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Office of Inspector General

Annual Report

2014

Minnesota Department of **Human Services**

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Executive Summary

This third Annual Report is intended to provide an overview of the previous year's work of the Office of Inspector General (OIG). This includes reviewing accomplishments, observed trends, and plans to improve protections for those who depend on public programs. This report also looks at what is being done to increase accountability of those who serve others, particularly those who access public funds to do so.

In short, 2014 is distinguished by substantial progress achieved on a number of fronts. The OIG continues to aggressively pursue provider and recipient fraud. Regarding provider fraud in Medical Assistance (MA), Minnesota's Medicaid program, over 400 cases were opened in 2014 and 420 were completed; some completed cases had been opened in the previous year. In addition, overpayments totaling over $7 million were recovered. Throughout the year, the OIG worked with county attorneys on multiple prosecutions related to county child care provider investigation cases. By publicizing these investigations with our partners and on our website, we are putting those who commit fraud on notice that their criminal actions will have consequences.

We also began on-site pre- and post-screening for those applying to become MA providers. This screening will expand in 2015 to include verifying fitness criteria, such as reviewing sample documentation, asking to see bonds and insurance, and following up on background study and criminal conviction information. In the future, we will be able to report on the number of terminated provider applications.

Considerable work also took place regarding recipient fraud investigations. Nearly 7,000 recipient fraud investigations were completed and over 1,000 administrative disqualification actions were taken.

Legislation was passed in the spring that for background studies requires the use of electronically submitted fingerprints and photographs of job applicants who work in settings where vulnerable adults and children receive services. Over 100 meetings with more than 2,000 stakeholders throughout the state helped informed the important system changes that will enhance safeguards for vulnerable adults and children.

The new background study system, NETStudy 2.0, is complex and connects to numerous partners. When the system launches in 2015, not only will background studies be significantly more accurate, but DHS and its partners will save substantial time and money.

This year the Licensing staff made enormous strides in eliminating the backlog of maltreatment reports (see page 19). Working with the DHS Office of Continuous Improvement, staff tackled the backlog and put new workflows and processes in place for handling incoming complaints to be investigated. Many staff worked long hours to reach this accomplishment; the result is no remaining backlog and a new process that benefits all affected parties.

In addition to providing a high level overview of OIG accomplishments in 2014, this report also captures some of the initiatives we are pursuing in 2015. Since its creation in 2011, the DHS Office of Inspector General has produced success stories in all areas of operation but more work needs to be done.

The OIG has identified several specific areas that need to be addressed. These include:

- **Child care provider fraud activities.** The OIG is seriously concerned about a pattern of child care fraud activities that involves deception and exploitation. It begins with recruiting parents as child care center employees with the condition that they enroll their children in a child care assistance program (CCAP) to ensure public funds revenue for the business; the scheme ends with exploiting four sets of victims: the children, parents, those on the Child Care Assistance Program waiting list and taxpayers.

  To address this problem, the OIG is proposing several legislative changes that will not only assist in the enforcement of the public policies, but will hopefully deter otherwise fraudulent providers from participating in these schemes in Minnesota.

  In order to better inform the public about fraudulent activity of providers, the OIG will also seek legislative change that will allow the department to disclose the amount of child care assistance funding paid to child care centers under certain circumstances. The information would become public data if the OIG's investigation determines that financial misconduct has occurred, and the disclosure would not identify any family that is receiving child care assistance.

- **Sexual abuse of a child in care.** This year the OIG noted an increase in the number of Temporary Immediate Suspensions of family child care licenses based on sexual abuse of a child in care by an individual in the home. These cases also identify a lack of supervision by the family child care provider. New training requirements have been put in place but OIG will continue to monitor to determine the effect of the new requirements.

- **PCA fraud.** The OIG took steps this year to ramp up efforts to deal with fraud associated with personal care assistants. The most common form of fraudulent activity is billing for services that were not actually provided. Some caregivers falsify their timesheets, obtain the recipient's signature, and submit false information to their employers. In some cases, the employer personal care provider organization is participating in the fraud, and in the most challenging cases to investigate and prove, the recipient is also in collusion.

  To address this type of fraud, the OIG proposed modest policy changes in the 2015 legislative session as well as implement some additional approaches not requiring legislative authority. For example, the OIG will seek legislation that requires increased responsibilities for agencies that bill for PCA services to perform more verification that services are actually provided. Some non-legislative areas being explored include: expanding payment blocks, random audits, evaluating technology solutions and conducting more onsite monitoring.

- **Methadone treatment program accountability.** This is another area that the OIG will work to address in the coming year. These programs provide an invaluable treatment alternative that saves lives, particularly as opioid addiction increases dramatically in Minnesota. Program

concerns include a lack of oversight of methadone dose prescribing, methadone diversion (sale) by recipients and the prescribing of Methadone without knowledge of, or sufficient regard for, other prescription drugs that the clients may be receiving through other clinics and pharmacies.

Working with the provider community the OIG will propose several practice improvements including enrolling all prescribing physicians affiliated with methadone treatment programs, requiring a face-to-face meeting between the prescriber and the client when high doses of methadone are prescribed, requiring license holders to report drug diversion to law enforcement when it occurs on the premises of the program and clarifying the expectations related to monitoring other prescriptions through the Prescription Monitoring Program.

- **Gaps related to abruptly closing programs.** Over the last year, two outpatient mental health programs closed abruptly related to financial problems, and the OIG closed a child care center suddenly due to the inadequate safety of children. In all of these cases, issues surfaced due to gaps in very valuable services in the community. The OIG will pursue two important provisions to better prepare Minnesota for the next similar event. The first provision aims to clarify the client record transfer arrangement agreements. In addition, the OIG hopes to change the existing receivership sections of the law by expanding the procedures to nonresidential and outpatient services

- **Fraud in the Nonemergency Medical Transportation Program.** By law, Minnesota is required to reimburse the cost of transportation provided for medically necessary healthcare appointments for recipients enrolled in the Minnesota Health Care Programs. Enhancing documentation requirements will make fraudulent billings more apparent and deter providers from falsifying information. The OIG will be pursuing statutory language that will require substantially more information by those who bill for transportation, including the name of the recipient who is receiving the transportation service as well as the pick-up and destination addresses.

- **Deaths of infants in CD treatment programs.** In six state chemical dependency programs, parents in inpatient treatment are allowed to bring one or more children with them. This is done to promote stability in a family structure. This year there were two infant deaths in these programs - both preventable. The deaths pointed out the ambiguity regarding who was responsible for supervising the infants at the time of their death. The OIG is proposing legislation that would modify the licensing requirements so that parents are assessed on their ability to meet the health and safety needs of their child before bringing children in to the program. Other proposals call for parenting skills training and establishing procedures for when a child in the program is supervised by another client in the program.

While the OIG made significant progress in a number of areas in 2014, more work remains. The OIG is poised and eager to continue to advance the integrity goals in the DHS Framework for the Future in order to reduce fraud, waste and abuse.

Office of Inspector General Overview

The DHS Office of Inspector General (OIG) was created in 2011 to allow DHS to increase its focus on fraud prevention and investigations. The OIG model is used by the U.S. Department of Health and Human Services as well as a number of other states.

Originally, the OIG consisted of the Licensing Division and the Financial Fraud and Abuse Investigations Division. In July 2013, the Background Studies area, which had been part of the Licensing Division, became a separate division.

