## 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. [redacted] – 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* [redacted] Expert Report at p.3. Mr. [redacted]e 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.[1]

*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

[1] 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]e 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

(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) | 17.50% | 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 | LAC, 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 | LAC, 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 | LAC | 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 |

## CONTRACT - 18 FDZR

| CASE MANAGEMENT | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 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 |
| [redacted] | Case Management | MSW | Social Work | LSW. LCSW within 2 years under clinicl 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 |
| [redacted] | 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 |
| [redacted] | Case Management | MSW | Social Work | LSW. 2 year plan for LCSW licensure supervised by [redacted] CSW. 1 1/2 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 |
| [redacted] | Case Management | MSW | Social Work | LSW. 2 year plan to otain 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[2] 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.

[2] 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 (*Hours worked – therapy hours worked*) |
|---|---|---|---|---|---|
| [redacted] | 144 | 36.2% | 52 | 100 | 44 |
| [redacted] | 144 | 36.2% | 52 | 98 | 46 |
| [redacted] | 152 | 50% | 76 | 76 | 76 |
| [redacted] | 152 | 36.2% | 55 | 84 | 68 |
| [redacted] | 160 | 50% | 80 | 81 | 79 |
| [redacted] | 128 | 50% | 64 | 77 | 51 |
| [redacted] | 160 | 36.2% | 58 | 80 | 80 |
| [redacted] | 152 | 50% | 76 | 66 | 86 |
| **TOTAL** | | | **513** | | **530** |

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**

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, DCPP, Medicaid, SSI, etc.)

Monthly Treatment Plan - 30 min/wk

Financial Oversight - 15 minutes
*(WEP, W2's, money requests, transportation vouchers, etc.)

Total number of weekly case management hours provided: 6.0 hours

Total number of contracted weekly case management hours required: 5.5 hours

Community Program - Additional Weekly Case Management Activities, School registration and coordination: 45 minutes

Total number of weekly case management hours provided by the Community Programs: 6 hours and 45 minutes

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 1st 24 hours)<br>-Review and signature of all required paperwork (within 48 hours)<br>-On-site family psycho educational activities consistent w/ comprehensive treatment & discharge plan (as needed/monthly)<br>-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." [redacted] Expert Report at p. 4. Mr. [redacted] 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. [redacted]'s personal knowledge to counsel, dismissively labeling that insight as "not tenable." DAR at p. 10. However, Mr. [redacted], 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. [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.

### 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.[3] 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

[3] 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.
>
> [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.

**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 [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.

### 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).

| | |
|---|---|
| **Treatment Recommendations:** | 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 [redacted] academic issues through participation in on campus school program. In addition, the team recommends trauma survivor group, psychosexual education and extra-curricular activities. |

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. [redacted] observed, "[f]orcing residents to participate in inappropriate services or undergo lengthy therapy sessions can be clinically harmful." [redacted] 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—[redacted], [redacted], and [redacted]—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. [redacted] 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.4 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

[4] 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 Bonne 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

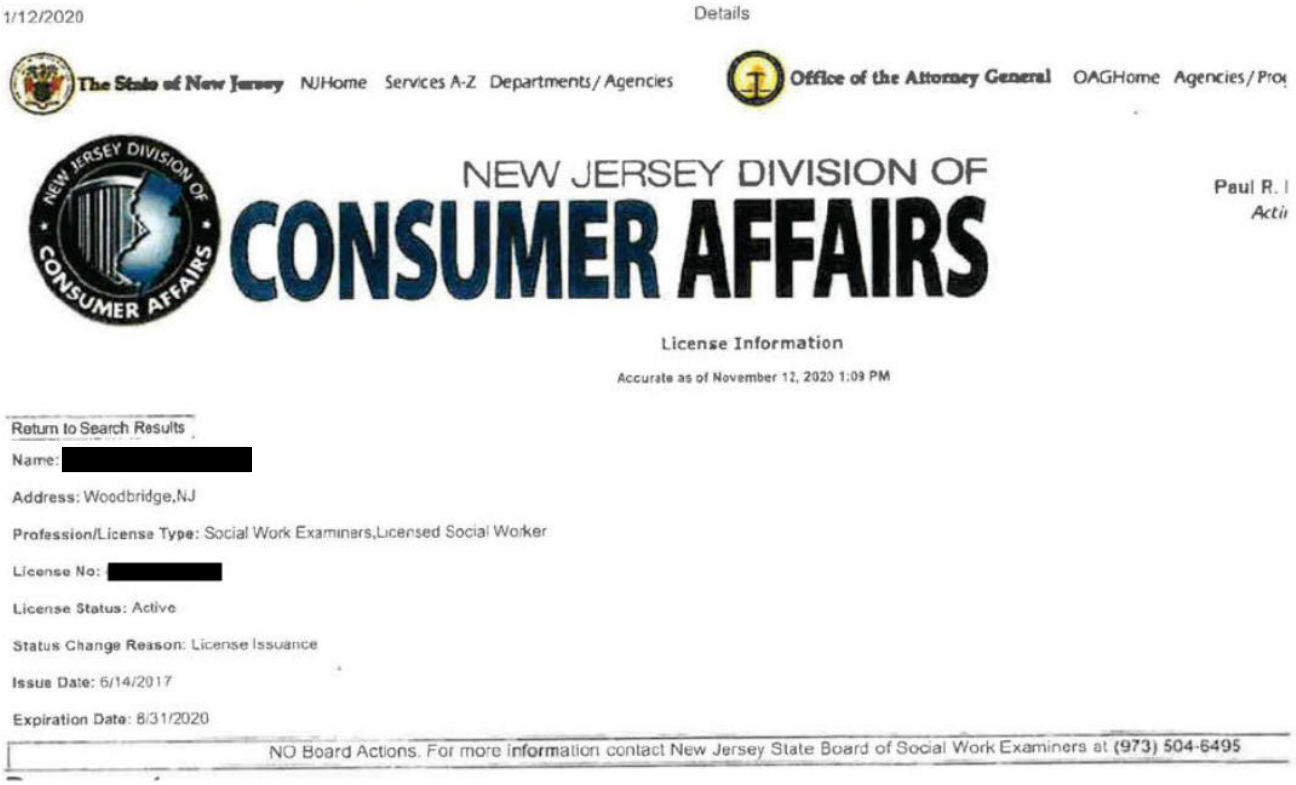
**Audit Finding - SECTION C**
**The Two Unlicensed Coordinators Were Promptly Addressed**

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.