided more session-specific details in the progress notes, should not have copied a model from another clinician, and should have clearly included a notation that the group was continuing its discussion from a prior session. However, the lack of such detail in the progress notes does not in any way mean, as OSC maintains, that the notes do not reflect the actual therapy provided or the topics covered by the group. To avoid this issue from reoccurring, Bonnie Brae has implemented processes to ensure that group therapy notes are more robust going forward, including the establishment of an internal committee to audit a sampling of group therapy notes, track findings, and respond accordingly.

#### **OSC's Response**

OSC found that Bonnie Brae's clinical coordinators used duplicated notes and, based on that finding, concluded that those notes failed to satisfy regulatory requirements that require that such notes have to be detailed and accurate. Bonnie Brae acknowledges that its clinicians "should have provided more

session-specific details,” but still maintains that these instances do not mean that the notes failed to reflect the actual therapy provided. OSC finding that the notes in question were identical narratives, with no session-specific details, no indication of continuation from prior sessions, and no tailoring to the youth present, demonstrates that these notes lacked the specificity required by regulation.

In sum, despite Bonnie Brae’s efforts to minimize the existence of these duplicated notes, the regulations and Bonnie Brae’s contracts require contemporaneous documentation reflecting the actual services provided. Bonnie Brae did not meet these contractual and regulatory requirements and, accordingly, OSC did not modify this finding.

### Deficient Clinical Therapy Hours

#### Excerpt of Bonnie Brae’s Objections

##### Audit Finding - B(1)

##### **Bonnie Brae Generally Made the Required Minimum Therapy Hours Available to its Residents and Their Families**

OSC contends that Bonnie Brae failed to provide the required clinical therapy hours for some of its residents – 13 of 101 residents in February 2020 and 8 of 26 residents in February 2021. Bonnie Brae conducted its own independent analysis and arrived at a different calculation for most of the residents in question. As outlined in our Prior Submissions, the majority of these residents met the required clinical therapy hours. In fact, several of the residents far exceeded the minimum requirements.

In reviewing the supporting documentation, we note that OSC continues to not give Bonnie Brae credit in some instances for scheduled Family Group Therapy sessions that did not take place because the family did not attend the scheduled event, and that OSC reversed credit for some sessions previously credited in the SOF. First, the family therapy time should be credited to Bonnie Brae. The organization made efforts to arrange and staff the service, but for reasons outside of Bonnie Brae’s control, the session did not take place. The DAR implies that these services were not rendered due to Bonnie Brae’s shortcomings; however, the fact is that the services were made available, but the families in these instances failed to attend their scheduled session.

As the treatment plans indicate, the treatment team plots a course of monthly therapy for each resident. This is done with complete transparency to the resident, the resident’s guardian(s), and the State’s care management organization and unified case management worker. In fact, one hundred percent of surveyed DCF-contracted caseworkers indicated that they help decide the child’s treatment goals and participate in the child’s treatment. *See* BB-CK-2907; *See also* BB-CK-00020 (excerpted below for an example of treatment plan course of treatment); BB-CK-00025 (showing resident, resident’s mother, and CMO/UCM worker signature on treatment plan).

<b>Treatment Recommendations:</b>	Treatment team recommends Emotional Management group 2x per week and individual therapy to address emotional management issues. Team recommends family therapy 2x per month to address family issues. Team would like to address ██████ academic issues through participation in on campus school program. In addition, the team recommends trauma survivor group, psychosexual education and extra-curricular activities.
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Where a family is unwilling to engage in family therapy, it is not clinically appropriate to alter the individualized and thoroughly vetted treatment plan and substitute the family therapy hours with another form of therapy. As Mr. █████ observed, “[f]orcing residents to participate in inappropriate services or undergo lengthy therapy sessions can be clinically harmful.” █████ Expert Report at p. 5. Thus, Bonnie Brae should not be penalized for refusing to add clinically inappropriate services that would conflict with a resident’s treatment plan to compensate for a family’s lack of attendance.