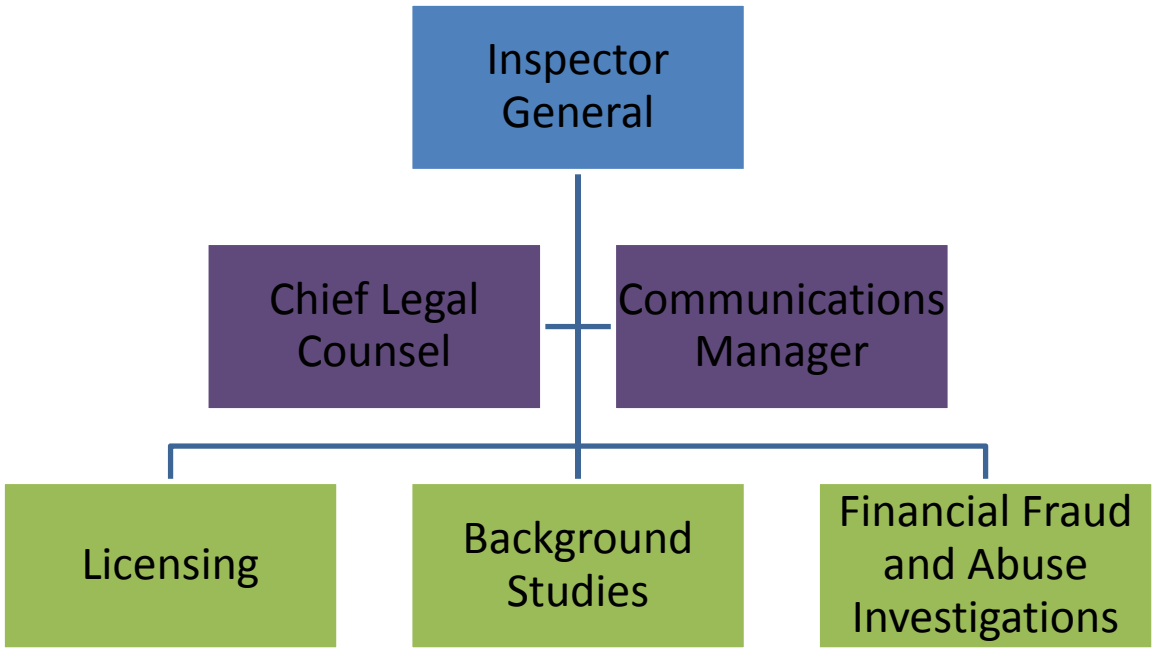
The 2013 Legislature authorized 42 new OIG positions, including six in the child care fraud investigations area. There are 211 positions in the OIG which is located at 444 Lafayette Road in St. Paul, Minnesota.

The Office of Inspector General is accountable to many stakeholders.

OIG Mission: By partnering with others, we help to protect and promote the health, safety, and well-being of people receiving human services and health care. We do this by objectively and consistently enforcing applicable regulations. We demonstrate our commitment to program integrity by improving the detection and recovery of misdirected public funds, administering sanctions, supporting prosecutions, and applying lessons learned from investigations to improving policies designed to prevent fraud, waste, and abuse in DHS publicly funded programs.

Monitoring, Investigating, Correcting, Preventing

Office of Inspector General Organization Chart



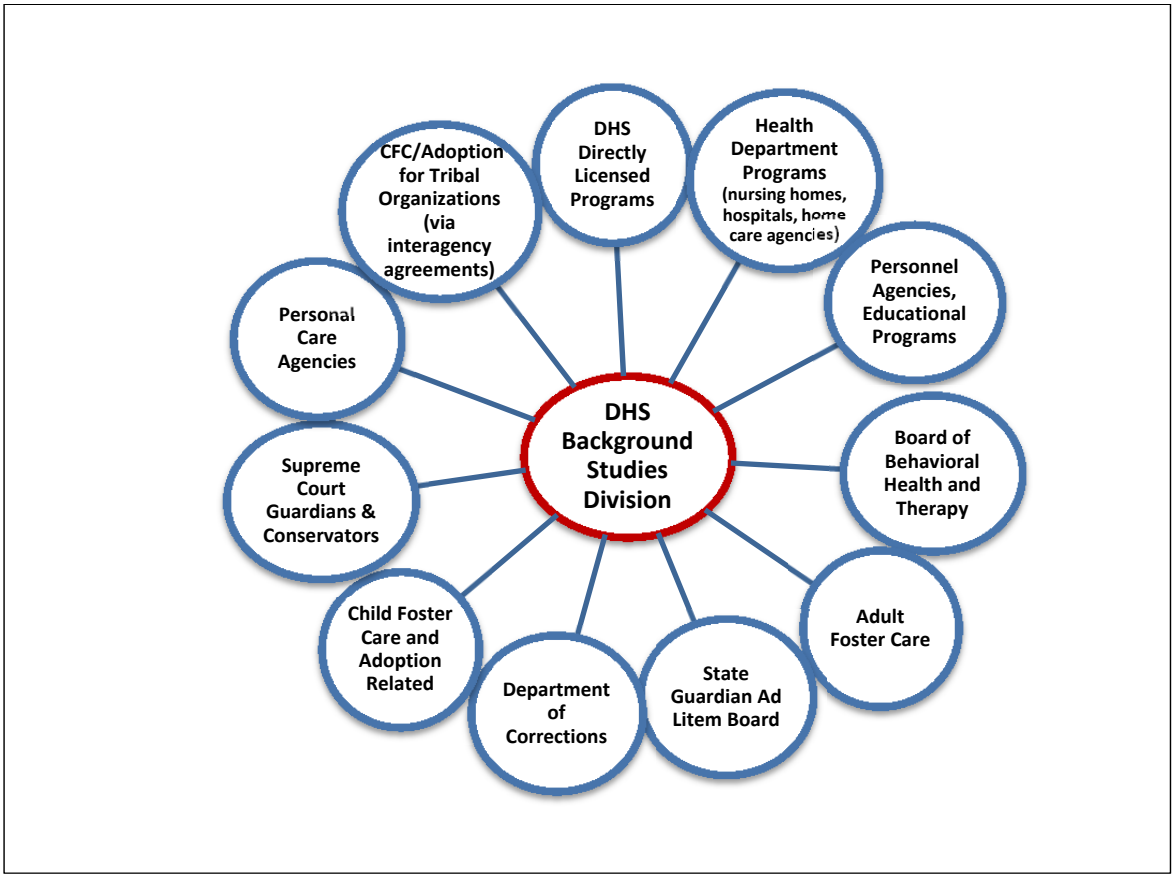
Office of Inspector General: Background Studies Division

The Background Studies Division conducts required background studies on specific individuals. They include:

- Current and/or prospective employees/contractors who will have direct contact with vulnerable populations
- Volunteers who will have unsupervised direct contact with vulnerable populations (e.g., student interns)
- Anyone age 13 and over living in a household where a licensed program will be provided (e.g., child care and foster care).

To help protect people who receive health care and human services, individuals with certain criminal or maltreatment histories are disqualified by law from working in various settings that serve children and vulnerable adults. Background studies are governed by Minnesota Statutes, Chapter 245C.

Figure 1 shows the range of entities for which the Division conducts background studies. Not every specific entity type is represented here; this shows the general categories.



a. Figure 1

Individuals affiliated with these programs are required to undergo background studies. All applicants for a license through the Department of Health and the Department of Human Services, their owners and managerial officials, also are required to undergo a background study. Finally, if the DHS Commissioner has reasonable cause to believe a disqualifying criminal or maltreatment history exists, background studies may also be required of individuals who may have unsupervised access to vulnerable populations without providing direct contact services (e.g., a frequently visiting boyfriend of a child foster care provider or an individual age 10-to-12 living in a household where a licensed program will be provided).

All background studies include a review of criminal records obtained from the Minnesota Bureau of Criminal Apprehension (BCA). The review is based on using a name and date of birth search, and lead investigating agency records of individuals who have maltreated a child or vulnerable adult. The scope of the background study expands when the study relates to child foster care or adoption. Those background studies include a fingerprint-based check of records from the FBI, and a check of child abuse and neglect findings in any state in which the individual has lived in the past five years. The background study also includes an FBI check when there is reasonable cause. These checks require staff to obtain and review court and arrest records from other states.

The Human Services Background Study Act defines offenses which disqualify an individual from any position having direct contact with, or access to, persons receiving services. The law also specifies whether a disqualification is permanent or time-limited. The following chart shows the disqualification period based on offense.

Severity of Offense	Disqualification Period
Most serious felonies	Permanent
Other felonies	15 years
Gross misdemeanors	10 years
Misdemeanors and serious or recurring maltreatment	7 years

Table 1

Table 2 shows the number of background studies that were completed for the past five years and the number of disqualifications that resulted. In 2014, 83 percent of the background studies returned no criminal or maltreatment information. These individuals were approved within a matter of a day or two. Seventeen percent of the studies returned records of criminal offenses of substantiated maltreatment that required careful review. The review first determined whether the potentially disqualifying information belonged to the background study subject and second, whether the information would cause disqualification under the background study law. In about half of these cases, the records did not belong to the subject of the background study. As the chart shows, the percent of studies resulting in disqualification has fluctuated slightly over the past five years, ranging from two-to-four percent, with 2014 showing three percent.

