OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Personal Care Assistance

JANUARY 2009

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

January 2009

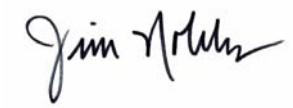
Members of the Legislative Audit Commission:

People enrolled in Minnesota's publicly funded health care programs may be eligible to receive certain personal care assistance in their homes and communities. In response to legislative concerns, the commission directed OLA to evaluate how well the services are being administered.

We found that the services have been subject to minimal state regulation and oversight, even though expenditures have grown significantly and the program is vulnerable to fraud and abuse. Administration of the services needs to be improved, and we offer several recommendations.

Our evaluation was conducted by Joel Alter (manager), Carrie Meyerhoff, and Lolyann Connor. We received the full cooperation of the Department of Human Services, and we also received helpful advice from the Department of Health, counties, health plans, consumer advocates, and service recipients.

Sincerely,



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Summary

Personal care assistance is an important service to many Minnesotans, but it lacks sufficient state oversight and accountability.

Major Findings:

- Between fiscal years 2002 and 2007, estimated publicly funded personal care assistance (PCA) expenditures grew by 164 percent, from $153 million to just over $400 million annually (p. 16).
- Personal care services remain unacceptably vulnerable to fraud and abuse (p. 43).
- Provider agencies are allowed to administer PCA services without demonstrating their understanding of state requirements (pp. 51-54).
- Many recipients strongly value the PCA services they receive, although there has been little systematic analysis of outcomes (pp. 59-60).
- The Department of Human Services (DHS) has implemented a weak quality assurance review program for PCA services (p. 65).
- Minnesota has not implemented sufficient controls and guidance to ensure that assessments of individuals' need for PCA services are reasonably consistent around the state (p. 31).
- DHS protects vulnerable recipients by screening providers for records of criminal offenses, but many adult recipients do not have the abuse prevention plans required by state law (p. 76).
- Supervision of personal care assistants is sometimes inadequate (p. 68).

Recommendations:

- DHS should promptly and regularly analyze claims data to identify improper payments (p. 55). It should also conduct more quality assurance reviews and investigations of PCA agencies (pp. 66, 56).
- The Legislature should establish mandatory training requirements for PCA assessors and the provider agencies that administer PCA services (pp. 38, 56).
- The Legislature should require that all Medical Assistance State Plan PCA recipients have their services periodically supervised by a "qualified professional" (p. 70).
- The Legislature should amend statutes to give DHS responsibility for investigating all maltreatment reports involving unlicensed personal care provider agencies (p. 75).
- DHS should identify topics that all personal care assistants need to understand. PCA agencies and service recipients should arrange for training in these topics, as needed (p. 87).

Report Summary

Personal care assistance (PCA) helps individuals living in non-institutional settings who are unable to care for themselves. It can include assistance with daily living activities, behavior issues, or other health-related tasks. Minnesota offers PCA as a benefit through several publicly funded health care programs. Most PCA services are funded by Medical Assistance, Minnesota's Medicaid program.

Total annual spending for Minnesota's PCA services exceeds $400 million.

The Minnesota Department of Human Services (DHS) has overall administrative responsibility for the state's health care programs. However, since the late 1980s, personal care provider agencies have played a major role in day-to-day administration of PCA services. In fiscal year 2008, over 500 provider agencies were paid to administer PCA services. These agencies are not required to have state licenses, and most are unlicensed.

PCA spending has grown significantly.

Between fiscal years 2002 and 2007, Minnesota's estimated total annual spending for PCA services grew from $153 million to just over $400 million. This represented growth of about 21 percent per year. The spending growth occurred because of increases in the number of recipients, not increases in spending per recipient. Possible reasons for growth in PCA use include the state's move away from institutional forms of care, limited amounts of other types of community-based services, and expansions of PCA eligibility and service options.

The state should provide more guidance to ensure that individuals have relatively equal access to PCA services.

There are large differences in the rates of PCA use among Minnesota counties. For example, the number of fee-for-service PCA recipients per 1,000 Medical Assistance-eligible persons with disabilities ranges from less than 50 in several counties to more than 300 in others. These differences suggest that residents have unequal access to PCA services.

Inconsistencies in assessment practices are one plausible reason for these differences. Counties differ in the extent to which they have assessed individuals as having certain disabilities, such as behavior issues. DHS provides voluntary training for assessors, but some assessors have not taken DHS's comprehensive or advanced courses. We recommend that the Legislature mandate minimum training levels for assessors.

Assessors need more state guidance for determining who should get PCA services and how much. DHS should start with guidance for assessing behavior issues, an area that accounts for some of the recent growth in PCA enrollment. Many assessment agencies would welcome additional guidance in this area, although some people believe the widespread use of PCA for behavior issues largely reflects the lack of better alternatives. Assessment guidelines should not be too rigid, given the need to take into account individual circumstances.

We also recommend that DHS periodically review samples of assessments. This would help ensure consistency in decisions that have large state fiscal impacts.

PCA services remain too vulnerable to fraud and abuse.

Improper payments for PCA services have been a significant problem.

DHS is responsible for ensuring the overall fiscal integrity of the state's publicly funded health care programs. There is not definitive information about the total amount and nature of improper payments for Minnesota's PCA services, but these services are unacceptably vulnerable to fraud and abuse.

Investigations of possible improper PCA payments consume a disproportionately large share of the state's Medicaid fraud investigation resources. Although PCA accounts for less than 10 percent of Minnesota's total Medicaid spending, PCA cases account for an estimated 65 percent of DHS fraud investigators' time and half of the Attorney General's Medicaid prosecutions. Nevertheless, most PCA fraud investigations have been narrow in scope, usually done in response to complaints and focusing on an individual caregiver or recipient. DHS should reallocate existing resources to conduct more PCA-related investigations, especially given the recent increase in the number of new PCA agencies.

The Legislature should require PCA agencies to complete state training before they can provide services.

DHS has taken some steps to address past problems with improper payments. For instance, DHS assigned unique numbers to PCA caregivers starting in 2005 to help identify implausible claims for payment. But, through 2008, DHS had not established controls to prevent payment for clearly inappropriate claims. For one month, we identified more than 400 cases in which DHS paid claims for personal care assistants who allegedly worked more than 24 hours in a day. There were also 152 cases in which caregivers reportedly worked consecutive 24-hour workdays. DHS's failure to prevent payment of these improper claims raises questions about its ability to detect less obvious problems.

In addition, PCA agencies have often provided services without the documentation required by the state for reimbursement. During on-site reviews of PCA agencies' records, we were unable to fully reconcile paid claims and timesheets for 23 percent of a sample of recipients. Also, 26 percent of a sample of recipient files did not have up-to-date care plans for the period of services we reviewed, and 28 percent lacked a current statement attesting to the recipient's medical need for services.

To help foster better compliance, DHS implemented a voluntary, three-day training program in January 2008 for key PCA agency staff. Through 2008, 31 percent of personal care provider agencies have had at least one staff person complete the training. We recommend that the Legislature mandate completion of this training by all PCA agencies. Also, clearer state policies about which PCA services will be covered by the state might improve agency compliance.

The state has not taken sufficient steps to ensure high quality services and protect vulnerable recipients.

The state has conducted one statewide survey of PCA recipients (in 2003). That survey indicated that most recipients rated their services as "excellent" or "good," and current recipients told us about the importance of PCA services in helping them lead fuller lives.

DHS has been working to develop a quality assurance system for a broad range of community-based services

There has been limited state review of provider agencies, and many personal care assistants lack sufficient supervision by professionals.

(including PCA), but it never completed a PCA quality assurance plan required by the Legislature in 2001. Despite the state's large investment in PCA services, there is little information on service outcomes or cost-effectiveness.

DHS started conducting quality assurance reviews of PCA agencies in 2006. But this program has had limited impact, due partly to inadequate staffing. Nearly all quality assurance reviews have been initiated by complaints, leaving little time for potentially valuable reviews of randomly selected agencies. Also, we saw little evidence of follow-up by quality assurance staff after initial reviews, contrary to DHS policy.

Ongoing supervision is another way to help ensure the quality of PCA services. Currently, Minnesota statutes have contradictory provisions about whether PCA services must be subject to professional supervision. In practice, however, DHS allows recipients to forgo this type of supervision. In fiscal year 2007, 22 percent of recipients had no paid supervision. Among recipients with paid supervision, one-third received an average of 30 minutes or less of paid supervision per month. In our view, supervision not only helps ensure that recipients are being well served but also provides accountability to the state. Thus, we recommend amending statutes to ensure that all Medical Assistance State Plan recipients have their PCA services professionally supervised.

There has been longstanding discussion about whether PCA agencies should be licensed by the state. In our view, implementing effective quality assurance reviews and supervision (in combination with some other recommendations in this report) would be a better use of scarce resources than requiring PCA agency licensure at this time.

State law's designation of which state and local agencies are responsible for investigating maltreatment allegations involving PCA agencies is overly complicated. We recommend that DHS be given sole responsibility to investigate allegations involving unlicensed agencies. Also, DHS should ensure that recipients have clearer information about whom to contact about maltreatment or other service-related concerns. Furthermore, many PCA agencies have not developed individual abuse prevention plans for adult recipients, contrary to statutory requirements, and DHS should monitor this.

Finally, many personal care assistants have minimal training and excessive work hours. Statutes do not require formal training for personal care assistants. We recommend that DHS more clearly define which topics must be addressed by PCA agencies and service recipients in their caregiver training. In addition, we found that about 25 percent of personal care assistant workweeks exceeded 40 hours, raising questions about the quality of care provided.

Introduction

Personal care assistance (PCA) is an important service for many low-income and disabled individuals in Minnesota. Effective services delivered to people in their homes can enable them to live independent, productive lives and avoid expensive institutional services. The Legislature has recognized this by authorizing personal care services as a benefit in some of the state's publicly funded health care programs.

But Minnesota, like other states, faces challenges in overseeing the delivery and quality of home-based services. With that in mind, we focused our evaluation on the "integrity" of personal care services by addressing the following questions:

- **Who uses PCA, and how does its use vary around the state? Have sufficient steps been taken to ensure a consistent, sound process for assessing potential service recipients?**

- **Has the state taken sufficient steps to prevent fraud, abuse, and other types of improper payments for PCA services?**

- **Does the state have effective ways of ensuring the quality of PCA services and protecting recipients from harm?**

We examined personal care services paid for by publicly funded health care programs, primarily Medical Assistance. These included services the state paid for on a "fee-for-service" basis, as well as those paid for through the state's payments to managed care organizations. We devoted more of our analysis to fee-for-service care because (1) it accounts for a significant majority of the state's PCA expenditures and (2) the state collects more data on services funded through fee-for-service than services funded through managed care.

We used several sources of data from the Minnesota Department of Human Services (DHS). To better understand recent trends, we analyzed the department's data on PCA recipients, services, and expenditures for fiscal years 2002 through 2007. We also used DHS data to analyze assessments of PCA recipients, training records of assessors and PCA agencies, and appeals filed by PCA recipients.

In addition, we examined the nature and scope of oversight provided by state agencies. We reviewed investigations of fraud and abuse conducted by DHS's Surveillance and Integrity Review Section, quality assurance reviews conducted by DHS's disability services staff, and cases prosecuted by the Minnesota Office of the Attorney General.

We also visited 26 PCA agencies, selected at random from agencies across the state. During these visits, we reviewed samples of recipient and employee files,

interviewed agency owners and administrators, and collected information on employee training and wages.

Finally, we talked with a wide variety of people to get perspectives on PCA services. We interviewed officials from the departments of Human Services and Health, service recipients and family members, disability advocates, managed care administrators, and county staff.

Our report offers some recommendations regarding the state's standards for personal care provider agencies. However, the 2008 Legislature required the Minnesota Department of Health to prepare recommendations on personal care provider standards by February 15, 2009, so we limited our analysis in this area.[1] Also, we did not evaluate the "Self-Directed Supports Option," a type of personal assistance authorized by the 2007 Legislature.[2]

[1] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7.

[2] *Minnesota Statutes* 2008, 256B.0657. The self-directed supports option allows recipients to purchase services under an approved budget plan. The services can include PCA, as well as "items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance" (subd. 6).

1 Background

Due to health concerns, some people need help caring for themselves. Assistance may be needed for short or long periods of time. Most long-term care in the U.S. is unpaid care provided informally by family, friends, and community members. For example, an adult child might help an aging parent grocery shop and prepare meals.

Government health care programs can provide assistance, too. Personal care assistance (PCA) services provided through government health care programs help certain individuals who are unable to fully care for themselves. PCA services may help people stay in their homes and communities, rather than spending time in hospitals or other institutional settings. Personal care assistants provide a range of services—from assistance with activities of daily living (such as eating, bathing, and dressing) to more specialized tasks (such as applying and maintaining prosthetics).

In this chapter, we provide an overview of PCA services. We examine federal and state regulations, how PCA services are administered, and how individuals access services. We also review trends in Minnesota spending for PCA services over the past several years.

PCA SERVICES

Minnesota offers PCA services as a benefit through several publicly funded health care programs, but the majority of PCA services are provided through Medical Assistance (the state's Medicaid program) and Medicaid waiver programs. Therefore, it is useful to review federal guidance for PCA services funded by Medicaid before examining how PCA services have been implemented in Minnesota.

Federal guidelines for Medicaid PCA are broad, giving states the ability to design services that meet their needs. To be eligible for Medicaid funding, personal care services must be: (1) authorized by a physician in accordance with a plan of treatment, or otherwise authorized in accordance with a service plan approved by the state; (2) provided by a qualified individual who is not a member of the individual's family; and (3) delivered to an individual at home or in another location.[1]

The U.S. Department of Health and Human Services (DHHS) has provided states with additional guidance on what "personal care services" includes and which

[1] *42 U.S. Code*, sec. 1396d(a)(24) (2008). Federal law also specifies that personal care services cannot be provided to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease.

family members can be compensated for providing the services. According to DHHS, personal care assistance may include:

> hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs [activities of daily living] and IADLs [instrumental activities of daily living]. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.[2]

DHHS also clarified that spouses of recipients and parents of minor recipients are family members who cannot be compensated by Medicaid for providing PCA services.[3] Other family members may be compensated for providing PCA services.[4]

Within federal guidelines, Minnesota offers a broad range of personal care assistance (PCA) services.

As Table 1.1 shows, PCA services in Minnesota fall into four categories: (1) activities of daily living; (2) instrumental activities of daily living; (3) health-related functions; and (4) redirection and intervention for behavior.[5] For example, a personal care assistant might remind a person to bathe, help her dress, or prepare a meal. PCA services may be delivered in a one-to-one ratio (i.e., one assistant and one recipient) or in a "shared care" arrangement. An example of shared care is two children in the same child care program receiving personal care assistance from the same person at the same time.[6]

In addition to PCA services that involve direct assistance to individuals at home or in their communities, Minnesota's publicly funded PCA activities include: (1) assessments of individuals' service needs and (2) supervision of personal care assistants by "qualified professionals." Assessments determine whether PCA is an appropriate service for enrollees in publicly funded health care programs—and, if so, the amount of personal care time needed.[7] Supervision by a qualified

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[2] U.S. Department of Health and Human Services, *State Medicaid Manual*, part 4, sec. 4480, part C.

[3] U.S. Department of Health and Human Services, *State Medicaid Manual*, part 4, sec. 4480, part D.

[4] *Ibid*. According to the *State Medicaid Manual*, family members are "legally responsible relatives." Thus, the enumeration of family members who may be compensated for providing care "will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements."

[5] *Minnesota Statutes* 2008, 256B.0655, subds. 1a, 1d, 1e, and 2.

[6] "Shared care" may be provided in a one-to-two or one-to-three ratio. *Minnesota Statutes* 2008, 256B.0655, subd. 5(b) and (c).

[7] As described later, assessments generally are completed by public health nurses.

professional is an option available to recipients of PCA services.[8] The qualified professional's role is to help develop a care plan that addresses the recipient's needs, train the personal care assistant, and provide ongoing monitoring of the PCA services.

Table 1.1: Categories of Personal Care Assistance Services Authorized by Minnesota Law

Activities of Daily Living

- Eating
- Toileting
- Grooming
- Dressing
- Bathing
- Transferring[a]
- Mobility[b]
- Positioning[c]

Instrumental Activities of Daily Living[d]

- Meal planning and preparation
- Shopping for food, clothing, and other essential items
- Getting around and participating in the community
- Managing finances
- Performing essential household chores
- Communicating by telephone and other media

Health-Related Functions

- Functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant

Redirection and Intervention for Behavior

- Includes observation and monitoring

[a] Transferring is the process of moving from one seating/reclining area or position to another.

[b] Mobility is the process of moving from one place to another, including with use of a wheelchair.

[c] Positioning is the process of moving a person's body for necessary care and comfort or to relieve any pressure areas.

[d] Personal care assistance services may be used for instrumental activities of daily living if a person has a need for assistance with one or more activities of daily living, health-related functions, or behavior.

SOURCES: *Minnesota Statutes* 2008, 256B.0655, subds. 1a, 1d, 1e, and 2.

Minnesota pays for PCA services on either a fee-for-service or managed care basis.

Minnesota pays for PCA services on either a fee-for-service or managed care basis, depending on the approach used to pay for an individual's overall public health care program benefits. Under fee-for-service, health care providers submit bills to the Department of Human Services (DHS) for reimbursement after

[8] A qualified professional is a registered nurse, mental health professional, or licensed social worker. Personal care assistants performing health-related functions must do so under the direction of a qualified professional or doctor. *Minnesota Statutes* 2008, 256B.0625, subd. 19c, and 256B.0655, subd. 2(e).

services have been provided. DHS pays for eligible costs, and there are no caps on the state's cumulative spending for fee-for-service health care.[9] In contrast, DHS pays managed care organizations at a predetermined, fixed rate that covers a wide variety of services. Managed care organizations administer the services on behalf of DHS, and they bear responsibility for enrollee costs that exceed the predetermined payment amounts. As we discuss in Chapter 2, most PCA recipients get services on a fee-for-service basis.[10]

ADMINISTRATION AND REGULATION

The Department of Human Services has overall administrative responsibility for publicly funded PCA services in Minnesota.

DHS has responsibility for the overall administration of the state's publicly funded health care programs. State law directs DHS to "plan and implement a unified, accountable, comprehensive health services system."[11] In addition to these broad responsibilities, the law assigns DHS some important duties that are specific to PCA services. Of particular note, the law requires DHS to (1) have an ongoing PCA audit process for potential fraud and abuse, (2) authorize PCA services before they are provided to recipients, and (3) establish a PCA quality assurance plan for the state.[12] The law also authorizes DHS to oversee service providers' compliance with PCA-related laws, rules, and policies.[13]

Prior to 1987, DHS played a fairly direct role in the day-to-day administration of Minnesota's PCA service delivery. For example, personal care assistants could submit bills directly to DHS, and DHS made direct payments to these caregivers. However,

- **Since the late 1980s, state law has authorized provider agencies to play a major role in the day-to-day administration of PCA services.**

The 1987 Legislature authorized DHS to select agencies to carry out detailed PCA administrative duties for the state. The law said that these agencies must "contract with or employ and train staff to provide and supervise the provision of personal care services."[14] Today, these agencies submit claims for services provided by their personal care assistants, and DHS makes payments for PCA services to these agencies.

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[9] As we discuss in Chapter 2, generally there is a cap on the fee-for-service dollar amount of PCA services an individual can receive.

[10] In Medical Assistance, seniors are required to receive services through managed care, while people with disabilities can choose between fee-for-service and managed care. One of Minnesota's managed care programs for people with disabilities—Special Needs Basic Care—does not cover PCA services.

[11] *Minnesota Statutes* 2008, 256B.04, subd. 1a.

[12] *Minnesota Statutes* 2008, 256B.0655, subds. 2(g), 4, and 9.

[13] *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[14] *Laws of Minnesota* 1987, chapter 378, sec. 15.

Personal Care Provider Agencies

There are two varieties of PCA provider agencies: Personal Care Provider Organizations (PCPOs) and PCA Choice agencies.[15] The agencies' roles and responsibilities differ, as shown in Table 1.2. A recipient's responsibilities also differ, depending on the type of agency with which he or she chooses to work.

Table 1.2: Responsibilities of Personal Care Provider Agencies

	Personal Care Provider Organization	PCA Choice Agency	Recipient or Responsible Party
Staffing Responsibilities			
Recruit and hire personal care assistant and qualified professional	X		X
Enroll personal care assistant with the Department of Human Services	X	X	
Initiate criminal background check for personal care assistant	X	X	
Train the personal care assistant	X		X
Schedule personal care services	X		X
Provide for back-up assistant	X		X
Monitor personal care assistant and fire if necessary	X		X
Responsibilities Specific to Individual Recipients			
Verify recipient eligibility for public health benefits	X	X	
Obtain initial and annual Physician's Statement of Need	X	X	
Maintain care plan	X	X	
Notify county public health nurse when a new assessment is needed	X	X	
Implement and document responsible party requirements when recipient cannot direct his or her own care	X	X	
Maintain documentation of services	X	X	

NOTE: This list of responsibilities is not exhaustive. It highlights some of the distinctions between responsibilities of Personal Care Provider Organizations and PCA Choice agencies.

SOURCE: Department of Human Services, "Comparison Chart: Personal Care Provider Organization and PCA Choice Agency," January 2007; abridged by Office of the Legislative Auditor.

PCPOs have a fairly traditional employer-employee relationship with the personal care assistants they employ. PCPOs are responsible for recruiting, hiring, and training individuals to work as personal care assistants.[16] Additional responsibilities include monitoring assistants' work and firing them, if necessary. PCPOs also employ a qualified professional to provide supervision for recipients who elect it.

[15] Besides personal care provider agencies, DHS authorizes some other types of health care agencies to provide PCA services. For example, Medicare-certified home health agencies and private duty nursing agencies can provide PCA services. The agencies that provide direct PCA services have typically been nongovernmental organizations.

[16] A PCPO must hire a personal care assistant selected by a recipient as long as the person meets the organization's employment requirements.

In contrast, PCA Choice agencies have a more limited role. Recipients who opt for PCA Choice are selecting a more consumer-directed approach, in which the agency acts largely as a "fiscal intermediary." In essence, PCA Choice agencies share employment responsibilities with the recipients of PCA services. Recipients who choose to work with a PCA Choice agency are responsible for recruiting, training, monitoring, and firing their assistants. The recipients are also responsible for finding a qualified professional and scheduling supervision if they have chosen to receive qualified professional supervision. Recipients might elect PCA Choice for the greater control it affords them. In addition, the reduced administrative responsibilities of PCA Choice agencies might allow the agencies to provide higher compensation to personal care assistants than PCPOs can afford.

The two types of agencies have some responsibilities in common. Both are responsible for enrolling personal care assistants with DHS, initiating background checks, submitting claims to DHS for services and supervision, and paying personal care assistants and qualified professionals. In addition, PCPOs and PCA Choice agencies are required to: (1) verify a recipient's eligibility for publicly funded health care benefits monthly, (2) obtain and keep updated the Physician Statement of Need that asserts an individual's medical need for PCA services, and (3) maintain documentation of services on timesheet forms created or approved by DHS.

Regulation of PCA Providers

Over 39,000 personal care assistants provide PCA services in Minnesota.

Personal care provider agencies must meet certain state requirements before they can provide publicly funded PCA. For example, as listed in Table 1.3, agencies must demonstrate financial solvency and maintain a fidelity/dishonesty bond.[17] Table 1.3 also lists requirements for personal care assistants. For example, personal care assistants usually must be 18 or older and, consistent with federal law, cannot be the spouse of the recipient or a parent of a recipient who is a minor child.[18] Owners and managers of personal care provider agencies and personal care assistants must pass a criminal background check. Provider agencies and assistants that meet all of the requirements can be enrolled with DHS. As of the beginning of fiscal year 2008, over 39,000 personal care assistants were enrolled with and considered active by DHS.[19]

[17] A fidelity/dishonesty bond covers work-related activities of employees who have access to a recipient's personal property. For example, it provides insurance against theft of a recipient's property by a personal care assistant.

[18] *Minnesota Statutes* 2008, 256B.0655, subd. 1f, and 256B.0625, subd. 19a. Individuals who are at least age 16 and have completed related job training or a certified home health aide competency evaluation may serve as personal care assistants.

[19] This count excludes personal care assistants who were only active with managed care organizations.

Although personal care providers must meet some state requirements, they are not required to obtain a state license.

Table 1.3: Selected Requirements for Personal Care Assistance Providers

Personal Care Assistants

Must:	Must Not:
• Be at least age 18 (or at least 16 and completed a related training program or competency evaluation) • Have acquired through training or experience the necessary skills to provide personal care assistance • Be able to communicate with a recipient and deliver care consistent with the recipient's needs • Pass a criminal background check	• Be the recipient's spouse or parent of a recipient who is a minor • Be a recipient of personal care assistance • Be the recipient's responsible party

Personal Care Provider Agencies[a]

Must:
• Use generally accepted accounting principles • Demonstrate financial solvency • Be owned and managed by individuals who have passed a criminal background check • Maintain fidelity/dishonesty bond • Maintain liability insurance

NOTE: Health care providers in general, and personal care assistance providers in particular, must meet many requirements. This table focuses on requirements for enrollment with the Department of Human Services as a personal care provider agency or personal care assistant.

[a] Personal care provider agencies employ personal care assistants. Agencies include Personal Care Provider Organizations and PCA Choice agencies. Some other types of health care providers, such as home health agencies and private duty nursing agencies, may also provide PCA. If they offer PCA, these agencies must meet the requirements for personal care provider agencies, in addition to any requirements specific to their agency type.

SOURCES: *Minnesota Statutes* 2008, 256B.0625, subd. 19a, and 256B.0655, subds. 1f and 1g; and *Minnesota Rules* 2008, 9505.0335, subd. 5.

State regulation of PCA provider agencies is fairly limited. Unlike many agencies that provide home care services in Minnesota,

- **State law currently exempts PCA agencies that provide Medicaid-funded services from licensure by the Minnesota Department of Health.**

The Minnesota Department of Health licenses many types of agencies that provide home care services. On several occasions, the Legislature has considered whether PCA provider agencies should be licensed by a state agency. However, the 2008 Legislature exempted all providers of Medicaid-funded PCA

services from licensure requirements, pending implementation of provider standards recommended by the Department of Health.[20]

Some agencies that provide PCA services have state licenses. For example, some home health agencies provide PCA services, and they are licensed by the Department of Health and certified by the federal government to provide Medicare services. But, while agencies must enroll with DHS to provide personal care services, they are not required to obtain a license.

In fiscal year 2007, unlicensed personal care provider agencies delivered over three-quarters of the state's fee-for-service PCA services. DHS paid 417 unlicensed personal care provider agencies $234 million for PCA services delivered in 2007. In contrast, DHS paid 78 licensed home health agencies just over $41 million for PCA services that year.

INDIVIDUAL ELIGIBILITY AND ACCESS

Minnesota is one of 36 states that offer personal care services as a standard benefit for Medicaid recipients.

To receive PCA services in Minnesota, an individual must be eligible for one of the government-funded health care programs that include these services as a benefit and meet additional eligibility criteria specific to PCA. Table 1.4 lists Minnesota's health care programs that include PCA and general information about the programs' eligibility requirements. For example, Medical Assistance (MA) is a health care program funded by the federal and state governments that provides health care to low-income families, children, pregnant women, and people who are elderly or disabled. Eligibility for MA is based on income, residency, and citizenship status. Since 1977, Minnesota has included PCA services as a standard benefit in its MA State Plan, and it is one of 36 states that do so.[21]

Individuals who are eligible for a Medicaid Home and Community-Based Services waiver program can access extra quantities of PCA services beyond those provided as a standard benefit through the MA State Plan. For these waiver programs, the U.S. Department of Health and Human Services waives certain requirements that apply to state plans, allowing states to provide benefits unavailable to the Medicaid population as a whole to individuals who meet eligibility criteria for care in an institutional setting.[22] For example, individuals

[20] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7, codified in *Minnesota Statutes* 2008, 144A.46, subds. 1 and 2. The Legislature required the department to make recommendations in consultation with DHS by February 15, 2009. We discuss the issue of PCA provider agency licensure further in Chapter 5.

[21] For states offering personal care assistance, see: U.S. Department of Health and Human Services, *Medicaid At-a-Glance 2005: A Medicaid Information Source* (Washington, DC, 2005), 10. The federal government requires that states include certain benefits in their Medicaid state plan, but it also gives states the option of including others. Since the mid-1970s, the federal government has allowed states to offer personal care assistance as an optional benefit under their Medicaid state plan.

[22] Home and Community-Based Services waiver programs provide an alternative to institutional care. Therefore, an individual must have health needs that would qualify them for care in an institutional setting in order to be eligible for one of these waiver programs.

Table 1.4: Minnesota Health Care Programs Offering Personal Care Assistance Services

Program	To be Eligible, Individuals Must:
MEDICAL ASSISTANCE (MA)	• Meet income and asset limits • Be a Minnesota resident • Be a U.S. citizen or qualified noncitizen • Be under age 21, a parent of a minor child, pregnant, age 65 or older, or blind or disabled
MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS	
Community Alternative Care Waiver	• Be MA-eligible • Need hospital level of care • Be disabled • Be chronically ill/medically fragile • Be under age 65
Community Alternatives for Disabled Individuals Waiver	• Be MA-eligible • Need nursing facility level of care • Be disabled • Be under age 65
Developmentally Disabled Waiver	• Be MA-eligible based on disability diagnosis • Need intermediate care facility for persons with mental retardation level of care • Be diagnosed with mental retardation or a related condition
Elderly Waiver	• Be MA-eligible • Need nursing facility level of care • Be age 65 or older
Traumatic Brain Injury Waiver	• Be MA-eligible • Need specialized nursing facility or neurobehavioral hospital level of care • Be diagnosed with traumatic or acquired brain injury • Experience significant behavior and cognitive deficits related to injury • Be under age 65
MINNESOTACARE	• Meet income limits (higher than under MA) • Be a Minnesota resident • Be a U.S. citizen or qualified noncitizen • Have no health insurance or Medicare for four months • Be younger than age 21 or pregnant[a]
ALTERNATIVE CARE	• Have insufficient income and assets for more than 135 days of nursing home care • Need nursing facility level of care • Be age 65 or older

NOTE: To receive personal care assistance (PCA), individuals must meet specific criteria for PCA in addition to the program eligibility criteria. For PCA, individuals must: (1) be in stable health, (2) be able to direct their own care (or have a responsible party who can), and (3) have a medical need for services.

[a] In the MinnesotaCare program, PCA is available only to persons under age 21 and women who are pregnant. There are no asset limits for these participants.

SOURCES: Department of Human Services, *Disability Services Program Manual*, "Waivers;" Department of Human Services, "Minnesota Health Care Programs," July 2008; Department of Human Services, "Alternative Care Program," February 2008; and Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 7-9.

in the Elderly Waiver program must qualify for MA, need a level of care that would otherwise be provided in a nursing facility, and be age 65 or older. Most states offer personal care assistance services through at least one waiver program.

Finally, Minnesota has chosen to offer PCA services through MinnesotaCare and Alternative Care. PCA through MinnesotaCare is available only to pregnant women and children. The Alternative Care program is for elderly individuals whose income and assets are too high to qualify for MA.

Individuals who meet health care program eligibility criteria must meet additional conditions before receiving PCA. Individuals must: (1) be in stable health, (2) be able to direct their own care (or have a responsible party who can direct their care), and (3) have a medical need for services. Figure 1.1 illustrates the process Minnesota follows to determine whether fee-for-service recipients in the MA State Plan meet these conditions.

To receive PCA services, individuals must have documentation of their medical need for these services.

The first step in accessing PCA is an independent assessment of a person's eligibility and need for services. Most PCA assessments are conducted by public health nurses (PHNs). Assessments are available to all MA individuals upon request and are required at least annually for people already receiving PCA services.[23] The initial assessment is completed face-to-face, generally in a potential recipient's home.[24] During an assessment, the nurse (1) documents the person's health status, (2) makes a judgment about the person's ability to direct his or her care, and (3) determines whether the individual needs assistance in the four categories shown in Table 1.1.

If the nurse determines that a person cannot direct his or her own care, a "responsible party" must be present during the assessment. Responsible parties participate in decisions about and supervision of PCA services for recipients who are unable to fulfill these responsibilities.[25] If, after the assessment, the PHN concludes that the individual needs assistance, the nurse determines an appropriate amount of time to fulfill the individual's needs.[26]

The PHN also explains four choices that the recipient or responsible party must make. First, the recipient must decide whether supervision of the personal care assistant will be done by the recipient/responsible party or a qualified professional.[27] Second, the PHN explains the difference between a traditional Personal Care Provider Organization and a PCA Choice agency, and the

[23] *Minnesota Statutes* 2008, 256B.0655, subd. 1b.

