DEPARTMENT OF HUMAN SERVICES

2016 Annual Report

DHS Office of Inspector General

May 2017

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Executive Summary

This 2016 report provides annual highlights of the important work and accomplishments of the Office of Inspector General (OIG). It also identifies trends and future challenges as the Office continues its work to improve program integrity, accountability and protections for Minnesotans who rely on public programs.

2016 marked the OIG's fifth anniversary. To sharpen focus on the integrity and transparency of programs that spend billions of taxpayer dollars and touch more than a million Minnesotans, the Office was created in 2011 by bringing the Department of Human Services' fraud prevention and recovery functions together with the licensing division, including background studies.

Since then, the OIG has:

- Completed more than 1.45 million background studies
- In partnership with counties, licensed approximately 22,000 service providers annually
- Recovered more than $69 million in Medical Assistance (MA) overpayments
- Conducted more than 37,000 public recipient investigations and identified more than $23 million in overpayments through the Fraud Prevention Investigation program with the counties.

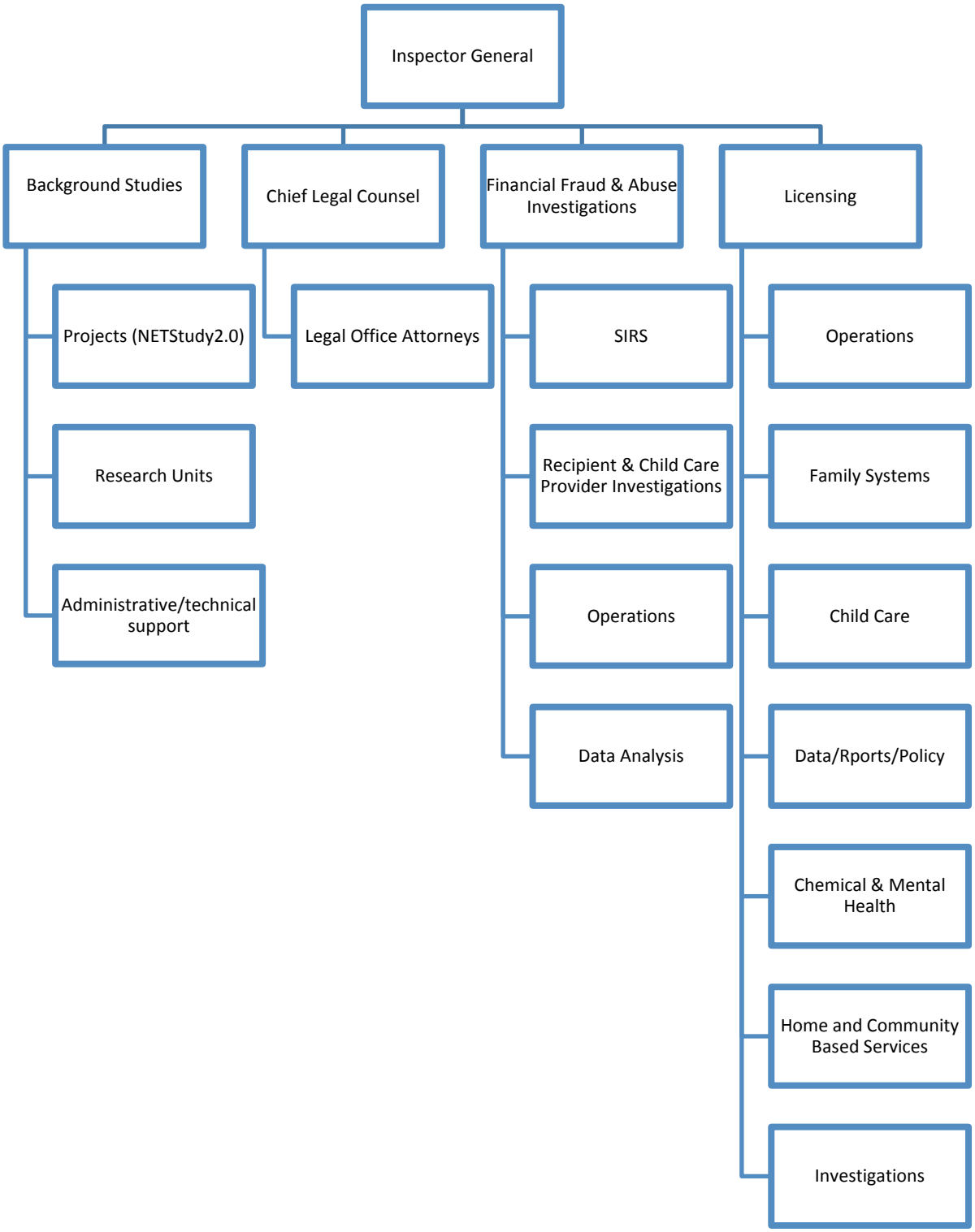
Work done in 2016 contributed significantly. During the year, the Background Studies Division made substantial progress implementing the first phase of NETStudy 2.0. This new fingerprint-based system produces more accurate background studies and monitors the criminal activity of people who have already completed a study. It means people receiving services are safer and the OIG is more efficient in its work.

In the Financial Fraud and Abuse Investigations Division, a record $28 million was recovered in fraudulent or improper payments from MA providers. The Child Care Provider Investigations unit continued to target child care centers fraudulently billing the Child Care Assistance Program.

The Licensing Division conducted more than 3,000 licensing inspections, licensing complaint investigations and maltreatment investigations at licensed facilities throughout Minnesota, ensuring the ongoing health and safety of more than 300,000 Minnesotans who receive services from a DHS-licensed provider.

None of this work would have been possible without the effort and dedication of the more than 225 people who work in the OIG. While we celebrate the accomplishments, we know that we have ongoing and new challenges to tackle. We look forward to a productive 2017 that continues our focus on integrity, accountability and protecting those who receive services through our public programs.

Office of Inspector General Organization Chart



Background Studies Division

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

- Applicants for licensure and 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 and adult 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; it is not all inclusive.