Background Studies Data

Background studies (calendar year)	**2010**	**2011**	**2012**	**2013**	**2014**
Number of studies completed	268,239	270,729	271,476	277,906	311,961
Number of disqualifications	10,275	10,115	8,112	6,235	9,276
Percent of studies resulting in disqualification	4%	4%	3%	2%	3%

Table 2

Accomplishments

Strengthening Background Studies Procedures

The OIG proposed significant system enhancements and law changes to the 2014 Legislature that were designed to:

- Improve the accuracy of DHS background studies
- Increase protections for vulnerable adults and children who receive services from those who are required to have a background study, and
- Significantly speed the background study process for most background study subjects.

Prior to and during the legislative session, OIG staff met with over 2,000 stakeholders, including legislators, providers, labor unions, professional licensing boards, and other state agencies to provide a thorough overview of the proposed enhancements, answer questions and gather feedback and advice. The proposal ultimately passed the House and Senate unanimously. Following the legislative session, a redesign of the current background study system began which will include a number of new enhancements.

The biggest change in the system is the transition from obtaining criminal records from the Bureau of Criminal Apprehension based on a comparison of the subject's name and date of birth under the current system, to the OIG's receipt of criminal history information based on the subject's fingerprints. Using fingerprints to conduct state BCA record checks will virtually eliminate all "false hits" that require the review of criminal records of people with names that are similar to the actual background study subjects.

Other enhancements include using photographs to confirm the identity of background study subjects so employers can verify that the person who submitted fingerprints for the background study is the same person they intend to hire. Real-time updates of criminal case information will be obtained from the Minnesota Court Information System. Additionally, the new system will perform automated checks to determine if the subject has been excluded from serving in any setting reimbursed with Medicaid funds, relieving employers of this duty specified under federal law. The

enhancements are all part of a new electronic system, NETStudy 2.0, which will be used to initiate background study requests and communicate the results to the providers.

Because the new system will be receiving ongoing updates regarding the subjects' criminal offenses and maltreatment activity, and regular updates regarding Medicaid exclusions, repeat background studies won't be needed when individuals change jobs or take a second job. The system also creates administrative efficiencies for providers, reduces hiring time, and provides a more robust and comprehensive study. Vulnerable adults and children who receive services will be better protected as a result of more thorough studies that are subject to ongoing updates.

During the summer and fall, nine community meetings were held to provide information and updates about the impending background study changes and to gather additional feedback. The meetings occurred in locations across the state, and gave participants an opportunity to ask questions and share ideas about implementation.

Participants ask questions about the new background studies system at an August information session in Worthington.

The Background Studies Division implemented pilot testing in July with a number of nursing homes to begin testing various aspects of NETStudy 2.0. Additional programs were added to the pilot in the fall. Pilot participants provided valuable feedback to staff leading to adjustments in the design of the system. By the end of 2014, as part of the pilot testing, over 1,600 background studies have been completed in the new NETStudy 2.0.

Because the new system requires that every background study subject participate in the fingerprinting and photographing, the division issued a Request for Proposals to secure a vendor to establish statewide infrastructure locations for study subjects. The OIG contracted with 3M Cogent; in September, the vendor began securing sites throughout the state and developing system interfaces. By the end of 2014, 3M Cogent had secured sites in 26 locations throughout the state and was working to establish an additional 17 sites. The cost of fingerprinting and photographs will be $9.10 anywhere in the state.

Looking Forward

The Division is pursuing 2015 legislative changes that include:

- Conducting national criminal record checks for Red Lake Nation staff who work at the tribe's nursing facility
- Using the new background study system more fully to enhance the speed and breadth of background studies on individuals in certain Minnesota Department of Health programs who reside outside of Minnesota
- Expanding the scope of background studies to include:
    - MNsure consumer assistance partners
    - Individuals affiliated with house services funded under the Group Residential Housing Program
    - Non-emergency medical transportation providers.

National Criminal Record Checks:

The 2011-2013 Office of Inspector General annual reports contained information and updates on the $3 million grant from the federal Centers for Medicare & Medicaid Services (CMS) that was awarded to DHS in 2012 to make enhancements to the background study system. The system improvements described above are primarily funded by this grant and satisfy many of the federal grant requirements. However, an additional system change to be pursued with a future Legislature will be the authority to expand every background study to include a national criminal record review using the National Criminal Records Repository maintained by the FBI. The FBI is also developing a system that will automatically inform DHS when a background study subject who had a fingerprint-based FBI record check commits a subsequent crime in any state.

Child Care Background Studies:

The federal Child Care and Development Block Grant Act of 2014, enacted on November 19, 2014, will direct several significant changes for child care center and family child care settings, including changes to the way background studies are completed.

All background studies for child care settings will be required to be fingerprint-based and to include national criminal record review using the National Criminal Records Repository maintained by the FBI, as described above. The system improvements are underway and the plan to pursue legislative approval for national criminal record checks puts Minnesota in a good place from a compliance perspective. However, the transition to a federally compliant system for background studies completed on family child care providers and legally nonlicensed child care providers will require more extensive changes and legislative approval. These background studies are currently name-based Minnesota studies performed by counties. During the second half of 2015, the OIG will begin extensive outreach to work with counties to explore the possibility of seeking legislative directive to move the current background study duties to the state to take advantage of NETStudy 2.0.

Office of Inspector General: Financial Fraud and Abuse Investigations

The DHS Office of Inspector General is responsible for investigating fraudulent activities within DHS-administered public programs. The Financial Fraud and Abuse Investigations division investigates MA and child care providers, and public benefit recipient fraud.

As the state Medicaid agency, DHS is federally mandated to implement a statewide Surveillance and Integrity Review Section (SIRS)[1] that investigates the billing and delivery of health services by providers and the use of health services by recipients. Established in 1975, SIRS oversees billings for the $10 billion Medicaid industry in Minnesota. The Section's purpose is to:

- Identify and investigate cases of fraud and overbilling
- Recover overpayments
- Withhold payments
- Suspend or terminate providers in MHCP
- Prevent financial fraud and waste in MHCP
- Protect recipients
- Identify system edits that prevent improper provider payments.

SIRS consists of three units: Provider Investigations, the Minnesota Restricted Recipient Program, and Health Care Federal Audit and Provider Surveillance.

Provider Investigations is responsible for investigating health care provider claims paid by MHCP.[2] Each year SIRS conducts hundreds of investigations resulting in:

- Education of providers and identification of overpayments
- Referrals of provider cases for criminal prosecution by MFCU
- Suspensions and terminations of providers from MHCP.

Investigators conduct desk reviews and onsite investigations of MHCP providers, educate providers and recipients, and identify gaps in payment or health care policy that have resulted in improper billings or service use. SIRS investigators are experienced in a variety of disciplines, including pharmacy, nursing, mental health care, physician services, respiratory therapy, law enforcement and accounting.

DHS contracts with health plans to provide MHCP services under managed care programs. Approximately 73% of MHCP recipients are enrolled in managed care organizations (MCOs). SIRS staff provides oversight and technical assistance to these organizations in identifying, investigating, and combating fraud and abuse. The MCOs report to DHS on their program integrity activities while DHS conducts biannual on-site reviews of each plan's fraud and abuse program. Additionally, SIRS may choose to investigate a provider jointly with MCOs or refer a provider to an MCO for an investigation.