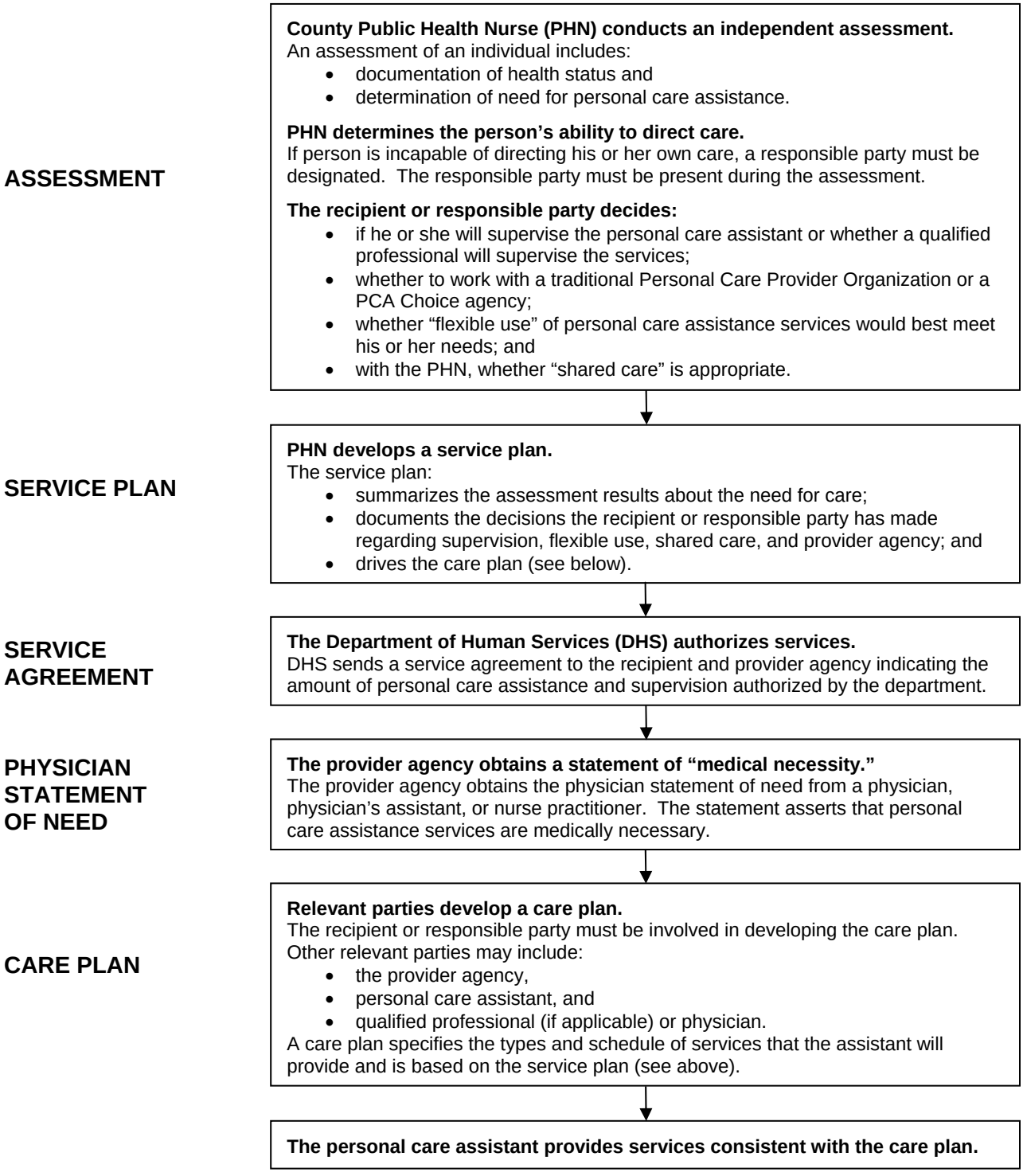
[24] An initial assessment can be completed in a nursing home or hospital in anticipation of a person's release from the institution, but PCA services cannot be delivered in these settings. Assessments of PCA recipients are repeated when there is a change in condition and at least annually. Not all follow-up assessments must be conducted face-to-face.

[25] If a responsible party is not present, the nurse must stop the assessment.

[26] Assessors recommend the number of minutes of assistance a person needs. For example, an assessor might determine that a person needs 10 minutes of assistance per day to bathe.

[27] As noted earlier, a qualified professional is a registered nurse, mental health professional, or licensed social worker.

Figure 1.1: Process for Accessing Personal Care Services



NOTE: This figure shows the process for accessing personal care assistance services provided on a fee-for-service basis through Minnesota's Medical Assistance State Plan.

SOURCE: Office of the Legislative Auditor.

recipient chooses an agency with which to work from among those enrolled with DHS. Third, the recipient indicates a preference for standard or "flexible use" of the assessed PCA time. PCA time is generally authorized through service agreements lasting one year.[28] Standard use is a fairly equal distribution of PCA services over the course of the service agreement, while flexible use allows recipients to vary their PCA use within six-month time periods. For example, flexible use would allow a school-aged child to receive more PCA during the summer months, and less during the school year. Finally, the recipient and PHN determine whether services should be provided one-to-one or through shared care.

Assessments by public health nurses play a key role in determining the PCA services individuals will receive.

The assessment results in a "service plan" and a "service agreement." The service plan includes the nurse's recommendation for the amount of PCA time and qualified professional supervision needed, and it records the individual's decisions in the four areas described above. DHS directs the public health nurse to send a copy of the service plan to the recipient and the personal care provider agency with which the recipient has chosen to work.[29] The service agreement documents DHS's authorization of a certain amount of PCA time and supervision. Until 1997, DHS had nurse consultants review PCA assessments and decide how many hours of services should be authorized. Since then, however, DHS has typically authorized services without second-guessing assessors' judgments.

After the assessment, the recipient arranges for services with the chosen PCA agency. It is the agency's responsibility to obtain a statement from a medical professional that services are medically necessary. The statement must be made using a form created by DHS called the "physician statement of need."[30] The agency also works with the recipient to develop a care plan that outlines the specific services that the personal care assistant will provide. The care plan and physician statement of need must be updated at least annually.[31]

The process for managed care recipients is quite similar to the process by which fee-for-service recipients access services. The main difference is that managed care organizations—not DHS—authorize PCA services for managed care enrollees. Managed care organizations may authorize different amounts of service than those recommended by the assessor. However, DHS has directed

[28] Authorizations can cover shorter periods of time.

[29] As we discuss in Chapter 4, some personal care provider agencies have said that they do not receive copies of service plans. Service plans contain important information about recipients' needs for PCA and are useful when developing care plans.

[30] A physician, physician's assistant, or nurse practitioner determines whether PCA services are medically necessary.

[31] Department of Human Services, *MHCP Provider Manual*, Chapter 24, and *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

managed care organizations to clearly document and explain differences in the assessed and authorized service amounts in the recipient's service plan.[32]

Since Minnesota first authorized PCA services in the 1970s, there have been many changes in the regulations that govern them. We found that:

- **Changes in Minnesota laws and rules have broadened PCA eligibility, access, and consumer choice.**

Minnesota's PCA services are quite different now from when they were first authorized in the 1970s.

Some changes expanded the population of individuals eligible to receive PCA services. Initially, PCA services in Minnesota were restricted to people with physical disabilities who could direct their own care. Definitions of "responsible party" were enacted in state rules in 1987 and in state law in 1992, thus authorizing PCA services for people who could not direct their own care.[33] In 1991, the Legislature authorized the use of PCA services for behavior-related problems.[34]

In addition, some changes may have broadened the appeal of PCA services to persons who would not have used them previously. For instance, in the early years of Minnesota's PCA program, family members were not allowed to provide PCA services.[35] In 1991, the Legislature placed criteria in statute for DHS-authorized "hardship waivers," which allowed certain family members to provide PCA services.[36] For potential recipients who preferred care provided by a relative, this statutory change authorized an alternative approach. In 2003, the Legislature repealed the requirement for hardship waivers, making it easier for certain family members to serve as personal care assistants.[37] The 2003

[32] Department of Human Services, *Clarification of Policy for Personal Care Assistant (PCA) Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 4, 6-7. In addition, managed care organizations must give an individual a notice of denial, termination, or reduction that outlines the individual's right to appeal the authorized amount when it is different from the assessed amount.

[33] *Minnesota Rules* 9505.0335, subp. 1, adopted October 5, 1987, and *Laws of Minnesota* 1992, chapter 391, sec. 3.

[34] *Laws of Minnesota* 1991, chapter 292, art. 4, sec. 12, authorized PCA for people exhibiting "complex behavior" on a daily basis. This included self-injurious behavior, unusual or repetitious habits, withdrawal behavior, hurtful behavior to others, socially offensive behavior, destruction of property, or a need for constant one-on-one supervision for self-preservation. Also, *Laws of Minnesota* 1993, First Special Session, chapter 1, art. 5, sec. 52, added "redirection and intervention for behavior" to Minnesota law's list of PCA services eligible for payment.

[35] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3, limited personal care assistants to non-family members, reflecting a federal prohibition on the use of Medicaid funds for caregivers who were family members of recipients.

[36] *Laws of Minnesota* 1991, chapter 292, art. 7, sec. 12.

[37] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 27. This repealed the statute that had prohibited provision of PCA services without a waiver by (1) parents of adult recipients, (2) adult children of recipients, or (3) siblings of recipients.

Legislature also gave recipients the option of naming a responsible party who did not live with the recipient; previously, this was not allowed.[38]

The Legislature has also made many changes that increase consumer choices. Most notably, the 1999 Legislature authorized PCA Choice agencies as alternatives to PCPOs.[39] As noted earlier, working with a PCA Choice agency allows recipients to fulfill many responsibilities that would otherwise be performed by traditional provider agencies. For example, recipients under PCA Choice recruit, monitor, and fire their own personal care assistants. In addition, the 1999 Legislature authorized the flexible use of authorized PCA hours.[40]

SPENDING

We examined how Minnesota's total spending for PCA has changed over time and how Minnesota's spending compares with that of other states. We found that:

- **Minnesota's expenditures for personal care services increased by an estimated 164 percent between fiscal years 2002 and 2007.**

Minnesota spent over $400 million for PCA services in fiscal year 2007.

As Figure 1.2 shows, we estimated that Minnesota spent just over $400 million for PCA services in fiscal year 2007, up from $153 million in 2002.[41] This represents growth of roughly 21 percent per year.

There was significant growth in both the managed care and fee-for-service components of overall PCA spending. Managed care costs for PCA grew at an annual rate of 35 percent between 2001 and 2007 (from $15 million to $92 million). However, the majority of PCA spending growth occurred in the fee-for-service area. Minnesota spent almost $316 million on fee-for-service PCA delivered in fiscal year 2007, up from $135 million in 2002. This $181 million increase in spending represented growth of over 18 percent a year, although rates of increase were lower in 2006 and 2007 than in earlier years.[42]

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[38] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 26.

[39] *Laws of Minnesota* 1999, chapter 245, art. 4, sec. 56.

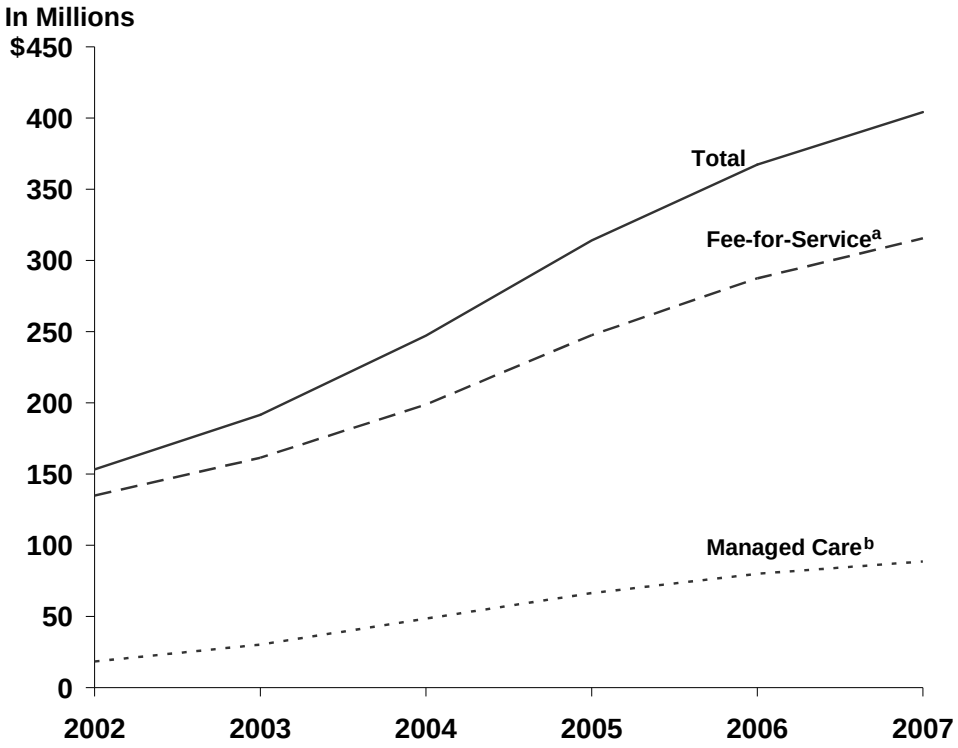
[40] *Laws of Minnesota* 1999, chapter 245, art. 4, sec. 55.

[41] Our spending estimates do not include expenditures by Minnesota's three county-based purchasing organizations, due to incomplete data. In calendar year 2007, two of these organizations spent a total of $1.63 million on PCA services; the county-based purchasing organization serving the largest number of counties (South Country Health Alliance) was unable to provide us with comparable data in a timely manner. The managed care fiscal year figures are estimates based on calendar year data. The data reflect spending funded by MA and MinnesotaCare. However, spending for Minnesota Disability Health Options, a managed care program for certain people with disabilities, is excluded.

[42] Data include fee-for-service PCA delivered through all of Minnesota's publicly funded health care programs, not just Medicaid. Costs reflect PCA services, assessments, and qualified professional supervision. The federal government pays for half of Minnesota's Medicaid costs.

Between 2002 and 2007, Minnesota's total spending on PCA services increased by about $250 million.

Figure 1.2: Minnesota Spending on Personal Care Assistance, Fiscal Years 2002-07



[a] Fee-for-service data reflect spending for personal care services delivered in each fiscal year.

[b] Fiscal year spending through managed care is an estimate based on calendar year data.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data and Minnesota Council of Health Plans data.

Between 2002 and 2007, most fee-for-service PCA spending was for services to MA State Plan and Medicaid waiver participants. Growth in spending for these participants appears to be related to an increase in the number of persons receiving care, while service use per recipient decreased. The decline in service use per recipient was particularly pronounced for MA State Plan participants.[43] As Table 1.5 shows, the number of MA State Plan recipients of PCA services increased by 170 percent between 2002 and 2007, while PCA units of service per recipient decreased by almost 14 percent.

[43] We defined "MA State Plan participants" as individuals who received PCA during the year only as state plan participants. They do not include individuals who participated in a waiver program for any part of the year. For this analysis, we also excluded individuals who were assessed for services but did not receive a service agreement for PCA services.

While Minnesota's number of PCA recipients has increased, cost per recipient has declined.

Table 1.5: PCA Spending, Medical Assistance State Plan Participants, Fiscal Years 2002-07

Year	Recipients[a]	Spending[b]	Spending Per Recipient	Units Per Recipient[c]
2002	4,314	$ 88,343,222	$20,478	5,594
2003	5,120	102,377,352	19,996	5,292
2004	7,047	129,962,476	18,442	4,876
2005	8,926	169,337,648	18,971	5,023
2006	10,425	198,373,911	19,029	4,984
2007	11,652	219,221,808	18,814	4,822
Percentage change	170%	148%	-8%	-14%

NOTE: Table includes fee-for-service spending only.

[a] Recipients include nonwaiver recipients of MA State Plan personal care assistance who had a service agreement with the Department of Human Services that included direct services and/or qualified professional supervision.

[b] Spending includes personal care assistance, assessment for PCA needs, and qualified professional supervision.

[c] Units reflect only direct PCA services, not assessments or qualified professional supervision. One unit of PCA equals 15 minutes.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Recent growth in PCA expenditures could be related to the changes in program eligibility and access discussed in the previous section, but it could also be related to Minnesota's efforts to deinstitutionalize services for MA recipients. For instance, from fiscal years 2002 to 2007, Minnesota's average monthly number of MA recipients in nursing facilities declined by 18 percent, and its average monthly number of MA recipients in intermediate care facilities for people with mental retardation declined by 25 percent. In addition, Minnesota downsized several regional treatment centers in recent years, and "Rule 36" facilities for adults with mental illness have been limited to 90-day stays since 2001.[44] Also, enrollment limitations or reductions in some types of community-based services—such as Medicaid waiver programs—may have contributed to increased reliance on PCA services.[45]

[44] In Minnesota, community-based residential facilities for adults with mental illness have commonly been called "Rule 36" facilities.

[45] For example, a 2008 DHS report showed 4,893 people on waiting lists for services through Minnesota's Developmental Disabilities Waiver. Nearly 1,300 of these people were receiving home care services (such as PCA) while waiting for waiver services, although PCA is also a service people can receive once they qualify for waiver services. See Department of Human Services, *Annual Report on the Use and Availability of Home and Community-Based Waivers for Persons with Disabilities* (St. Paul, February 2008), 21-22.

Other states have also been transitioning many Medicaid recipients from institutional services to community-based services.[46] We examined Minnesota's ranking among states on several recent measures of PCA spending and found that:

- **Minnesota's Medicaid spending for PCA services has been higher than that of most states.**

As shown in Table 1.6, Minnesota spent 5 percent of its MA State Plan dollars on PCA services in 2007, more than twice the median of other states with PCA expenditures under their state plans.[47] Minnesota also had per capita and per recipient PCA expenditures well above the national medians. Among the 12 states that spent more than $100 million for Medicaid state plan personal care services in fiscal year 2002, Minnesota had the largest 2002-07 growth rate in these expenditures.

Table 1.6: Minnesota's Rank Among States on Medicaid Personal Care Expenditures

Measures of Personal Care Spending	Minnesota	Median	Minnesota Rank
Personal Care Spending, as a Percentage of Total Medicaid Spending, 2007	5.1%	2.3%	7 out of 35
Personal Care Spending per Capita, 2007	$60.44	$23.41	7 out of 35
Personal Care Spending per Participant, 2004	$14,620	$5,968	6 out of 30

NOTES: Measures are based on Medicaid state plan expenditures for fee-for-service health care. For each measure, a ranking of 1 represented the state with the highest spending or percentage. The 2007 measures are from the Thomson Reuters Healthcare report; the 2004 data are from the Kaiser report.

SOURCES: Office of the Legislative Auditor, analysis of Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long-Term Care Expenditures in FY 2007* (Thomas Reuters Healthcare, September 26, 2008); and Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Service Programs: Data Update* (Washington, DC, December 2007).

[46] One impetus toward deinstitutionalization was a 1999 U.S. Supreme Court decision (Olmstead v. L.C. [98-536] 527 U.S. 581 [1999]) that required states to provide community-based services to people with mental disabilities when (1) the state's treatment professionals recommend this, (2) the affected persons do not oppose this, and (3) the placement can be reasonably accommodated.

[47] Minnesota's PCA spending as a percentage of total Medicaid state plan spending (5.1 percent) ranked behind California, New Mexico, Alaska, New York, Washington, and Nevada. More generally, Minnesota ranks high among states in the percentage of Medicaid long-term care dollars spent on community-based services, rather than institutional care. For example, Minnesota spent 63 percent of its Medicaid long-term care dollars on community-based services in 2007, which was fourth highest among the 50 states.

2 Recipient Characteristics, PCA Use, and Assessment

As discussed in Chapter 1, Minnesota's spending on personal care assistance (PCA) services increased greatly over the past several years. This spending growth resulted largely from increases in the number of PCA recipients, not from increases in the amount of services used per person.

In this chapter, we present information on the growth in the number of people receiving PCA services, their characteristics, and their choices about the personal care services they receive. We examine how PCA use varies around the state, giving particular attention to one possible explanation for this variation—assessment practices—over which the state has some influence.

RECIPIENT CHARACTERISTICS AND PCA USE

Personal care services address the diverse service needs of a wide variety of individuals. Before looking at the characteristics of users and their services in detail, we begin with two observations about Minnesota's overall use of PCA services:

- **About 25,000 people—or about 1 of every 200 Minnesotans—received publicly funded PCA services in calendar year 2007.**

- **There was large growth in the number of Minnesotans who received PCA services in the past several years.**

Most recipients obtain personal care services through fee-for-service rather than managed care.

As we noted in Chapter 1, the Minnesota Department of Human Services (DHS) pays for health care services in two main ways: (1) on a fee-for-service basis, or (2) through payments to a managed care organization. In calendar year 2007, about 71 percent of PCA recipients were served through a fee-for-service approach, and the rest were served through managed care.[1]

Our analysis of DHS Medical Assistance (MA) data showed that the number of fee-for-service PCA recipients grew by 124 percent between fiscal years 2002 and 2007.[2] This included 170 percent growth in the number of persons receiving

[1] An undetermined number of PCA recipients receive services through both fee-for-service and managed care.

[2] These numbers exclude recipients who were assessed for services but did not receive a service agreement for PCA during the fiscal year.

PCA services under the MA State Plan, as well as 60 percent growth in the number of waiver participants receiving PCA.[3]

In addition, a recent DHS analysis indicated that the size of Minnesota's managed care PCA population grew by an even larger percentage over a similar period.[4] Between calendar years 2002 and 2007, the number of managed care participants receiving PCA grew by 270 percent, with seniors accounting for three-fourths of this growth.

The number of people receiving personal care assistance (PCA) services has grown much more quickly than Minnesota's population overall.

These increases in PCA enrollment occurred during a time when there was a more modest increase in Minnesota's total population, including its numbers of seniors and MA recipients.[5] It is likely that the number of people needing PCA services will increase in coming years as Minnesota's population ages. The state demographer projects that the size of Minnesota's population age 65 and older will increase by 92 percent between 2010 and 2030.

Characteristics

The fee-for-service and managed care PCA populations showed two notable differences in 2007. First, PCA recipients served by managed care tended to be older than PCA recipients served by fee-for-service care. About 76 percent of the PCA recipients served by managed care were age 65 or older, compared with just 10 percent of the PCA recipients in fee-for-service care.[6] Second, the average PCA recipient in managed care tended to receive fewer hours of PCA services than the average fee-for-service PCA recipient.[7] DHS staff believe this reflected a greater predominance of people with serious disabilities in the fee-for-service population than in the managed care population.

The rest of this section focuses on the characteristics of the Medicaid fee-for-service PCA population. Table 2.1 summarizes the characteristics of this population overall plus its two components: (1) MA State Plan participants and (2) Medicaid waiver program participants. In general, MA State Plan PCA recipients were more likely than PCA recipients in a waiver program to be children (41 percent vs. 22 percent), nonwhite (50 percent vs. 22 percent), and residents of the Twin Cities metropolitan area (63 percent vs. 50 percent).

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[3] Chapter 1 explained the difference between the MA State Plan and waivers. We defined "MA State Plan recipients" as individuals who received PCA only as state plan participants. They do not include individuals who participated in a waiver program for any part of the year.

[4] Vicki Kunerth, Director, DHS Performance Measurement and Quality Improvement, memorandum to Joel Alter, Office of the Legislative Auditor, and Anne Henry, Minnesota Disability Law Center, *Data on PCAs and Home Health Aides Services to MHCP*, October 2, 2008.

[5] Minnesota's total population increased by less than 5 percent between 2002 and 2007. The state's number of seniors increased by 15 percent during this period, and the number of MA-eligible persons increased by 25 percent.

[6] The percentage of all fee-for-service PCA recipients age 65 or older (10 percent) is somewhat higher than the percentage of MA-funded fee-for-service recipients age 65 or older (7 percent, as shown in Table 2.1).

[7] An analysis by DHS indicated that the average fee-for-service PCA recipient received about 105 hours of service per month, compared with 73 hours per month for the average managed care recipient.

Table 2.1: Characteristics of Medicaid Fee-for-Service Personal Care Assistance Recipients, Fiscal Year 2007

	All Recipients		PCA Recipients in Medical Assistance State Plan[a]		PCA Recipients in Waiver Programs	
	Number	Percentage	Number	Percentage	Number	Percentage
Age						
5 years old or younger	1,312	8.0%	1,168	10.0%	144	3.0%
6 to 17 years old	4,519	27.4	3,594	30.8	925	19.1
18 to 22 years old	1,003	6.1	669	5.7	334	6.9
23 to 64 years old	8,458	51.3	5,621	48.2	2,837	58.5
65 years old or older	1,208	7.3	599	5.1	609	12.6
Total	16,500		11,651		4,849	
Sex						
Female	8,448	51.2	5,675	48.7	2,773	57.2
Male	8,053	48.8	5,977	51.3	2,076	42.8
Total	16,501		11,652		4,849	
Race						
White	9,042	58.5	5,420	50.2	3,622	77.7
Black or African American	3,954	25.6	3,273	30.3	681	14.6
Asian	1,542	10.0	1,360	12.6	182	3.9
Other[b]	930	6.0	752	7.0	178	3.8
Total	15,468		10,805		4,663	
Interpreter Needed						
No	14,016	86.7	9,454	83.2	4,562	95.0
Yes	2,148	13.3	1,908	16.8	240	5.0
Total	16,164		11,362		4,802	
Residence						
Twin Cities Metropolitan Area	9,767	59.3	7,335	63.0	2,432	50.4
Central	1,786	10.8	1,163	10.0	623	12.9
Northeast	1,262	7.7	896	7.7	366	7.6
Northwest	1,955	11.9	1,374	11.8	581	12.0
Southeast	903	5.5	448	3.8	455	9.4
Southwest	795	4.8	424	3.6	371	7.7
Total	16,468		11,640		4,828	

NOTES: Includes recipients of PCA direct services or supervision. For most characteristics, some recipients were missing information. Missing values are not included in the totals, so totals vary by characteristic. Overall, there were 16,501 recipients in 2007: 11,652 State Plan recipients and 4,849 waiver recipients.

[a] Includes recipients who received PCA services as a participant in the Medical Assistance State Plan, not a Medicaid waiver program.

[b] Includes American Indians, Alaskan Natives, Pacific Islanders, and Native Hawaiians.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Recipients of PCA services have a wide range of disabilities. The most frequent categories of diagnoses cited in fiscal year 2007 assessments of MA State Plan PCA recipients were various types of mental disorders, such as attention deficit disorder; autism; and schizophrenic, bipolar, manic, and depressive disorders. Diabetes, infantile cerebral palsy, and "other paralytic syndromes" (such as

paraplegia and quadriplegia) were other categories of diagnoses among those most commonly cited.[8]

We also examined the "home care rating" that is the result of each MA State Plan recipient's assessment for PCA services. The rating is based on an individual's need for assistance with activities of daily living, behavior issues, and complex medical needs. Among fiscal year 2007 State Plan PCA recipients, 56 percent had a home care rating that indicated the presence of behavior issues.[9] The proportion of recipients with behavior issues varied considerably by age. In 2007, 79 percent of recipients under the age of 18 had a behavior-related home care rating, compared with 40 percent of recipients age 18 or older.

Figure 2.1 highlights changes that occurred in the composition of the MA State Plan PCA population in recent years. In particular,

- **Between fiscal years 2002 and 2007, there were sizable increases in the percentage of MA State Plan PCA recipients who had behavior issues or lived outside the Twin Cities metropolitan area.**

A majority of fee-for-service PCA recipients have behavior-related issues.

Recipients assessed as having behavior issues now account for a larger share of the PCA population than they did several years ago. Among fee-for-service recipients served under the MA State Plan, the percentage of recipients with behavior issues grew from 42 to 56 percent between fiscal years 2002 and 2007.

In addition, there has been a shift in the geographic distribution of PCA recipients served under the MA State Plan. The percentage of State Plan recipients living outside the seven-county Twin Cities area increased from 27 percent in fiscal year 2002 to 37 percent in 2007. The number of Twin Cities PCA recipients grew significantly during this period, but the number of outstate recipients grew even faster (especially in northern Minnesota). Later in this chapter, we discuss inter-county variation in service use in more detail.

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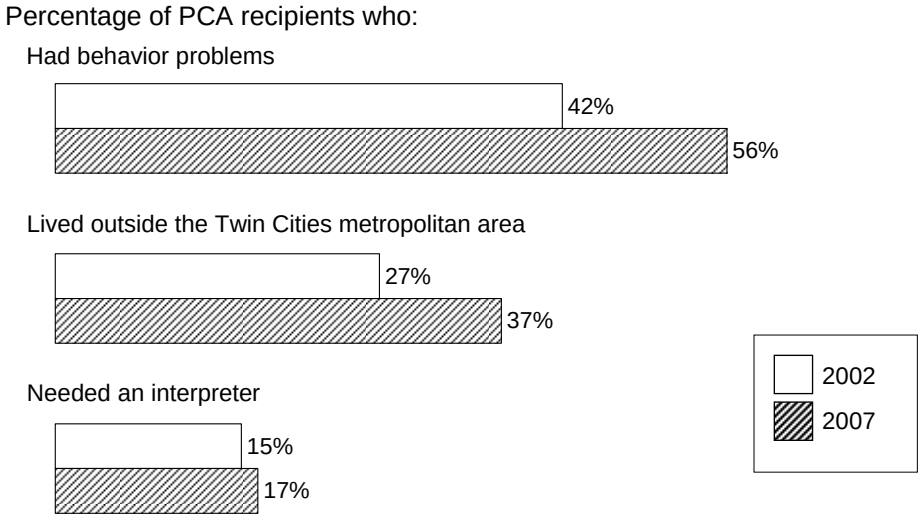
[8] Diagnoses categories reflect the U.S. Department of Health and Human Services ICD-9-CM codes for October 2007 through September 2008, as published in: Ingenix, *ICD-9-CM Expert for Hospitals Volumes 1, 2, and 3: International Classification of Diseases, 9th Revision, Clinical Modification, Sixth Edition* (2007). During an assessment for MA State Plan PCA, a nurse indicates up to three diagnoses for the individual being assessed. We counted only the most recent assessment for individuals who received multiple assessments related to their 2007 use of PCA services. The diagnoses might be self-reported by the individual or based on the nurse's previous experience with the individual. Nurses are not required to indicate more than one diagnosis, even if more than one has been made. Our analysis included all diagnoses categories indicated for each individual, but it did not count multiple diagnoses from within the same category. For example, a person diagnosed with both "expressive language disorder" and "unspecified delay in development" was counted only once in the category "specific delays in development."

[9] For the most part, individuals with behavior issues included those whose assessments for State Plan PCA services indicated a regional treatment center level of care or Level I or Level II behavior. For less than 2 percent of State Plan PCA recipients, we determined the presence of behavior issues based on assessments for a waiver program. Level I behavior causes, or could cause, self-injury, injury to others, or destruction of property. Examples of Level I behavior include head banging, hitting others, and fire setting. Level I behaviors must be documented by a mental health professional or physician. Level II behavior includes unusual or repetitive habits, withdrawn behavior, and offensive behavior. Examples of Level II behavior include repetitive hand washing, avoiding personal interactions, and bullying.

Figure 2.1: Changes in the MA State Plan PCA Recipient Population, Fiscal Years 2002-07



NOTE: Figure reflects fee-for-service PCA recipients only.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

The number of fee-for-service PCA recipients who needed an interpreter almost tripled between 2002 and 2007.

Increases in the number of non-English speaking PCA recipients have presented new challenges. The percentage of MA State Plan recipients who identified themselves as needing an interpreter grew from 15 to 17 percent between fiscal years 2002 and 2007, but the actual number needing an interpreter grew from 643 to 1,908 during this period. Recipients often arrange to get PCA services from someone who speaks their language, but language and cultural differences sometimes complicate the PCA assessment process because an interpreter is needed. Representatives of a nursing organization that conducts assessments mostly in the Twin Cities area told us that it needs interpreters for 60 percent of its PCA assessments.

Service Use

We also examined the nature of the PCA services received by participants in the MA State Plan. These service characteristics are determined during the assessment process. During the assessment, the nurse determines whether an individual can direct his or her own care or if a responsible party is needed. In 2007, about 57 percent of MA State Plan PCA recipients had a designated responsible party. Over 90 percent of the recipients under age 18 had a responsible party, compared with an estimated 23 to 34 percent of adult recipients.[10]

[10] We are unable to be more precise in our estimate of the percentage of adult recipients who had a responsible party due to missing information for 11 percent of the cases.