Second, it is unclear why OSC reversed credit for certain therapy sessions. We have resubmitted documentation for those sessions and ask that OSC reconsider its reversal. *See* BB-CK-2908 - 2913.

On a separate note, as referenced in our Prior Submission, there are three residents in February 2021—specifically—████, █████, and █████—who fell short of their respective clinical hours because they were admitted to Bonnie Brae during that particular month. As we explained in the Prior Submissions, as part of Bonnie Brae’s COVID protocols in effect in February 2021, new residents started off in quarantine in a separate cottage until they were cleared to move into the milieu, which delayed the start of full therapy services. Moreover, new admittees undergo an onboarding process, including orientation, completion of admission paperwork, and clinical evaluations for group assignments. The treatment team must first make an “individualized, needs driven assessment” before therapy starts in full as a “one-sized fits all approach” is clinically inappropriate. █████ Expert Report at 2. Consequently, during the pandemic, it took a week or longer after admission for a resident to be assigned and fully integrated into therapy groups. The circumstances surrounding these three residents were isolated incidents related to their admission dates and should not be counted against Bonnie Brae’s contract compliance.

### **OSC’s Response**

OSC found that Bonnie Brae’s documentation showed that it failed to provide contractually required clinical therapy hours. Bonnie Brae does not provide any facts to refute that finding. Instead, Bonnie Brae points to families missing therapy sessions as a rationale for why it did not meet these requirements. Although that may have been the case, Bonnie Brae does not contest that its failure to make up those sessions amounted to an impermissible reduction in hours below the contract requirements.

With regard to OSC’s adjustments in calculations, OSC made those adjustments after comparing progress notes with the attendance records of the clinical coordinators. OSC found that it had erroneously made three reversals, which it has credited in this report. OSC’s remaining adjustments reflect an accurate assessment of the record, not an error. Regarding the three February 2021 admissions, Bonnie Brae did not provide the duration of their protocols. Two of the three youth had documented individual therapy on a Friday, the day after their admission date, with their cottage-assigned clinical coordinator, as did the other youths in their cottage. They also attended the regularly scheduled group therapies on each Tuesday thereafter. Bonnie Brae did not obtain any approved deviation from those requirements, nor did it document alternative therapeutic interventions during the quarantine period. Accordingly, OSC found that the cited youths did not receive the required clinical therapy hours.

Based on the documentation showing that Bonnie Brae failed to provide contractually required clinical therapy hours and Bonnie Brae’s failure to rebut that finding, OSC did not modify this finding.

## Deficient Psychiatric Hours

### Excerpt of Bonnie Brae's Objections

#### Audit Finding - B(2)

##### Residents Met the Required Minimum Psychiatric Hours

OSC claims that residents in the SPEC program received 11.25 minutes less face-to-face psychiatric services per week than contractually required. More specifically, OSC contends that Bonnie Brae provided 45 minutes of face-to-face psychiatric care per week to SPEC residents rather than the contractually allotted 56.25 minutes. That is not so.

During the audited time period, psychiatric services consisted of two separate activities: psychiatric care group therapy and current mental status check.<sup>4</sup> As the progress notes indicate, the weekly group therapy sessions spanned 45 minutes. The current mental status check was a separate activity of at least 15 minutes where the psychiatric staff reviewed and logged the resident's appearance, motor activity, attitude, speech, mood, affect, thought process, thought content, concentration, and assessed whether the resident possessed any suicidal or homicidal ideations. The individual checks were sometimes performed before or after the group sessions and sometimes on different dates altogether.

Because the current mental status check did not regularly occur at a scheduled time, the EHR team scheduled the mental status check within the EHR system for the same time as the psychiatric group session. This was done as a reminder to the psychiatric staff to perform such checks and, as stated above, the event needed to be scheduled in the system before an electronic note could be generated. This approach led to the date/time field for the current mental status electronic record to automatically populate with the same date and time as the group therapy session. Although the records show that the current mental status checks were performed, OSC gave Bonnie Brae no credit for the activity. Consequently, the purported shortfall is attributable to the flawed setup in the EHR system and is not indicative of a lack of service.