FIGURE 1

Individuals affiliated with these programs are required to undergo background studies. All applicants for a license issued by the Minnesota Department of Health (MDH) and the Department of Human Services

(DHS), as well as the owners and managerial officials, are also 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), including the state Predatory Offender Registry, and records of individuals who have been found responsible for maltreatment of a child or vulnerable adult by Minnesota counties, MDH or DHS. There are three instances when the background study also includes a national criminal history record check through the FBI: when there is reasonable cause to believe the individual has a record in another state; when the individual resides outside Minnesota and the study relates to a licensed nursing home, home care agency or boarding care home; or when the study relates to child foster care or adoption. Studies for child foster care and adoption include a check of child abuse and neglect findings in any state in which the individual has lived in the past five years. Studies for out of state residents working in nursing homes, home care agencies or boarding care homes include a check for maltreatment in their state of residence. Many background studies require staff to obtain and review records from other states.

The Human Services Background Study Act defines acts and offenses that 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.

Table 1 shows the disqualification period based on offense.

Disqualification period based on offense

Level of Offense	Disqualification Period
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 2016, 85 percent of the background studies returned no criminal or maltreatment information. These individuals were approved in a day or two. Fifteen 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 2016 showing a 3 percent rate of disqualification.

Background studies data

Background studies (calendar year)	2012	2013	2014	2015	2016
Number of studies completed	271,476	277,906	311,961	327,000	358,826
Number of disqualifications	8,112	6,235	9,276	12,622	10,726
Percent of studies resulting in disqualification	3%	2%	3%	3.8%	3%

TABLE 2

Accomplishments

Strengthening background study procedures

In May 2014, the Legislature unanimously passed and the governor signed the NETStudy 2.0 authorizing law that significantly enhanced the DHS background study system. It was designed to:

- Improve the accuracy of DHS background studies by using fingerprints to check against criminal records
- Increase protections for vulnerable adults and children who receive services from those who are required to have a background study
- Accelerate the background study process for most background study subjects
- Use technology to provide daily updates to study subjects' determinations.

Implementation of enhanced background study system NETStudy 2.0 - phase one

A $3 million grant from the federal Centers for Medicare & Medicaid Services (CMS) funded many of the enhancements to NETStudy 2.0, and helped satisfy many of the federal grant requirements. To transition to a fingerprint-based system, DHS secured a contract with a fingerprint vendor, 3M Cogent, to establish a statewide infrastructure for fingerprinting and photos. This became fully operational in 2015 with more than 60 locations throughout the state. The cost of fingerprinting and photographs is $9.10 anywhere in the state under the new system; the process should only be needed once in a person's career except in limited instances.

Pilot testing of NETStudy 2.0 began in 2015 with a limited number of providers. A phased-in implementation of the more than 13,000 providers for which DHS conducts background studies began in December 2015. All provider types[1] in this first phase of the transition were expected to be using NETStudy 2.0 by March 1, 2017.

Staff conducted extensive outreach with providers in advance of the transition and provided information and updates through a variety of channels. Training and support continue. Refinements to NETStudy 2.0

[1] Phase one providers represent 99.99 percent of all entities who submit background study requests through NETStudy 2.0.

will be ongoing. Staff will continue to work with the fingerprinting vendor and the state's IT agency to improve the system based on feedback from stakeholders.

By using fingerprints to conduct state BCA record checks the number of "false hits" is negligible. Receiving real-time updates through interface with the Minnesota Court Information System, in addition to receiving updated information regarding substantiated maltreatment, essentially refreshes subjects' background study determinations daily and eliminates repeat checks for criminal and maltreatment information when individuals change jobs.

Other enhancements with NETStudy 2.0 include using photographs to confirm the identity of background study subjects so employers can verify that the person who submitted fingerprints for the study is the same person they intend to hire. 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 monthly duty specified under federal law. NETStudy 2.0 provides administrative efficiencies for providers, reduces hiring time, and provides a more robust and comprehensive study. Vulnerable adults and children who receive services are better protected as a result of more thorough studies that are subject to ongoing updates.

NETStudy 2.0 provider/user feedback

Feedback from providers who have been using NETStudy 2.0 has been very positive. Providers appreciate the speed in which background studies are completed, which provides them quicker access to qualified staff, as well as administrative efficiencies.

Looking forward - phase two

DHS also conducts required background studies with unique requirements for a number of entities through interagency agreements. Examples include background studies on prospective guardians and conservators, and guardians ad litem, and background studies for a number of tribal organizations related to prospective child foster care and adoptive homes. The focus is now on development and programming related to background studies for phase two entities.

National criminal record checks

The $3 million grant from CMS funded many of the enhancements to the background study system and helped satisfy many of the federal grant requirements. DHS hopes to pursue legislative authority to expand every background study to include a national criminal record check through the FBI.

This is important because serious crimes committed in other states can be missed without an FBI record check. 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. This is especially important for background study subjects who work in Minnesota but reside in bordering states.

Child care background studies

The federal Child Care and Development Block Grant Act of 2014 directs several significant changes for all licensed child care programs, legal nonlicensed providers, and license exempt centers, including changes to the way background studies are completed.

All background studies for child care settings will need to be fingerprint-based and include a national criminal record review using a query of the National Criminal Repository. With system improvements underway, Minnesota is well-positioned to implement the enhanced requirements. 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 extensive changes to the background study law and legislative approval. DHS is proposing changes to the law and seeking legislative approval to align with federal requirements in the 2017-2018 legislative session.

Financial Fraud and Abuse Investigations Division

The Financial Fraud and Abuse Investigations Division (FFAID) is responsible for investigating fraudulent activities for DHS public programs. It investigates:

- Billing violations by providers who are reimbursed by Medical Assistance and the Child Care Assistance Program
- Recipients of, or applicants for, public benefits when there is suspicious or questionable eligibility.

(SIRS) MA provider investigations

The Surveillance and Integrity Review Section (SIRS) oversees provider billing for the $11 billion Medicaid industry, called Medical Assistance (MA), in Minnesota. SIRS[2] investigates the billing and delivery of health services by providers and the use of health services by recipients. The Section's purpose is to:

- Prevent financial fraud and abuse by MA providers
- Identify and investigate suspected fraud and abuse
- Withhold payments when there is a credible allegation of fraud or where it is necessary to protect the public welfare and the interests of the MA program
- Suspend or terminate MA providers
- Protect recipients
- Identify and recover overpayments
- Recommend system edits preventing improper payments.

SIRS consists of three units: Provider Investigations, the Minnesota Restricted Recipient Program and the Federal Audit and Provider Screening Unit.