During the assessment, recipients also decide whether they want shared care, supervision, and flexible use. According to 2007 paid claims, 6 percent of MA State Plan PCA recipients received at least some shared care (in which one personal care assistant works with two or three recipients at the same time). Data on paid claims also reveal that 81 percent of State Plan PCA recipients received qualified professional supervision in 2007, down from 92 percent in 2002.[11] In addition, the vast majority of recipients (98 percent) chose flexible use of PCA services. The flexible use option allows an individual to use varying amounts of PCA services during six-month periods.[12]

There is considerable variation in the quantity of PCA services received by individuals. Among MA State Plan recipients who used PCA services in each month of fiscal year 2007, 17 percent received an average of over 8 hours of assistance per day, while 3 percent received an average of 1 hour or less.[13] Overall, the average full-year MA State Plan PCA recipient received 5.0 hours of PCA services per day in fiscal year 2007, down from 5.8 hours in fiscal year 2002.

The median annual cost of PCA for Medical Assistance State Plan participants who received services throughout 2007 was $23,783.

We also examined the annual cost of MA State Plan PCA services for individuals who received these services during each month of fiscal year 2007. The median cost per recipient was $23,783, and 87 percent of these recipients had annual costs under $50,000. Individuals with costs of $50,000 or more accounted for 13 percent of full-year recipients, but their services accounted for 31 percent of the total cost of PCA services to full-year recipients.

Finally, we looked at a recent six-year period to determine how long 2007 recipients had been receiving PCA services. Among individuals who received MA State Plan PCA services in fiscal year 2007, 16 percent received some form of PCA services in every year of the fiscal year 2002-07 period. In fact, about 7 percent used PCA services in each of the 72 months during the 2002-07 time period. On the other hand, about 32 percent of fiscal year 2007 State Plan PCA recipients used PCA services in 12 or fewer months during the six-year period.[14]

[11] It is possible that some individuals who opted in their assessments for shared care or supervision by a qualified professional did not actually receive these types of services during the year.

[12] During the assessment, recipients also decide whether they want to use a PCA Choice agency or a traditional Personal Care Provider Organization (PCPO). A PCA Choice agency acts as a fiscal intermediary for recipients and allows for more consumer direction than is available through a PCPO. We found that DHS does not have reliable information about the extent to which recipients chose a PCA Choice agency over a PCPO.

[13] This measure understates the number of PCA hours per day people actually received on the days they received care. We calculated the measure based on total units of PCA paid during the fiscal year divided by 365 days.

[14] Services include PCA, assessments, and supervision. Although recipients were MA State Plan participants in 2007, they may have received services as a Medicaid waiver participant or non-MA participant in earlier years.

Variation in Service Use Across Minnesota

Ideally, individuals' access to PCA services should not depend on where in Minnesota they live. Some differences in service use across the state are inevitable, but significant variation may indicate inequitable access to services.

We examined inter-county differences in PCA use among fee-for-service MA recipients. To help us account for differences in counties' poverty and disability rates, we compared each county's number of PCA recipients for a given year to the county's total number of MA-eligible persons with disabilities. We found that:

- **Large differences in the rates of PCA use among Minnesota counties suggest that Minnesota residents do not have equal access to PCA services.**

Access to PCA services appears to vary significantly across Minnesota.

Table 2.2 shows fee-for-service PCA utilization rates in selected counties for fiscal year 2007. In aggregate, there was a greater rate of use of PCA services in the seven-county Twin Cities metropolitan area (159 PCA recipients per 1,000 MA-eligible persons with disabilities) than in the rest of Minnesota (129 PCA recipients per 1,000 MA-eligible persons with disabilities). Of particular significance, there were sizable variations in the rates of PCA use among individual counties, especially outside the Twin Cities metropolitan area. Among all 87 counties, the number of residents receiving PCA services per 1,000 MA-eligible persons with disabilities ranged from 10 (Cook County) to 313 (Beltrami County). Among counties with populations exceeding 50,000, rates of PCA use ranged from 80 recipients per 1,000 MA-eligible persons with disabilities (Blue Earth County) to 234 (Chisago County). There was less variation among Twin Cities metropolitan counties in rates of PCA use, ranging from 127 recipients per 1,000 MA-eligible persons with disabilities (Ramsey County) to 192 (Washington County).

In addition, there was wide variation in counties' recent rates of growth in the number of PCA recipients. Between fiscal years 2002 and 2007, the number of PCA recipients living in the Twin Cities metropolitan area grew by 112 percent, compared with a 151 percent increase in the rest of Minnesota. The largest percentage growth during this period was in northwestern Minnesota (275 percent), followed by northeastern Minnesota (149 percent). Beltrami County—which we noted above had the highest PCA utilization rate of any county in 2007—experienced 573 percent growth in its PCA recipient population between 2002 and 2007. In contrast, there were lower growth rates in southwestern Minnesota (85 percent) and southeastern Minnesota (97 percent).[15]

[15] For the most part, the percentage increases in the number of PCA recipients in individual counties and regions far exceeded recent increases in the state's general population and number of MA-eligible persons. Thus, most increases in counties' number of PCA recipients appear to be due to increased PCA utilization rates, not population increases.

Table 2.2: Use of Fee-for-Service PCA Services in Selected Counties, Fiscal Year 2007

	PCA Recipients	Total MA-Eligible Persons with Disabilities	PCA Recipients per 1,000 MA-Eligible Persons with Disabilities
Statewide	16,336	112,385	145
Twin Cities Metropolitan Area	9,699	61,082	159
Washington	441	2,300	192
Hennepin	5,128	29,025	177
Anoka	881	5,068	174
Carver	127	758	168
Scott	195	1,227	159
Dakota	790	5,859	135
Ramsey	2,137	16,845	127
Outstate Counties	6,637	51,303	129
Highest Rates			
Beltrami	417	1,333	313
Mahnomen	56	182	308
Isanti	139	532	261
Kanabec	90	374	241
Cass	162	676	240
Lowest Rates			
Pipestone	10	222	45
Lake of the Woods	3	79	38
Big Stone	5	162	31
Lincoln	3	111	27
Cook	1	100	10
Counties with Over 50,000 Population			
Chisago	163	698	234
Wright	232	1,310	177
Crow Wing	225	1,330	169
St. Louis	764	7,026	109
Olmsted	277	2,560	108
Stearns	290	2,737	106
Rice	95	908	105
Otter Tail	120	1,204	100
Clay	137	1,442	95
Blue Earth	101	1,255	80

NOTE: The number of recipients includes any recipient who received fee-for-service Medicaid PCA services during the fiscal year, excluding those whose only paid services were assessment or supervision.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data and U.S. Census 2007 county population estimates.

Several factors could contribute to variation in the use and growth of PCA services around the state. First, some local officials we interviewed partly attributed their counties' high PCA utilization rates to increased consumer information about PCA services. Specifically, these officials mentioned

promotion of services by parents and advocacy groups, marketing by provider agencies, or outreach by the counties. Second, high PCA utilization rates might reflect unusual concentrations of people with challenging service needs. For example, some local public health officials told us that counties that used to have regional treatment centers are home to many former residents of these centers.[16]

There are several possible explanations for county variation in PCA use.

Third, the limited availability of PCA providers in some counties may contribute to those counties' relatively low use of these services. For instance, the director of a public health agency in southwestern Minnesota told us his region's low rates of PCA use partly reflect the fact that only one personal care provider agency is based in his agency's service area. Finally, the availability of alternatives to PCA services may affect demand for PCA services. For example, some counties may have more extensive resources than others for providing home and community-based services besides PCA to disabled recipients.[17]

The next section discusses assessment, which is another possible explanation for differences in counties' PCA utilization and growth rates. Counties play the lead role in assessments that determine individuals' initial and ongoing need for PCA services. Inconsistencies among counties in this "gate-keeping" role could affect whether (and how much) PCA services are provided to their residents.

ASSESSMENTS FOR PCA SERVICES

Minnesota law defines a PCA assessment as "a review and evaluation of a recipient's need for home care services conducted in person."[18] After a person begins to receive PCA services following an initial assessment, subsequent assessments must occur at least annually. The law requires a new assessment when there is a significant change in a recipient's condition or need for PCA services.[19]

Most PCA assessments are conducted by a county public health nurse or a certified public health nurse under contract with the county. For recipients of certain Medicaid waiver services, assessments may be conducted by a county case manager or service coordinator. DHS's *PCA Consumer Guidebook* informs

[16] Our analysis of PCA utilization rates took into account differences in counties' total numbers of MA-eligible persons with disabilities—that is, individuals who qualified for Supplemental Security Income or Retirement Survivors Disability Insurance, or whose disability had been determined by a state medical review team. We did not consider differences in the *types* of disabilities counties' residents had.

[17] MA recipients in all 87 counties can receive services through either fee-for-service or managed care. We did not examine the extent of differences among counties in use of fee-for-service versus managed care, but such differences could also affect counties' fee-for-service PCA use rates.

[18] *Minnesota Statutes* 2008, 256B.0655, subd. 1b.

[19] A "service update"—which may be completed by telephone—can substitute for the annual face-to-face assessment for two consecutive assessments in cases where there is no significant change in the recipient's condition or need for increased services.

potential recipients that an assessment "should take about one hour to complete."[20]

All MA participants are entitled to an assessment for PCA services, upon request. Individuals or their responsible parties may contact the county directly to request an assessment, or another person or agency (such as a personal care provider agency) may request an assessment on behalf of a potential PCA recipient. An assessment must be completed within 30 days of a request.

An assessment determines the amount of PCA services an individual needs.

Assessors use one of two standard instruments to help determine individuals' need for services. Assessors complete the *MA Health Status Assessment* for MA State Plan participants and participants in the Developmental Disabilities Waiver program. The *Long-Term Care Consultation* is used for participants of other waiver programs. Both assessment instruments guide assessors through a determination of an individual's health status and ability to complete various activities independently to arrive at a recommendation for needed services. The remainder of this section describes the *MA Health Status Assessment*, which is used for most PCA assessments.[21]

The *MA Health Status Assessment* is a 17-page document used by assessors to record individuals' need for assistance to (1) accomplish activities of daily living and instrumental activities of daily living, (2) complete health-related tasks (such as dressing a wound), and (3) address behavior-related issues. Assessors ask individuals about their need for assistance in each of these areas, and they observe accomplishment of tasks, if appropriate. For example, to determine time needed to assist with medications, an assessor might ask an individual to get his or her medications and bring them to the area where the assessment is occurring.[22] The assessor determines the daily number of minutes of assistance the individual needs for the three areas listed above. The assessor also determines whether the individual has a "dependency" in each of eight activities of daily living.[23]

After completing the assessment instrument, the assessor has the information needed to determine the individual's "home care rating." The home care rating determines the maximum amount of PCA time an individual can receive. The

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[20] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 11.

[21] The *Long-Term Care Consultation* has more detailed questions about individuals' health issues, abilities to complete various tasks, and support systems. It is used to determine the appropriateness and need for various waiver services, not just personal care assistance.

[22] The assessor obtains detailed information about the medications, the frequency with which they are taken, and assistance needed to take them. Also, by asking the recipient to retrieve the medications, the assessor can observe the person's ability to move about.

[23] "Activities of daily living" include dressing, grooming, bathing, eating, transferring, mobility, positioning, and toileting. To determine the individual's level of dependence, the assessor considers how much help the person needs from others. A child's need for assistance in activities of daily living takes into account the child's age, usual milestones in child development, and typical parental responsibilities. For example, a child up to one year old cannot be found "dependent" in the area of mobility.

home care rating is based on the individual's: (1) number of dependencies; (2) behavior-related needs; and (3) complex medical needs. For example, an individual with two dependencies, no behavior-related issues, and no complex medical needs would have a home care rating that allows a maximum of just over 2.5 hours of PCA a day. The actual amount of PCA time the person receives depends on the number of minutes the assessor calculated that the person needs across all of the areas covered by the assessment.

Assessment Consistency and Accuracy

Inconsistent assessment practices are a possible explanation for variation in counties' PCA service use.

It is important to have reasonably consistent practices throughout Minnesota for assessing recipient needs for personal care services. This is because (1) the assessment process gives local agencies an important role in decisions that have direct fiscal consequences for the state, and (2) for simple fairness reasons, people should have similar access to state-funded services regardless of where in Minnesota they live. To help us consider the issue of assessment consistency, we analyzed statewide data and interviewed representatives of DHS, organizations that conduct assessments, health plans, and consumer advocacy groups.[24] We concluded that:

- **Minnesota has not established sufficient guidance and controls to ensure reasonably consistent, sound assessments of individuals' need for PCA services.**

In this section, we highlight reasons why the Legislature and DHS should take additional steps. First, our analysis of assessment-related data suggests that assessment inconsistencies are a plausible explanation for some of the wide variation in PCA use around the state. Second, the state's oversight of assessment decisions has been limited. DHS has not provided guidance to help translate assessment findings into decisions about how much care individuals should receive, nor has it systematically monitored the reasonableness of assessment decisions. This is one reason that people from agencies that conduct or contract for assessments expressed concern about inconsistencies in assessment decisions. Third, the state has not mandated specialized training for PCA assessors, and intensive training courses have not always been available from the state. However, even with training, assessors sometimes reach different conclusions about individuals' need for services when presented with the same facts.

Inconsistencies Among Counties

In the previous section, we noted that rates of PCA use vary widely around the state. Assessment inconsistencies are one of several possible reasons for these

[24] We could not conclusively determine from the PCA utilization data how much of the inter-county differences in PCA use is due to assessor inconsistency. Each assessment is conducted by one assessor, so there is no opportunity to compare assessors' judgments about a recipient. Also, the needs of individual clients can be affected by unique circumstances. Thus, we supplemented our data analysis with other sources of information (such as interviews and reviews of appeals cases) to draw conclusions.

differences. To supplement the earlier analysis, we looked at inter-county differences in PCA use for certain subcategories of recipients. These subcategories were based on assessors' home care ratings of individual recipients. We found that:

- **Counties differed in the extent to which individuals were assessed as having certain disability issues needing PCA services.**

We examined data on PCA recipients who were assessed with behavior issues. This is a subcategory that experienced significant recent growth in its number of recipients. Table 2.3 shows two measures of PCA service use, focusing on counties with at least 100 PCA recipients in fiscal year 2007. First, the table shows wide county variation in the percentage of PCA recipients that had behavior issues. For example, 77 percent of Douglas County's PCA recipients were assessed as having behavior issues, compared with only 34 percent of recipients in Beltrami County. Second, the table shows wide variation in each county's PCA recipients with behavior issues as a percentage of the county's total number of Medicaid-eligible people with disabilities. Percentages ranged from 3 percent (Blue Earth County) to 18 percent (Isanti County).[25] This suggests that some counties were more likely than others to assess people as having behavior issues.

Differences in assessment practices can have significant cost impacts.

We also looked at statewide assessment data for PCA recipients with "Level I behaviors," the largest subgroup of persons with behavior issues.[26] Specifically, we examined differences among counties in the average hours of service recommended by PCA assessors for these individuals. We focused on the 11 counties that conducted at least 100 PCA health status assessments resulting in this home care rating during fiscal year 2007. Among these counties, the average hours of service recommended per recipient with Level I behaviors varied considerably. At the low end, assessors in Stearns and Ramsey counties recommended an average of 3.6 hours and 4.3 hours per day, respectively. In contrast, assessors in Kandiyohi, Crow Wing, and Washington counties recommended an average of 9.2, 7.8, and 7.5 hours per day, respectively.[27] The difference in average recipient hours between the highest and lowest counties above represented a cost difference of more than $30,000 annually per recipient.

[25] In addition, we found considerable variation among counties in the number of PCA recipients assessed as *not* having behavior problems. Focusing on counties with more than 100 total PCA recipients in fiscal year 2007, we looked at the number of recipients served for non-behavior problems as a percentage of those counties' total MA-eligible people with disabilities. This percentage ranged from 3 percent (Benton County) to 20 percent (Beltrami County).

[26] "Level I behaviors" cause or have the potential to cause (1) injury to self, (2) injury to others, or (3) destruction of property.

[27] Among the 11 counties, differences in these recipients' average number of dependencies in activities of daily living did not explain variation in the hours recommended by the assessors. For recipients with Level I behaviors, these counties' average total minutes recommended by the assessor was highly correlated both with (1) time recommended for addressing Level I behaviors (r= +0.92) and (2) time recommended for service needs other than Level I behaviors (r= +0.74).

Individuals within the same disability subgroup can have unique circumstances that affect their need for PCA services. Undoubtedly, some variation in assessors' decisions reflects these case-by-case differences. However, by focusing on counties with relatively larger numbers of cases, we think our analysis reflects assessment inconsistencies among counties more than differences in the counties' recipient characteristics.

Table 2.3: Variation in Identification of Behavior Issues Among Fee-for-Service PCA Recipients, Selected Counties

	County PCA Recipients Assessed as Having Behavior Issues as a Percentage of:	
County	All PCA Recipients in the County[a]	The County's MA-Eligible Population with Disabilities
Douglas	77	10
Wright	76	13
Benton	74	8
Sherburne	72	12
Carver	71	11
Isanti	71	18
St. Louis	71	7
Crow Wing	69	11
Anoka	67	11
Washington	67	12
Otter Tail	65	6
Kandiyohi	64	10
Carlton	62	12
Chisago	62	13
Becker	61	9
Itasca	59	8
Scott	57	9
Dakota	57	7
Clay	56	5
Stearns	53	5
Ramsey	50	6
Hennepin	48	8
Winona	47	5
Polk	47	5
Blue Earth	47	3
Olmsted	46	5
Cass	34	8
Beltrami	34	10

NOTE: The table only includes counties that had at least 100 total Medicaid-funded PCA recipients in fiscal year 2007.

[a] Percentages are based on the total number of Medicaid-funded PCA recipients who were given a case mix rating or home care rating during the assessment process.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

State Guidance and Oversight for Assessors

The state has taken some important steps to bring uniformity to assessment decisions. Nearly 20 years ago, DHS developed a "decision tree" that limits the cost of services an individual PCA recipient can receive, depending on the individual's specific assessed needs. Also, DHS has developed instruments that are used by assessors throughout Minnesota to determine individuals' need for PCA services. Despite these efforts:

- **Many agencies that conduct PCA assessments would like DHS to provide more guidance and oversight to ensure assessment consistency.**

There has been considerable debate among DHS, managed care organizations, consumer advocacy groups, and others on the merits of statewide guidelines for assessors. In 2006, some of Minnesota's managed care organizations drafted a set of guidelines to help their assessors recommend amounts of time for seniors assessed as needing PCA services. Recipient advocates expressed concern that the guidelines would cause assessors to overlook individuals' unique needs. DHS prohibited the use of such guidelines in 2006, and it recently stated:

> It is DHS policy that lead agencies (counties, managed care organizations, tribes) cannot use their own tools or guidelines that assign specific ranges and/or amounts of time for PCA service components.[28]

This prohibition on guidelines developed by individual organizations does not rule out the possibility of state-authorized assessment guidelines. Minnesota has caps on the amount that can be spent to serve individuals with various home care ratings, but there are no state guidelines for determining the amounts of time that should be allocated to PCA tasks. DHS trainers have generally advised assessors to use their best judgment. Sixteen states have developed guidelines that address the amount of time to assign to specific PCA tasks, according to a 2005 study.[29] This study noted considerable variation among states in the time guidelines adopted for particular tasks, perhaps reflecting differences in their processes for developing the guidelines and their existing levels of social supports for people with disabilities.

Assessment of PCA service needs for individuals with behavior issues is particularly challenging for assessors.

Many officials from Minnesota agencies that conduct assessments told us they would welcome state guidance, especially in the area of behavioral health. They told us that the state's existing PCA assessment instruments do not adequately assess behavior issues for adults or children. They said it can be especially difficult to distinguish severe behavior problems in children from behaviors that might be considered normal for a particular age. In addition, they said it is

[28] Department of Human Services, *Clarification of Policy for Personal Care Assistant (PCA) Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 6.

[29] Ernest L. Cowles and Robert Chiles, *Time per Task for In-Home Personal Care: A Cross-State Perspective* (Sacramento, CA: Institute for Social Research, California State University, September 6, 2005).

challenging for assessors to determine the right amount of time to recommend for PCA services related to behavior issues. For example, if an assessor is told that a child exhibits aggressive behavior an average of nine times a day, the assessor might decide to allocate 90 minutes of PCA time per day (10 minutes per incident) for "redirection" of the child's behavior. However, there is no guarantee that the PCA will be on the job at those times during the day when the child's behavior needs attention.

More generally, representatives of agencies that conduct or contract for assessments expressed concern to us about assessment inconsistencies—among individual nurses, public and private assessment agencies, and individual health plans. For example, they described some assessors as "soft-hearted" or "thick-skinned," reflecting the amount of PCA service time the assessors recommended. Public health agency directors said recipients sometimes seek assessments from nurses they perceive to be more generous in granting service hours. One public health director said that PCA recipients have grown increasingly assertive about the services they want, resulting in some assessors finding it difficult to refuse recipients' requests. Because of these concerns, directors of some public health agencies told us they would welcome DHS oversight of local assessment decisions. DHS does not systematically review the reasonableness of PCA assessment decisions or the adequacy of the documentation presented by assessors to support their recommendations. Also, aside from the training exercise cited in the next section, DHS has not examined the extent to which assessors reach similar conclusions when assessing the same PCA recipients.

Assessor Training

Uniform training could help ensure that assessors use sound, consistent assessment practices, but:

- **There has been insufficient training of PCA assessors, reflecting uneven availability of state training courses over time and the absence of state requirements for minimum training levels.**

The Department of Human Services has offered training courses for PCA assessors sporadically.

The training opportunities DHS has offered to PCA assessors have been sporadic. We examined records of courses offered by DHS on PCA assessment since mid-1999. Participation levels in DHS training varied considerably from year to year, as shown in Table 2.4. In 2002 and 2003, for example, DHS offered no PCA assessment training courses due to budget constraints. Today, DHS's main PCA assessment course provides 20 hours of instruction over three days, covering a wide variety of assessment-related topics. DHS also offers short courses (two to four hours) on specific topics of interest to assessors. On one occasion, DHS offered a half-day course specifically for experienced assessors.

We examined the extent to which assessors of MA State Plan recipients have participated since 1999 in the more comprehensive or advanced assessment training courses offered by DHS. Specifically, we focused on participation in (1) courses of 12 hours or more in duration, or (2) the advanced training course

specifically designed for experienced assessors.[30] Based on a review of state records, we found that 35 percent of PCA assessments conducted during the first half of 2008 were done by assessors who had not completed a comprehensive or advanced PCA assessment training course from DHS since at least 1999.[31]

Table 2.4: Participant-Hours of Training in DHS's Courses on PCA Assessment, 2000-07

Year	Total Participant-Hours of Training[a]
2000	1,212
2001	300
2002	0
2003	0
2004	7,198
2005	978
2006	8,587
2007	1,238

[a] A "participant-hour" is one hour of training taken by one individual. A four-hour class attended by 20 individuals would result in 80 participant-hours of training. Some of the participants whose hours of training are included in this table were DHS employees.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services training records.

Training alone has not eliminated differences in assessors' recommendations for PCA services.

Even with training, assessors may reach differing conclusions about individuals' need for PCA services. We observed evidence of this at one of DHS's assessor training courses. After instructing assessors on how to conduct assessments and recommend hours of service, DHS trainers conducted an exercise in which the training participants watched an enactment of a hypothetical assessment and decided how much service time to recommend. In the course we attended, three groups of assessors separately reached consensus on the hours the hypothetical recipient should receive. The groups reached different conclusions on the individual's dependencies and made recommendations for time ranging from 3.5 hours to 5.5 hours per day.[32] Thus, even trained assessors can reach different conclusions from the same set of information.

Appeals of PCA assessment decisions also highlight the different conclusions sometimes reached by human services professionals. Individuals have a right to

[30] Our selection of a 12-hour threshold was intended to identify individual courses that were reasonably comprehensive, in light of DHS's current 20-hour training course. DHS offered assessment-related courses of 12 hours or more in 2000, 2001, and 2005-08. During 2004, DHS's main assessment course was only six hours long, so these training sessions did not meet the 12-hour threshold we used. DHS offered its course for experienced assessors in 2007.

[31] Among nurses who completed at least five MA State Plan PCA assessments in the first half of 2008, 31 percent had not completed at least a 12-hour training course or the advanced course for experienced assessors.

[32] As mentioned earlier, the number of dependencies is a critical factor in determining an individual's home care rating and, therefore, the dollar caps on PCA services. The ranges in recommended PCA time for this exercise have been even larger in some of the DHS training sessions we did not observe, according to past participants.

appeal if they disagree with service-related decisions by DHS or managed care organizations.[33] This process allows individuals to seek a hearing before a state human services judge. We reviewed the results of all 2007 PCA-related state hearings. Our analysis indicated that 97 percent of the PCA-related appeals cases involved disputes about the amount of time authorized for services by DHS or a managed care organization. Table 2.5 shows the outcomes of the 2007 appeals. In the most common type of PCA case—appeals of reductions in services from amounts previously authorized—judges reversed or modified the reductions 65 percent of the time.[34] On average, individuals who appealed reductions in services were granted a 24 percent increase in service time as a result of the

Table 2.5: PCA Appeal Outcomes by Type of Issue, 2007 Cases

		Percentage of Cases in Which the Human Services Judge:			
Main Issue Raised by the Appellant	Number of Cases	Affirmed Agency Position	Modified Agency Position	Reversed Agency Position	Other[a]
Agency's Initial Assessment Led to Denial of PCA Services	15	47%	N/A	40%	13%
Agency's Initial Assessment Did Not Result in Sufficient Amount of PCA Services	36	58	33%	3	6
Agency Reduced the Recipient's Amount of PCA Services	227	33	41	24	2
Agency Terminated PCA Services	40	55	N/A	43	3
Other Issue Related to Amount of PCA Time Authorized[b]	12	58	33	8	0
There Was a Gap in the Recipient's Periods of Authorized PCA Services	8	38	0	63	0
Other[c]	3	67	0	0	33
Total	341	40	32	25	3

NOTES: Table reflects only one issue for each appeal. Ten appeals involved multiple issues, such as a reduction in services and a gap in service periods; in these cases we categorized the appeal under the time-related issue. "Agency" in column headers refers to the Department of Human Services or the managed care organization. "N/A" indicates that modifications were not applicable; in cases involving denial or termination of services, there is no middle ground between the agency's position and the appellant's position.

[a] An example of an "other" decision is a judge requiring a new assessment and determination of time by a public health nurse.

[b] An example of "other issue related to amount of PCA time authorized" is an appellant who was awarded additional time after a reassessment but thought even more time was needed.

[c] Examples of "other" issues include whether the appellant should be allowed to use a fiscal intermediary or choose flexible use PCA.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services PCA-related appeals closed in 2007.

[33] Managed care organizations are required by state contracts to have internal grievance and appeals processes. Fee-for-service recipients—as well as managed care recipients who have already pursued managed care internal grievance procedures—have the option of filing an appeal under the state's "fair hearing" process.

[34] In cases involving reductions in recipients' hours, we defined a "reversal" to mean that the judge restored the number of hours the recipient received prior to the most recent assessment. A "modification" in such a case meant that the judge ordered a smaller reduction of hours than DHS or the managed care organization had authorized. Important information that was not available to the assessor, such as documentation of Level I behavior, sometimes informs judges' decisions.

appeal. When the judge reversed the reduction in services, an average of almost two hours was added to the individual's PCA time. Although just a small fraction of PCA assessments are appealed to the state, these cases indicate that judges and assessors sometimes reach very different conclusions when reviewing similar information about a recipient.

Recommendations

Minnesota's number of PCA recipients has grown significantly in recent years. Some parts of Minnesota use PCA services at much higher rates than others, and it is important to ensure that assessments are reasonably consistent. Assessments are not the only reasons for variations in PCA use, but they are a service the state can influence.

We recognize that PCA assessors have a very difficult job. Assessors are expected to accurately determine individuals' health status based on a single home visit, with limited time for direct observation. Potential service recipients sometimes try to persuade the assessor that a condition is more disabling than it really is, or they ask for assistance that is not authorized by state PCA policy. The assessor is expected to translate observations about individuals' unique circumstances into recommendations on the exact number of service minutes that should be authorized.

Assessors need increased training, guidance, and oversight.

Perhaps relying on 87 individual counties to conduct or arrange for PCA assessments invites inconsistencies in this process. However, we are not convinced that a more centralized approach, such as using DHS-employed assessors, would be cost-effective. Rather, we think DHS and the Legislature should bring greater standardization into the existing assessment process through increased training, guidance, and oversight.

RECOMMENDATIONS

The Legislature should require the Minnesota Department of Human Services to:

- ***Implement mandatory training requirements for persons conducting assessments of individuals' need for PCA services.***
- ***Develop additional guidance to help assessors determine the PCA service needs of persons with behavior issues.***
- ***Develop a process for periodically reviewing samples of PCA assessments for the purpose of ensuring reasonable levels of consistency.***

We think that new PCA assessors should be required to successfully complete a comprehensive DHS course in assessment, such as the three-day training course now offered. Also, because policies and practices change over time, there should be requirements for periodic training of experienced assessors. During the DHS

assessor training, we heard assessors ask many relevant questions about topics that required interpretation of existing laws or DHS policies. For example, one person asked whether an assessor should allocate time for recipients to receive PCA assistance for multiple baths in one day, noting that "ritual bathing" is a part of some religious practices.[35] DHS should also consider ways other than formal training to inform assessors throughout the state about how to apply state assessment policies to specific situations. Perhaps DHS could do this by using its web site to answer questions or provide guidance.

Also, we think PCA assessors need more state guidance. Guidelines can help ensure that judgments are fair and reasonably consistent. Guidelines are used in many areas of medicine to encourage the use of "best practices" or improve cost-effectiveness. In criminal justice, Minnesota requires judges to use advisory guidelines when sentencing offenders, while allowing judges to deviate from the guidelines.[36] Developing reasonable guidelines is a large undertaking, and we suggest starting with guidelines in the behavior area. This would address an area in which assessment agencies expressed particular frustration. Such guidelines could (1) identify ranges of time that may be appropriate to recommend for certain activities and (2) clarify circumstances that may justify deviation from guidelines. DHS should also consider recommending specialized behavioral health assessment instruments to supplement, where appropriate, the state's general assessment instruments. In our view, it is possible to have stronger state guidance on PCA assessments while still allowing assessors to make judgments based on individuals' unique needs.[37]

Finally, we recommend that DHS periodically review samples of PCA assessments. DHS could look at the adequacy of assessment documentation, or it could explore instances in which assessors' recommended amounts of time appear to be unusually large or small. Assessment decisions have important impacts on the services people receive and the costs borne by the state, so these decisions deserve careful state scrutiny.

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[35] In response to the question, DHS staff said that bathing multiple times in one day for religious reasons is not covered. According to *Minnesota Statutes* 2008, 256B.0655, subd. 2(c)(6), PCA services cover bathing necessary for personal hygiene.

[36] *Minnesota Statutes* 2008, 244.09.

[37] DHS is developing a computerized comprehensive assessment instrument that would replace the *MA Health Status Assessment* and the *Long-Term Care Consultation*. The department hopes this instrument could provide nurses with guidance on individuals' time needs based on recipients' specific conditions and the experience of recipients in similar situations. At this time, it is unclear exactly what form this guidance would take and when such an instrument might be implemented.

3 Fiscal Integrity

In 2002, the U.S. Department of Health and Human Services conducted an audit of Minnesota's personal care assistance (PCA) services. The audit concluded: "Based on our sample results, the State had no assurance that payments for personal care service claims during [federal fiscal year 1999] were proper and that compliance requirements were fully met."[1]

Since that report was issued, the state's fee-for-service expenditures for PCA services have nearly tripled. The Minnesota Department of Human Services (DHS) has made changes in its administration of PCA services in an effort to address fraud, abuse, and payment-related compliance problems, but concerns about these issues persist. In this chapter, we discuss the nature and extent of these issues, evaluate the state's efforts to address them, and offer recommendations.

BACKGROUND

Traditionally, efforts to ensure the "integrity" of the Medicaid program have focused on ways to identify and control improper payments. Improper health care payments result from fraud, abuse, and unintentional errors. Table 3.1 shows the federal Medicaid definitions of fraud and abuse. Improper payments can involve inappropriate actions of agencies that bill or pay for services, personal care assistants who provide services, or recipients who access services.

Table 3.1: Federal Medicaid Definitions of Fraud and Abuse

Fraud	"[A]n intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."
Abuse	"[P]rovider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."

SOURCE: *42 CFR* sec. 433.304 (2007).