[1] 42 CFR 456.3
[2] Also federally mandated in 42 CFR 456.23

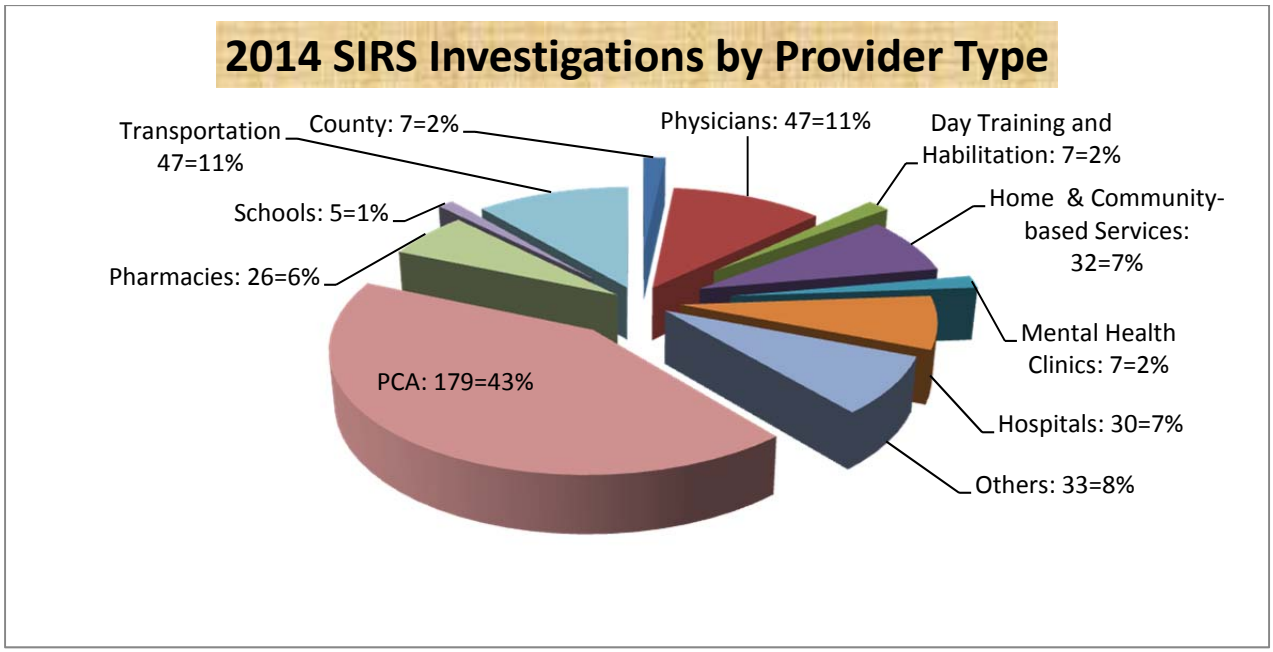


Figure 2

Provider Investigations 2014 Data Highlights	
Number of provider cases opened	409
Number of provider cases closed	420
Number of cases referred to MFCU[3]	46
Number of provider payment withholds	41
Number of provider suspensions or terminations	140
Amount of overpayment identify	> $7,000,000

Table 3

The Minnesota Restricted Recipient Program (MRRP) conducts post-payment reviews of Minnesota Health Care Program recipient claims to determine whether recipients are abusing or misusing services that result in unnecessary costs to the program or in payment for services that are not medically necessary. When recipients are placed in the program, they are restricted to one primary care provider, the primary care provider's clinic, one hospital and one pharmacy for either 24 or 36 months. In addition, many restricted recipients need medical care from specialists; this can only be obtained through a referral from the primary care provider. The restriction of a recipient, referred to as a "universal restriction," stays in place whether the individual is served under fee-for-service (FFS) or by a managed care organization.

[3] Minnesota Fraud Control Unit within the Minnesota Attorney General's Office

There are approximately 4,200 recipients in the Restricted Recipient Program in both fee-for-service and the managed care delivery systems.

MA Provider Recoveries				
Calendar Year	**2011**	**2012**	**2013**	**2014**
OIG Staff Investigations	$878,351	$1,907,822	$1,792,085	$3,863,900
Recovery Audit Contract	x	x	$136,171	$3,334,136
TOTAL	**$878,351**	**$1,907,822**	**$1,928,256**	**$7,198,036**

Table 4

Health Care Federal Audit and Provider Enrollment Surveillance ensures that federal mandates are implemented that relate to provider payment auditing and review.

Federally Mandated Post-Payment Review Contracts: 1) SIRS manages a federally-mandated contract with a Recovery Audit Contractor (RAC). Minnesota's Medicaid RAC is Health Management Systems, Inc. (HMS). This contractor audits Medicaid provider billings and medical records to identify overpayments and underpayments. This was the first full calendar year of activity by HMS which conducted hospital credit balance audits and reviews of inpatient hospital admissions. Table 5 summarizes investigations and recoveries identified by HMS. In 2015, HMS will expand its reviews to include audits of nursing home facility payments.

RAC Investigations 2014 Data Highlights

Number of provider investigations	230
Amount of recoveries	$3,334,136

Table 5

2) SIRS also coordinates and provides advice on audits conducted by a second contractor, Health Integrity, Inc. which contracts with the federal Centers for Medicare & Medicaid Services to conduct post-payment reviews of Medicaid provider billings. In 2014, Health Integrity continued its work on five large health care providers.

Recipient Investigations

The OIG coordinates and administers the Fraud Prevention Investigation (FPI) program. This program prevents ineligible applicants from receiving benefits or quickly identifies and takes action against recipients who are receiving benefits inappropriately. If investigators determine that a recipient unlawfully received benefits, investigators will work with county eligibility workers so the

amount of overpayment can be determined and steps taken to recover funds. Minnesota's FPI program has 12 single county and 13 regional county contracts which cover 74 counties. In the remaining 13 counties, investigations are handled by contracts with the local law enforcement agency.

Another type of recipient investigation is conducted by staff who specialize in fraud investigations linked to the MinnesotaCare Program. These cases are turned over to MinnesotaCare eligibility workers to determine the amount of loss and establish overpayments in order to recoup funds that had been disbursed to ineligible Minnesotans.