The Provider Investigations Unit is responsible for investigating health care provider billing claims.[3] Each year, SIRS conducts hundreds of investigations resulting in:

- Educating providers and identifying overpayments
- Prosecuting criminal providers
- Suspending and terminating MA providers
- Identifying gaps in payment or health care policies that have resulted in improper billing or payment.

[2] As the state Medicaid agency, DHS is federally mandated to implement a statewide Surveillance and Integrity Review Section. See 42 CFR 456.3.

[3] Also federally mandated in 42 CFR 456.23

SIRS investigators are trained in a variety of disciplines, including: pharmacy, nursing, mental health, chemical dependency, physician services, respiratory therapy, durable medical equipment (DME), hospice, and accounting.

CY 2016 SIRS completed investigations by provider type

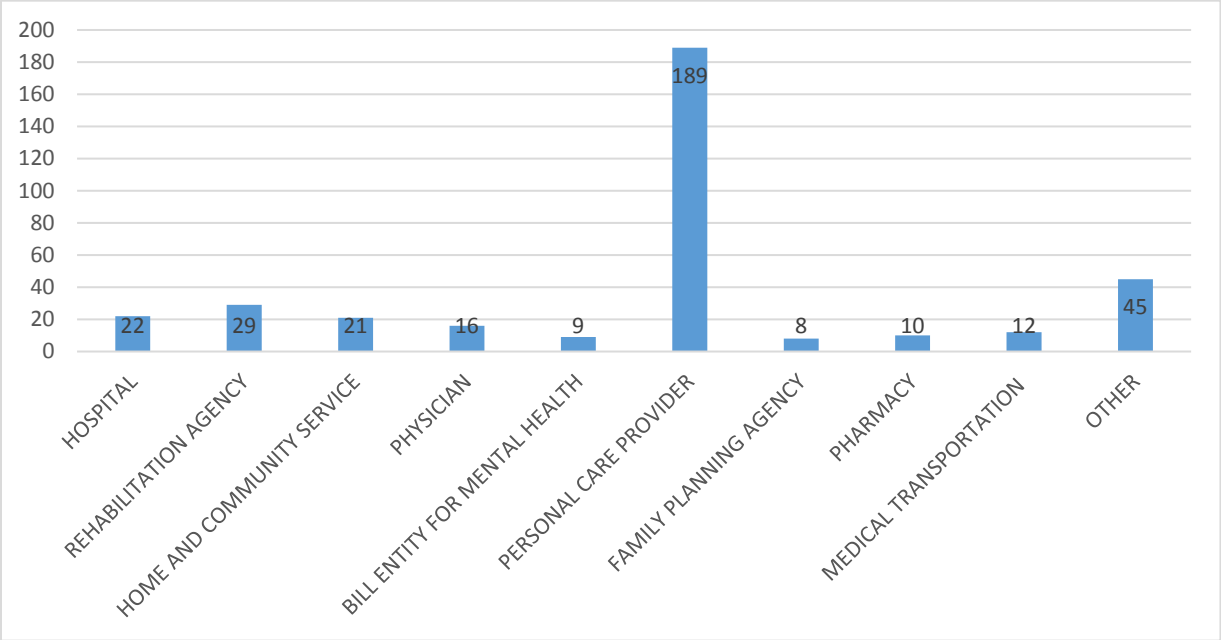


FIGURE 2[4]

CY 2016 provider investigations

Provider cases opened	498*
Cases referred to MFCU[5]	145
Provider payment withholds	70
Provider suspensions or terminations	116
National cases	13
Amount of overpayment identified	$30,252,653**

*Excludes RAC cases

**Amount of overpayment identified:

Provider investigation case	$3,236,612
RAC cases	$2,762,680
National cases	$24,253,361

TABLE 3

[4] Does not include Recovery Audit Contractor (RAC)

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

SIRS national cases

SIRS investigators and data analysts provide information and technical support to the National Association of Medicaid Fraud Control Units in filing civil actions against multi-state providers where MA funds have been paid to the multi-state provider. SIRS' participation in such civil cases provides recoveries for Minnesota's MA program.

CY 2016 SIRS MA provider recoveries (federal and state share)

Calendar year	2011	2012	2013	2014	2015	2016
OIG staff investigations	$878,351	$1,907,822	$1,792,085	$3,863,900	$1,969,243	$2,520,556
Recovery audit contract(started in 2013)			$136,171	$3,334,136	$4,032,344	$1,095,449
National cases	$7,006,328	$25,207,970	$16,469,446	$1,619,918	$2,383,063	$24,020,611
Claims corrections (state share only)					$560,602	$737,869
TOTAL	$7,884,679	$27,115,792	$18,397,702	$8,817,954	$7,258,373	$28,374,485

TABLE 4

SIRS oversight of managed care organization investigations

When DHS pays for health care services through contracted managed care organizations (MCOs), SIRS oversees the MCOs' investigations and integrity activities. Approximately 76 percent of Minnesota Health Care Programs recipients are enrolled with eight MCOs. The remaining 24 percent are enrolled in a fee-for-service (FFS) program operated by DHS. For MCO cases, SIRS refers allegations of improper payment or fraud by managed care providers to the eight[6] contracted MCOs and provides technical assistance to the organizations in identifying, investigating, and combating fraud and abuse. Occasionally SIRS will conduct a joint investigation of an FFS and MCO provider with MCO investigators if the suspected fraud or abuse appears to impact both payment systems.

[6] Hennepin Health and Metropolitan Health Plan are separately enrolled providers with DHS. However, Hennepin Health is doing business as Metropolitan Health Plan, the HMO license holder. For this reason they are counted as one managed care organization for purposes of this report. The other managed care organizations are Blue Plus, Health Partners, Itasca, Medica, PrimeWest, South County and UCare.

CY 2016 managed care investigations

Number of provider cases opened	784
Number of provider cases completed	518
Number of cases referred to MFCU/law enforcement	74
Number of provider adverse actions	216
Amount of identified overpayments (Including denied claims)	$8,259,459
Amount of recovered overpayments (Including denied claims)	$2,744,595

TABLE 5

SIRS post-payment audit contracts

The SIRS Federal Audit and Provider Screening Unit ensures federal mandates governing MA claims auditing are implemented. To expand the reach of SIRS post-payment investigations, DHS contracts with outside entities.