[1] U.S. Department of Health and Human Services, Office of Inspector General, *Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 Through September 30, 1999* (Chicago, April 23, 2002), 3.

State laws provide a general framework for assuring fiscal integrity in PCA services. The law requires criminal history checks for PCA agency managers, personal care assistants, and persons with more than 5 percent ownership of a PCA agency.[2] PCA agencies must maintain surety bonds and liability insurance.[3] To be paid for services, PCA agencies are required to maintain up-to-date records for individual recipients, including physician statements of need, service plans, care plans, and PCA timesheets.[4] PCA agencies must provide DHS with any requested information demonstrating compliance with laws, rules, or other policies; failure to do so can result in sanctions.[5] In addition, DHS is required to have an ongoing audit process to identify potential fraud and abuse in PCA services.[6]

Minnesota law requires the Commissioner of Human Services to establish procedures for identifying and investigating "suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a vendor of medical care."[7] The commissioner may impose sanctions against health care vendors and refer cases to the Minnesota Attorney General for criminal or civil prosecution.[8]

DHS contracts with managed care organizations to administer some publicly funded health care services, and DHS requires each of these organizations to have its own "integrity program." Each organization must have administrative arrangements or procedures to "guard against fraud, abuse and improper payments."[9] Also, each organization must annually report to DHS on its efforts to investigate, correct, and prevent fraud and abuse.

Personal care assistance (PCA) services are susceptible to fraud, although the total amount of improper payments is unclear.

NATURE AND EXTENT OF FISCAL INTEGRITY ISSUES

There is not definitive information about the total amount and nature of improper payments for Minnesota's PCA services.[10] However, based on our evaluation

[2] *Minnesota Statutes* 2008, 256B.0655, subds. 1f and 1g.

[3] *Ibid.*

[4] *Minnesota Statutes* 2008, 256B.0655, subd. 2(f).

[5] *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[6] *Minnesota Statutes* 2008, 256B.0655, subd. 2(g).

[7] *Minnesota Statutes* 2008, 256B.04, subd. 10.

[8] *Ibid.*, and *Minnesota Statutes* 2008, 256B.064.

[9] Department of Human Services contract with managed care organizations, section 9.15.1.

[10] A 2003 report by our office said there was inadequate information on the overall extent of improper payments in Minnesota's Medical Assistance program—see Office of the Legislative Auditor, *Controlling Improper Payments in the Medical Assistance Program* (St. Paul, August 2003), 19. DHS reviewed a representative sample of PCA claims in 2005, partly in response to that report, but it did not provide a dollar estimate of total improper payments in the PCA program.

and the work of Medicaid investigative units within DHS and the Office of the Attorney General, we concluded:

- **Minnesota's PCA services remain unacceptably vulnerable to fraud and abuse.**

The sections below discuss these vulnerabilities in more detail. The types of problems uncovered in investigations by DHS and the Attorney General's Office are significant, but usually these investigations have been undertaken in response to a complaint or referral. Thus, the problems documented by these units might not be representative of practices in all PCA agencies. To get a more balanced picture of problems with PCA services, we reviewed one month of PCA claims and conducted site visits to a random sample of PCA provider agencies. These efforts reinforced our concerns with the fiscal integrity of PCA services. We were not always able to conclude whether the problems we identified met the criteria for fraud or abuse, but the prevalence and nature of the issues we found indicate unaddressed risks to the financial integrity of PCA services.

Our concerns echo those of others who have closely examined PCA financial integrity issues. According to a 2005 report, the Office of the Attorney General considered PCA services to be "the most problematic of all of the state's health care programs in terms of fraud and abuse."[11] Also in 2005, the Medicaid investigative unit in DHS examined a representative sample of PCA claims and documented significant compliance problems.[12] In a more recent report, key administrators of publicly funded health care services in Minnesota concluded: "The common and individual interests of the PCA agencies, their PCA employees, and PCA clients has led to the unintended consequence of increasing fraudulent and abusive practices while in some cases placing vulnerable recipients at risk."[13]

Work and Findings of State Investigative Units

Minnesota's Department of Human Services (DHS) and Attorney General investigate allegations of Medicaid fraud.

The two primary state investigators of improper Medicaid payments are the Surveillance and Integrity Review Section (SIRS) of DHS and the Medicaid Fraud Control Unit of the Attorney General's Office. SIRS conducts post-payment reviews of PCA services to determine whether payments for the services were appropriate. Most SIRS investigations begin in response to a complaint from a provider, recipient, county agency, or other source. If SIRS finds evidence that a provider has committed fraud or abuse, it refers the case to the Attorney General's Office for further investigation and possible prosecution.

[11] Department of Human Services, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005), 40.

[12] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study: Compliance with DHS Policies* (St. Paul, September 2005).

[13] Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity and the PCA Program* (draft), July 2008, 3. The subcommittee included DHS staff plus officials from the private and public health plans that contract to administer health care services on behalf of the state.

The Attorney General also has the authority to pursue civil cases to recoup improper payments that do not involve fraud.

We found that:

- **Minnesota's state fraud investigators have devoted a disproportionately large share of their resources to PCA services due to concerns about financial integrity, and they have found a variety of problems.**

DHS fraud staff spend a majority of their time investigating PCA issues.

According to SIRS staff, PCA-related complaints make up the largest share of complaints they receive. Staff estimated that 65 percent of their time is spent on PCA issues. This is noteworthy, given that the state's total expenditures for PCA services account for less than 10 percent of Minnesota's total Medicaid spending. PCA cases also make up a large share of the Attorney General's Medicaid fraud caseload. Between January 2005 and December 2007, PCA cases accounted for 51 percent of the Medicaid cases opened by the Attorney General's Office.[14] In addition, PCA-related cases accounted for 29 of the 60 Medicaid cases (48 percent) prosecuted by the Attorney General from 2005 to 2007.

SIRS and Attorney General findings have documented many vulnerabilities with PCA services. Table 3.2 shows examples of cases investigated by SIRS staff. A majority of recent PCA investigations by SIRS involved cases in which PCA agencies billed the state for services not provided (or not documented). SIRS investigations typically identify improper payments for recovery by DHS.

The 2005 DHS study mentioned above reported significant compliance problems with agencies maintaining the documents that DHS requires for reimbursement for PCA services. Based on a statewide sample, the DHS study found that 42 percent of recipient files did not contain current, signed physician orders at the time of service. Furthermore, 52 percent of files did not contain a current, signed care plan at the time of service.[15]

In addition, a DHS committee that included key administrators of Minnesota's publicly funded health care programs noted that past investigations by DHS and health plans have identified the following problems: (1) personal care assistants who report hours worked in excess of actual hours worked; (2) agencies that do not keep sufficient records documenting services billed; (3) caregivers that discourage recipients from reporting when the caregiver does not show up for work; (4) agencies that tell recipients they are eligible for fewer hours of service than had actually been approved, and then bill the state for services not performed; and (5) recipients who sign blank time cards.[16]

[14] The Office of the Attorney General opened a total of 152 Medicaid cases during this three-year period. As a percentage of total cases opened, PCA cases grew from 42 percent in 2005 to 59 percent in 2007.

[15] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study*, 2.

[16] Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity*, 3-8.

Recent DHS investigations illustrate risks to the fiscal integrity of personal care services.

Table 3.2: Examples of Cases Investigated by DHS's Surveillance and Integrity Review Section (SIRS)

Claims for services not provided

- A recipient complained that she had not received services from her PCA agency for more than three months, although the agency had been paid for more than 700 hours of services during that time. The recipient said she had signed blank timecards on some occasions.
- A recipient learned she had used up her authorized PCA hours, even though she had not used PCA for several months. In a subsequent investigation of this agency, SIRS discovered that the agency had submitted claims for PCA services provided to seven recipients while they were in the hospital.

No statement of medical need for services

- SIRS reviewed records for ten recipients at a PCA agency. SIRS recovered more than $91,000, mostly due to evidence that recipients did not have proper "physician statements of need" certifying that PCA services were medically necessary.

Services provided by ineligible personal care assistants

- SIRS found that one agency allowed (1) two personal care assistants to continue providing services after their authorization to do so had been removed by DHS, (2) a personal care assistant to work before a criminal history study was initiated, and (3) four "responsible parties" of recipients to serve as those recipients' personal care assistants.

Inadequate documentation of hours worked

- Upon learning that the owner of a PCA agency was scheduled for deportation, SIRS conducted an on-site review of the agency's records. It found PCA timesheets that were not completed and did not reconcile to the amount of time claimed for state payment. SIRS determined that the agency should repay more than $113,000.

Kickback to parent

- The mother of a child receiving personal care assistance admitted to SIRS that she proposed an arrangement in which she and the personal care assistant shared the state's payments for services. The mother signed timesheets even when the assistant provided no services. The PCA agency agreed to repay the state $4,662.

Personal care assistant using two identification numbers

- During an investigation of a personal care assistant, SIRS discovered that she had a second personal care assistant identification number. Multiple numbers assigned to one person might allow for duplicate billing and inhibits DHS's ability to analyze all payments made on behalf of a caregiver. DHS sent letters to the assistant and PCA agency informing them of the termination of the two identification numbers.

SOURCE: Office of the Legislative Auditor, review of cases closed by SIRS in 2007 and early 2008.

The outcomes of state investigations indicate that financial integrity problems in PCA services are sometimes extensive. Table 3.3 shows the amounts of improper payments identified by SIRS for recovery in recent years, peaking at $544,000 in 2007.[17] In addition, DHS has suspended a number of PCA agencies and individual personal care assistants as a result of SIRS investigations. For example, between January 2006 and July 2008, SIRS suspended the operations of 21 PCA agencies. Also, between November 2007 and November 2008, SIRS suspended 52 individual personal care assistants.

DHS investigators identified over half a million dollars in improper payments to PCA agencies in 2007.

Table 3.3: Amounts of Improper PCA Payments Identified by SIRS for Recovery, 2002-07

Year	Amount
2002	$201,031
2003	90,281
2004	253,972
2005	87,814
2006	224,955
2007	543,721

SOURCE: Minnesota Department of Human Services, Surveillance and Integrity Review Section.

The Attorney General has obtained many criminal convictions in PCA-related prosecutions, often involving restitution to the state. There was an acquittal in only 1 of the 29 PCA-related cases prosecuted by the Attorney General in 2005-07; the rest resulted in convictions or plea agreements involving employees or owners of PCA agencies.[18] The amount of restitution ordered in cases over this three-year period totaled nearly $420,000.

OLA Review of PCA Claims

To provide balance to the complaint-based work of the state's investigative units, we reviewed all DHS-paid claims for PCA services provided during May 2008. We found:

- **DHS paid PCA service claims that asserted impossible or implausible work hours.**

In our review of claims, we found hundreds of instances of payments for impossible or implausible work hours. Our analysis of PCA claims data revealed 423 instances in which DHS paid claims for personal care assistants who

[17] The repayment amounts sought in individual cases are quite variable. In the 2007-08 cases we reviewed, SIRS sought recoveries ranging from $94 in one case to $154,000 in another.

[18] Most of the convictions were for theft by false representation or theft by swindle.

reportedly worked more than 24 hours a day.[19] In one instance, DHS paid for 254 hours of service by one personal care assistant on a single day.[20]

Some claims for PCA services indicated that assistants worked more than 24 hours a day or consecutive 24-hour workdays.

We also found 314 instances in which claims reflected a 24-hour workday. DHS staff indicated that such claims are questionable because DHS does not pay personal care assistants to sleep. Because there might be rare cases in which a 24-hour workday cannot be avoided, we looked for instances of caregivers with consecutive 24-hour workdays. These instances might indicate fraud. At a minimum, if the hours were accurately reported, they would represent a safety risk for the personal care assistant and recipient. We found that 152 of the 24-hour workdays represented consecutive 24-hour workdays. Based on paid claims, one PCA worked 24 hours each day of the month.

In total, we identified 575 personal care assistant workdays that represented either (1) workdays for which the personal care assistant reportedly worked more than 24 hours or (2) consecutive 24-hour workdays. These workdays accounted for less than 0.2 percent of total days worked in May 2008.[21] Still, these cases represented claims totaling about $308,000.[22]

OLA File Reviews at PCA Agencies

We also conducted site visits at 26 PCA agencies in August and September 2008, partly to examine fiscal integrity issues. During the site visits, we reviewed agency records for samples of recipients and their personal care assistants. In all, we reviewed files for 185 recipients and 238 personal care assistants. Specifically, we reviewed agencies' supporting documentation for claims covering April 13-19, 2008, and we reviewed compliance with documentation requirements agencies must meet to receive state payments. Our sample was too small for us to draw general conclusions about all PCA provider agencies. However, because we selected the agencies at random, the extent of the problems we found was striking. We found:

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[19] Claims for PCA services indicate the person who received services, the personal care assistant who provided them, and the date of service. Most of the cases we identified were based on multiple claims for individual personal care assistants, not single claims. Also, for most of these assistants, a single agency submitted all of the claims.

[20] A recent federal report examined PCA claims data from five states, including Minnesota, for possible payment errors—see U.S. Department of Health and Human Services, Office of Inspector General (OIG), "Memorandum Report: Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day" (Washington, DC, 2008). Using data for Minnesota claims from the last three months of 2005, the OIG found claims in which PCA services exceeded 24 hours a day per recipient, amounting to 35,751 hours. Our analysis focused mainly on claims exceeding 24 hours per day *per personal care assistant* because there is no defensible explanation for such claims. In contrast, claims might legitimately reflect over 24 hours of care in a day for a recipient. For example, a person might require the services of more than one personal care assistant at a time. We also looked for claims exceeding 24 hours of PCA in a day *per recipient*. May 2008 claims indicating that an individual received more than 24 hours of assistance in a day totaled 11,900 hours.

[21] The 130 personal care assistants involved in these cases represented about 0.7 percent of the roughly 18,000 personal care assistants for whom claims were submitted for May 2008.

[22] We did not determine whether all or just a portion of each claim was questionable.

- **PCA agencies provided services to many recipients without the documentation required by DHS for reimbursement for PCA services.**

As discussed below, we found problems with the timesheets, care plans, and physician statements of need that providers are required to keep on file in order to be reimbursed for PCA services.

Files at some provider agencies indicated lax administration of PCA services.

Our comparison of paid claims to agency timesheets found mismatches in a minority of cases, but the problems were concerning. For 23 percent of recipients whose files we examined, there was at least one day during the week we reviewed for which timesheets and claims did not reconcile.[23] Typically, these cases were characterized by (1) more hours claimed by the agency than the personal care assistant reported on the timesheet, (2) a claim submitted on behalf of a different personal care assistant than the one who completed the timesheet, or (3) the absence of valid timesheets for the date(s) in question.[24] At one PCA agency we visited, timesheets for individual recipients covering extended periods were repeatedly photocopied, with changes in only the dates of service. In two cases at this agency, we observed timesheets with apparently forged recipient signatures (as indicated by misspellings of the recipients' names).[25]

Also, we often found minimal documentation by PCA agencies to verify that qualified professionals provided the hours of supervision for which the state paid. Some agencies submitted single claims to the state for several weeks of supervision, covering multiple qualified professionals and multiple recipients. Qualified professionals usually did not have timesheets indicating the exact hours they spent supervising individual personal care assistants.

Minnesota law requires that PCA agencies have an individual recipient's care plan (signed by the recipient) and physician statement of need on file "[i]n order to be paid for personal care assistant services."[26] Thus, these documents are considered essential under Minnesota law for ensuring the integrity of PCA services. As we described in Chapter 1, a care plan is a written description of the PCA services an individual is supposed to receive. DHS's health care program provider manual requires PCA agencies to update the care plan annually. Without a current care plan for reference, it is impossible to determine if personal care assistants are providing the services an individual needs and for which they are being paid. The physician statement of need reflects a medical professional's

[23] Some recipients had multiple personal care assistants during the week we examined. The 23 percent figure was calculated based on a total of 259 unduplicated recipient-caregiver combinations for which we reviewed claims documentation during site visits.

[24] In addition, 3 percent of the recipients whose files we reviewed had a timesheet-claim mismatch that did not work to the agency's financial advantage. In other words, the timesheet reported more time than the agency claimed for state billing purposes.

[25] Beyond the 23 percent of cases in which we found significant timesheet-related issues, there were numerous minor problems with timesheets that suggested carelessness by the PCA agencies. For example, many timesheets did not have the personal care assistant's provider number or the recipient's birth date or Medical Assistance number.

[26] *Minnesota Statutes* 2008, 256B.0655, subd. 2(f).

judgment that a recipient has a medical need for PCA services. As explained earlier, Medicaid-funded PCA services must be medically necessary. Minnesota law requires that physician statements of need be updated annually.[27]

Agencies did not have up-to-date care plans in 26 percent of recipient files we reviewed. An additional 43 percent of files included a care plan, but it was not signed by the service recipient or responsible party. Unsigned care plans do not comply with statutory requirements, and they provide no clear documentation of consumer participation in the development of the plan. In our view, DHS bears some responsibility for the absence of recipient signatures on these plans. DHS has distributed a template for a care plan that agencies may use, but it does not include a place for the signatures of the recipient (or responsible party) or qualified professional.

Over one-fourth of files we reviewed did not contain appropriate documentation of a recipient's medical need for PCA services.

We found similar problems with the physician statements of need. Twenty-eight percent of recipient files we examined did not have a current physician statement of need at the time the claimed services were provided. In some cases, it appeared that doctors were not timely in completing these documents and returning them to the PCA agency. In other cases, there was no evidence that the PCA agency sought a physician statement of need in a timely manner.

We did not determine whether the problems cited above represented intentional efforts by PCA agencies, personal care assistants, or recipients to obtain unauthorized financial benefits. If the compliance problems we observed do not indicate fraud, however, they certainly reflect laxity in the administration of PCA services. A lapse of several days or months without a current care plan or physician statement of need might not have an adverse impact on the services actually provided to recipients. However, violations of payment rules established by the Legislature and DHS undermine the fiscal integrity of PCA services and should not be taken lightly.

STATE EFFORTS TO ADDRESS PROBLEMS

The state relies on several approaches to foster financial integrity in PCA services. These include (1) investigations by state fraud units, (2) controls on agencies' claims for payment, (3) screening agencies during the provider enrollment process, and (4) providing agencies with training and information. Below, we describe these efforts and identify areas still needing attention.

State PCA-Related Investigations

As noted earlier, the state has two units that investigate fraud and abuse in the Medicaid program, and each has devoted significant resources to PCA issues. Investigations by SIRS and the Attorney General have led to suspensions of providers, recoveries of improper payments, and even criminal convictions. Concerns expressed by these units have contributed to DHS's efforts to

[27] *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

implement stronger financial controls and procedures. Still, it is important to note that:

- **The scope and breadth of the state's PCA-related investigations have often been limited.**

Due to resource constraints, state fraud investigations have often had a narrow focus.

First, SIRS staff have rarely had the time or resources to conduct audits of randomly-selected PCA agencies. The main exception was a 2005 compliance review of a statewide sample of PCA claims, selected at random. Second, SIRS usually conducts investigations in a somewhat limited number of PCA agencies in a given year. In 2006, SIRS investigated 31 personal care provider agencies; in 2007, it investigated 34 of these organizations.[28] The questionable claims we discussed earlier were associated with personal care assistants working for 70 agencies. At its 2006-07 rate, SIRS would need over two years to investigate these agencies, especially if it continued to conduct investigations in response to complaints.[29] Third, SIRS investigations most often focus on the actions of a single person, rather than looking more broadly at practices throughout an agency. We reviewed 41 cases closed in 2007 and early 2008, and more than 60 percent focused on a single personal care assistant or a single recipient. There were exceptions, such as a case in which SIRS expanded its investigation of an agency to review state payments made on behalf of all of the agency's personal care assistants over the course of a year. SIRS staff said they would prefer to look in more depth at more agencies, if resources allowed.

Limits on the scope of SIRS investigations also limit the volume of cases referred for prosecution to the Attorney General. Still, staff in the Attorney General's Office have implemented their own limits, restricting their investigation of PCA-related referrals to cases with potential recoveries exceeding $5,000. Attorney General staff welcomed the Minnesota U.S. Attorney's Office's creation in 2008 of a multi-agency task force to focus on investigation of PCA services. This task force includes staff from the U.S. Attorney, Minnesota Attorney General, U.S. Department of Health and Human Services Office of the Inspector General, Federal Bureau of Investigation, and Internal Revenue Service. Attorney General staff told us the involvement of federal agencies is providing resources for surveillance and investigation that were not previously available.

Controls on PCA Claims

DHS has instituted some important policies and procedures to improve accountability for PCA claims. In 2005, DHS established an enrollment process to assign provider identification numbers to individual personal care assistants,

[28] SIRS investigated 101 personal care provider agencies in 2005, mainly during its compliance review of a random sample of claims.

[29] It is likely that not all 70 agencies require investigation, but this example reinforces the inability of SIRS to respond to anything but complaints at its current rate of investigations.

enhancing its ability to monitor the hours worked by individual caregivers.[30] Also, effective April 1, 2008, DHS policy required PCA agencies to submit separate payment claims for each day of service by each personal care assistant. Previously, PCA agencies could submit individual claims that covered multiple days of service by a personal care assistant. This change made it possible for state investigators to identify actual hours of work claimed for an individual personal care assistant per day. SIRS staff can now directly compare the claimed work hours on a date with the hours reported for that date on personal care assistants' timesheets.

DHS has changed some procedures to improve fiscal integrity, but it needs to do more.

In addition, DHS announced a policy that it would not pay for more than 24 hours of service per day per personal care assistant, effective May 1, 2008. However, as our earlier discussion illustrates, we found:

- **Through late 2008, DHS had not implemented an effective way to stop payments in cases that involved reports of impossible or excessive work hours.**

In fall 2008, DHS staff confirmed that they had not yet implemented a way to systematically identify and prevent payment of claims for more than 24 hours per day per personal care assistant. DHS officials told us that the agency intends to implement a way to flag these excessive claims by early 2009.

DHS's failure to prevent payment of these clearly improper claims through improvements in its claims processing procedures raises questions about its ability to detect less obvious problems. Detecting improprieties in cases involving more limited work hours would involve, at a minimum, some review of agencies' documentation supporting the claims. But even with on-site visits, it might be difficult to detect cases in which a recipient and a personal care assistant have colluded to defraud the state—especially if the fraudulent claims submitted to the state matched the timesheets signed by the recipient and caregiver. Such fraud might only be detected with on-site surveillance of recipients and personal care assistants.

PCA Agency Enrollment

Since 1988, Minnesota has relied on provider agencies to administer personal care services on behalf of the state. DHS enrolls organizations that perform key administrative tasks: submitting claims to the state, paying caregivers, and sometimes recruiting and supervising personal care assistants. We found that:

- **Current state requirements for PCA provider agencies are insufficient to prevent enrollment of agencies with questionable management skills.**

[30] In our review of personal care assistants' provider numbers, we identified a relatively small number of personal care assistants who had more than one provider number. Multiple provider numbers could prevent DHS from easily identifying individuals with excessive work hours.

It is relatively easy in Minnesota to establish an agency authorized to administer PCA services. State law sets relatively few requirements for an agency to enroll with the Department of Human Services as a "personal care provider organization." As discussed in Chapter 1, there is no requirement for such agencies to obtain a license from the state. The law specifies that: (1) agency managers and primary owners must pass criminal background checks, and (2) the agency must maintain a surety bond and liability insurance.[31]

There is too little scrutiny of agencies seeking to provide PCA services.

State rules set forth additional requirements for agencies seeking to provide PCA services, but DHS's scrutiny of compliance with these requirements has been limited. For example, the rules require applicants to demonstrate that their services will be cost-effective, they follow generally accepted accounting principles, they have a system of personnel management, and they have a quality assurance mechanism.[32] DHS staff told us they review the applying agency's bank balance and verify the credentials of the agency's "qualified professionals," but they do not independently verify agency compliance during the enrollment process with many of the other enrollment requirements in state rules. For some agency enrollment requirements—such as having a grievance process—DHS officials told us they monitor compliance through quality assurance reviews (which would only be conducted after agencies have started providing services).

Both DHS and the Attorney General have voiced concern that it is too easy for former owners of fraudulent PCA agencies and owners without necessary management skills to enroll new PCA provider agencies in Minnesota. In several cases, DHS has suspended payments to certain PCA agencies, only to find later that the agency's owners have started a new PCA agency with a different name. In addition, DHS officials told us that basic management issues are the topic of many of the calls PCA agencies make to DHS's call center for health care providers.

DHS has developed a process to ensure that enrolled PCA agencies continue to meet certain enrollment requirements. The process calls for DHS to annually send a letter to PCA agencies to verify and update information about the agencies' liability insurance, surety bond, qualified professional, and ownership. As of late 2008, however, DHS placed implementation on hold due to reallocation of resources to other projects. When the project is complete, the letter will be sent automatically, based on a PCA agency's liability insurance expiration date.

PCA Agency Training

One way to prevent improper payments for PCA services is to ensure that agency officials are knowledgeable about state PCA requirements and billing practices. Many PCA agencies are relatively new, and health care officials have raised

[31] *Minnesota Statutes* 2008, 256B.0655, subd. 1g. As part of the provider enrollment process, DHS does some additional tasks, such as determining whether the agency appears on a federal list of businesses excluded from eligibility for health care program payments.

[32] *Minnesota Rules* 2008, 9505.0335, subp. 5.

questions about their management capabilities. From the beginning of 2007 through July 2008, DHS newly enrolled an average of nearly 12 unlicensed personal care provider agencies per month, compared with 7.6 per month from 2003 through 2006. Overall, the number of unlicensed personal care provider agencies paid by the state for PCA services increased from 167 in fiscal year 2002 to 417 in fiscal year 2007, an increase of 150 percent. During this period, the number of licensed home health agencies paid to provide PCA services was more stable, declining slightly from 82 in fiscal year 2002 to 78 in fiscal year 2007.

Many agencies that administer PCA services are also relatively small. Table 3.4 shows that more than half of all PCA agencies served 15 or fewer fee-for-service recipients in fiscal year 2007. In fact, 31 percent of agencies served five or fewer fee-for-service recipients. Between 2002 and 2007, there was particular growth—174 percent—in the number of unlicensed personal care provider agencies serving 15 or fewer fee-for-service recipients.[33] The increase in the number of relatively small PCA agencies has raised questions about whether these agencies have the required management skills to comply with PCA requirements.[34]

Table 3.4: Provider Agencies by Number of Fee-For-Service PCA Recipients Served, Fiscal Year 2007

	Number of Agencies in These Size Categories			Percentage of Agencies in These Size Categories		
Number of Recipients	Unlicensed Personal Care Provider Agencies	Licensed Home Health Agencies[a]	Total	Unlicensed Personal Care Provider Agencies	Licensed Home Health Agencies	Total
1 to 15 recipients	225	37	262	54.0%	47.4%	52.9%
16 to 50 recipients	110	16	126	26.4	20.5	25.4
51 to 100 recipients	51	18	69	12.2	23.1	13.9
Over 100 recipients	31	7	38	7.4	9.0	7.7
Total	417	78	495	100.0%	100.0%	100.0%

[a] The number of home health agencies includes only the agencies that submitted claims for PCA services.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

[33] Aside from the fiscal integrity issues raised by the increase in new PCA agencies, we also heard concerns that the larger number of small PCA agencies may have increased statewide PCA administrative costs, due to diseconomies of scale. We could not readily determine whether this has occurred because PCA agencies do not report their administrative costs to the state.

[34] Recently, a working group of DHS and health plan officials said that some PCA agencies trying to compete in this market "increase their profit margin by minimizing client support, record keeping, and PCA oversight." See Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity*, 3.

In an effort to help the increasing number of new PCA agencies, DHS has taken some important steps to increase training opportunities. Most notably, DHS started in January 2008 to offer a three-day training program for PCA agency owners and administrators.[35] Key topics covered during this program include how recipients obtain PCA services, eligibility of services for state reimbursement, statutory requirements affecting PCA agencies, and how to bill DHS for services provided. However:

- **Training for administrators of PCA agencies is voluntary, and most agencies have not yet had a staff person attend it.**

We examined DHS records showing which PCA agencies have had owners or staff who attended the three-day training sessions. We focused on unlicensed personal care provider agencies because these agencies are subject to fewer state requirements and have less experience billing the state for services than licensed home health agencies. Through the end of 2008, only 31 percent of the personal care provider agencies enrolled with DHS had at least one staff member who had completed the training.

Policies on Services Eligible for Payment

Without clearer state policies, PCA provider agencies may misunderstand the types of services their employees can deliver.

It is important for DHS to have clear state policies about which types of services are eligible for state payment. Such policies help PCA agencies comply with the law; they also help state investigators enforce the law. State law lists activities that are eligible and ineligible for state PCA payments.[36] Nevertheless, we concluded that:

- **There is too much ambiguity in state policy about the specific types of PCA services that may be covered by state payments.**

In training sessions, DHS staff have provided guidance to supplement the provisions in law. Presumably, DHS has offered this guidance to help agencies apply broad policies to real circumstances that PCA agencies may encounter. For instance, DHS trainers have said that non-covered services include: mentoring, educational training or support for recipients, daycare or babysitting, helping recipients with homework, providing vocational or recreational skills training, providing or supporting independent living skills, and respite care for parents or other family members. However, we are not aware of written policies that explicitly prohibit payment for these activities.

During our study, we observed and heard varying notions about what PCA services include. In an appeals case, a state human services judge ruled in favor of limiting certain aspects of a recipient's PCA services, noting that "companionship is not a service that is medically necessary." Yet we also reviewed records indicating that some personal care assistants played games,

[35] In addition, DHS started offering half-day "labs" for PCA agencies in mid-2007, focusing largely on proper billing.

[36] Most of these provisions are in *Minnesota Statutes* 2008, 256B.0655, subd. 2.

watched TV, or did homework with recipients or walked recipients' dogs. In addition, recent increases in the number of PCA recipients assessed as having behavioral problems may raise questions about what specific services personal care assistants can provide to these recipients without providing "therapy."[37] Finally, state fraud investigators told us it is sometimes difficult to determine agency compliance due to ambiguities about which PCA activities are allowable. In general, we think there is room for state policy to more clearly specify which services can be reimbursed with federal and state funds for health care services.

RECOMMENDATIONS

The vulnerability of PCA services to fiscal integrity problems and our evaluation of the state's efforts in this area lead us to make several recommendations to the Department of Human Services and the Legislature.

RECOMMENDATION

DHS should regularly and promptly analyze its data on paid claims for PCA services to identify and recoup payment of improper claims.

Analyzing claims data should be a first step in identifying questionable payments for PCA services.

Analysis of claims data is a relatively low-resource approach to identifying agencies that may be submitting erroneous or fraudulent claims.[38] In light of the resource constraints under which the state's fraud units operate, strategic analysis of claims data could help focus limited resources on clear problems. Although the questionable claims we identified represented a small percentage of all claims, we think this type of data analysis is important. The claims we identified were associated with personal care assistants working for over 10 percent of the agencies with paid claims in May (70 of 514 agencies). Additional analysis of data would allow DHS to focus on the agencies with a greater number or frequency of problem claims. For example, one agency was responsible for the seven instances in which a personal care assistant allegedly provided over 100 hours of care in a day. According to DHS, SIRS has started doing more post-payment reviews of this type in recent months.

We think there is a strong need for the state to increase its oversight of PCA agency compliance. SIRS has conducted useful, well-documented reviews of PCA agencies, and the state would benefit from more frequent reviews of this sort.

[37] According to a "resource document" in DHS's Disability Services Policy Manual: "PCA staff are not trained or paid to do mental health or behavioral therapy following a behavioral plan written by a mental health professional. [Personal care assistants] may be oriented to a behavior/treatment plan including if and where their role in observation, monitoring, intervention and redirecting fits into the overall behavior/treatment plan."

[38] In some cases, analysis of data alone would not definitively identify improper claims. For personal care assistants whose excessive work hours were accumulated over numerous agencies, additional investigation might be required to determine which specific claims were valid and which were not.

Risks to the fiscal integrity of PCA services suggest the need for sustained attention from state fraud investigators.

RECOMMENDATION

To the extent possible, DHS should reallocate existing resources to conduct more PCA-related investigations.

PCA services already consume a disproportionate share of DHS's investigative resources. Also, we recognize that DHS operates within financial constraints, and PCA is only one part of the Medicaid program it administers. However, it is important for DHS to aggressively review PCA agencies, for several reasons. First, there are many relatively new agencies administering PCA services, and these types of agencies may pose a greater risk for improper payments than well-established agencies. Second, state investigators generally believe that there are greater vulnerabilities in PCA services than in most other Medicaid services. DHS officials told us that the state may be obligated to repay the federal government for improper payments even in cases where the state is unable to recoup money owed by the provider agency, so the state bears an important financial risk. Third, past PCA investigations have led to constructive procedural changes to improve integrity, such as requirements for the enrollment of personal care assistants and for single-day claims. Therefore, we think that expenditures on PCA investigations have been a sound investment.