Recipient Fraud Investigations – CY 2014

Individual Completed Investigations Involving Multiple Benefits

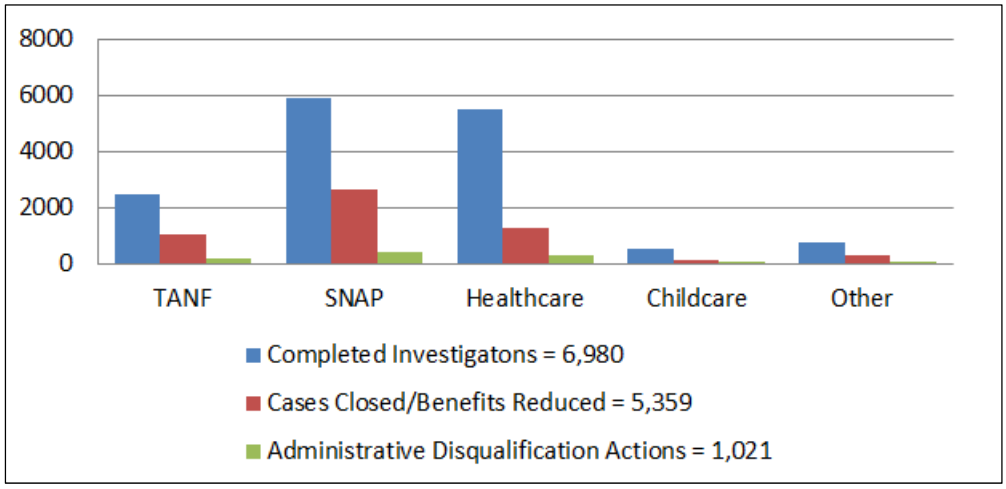


Figure 3

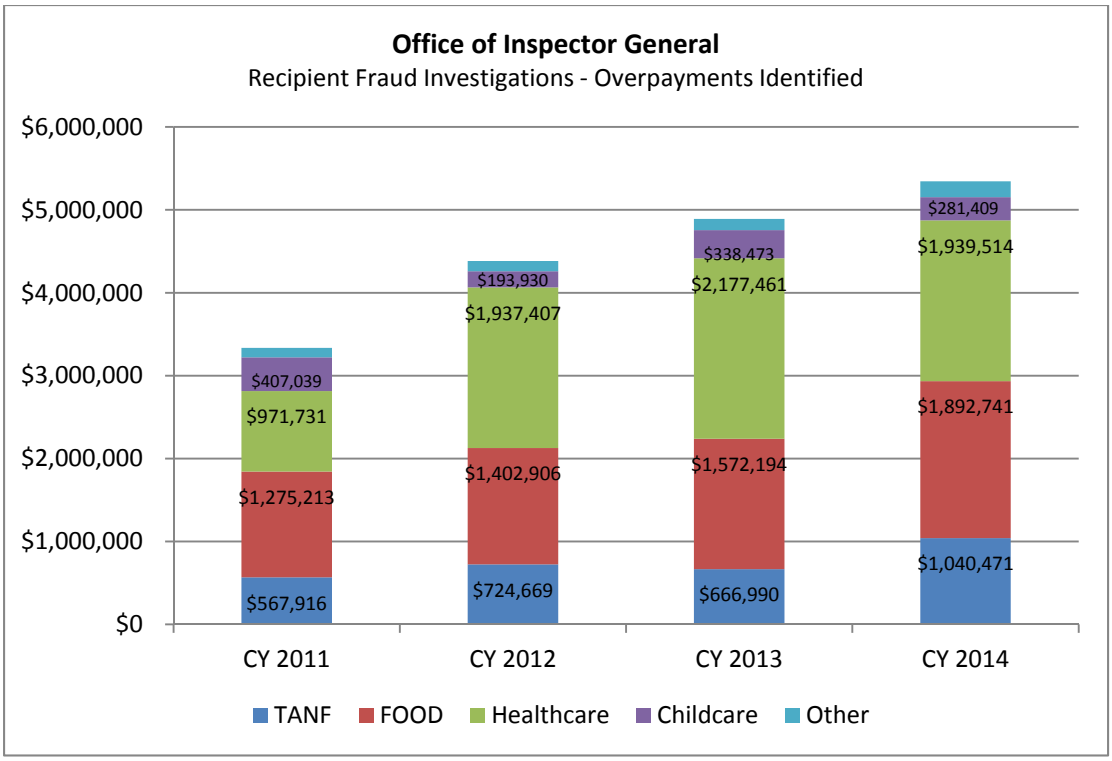


Figure 4

Accomplishments of 2014

Screening visits In December, the OIG began conducting screening visits for high- and moderate-risk new provider agencies seeking to enroll as an MA provider. The majority of screenings have been conducted on unlicensed Personal Care Provider Organizations (PCPOs). The screeners verify the information provided in the application and determine whether the provider is properly set up and equipped to run the business. When conducting the first few screening visits, the enrollment process was ended for an agency that was found incapable of providing the services for which the agency intended to bill DHS. This new screening initiative will also include a post-enrollment onsite visit to observe the business practices underway and to look for any red flags that might warrant a full investigation.

While the OIG is responsible for investigating fraudulent activity in all 80-plus types of Medicaid service providers, a disproportionate share of work relates to PCA services. This year, the PCA program represented seven percent of reimbursed services yet accounted for 43 percent of the OIG's investigative work.

In the past two years, the OIG completed 300 PCA fraud investigations that identified over $1.8 million in overpayments. In 75 percent of the cases investigated, the outcome was termination, suspension, or convictions by MFCU referred from SIRS investigations. Some stipulated agreements allow the continuation of services while DHS recovers the overpayment through reduced reimbursement for subsequent services until the repayment has been completed.

Recovery of overpayments DHS pursues every overpaid dollar and continues to look into a number of avenues to increase actual recoveries. Two methods begun this year that will increase recoveries include:

- Expanding collaboration with the Department of Revenue to use existing procedures to garnish wages and liquidate assets of those who must repay fraudulently obtained funds
- Expanding the collection on surety bonds for failed businesses.

Child Care Provider Investigations A new section within OIG is the Child Care Provider Investigations unit which investigates fraud committed by child care providers who receive Child Care Assistance Program (CCAP) funds. CCAP is jointly funded by the U.S. Department of Health and Human Services, DHS and various counties to provide child care to eligible families so parents can complete their education and enter the workforce.

Staffing for this new investigative unit was completed in spring 2014. The unit consists of a manager, two contracted Bureau of Criminal Apprehension agents, four investigators, and an analyst. The unit investigates complaints and tips from the public and county human services staff. DHS licensing inspectors are also important sources of leads because they visit child care centers daily and can recognize a functioning center from one that is merely posing as one. Until this unit was established, there had not been a dedicated resource for investigating child care provider fraud. Challenged with a backlog of serious reports of abuse, the unit has started with large, complex criminal cases rather than smaller administrative cases.

A common theme in fraud schemes is to bill for large amounts of services that are never provided. As cases are investigated, staff work closely with county human services personnel, local police and sheriffs' departments, county attorneys, various areas within DHS, as well as a variety of federal law enforcement agencies. (See more about child care fraud in the Trends section.)

Office of Inspector General: Licensing

The Department of Human Services, in partnership with counties, licenses approximately 22,000 service providers and monitors and investigates their compliance with Minnesota laws and rules. The DHS Licensing Division is part of the Office of Inspector General. It enforces licensing standards designed to protect the health, safety, rights, and well-being of children and vulnerable adults who receive assistance from human services programs. Licensed programs have the capacity to serve over 275,000 individuals in child care centers, adolescent group homes, adult day service centers, day training and habilitation programs, as well as residential and outpatient programs for people with chemical dependency, mental illness, or developmental disabilities.

The Division's work involves:

- Licensing programs directly through monitoring and enforcement activities
- Overseeing licensing functions delegated to counties and private agencies
- Conducting investigations of alleged maltreatment.

Accomplishments of 2014

Directly-licensed programs

For directly-licensed programs, the OIG issued approximately 3,700 licenses covering 10 types of services. The licensing process is designed to assure that programs meet minimum standards related to the health, safety, rights, and wellbeing of children and vulnerable adults.

Table 1 summarizes the licensing activities related to directly-licensed programs over the last five calendar years. Due to ongoing implementation of the new 245D Home and Community-based Services (HCBS) standards, which took effect on January 1, 2014, licensing staff have been committed to providing technical assistance to existing license holders and to providers who are becoming licensed for the first time. Onsite inspections will resume in 2016. Therefore, there was a decrease in completed inspections along with the expected continued decrease in correction orders and sanctions issued in 2013 and 2014. The table shows a significant increase in the number of licensing sanctions issued in 2014, compared to 2013. The 2013 numbers show a decrease from the general trend over the previous years, attributable in part to the new 245D Home and Community-based Services rollout. But the significant overall increase for 2014 is attributed to the completion of a large backlog of maltreatment investigations. Many of these backlogged investigations resulted in a finding of substantiated maltreatment and corresponding fines issued to the license holders. (See more discussion of maltreatment investigations on pages 18 and 19.)

TABLE 1: DIRECTLY-LICENSED PROGRAMS

Licensing Activity (by calendar year)	2010	2011	2012	2013	2014
Licensing inspections completed	1,692	1,819	1,729	1,256	1,168
Licensing complaint investigations completed	507	550	590	529	543
Correction orders issued	1,685	1,735	1,527	1,207	1,201
Licensing sanctions issued	227	247	239	158	369

Delegated licensing

The Division also licenses approximately 14,000 programs through the oversight of licensing functions delegated by statute to counties and private licensing agencies. Services licensed through counties are generally provided in residential neighborhoods and most often in family homes such as family child care, foster care provided to children and adults, and family adult day services. In addition to counties, private agencies licensed by DHS oversee a limited number of child foster care providers.

Licensing activities completed by counties and private licensing agencies include:

- Processing license applications
- Conducting routine site visits
- Investigating complaints of alleged licensing requirement violations
- Issuing correction orders
- Recommending licensing sanctions to the Department.

The Division evaluates recommendations for sanctions made by the county and private licensing agencies, and issues sanction orders to license holders as necessary.

Table 2 summarizes the number of sanctions issued to license holders in settings in which the county is monitoring the services, along with the number of new and closed programs over the last five calendar years.

TABLE 2: DELEGATED PROGRAMS

Licensing Activity (by calendar year)	2010	2011	2012	2013	2014
Licensing sanctions issued	510	642	725	760	757
First time licenses issued	1,179	2,120	1,995	2,062	2,083
Programs that closed	2,593	2,759	2,653	2,695	2,534

In addition, the county monitors the physical plant requirements for another 3,404 programs licensed to provide services under 245D Home and Community-based Services. DHS Licensing Division staff monitor the services provided in those settings.

Maltreatment investigations

The DHS Licensing Division is responsible for completing maltreatment investigations in approximately 8,800 licensed settings. Minnesota statutes govern the process and timeframe for completing an investigation.[4] The process was developed to protect the health, safety, and well-being of vulnerable adults and children who receive services in DHS licensed programs. The challenge has been to balance the need for quick turnaround of these cases against increasingly complex maltreatment laws and high standards of quality and integrity.

[4] The investigations are completed according to Minnesota Statutes, section 626.557, the Vulnerable Adults Act, and Minnesota Statutes, section 626.556, the Maltreatment of Minors Act.