In 2016, SIRS managed a federally mandated contract with a Recovery Audit Contractor (RAC), Health Management Systems, Inc. (HMS). SIRS directs the scope and determines the provider groups audited. The RAC contractor audits MA provider billings and medical records to identify overpayments and underpayments. In 2016, HMS conducted hospital credit balance audits and inpatient hospital admissions audits, and reviewed outpatient hospital claims and inpatient hospital observation payments.

CY 2016 RAC investigations

Number of provider investigations	412
Amount of recoveries	$1,095,449

TABLE 6

CMS hired unified program integrity contractors to review both Medicare and Medicaid providers. While CMS directs the scope of audit under this program, SIRS coordinates and provides technical assistance and data on audits.

SIRS provider screening

The SIRS Federal Audit and Provider Screening Unit verifies provider compliance with enrollment standards through on-site visits to providers who are at risk of committing fraud.

Under federal and state law, DHS requires all enrolled providers to be screened based on the level of risk of fraud, waste, or abuse to the MA program. The screening of providers in the “moderate” and “high-risk” categories requires conducting unscheduled, unannounced site visits at the provider’s practice location. The screening investigators conduct pre- and post-enrollment site visits to verify that the enrollment information submitted to DHS is accurate and complies with federal and state law, and that there is evidence that a business entity actually exists (i.e., qualified staff, enrollment requirements, equipment, files). These visits also identify potential program integrity concerns that sometimes result in a referral to the SIRS Provider Investigations Unit. The screening visits began in December 2014, and at a minimum, will be repeated every five years for existing enrolled providers. Sixty-one providers failed site visits. The breakdown for these providers is as follows: Personal Care Provider Organizations (PCPO)

(18), transportation providers (16), followed by Adult Rehabilitative Mental Health Services (ARMHS), Children's Therapeutic Services and Supports (CTSS), and others.

CY 2016 screening site visits

Site visits performed	671
Providers who failed the site visit	61
Site visit referrals to provider investigations	103

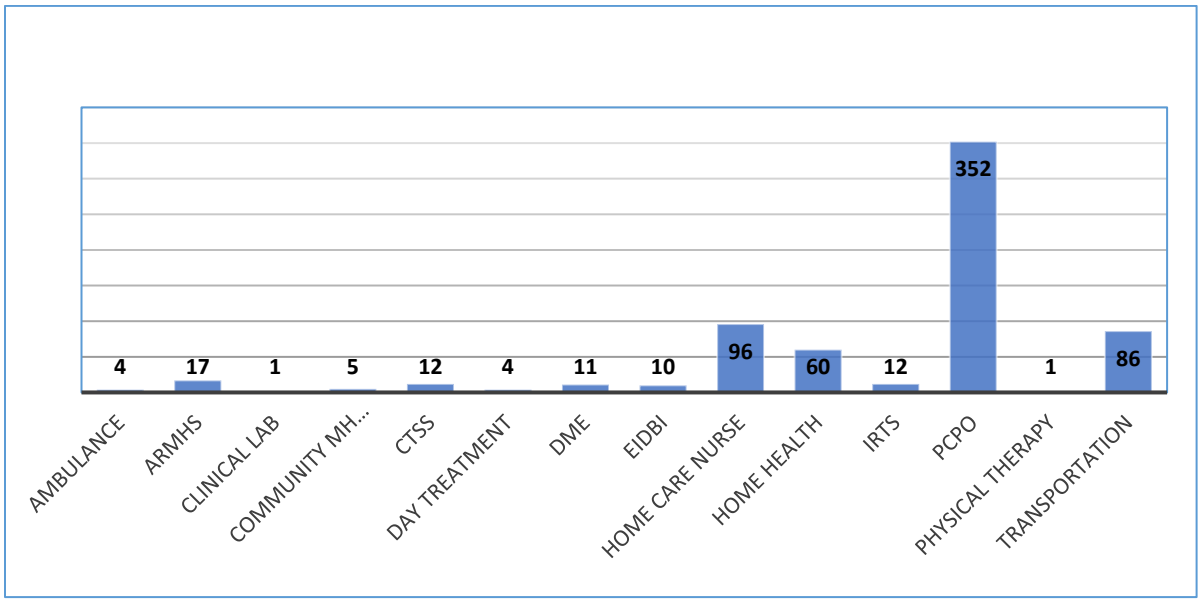
TABLE 7

CY 2016 SIRS provider investigation actions based on screening unit referrals

Provider cases opened	39
Provider payment withholds	8
Provider referrals to MCOs	5
Cases referred to MFCU	12
Notice of agency action issued	5
Amount of overpayment identified	$128,629

TABLE 8

CY 2016 screening site visits by provider type*



* ARMHS -- Adult Rehabilitative Mental Health Services; CTTS – Children's Therapeutic Services and Supports; DME -- Durable Medical Equipment; EIDBI – Early Intensive Development and Behavior Intervention; IRTS – Intensive Residential Treatment Services' PCPO -- Personal Care Provider Organization.

FIGURE 3

Minnesota Restricted Recipient Program (MRRP)

MRRP conducts post-payment reviews of MA recipient medical billing claims to determine whether recipients are receiving services that are not medically necessary and/or are abusing or misusing services that result in unnecessary costs. When recipients are placed in the program, they are restricted for either 24 or 36 months to one primary care provider, the primary care provider's clinic, its affiliated hospital and one pharmacy. A recipient's restriction may be lengthier if a review of services shows continued program violations or misuse of services. 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 regardless of whether the individual is served under FFS or by an MCO. MRRP ensures that Minnesota restriction requirements are followed by MCOs.

In 2010, there were 1,431 restricted recipients in the program. In 2014, there were 3,599 recipients and in 2016, there were an estimated 3,785 recipients in the program for the FFS and MCO delivery systems. After a recipient is placed in the restricted recipient program, there is a significant reduction in expenditures for services and total visits. Emergency room visits and length of inpatient stays are reduced by more than 50 percent and prescription fills drop more than 40 percent. This leads to a savings in health care expenditures per year from $4,000 to $5,000 per recipient over the restricted period, as well as better coordination of care and services for recipients.