The 2009 Legislature should have discussions with DHS officials about the potential for increased PCA agency oversight within existing resources and authority. If legislators subsequently want to consider *additional* ways to increase oversight, we think two options should be considered. First, the Legislature could authorize annual enrollment fees for PCA agencies to help offset the costs of state regulation and oversight. The Legislature has often authorized fees for this purpose for licensed facilities, but it has not done so for unlicensed personal care provider agencies. Second, the Legislature could require PCA agencies to submit additional information to the state, perhaps allowing DHS to conduct improved oversight even in cases where it cannot conduct compliance reviews in the field. For example, if PCA agencies were required to provide DHS with copies of each PCA recipient's most recent physician statement of need, DHS might be able to audit agency compliance more efficiently.

There should be stricter enrollment standards for PCA provider agencies.

RECOMMENDATION

The Legislature should require representatives of new and existing personal care provider agencies to periodically complete comprehensive state training on PCA standards and practices.

In our view, new PCA agencies should not be allowed to enroll with DHS until key staff have completed a course such as the three-day course implemented by DHS in 2008. In addition, agencies already serving PCA recipients should be required to have staff periodically complete this training.

RECOMMENDATION

The Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency's owners or administrators have previous violations of federal or state regulations.

Stricter enrollment standards—such as requiring new PCA agencies to complete a DHS training course—might dissuade some owners of questionable agencies from trying to restart their businesses. However, we also think the law should clarify that DHS may consider the track record of agencies' owners and administrators when determining whether to authorize the agencies' enrollment in the PCA program. Minnesota law has this type of provision for some other types of service providers. For instance, the law authorizes the Department of Health to deny home care licenses to agency owners or managers whose licenses have previously been revoked.[39]

RECOMMENDATION

The Legislature should direct DHS to propose more specific policies regarding which PCA activities are (and are not) reimbursable.

PCA agencies should be able to get clear, detailed descriptions in easily-accessible state policies about which services are reimbursable. For example, someone who has not attended a DHS training session might not understand that helping a PCA recipient with homework is not considered by DHS to be a reimbursable activity. The Legislature should consider whether clarifications of policies on reimbursable activities should be developed through amendments to state laws or rules rather than less formal processes, such as amendment by DHS of its administrative policies and manuals.

[39] *Minnesota Statutes* 2008, 144A.46, subd. 3.

4 Service Quality

State oversight of service quality is important in personal care assistance (PCA) for several reasons. PCA services are provided to potentially vulnerable individuals in their homes. Unlicensed individuals, most often employed by unlicensed agencies, provide the care. Professional supervision of the care is done at the recipient's or responsible party's option. In this environment, it is important for the state to ensure that providers understand and follow the policies and procedures designed to result in appropriate care.

In this chapter, we discuss various topics that affect the quality of PCA services: (1) measurement of service outcomes, (2) statewide quality assurance planning, (3) periodic quality assurance reviews of provider agencies, (4) ongoing supervision of PCA services, (5) protection of service recipients from maltreatment, (6) the adequacy of information consumers receive, (7) the reasonableness of caregivers' work hours, and (8) caregiver training and compensation. Weaknesses in these areas place service recipients at risk, and we highlight needed improvements that merit the attention of the Legislature and Department of Human Services (DHS).

OUTCOMES

Given Minnesota's large investment of public dollars in personal care services, it would be useful to have information demonstrating the impact of these expenditures. However, it is unclear what measures should be used to evaluate these services. This is because:

- **Minnesota statutes do not clearly define the intended outcome of personal care services.**

Minnesota law lists various activities that qualify for state payment, but it does not state an ultimate purpose for PCA services. DHS's *PCA Consumer Guidebook* says these services are "designed to support people of all ages with disabilities to live independently in the community."[1]

To better understand the impact of PCA services, we talked with consumer advocates and several groups of service recipients, and we reviewed previous research. We found:

- **There has been little systematic analysis of PCA outcomes or cost-effectiveness, in Minnesota or elsewhere, but many recipients strongly value the PCA services they receive.**

[1] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 7.

We are not aware of any formal evaluations of the cost-effectiveness of PCA services in Minnesota, so we examined research conducted elsewhere.[2] Researchers have evaluated various types of home and community-based services, but few carefully controlled studies have specifically examined personal care services.[3] For example, a 2008 research summary on personal care services for children with intellectual impairments found hundreds of articles from many countries discussing personal care services, but only one study met the authors' criteria for scope and methodological rigor.[4]

Personal care assistance (PCA) recipients expressed considerable satisfaction with their services in Minnesota's only statewide user survey.

In Minnesota, there has been one statewide survey of PCA consumers. That survey, conducted in 2003, found that: "In general, PCA consumers express strong satisfaction with the quality of care they receive through the PCA program, PCA workers, and their provider agencies."[5] Overall, 69 percent of the surveyed consumers rated quality of care as "excellent," 25 percent "good," 5 percent "fair," and 1 percent "poor." The survey asked recipients to name the most valuable aspect of PCA services, and "most consumers described how it helps them and their families to lead a more active, less stressful life."[6] In addition, recipients generally said they liked being able to choose their own personal care assistants and schedule services when needed.[7]

The 2007 Legislature directed DHS to conduct an annual survey of recipients served by various disability programs "to determine the effectiveness and quality" of these services.[8] It specified that "[t]he survey shall analyze whether desired outcomes have been achieved for persons with different demographic,

[2] *Minnesota Statutes* 2008, 256B.0655, subd. 1b, requires individual client assessments to include an "evaluation of service effectiveness." In practice, however, PCA assessments do not involve measurement of service impacts on clients' health or well-being. Rather, the "cost-effectiveness" portion of the assessment requires an assessor to determine that the estimated cost of PCA and other home care services does not exceed a dollar limit established by DHS for the individual's assessed needs. Also, *Minnesota Rules* 2008, 9505.0335, subp. 5, requires each PCA agency applying to enroll with DHS to "demonstrate the cost effectiveness of its proposal for the provision of personal care services," but DHS does not have criteria for evaluating this. DHS recently hired a consulting firm to study PCA services, including an analysis of cost-effectiveness.

[3] Some useful reviews of past research include: David C. Grabowski, "The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence," *Medical Care Research and Review* (February 2006), 3-28; National Council on Disability, *Consumer-Directed Health Care: How Well Does It Work?* (Washington, DC, October 26, 2004); and Paul Montgomery, Evan Mayo-Wilson, and Jane A. Dennis, "Personal Assistance for Children and Adolescents (0-18) with Intellectual Impairments," *Cochrane Database of Systematic Reviews*, Issue 3 (2008), 1-25.

[4] Montgomery, Mayo-Wilson, and Dennis, "Personal Assistance for Children and Adolescents (0-18) with Intellectual Impairments."

[5] Cara L. Bailey, *Minnesota's 2003 PCA Consumer Survey* (St. Paul: Wilder Research Center, for the Minnesota Department of Human Services, May 2004), 1. The survey was based on responses from 455 randomly selected PCA recipients.

[6] *Ibid.*, 4.

[7] *Ibid.*, 44-45.

[8] *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18, subd. 3. The law required the survey for home and community-based waiver service programs, but DHS staff told us it will be conducted for Medical Assistance State Plan recipients, too. The law required field testing of the survey in 2008.

diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs." Although this survey will cover a broad range of service recipients when it is implemented, it has the potential to provide useful information about PCA services.

During our evaluation, we talked with many PCA recipients, family members, and consumer advocates who emphasized the valuable role that PCA services play. Recipients emphasized that PCA services increase their ability to lead a normal life. For instance, one recipient told us he would be in a nursing home without PCA services, due to physical disabilities that prevent him from getting out of bed on his own and doing daily personal tasks. With PCA, he runs his own business and participates regularly in community activities. We also heard from a mother of twin five-year-olds who have intellectual disabilities, autism disorders, and speech impairments. Before getting PCA services, it was difficult for the woman and her disabled husband to protect the children from harm. For example, the children sometimes ran away or played with knives. PCA services have enabled the mother to focus on the needs of one child at a time, without placing the safety of the other child at risk.

Based on our interviews, it also seemed to us that many PCA owners and administrators have a sincere desire to serve the best interests of their recipients. For example, one agency owner told us she went into the home health care business to help recipients avoid the fate of her grandfather, who was beaten to death in a nursing facility. Another agency's first PCA recipient needed a kidney transplant, and the agency's owner donated one of hers when the recipient had difficulty finding a compatible donor. Some owners started their PCA agencies following years of experience in nursing or home health care.

It is difficult to measure the cost-effectiveness of personal care services.

Even if consumers are generally satisfied with the personal care services they receive, it is difficult to conclusively measure the cost-effectiveness of these services. In part, this is because it is hard to quantify the extent to which consumers of home-based services would otherwise be living in more expensive institutional settings.[9] In addition, there are long-standing concerns that expansions of home and community-based service options may have contributed to higher aggregate long-term care expenditures, due to some substitution of publicly funded care for informal, unsubsidized care.[10]

QUALITY ASSURANCE PLAN

The 2001 Minnesota Legislature required DHS to develop a quality assurance plan for PCA services. According to the law, the plan should include:

[9] Medicaid waivers for home and community-based services are specifically targeted to persons who would otherwise qualify for institutional care. However, non-waiver recipients account for most of Minnesota's PCA recipients, and it is unclear what their needs for institutional care would be if PCA services were not available.

[10] For example, see Pamela Doty, U.S. Department of Health and Human Services, *Cost-Effectiveness of Home and Community-Based Long-Term Care Services* (Washington, DC, June 2000). According to this report, a review of research indicated that a so-called "woodwork effect" "seriously impedes the cost-effectiveness of home and community-based services."

> (1) performance-based provider agreements; (2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports; (3) ongoing monitoring of consumer health and well-being; and (4) an ongoing public process for development, implementation, and review of the quality assurance plan.[11]

We found that:

- **The Department of Human Services has not completed the personal care assistance quality assurance plan required by law.**

DHS has done some work on quality assurance, but it has not completed the plan required by the 2001 Legislature. DHS addressed one component of the plan through a PCA consumer satisfaction survey in 2003. The survey gathered information on satisfaction with various aspects of PCA services, including assessments, service quality, and assistants' training.[12] DHS has not conducted another statewide consumer survey since that time.

Over the years, the department has pursued some additional quality assurance initiatives. For example, as Table 4.1 shows, DHS developed a guidebook for PCA consumers in 2003.[13] In 2006, the department started conducting on-site reviews of PCA agencies. Two years later, DHS started offering training for personal care provider agencies.

In addition, DHS has engaged in broad quality assurance planning for home and community-based care, including PCA. For example, in response to 2005 legislation, a group convened by DHS studied and recommended a quality assurance model for disability services, including PCA.[14] The resulting report recommended: a state quality commission; regional quality councils to identify, design, and implement initiatives to improve services; annual surveys of service recipients; outcome-based quality assessment; and an effective system of reporting abuse, neglect, and exploitation. The Legislature included some of these recommendations in legislation requiring development of a "quality management, assurance, and improvement system" for individuals receiving

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[11] *Laws of Minnesota* First Special Session 2001, chapter 9, art. 3, sec. 41, codified in *Minnesota Statutes* 2008, 256B.0655, subd. 9.

[12] Bailey, *Minnesota's 2003 PCA Consumer Survey*.

[13] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 5.

[14] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 57, and Minnesota Quality Assurance Panel, *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel, Final Report* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, February 2007).

disability services.[15] Although the legislation focuses on waiver programs, DHS intends to also apply it to PCA provided through the Medical Assistance (MA) State Plan.

The Department of Human Services (DHS) has undertaken some quality assurance initiatives, but it has not developed a quality assurance plan for PCA services.

Table 4.1: Quality Assurance Activities for Personal Care Assistance Services, 2001 to Present

2001	Minnesota Legislature requires the Minnesota Department of Human Services (DHS) to develop a quality assurance plan for personal care assistance (PCA). The plan is never completed.
2003	DHS contracts for a survey of PCA consumers. DHS produces a PCA Consumer Guidebook.[a]
2005	The Legislature mandates that DHS study and recommend a quality assurance system for disability services. The Commissioner of DHS creates a quality assurance panel to complete the study.
2006	DHS begins conducting quality assurance reviews of personal care provider agencies.
2007	The quality assurance panel recommends: (1) a state "quality commission;" (2) regional "quality councils" to identify, design, and implement initiatives to improve services; (3) annual surveys of service recipients; (4) outcome-based quality assessment; and (5) an effective system of reporting abuse, neglect, and exploitation. The Legislature passes a law requiring a quality management, assurance, and improvement system for individuals receiving disability services through waiver programs. DHS decides to incorporate home-based services delivered outside of waivers, including PCA.
2008	DHS begins offering a voluntary three-day training program for personal care provider agencies.

NOTES: Some DHS activities that are not specific to personal care assistance could affect the quality of PCA services. For example, fiscal accountability is addressed by the Surveillance Integrity and Review Section (SIRS) through its post-payment reviews and investigations of Medicaid programs. SIRS is discussed in Chapter 3. Also, consumer choice can help ensure quality, and some choice is built into PCA services. For example, recipients (or their responsible parties) can choose their PCA and whether they want qualified professional supervision.

[a] DHS updates the consumer guidebook periodically so that it stays current.

SOURCES: *Laws of Minnesota* First Special Session 2001, chapter 9, art. 3, sec. 41; Cara L. Bailey, *Minnesota's 2003 PCA Consumer Survey* (St. Paul: Wilder Research Center, for the Minnesota Department of Human Services, May 2004); Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007); *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 57; Minnesota Quality Assurance Panel, *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel, Final Report* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, February 2007); and *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18.

[15] *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18, codified in *Minnesota Statutes* 2008, 256B.096.

Overall, DHS's plan to develop a quality assurance system that focuses on a broad array of services, not just PCA, seems like a reasonable approach. But most of these activities are awaiting implementation, eight years after the Legislature mandated a PCA quality assurance plan.

QUALITY ASSURANCE REVIEWS

DHS started conducting quality assurance reviews of PCA agencies in 2006.

In 2002, the Office of the Inspector General for the U.S. Department of Health and Human Services completed an audit of Minnesota's claims for Medicaid PCA costs. Having found improper payments and provider noncompliance that could negatively affect quality of care, the Inspector General recommended that Minnesota "develop oversight mechanisms that would ensure compliance with [PCA] program rules."[16] Four years later, another Inspector General report noted that Minnesota was one of three states that did not conduct reviews or audits to ensure that personal care assistants meet program requirements.[17] The 2005 Minnesota Legislature authorized DHS to monitor PCA agencies for compliance with laws and rules.[18] The following year, DHS created a Quality Assurance Review program and began conducting reviews of PCA agencies. The program's mission is "to build better providers through education, training, and compliance."[19]

In our view, DHS's Quality Assurance Review program contains elements that could contribute to an effective program. These elements include a mission statement that clarifies and focuses the intended purpose of the program, and an investigative process and procedures that could help ensure that staff conduct reviews in a consistent manner.

The process that DHS has developed to fulfill its quality assurance mission includes: (1) procedures for receiving and assigning complaints for review; (2) procedures and a timeline for scheduling and conducting site visits or desk audits; and (3) a schedule for follow-up with providers.[20] Upon receiving a PCA-related complaint, staff determine whether it raises an issue that needs investigation by quality assurance staff or the Surveillance Integrity and Review Section (SIRS). Quality assurance staff address issues regarding service quality and recipient health and safety. In contrast, SIRS, discussed in Chapter 3, addresses complaints involving money, such as investigating alleged improper payments.

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[16] U.S. Department of Health and Human Services, Office of Inspector General, *Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 through September 30, 1999* (Washington, DC, April 2002), 6.

[17] U.S. Department of Health and Human Services, Office of Inspector General, *States' Requirements for Medicaid-Funded Personal Care Service Attendants* (Washington, DC, December 2006 revision), 18.

[18] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 19, codified in *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[19] Department of Human Services, "[PCA Quality Assurance] Investigative Process," April 13, 2007.

[20] For desk audits, providers send requested documentation to DHS.

During quality assurance site visits, staff review recipient and personal care assistant files to determine whether all necessary documents are in place. Staff also interview the owner or manager of the personal care provider agency. Staff inform the provider of their findings and follow up with a letter indicating deficiencies and whether a corrective action plan is needed. As appropriate, staff also give the provider educational materials. DHS policy calls for follow-up site visits to agencies 3, 6, and 12 months after the initial review. The process also directs staff to fully document each quality assurance review.

In spite of the process outlined above, we found that:

- **The Department of Human Services has implemented a weak Quality Assurance Review program with limited impact.**

Evidence of this is seen in: (1) the amount of staff and other resources the department has devoted to this area, (2) the breadth of program coverage, and (3) documentation of completed reviews.

DHS has not adequately staffed its PCA quality assurance program.

The number of staff and level of other resources assigned to the quality assurance program are too low to maintain a strong presence. At one time, four staff conducted reviews, with one person focused on desk audits and three conducting field audits. Although the number of PCA providers has grown, currently fewer than two full-time staff conduct reviews for the entire state. In fiscal year 2007, 495 personal care provider and home health agencies were paid for providing PCA services.[21] A full-time equivalent of fewer than two staff cannot provide sufficient attention to this number of agencies.

In addition, DHS suspended work on a database for the Quality Assurance Review program when it reassigned the staff developing it to other tasks. According to the program's lead staff person, the database would have assisted with fieldwork documentation and allowed her to generate summary reports and statistics on review findings. In late 2008, DHS officials told us that work has resumed on this database and it will soon be operational.

Further undermining a strong and proactive Quality Assurance Review program, the breadth of coverage provided by the program is inadequate. Evidence of inadequate coverage is seen in the number of and impetus for quality assurance reviews. We found documentation of 34 quality assurance reviews completed between the program's start in 2006 and mid-2008. Even if DHS conducted 34 reviews a year, it would take staff over 14 years to review all of the personal care and home health agencies that provided services in fiscal year 2007. Furthermore, evidence of follow-up by DHS with providers who have been

[21] This figure includes personal care and home health agencies that were paid through Medical Assistance for providing fee-for-service PCA services in fiscal year 2007.

reviewed is virtually nonexistent. We found evidence of follow-up in only 2 of the 26 quality assurance files we reviewed.[22]

Complaints were the impetus for most of the quality assurance reviews. Reviewing agencies based on complaints may be a sound strategy for prioritizing the use of scarce resources, but ideally a Quality Assurance Review program should include some random and "preemptive" reviews. Reviews of randomly selected agencies would give the department and other interested parties a better sense of the overall quality of personal care provider agencies and the issues that need attention. Preemptive reviews—that is, reviews conducted shortly after a provider's enrollment—would provide initial assurance that personal care provider agencies understand and comply with program requirements. Given concerns voiced by DHS and the Attorney General about the management capabilities of some providers, preemptive reviews seem like a wise idea.

Better documentation of quality assurance reviews could help DHS ensure that they are timely, consistent, and effective.

Finally, DHS quality assurance reviews were poorly documented, contributing to a weak Quality Assurance Review program. We were unable to evaluate the actual work completed by staff because of poor documentation. For example, we could not establish the timeliness of reviews or the extent to which staff adhered to the quality assurance process and procedures. Thorough and clear documentation of reviews could provide management with information on the extent of PCA agencies' compliance and areas of noncompliance. This knowledge could help the department identify topics to include in training or other communication with provider agencies. In addition, documentation could help management ensure that reviews are timely, consistent, and effective.

RECOMMENDATION

The Department of Human Services should strengthen its Quality Assurance Review program by: (1) increasing resources devoted to it; (2) expanding the number and types of reviews; and (3) improving documentation.

DHS needs to closely oversee the agencies that administer PCA services on its behalf. These agencies are not required to go through a licensing process, so it is especially important for them to be reviewed periodically.

SUPERVISION OF PCA SERVICES

From the time that publicly funded personal care services started in Minnesota in the late 1970s, there have been statutory provisions addressing supervision of these services. In 1977, the Legislature authorized Medical Assistance payment

[22] As mentioned above, DHS's investigative process says that follow-up site visits should be conducted after 3, 6, and 12 months. Although we found evidence of 34 completed reviews, we focused our evaluation of program files on site visits instead of desk audits. The eight files that we did not evaluate documented desk audits.

of PCA services "supervised by a registered nurse."[23] In 1999, the Legislature amended PCA supervision requirements in state law by substituting the term "qualified professional" for "registered nurse."[24] Today, for purposes of PCA supervision, "qualified professionals" are defined as registered nurses, mental health professionals, and licensed social workers, and they have the duties outlined in Table 4.2.[25] However, our review of existing statutes also indicated that:

- **Minnesota laws have contradictory provisions governing the requirements for supervision of PCA services.**

Recipients decide whether they want their PCA services supervised by a qualified professional.

Table 4.2: Supervision Duties of a "Qualified Professional"

- Through direct observation or consultation with the recipient, ensure that the personal care assistant is capable of providing the required personal care services.
- Ensure that the personal care assistant is knowledgeable about the care plan before providing personal care services.
- Ensure that the personal care assistant is knowledgeable about the recipient's health conditions and health-related observations that need to be made.
- Through direct observation or consultation with the recipient, conduct written evaluations of PCA services (1) within 14 days after placement of a personal care assistant with the recipient, (2) at least once every 30 days during the first 90 days of PCA services, and (3) at least once every 120 days after the first 90 days of PCA services.
- Review the care plan with the recipient and make necessary revisions at least once every 120 days following development of the plan. Ensure that the personal care assistant and recipient know about any changes in this plan.
- Ensure that records are kept showing the PCA services provided and the time spent doing so.
- Determine that a recipient is still capable of directing his or her own care (or, alternatively, that the recipient has a responsible party).
- Determine with a physician that a recipient is a qualified recipient.

SOURCE: *Minnesota Statutes* 2008, 256B.0655, subd. 13.

[23] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3.

[24] *Laws of Minnesota* 1999, chapter 245, art. 4, secs. 44, 50, 51, 53, and 54.

[25] *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

One part of statutes specifies that PCA recipients (or their responsible parties) "may choose to supervise the personal care assistant or to have a qualified professional…provide the supervision."[26] In contrast, another part of statutes says that "personal care service to a qualified recipient…shall be under the supervision of a qualified professional."[27] Thus, the statutes are at odds regarding whether supervision by a qualified professional is required in all cases or only in cases where the recipient chooses it. But, in practice:

- **DHS allows PCA recipients to forgo ongoing supervision by a qualified professional.**

According to DHS, nurses conducting PCA assessments should offer recipients three supervision options: (1) the recipient will conduct all supervision of the personal care assistant, (2) a qualified professional will conduct all supervision, or (3) the recipient and qualified professional will share supervision tasks. A form developed by DHS requires the assessing nurse and recipient to specify one of these arrangements for each of several supervision tasks.

For certain recipients, DHS supervision requirements are less stringent than those required by state law.

DHS has also authorized supervision responsibilities for some qualified professionals that are less stringent than those in state law. Table 4.2 showed that the law requires qualified professionals to conduct written evaluations of individuals' PCA services at least every 120 days (and more frequently in the early weeks of service). But, for recipients who have opted to get services and qualified professional supervision from a "PCA Choice" agency, the supervision requirements adopted by DHS differ from those in statute. DHS's policies only require a qualified professional who supervises a PCA Choice recipient to visit the recipient "at least once a year."[28] Also, DHS policies do not specify whether the qualified professional must prepare a written evaluation of services in these cases.

To assess the actual extent to which qualified professionals supervise PCA services, we looked at two sources of data. First, we analyzed statewide MA payments to PCA agencies for supervision of fee-for-service recipients.[29] Second, during site visits to 26 PCA agencies, we reviewed documentation of supervision in recipient files. We found that:

- **Most PCA recipients have their services supervised by qualified professionals, but supervision frequency and documentation is sometimes inadequate.**

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[26] *Minnesota Statutes* 2008, 256B.0655, subd. 2(e). This supervision provision was passed by the Legislature in 2001. This section of the law also requires that any health-related tasks delegated to a personal care assistant by a licensed health care professional must be supervised by a qualified professional or under the direction of the recipient's physician.

[27] *Minnesota Statutes* 2008, 256B.0655, subd. 13. This subdivision was added by the 2007 Legislature.

[28] Department of Human Services, *Disability Services Program Manual*, Personal Care Assistance Choice Option.

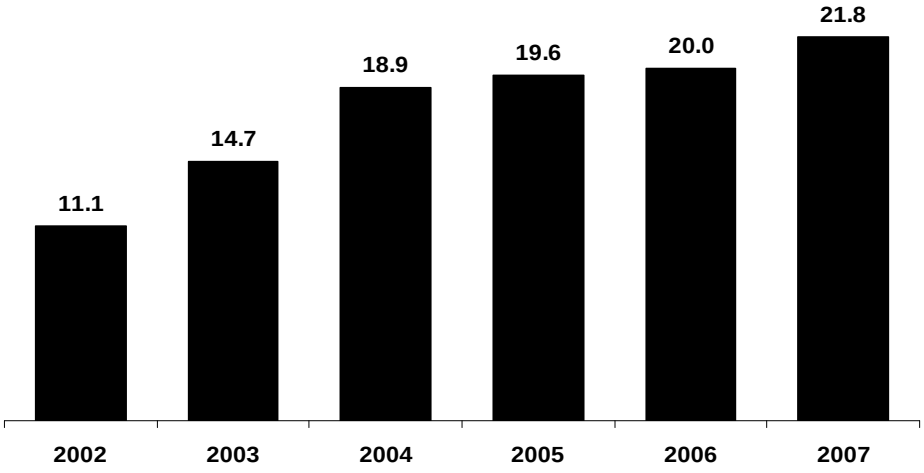
[29] Effective October 2008, the state pays for PCA supervision at a rate of $28.56 per hour.

Our review of statewide payment data indicated that 78 percent of fee-for-service PCA recipients in fiscal year 2007 received paid supervision from a qualified professional. However, Figure 4.1 shows that the percentage of recipients with no paid supervision on their behalf increased from 11 percent in fiscal year 2002 to 22 percent in fiscal year 2007. Furthermore, there were many cases in which the supervision provided by qualified professionals was for modest amounts of time. In fiscal year 2007, one-third of the individuals who received qualified professional supervision received a half hour or less per month, on average.

During our site visits, we examined the extent and nature of supervision by qualified professionals, based on documents in recipient files. We first determined which recipients had elected to receive their supervision from a qualified professional.[30] Of those who had, we found that 82 percent of these recipients had documentation of at least one written evaluation of PCA services in their files. However, only 57 percent of recipients had evaluations of PCA services that complied with the frequencies specified by state law and DHS. Also, many of the written evaluations of PCA services consisted only of checklists, with few or no narrative comments by the qualified professional.

Increasingly, PCA recipients have not had professional supervision of their services.

Figure 4.1: Percentage of Medical Assistance Fee-for-Service PCA Recipients Without Paid Supervision, Fiscal Years 2002-07



SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

[30] Most often, we relied on the recipient's service plan to specify whether the recipient had elected to have supervision by a qualified professional. For files without service plans, we looked for other documentation or talked with the PCA agency's staff to determine supervision arrangements for the recipients. Of the 185 recipients whose files we reviewed, we saw evidence that 151 elected to have supervision by a qualified professional.

In addition, we observed one problem that does not appear to be specifically addressed by statutes, rules, or other state policies. In 2 of the 26 agencies we visited, we saw cases in which a recipient's personal care assistant also served as the recipient's qualified professional. Such an arrangement would not allow for independent supervision of the recipient's PCA services.

We heard significant disagreements from PCA agency directors about the need for ongoing supervision by qualified professionals. On one hand, the director of a PCA agency told us that all of his 90 recipients were capable of supervising their own services. He said his agency has not arranged for qualified professional supervision of any of his recipients during the past year. Recipient files we reviewed at this agency had no documentation about the adequacy of services provided to recipients.

On the other hand, some agency directors told us that all PCA recipients should have ongoing, external supervision. In fact, some directors said they only enroll recipients who are willing to accept periodic supervision of their services by a nurse. They cautioned that even family members and friends who are serving as personal care assistants do not always act with the recipient's best interests in mind.

Supervision by qualified professionals helps protect recipients and provides some accountability to the state for its expenditures.

In our view, ongoing supervision of recipients by qualified professionals serves important purposes. First, supervision helps ensure that vulnerable persons are receiving appropriate services and that their health and safety are being protected. Some service recipients (or their responsible parties) may be capable of judging for themselves—without the assistance of a qualified professional—whether PCA services are meeting recipient needs. But supervision also serves a second purpose, for which the role of the qualified professional seems less dispensable. Supervision by qualified professionals helps provide accountability to the state that its public expenditures have been used wisely—specifically, that services were actually provided, and the caregivers delivered satisfactory care. For this reason, we have serious concerns about state policies that allow recipients to "opt out" of supervision by a qualified professional from their first day of PCA service.

RECOMMENDATIONS

The Legislature should clarify state statutes to ensure that all MA State Plan PCA recipients have their services periodically supervised by a qualified professional.

The Legislature should amend state law to prohibit the same person from serving as both the qualified professional and personal care assistant for a recipient on an ongoing basis.

Individuals who receive PCA services through Medicaid waivers have case managers who help to coordinate and oversee their services. In contrast, recipients who receive services through the Medical Assistance State Plan typically do not have case managers. Thus, while it might be useful for all PCA recipients to have supervision by a qualified professional, it seems especially

important for the Legislature to require ongoing supervision of services for State Plan recipients.

In our view, all PCA recipients should receive some supervision from a qualified professional, although reductions in this supervision should be available when a personal care assistant has served a recipient for an extended period. For instance, perhaps statutes should require PCA services to be evaluated at least every 120 days by a qualified professional during a personal care assistant's fourth through twenty-fourth month of service to a recipient. Subsequently, there could be opportunities for reduction of supervision for those recipients who would prefer this, subject to approval by DHS or the managed care organization that administers the case on behalf of DHS.

In addition, we think that DHS should do more to encourage effective supervision of PCA services by persons other than qualified professionals. For example, DHS should help to ensure that "responsible parties" (where they have been designated) are aware of their duties. State law requires responsible parties to "monitor the services at least weekly according to the plan of care."[31] But, if weekly monitoring by responsible parties occurs, our site visits did not find that it is systematically documented in PCA agency records. Also, some PCA agency directors expressed concern about the lack of active involvement by responsible parties. We liked the approach of one PCA agency that provides its responsible parties with a "contract" that spells out their duties in detail.

Responsible parties and provider agencies could play stronger roles in supervision of PCA services.

RECOMMENDATION

DHS should develop a stand-alone document for PCA assessors and PCA agencies to distribute that clearly and concisely states the duties of a responsible party.

There is a list of responsible party duties in DHS's *PCA Consumer Guidebook.*[32] However, this guidebook is a lengthy document, and it would be useful to have a document focused solely on responsible party duties that could be readily distributed to these parties at the time a recipient is assessed or begins services. Until recently, DHS listed the duties of responsible parties on the standard form used by assessors to develop recipients' service plans. DHS staff told us they would like to develop a "fact sheet" on responsible party roles and a tool that would demonstrate responsible parties' understanding of these roles.

Also, we think that problems with service quality and fiscal integrity are less likely to occur if DHS encourages PCA agency administrators to maintain regular contact with recipients.

[31] *Minnesota Statutes* 2008, 256B.0655, subd. 1h.

[32] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 16.

RECOMMENDATION

DHS should amend its provider manual to require Personal Care Provider Organizations to periodically make visits or phone calls to recipients' residences to verify that scheduled services are actually being provided.

Some PCA agencies periodically make phone calls or unannounced visits to recipients' homes to verify that the personal care assistant is working the scheduled shift. We think this is a good practice, and DHS should provide guidance to agencies about how to do this.

PROTECTION OF VULNERABLE PCA RECIPIENTS

Recipients of publicly funded PCA services are considered vulnerable to maltreatment. According to Minnesota law, individuals age 18 or older who receive services "from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program" are considered to be "vulnerable adults."[33] In addition, state law considers children under 18 to be potentially vulnerable to physical abuse, neglect, or sexual abuse, and it has specific provisions for reporting and investigating allegations involving children served by unlicensed Personal Care Provider Organizations.[34]

Responsibility for Maltreatment Investigations

As shown in Table 4.3, Minnesota law has a complicated set of provisions regarding agency responsibility for maltreatment investigations. The agencies with investigative responsibilities differ, depending on whether the alleged victims are (1) adults or children, and (2) served by licensed or unlicensed PCA agencies. We found that:

- **It is unclear whether alleged maltreatment of PCA recipients has been adequately investigated, partly reflecting confusion about which agencies are required to conduct the investigations.**

For allegations of child maltreatment, Minnesota law gives the Department of Health responsibility for investigations involving unlicensed home care agencies.[35] However, as of late 2008, the Department of Health web site said the

[33] *Minnesota Statutes* 2008, 626.5572, subd. 21. This law also says adults with "a physical or mental infirmity or other physical, mental, or emotional dysfunction" are vulnerable adults. Thus, it is reasonable to assume that adults whose need for PCA services has been documented by a physician would be considered vulnerable, even if they are served by organizations that do not *exclusively* provide PCA services under Medical Assistance.