Table 3 lists pertinent information concerning investigations

TABLE 3: INVESTIGATIONS					
	FY 10	**FY 11**	**FY 12**	**FY 13**	**FY 14**
Reports received, in-office investigation	4,703	4,721	5,323	5,679	5,840
No jurisdiction, referral made	266	235	401	407	438
Assigned, out-of-office maltreatment investigation	710	785	880	718	735
Assigned, licensing investigation	537	679	591	666	596

Table 4 shows the results of these investigations

TABLE 4: MALTREATMENT REPORTS					
	FY 10	**FY 11**	**FY 12**	**FY 13**	**FY 14**
Maltreatment reports completed	695	822	648	704	1,015
- Reports with maltreatment not substantiated	497	604	474	512	631
- Reports with maltreatment substantiated	198	218	174	192	384
- Percent substantiated	28.5%	26.5%	26.9%	27.3%	37.8%
- Number of individuals disqualified	57	90	57	54	121

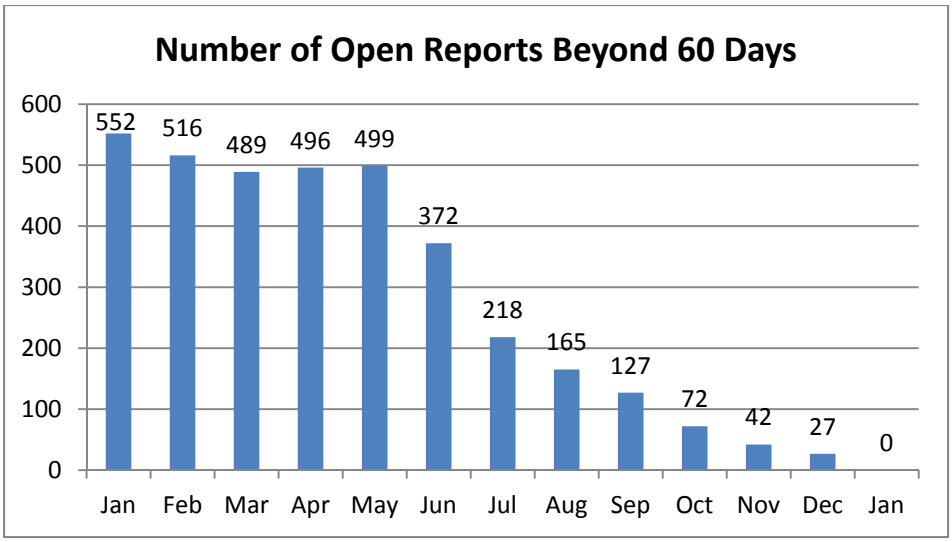
2014 Highlight: Maltreatment investigation streamline project

In May 2014, the Licensing Division began working with the DHS Office of Continuous Improvement to review all aspects of the maltreatment investigation process. The goal was to develop a comprehensive set of steps for staff to improve the timeliness of maltreatment reports assigned for investigation after June 30, 2014, while continuing work on eliminating the backlog of investigations pending longer than 60 days.

On July 1, the Investigations Unit began implementing new workflows and processes to ensure reports are completed within 60 days. The changes include:

- Creating a central intake unit
- Developing an electronic file management and workflow system, and
- Streamlining the review and approval processes when maltreatment is not substantiated.

Improvements implemented to date have eliminated the backlog of pending reports that exceed the 60-day timeframe. In addition, no report has exceeded the 60-day timeline for completion between July 1 and December 31, 2014.



Further information regarding the Division's investigatory functions is contained in the Office of Inspector General/Licensing Division Maltreatment Report Data for Fiscal Year 2014.

Trends:

The annual report offers an opportunity to examine trends over previous years. Notable trends in 2014 included: a continued decrease in the number of infant deaths occurring in family child care settings over previous years; an increase in licensing actions against family child care providers due to sexual abuse of a child in care by an individual in the home; and, an increase in licensing sanctions due to eliminating persistent backlog of maltreatment investigations.

During 2014, the number of infant deaths in licensed child care settings remained low, after falling dramatically in 2013 from the prior two years. In 2014, there was one infant death in family child care compared to three infant deaths in 2013, nine deaths in 2012, and 11 deaths in 2011. Previous year end reports explored the alarming trend in infant deaths in licensed family child care settings as well as the actions taken by the Department in response – including proposing new training requirements as part of a high profile "Safe Sleep Initiative" in 2013. Many of the proposals were adopted by the 2013 Legislature and were implemented at the state and county level over the last 18 months.

Although the statutorily- mandated focus of HCBS licensing work on technical assistance rather than annual inspection reviews contributed to the decrease in correction orders and sanctions issued in 2013, there was an overall increase in licensing sanctions issued in 2014. Staffing increases from the 2013 Legislature significantly contributed to completing backlogged work in the maltreatment investigations unit, described elsewhere in this report. As a result of the increase in completed reports where maltreatment was determined to have occurred, more sanctions were issued in 2014. However, the average number of sanctions for 2013 and 2014 combined was 264, which represents a slight increase from previous years.

In addition, the number of licensing sanctions issued in delegated licensing programs remained about the same at a total of 757 in 2014 compared to 760 sanctions issued in 2013. Within licensing

sanctions issued, there was an increase in 2014 in temporary immediate suspensions in which the license holder must immediately cease operation due to the serious nature of the licensing violations noted by a licensor during an inspection. Of the 757 sanctions issued in 2014, 100 included temporary immediate suspensions (13.2% of total sanctions). This compares to 88 temporary immediate suspensions (11.6% of total sanctions) issued in 2013, 119 temporary immediate suspensions (16.4% of total sanctions) issued in 2012 and 95 temporary immediate suspensions (14.8% of total sanctions) issued in 2011.

Other Highlights:

2014 Highlight: Summary of OIG activities relating to Methadone clinics

Methadone maintenance programs are regulated and monitored at the state and federal level. Obtaining approval to operate an opioid addiction treatment program (OTP) involves meeting requirements of several state and federal regulatory agencies, including: the State Board of Pharmacy; the State Methadone Authority; the Drug Enforcement Administration, and the Center for Substance Abuse Treatment. In addition, each clinic needs to be accredited, like most other clinics and health-care facilities (i.e., hospitals). Despite the number of agencies involved and the regulations that exist at the federal level, Licensing staff have not been able to rely on federal enforcement of federal policies in a timely manner to respond to more immediate risks to the clients of opioid addiction treatment clinics.

During 2014, the licensing staff continued to implement legislative changes enacted in 2013 that strengthen the oversight of OTP clinics by incorporating other state agency and federal standards into DHS licensing laws. The new standards more closely regulate treatment procedures to enhance client safety and prevent misuse of this highly-addictive prescription drug. Violations of these new standards are now clearly enforceable at the state level, allowing Licensing staff to act on violations more quickly and effectively. In addition, Licensing staff have appropriately referred violations to other agencies when necessary.

Licensing staff also assisted with implementing legislation that was enacted in 2013 requiring prescribers in OTPs to first check the state's Prescription Monitoring Program's database, maintained by the Minnesota Board of Pharmacy, for other potentially complicating prescriptions issued to the client. In 2014, Licensing staff identified several cases where the OTP prescriber checked the database and obtained additional information about other medications prescribed to the OTP client by other health care professionals. This information led to enhanced communication between the prescriber at the opioid addiction treatment program and the other prescribers, resulting in limiting possible over-use or diversion of the medications prescribed.

Cross-division work within DHS is underway to develop a comprehensive statewide approach to address OTP-related transportation issues and will include managed care organizations as well. OIG is actively monitoring provider submissions using new billing forms that became effective in March to identify transportation billing anomalies. Results may lead to recoupment of fees paid and may inform future legislative proposals regarding more specific documentation requirements relating to destination and mileage reimbursement.

Licensing staff are also developing standards for the medical directors of OTPs, and all prescribers associated with OTPs, to provide more oversight and enable DHS to address billing policies to prevent inconsistencies and double billing. Examples being considered include a requirement that all prescribers associated with OTPs be enrolled with DHS as an individual health care provider; currently only the clinic is required to be enrolled. Another proposal would require a prescriber at an OTP to meet face-to-face with the client when the dispensed dose of methadone exceeds certain limits (e.g., 150 mg. or 24 mg. of buprenorphine) to ensure the client is receiving the appropriate services for this usage and to help reduce the possibility of diversion.

2014 Highlight: OIG activities relating to Home and Community-based Services and Family Systems

In 2012, the Minnesota Legislature enacted Minnesota Statutes, chapter 245D (Home and Community-Based Services). The legislation was passed in part to comply with a corrective action plan ordered by the federal Centers for Medicare and Medicaid Services (CMS) to ensure continued federal funding of Minnesota's HCBS waiver programs. The legislation became effective on January 1, 2014. Prior to this time, many home and community-based waiver providers were not required to be licensed and service standards were managed through county contracts. CMS deemed this unacceptable.

On January 1, 2014, DHS converted approximately 1,600 developmental disabilities programs previously licensed under Minnesota statutes, chapter 245B into 594 HCBS licenses under Minnesota Statutes, chapter 245D thereby repealing chapter 245B. In addition, 677 providers that were previously unlicensed were issued an HCBS license this year. The HCBS license is a statewide license. When residential supports and services are provided in a community residential setting or day services are provided in a location that is controlled by a 245D license holder, each location receives a secondary license for basic physical plant standards. DHS performs all licensing compliance monitoring and enforcement functions of 245D licensed programs, including:

- Licensing inspections
- Licensing complaint investigations
- Evaluation of license applications
- Issuance and re-issuance of 245D licenses.