Recipient and child care provider investigations

Public recipient investigations

The OIG is responsible for overseeing and administering the Fraud Prevention Investigation (FPI) program that includes providing training for county investigators and eligibility staff. The purpose of the FPI program is to quickly investigate cases in which information indicates that a person has applied for, or is receiving, public benefits to which they are not entitled. By focusing investigative efforts on the front end, benefits to ineligible recipients can be terminated sooner; this significantly reduces the loss to Minnesota taxpayers. The program covers 74 counties. In the remaining counties and tribes, benefit fraud investigations are handled by the local law enforcement agency.

Recipient fraud investigations – overpayments identified

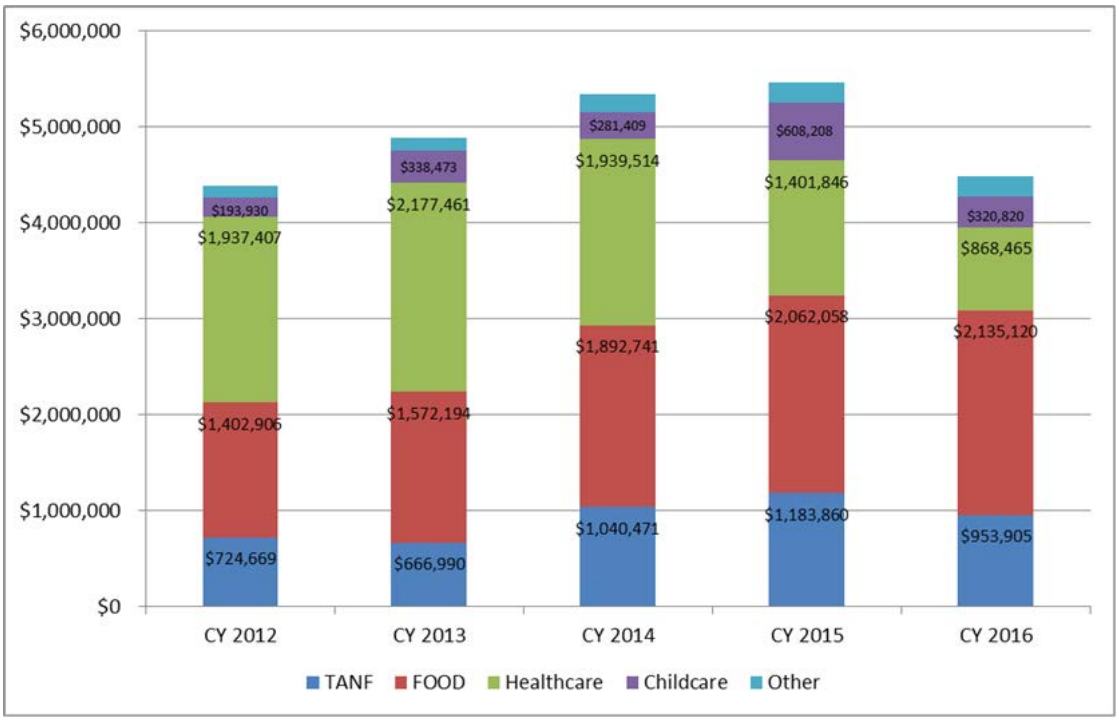


FIGURE 4

CY 2016 recipient fraud investigations – individual completed investigations involving multiple benefits

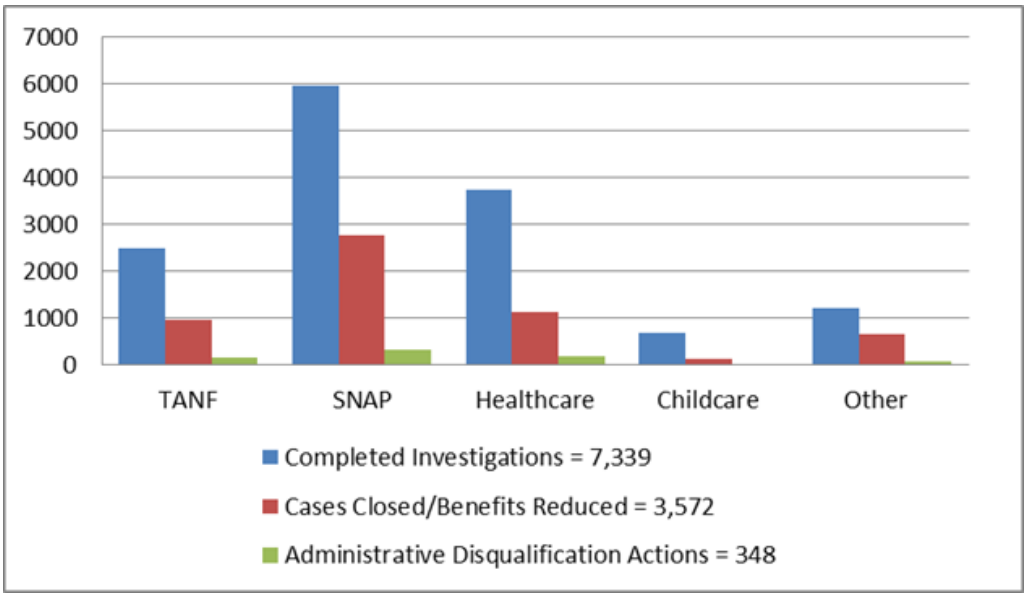


Figure 5

MinnesotaCare investigations

The OIG also conducts investigations where a recipient's health care is provided through MinnesotaCare, a health care program for Minnesotans with low income. Investigators determine if recipients made accurate representations during the application process or after enrollment to ensure that only people meeting program requirements are enrolled.

During 2016, investigators reviewed 3,440 cases. After an initial review, 2,823 cases (82 percent) were found to contain no eligibility issues, while 617 cases required additional investigation to resolve eligibility questions. Ultimately, it was determined that in 284 cases (8.3 percent) payments were made for people who were not eligible. In these cases, the information was forwarded to the department's health care area to calculate overpayments or to take appropriate action. Premium savings are identified where an active recipient on MinnesotaCare is found to be ineligible and the case is closed.

CY 2016 MinnesotaCare recipient investigations

Total cases reviewed	3,440
Completed investigations	617
Case referrals sent to DHS health care	284
Premium savings	$72,932
Overpayments assessed	$319,870

TABLE 9

MinnesotaCare investigators also collaborated with technology staff to develop a new case management system that is scheduled to launch in early 2017. This will allow better tracking of cases and improved coordination with the Health Care Administration.