[34] *Minnesota Statutes* 2008, 626.556, subds. 1, 2(b), 2(i), and 3(c).

[35] *Minnesota Statutes* 2008, 626.556, subd. 3c(c).

Table 4.3: Agency Compliance with Requirements for Investigations of Maltreatment Allegations Involving PCA Recipients

Statutory Assignment of Responsibility[a]	Compliance With This Requirement
Investigations of Alleged Maltreatment of Adults	
Licensed home care providers: State law designates the Minnesota Department of Health (MDH) as the lead investigative agency for licensed home care providers. *Minnesota Statutes* 2008, 144A.46 specifies which agencies must be licensed as "home care providers."	MDH complies with the requirement to conduct maltreatment investigations of the agencies it licenses as home care providers.
Licensed Personal Care Provider Organizations: State law designates the Minnesota Department of Human Services (DHS) as the lead investigative agency for providers licensed as Personal Care Provider Organizations.	There are no organizations licensed as Personal Care Provider Organizations, despite requirements for provider licensure in *Minnesota Statutes* 256B.04, subd. 16. Thus, there are no licensed Personal Care Provider Organizations at which DHS can conduct investigations.
Unlicensed PCA agencies: **MDH:** State law designates MDH as the lead investigative agency for programs "required to be licensed" as home care providers. From 1997 to 2008, *Minnesota Statutes* chapter 144A said that the only Personal Care Provider Organizations exempt from MDH's home care provider licensure were those serving just one person. In 2008, the Legislature exempted all Personal Care Provider Organizations from licensure pending implementation of new provider standards.	Due to lack of legislative funding, MDH did not implement licensure of Personal Care Provider Organizations between 1997 and 2008. During this time, MDH also did not investigate maltreatment involving Personal Care Provider Organizations that were subject to home care provider licensing requirements.
DHS: State law designates DHS as the lead investigative agency for providers "required to be licensed" as Personal Care Provider Organizations.	DHS staff said they have not done investigations involving Personal Care Provider Organizations because there are no requirements for DHS licensure of these agencies.
Counties: State law says that county social service agencies (or their designees) are the lead investigative agencies for "all other reports." This would include reports involving personal care provider agencies not required to be licensed.	DHS did not have a comprehensive system for tracking county adult protection investigations until 2008, so county compliance with statutory investigative requirements is unclear.
Investigations of Alleged Maltreatment of Children	
State law says MDH is responsible for investigating allegations of child maltreatment in unlicensed home health care.[b] The law does not specify which agency shall investigate maltreatment cases involving licensed home care agencies, although MDH has general authority to investigate complaints involving home care providers, as defined in *Minnesota Statutes* 2008, 144A.43, subd. 4.[c]	MDH's web site says that MDH's Office of Health Facility Complaints only investigates complaints related to "licensed facilities."

[a] *Minnesota Statutes* 2008, 626.5572, subd. 13.

[b] *Minnesota Statutes* 2008, 626.556, subd. 3c.

[c] *Minnesota Statutes* 2008, 144A.51-144A.53.

SOURCE: Office of the Legislative Auditor, review of statutes and Department of Health web site, and interviews with agency officials.

State agencies have played a limited role in investigation of PCA-related maltreatment allegations.

department only handled complaints involving *licensed* agencies.[36] This inaccurate description of the department's authority may have discouraged reporting of PCA-related complaints to the department, given that the majority of agencies administering PCA services are unlicensed. In addition, Minnesota's child maltreatment law does not specify which agency is required to investigate cases involving home care providers licensed by the Department of Health.[37] The Department of Health told us it received only six PCA-related child maltreatment allegations during a recent 30-month period. Four involved unlicensed agencies and two involved licensed agencies.

For allegations of adult maltreatment, the Department of Human Services is supposed to investigate maltreatment in agencies "licensed or required [by law] to be licensed" as Personal Care Provider Organizations.[38] However, the law does not specifically require licensure of Personal Care Provider Organizations, so DHS has not conducted PCA-related maltreatment investigations.[39] The law also requires the Department of Health to investigate maltreatment in agencies "which are licensed or are required to be licensed" as home care providers. Between 1997 and 2008, *Minnesota Statutes* chapter 144A required that certain Personal Care Provider Organizations be licensed by the Department of Health as home care providers, although the Legislature did not fund implementation of licensure.[40] The Department of Health has not conducted investigations of adult maltreatment in unlicensed PCA agencies.

Table 4.3 also shows that county agencies are supposed to investigate adult maltreatment allegations that are not within the purview of the departments of Health or Human Services. Unfortunately, it is difficult to know the extent of

[36] Department of Health, http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm, accessed December 8, 2008. Department of Health officials told us they will clarify on the web site that the department does, in fact, conduct child maltreatment investigations in unlicensed PCA agencies.

[37] *Minnesota Statutes* 2008, 626.556, subd. 3c, gives the Department of Health responsibility for investigating child maltreatment in facilities licensed under *Minnesota Statutes* 144.50 to 144.58. However, it does not address providers licensed as home care providers under *Minnesota Statutes* 144A.46.

[38] *Minnesota Statutes* 2008, 626.5572, subd. 13(b).

[39] *Minnesota Statutes* 2008, 256B.04, subd. 16, requires the departments of Human Services and Health to jointly develop rules "to be applied to the licensure of personal care services provided under the medical assistance program." The law does not specify whether this requirement pertains to licensure of agencies or individuals, although DHS is given responsibility for determining which standards are appropriate. Rules for licensing Personal Care Provider Organizations have never been implemented, and DHS officials told us that the Legislature has not communicated a desire for DHS to expand its maltreatment investigation duties to include unlicensed PCA agencies.

[40] From 1997 to 2008, *Minnesota Statutes* 144A.46, subd. 2, exempted from home care provider licensure "a person or organization that exclusively offers, provides, or arranges for personal care services to only one individual under the medical assistance program." Other personal care organizations were not exempt. However, *Laws of Minnesota* 2008, chapter 230, sec. 7, applied the exemption to all personal care organizations until new provider standards are implemented.

county investigations involving PCA because DHS did not implement a comprehensive case tracking system for county investigations until 2008.[41]

Disagreements about agencies' investigative authority can impede timely maltreatment investigations.

Agency disagreements about how to interpret state maltreatment statutes have sometimes been an impediment to timely, effective investigations. In a 2006 report about the death of a PCA recipient, Minnesota's Ombudsman for Mental Health and Mental Retardation said: "For a period of time, it appeared that no one was going to investigate this case."[42] Eventually, a county agency conducted an investigation at the ombudsman's urging.[43] But, because of the jurisdictional disputes in this case, the ombudsman recommended that the Legislature amend vulnerable adult laws to specify one entity to be the lead investigative agency in cases involving PCA services. The Legislature has not taken this action.

RECOMMENDATIONS

The Legislature should amend statutes to give the Department of Human Services responsibility to investigate all reports of maltreatment involving unlicensed personal care provider agencies paid through DHS-administered health care programs.

The Legislature should amend Minnesota Statutes 626.556 so that the Department of Health is responsible for investigating alleged child maltreatment involving personal care services provided by agencies licensed by the department as home care providers.

We think it would be best for the Legislature to give DHS the responsibility to conduct maltreatment investigations involving all unlicensed personal care provider agencies. DHS already has authority to enroll these agencies to deliver PCA services and monitor their compliance with state requirements. For licensed provider agencies, we think it makes sense for the licensing agency to conduct maltreatment investigations, although the statutes regarding the Department of Health's authority in this area need clarification.[44]

[41] Counties were asked to enter information into the tracking system from January 2008 forward. DHS staff told us that, as of late 2008, all counties except Hennepin had entered their 2008 information.

[42] Office of Ombudsman for Mental Health and Mental Retardation, *In Re the Death of Jesse David Anderson* (St. Paul, January 13, 2006), 19. This office is now called the Office of the Ombudsman for Mental Health and Developmental Disabilities.

[43] The administering agency provided some of its PCA services as a Personal Care Provider Organization and some as a Department of Health-licensed home health agency. The Department of Health reviewed the case's compliance with Minnesota's "Home Care Bill of Rights" but later forwarded the case to the county because department staff believed they lacked jurisdiction to act.

[44] Sometimes a PCA agency is a licensed provider of some services and an unlicensed provider of others, further complicating the issue of which state agency should investigate maltreatment allegations. For such cases, the Legislature should consider ways to ensure continuity in the investigative process—for example, by authorizing a single state agency to investigate all issues related to a provider's licensed or unlicensed operations, or by authorizing joint investigations by the departments of Health and Human Services.

In addition, we observed that:

- **For children served by unlicensed personal care provider agencies, Minnesota law does not require that allegations of maltreatment be reported to independent agencies.**

When persons who are mandated by law to report abuse or neglect become aware of possible maltreatment in a *licensed* facility, they are required by law to make a report to the agency responsible for the facility's licensure.[45] But in cases of alleged child maltreatment in *unlicensed* personal care agencies, this law appears to require reporting to the unlicensed provider agency.[46] In our view, this does not provide adequate assurance that the report will be investigated, particularly if employees of the unlicensed agency are the alleged perpetrators.

RECOMMENDATION

The Legislature should amend Minnesota Statutes 626.556, subd. 1, to require that reports of maltreatment involving children served by unlicensed personal care provider agencies be made to the Department of Human Services.

Individual Abuse Prevention Plans

We also examined the extent to which PCA agencies take steps to prevent maltreatment of the recipients they are serving. State law requires all licensed and unlicensed personal care providers to develop an individual abuse prevention plan for each adult recipient. According to the law, this plan must include:

> [A]n individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.[47]

We found that:

- **There is noncompliance with the state requirement for PCA agencies to develop individual abuse prevention plans for their adult recipients.**

[45] *Minnesota Statutes* 2008, 626.556, subd. 3. For children, this statute defines a "mandated reporter" as a professional (or a professional's delegate) who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement.

[46] *Ibid.*

[47] *Minnesota Statutes* 2008, 626.557, subd. 14(b).

DHS should monitor PCA providers' compliance with state requirements for individual abuse prevention plans.

During our visits to 26 PCA agencies, we examined whether the files of 144 adult service recipients contained individual abuse prevention plans. We found that only 29 percent of these recipients had such plans in their files. In addition, it is worth noting that there is no requirement in state law for personal care provider agencies to develop abuse prevention plans for the *children* they serve.

RECOMMENDATIONS

The Department of Human Services should (1) remind PCA agencies about their obligation to develop individual abuse prevention plans and (2) monitor compliance with this requirement during quality assurance reviews.

The Legislature should consider whether to require PCA agencies to develop individual abuse prevention plans for children, as the law requires for adults.

Criminal Background Checks

Another way that PCA agencies help ensure the safety of their recipients is by initiating criminal background checks on their employees. We found that:

- **DHS has taken important steps in recent years to ensure that the individuals providing PCA services have the required criminal background checks.**

For more than a decade, state law has required criminal background checks for all personal care assistants. However, a 2005 DHS study found that 19 percent of personal care assistants statewide did not have a completed background check on file at the time the person provided services to recipients.[48] In 2005, DHS adopted a policy requiring the state enrollment of individual personal care assistants before PCA agencies could be reimbursed for their services.[49] When a personal care assistant enrolls with DHS, the provider agency that will employ the assistant initiates a background check by DHS. Probably because of this requirement, we found documentation of background checks in nearly all employee files we reviewed at PCA agencies. We reviewed the files of personal care assistants at 26 agencies. In 97 percent of these cases, we found documentation that a background check had been completed at the time the personal care assistant provided services in April 2008.[50]

[48] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study: Compliance with DHS Policies* (St. Paul, September 2005), 2.

[49] Department of Human Services, "Individual Personal Care Assistant Enrollment," MHCP Provider Update PCA-05-01 (June 28, 2005).

[50] There were 225 personal care assistants for whom we collected information on background checks.

State background checks have screened out many potentially risky caregivers, but they do not guarantee the safety of service recipients.

Existing background check practices do not guarantee the safety of PCA recipients. As with employees of other types of human services and health care agencies, a personal care assistant can begin providing services to a recipient once a state background check has been *initiated* but before it has been *completed*.[51] In addition, a background check is done when a personal care assistant first seeks employment with a PCA agency, but there is no requirement for the agency to subsequently obtain updated background checks of the employee. Thus, it is possible that PCA agencies may be unaware of offenses by employees since the time of their most recent background checks.[52] Also, most background checks do not examine whether an individual has prior criminal offenses in states other than Minnesota.[53] Despite these limitations, background checks provide an important method of screening out individuals who might pose a risk to vulnerable recipients. Between January 2006 and June 2008, DHS conducted nearly 59,000 background checks on people seeking to work for unlicensed personal care provider agencies, and more than 3,100 people (5.3 percent) were disqualified from serving as a personal care assistant on the basis of these checks.[54]

Although background checks help to safeguard recipients from personal care assistants with criminal histories:

- **Minnesota law does not require that DHS conduct background checks of all qualified professionals who supervise PCA services.**

For recipients who receive services from a PCA Choice agency, statutes specify that one of the agency's duties is to "request and secure background checks [from DHS] on personal care assistants and qualified professionals."[55] But for other recipients, there is no requirement for agencies to obtain background checks on qualified professionals.

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[51] *Minnesota Statutes* 2008, 245C.04, subd. 3. *Minnesota Statutes* 2008, 245C.13, subd. 2, requires such individuals to be under "continuous direct supervision."

[52] In our review of personal care assistants' files during site visits, 77 percent of the most recent background checks for PCAs we reviewed were conducted since January 2006. One personal care assistant's most recent background check was from 1996; this was the oldest "current" background check we saw. *Minnesota Statutes* 2008, 245C.05, subd. 7, requires probation officers to notify DHS of an individual's criminal conviction if the person is affiliated with a DHS-regulated program. The extent to which these notifications occur is unclear.

[53] *Minnesota Statutes* 2008, 144.057, subd. 1, requires that background checks of individuals who work for licensed home care agencies must include a search of criminal history records in the state where the person resides. This is not a requirement for unlicensed PCA agencies, although *Minnesota Statutes* 2008, 245C.02, subd. 15, authorizes DHS to search records from other states if DHS has "reasonable cause" to believe the subject has a history that would disqualify the individual or pose a risk to others. In 2007, DHS requested fingerprints from individuals (for purposes of a multi-state background check) in 1.4 percent of its 22,940 background checks related to personal care provider agencies.

[54] DHS disqualified a higher percentage of potential personal care assistants due to failed background checks than it disqualified for most other types of services for which it conducted background checks.

[55] *Minnesota Statutes* 2008, 256B.0655, subd. 7.

RECOMMENDATION

The Legislature should amend Minnesota statutes to require all agencies providing personal care services to obtain background checks on their qualified professionals.

In our view, the statutes should be amended so that qualified professionals are subject to background checks, regardless of the type of agency for which they work.

ADEQUACY OF CONSUMER INFORMATION

Service recipients need good information to make informed choices.

Users of PCA services should have the information needed to make informed choices and report problems when they arise. During our evaluation, we heard various concerns from consumer advocates, DHS staff, and others about the adequacy of consumer information. Our review of these issues was not exhaustive, but this section discusses selected problems that need attention.

Information on Maltreatment Reporting

Because of the complicated provisions in state law for investigation of maltreatment allegations involving PCA recipients, we wondered whether individual recipients get clear, consistent information about whom to contact with complaints or concerns. Each PCA agency determines the types of information its recipients need when they begin services. DHS has distributed thousands of copies of its *PCA Consumer Guidebook* over the past several years, although there is no requirement that recipients receive a copy. We examined the "Consumer Safeguards" portion of DHS's guidebook to see what advice it offers to potential victims of maltreatment. We found:

- **DHS has not provided PCA recipients and responsible parties with adequate information about which agencies to contact with concerns about abuse or neglect.**

The DHS guidebook gives examples of physical abuse, sexual abuse, and financial exploitation; it does not give examples of neglect. The guidebook then says: "If any of these types of abuse are happening to you, you need to report this immediately to someone who can help you. This could be your case manager, a friend or family member, or your PCA agency. If you are in immediate danger, call 911."[56]

In our view, the information provided in the DHS guidebook is not sufficiently helpful. Most PCA recipients do not have a "case manager," and some may be

[56] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 17.

DHS should provide recipients with better information for reporting abuse and neglect.

uncomfortable disclosing a concern to a friend, family member, or PCA agency (especially if a PCA agency's employee is the source of the concerns). Also, each county is required by law to have a "common entry point" for reports of suspected maltreatment, but the DHS guidebook does not mention this. In addition, DHS quality assurance staff investigate quality-related consumer complaints, but the guidebook does not indicate how to contact these staff. Furthermore, the guidebook provides minimal explanation of the roles played by three state ombudsman offices on behalf of recipients. The guidebook has only a brief mention of the Ombudsman for Mental Health and Developmental Disabilities, and it does not mention the Ombudsman for Managed Care. The guidebook lists issues the Ombudsman for Long-Term Care can address, including "abuse or neglect issues." But staff with the Ombudsman for Long-Term Care office told us that consumers often do not know whom to contact with concerns, and even the ombudsman staff sometimes struggle to advise recipients about where to report their concerns.

RECOMMENDATION

The Department of Human Services should develop a concise, useful document that indicates whom PCA recipients can contact with service-related concerns. The department should require all PCA agencies to distribute this to recipients.

Information to Help Consumers Select Providers

We also observed that:

- **DHS provides consumers (and the agencies that help consumers select providers) with little information to help them make informed choices of personal care provider agencies.**

DHS has a provider directory on its web site. Under "Personal Care Services," the directory lists nearly 1,000 PCA agencies. The agencies can be sorted by location, but other information to distinguish the agencies is very limited.

RECOMMENDATION

DHS should post relevant documents from its quality assurance reviews of PCA agencies on its public web site.

At a minimum, we think that DHS should give consumers access to information from its recent quality assurance reviews. For example, it might be helpful for consumers (or agencies that help consumers find appropriate services) to see (1) the DHS letter summarizing the findings of a quality assurance review and (2) the provider's corrective action plan. This will be more useful once DHS conducts reviews of a larger number of PCA agencies. In general, however, we

think that well-done quality assurance reviews could provide some insights for consumers seeking a reputable PCA agency.

Copies of PCA Assessments

The information collected during a PCA assessment could be helpful to the PCA agency that eventually must oversee services for this individual. However:

- **Agencies that conduct or arrange for PCA assessments do not always send copies of the assessments to the PCA agencies that will provide services to the recipient.**

Staff at several PCA agencies told us this has been a problem for both fee-for-service and managed care service recipients. Agency staff prefer to know as much as possible about the individuals they will be serving. Although PCA recipients may develop their own care plan, they may also develop it with assistance from the PCA agency's qualified professional or the recipient's doctor.

Provider agencies should be able to obtain copies of their service recipients' assessments.

RECOMMENDATION

The Legislature should require counties and managed care agencies that arrange for PCA assessments to provide timely copies of the assessment reports to PCA agencies that will be providing services, if they request them.

A copy of the assessment findings can be a useful resource during development of the care plan. Currently, state law does not specifically require the counties or managed care organizations responsible for assessments to send copies of the assessment reports to the relevant provider agencies.

Some PCA agencies also said they have not received copies of PCA recipients' service plans from counties or managed care organizations. Existing law and state policy already require timely provision of service plans to recipients and providers, so we offer no recommendation for statutory change.[57] However, PCA agencies should inform DHS of noncompliance so that DHS can enforce this requirement.

Home Care Bill of Rights

In our discussions with PCA recipients, recipient advocates, PCA agencies, and others, we heard a variety of other concerns regarding the quality of services provided to recipients. We did not independently confirm most of these reports, but many of the concerns were credible and should be taken seriously. For example, we heard reports of: personal care assistants who exploited recipients through unauthorized use of bank or long-distance calling cards; personal care

[57] *Minnesota Statutes* 2008, 256B.0655, subd. 1i, and Department of Human Services, *Clarification of Policy for Personal Care Assistant Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 7.

assistants who reportedly borrowed money from recipients or stole items from a recipient's household; and PCA agencies that have served as landlords to their recipients, potentially restricting the ability of the recipients to move to other locations. We saw an example of a "noncompete agreement" that personal care assistants employed by one PCA agency were asked to sign, potentially limiting the ability of recipients to use a personal care assistant who chose to seek employment at a different PCA agency. We also saw examples of service reduction notices sent to recipients that were poorly worded or did not carefully explain the changes in the recipient's services.

Minnesota state law contains a "Home Care Bill of Rights" to help protect people receiving home care services.[58] This law establishes 21 rights that home care consumers have, such as the right to refuse services and the right to choose freely among service providers. However:

- **The extent to which PCA recipients have been made aware of Minnesota's Home Care Bill of Rights is unclear.**

State law establishes protections for home care recipients, but these have not always been communicated to PCA recipients.

The law says the Home Care Bill of Rights is established "for the benefit of persons who receive home care services," apparently including personal care services.[59] Also, the law says: "A copy of these rights must be provided to an individual at the time home care services are initiated."[60] But the bill of rights posted on the Department of Health's web site as of late 2008 declared that it only pertains to licensed facilities.[61] We are not aware of specific DHS policies or instructions regarding the distribution of the bill of rights to PCA recipients. In 2008, a DHS work group's meeting minutes said: "Most PCA agencies do not provide [information on the bill of rights] nor are they required to unless they have licensure from the Minnesota Department of Health."[62]

RECOMMENDATION

The Legislature should amend statutes to explicitly require unlicensed personal care provider agencies to provide Minnesota's Home Care Bill of Rights to the recipients they serve. The Department of Human Services should incorporate discussion of the bill of rights into its training program for PCA agencies.

We think the applicability of the Home Care Bill of Rights to unlicensed personal care provider agencies needs to be explicitly addressed in statute. The bill of rights might not prevent service problems from arising. However, if these rights

[58] *Minnesota Statutes* 2008, 144A.44.

[59] *Minnesota Statutes* 2008, 144A.44, subd. 1, and 144A.43, subd. 3.

[60] *Minnesota Statutes* 2008, 144A.44, subd. 2.

[61] In December 2008, the Department of Health told us that it intends to clarify on its web site that the bill of rights applies to all PCA provider agencies.

[62] Department of Human Services, Consumer Health and Safety/Quality Assurance Topic Team, June 24, 2008, meeting minutes.

are given to service recipients in a clear, understandable way, they might help consumers determine whether to initiate a complaint or an appeal.

PERSONAL CARE ASSISTANT WORK HOURS

In Chapter 3, we noted that DHS has made payments to PCA agencies for some personal care assistants whose reported workdays or workweeks were very lengthy. In some cases, DHS paid for amounts of services by personal care assistants that we said were implausible, apparently reflecting improper payments by DHS. In addition:

- **Long work hours claimed for some personal care assistants raise questions about the quality of services provided.**

Frequently, personal care assistants work hours in excess of those recommended by Minnesota's Ombudsman for Mental Health and Mental Retardation. In a 2006 report, the ombudsman offered the following opinion: "No PCA should be allowed to work more than 40 hours per week except for extraordinary or emergency situation[s]."[63]

We reviewed claims for PCA services provided in May 2008 to determine the extent to which personal care assistants' workweeks fell within the ombudsman's recommendation. One-fifth of the weeks that personal care assistants worked in May 2008 exceeded 40 hours per week (13,208 of 63,163). Ten percent of the workweeks (6,460) included 50 hours or more of PCA services, and 6 percent (3,837) included 60 hours or more.[64]

Table 4.4 shows that almost 4,500 personal care assistants worked more than 40 hours at least one week in May 2008. These workers represented almost 25 percent of the personal care assistants who worked at least one week during the month. Almost 13 percent of the personal care assistants worked all four weeks in excess of 40 hours. Of more concern, claims data show that almost 4 percent of personal care assistants worked four workweeks of 60 hours or more.

[63] Office of Ombudsman for Mental Health and Mental Retardation, *In Re the Death of Jesse David Anderson*, 20. This office is now called the Office of the Ombudsman for Mental Health and Developmental Disabilities.

[64] We counted weeks as Sunday through Saturday, beginning Sunday, May 4, 2008. If a personal care assistant worked any hours during the week, we counted the week as a workweek. The claims we reviewed are described in Chapter 3 and include those with implausible work hours.

Excessive work hours raise questions about service quality and safety.

Table 4.4: Personal Care Assistant Workweeks, May 2008

Personal Care Assistants Whose Claimed Work Included:	Number	Percentage of PCAs who Worked in May 2008 (N=18,143)
Any workweeks over 40 hours	4,499	24.8%
Four workweeks over 40 hours	2,274	12.5
Any 50-plus hour workweeks	2,279	12.6%
Four 50-plus hour workweeks	1,101	6.1
Any 60-plus hour workweeks	1,350	7.4%
Four 60-plus hour workweeks	645	3.6

NOTES: Includes personal care assistants who worked at least one week in May 2008. Weeks are measured Sunday through Saturday, beginning Sunday, May 4, 2008. Some assistants worked fewer than all four weeks. Claims include those reflecting implausible workdays, such as those exceeding 24 hours a day.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

We also looked at the length of personal care assistants' workdays, as reported in the claims of the personal care provider agencies. As Table 4.5 shows, a small percentage of personal care assistants provided care for very long hours, day after day. For example, according to claims data, 469 personal care assistants provided 10 or more hours of care a day for 16 or more days in a row. In fact, according to claims, 288 personal care assistants provided 10 or more hours of care every day of the month.

If the excessive claimed work hours were actually worked, they raise real concerns about the quality and safety of care that recipients are getting from fatigued personal care assistants. If the assistants identified in the claims did not actually work the hours attributed to them, it raises two additional concerns about the quality of care. One concern is that some recipients may not be getting the reported care. Second, if people other than the staff identified in the claims are providing the hours of care claimed, DHS has no way of knowing who is actually providing the care and whether these staff meet the requirements for being a personal care assistant. For example, it is not known whether the person providing the care would pass a criminal background check.[65]

[65] It is clear that some personal care provider agencies are submitting claims that do not reflect who is actually providing the personal care services. For example, our review of claims across all provider agencies indicated that some personal care assistants were reported to have provided more than 24 hours of care in a day.

Table 4.5: Personal Care Assistant Claimed Work Hours, May 2008

Personal Care Assistants Whose Claimed Work Included:	Number	Percentage of PCAs who Worked in May 2008 (N=18,330)
16 or more consecutive workdays lasting:		
8 hours or more	908	5.0%
10 hours or more	469	2.6
12 hours or more	227	1.2
16 hours or more	57	0.3
20 hours or more	19	0.1
31 consecutive workdays lasting:		
8 hours or more	594	3.2%
10 hours or more	288	1.6
12 hours or more	118	0.6
16 hours or more	27	0.1
20 hours or more	10	0.1

NOTE: Claims include those reflecting implausible workdays, such as those exceeding 24 hours a day.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

PERSONAL CARE ASSISTANT TRAINING AND COMPENSATION

Some recipients want their caregivers to have better training.

Personal care assistants should provide reliable, competent services consistent with recipients' care plans. In a state-sponsored survey of PCA recipients in 2003, 80 percent said their personal care assistants did not need more training.[66] But, when asked to identify one thing they would change about their PCA services, the survey respondents most often cited issues related to PCA wages, training, and recruiting.[67] We heard concerns from some recipients and their family members about caregivers who did not have sufficient understanding of the recipient's disability or failed to show up on time to provide services. Thus, we looked at statutory provisions regarding training and talked with PCA agencies about how they train their employees.

State law requires personal care assistants to meet at least one of the five training options shown in Table 4.6. Four of the options involve formal training programs, such as a program that trains nursing assistants. The fifth option does not involve a formal training program. Rather, under this option, the PCA agency makes a determination that the personal care assistant has appropriate skills, whether through training or experience. During our site visits to PCA agencies, we asked agency directors to provide us with information on how a

[66] Bailey, *Minnesota's 2003 PCA Consumer Survey*, 26.

[67] *Ibid.*, 22.

sample of their employees met the statutory training requirements.[68] We found that:

- **Staff with limited amounts of formal training provided most PCA services, and PCA agencies varied significantly in the way they trained their employees.**

Of 306 personal care assistants on whom agencies provided information to us, 84 percent met the state training requirements solely through the PCA agency's determination of competence, not a formal training program.

Many personal care assistants have not completed a formal training program.

Table 4.6: Personal Care Assistant Training Requirements in Minnesota Law

Personal care assistant training must include successful completion of one or more of the following:

1. A nursing assistant training program or its equivalent, for which competency is determined by a statewide test.
2. A homemaker home health aide pre-service training program, using a curriculum recommended by the Department of Health.
3. An accredited education program for registered nurses or licensed practical nurses.
4. A training program that provides the skills required to perform PCA services specified in law.
5. A determination by the personal care provider that the personal care assistant has, through training or experience, the skills required to perform the PCA services specified in law.

SOURCE: *Minnesota Statutes* 2008, 256B.0655, subd. 1f(b).

During our site visits to 26 PCA agencies, we asked agency administrators to explain how they train their personal care assistants. State policies do not address the content of agencies' in-house training, and we found that agencies' training practices varied considerably. Some agencies had detailed training curricula. For example, one agency requires all personal care assistants to complete 18 hours of training on general policies and procedures, first aid, and medication supervision within their first six months of employment. This agency also requires employees to annually complete courses on topics such as suicide prevention and vulnerable adult policies. Other agencies handled training more informally—through one-on-one instruction at the agency or the recipient's

[68] At each agency, we selected a sample of 15 recipients who received services during April 13-19, 2008. We reviewed the files of up to 16 personal care assistants associated with these recipients. If the recipients had more than 16 assistants during this period, we selected a sample of 16.

home. DHS does not offer in-person training courses for caregivers, but many agency directors told us they would welcome any training DHS could offer.[69]

Except in cases where the recipients choose to train their own personal care assistants, we think it makes sense for PCA agencies to retain primary responsibility for employee training. PCA services are scattered around the state, and it would be expensive and logistically difficult for DHS to provide timely training to personal care assistants throughout the state. However, we think DHS could provide stronger guidance on training.

DHS should provide more guidance about the training caregivers need.

RECOMMENDATION

The Department of Human Services should define a set of topics on which personal care assistants should receive training.

While it would not make sense for DHS to train caregivers on how to meet the needs of particular individuals, DHS should identify general policies and procedures that all personal care assistants need to understand. The training topics identified by DHS could address various issues, ranging from proper timesheet reporting to practices for preventing the spread of infections. DHS should monitor compliance with training requirements during quality assurance reviews. Also, DHS should consider ways it could help recipients and PCA agencies to train their employees—perhaps by: (1) directing them to useful training resources, (2) developing training materials or videos that recipients and PCA agencies could use, or (3) contracting with vendors that offer meaningful online training.

In addition to wanting well-trained personal care assistants, PCA recipients told us they would like to have adequately compensated caregivers. Some recipients said that low wages contribute to staff turnover. Agency directors told us that wage levels can be an important factor in their ability to attract (or retain) recipients or personal care assistants.

At the time of our site visits, the state paid PCA agencies $15.92 per hour of direct care services provided. From this amount, agencies paid for payroll taxes, workers compensation, unemployment insurance, liability insurance, and bonding (altogether, an estimated $1.36 per hour, according to one agency). In addition, agencies paid for general overhead expenses, such as rent and utilities, billing costs, administrative and support staff, and employee background checks.

We obtained data on personal care assistant wages from 25 of the PCA agencies we visited.[70] Our sample is not necessarily representative of all personal care assistants, but it provides an indication of wages at a group of randomly selected

[69] DHS has a contract with the College of Direct Support, which provides online training in topics related to personal care assistance. The cost of this contract has been about $70,000 per year. However, use of the training by provider agencies and individuals has been very limited, and the online training information has not been customized to address Minnesota-specific requirements.

[70] We requested wage data for the personal care assistants whose training credentials we reviewed.

agencies. The median wages at individual PCA agencies ranged from a low of $9.00 an hour at an agency in southeastern Minnesota to $12.25 an hour at an agency in a western Twin Cities suburb. Among the 299 employees on whom we collected wage data, the median wage was $10.45 an hour. Two agencies that mainly served PCA Choice recipients had higher median salaries than other agencies, probably because they did not have to recruit, train, and supervise employees as extensively as other agencies.