#### OSC's Response

Bonnie Brae asserts that Specialty Residential Treatment Center youth received additional face-to-face psychiatric services beyond the documented 45-minute group therapy session. In support, Bonnie Brae now relies on documentation labeled "Current Mental Status (CM – Group)" to claim additional psychiatric service time beyond what is contained in its group therapy progress notes. These group activity entries show the same date and time as the group therapy sessions.

Bonnie Brae's explanation that it scheduled these mental status checks concurrently with group therapy as a "reminder" is unpersuasive. Bonnie Brae failed to document mental health status checks separately from face-to-face psychiatric services. Moreover, the fact that Bonnie Brae scheduled these checks at the exact time as a separately scheduled clinical service does not reasonably support Bonnie Brae's position that it separately provided this face-to-face mental health status check. Finally, Bonnie Brae's acknowledgement that it used a flawed approach to implement these mental health

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<sup>4</sup> As discussed during the Exit Conference, Bonnie Brae changed its clinical model for delivering psychiatric services in 2023 and stopped performing group psychiatric therapy in favor of individualized therapy.

status checks does not change OSC's underlying finding that Bonnie Brae failed to document that it provided the required 45 minutes of face-to-face psychiatric services.

Based on the documentation showing that Bonnie Brae failed to provide contractually required psychiatry services, and Bonnie Brae's failure to rebut that finding, OSC did not modify this finding.

## Two Unlicensed Clinical Coordinators

### Excerpt of Bonnie Brae's Objections

#### Audit Finding - SECTION C

#### The Two Unlicensed Coordinators Were Promptly Addressed

Bonnie Brae acknowledges that it briefly employed two unlicensed clinical coordinators. The DAR, however, lacks context and does not set forth the reasons for the issues or Bonnie Brae's prompt corrective actions.

The first unlicensed clinician, [REDACTED], was conditionally hired as a clinical coordinator on September 9, 2019, subject to her receiving an LCSW license within 90 days and she worked under the direct supervision of Bonnie Brae's then-Clinical Director. Bonnie Brae disclosed [REDACTED]'s hiring to DCF in its September 30, 2019, SPEC PSSR. When [REDACTED] did not earn her license within the allotted time, she was granted a short extension to pass the licensing exam. OSC asserts that Bonnie Brae did not disclose this extension to DCF, but as documents produced during the audit demonstrate, Bonnie Brae was encouraged by its contract administrator to provide interim staffing updates and changes via email or telephonically rather than through the formal PSSR process. Consistent with Bonnie Brae's practices and strong rapport with its contract administrator, it is far more likely that the one-time extension was vetted with the contract administrator rather than unilaterally granted by Bonnie Brae.

In any event, on February 24, 2020, after [REDACTED] notified Bonnie Brae that she failed the exam, she was reassigned to a temporary case manager role on that same date and DCF was contemporaneously notified of the change. Following [REDACTED]'s reassignment, OSC alleges that she provided clinical services for two additional days: February 25, 2020, and February 27, 2020. However, as OSC noted in Section A(6), [REDACTED] was absent on February 27, 2020, and did not perform any services on that day. A note was incorrectly generated for that date due to the aforementioned EHR system flaw, as the session was scheduled in the system prior to [REDACTED]'s reassignment. Thus, at most, there may have been a one-day lag time in the implementation of [REDACTED]'s reassignment.

The second unlicensed clinician, [REDACTED], was hired as a clinical coordinator on November 16, 2020. In accordance with its onboarding diligence process, Bonnie Brae conducted a license status search on the Division of Consumer Affairs ("DCA") website prior to hiring [REDACTED]. DCA's database indicated that [REDACTED]'s license was "active" and that she was not subject to any board actions. See BB-CK-2407. Bonnie Brae relied on the search result in allowing [REDACTED] to begin employment four days later.