Child care provider investigations

The Child Care Provider Investigations Unit identifies and takes appropriate action against child care centers that fraudulently bill the state's Child Care Assistance Program (CCAP). This program provides payments to child care providers at low or no cost to eligible families to assist parents in obtaining necessary education or job experience. Reducing fraud allows more families to participate in CCAP because there currently is a waiting list for families needing assistance.

Administrative child care provider investigations

The administrative arm of this area conducts administrative (non-criminal) investigations of child care centers that receive CCAP payments. Investigators use a variety of methods to determine if a provider is accurately billing this program, whether it has the necessary documentation to support its billing, and whether the documentation the provider submits is accurate. If there is adequate support for the billing, the investigation is closed. If a significant discrepancy exists between the billing and the attendance records, the investigation continues. The result of these types of cases could be an overpayment against the provider, a disqualification from the program or a criminal investigation depending on the facts and evidence.

Criminal child care provider investigations

The OIG contracts with the BCA to have two agents assigned to child care provider investigations. When OIG investigators observe evidence of criminal activity during their administrative investigations, the information is forwarded to BCA agents who evaluate the evidence and determine whether a criminal investigation is warranted. At times the BCA requests other (generally federal) law enforcement agencies to jointly investigate the case. BCA agents may also receive requests to assist other law enforcement agencies with investigations of cases involving financial fraud by child care providers. Upon completion, these cases are forwarded to either a county attorney or the U.S. Attorney's Office depending on the information documented during the investigation.

Child care provider administrative investigations CY2016

Number of child care provider investigations initiated	57
Percentage of investigations that identified overpayments	32.4%
Value of identified overpayments	$382,379

TABLE 10

Child care provider criminal investigations CY2016

Number of child care provider investigations completed	3
Number of felony convictions obtained	3
Restitution from criminal cases	$137,105
Number of child care centers where payments were stopped	3
Average payments made to centers in the 24 months prior to payment stop	$1,670,000

TABLE 11

2016 accomplishments

- This year the OIG completed more than 189 personal care assistant (PCA) fraud, abuse or overpayment investigations that identified more than $1.4 million in overpayments. In 42 percent of the cases investigated, the outcome was a termination, suspension, conviction, or stipulated agreement. Some stipulated agreements allow the continuation of services while DHS recovers the overpayment through reduced reimbursement for subsequent services until the repayment has been made. The OIG completed 172 cases on other provider types, where only 13 percent of the cases investigated resulted in a termination, suspension, conviction, or stipulated agreement.
- SIRS continues to collect surety bonds for failed businesses. In 2016, SIRS collected more than $232,000 in bonds relating to four investigations of Minnesota Health Care Programs (MHCP) providers.
- During 2016, the OIG expanded its oversight of Minnesota's eight managed care organizations' program integrity units. This expanded oversight included:
    - Enhancing training and education of program integrity unit leadership
    - Increasing the interaction with, and coordination between, the MCOs and the OIG
    - Refining reporting obligations of MCO anti-fraud activity
    - Initiating a comprehensive review of MCO program integrity assets and capabilities

- Designing and developing a process to audit each plan's program integrity unit's performance, and retaining a full-time auditor to operationalize this effort, and
- Increasing data mining efforts across both MCO and FFS transaction data.

Looking forward

In the coming year the SIRS unit will focus on:

- Expanding oversight of MCO program integrity: The OIG will continue to expand oversight of Minnesota's eight managed care organizations' program integrity units. This will include: completing a comprehensive review of each organization's program integrity assets and capabilities, a review of MCO program integrity policies and procedures, initiating performance audits of each plan's program integrity unit and expanding data mining activity across MCO and FFS claims data.
- Expanding documentation requirements: The OIG has proposed legislation in 2017 to establish minimum documentation requirements in waiver services as required by federal law. Beyond the minimal documentation requirements for all waivered services, the OIG proposed specific additional documentation requirements for adult day care, transportation, and equipment or supplies. If enacted, SIRS will be able to verify that services were appropriately documented and seek recovery from service providers when billed services fail to meet requirements.
- Reviewing risk categories: With the increased investigations of behavioral health and chemical dependency providers, and enhanced enforcement tools over waivered services providers, SIRS, DHS Health Care and program policy areas will assess these providers to determine whether they should be classified as moderate- or high-risk providers under state law.

The OIG will continue to recommend policy and statute language changes to reduce the amount and frequency of fraud involving the programs it investigates. The goal is to more quickly identify and investigate those who are not providing services and submitting false billing for program funds.

Work continues on addressing reports of suspected fraudulent billing or other suspect fraudulent activity by highly paid CCAP providers. These include instances where providers are only employing parents with several CCAP-eligible children, and mothers are being paid to watch their children at home instead of bringing them to the child care center and/or issuing mothers false pay stubs. This results in many children not receiving a legitimate pre-school education and mothers not receiving legitimate job experience.

OIG remains very concerned about billing fraud by a number of child care centers receiving CCAP payments. While the number of child care centers engaged in this type of criminal activity is relatively small, the dollar loss to the program and taxpayers can be substantial.

Licensing Division

The Department of Human Services, through the Licensing Division, is responsible for enforcement of licensing standards and maltreatment laws that are designed to protect the health, safety, rights, and well-being of children and vulnerable adults who receive services from programs governed by the Human Services Licensing Act.

In 2016, DHS licensed approximately 22,000 service providers with a statewide licensed capacity to serve more than 291,000 individuals. DHS is responsible for directly licensing child care centers and

adult day care centers, as well as residential and outpatient programs for people with chemical dependency or mental illness. For other services (e.g., family child care, child foster care, adult foster care, and family adult day care), state law delegates the authority to license programs to counties and private agencies.

The Division's paramount purpose remains the protection of the health, safety, rights, and well-being of people served by licensed programs. While performing current licensing responsibilities and looking toward new initiatives, the Division continues to strive to improve systems and processes to enhance efficiencies and customer service.

The Division's work is statewide and involves:

- Licensing programs directly through monitoring and enforcement activities, including investigations of alleged violations of licensing standards
- Managing and overseeing licensing functions delegated to counties and private agencies, and
- Assessing and conducting investigations of alleged maltreatment.

Directly-licensed programs

The licensing process is designed to ensure that programs meet minimum standards related to the health, safety, rights and well-being of children and vulnerable adults. In 2016, there were 7,986 active licenses for directly-licensed programs covering 12 types of services.