5 Other Issues

The earlier chapters of this report have addressed issues that affect the overall integrity of personal care assistance (PCA) services—particularly assessment of recipients, financial oversight, and quality assurance. This chapter addresses several additional PCA issues that deserve the Legislature's consideration. These issues include: (1) the use of family members as personal care assistants, (2) the adequacy of PCA services for people with behavioral health issues, (3) standards for PCA provider agencies, and (4) the basis of judges' decisions in PCA appeals.

USE OF FAMILY MEMBERS AS PERSONAL CARE ASSISTANTS

Over the years, there has been significant change in the state's policy about who can serve as a personal care assistant. When the Legislature first authorized Medical Assistance expenditures for PCA services in 1977, the law specified that services could not be provided by a family member of the recipient.[1] In 1990, the Legislature enacted narrower restrictions, stating that PCA services could not be provided by the recipient's spouse or legal guardian, nor could parents serve as personal care assistants for their children under age 18.[2] In 1991, the Legislature also prohibited the provision of PCA services by (1) parents of adult recipients, (2) adult children of recipients, or (3) adult siblings of recipients, unless the relative met one of the "hardship criteria" specified in law and received a waiver from the Department of Human Services (DHS).[3] The 2003 Legislature repealed the requirement for hardship waivers, making it easier for certain relatives to provide PCA services.[4] Since then, Minnesota law has allowed relatives to serve as personal care assistants, with two major exceptions: people may not serve as personal care assistants for their spouses or minor children. According to a 2004 survey, 18 of 24 responding states that offered PCA services to adults under a

[1] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3.

[2] *Laws of Minnesota* 1990, chapter 568, art. 3, sec. 51.

[3] *Laws of Minnesota* 1991, chapter 292, art. 7, secs. 11-12. The hardship criteria adopted into law in 1991 included relatives who: (1) resigned from a job to provide PCA services for the recipient, (2) went from a full-time job to a part-time job to allow time to provide personal care, (3) took a leave of absence without pay to provide personal care, (4) incurred substantial expenses to provide personal care, or (5) must provide personal care due to labor shortages of qualified personal care assistants.

[4] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 27.

Medicaid state plan said they allowed family members other than spouses and minor children to be personal care assistants.[5]

Some people expressed concerns to us about the state's reduced restrictions on people serving as personal care assistants to family members. First, they suggested that repeal of the hardship waiver may have been a factor in recent growth in the size of Minnesota's PCA recipient population. Unfortunately, DHS does not collect information on familial connections between PCA recipients and providers. Thus, we were unable to determine how many recipients have a relative as a personal care assistant, nor could we examine trends in this over time.

Second, some people expressed concern that paid care by relatives of recipients might sometimes encourage fraud or weaken the quality of care. For example, some PCA assessment agencies told us that family members have tried to convince assessors that recipients' service needs are greater than they really are. One PCA agency told us it does not hire family members to serve as personal care assistants because it prefers to have clear "professional boundaries" between recipients and their personal care assistants. Some people suggested that recipients may be less inclined to report problems with the amount or quality of services actually provided when the personal care assistant is a family member.

Allowing certain family members to be paid as caregivers can be beneficial.

On the other hand, many people told us that it is important to preserve the option of using family members as caregivers. Some PCA agencies mostly use family members as caregivers for immigrants or other recipients with limited English skills. Staff at these agencies said that, in many cases, family members can communicate with recipients and win their trust more effectively than others. Also, some people told us that family members may have a stronger incentive to provide reliable, high-quality care to recipients than people who have no ongoing connections with the recipients.

Overall, we concluded that:

- **Minnesota's existing policies about the use of family members as personal care assistants are reasonable, and we offer no recommendations for changes.**

For the most part, people who expressed concerns about family members serving as personal care assistants did not favor eliminating this option or reinstating past restrictions such as the hardship waiver. In our view, the potential benefits of using family members as personal care assistants are significant. We think that any risks of relying on family members as caregivers can be mitigated through

[5] Laura L. Summer and Emily S. Ihara, *The Medicaid Personal Care Services Benefit: Practices in States That Offer the Optional State Plan Benefit* (Washington, DC: Georgetown University Health Policy Institute, 2005), Table 12. The authors identified 26 states and the District of Columbia that offered the personal care services benefit to adults under their Medicaid state plans. Three states did not respond to the survey question about state restrictions on family members as service providers.

general improvements in the supervision and oversight of PCA services, as recommended elsewhere in our report.

ADEQUACY OF SERVICES FOR PEOPLE WITH BEHAVIOR ISSUES

Since 1993, Minnesota law has authorized the use of PCA services for "redirection and intervention for behavior, including observation and monitoring."[6] There has been a large, recent increase in the number of PCA recipients assessed as having behavior issues or mental health issues, as discussed in Chapter 2. Some people attributed the increase to reductions in other types of institutional or community-based services for individuals. In addition, assessors expressed frustration about the difficulties they have experienced in trying to accurately assess and determine services for people with behavior issues.

Some people with behavior issues need more help than personal care assistants can provide.

We did not evaluate whether Minnesotans with behavior issues are being adequately served by PCA or other services. This is a large, complex issue. Personal care assistance may play an important role in the lives of people with behavior issues. However, some persons with significant behavior issues need more help than personal care assistants with minimal training can provide. This additional help could include specialized interventions or treatment, perhaps by trained mental health professionals or behavior aides.

Earlier, we recommended that DHS provide additional guidance to PCA assessors to help ensure consistent, sound recommendations about the nature and quantity of PCA services for people with behavior problems. In addition, we think DHS should continue to examine broader issues about the adequacy and quality of services—PCA and others—for people with behavior problems and mental health issues. We offer no specific recommendations because this is already an ongoing responsibility of DHS. However, DHS should consider ways to evaluate existing services and recommend any necessary improvements.

STANDARDS FOR PCA AGENCIES

Regulation of PCA agencies has been a recurring issue for the Legislature. Most of Minnesota's personal care services are provided by unlicensed staff who work for unlicensed agencies. The 1991 Legislature required the departments of Human Services and Health to jointly promulgate licensing rules for personal care services funded by Medical Assistance.[7] In 1992, DHS issued a report stating that "minimum safety and quality of care standards can be attained most efficiently and cost effectively through licensure of agencies, rather than through

[6] *Minnesota Statutes* 2008, 256B.0655, subd. 2(c)(16).

[7] *Laws of Minnesota* 1991, chapter 292, art. 7, sec. 8, as codified in *Minnesota Statutes* 2008, 256B.04, subd. 16.

licensure of individuals."[8] DHS recommended licensure of agencies that provide up to 75 percent of their personal care services through Medical Assistance. DHS staff told us that, largely because of cost concerns, legislation to implement these recommendations did not pass.

The 1997 Legislature required the Department of Health to draft rules on licensure of personal care providers for the Legislature's consideration.[9] The department did so, and it estimated that the annual cost of administering a licensure program for 150 PCA agencies would be about $1 million.[10] According to DHS staff, the Legislature did not appropriate funds to cover these costs and licensure was not implemented. Nonetheless, from 1997 to 2008, the only personal care agencies exempted in law from state licensure requirements were agencies that served one individual under the Medical Assistance program.[11]

In 2008, the Legislature exempted all providers of Medicaid-funded PCA services from licensure requirements.[12] The law says this exemption will remain in effect until PCA provider standards are implemented, based on recommendations due from the Department of Health by February 15, 2009. We do not know which standards the Department of Health will recommend, or what it might cost to implement these standards. Although the Legislature could require PCA agencies to obtain state licenses,

- **Approaches other than licensure of PCA agencies might be less expensive and equally effective at improving agencies' compliance with state requirements.**

Personal care provider agencies need more standards and state oversight.

Licensure is arguably the most restrictive form of state regulation for agencies or professions. In the past, the Legislature has mandated—but not appropriated funding for—the licensure of PCA agencies. With the recent increase in the number of PCA agencies, the cost of administering licensure would probably be much greater now than it was when the Legislature previously decided that licensure would be too expensive.

PCA agencies need greater oversight, and their key staff should be well trained in state policies. Toward this end, chapters 3 and 4 recommended (1) more investigations and quality assurance reviews of PCA agencies and (2) mandatory participation by PCA agencies in DHS's intensive training courses for agency officials. We think these would be good starting points for improving compliance and accountability. At a time when the state faces significant budget constraints, it would be more cost-effective to build on existing DHS

[8] Department of Human Services, *A Report to the Legislature on Recommendations for a Personal Care Services Licensure Rule* (St. Paul, 1992), ii.

[9] *Laws of Minnesota* 1997, chapter 195, sec. 5.

[10] Minnesota Department of Health, *A Report to the Minnesota Legislature on a Draft of Proposed Rules for a Unique Licensure Category for Providers of Personal Care Assistant Services* (St. Paul, January 1999), 10.

[11] *Laws of Minnesota* 1997, chapter 195, sec. 1.

[12] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7.

mechanisms for improving compliance—namely, the PCA provider enrollment process, training courses for PCA agencies, and quality assurance reviews of PCA agencies—than by beginning a new licensing process. If DHS's initial steps do not have the intended effects, however, legislators should consider requiring PCA agencies to be licensed or obtain some type of certification.

Another issue related to provider standards is the financial liability of PCA agencies. We found that:

- **State law does not explicitly address the financial liability of PCA Choice agencies for improper payments.**

The law authorizes DHS to deny, revoke, or suspend individual recipients' authorization to use PCA Choice agencies if the use of the option has led to abusive or fraudulent billing.[13] However, DHS financial integrity staff expressed concern to us that PCA Choice agencies might not bear legal liability for improper payments, limiting DHS's ability for recoveries.[14] DHS staff said that, unless they have clear evidence that a PCA Choice agency was aware of improprieties by a recipient or personal care assistant, DHS may have little basis for pursuing recoveries. Because of this, DHS sometimes gives lower priority to investigating complaints involving PCA Choice agencies (to the extent that it knows this). Some PCA Choice agencies disagree with DHS's characterization of their liability. For example, one agency director told us that the PCA Choice agency "is the employer of record and is liable for all financial aspects of the PCA Choice program."

The Legislature should clarify the financial liability of certain provider agencies.

In addition, we found that DHS's Medicaid information system often lacks reliable information to indicate which recipients have elected to receive services under the PCA Choice option. Without information on the total number of PCA Choice cases in the state, it is impossible to estimate the magnitude of the financial risks resulting from the state's inability to recover improper payments in these cases.

RECOMMENDATIONS

The Legislature should amend Minnesota Statutes 256B.0655, subd. 7, to clarify the financial liability of PCA fiscal intermediaries for improper payments involving their recipients or employees.

DHS should ensure that its Medicaid Management Information System contains accurate reporting about which PCA recipients have elected to get services under Minnesota's PCA Choice option.

[13] *Minnesota Statutes* 2008, 256B.0655, subd. 7(i).

[14] PCA Choice agencies act as fiscal intermediaries for PCA Choice recipients, processing claims from the personal care assistant and receiving payments from the state. PCA Choice recipients recruit, train, and supervise their personal care assistants.

In our view, the statutes should explicitly address the liability of PCA Choice agencies for improper payments. PCA Choice agencies play a more limited role in PCA services than other PCA provider agencies, but PCA Choice agencies should still bear some responsibility for the personal care assistants they employ. Also, it is important for DHS to have accurate information about how many PCA recipients have opted for services under the PCA Choice model.

JUDGES' DECISIONS IN PCA APPEALS

In Chapter 2, we expressed concern about possible inconsistencies in PCA assessment practices. Individuals have the option of challenging assessment and other service decisions through the state's "fair hearing" appeals process. In this process, state human services judges consider evidence from the appellant and relevant administrative agency (DHS or a managed care organization) before rendering a judgment. Nearly all PCA-related appeals are filed by recipients in response to the outcomes of PCA assessments.

We reviewed all of the 2007 fair hearing decisions related to PCA appeals. During the course of our review, we observed that:

- **The outcomes of appeals appeared to depend partly on which judge heard the case.**

There were significant differences among judges in their likelihood of siding with appellants in personal care cases.

We observed that individual judges differed considerably in the extent to which they ruled for or against the appellants in the PCA cases. For example, among the eight judges who issued decisions on at least 18 PCA-related cases in 2007, the percentage of cases in which the position of DHS or the managed care agency was completely affirmed ranged from 11 percent for one judge to 68 percent for another. One judge who reversed a larger share of his cases than other judges appeared to apply a standard that other judges did not. Specifically, this judge expressed a preference for testimonial evidence provided during hearings over documentary evidence (such as the completed assessment form). For instance, in one case the judge said the following:

> Although the sworn testimony of a [public health nurse] might be accorded more weight than that of the appellant and his son if both sides were present to testify, mere unsworn assertions on a form do not receive as much weight as appellant's sworn testimony. I do recognize the potential bias in appellant's testimony and that of his son; however, where the [public health nurse] is not present to challenge the appellant's corrections of the record in this hearing, it is difficult for the [human services judge] to sustain the [public health nurse's reduction in services].

State law offers general guidance to human services judges regarding which party bears the "burden of persuasion" in appeals decisions. The law says:

> The burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. If there is no specific law, then the participant in the hearing who

> asserts the truth of a claim is under the burden to persuade the appeals referee that the claim is true.[15]

This language applies to a wide range of human services cases, not just PCA appeals. Based on our review of appeals cases and an interview with an assistant chief human services judge, we concluded that:

- **In practice, the statutory language defining which party has the "burden of persuasion" in appeals cases has provided limited guidance to judges.**

In the appeals decisions we reviewed, it appeared that judges required the party proposing a change in PCA services to bear the burden of proof. A majority of the cases we reviewed involved recipient appeals of service reductions, and judges in these cases placed the burden of proof on the agency (DHS or a managed care organization) that had reduced the recipient's PCA services in response to a new assessment.

We asked one of the state's assistant chief human services judges to clarify how the statutory language regarding the burden of persuasion is applied by the appeals judges. He said the statutory language is "not practical" and that judges usually follow other rules not formally established in state policy. Specifically, he said that case law and legal treatises have established that parties seeking changes in the status quo bear the burden of proof. For example, he said, if an agency's assessment of a PCA recipient leads to a reduction in the recipient's services, the agency would bear the burden to show that the reduction was reasonable.[16] Or, he said, if a recipient wants authorization for more PCA services than the recipient currently receives, the recipient would bear the burden of proof. Also, the assistant chief human services judge said that the overall quality and weight of the evidence presented by both sides in an appeal has an important impact on a judge's decision.

RECOMMENDATION

The state's chief human services judge should periodically review summary data showing the outcomes of PCA appeals for individual judges. Where appropriate, the chief judge should take steps to reduce inconsistencies—for example, through the development of increased training or clearer guidelines for judges.

We think decisions by human services judges should show a reasonable level of consistency. Judges exercise discretion as they consider the unique circumstances of cases, and this is appropriate. However, the chief human

[15] *Minnesota Statutes* 2008, 256.0451, subd. 17.

[16] In such a case, however, there could still be debate about which party is seeking to change the status quo (and thus bears the burden of proof): the administrative agency that has reduced a person's PCA services, or the recipient who is seeking to overturn an action implemented by the administrative agency in response to a new assessment of the recipient's circumstances.

services judge should ensure that individual judges use similar standards to assess evidence and have consistent interpretations of how to apply the "burden of persuasion." Also, the chief judge should ensure that judges have sufficient knowledge of the human services policies relevant to their cases.[17] If DHS officials believe that existing statutory language on the "burden of persuasion" is inappropriate or unclear, they should seek changes.

[17] DHS staff told us there were five occasions from 2005 through 2008 when they provided information and answered questions on PCA-related topics at staff meetings of the human services judges. Typically, the judges devote one hour of their monthly staff meetings to discussion of a specific human services topic area.

List of Recommendations

- The Legislature should require the Minnesota Department of Human Services to:

  - ✓ Implement mandatory training requirements for persons conducting assessments of individuals' need for PCA services.

  - ✓ Develop additional guidance to help assessors determine the PCA service needs of persons with behavior issues.

  - ✓ Develop a process for periodically reviewing samples of PCA assessments for the purpose of ensuring reasonable levels of consistency (p. 38).

- DHS should regularly and promptly analyze its data on paid claims for PCA services to identify and recoup payment of improper claims (p. 55).

- To the extent possible, DHS should reallocate existing resources to conduct more PCA-related investigations (p. 56).

- The Legislature should require representatives of new and existing personal care provider agencies to periodically complete comprehensive state training on PCA standards and practices (p. 56).

- The Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency's owners or administrators have previously documented violations of federal or state regulations (p. 57).

- The Legislature should direct DHS to propose more specific policies regarding which PCA activities are (and are not) reimbursable (p. 57).

- The Department of Human Services should strengthen its Quality Assurance Review program by: (1) increasing resources devoted to it; (2) expanding the number and types of reviews; and (3) improving documentation (p. 66).

- The Legislature should clarify state statutes to ensure that all MA State Plan PCA recipients have their services periodically supervised by a qualified professional (p. 70).

- The Legislature should amend state law to prohibit the same person from serving as both the qualified professional and personal care assistant for a recipient on an ongoing basis (p. 70).

- DHS should develop a stand-alone document for PCA assessors and PCA agencies to distribute that clearly and concisely states the duties of a responsible party (p. 71).

- DHS should amend its provider manual to require Personal Care Provider Organizations to periodically make visits or phone calls to recipients' residences to verify that scheduled services are actually being provided (p. 71).

- The Legislature should amend statutes to give the Department of Human Services responsibility to investigate all reports of maltreatment involving unlicensed personal care provider agencies paid through DHS-administered health care programs (p. 75).

- The Legislature should amend *Minnesota Statutes* 626.556 so that the Department of Health is responsible for investigating alleged child maltreatment involving personal care services provided by agencies licensed by the department as home care providers (p. 75).

- The Legislature should amend *Minnesota Statutes*, 626.556, subd. 1, to require that reports of maltreatment involving children served by unlicensed personal care provider agencies be made to the Minnesota Department of Human Services (p. 76).

- The Department of Human Services should (1) remind PCA agencies about their obligation to develop individual abuse prevention plans and (2) monitor compliance with this requirement during quality assurance reviews (p. 77).

- The Legislature should consider whether to require PCA agencies to develop individual abuse prevention plans for children, as the law requires for adults (p. 77).

- The Legislature should amend Minnesota statutes to require all agencies providing personal care services to obtain background checks on their qualified professionals (p. 78).

- The Department of Human Services should develop a concise, useful document that indicates whom PCA recipients can contact with service-related concerns. The department should require all PCA agencies to distribute this to recipients (p. 80).

- DHS should post relevant documents from its quality assurance reviews of PCA agencies on its public web site (p. 80).

- The Legislature should require counties and managed care agencies that arrange for PCA assessments to provide timely copies of the assessment reports to PCA agencies that will be providing services, if they request them (p. 81).

- The Legislature should amend statutes to explicitly require unlicensed personal care provider agencies to provide Minnesota's Home Care Bill of

Rights to the recipients they serve. The Department of Human Services should incorporate discussion of the bill of rights into its training program for PCA agencies (p. 82).

- The Department of Human Services should define a set of topics on which personal care assistants should receive training (p. 87).

- The Legislature should amend *Minnesota Statutes* 256B.0655, subd. 7, to clarify the financial liability of PCA fiscal intermediaries for improper payments involving their recipients or employees (p. 93).

- DHS should ensure that its Medicaid Management Information System contains accurate reporting about which PCA recipients have elected to get services under Minnesota's PCA Choice option (p. 93).

- The state's chief human services judge should periodically review summary data showing the outcomes of PCA appeals for individual judges. Where appropriate, the chief judge should take steps to reduce inconsistencies—for example, through the development of increased training or clearer guidelines for judges (p. 95).

List of Key Terms

APPENDIX

Assessment. An evaluation of an individual's need for personal care assistance (PCA) services, conducted by a public health nurse, case manager, or service coordinator. Assessments must occur at least annually, or when there is a significant change in a recipient's condition or need for PCA services.

Care plan. A written description of specific PCA services to be provided to a recipient, as developed by the qualified professional or recipient's physician with the recipient or responsible party.

Fee-for-service. An approach the state uses to pay for health care services in which providers submit bills to the Department of Human Services (DHS) for reimbursement after services have been provided. Most PCA recipients in Minnesota participate in fee-for-service health care.

Flexible use. PCA recipients may opt for "flexible use" (rather than "standard use") of their authorized hours of PCA services. This option allows for variation in the pattern of service use within a period of time not exceeding six months.

Managed care. An alternative approach to fee-for-service payment of health care. Under this approach, DHS pays managed care organizations at a predetermined, fixed rate that covers a wide variety of health-related services. Managed care organizations administer the services on behalf of DHS, and they bear responsibility for enrollee costs that exceed the predetermined payment amounts.

Medicaid waivers. States may apply to the U.S. Department of Health and Human Services for waiver of certain requirements that apply to Medicaid "state plans." Medicaid Home and Community-Based Services waivers allow states to provide benefits unavailable to the Medicaid population as a whole to individuals who meet eligibility criteria for care in an institutional setting.

Medical Assistance State Plan. Minnesota's Medicaid program is known as "Medical Assistance." Each state's Medicaid program operates under a state plan that identifies the standard benefits the state will provide to its qualified recipients. Most PCA services in Minnesota are provided under the Medical Assistance State Plan.

PCA Choice agency. Recipients may opt to have their PCA services administered by a PCA Choice agency. This agency acts largely as a "fiscal intermediary." In essence, PCA Choice agencies share employment responsibilities with the recipients of PCA services. Recipients who choose to work with a PCA Choice agency are responsible for recruiting, training,

monitoring, and firing their assistants. The recipients are also responsible for finding a qualified professional and scheduling supervision if they have chosen to receive qualified professional supervision.

Personal care assistant. A person who provides services to a PCA recipient according to the recipient's care plan.

Personal Care Provider Organization. A PCA recipient may choose to have PCA services administered by a Personal Care Provider Organization (PCPO). This type of organization is responsible for recruiting, hiring, and training individuals to work as personal care assistants. Additional responsibilities include monitoring assistants' work and firing them, if necessary. PCPOs also employ a qualified professional for recipients who elect this type of supervision.

Physician statement of need. Required by state law, this document attests to an individual's medical need for PCA services.

Qualified professional. A mental health professional, registered nurse, or licensed social worker who supervises the personal care assistant if the PCA recipient chooses this type of supervision.

Responsible party. An individual who directs the PCA services of an individual who is not capable of doing so. The responsible party must be capable of providing the support necessary to assist the recipient to live in the community, be at least 18 years old, actively participate in planning and directing the PCA services, and not be the personal care assistant.

Service agreement. A document that states DHS's (or a managed care organization's) authorization of a certain amount of PCA time and supervision.

Service plan. This document includes the nurse's recommendation (based on the assessment) for the amount of PCA time and qualified professional supervision needed, and it records the individual's decisions regarding (1) who will supervise the personal care assistant, (2) the type of PCA agency to be used, (3) standard or flexible use of authorized hours, and (4) the use of one-to-one or shared care.

Shared care. PCA services provided by a personal care assistant to two or three individuals simultaneously.

Minnesota Department of **Human Services**

January 9, 2009

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to your report "Personal Care Assistance." The Department of Human Services (DHS) appreciates the time and effort of the Office of the Legislative Auditor in reviewing the Personal Care Assistance (PCA) program. This report confirms the importance of the PCA program as a source of support in the community for many Minnesotans who are elderly or have a disability.

We support the key recommendations of the report, which are consistent with our current goals and objectives. The development and implementation of some of these changes is already underway. We plan to bring a number of these proposed changes to the Legislature this year.

We do have concerns about the recommendation that the Legislature amend statutes to give DHS responsibility for both investigating all maltreatment reports and enforcing the Home Care Bill of Rights involving state-funded personal care services. Currently, the Minnesota Department of Health completes vulnerable adult investigations and investigates complaints under the Home Care Bill of Rights when related to a licensed home care service provider.

We believe that consolidating both the responsibility for investigating alleged maltreatment and enforcing the Home Care Bill of Rights with one agency would be more effective and efficient.

Thank you again for the work of your office in conducting this evaluation and addressing important issues regarding the availability, effectiveness, and management of personal care assistance services.

Sincerely,

Cal R. Ludeman
Commissioner

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Medical Nonemergency Transportation

FEBRUARY 2011

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OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2011

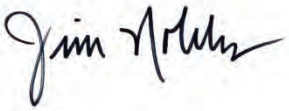
Members of the Legislative Audit Commission:

The State of Minnesota is required by federal law to provide medical nonemergency transportation assistance to recipients of Medical Assistance (MA). We found that the state has established an administrative structure for the program that is duplicative and confusing. We recommend that the Legislature require the Minnesota Department of Human Services to present a proposal to the 2012 Legislature that creates a single administrative structure for the program.

We found that using a broker to help determine MA recipients' eligibility and schedule rides has reduced certain transportation costs, but data limitations prevented us from determining whether total savings outweighed the costs of using a broker. Finally, we found that oversight of the program by the Department of Human Services has been weak, and we make recommendations to improve data collection and program accountability.

Our evaluation was conducted by Jo Vos (evaluation manager), Dan Jacobson, and David Kirchner. The Department of Human Services, Medical Transportation Management, Inc., and various other groups and individuals cooperated fully with our evaluation. We thank them for their assistance.

Sincerely,



James Nobles
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Medical Nonemergency Transportation

Minnesota should simplify its complex and confusing administrative structure for the medical nonemergency transportation program.

Major Findings:

- In fiscal year 2010, Minnesota spent about $38 million on medical nonemergency transportation for Medical Assistance (MA) recipients covered by the state's fee-for-service system. (p. 13)
- Minnesota has two separate administrative structures for nonemergency transportation, "access" and "special," that are duplicative and confusing. (pp. 4-8; 19-22)
- The Department of Human Services' (DHS) oversight of nonemergency transportation has been weak, and it collects very little data on the program statewide. (pp. 49-60)
- More specifically, DHS administers key elements of "special" transportation (which offers the most costly and highest levels of service) in an ad hoc fashion, without using rulemaking procedures, developing formal policies, or notifying the public about changes in practice. (pp. 21-22)
- Since 2004, DHS has contracted with a private company to "broker" or coordinate varying parts of its nonemergency transportation program. (pp. 41-43)
- Through its broker, DHS has frequently limited recipients' eligibility for "special" transportation to very short time periods—often one day—which is inconsistent with contract language. (pp. 28-32)
- Brokering has reduced certain transportation costs, although total savings are unclear. (pp. 43-46)

Key Recommendations:

- The Legislature should require DHS, with input from interested parties, to present a proposal to the 2012 Legislature that creates a single administrative structure for medical nonemergency transportation. (p. 32)
- The Department of Human Services should propose statutory changes to address the length of time recipients are eligible for "special" transportation and the frequency of assessments. (p. 33)
- The Legislature should clarify state law on eligibility for "special" transportation when appropriate "access" transportation is not available. (p. 33)
- The Department of Human Services should publish "special" transportation eligibility policies and seek comments from interested parties when changing them. (p. 34)
- The Department of Human Services should identify, collect, and report key measures related to program performance statewide and periodically verify data submitted by the broker and counties. (p. 60)

Report Summary

Minnesota uses two separate administrative structures to help Medical Assistance recipients obtain nonemergency transportation to and from medical appointments.

Administration of the nonemergency transportation program has lacked transparency.

The federal government requires states to provide Medicaid recipients with medical nonemergency transportation assistance to the nearest qualified provider for covered services, using the least expensive type of appropriate transportation. The program's purpose is to help lower overall medical costs by enabling recipients to receive routine, preventive health care. Although transportation services are federally mandated, states have wide latitude in how to administer services. In Minnesota, the Department of Human Services (DHS) oversees the program for Medical Assistance (MA) recipients covered by its fee-for-service system.

Minnesota's two administrative structures for nonemergency transportation are duplicative and confusing.

Minnesota has two separate categories of nonemergency transportation: access and special. "Access" transportation is available to all MA recipients. The program pays mileage when recipients drive to and from medical appointments or when family, friends, or volunteers drive them. It also pays for public transit and taxi-style vehicles where drivers provide limited assistance to recipients. Counties are primarily responsible for access transportation, and they vary widely in how they administer the program and the types of transportation available in their communities.

In contrast, "special" transportation is only available to MA recipients who have a physical or mental impairment that prohibits them from safely using access transportation. Special transportation drivers must provide certain "driver-assisted services," including helping recipients into and out of medical facilities. State-certified taxi-style vehicles provide ambulatory, wheelchair, and stretcher services. Primary responsibility for special transportation for MA recipients rests with DHS; counties do not play a direct role.

Although access and special transportation share the same goal—to transport MA recipients to and from medical appointments—they differ in terms of recipient eligibility, program administration, types of transportation available, and data collection. Transportation providers often offer both types of service, and some MA recipients move back and forth between the two categories, sometimes in the same day.

The Department of Human Services administers key elements of special transportation in an ad hoc fashion.

The department has contracted with a private company (Medical Transportation Management, Inc., or MTM) to determine special transportation eligibility statewide since 2004. But DHS has provided MTM with few written instructions or formal guidelines on how to determine eligibility beyond the vague guidance contained in the contract and state law. Instead, DHS has relied on informal verbal and e-mail communications to tell MTM how to perform its duties. Also, DHS has made key implementation decisions administratively without the public notice and comment periods required by the rulemaking process. Finally, DHS has not routinely informed recipients and other interested parties of changes in the eligibility process.

Administrative rules for the program are outdated.

The way in which DHS has defined special transportation eligibility has resulted in a few MA recipients falling "between the cracks." They appear eligible under state law, but are not eligible in practice. Also, state law defines eligibility for special transportation based on recipients' inability to safely use access transportation. But DHS has consistently determined that MA recipients are not eligible for special transportation when appropriate types of access transportation are simply unavailable for them to use.

The Legislature has made many changes to the nonemergency transportation program over the last decade, but DHS has not significantly changed its special transportation rules since 1987. The rules are generally silent on many important matters open to interpretation, and some do not reflect current law.

The department has limited many recipients' eligibility for special transportation to very short time periods.

The department's contract with MTM requires that special transportation eligibility periods generally parallel those used for Social Security Insurance Disability determinations, which are, at a minimum, six months. However, MTM granted eligibility for only one day to 40 percent of special transportation recipients needing ambulatory or wheelchair services over the last three years.

Furthermore, the 2010 Legislature directed that, barring changing circumstances, eligibility assessments not be done more than once a year on any individual (previously twice a year). While this gives DHS discretion to initiate assessments when needed, statutes anticipate that frequent assessments will be the exception, not the rule.

While brokering has reduced certain transportation costs, total savings are unclear.

The department has contracted with MTM to "broker" varying parts of its nonemergency transportation program since 2004. Brokering includes determining eligibility, scheduling trips, and distributing those trips among providers.

Because of data limitations, we cannot say whether using a broker has saved the state more money than it has cost. However, we identified three areas where savings have occurred. First, after the 2003 Legislature made DHS, not physicians, primarily responsible for determining special transportation eligibility, the department hired MTM to determine eligibility. Subsequently, there was a large shift in trips provided from special transportation to less-costly access transportation. This shift has reduced nonemergency transportation costs by about $400,000 a year. Second, when MTM brokered special transportation in the Twin Cities area (October 2007 through January 2008), the number of miles special transportation providers were reimbursed for trips dropped, saving about $400,000 to $600,000 a year. Third, after MTM began brokering access transportation in the Twin Cities area in 2004, the proportion of trips that used taxi-style vehicles to provide curb-to-curb service increased, while the proportion providing more-costly door-to-door service decreased, which saved about $140,000 to $200,000 in fiscal year 2010.

When Twin City area counties began contracting with MTM to broker access transportation instead of DHS, total administrative costs declined.

Weak oversight by the Department of Human Services has resulted in the state paying more than it should have for some parts of the program.

The counties paid MTM $4.4 million in fiscal year 2010, or about $5.70 per completed trip. In comparison, DHS paid MTM $6.7 million for fiscal year 2009, or about $8.30 per trip.

Transportation spending per eligible MA recipient has decreased in the Twin Cities area since 2004, but has increased outstate.

Between fiscal years 2000 and 2010, average spending per eligible person in the Twin Cities area declined from $222 to $166. At the same time, outstate spending increased from $88 to $131 per eligible person. Outstate counties' costs were less because they used more lower-cost types of travel. In 2010, 69 percent of their spending was for reimbursing volunteer drivers and recipients (or their families or friends) for mileage. In contrast, 93 percent of Twin Cities area spending was for taxi-style vehicles, a higher-cost option.

Statewide, about 4 percent of eligible MA recipients used special transportation in fiscal year 2010. Because DHS does not collect comparable data on access transportation, statewide usage is unknown. In the Twin Cities area, about 18 percent of eligible MA recipients used access transportation in 2010.