According to state law, the licensing inspection of community residential settings' physical plant is the responsibility of counties. As a result of the license conversion from adult foster care to community residential setting, oversight of the services and records of persons receiving services and staff records will now be under the purview of DHS. Oversight of the physical plant requirements will remain with the counties. As a result, the Home and Community-Based Services and Family Systems Units coordinated their efforts to provide information and training to county partners regarding the conversion of more than 3,300 corporate adult foster care homes to a Community Residential Setting license as a result of 245D legislation.

Foster care services under the Elderly Waiver or Alternative Care programs were excluded from the conversion. Technical assistance through outreach to the county licensing agencies included video conferences, presentations at the Minnesota Adult Foster Care Worker Association, and newsletter

articles. In addition, information was provided through sample forms, sample policies and procedures, self-monitoring checklists, and updated information on OIG web pages.

The HCBS unit also collaborated with the Disability Services Division this year to assist with provider training through the Positive Support Community of Practice webinars. Licensing staff assisted in developing training materials that were available at trainings and to assist with questions during these webinars.

In addition, the HCBS unit has collaborated with the Minnesota Department of Health to jointly develop an integrated licensing system for providers of both home care services and home and community-based services. Integrated licensing creates a new model for regulation that allows a broader scope of service delivery. This work across state agencies has identified opportunities for enhancing efficiencies and effective regulatory oversight, and furthers OIG's goal of protecting the health, safety, and rights of persons who receive services from regulated providers.

Looking Forward

Child Care Development Block Grant Act of 2014 Prompts Change

The federal Child Care and Development Block Grant Act of 2014, enacted on November 19, results in several significant changes for child care center and family child care licensing. Many of the changes will require state law changes, funding, and/or systems programming changes. The most significant changes for child care licensing include:

- Annual unannounced inspections of child care centers and family child care programs to monitor compliance with all child care licensing standards. Inspections are currently done every two years.
- Expanded background study requirements to include use of fingerprints, an FBI record check for each background study, and repeat background studies every five years.
- New requirements for licensing, monitoring and inspection reports. Electronic publishing of the number of deaths, serious injuries, and instances of substantiated maltreatment presented in a consumer-friendly and easily accessible format.
- Requirements for a national hotline and website for child care consumer information that will allow reporting of maltreatment and licensing violations.
- Requirements to ensure that licensors are qualified to inspect licensed programs and receive training in related health and safety requirements and in all aspects of the state's licensure requirements.
- Requirements for a statewide child care disaster plan dealing with potential emergencies or disasters. Requires licensed programs to address events - such as violence at a child care facility - as part of emergency preparedness and response planning.

The OIG and DHS Child Development Services Division have analyzed the impact of these federal requirements and are working to develop an implementation plan. It will be necessary to develop

significant legislative proposals for the 2016 legislative session to address these new requirements. County and other stakeholder input will be part of the planning process.

Trends and Proposed Solutions:

Over the past year, several issues have been raised through observed trends or serious concerns brought to the attention of the OIG. This section will identify those current issues and the OIG's planned intervention.

a. Child Care Fraud

Problem: Through child care fraud investigation activities over the past year, the OIG has discovered a problematic theme involving deception and exploitation. The pattern involves the recruitment of parents as child care center employees with the condition that they enroll with a child care assistance program (CCAP) to ensure public funds revenue for the business. The hourly wage for these parents varies, and parents with more children are offered a higher wage. Some individuals with one child or no children are not hired, and parents who lose their CCAP eligibility also lose their employment. These employees are pressured to recruit other parents to participate in this arrangement. The employers often have far more staff than are typical for a child care provider.

After these parents are "hired" and have a job to report for CCAP purposes, the employers will ask them to stay home with their children. The employer pays the parent in cash, but also provides a fictitious pay check stub for the parent to show the county eligibility worker in order to feign legitimate employment. This scheme clearly exploits four sets of victims:

1. **The children.** Minnesota's policies and CCAP program recognize the value of quality child care and how its preparation of young children for school has been shown to provide significant payoffs for everyone, especially the children who will experience life-long benefits from a better start. When the child care that is available through Minnesota's program is not provided to the children who not only deserve it, but are enrolled to receive it, those children are missing this opportunity and are denied the benefit.
2. **The parents.** The CCAP programs offer child care support for low income parents so they can establish a foothold in the workforce. It is also offered for those who are pursuing educational activity that will provide that foothold. When the child care is not provided, and fictitious employment establishes their eligibility, the parents lose that opportunity for this supportive arrangement and their autonomy is not enhanced.
3. **The waiting list.** At the time of this report, there are over 6,100 families on the waiting list for the CCAP program. When the funds are fraudulently redirected to some other purpose, these families are all denied the opportunities the program provides.
4. **The taxpayers.** Minnesota's policy is to support the early development of our children and to support parents who need a hand up in achieving independence. When Minnesota's supportive effort is redirected through fraudulent activity, it victimizes all taxpayers and erodes trust in the public program.

Proposals: To address this problem, the OIG is proposing several legislative changes that will not only assist in the enforcement of the public policies, but will hopefully deter otherwise fraudulent

providers from activating these schemes in Minnesota. The OIG will ask the 2015 Legislature to enact the following statutory changes:

1. To give the OIG the same authority that counties have to stop payments to fraudulent providers;
2. To enhance the responsibility for documentation of attendance by child care providers, with the ability to recover the public funds paid for care when there is no documentation showing that the care was provided;
3. To establish a new responsibility for child care providers to report an extended pattern of a child's non-attendance. Specifically, providers would need to report when a child has missed more than half of the days in a month for which the CCAP program is authorized to reimburse the child care provider;
4. To establish a new criminal offense related to the specific recruitment of employees based on family status or public assistance eligibility. This is already a violation of the Minnesota Human Rights Act, which is subject only to civil action brought by an aggrieved party; this proposal would make the activity a felony level crime;
5. To establish that if a person's fraudulent billing of one public program disqualifies the person from that program, it also disqualifies the provider from billing other public programs for the same length of time;
6. Clarifying the OIG's investigative subpoena authority – establishing the ability to order that the subpoena not be disclosed to the subject of the records unless agreed to by the commissioner or there is a court order. This will allow the OIG to investigate and document financial transactions by fraudulent providers for purposes of administrative actions.
7. In order to better inform the public about fraudulent activity of providers, the OIG will pursue legislative change that will allow the department to disclose the amount of child care assistance funding paid to a child care center under certain circumstances. The information would become public data if the OIG's investigation determines that financial misconduct has occurred. The disclosure would not identify any family that is receiving child care assistance.

These statutory changes will enhance program integrity in the child care assistance program, by not just giving the OIG additional tools to combat fraud, but to act as a deterrent so that the funds are more appropriately spent in the first place. Within the OIG, Licensing Division staff have begun monitoring child care centers for compliance with the child care assistance funding requirements, referring cases to the Financial Fraud and Abuse Investigation Division, which in turn provides information for disqualification of individuals by the Background Study Division from being license holders or working in positions that allow direct contact or access to people receiving services from other human services and health care programs in Minnesota.

b. Sexual Abuse of Children in Family Child Care Homes

Problem: During 2014 the OIG noted an increase in the number of Temporary Immediate Suspensions of family child care licenses based on sexual abuse of a child in care by an individual in the home. These cases also identify a lack of supervision by the family child care provider.

This number has fluctuated over the years, from eight in 2011, 12 in 2012, six in 2013, and 12 in 2014.

Proposal: Even though the number of cases had decreased from 12 to six from 2012-to-2013, the OIG proposed legislative changes in 2013 to expand the training requirements in this area for family

child care providers. The 2013 Legislature passed the proposed changes which became effective on July 1, 2014. These changes are underway:

1. The "supervising for safety" training course is developed by the DHS Child Development Services Division and specifically addresses sexual abuse in the training curriculum.
2. In addition, Child Development Services uses the Licensing Division's annual Temporary Immediate Suspension summary data to inform content development of the two-hour supervising for safety trainings that are offered for the annual training requirement.
3. Effective July 1, 2014, prior to initial licensure, all license holders and caregivers are now required to complete a six-hour "Supervising for Safety" training course.
4. An additional two hours of training on supervising for safety is also required annually for all family child care providers.
5. County licensors are also provided an annual reminder regarding supervision issues along with the annual Temporary Immediate Suspension summary data to inform their licensing work and technical assistance they provide to family child care providers.