The work begins at the point of application and includes evaluating whether the applicant meets the requisite standards to be licensed. For licensed programs, licensors conduct periodic on-site inspections to evaluate compliance with the applicable licensing requirements. These are unannounced and generally occur every two years. Programs may be visited more often based on performance and, in some cases, the reviews may occur less often due to the Division's staffing limitations. Programs with the most compliance problems are visited more often. Licensors also conduct investigations of suspected or reported licensing violations, and receive and evaluate critical incident reports for certain programs. Some of these reports prompt further action.

During inspections and investigations, licensors review files, policies, procedures, and other documentation required by statute or rule, and interview individual facility staff. Licensors provide technical assistance, inform the license holder of areas of non-compliance that require correction and make recommendations related to improving the services they provide. Depending upon the results of the review, a correction order or licensing sanction may be issued. Correction orders detail the findings of the review and specific areas of noncompliance. Licensing sanctions are ordered based on the nature, severity or chronicity of the violation(s) and the effect on the health, safety, or rights of the people served by the program. These actions include placing a program's license on conditional status, issuing fines, or suspending or revoking the license.

CY 2016 licensing activities related to directly-licensed programs

Active directly-licensed programs (on 12/31)[7]	7,935
New licenses issued	490
Licenses that closed[8]	290
Licensing inspections completed	1,472
Licensing complaint out-of-office investigations completed	1,268
Correction orders issued	1,261
Licensing sanctions (application denials, fines, conditional licenses, suspensions, revocations) issued	292

TABLE 12

Delegated licensing

In 2016, the Licensing Division also indirectly licensed approximately 18,247 programs through the oversight of licensing functions delegated by statute to counties and private licensing agencies. This number includes 14,219 indirectly-licensed programs and 4,028 residential settings licensed under the 245D Home and Community-Based Services (HCBS) standards where the Division monitors the services being delivered and the county monitors the physical plant standards. Programs licensed through counties are generally provided in residential neighborhoods and most often in family homes, such as family child care, child foster care, adult foster care 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.

This work must be completed within statutory and rule standards, and guidance provided by 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. Due to the serious nature

[7] These numbers include Home and Community-Based Services (HCBS) facility licenses where DHS monitors the services being delivered and the county monitors the physical plant standards. These are counted as both directly-licensed and indirectly-licensed programs. There were 3,973, 3,948, and 4,028 HCBS facility licenses in 2014, 2015, and 2016, respectively.

[8] Licenses that closed were due to voluntary closure, revocation, settlement agreement, or closure due to conversion (i.e., conversion of a license to a 245D license). This includes any changes of ownership even if the same service class is operating at the same location. The significant increase in licenses that closed is due, in part, to the creation of new license types and the changeover of some licenses following the enactment of Chapter 245D in 2014.

of situations that lead to sanctions and the gravity of some of the orders, evaluating and acting on these cases is a priority for staff.

CY 2016 licensing activity for indirectly-licensed programs

Active indirectly-licensed programs (on 12/31)	14,182
Licensing sanctions (application denials, fines, conditional licenses, suspensions, revocations) issued	640
New licenses issued	2,745
Licenses that closed	2,632

TABLE 13

Intake and investigations – maltreatment and licensing

DHS Licensing is responsible for assessing and completing investigations of maltreatment reports and licensing complaints received in approximately 9,100 licensed settings. Minnesota statutes and rules govern the process and timeframe for completing investigations involving both maltreatment reports and licensing complaints.[9]

The processes for investigating reports of maltreatment and licensing complaints were developed to protect the health, safety and well-being of vulnerable adults and children who receive services in DHS licensed programs. The Division's challenge is balancing the need for quick turnaround of these cases against increasingly complex statutory requirements, while maintaining high standards of quality and integrity.

All maltreatment reports and licensing complaints receive a thorough in-office investigation to determine and prioritize reports that need further investigation. In-office investigations involve gathering additional information to determine jurisdiction, whether the allegation was reportable as maltreatment or a licensing violation, and whether further investigation is needed. Reports that are determined to need further review are assigned for an out-of-office investigation. More detailed information and trend analysis is found in the Office of Inspector General's FY2016 Report on Vulnerable Adult Act.

[9] The maltreatment 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. Licensing activities are governed by Minnesota Statutes, Chapter 245A and any corresponding rules.

CY 2016 DHS reports and complaints received and assigned

Total Maltreatment Reports and Licensing Complaints received	7,673
No jurisdiction[10]	870
Not assigned for out-of-office investigation (in-office investigation only)	4,861
Assigned, out-of-office maltreatment investigation	779
Assigned, out-of-office licensing investigation	1,163

TABLE 14

If information obtained from the in-office investigation appears to meet the statutory definition of maltreatment, and indicates harm, or a high risk of harm, to the vulnerable adults or child affected, the report is assigned for out-of-office investigation. Currently, each investigation must determine:

- What occurred and whether the event met the definition of maltreatment
- Whether it was an individual, a facility, or both that were responsible for maltreatment
- Whether the maltreatment committed by an individual was serious and/or recurring, which would result in being disqualified from direct contact services; and
- Whether further action is required by DHS related to the facility or the individual.

CY 2016 DHS results of maltreatment out-of-office investigations

Total maltreatment out-of-office investigations completed	781
Reports with maltreatment not substantiated	507
Reports with maltreatment substantiated	274

TABLE 15

Maltreatment out-of-office investigations **completed** differ from the number **assigned** (see Table 14) and may include reports assigned from previous years, and investigations and reports assigned and not completed in a calendar year. In 2016, the percent of maltreatment cases completed on time (within 60 days) was more than 90 percent.

When an individual is determined to have been responsible for maltreatment, and the maltreatment is determined to have been serious or recurring, the determination results in the disqualification of the individual from providing direct contact services in all DHS-licensed services. In 2016, there were 96 individuals disqualified. When a program is determined to have been responsible for maltreatment, the determination results in a licensing sanction, including a $1,000 fine.

[10] "No jurisdiction" means that reports or complaints fell under the jurisdiction of another agency or another unit within DHS.