1/12/2020

Details



The State of New Jersey NJHome Services A-Z Departments/Agencies



Office of the Attorney General OAGHome Agencies/Pro



# NEW JERSEY DIVISION OF CONSUMER AFFAIRS

Paul R. I  
Acti

## License Information

Accurate as of November 12, 2020 1:09 PM

[Return to Search Results](#)

Name: [REDACTED]

Address: Woodbridge, NJ

Profession/License Type: Social Work Examiners, Licensed Social Worker

License No: [REDACTED]

License Status: Active

Status Change Reason: License Issuance

Issue Date: 6/14/2017

Expiration Date: 8/31/2020

NO Board Actions. For more information contact New Jersey State Board of Social Work Examiners at (973) 504-6495

OSC contends that Bonnie Brae failed to properly verify [REDACTED]'s license because, at the bottom of the search page, and inconsistent with the "active" classification, the site also indicated a license expiration date of August 31, 2020. [REDACTED], however, was hired in the middle of the COVID-19 pandemic. During this public health emergency, the State and regulators were frequently providing grace periods and relaxing deadlines across various sectors and legal systems. Under these circumstances, it was not unreasonable for Bonnie Brae to accept DCA's public display of the active status of [REDACTED]'s license. Once Bonnie Brae learned that [REDACTED]'s license was, in fact, expired, it promptly terminated her employment. That said, Bonnie Brae has since implemented a new license verification policy to ensure this type of situation does not occur again.

Lastly, it is important to note that both circumstances involving [REDACTED] and [REDACTED] were temporal in scope, predated OSC's audit, and were rectified through Bonnie Brae's internal system. Indeed, Bonnie Brae has already implemented robust processes to verify credentials for newly licensed professionals and requires monthly verification for all professional licenses for existing staff. Accordingly, Bonnie Brae's new verification policy will prevent any administrative oversight regarding its employees' licenses.

### OSC's Response

Bonnie Brae's explanation does not resolve OSC's concerns regarding Bonnie Brae's use of unlicensed individuals in clinical coordinator roles. The contract requires that staff serving in these positions hold the appropriate license at the time they provide services. Bonnie Brae was required to verify licensure and ensure the accuracy of all staffing submissions and clinical documentation, but it failed to do so in the identified instances.

With respect to [REDACTED], Bonnie Brae's own documentation contradicts its claim that it properly managed this matter. Although Bonnie Brae now states she was hired pending receipt of a Licensed Clinical Social Worker, the PSSR Bonnie Brae submitted to DCF identified her as a Licensed Social Worker (LSW), even though she never obtained that license. Bonnie Brae's speculation that an extension was "likely vetted" by its contract administrator is unsupported; any DCF approval allowing an unlicensed individual to function in a licensed role should have been documented. In addition, [REDACTED] signed progress notes using the LSW designation despite not holding that credential.

Regarding [REDACTED], even accepting Bonnie Brae's assertion that it relied on the Division of Consumer Affairs website, Bonnie Brae fails to demonstrate that it performed adequate pre-hire due diligence. The online record listed an "active" status but also displayed an August 31, 2020 expiration date, which was more than two months before Bonnie Brae hired her in November. Further, if Bonnie Brae had performed additional checks, including a basic background or reference check, it likely would have disclosed the issues at her previous employer—the same issues that ultimately resulted in her license being suspended after she left Bonnie Brae. It is worth noting that [REDACTED] signed progress notes without any licensure designation, which should have been immediately apparent through routine supervisory review. The absence of a professional credential on her documentation was an obvious red flag requiring follow-up to confirm her licensure status.

While Bonnie Brae characterizes these issues as "temporal," the duration of the noncompliance is not relevant. OSC found that Bonnie Brae allowed unlicensed individuals to function in positions that require licensure. These are not minor administrative mistakes; they reflect systemic weaknesses in hiring, credentialing, and supervisory processes. While OSC acknowledges Bonnie Brae's subsequent efforts to improve its verification procedures, those corrective measures do not negate the compliance failures that occurred during the audit period.