This trend will be closely monitored to determine the effect of implementing the new training requirements.

c. Personal Care Assistance Fraud

The PCA program in Minnesota supports more than 30,000 individuals, allowing them to live in their own homes and as independently as possible for as long as possible. The services are tailored to the specific needs of the recipient, and the services can be delivered by friends, relatives, or employees in the privacy of the recipient's own home. But what makes these services so accessible and helpful to individuals also makes them vulnerable to fraudulent billing. PCAs with low level professional credentials, in relatively low wage positions, provide services and document these services with little oversight by their employer. So while the DHS OIG is responsible for investigating fraudulent activity in all 80 types of Medicaid service providers, a disproportionate share of the work relates to PCA services. In Minnesota, the $600 million spent in the PCA program represents just seven percent of the reimbursed services, yet in 2014 this seven percent of the funds accounted for 43 percent of the OIG's investigative work.

The unlicensed PCPOs submit the claims for MA reimbursement. All claims must be supported by actual timesheets for the PCA, and each timesheet must be signed by the recipient of the PCA services.

Problem: The most common form of fraudulent activity is billing for services that were not actually provided. Some caregivers in these low wage positions cannot resist the temptation to pad their timesheets, obtain the recipient's signature, and submit false information to their employers. In some cases, the employer PCPO is participating in the fraud. In the most challenging cases to investigate and prove the recipient also colludes in the ruse. Care recipients sign off on inaccurate timesheets for many reasons, including:

- Some are sympathetic to a relative caregiver's plight
- Some collude with the caregiver and receive remuneration for their participation in the scheme
- Still other vulnerable adults are duped or coerced into signing a fraudulent document.

Proposals: The OIG will propose some modest policy changes in the 2015 legislative session and implement some additional approaches not requiring legislative authority. Legislatively, the OIG will seek an increase in the responsibilities for agencies that bill for PCA services to perform more verification that services are actually provided. A legislative proposal will require that billing agency must randomly verify during each 90-day period that a PCA is in attendance and providing care by calling and speaking with both the PCA and the recipient of PCA services. Agencies that have employed an electronic verification system may seek approval for their use of that system as an alternative to the phone calls.

Other changes to be implemented over the next year include:

Expand Blocked Payments Efforts will continue to expand the number of automated payment blocks within the Medicaid Management Information System (payment system). For example, DHS will seek electronic access to an incarceration record system maintained by the Department of Corrections so that claims will be automatically denied if a PCA or recipient is incarcerated. Similarly, DHS will attempt to modify the data system to prevent payments for PCA services when it's determined that a PCA who is also a public client was hospitalized and unable to provide services. The current system blocks payments when a recipient is hospitalized and a PCA attempts to bill for services during the recipient's hospital stay.

Random Audits The OIG will begin randomly selecting personal care provider organizations for audits. The agency currently has this authority and will make these types of audits a priority.

Evaluate Technology Solutions The department will issue a formal Request for Information to learn about the latest and most effective technology available to verify the provision of services by PCAs. There may not be one solution for all settings, but the benefit to some situations may significantly justify the additional costs.

Increase Onsite Monitoring Until technology solves the problem of verifying services and attendance, the OIG will explore the appropriateness of increasing the expectations that PCA agencies perform additional PCA monitoring. Some agencies suggest an approach that involves random site visits to observe the PCA providing the service, combined with random phone calls to the home to speak with both the PCA and the recipient during the scheduled PCA visit. More work will be done and a proposal for a statutory change may be pursued.

d. Methadone Treatment Program Accountability

Methadone treatment programs provide an invaluable treatment alternative that save lives, particularly with the dramatic increase of opioid addiction in Minnesota.

Problem: Concerns brought to the attention of the OIG have included a lack of oversight or methadone dose prescribing, methadone diversion (sale) by recipients - even in the parking lot of the service provider - and the prescribing of Methadone without knowledge of, or sufficient regard for, the other prescription drugs that the clients may be receiving through other clinics and pharmacies. Unfortunately, over the past few years, community-related problems have developed that erode confidence in the treatment approach.

Proposal: Working with the provider community, the OIG will propose several practice improvements for these providers:

1. Enrollment of all prescribing physicians associated affiliated with methadone treatment programs – as they are for other publicly funded services in Minnesota. This way there is assurance that the physician who is prescribing from Florida is actually licensed to practice in Minnesota and is not disqualified by the federal OIG for fraudulent activity in another state.

2. Requiring a face-to-face meeting between the prescriber and the client when high doses of methadone (above 150 mg.) are prescribed, that there be a face-to-face meeting between the prescriber and the patient, and that every time a dose is increased from then on, another face-to-face meeting occurs.

3. Requiring license holders to report drug diversion to law enforcement when it occurs on the premises of the program. The OIG has been contacted by law enforcement agencies that would like providers to play a more active role in preventing diversion.

4. Clarifying expectations related to monitoring other prescriptions through the Prescription Monitoring Program. This proposal requires Methadone prescribers to be informed when the client is receiving other controlled substance prescriptions from another prescriber, and to require the Methadone prescriber to document whether or not the other prescriptions, in combination with the Methadone, place the client at risk. The proposal will also require that, if at any time the prescriber believes that combination of controlled substances places the client at risk of harm, the methadone program must ask the client to give consent so the multiple prescribers may discuss the client's condition warranting the multiple prescriptions. This client cooperation must be weighted in evaluating the appropriateness of take-home doses.

e. Gaps related to abruptly closing programs

Problem: Over the last year, two outpatient mental health programs closed abruptly related to financial problems, and the OIG closed a child care center abruptly due to the inadequate safety of children. In all these cases there were issues related to the gaps in very valuable services in the community that gave rise to a discussion about possible voluntary or involuntary receivership by the state. Under receivership, the state would petition the court for the authority to take over control of the program and hire a managing entity to continue the services until either the clients are transitioned to other providers while the program closes or the program is transitioned to a different operator. Also problematic, particularly for treatment programs, has been the lack of clarity regarding where treatment records should go following the closure.

Proposal: There are two important provisions to be pursued by the OIG to better prepare Minnesota for the next similar event:

1. Clarification of the record transfer arrangement agreements requiring providers to annually renew arrangements with another party to receive their records should they need to close abruptly.
2. Changes to the existing receivership sections of the law that currently only address residential services – expanding the procedures to nonresidential and outpatient services.

f. Deaths of infants in chemical dependency treatment programs

Minnesota has established and supported a very valuable service – six inpatient chemical dependency programs allow the parent to bring one or more children with them to treatment. This service often strengthens the family rather than complicates it by separating the children from their parent.

Problem: In 2014, there were two infant deaths in these programs; both were preventable. The deaths pointed out the ambiguity regarding who was responsible for supervising the infants at the time of their death.

Proposal: Legislation to modify the licensing requirements will be pursued and will include requirements that these treatment programs:

1. Assesses the parent's ability to meet the health and safety needs of the child while in the program
2. Provide parenting skills training
3. Maintain a procedure for when one client's child may be supervised by another client in the program.

g. Fraud in the Nonemergency Medical Transportation Program

According to state and federal law, Minnesota must reimburse the cost of transportation provided to medically necessary healthcare appointments for recipients enrolled in the Minnesota Health Care Programs.

Problem: The OIG completed a review of a sample of providers and their documentation that showed that:

1. For 11 percent of the trips reviewed, there was no way to verify that the trip was for a legitimate medical appointment
2. For over 41 percent of the trips, the records were so inadequate that it could not be verified that the trip even occurred
3. Related to the requirement that mileage only be claimed for the shortest route:
    a. For 46 percent of the trips reviewed, claimed mileage was greater than two miles further than the shortest route
    b. For 27 percent of the trips reviewed, claimed mileage was greater than six miles from the shortest route
    c. For 16 percent of the trips reviewed, claimed mileage was 10 or more miles longer than the shortest trip.

Proposal: The OIG will pursue statutory language clarifying the requirements for documenting billed services that would include documenting:

1. The recipient's name on each page of documentation
2. The odometer readings for each trip
3. The license plate number of the vehicle that was used
4. The number of occupants in the vehicle during the trip
5. The name of any extra attendant, when used, and
6. A signed certification for each trip by both the driver and the recipient of the service that verifies the accuracy of the documentation.