2016 Accomplishments

Mobile child care electronic licensing inspection checklist

The federal Child Care and Development Fund is a significant source of funding for Minnesota's Child Care Assistance Program. The Child Care and Development Block Grant (CCDBG) Act reauthorized the law governing fund for the first time since 1996 and represents a historic re-envisioning of the program. The new federal law makes significant advancements by defining health and safety requirements for child care providers, outlining family-friendly eligibility policies, expanding quality improvement efforts, and ensuring that parents and the public have clear information about the child care choices available to them. Specifically, DHS must:

- Conduct annual inspections of licensed family child care providers receiving child care assistance payments
- Post the results of monitoring and inspection reports, including the date of the inspection and information on corrective action taken by the provider to address noncompliance with health and safety requirements
- Post on a website the number of deaths, serious injuries and instances of substantiated child abuse that occurred in child care settings each year.

To help meet these new data reporting requirements and use licensing inspection report data, the Licensing Division has been developing and using mobile technology for on-site inspections. This will allow for better and more immediate use of data for caseload management and supervisory oversight, as well as provide counties and the Division with data that will inform future business practices and policymaking. It will also allow the Licensing Division to provide online information about inspection reports and the results of monitoring visits conducted by state and county licensors.

In 2016 the Licensing Division began working with a small group of county licensors for consultation and input on the design and functionality of the electronic checklist. Their input has been extremely valuable in helping DHS design a tool that enhances compliance with the new federal requirements when authorized by the Legislature. By the end of 2016, DHS was beta testing an electronic checklist for state and county licensors to use in monitoring and recording regulation compliance information for licensed child care providers. The new technology will create efficiencies that will lead to increased protection and improved quality of care for children. Although closely tied to the implementation of the CCDBG reauthorization changes, this electronic checklist will eventually impact work and modernize the way that the Division monitors its licensed programs.

Statewide child care disaster plan

In 2016, Minnesota successfully implemented a key federal block grant requirement that did not need statutory authority. The Licensing Division, in partnership with child care providers, parents and guardians, emergency managers, counties, and child advocacy organizations, developed two emergency planning resources that prioritize the health and safety of children in care - *Keeping Kids Safe* and *Minnesota's Statewide Child Care Emergency Plan*. The Licensing Division also made a number of changes to its website to add information about licensing processes and to address commonly asked questions. The Licensing Division also held a number of stakeholder meetings to discuss the federal requirements with licensed providers and to identify future opportunities to enhance licensed child care.

Continuous improvement projects

Reducing length of time to process child care center applications. To reduce the time needed to complete a child care center license application, this project focused on increasing efficiency, communication and understanding of the licensure application process.

Before the project, applications for child care center licensure took 178 days on average to process and complete. Feedback showed the process was challenging and cumbersome for prospective license holders. It caused confusion, significant wait times and delays for applicants who wanted to open a center.

Following the changes, applications processed from Nov. 25, 2015 through Nov. 16, 2016 took an average of 129 days, a 28 percent reduction. Additionally, 55 percent of applications were completed within 120 or fewer days. The DHS Licensed Child Care Center Application Continuous Improvement Project was nominated for a Better Government Award by Human Services Commissioner Emily Piper.

Reducing backlog in the Intake and Death Assessment process. In 2016, changes were made to the process for reviewing reports of death received by the Central Intake Unit to improve the overall process and eliminate a backlog of reports. When an individual receiving services licensed by DHS dies, the provider is required to report the death. The Central Intake Unit reviews all death reports to ensure there were no maltreatment or licensing concerns. In addition, the unit contacts family members, case managers, guardians, or others involved in the individual's life to ensure there were no concerns regarding the care and services provided prior to, or at the time of, the individual's death.

The Central Intake Unit received a total of 466 death reports in 2016. By October 2016, there was a backlog of 346 death reports that were triaged and comprehensively assessed, but lacked data entry and a public summary. To address this backlog, the Central Intake Unit created and implemented the use of a Death Assessment Tracking System that streamlined and strengthened the capability to triage, thoroughly assess, review, and document death reports. With the implementation of the new tracking system, the backlog was completed by Dec. 1, 2016, and the entire death review process can now be completed within 30 days.

Data and policy capacity

The Data and Policy Unit was created to improve the analysis and use of data within the Licensing Division. The unit consists of a manager, a data analyst, three agency policy specialists, and a legislative liaison whose goals are to assist with strategic planning by providing accurate and actionable data analysis, informed and evidence-based policy insights, and meaningful stakeholder engagement. The unit assists in responding to requests with a data component, including responding to more than 150 requests for licensing data (internal and external requests) including those from the media

Additionally, the Data and Policy Unit is analyzing key trends for the Licensing Division. Most recently, the unit completed a report on licensed child care in Minnesota. The report included the licensing activity, data and trends for licensed family child care and child care centers in fiscal year 2015.

Subsequently, the unit published several fact sheets and an issue brief analyzing the trends in child care availability and monitoring of licensed providers. The information will also be used to provide information and data for unit staff and policy makers.

The unit is also responsible for myriad legislative activities. Staff provide insight on the policies, language and data necessary for the governor's budget and policy proposals affecting the Licensing Division. Staff have also improved the consistency and speed of responses to requests from the legislature and other technical assistance requests.

Looking forward

The Division's paramount purpose remains the protection of the health, safety, rights, and well-being of people served by licensed programs. While performing current licensing responsibilities and looking toward new initiatives, the Division continues to strive to improve systems and processes to enhance efficiencies and customer service.

Streamlining the licensing process for changes in ownership and provisional licensing

The Licensing Division continues to seek ways to streamline the work of the Licensing Division and provide greater clarity for businesses seeking to buy existing programs that require a DHS license while enhancing program integrity and protecting the health and safety of service recipients. An important area of focus has been clarifying licensing requirements and practices following the sale of a licensed program and developing a process for issuing provisional licenses to new providers.

As more and more businesses seek to expand, through acquiring existing programs or merging with other businesses, the Division has been seeking new ways to streamline ownership changes and facilitate the licensing process when a business seeks to acquire a DHS-licensed program that is operating. However, a license issued by DHS to a program or business cannot be transferred, so a new license application must be submitted and license approval granted if an existing licensed program is being sold. In many circumstances, the change-in-ownership does not significantly alter the staff, policies, or services of the program.

The Division is also exploring the creation of a provisional license for some newly licensed providers to help enhance compliance in the first years of licensure. Provisional licenses are commonly used in other states for new providers and could benefit both providers and the Division if enacted.