Lack of consistent and reliable data has hampered oversight efforts.

The department provides little statewide oversight of the program.

Although its most recent contract with the broker set forth numerous oversight mechanisms, DHS did not implement a formal quality assurance program to monitor the broker. Department oversight has largely consisted of informal communication and frequent meetings.

Weak monitoring and oversight contributed, in part, to DHS paying its broker about $1 million more than the amount agreed to in its contract for fiscal year 2006. Furthermore, DHS's decision to give MTM an inappropriate cost-of-living adjustment resulted in DHS paying the broker about $1.5 million too much in fiscal year 2009. Also, DHS recently examined special transportation reimbursements for transporting nursing home residents and found it had paid some providers about $500,000 for trips that did not appear to qualify for special transportation reimbursement.

State oversight of outstate counties is also lax, partly because DHS collects aggregate spending data, not individual trip data.

The department must improve its data collection efforts.

The department's data collection efforts vary, both across and within the two categories of nonemergency transportation (access and special). Furthermore, DHS does very little systematic checking to make sure that the data submitted from counties, transportation providers, or its broker are accurate or reasonable.

Given state and county budget problems, policy makers need better information about the cost-effectiveness of transportation assistance statewide. The department should routinely collect information, such as the number of individual participants, number of trips by type of transportation, and costs per trip on a statewide basis, regardless of how programs are administered.

Introduction

Minnesotans enrolled in Medical Assistance (MA), Minnesota's version of the federal Medicaid program, are eligible to receive nonemergency transportation assistance to obtain health-related services. Although a federally mandated benefit, Minnesota has considerable flexibility in how to provide transportation support, and it does so in various ways. Nearly two-thirds of Minnesota's MA population are enrolled in, and eligible to receive transportation help through, managed care health plans. The remaining one-third is covered by the state's fee-for-service system that allows them to receive transportation help through counties or the Department of Human Services (DHS).

Over the last several years, the state's approach for providing transportation assistance to MA recipients served by its fee-for-service system has frequently changed, most often regarding DHS's use of a private vendor to deliver different aspects of the program. On March 26, 2010, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate medical nonemergency transportation for MA recipients under the state's fee-for-service system.[1] We focused on the following research questions:

- **How have participation in, and costs for, medical nonemergency transportation for MA recipients changed over time, and why?**
- **Are special transportation eligibility assessments performed in a reasonable manner? To what extent have MA recipients appealed results?**
- **Has DHS exercised adequate oversight of transportation services statewide?**
- **To what extent do MA recipients receive appropriate and cost-effective nonemergency medical transportation?**
- **How do other states provide medical nonemergency transportation to Medicaid recipients?**

We used various research methods to answer these questions. First, we analyzed data collected by DHS and its contractor, Medical Transportation Management, Inc. (MTM), regarding program participants, trips, transportation provider reimbursements, costs, eligibility assessments, complaints, appeals, and customer satisfaction surveys. Second, we surveyed all county human services directors

[1] The Commission first directed OLA to evaluate medical nonemergency transportation in April 2009. Shortly thereafter, however, the Commission postponed the evaluation for one year due to program changes adopted by the 2009 Legislature.

about their transportation assistance programs.[2] Third, we collected data regarding MA recipient "no shows" from a small sample of transportation providers.[3] Fourth, we examined contracts, budgets, reports, and other documents related to nonemergency transportation in Minnesota and across the nation. Finally, we interviewed staff from the departments of Human Services and Transportation and MTM, as well as representatives from various interest groups, local governments, and transportation providers.

Our evaluation focused on medical nonemergency transportation within Minnesota's fee-for-service MA program; we excluded transportation services delivered through managed care health plans. We looked at transportation from a statewide perspective and, with the exception of examining DHS's use of a contractor to administer transportation services in the Twin Cities area, did not evaluate transportation services in individual counties. Also, we did not analyze the adequacy of the reimbursement rates paid to transportation providers, nor did we assess how the Minnesota Department of Transportation performed its certification responsibilities related to special transportation providers.

This report is divided into three chapters. Chapter 1 provides background information on Minnesota's medical nonemergency transportation program and data on participants, services, and costs over time. Chapter 2 examines issues specifically related to special transportation, including eligibility criteria, frequency of assessments, length of certifications, and appeals. Chapter 3 examines other management issues of interest to policy makers or interest groups, including using brokers, state oversight, and customer satisfaction.

[2] We sent questionnaires to 87 county human services directors and tribal health directors. We received responses from 78 directors, for an overall response rate of 90 percent.

[3] "No shows" refer to instances when transportation providers travel to designated pick-up sites to transport MA recipients to or from health-related services, but the recipients do not show up for the scheduled rides.

1 BACKGROUND

Created as a federal/state partnership in 1965, Medicaid is the nation's largest publicly funded health financing program for low-income people.[1] To qualify for Medicaid, an individual must meet financial criteria and belong to one of several eligibility categories: children under age 21, parents or caretakers of dependent children, pregnant women, persons who are blind or have a disability, and persons age 65 or older.[2] The federal government defines a minimum set of health-related services that must be offered to Medicaid recipients. This evaluation looks at one of those services, medical nonemergency transportation, within the context of Minnesota's fee-for-service system.

The federal government requires Minnesota to help Medical Assistance (MA) recipients obtain transportation to and from medical appointments.

Medical nonemergency transportation is a federally mandated benefit that enables Medicaid recipients to access approved health-related services. The federal government requires state Medicaid programs to provide nonemergency transportation assistance to the nearest qualified provider for covered services, using the least expensive type of appropriate transportation. The program's purpose is to help lower overall medical costs by enabling Medicaid recipients to receive routine, preventive health care. National studies have shown that transportation-related barriers prevent many Medicaid recipients from obtaining health care.[3] By providing transportation assistance for routine care, policy makers hope to better control nonemergency and emergency health care costs.

ADMINISTRATION

Although providing transportation assistance is a federal mandate:

- **States have wide latitude in how to administer medical nonemergency transportation for Medicaid recipients.**

Many factors can influence how states design and implement their transportation programs, including geography (urban vs. rural), population density, and the availability of transportation providers. According to the Kaiser Family Foundation, all 50 states and the District of Columbia provide some form of medical nonemergency transportation to Medicaid recipients, although program

[1] Social Security Act of 1965, Title XIX.

[2] For greater detail, see Minnesota House Research Department, *Medical Assistance* (St. Paul, October 2010); and Minnesota House Research Department, *Minnesota Family Assistance* (St. Paul, December 2009). States are free to extend services to additional populations as long as those services are paid for with state rather than federal funds. In the past, Minnesota has extended medical services to other groups such as unemployed single adults.

[3] For example, see R. Wallace, P. Hughes-Cromwick, and S. Khasnabis, *Access to Health Care and Non-emergency Medical Transportation* (Washington, DC: Transportation Research Board), 2005; and T. A. Acury, J. Presser, W. Gesler, and J. M. Powers, "Access to Transportation and Health Care Utilization in a Rural Region," *The Journal of Rural Health*, 2, no. (Winter 2005).

administration and services vary considerably.[4] For example, some states administer their transportation programs through counties or regional entities, while others administer them at the state level. Also, states may use a variety of transportation options, such as reimbursing for mileage, distributing passes for public transit, and paying for taxi-style services.[5]

States can also place conditions on or limit recipients' use of transportation services. For example, a few states require some Medicaid recipients to make copayments ranging from $.50 to $3.00 per trip.[6] Some states restrict the number or type of trips they will provide. For example, Alabama limits Medicaid recipients to two trips per month, while Indiana pays for up to 20 one-way trips of less than 50 miles per year.[7] Pennsylvania restricts recipients to trip costs of $50 or less per month.[8] California only pays for transportation when recipients' medical or physical condition prevents them from using "ordinary" types of transportation such as privately-owned cars or public transit.[9]

Minnesota divides medical nonemergency transportation into two separate categories: "access" and "special."

In Minnesota, the Department of Human Services (DHS) oversees the state's public assistance health care program and, more specifically, medical nonemergency transportation. In general:

- **Minnesota uses a two-pronged approach to provide transportation assistance that depends on recipients' level of physical or cognitive impairment.**

In the late 1970s, the Legislature created two major categories of nonemergency transportation for Medical Assistance (MA) recipients: "access transportation" and "special transportation."[10] As shown in Table 1.1, these categories differ in terms of recipient eligibility, program administration, and types of transportation that are available.

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[4] Kaiser Family Foundation, "Benefits by Service: Non-Emergency Medical Transportation Services (October 2008)," http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=4&cat=3&sv=21, accessed June 9, 2010.

[5] We use the term "taxi-style" services to refer to rides given in cars and vans operated by private companies, nonprofit groups, or public agencies. These vehicles operate in a similar fashion as taxis in that they provide individualized point-to-point service, but they generally focus on populations that have special needs. Taxi-style vehicles must also provide varying degrees of assistance to passengers not specifically required of taxis in general.

[6] Kaiser Family Foundation, "Benefits by Service."

[7] *Ibid.*

[8] Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, 2004), 60.

[9] California Department of Health Care Services, *California's Title XIX State Plan for Assurance of Transportation*, http://www.dhcs.ca.gov/formsandpubs/laws/Documents/StatePlan%20Attachment%203.1-D.pdf, accessed November 26, 2010.

[10] *Laws of Minnesota* 1978, chapter 560, sec. 10; and *Laws of Minnesota* Extra Session 1979, chapter 1, sec. 27. Early legislation referred to access transportation as "regular" transportation. For the sake of consistency, we use the term "access transportation" throughout this report.

Table 1.1: Minnesota's Medical Nonemergency Transportation Program

	Access Transportation	Special Transportation
Eligibility	All Medical Assistance recipients	Medical Assistance recipients unable to use access transportation
Administrative Responsibility	County human services agencies	State departments of human services and transportation
Transportation Providers	Recipients, family, and friends; volunteer drivers; public transit (including buses, light rail, and paratransit); and taxi-style service providers	MnDOT-certified special transportation taxi-style service providers

SOURCE: Office of the Legislative Auditor.

Access Transportation

Access transportation includes taxi-style vehicles, public transit, and mileage reimbursement for using personal vehicles.

"Access transportation" is available to all MA recipients covered by the state's fee-for-service system.[11] The Department of Human Services has defined access transportation to include: (1) vehicles owned by recipients, family, friends, and volunteers; (2) public transit, including fixed route buses and light rail, paratransit such as Metro Mobility, and other local options such as dial-a-ride; and (3) private or nonprofit taxi-style vehicles.[12] The department further requires that taxi-style vehicles provide recipients with either curb-to-curb or door-to-door assistance. Recipients receiving curb-to-curb services are responsible for getting themselves to the road or curb in front of their pick-up site before being helped by drivers. In contrast, drivers providing door-to-door services help recipients from outside the door of their pick-up site to outside the door of their drop-off site. The department further subdivides each of these two levels of service into ambulatory and wheelchair subdivisions.[13] Table 1.2 lists the various types of access transportation available to MA recipients, organized from the least to the most expensive.

[11] Unless otherwise stated, we use the terms "Medical Assistance recipients" and "MA recipients" to refer to public assistance recipients covered by the fee-for-service system and, thus, eligible for transportation services through Minnesota's medical nonemergency transportation program. The vast majority of these individuals are enrolled in MA, but other health program enrollees may be eligible to participate. Also, a small number of recipients enrolled in managed care health plans receive personal mileage and parking reimbursements through the transportation program set up for fee-for-service recipients.

[12] Paratransit is a term that refers to specialized transportation services required by the Americans with Disabilities Act (ADA) that respond to riders' individual requests for service. Paratransit generally serves riders within specific fixed route service areas that are unable to safely use traditional bus services.

[13] Consequently, DHS has defined four types of transportation assistance within the rubric of taxi-style services: ambulatory curb-to-curb, ambulatory door-to-door, wheelchair curb-to-curb, and wheelchair door-to-door.

Table 1.2: Types of Access Transportation Available to Medical Assistance Recipients

Type of Transportation	Description
Personal vehicles	MA recipients drive themselves to medical appointments; recipients may also be transported by family, friends, or others who have a personal relationship with recipients
Volunteer vehicles	Transportation provided by volunteers (individuals or organizations) with no relationship to recipients; services must be available to all community members
Public transit	Includes buses, light rail, paratransit, and other public transit services
Taxi-style vehicles	
Ambulatory, curb-to-curb	Drivers assist ambulatory MA recipients from the curb of the pick-up site to the curb of the of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Ambulatory, door-to-door	Drivers assist ambulatory MA recipients from the outside door of the pick-up site to the outside door of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Wheelchair, curb-to-curb	Drivers assist MA recipients in wheelchairs from the curb of the pick-up site to the curb of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Wheelchair, door-to-door	Drivers assist MA recipients in wheelchairs from the outside door of the pick-up site to the outside door of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Air travel	Private or commercial air travel; intra- or interstate carrier
Miscellaneous	
Parking	Recipients must use the most cost-effective option
Meals	Recipients must be traveling to, from, or at a medical appointment prior to 6 AM, between 11 AM and 1 PM, or after 7 PM; recipients must also be more than 35 miles from home
Lodging	Prior local approval required; community standards used to determine when lodging is appropriate

SOURCE: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010).

County human services agencies are primarily responsible for providing access transportation.

Counties are primarily responsible for access transportation, and they vary widely in how they administer the program and the types of transportation available. From July 2004 to July 2009, DHS contracted with a private company, Medical Transportation Management, Inc. (MTM), to broker access transportation for 11 counties in the Twin Cities area.[14] When the 2009 Legislature specifically prohibited the department from contracting for access transportation, these counties jointly contracted with MTM to continue brokering services.[15] Medical Assistance recipients who are covered by the fee-for-service

[14] The 11 counties were: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. As we discuss in Chapter 3, brokers' responsibilities include taking requests and scheduling trips among transportation providers.

[15] *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 34. Currently, 8 of the original 11 counties continue to jointly contract with MTM. Carver, Scott, and Wright counties opted to coordinate access transportation themselves.

system and need transportation in these counties call a central telephone number and MTM staff check eligibility, determine the most appropriate type of transportation, schedule rides, and reimburse transportation providers.[16]

In outstate counties, MA recipients under the fee-for-service system obtain transportation assistance in a variety of ways. In some counties, recipients contact their financial aid worker who verifies their eligibility, determines the most appropriate type of transportation, schedules trips, and submits the necessary paperwork for provider reimbursement. In other counties, financial aid workers, after verifying eligibility, refer recipients to a county transportation coordinator who determines the most appropriate type of transportation and schedules rides.

Special Transportation

"Special transportation," in contrast, is only available to MA recipients who have a physical or mental impairment that prohibits them from safely accessing and using buses, taxis, other commercial transportation, or private automobiles.[17] By law, special transportation drivers must provide certain "driver-assisted services," including helping recipients into and out of medical facilities.[18] The Department of Human Services has defined special transportation as (1) taxi-style vehicles certified by the Minnesota Department of Transportation (MnDOT) where drivers assist recipients from inside their homes or worksites to the inside of their medical providers' offices (commonly referred to as door-through-door service) and (2) MnDOT-certified taxi-style vehicles providing stretcher services (also door-through-door).[19] Table 1.3 lists the types of special transportation available to a subset of MA recipients, organized from the least to most expensive.

Special transportation, administered by the Department of Human Services (DHS), provides assistance to MA recipients who cannot use access transportation.

The Department of Human Services has primary responsibility for special transportation for MA recipients; counties do not play a direct role. The department contracts with MTM to determine whether MA recipients covered by the fee-for-service system are eligible for special transportation. Once MTM approves eligibility and sets a time frame for that eligibility, recipients or their caregivers call special transportation providers themselves when they need a ride to or from a medical appointment. Transportation providers submit their bills directly to the department for reimbursement.

[16] In lieu of obtaining prior trip approval, MTM allows MA recipients claiming personal mileage to simply maintain trip logs signed by their health providers. Recipients periodically send the logs to MTM.

[17] *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

[18] *Ibid.*

[19] The Minnesota Department of Transportation is responsible for regulating special transportation providers, drivers, and vehicles through a yearly certification and inspection program. *Minnesota Statutes* 2010, 174.30.

Table 1.3: Types of Special Transportation Available to Eligible Medical Assistance Recipients

Type of Transportation	Description
Ambulatory, taxi-style vehicles	Drivers assist ambulatory MA recipients to enter and exit through doors at pick-up and drop-off sites, including to or from their medical providers' appointment desks; drivers must also help recipients enter and exit vehicles and secure them into vehicles
Wheelchair, taxi-style vehicles	Drivers assist MA recipients in wheelchairs to enter and exit through doors at pick-up and drop-off sites, including to and from their medical providers' appointment desks; drivers must also help recipients enter and exit vehicles and secure them into vehicles
Stretcher vehicles	MA recipients travel in vehicles in a prone position

NOTE: Special transportation recipients may also be eligible to receive air travel, meals, and lodging, as listed in Table 1.2.

SOURCES: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010); and Office of the Legislative Auditor.

PARTICIPATION

In fiscal year 2010, about 776,000 Minnesotans were enrolled in the state's three major health care programs: Medical Assistance (MA), MinnesotaCare, and General Assistance Medical Care (GAMC).[20] Only a portion, however, were covered by the state's fee-for-service system and eligible to receive transportation assistance through their county of residence or DHS.[21] Overall:

- **During fiscal year 2010, about 253,000 Minnesotans were covered by the state's fee-for-service system and eligible to receive medical nonemergency transportation.**

Most of the individuals eligible for assistance—91 percent—were enrolled in MA, which serves mostly children and families, individuals 65 years or older, and people who have disabilities. Approximately 21,000 GAMC enrollees, primarily childless adults, were eligible for access (but not special) transportation during most of fiscal year 2010, until the Legislature revoked their eligibility, effective June 2010.[22] They made up about 8 percent of those eligible for transportation assistance in fiscal year 2010. The remaining 1 percent of the eligible population were children under 21 years and pregnant women enrolled in MinnesotaCare.

[20] Minnesota Department of Human Services, *Family Self-Sufficiency and Health Care Program Statistics* (St. Paul, January 2011), 30-32. Medical Assistance is the state's largest health care program and accounts for the vast majority of public assistance recipients receiving health benefits.

[21] Approximately two-thirds of the state's Medicaid population are enrolled in managed care health plans. For the most part, these individuals receive transportation assistance through their respective health plans rather than DHS's transportation program.

[22] Minnesota Department of Human Services, "Provider Impacts Due to GAMC Changes: Part 2," http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_150011#, accessed January 10, 2011.

Access Transportation

Medical nonemergency transportation is measured, in part, by "trips," with each trip being one-way. Thus, an individual going to and returning home from a doctor's visit is counted as making two trips—one trip to the doctor and another home again. Because trip data are not available on a statewide basis, our analysis focuses on trips in the Twin Cities area.[23]

Detailed data for the Twin Cities area indicate that most MA recipients covered by the fee-for-service system do not use access transportation. Overall:

- **In fiscal year 2010, about 18 percent of Medical Assistance recipients in the Twin Cities area received access transportation, averaging 35 trips to or from medical appointments.**

Out of 137,000 persons eligible for access transportation in the Twin Cities area, about 25,000 actually received assistance in fiscal year 2010. They took about 853,000 trips, or an average of 35 trips per year (among recipients who took at least one trip). About half of these recipients took ten or fewer trips, including 6,000 who took two or fewer trips. About 2,200 persons took 100 or more trips during fiscal year 2010.

About half of the MA recipients in the Twin Cities area who received access transportation took ten or fewer trips in fiscal year 2010.

As noted earlier, access transportation options range from personal automobiles to more specialized taxi-style vehicles that provide varying levels of driver assistance. Table 1.4 lists the current reimbursement rates for access transportation. As the table shows, rates vary by the type of transportation provided and the length of the trip.

We looked at the types of trips provided most often and found that:

- **Taxi-style vehicles accounted for nearly three-fourths of the access transportation trips taken in the Twin Cities area in fiscal year 2010.**

As shown in Table 1.5, taxi-style vehicles accounted for 71 percent of all access transportation trips in the Twin Cities area in fiscal year 2010. The next most common were trips in which recipients—or their friends or relatives—obtained mileage reimbursement (21 percent), followed by public transit (7 percent).

Taxi-style vehicles have provided the majority of access transportation trips in the Twin Cities area since MTM began coordinating services in July 2004. During the last six years, the share of trips provided by taxi-style vehicles has grown from 59 to 71 percent, while the shares attributable to personal and volunteer mileage have declined from 30 to 21 percent and 3 to 1 percent, respectively. Public transit's share has fluctuated between 5 and 8 percent.

Most access transportation trips using taxi-style vehicles have involved the least costly (ambulatory curb-to-curb) of the four service levels available, as shown in Table 1.6. Since fiscal year 2005, at least 80 percent of taxi-style trips each year

[23] Unless specifically noted, the term "Twin Cities area" covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright.

Table 1.4: Maximum Reimbursement Rates for Access Transportation, January 2011

Type of Reimbursement	Maximum Reimbursement Rate
Personal mileage	$.20 per mile
Volunteer mileage	$.51 per mile
Public transit buses/light rail	Full cost or $1.25 to $1.75 per trip; up to $65 for a monthly pass
ADA paratransit	Full cost or $2.25 to $3.00 per trip
Curb-to-curb taxi	$10 through the first 5 miles, plus $1.45 per mile thereafter
Door-to-door taxi	$12 through the first 5 miles, plus $1.45 per mile thereafter
Curb-to-curb wheelchair	$13 through the first 5 miles, plus $1.45 per mile thereafter
Door-to-door wheelchair	$15 through the first 5 miles, plus $1.45 per mile thereafter[a]
Air travel	Full cost
Parking	Full cost
Breakfast	Full cost or $5.50 maximum; must be in transit to, from, or at a medical appointment prior to 6 AM and be more than 35 miles from home
Lunch	Full cost or $6.50 maximum; must be in transit to, from, or at a medical appointment between 11 AM and 1 PM and be more than 35 miles from home
Dinner	Full cost or $8.00 maximum; must be in transit to, from, or at a medical appointment after 7 PM and be more than 35 miles from home
Lodging	$50 per night unless recipient obtains prior county approval

[a] As we discuss in Chapter 3, the Department of Human Services, through the broker, has been reimbursing door-to-door wheelchair transportation providers in the Twin Cities area at a base rate of $16 rather than $15.

SOURCE: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010).

were ambulatory curb-to-curb. Trips involving more expensive levels of service were much less common. For example, wheelchair trips, including curb-to-curb and door-to-door trips, have remained around 4 to 5 percent of all access transportation taxi-style trips.

Over the last several years, MTM has increasingly used the lower cost curb-to-curb service level for both ambulatory and wheelchair trips. Since fiscal year 2005, the share of ambulatory trips that are curb-to-curb has increased from 88 to 95 percent. The percentage of wheelchair trips that are curb-to-curb has increased substantially, going from 18 to 74 percent.

As we noted earlier, trip data are not available for counties outside the Twin Cities area. But as we show later in this chapter, DHS collects spending data statewide that indicate outstate counties rely primarily on personal and volunteer mileage reimbursement to provide access transportation.

Table 1.5: Access Transportation Trips in the Twin Cities Area, Fiscal Years 2005-2010

Type of Trip	Fiscal Year 2005	2006	2007	2008	2009	2010
Number of Trips (in thousands)	424	682	720	774	811	853
Percentage of Trips:						
Taxi-style vehicles	59%	65%	68%	70%	67%	71%
Driven by friend, relative, or self	30	26	22	21	23	21
Public transit	7	5	7	6	8	7
Volunteer drivers	3	4	3	3	1	1

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Table 1.6: Access Transportation Taxi-Style Trips in the Twin Cities Area, Fiscal Years 2005-2010

Since 2005, access transportation trips in the Twin Cities area have increased dramatically.

Type of Trip	Fiscal Year 2005	2006	2007	2008	2009	2010
Number of Trips (in thousands)	252	445	488	542	544	609
Percentage of Trips:						
Ambulatory	96%	95%	96%	96%	96%	95%
Curb-to-curb	88	88	83	86	92	95
Door-to-door	12	12	17	14	8	5
Wheelchair	4%	5%	4%	4%	4%	5%
Curb-to-curb	18	24	31	38	68	74
Door-to-door	82	76	69	62	32	26

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Special Transportation

About 10 percent of MA recipients qualify for special transportation, which provides higher, more costly levels of service.

Medical Assistance recipients may receive special transportation if they are certified as eligible for this service by MTM or if they live in a skilled nursing facility. In fiscal year 2010, about 10 percent of MA recipients were eligible for special transportation, including about 5,300 recipients that MTM certified as eligible for at least one day during the year and about 18,400 nursing home residents.[24]

As a result, few MA recipients actually use special transportation:

- **Statewide, about 4 percent of Medical Assistance recipients received special transportation in fiscal year 2010, averaging 38 trips to or from medical appointments.**

Overall, 9,700 MA recipients used special transportation in fiscal year 2010. Altogether, they took about 373,000 trips, or an average of 38 trips (among recipients who took at least one trip). Forty percent of these trips transported MA recipients in wheelchairs and 0.5 percent transported recipients on stretchers.

Table 1.7 shows the current reimbursement rates for special transportation statewide. Because DHS sets access transportation rates to generally fall below the special transportation rates set by the Legislature, special transportation trips typically cost more than corresponding access transportation trips using taxi-style vehicles.[25] For example, as shown in Table 1.8, reimbursement for a ten-mile trip for an MA recipient in a wheelchair would be $30.50 for special transportation and either $20.25 (curb-to-curb) or $23.25 (door-to-door) for access transportation.

Table 1.7: Reimbursement Rates for Special Transportation, January 2011

Type of Reimbursement	Minimum Reimbursement Rate
Ambulatory door-through-door	$11.50 base, plus $1.30 per mile
Wheelchair door-through-door	$17 base, plus $1.35 per mile
Stretcher	$60 base, plus $2.40 per mile and $9 per attendant (if needed)

NOTE: Base rates for transportation providers serving MA recipients in "super-rural" parts of the state are 11.3 percent higher than shown and per mile rates for providers in "rural" and "super-rural" parts of the state are 12 to 25 percent higher, depending on the number of miles driven.

SOURCE: *Minnesota Statutes* 2010, 256B.0625, subd. 17(b)(1).

[24] Minnesota Department of Human Services, *Nursing Facility Fact Sheet* (St. Paul, 2010).

[25] Special transportation providers must provide a higher level of assistance, referred to as door-through-door as opposed to curb-to-curb or door-to-door. They must also meet MnDOT certification requirements, which counties may or may not require taxi-style access transportation providers to meet.

Table 1.8: Examples of Costs for Taxi-Style Access and Special Transportation, January 2011

	Access Transportation		Special Transportation	
Trip Length and Type	Curb-to-Curb	Door-to-Door	Regular Rate	Rural Rate
5 miles				
Ambulatory	$10.00	$12.00	$18.00	$19.63
Wheelchair	13.00	15.00	23.75	25.44
Stretcher	n/a	n/a	81.00	84.00
10 miles				
Ambulatory	$17.25	$19.25	$24.50	$27.75
Wheelchair	20.25	22.25	30.50	33.88
Stretcher	n/a	n/a	93.00	99.00
20 miles				
Ambulatory	$31.75	$33.75	$37.50	$40.43
Wheelchair	34.75	36.75	44.00	47.04
Stretcher	n/a	n/a	117.00	122.40
45 miles				
Ambulatory	$68.00	$70.00	$70.00	$76.58
Wheelchair	71.00	73.00	77.75	84.58
Stretcher	n/a	n/a	177.00	189.15

NOTES: Special transportation trips that take place in areas classified as "rural" and "super-rural" may be billed at higher rates (rates for "super-rural" areas are not shown). Costs shown for access transportation are the maximum amounts allowed; providers may opt to bill less. N/a means that the service is not applicable.

SOURCES: Office of the Legislative Auditor, analysis of rates listed in Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, DHS Bulletin #10-21-02, January 13, 2010; and *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

COST TRENDS

Medical nonemergency transportation makes up a very small share of Minnesota's total MA spending. Overall:

- **In fiscal year 2010, total spending for medical nonemergency transportation was about $38 million—less than 1 percent of Minnesota's total Medical Assistance spending.**

In fiscal year 2010, MA spending in Minnesota totaled $7.2 billion.[26] Of this, state and local governments spent about $38 million on transportation assistance for MA recipients covered by the fee-for-service system, including $26 million for access transportation and $12 million for special transportation.[27] The federal

[26] Department of Human Services, *Family Self-Sufficiency*, 31.

[27] These figures exclude the administrative costs incurred by outstate counties for their access transportation programs (which are unknown), but include the administrative costs of the Twin Cities area counties that contract with MTM.

government funded about 62 percent of these expenditures, with state and local governments funding about 34 and 4 percent, respectively.[28]

Between fiscal years 2000 and 2010, overall spending for medical nonemergency transportation increased from $28 million to $38 million. Furthermore:

- **Over the last decade, there was a large spending shift away from special transportation and toward access transportation.**

Over the last decade, special transportation costs have been cut in half, while costs for access transportation increased five-fold.

As shown in Figure 1.1, special transportation spending declined from $23 million in fiscal year 2000 to $12 million in 2010, while access transportation spending increased from $5 million to $26 million. During this time period, the state adopted several mechanisms to help control transportation costs, including using a "broker" to coordinate access transportation in the Twin Cities area and determine eligibility for special transportation statewide. These changes, which were designed to shift usage from special to access transportation, are discussed in Chapters 2 and 3.

Since fiscal year 2000, medical nonemergency transportation spending has increased at about the same rate as the number of persons eligible for the transportation program. Figure 1.2 shows how spending per eligible MA recipient has changed over time. Statewide, spending per eligible person increased from $143 in fiscal year 2000 to a peak of $177 in 2009 before declining to $150 in 2010.

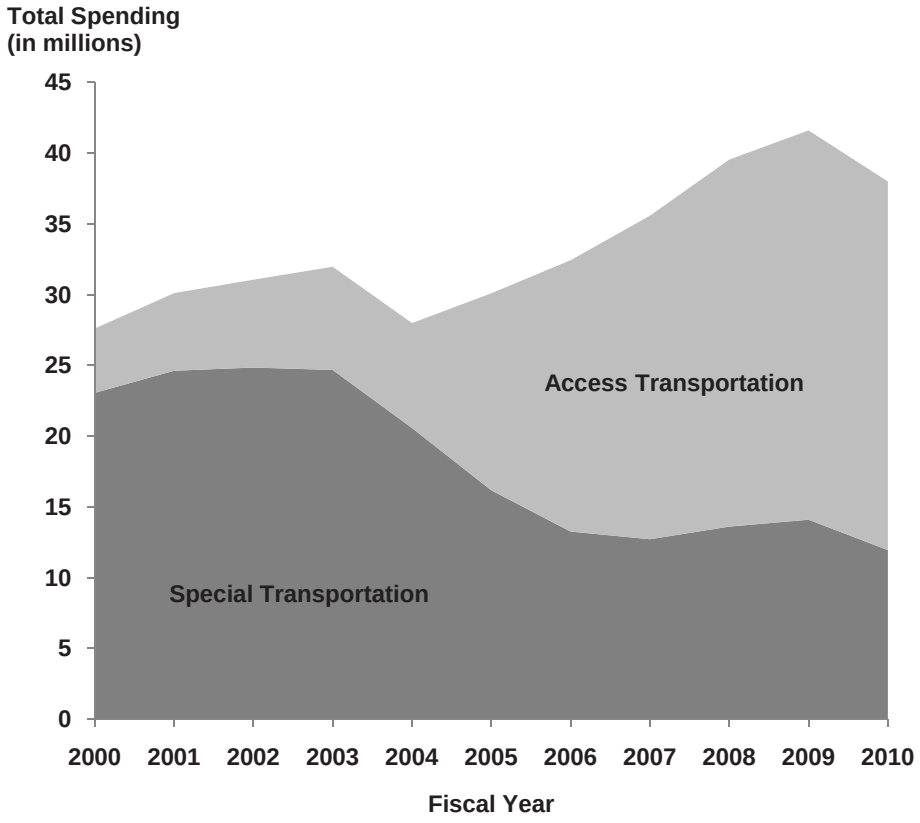
At the same time:

- **Medical nonemergency transportation spending per eligible Medical Assistance recipient has decreased in the Twin Cities area over the last ten years, but it has increased in outstate Minnesota.**

Between fiscal years 2000 and 2010, average spending per eligible person in the 11-county Twin Cities area declined from $222 to $166. During the same time period, spending in the other 76 counties increased from $88 to $131 per eligible person.

[28] The federal stimulus bill—the American Recovery and Reinvestment Act—increased the federal share from October 2008 through December 2010. The Education, Jobs, and Medicaid Assistance Act provided additional federal funding for the first six months of 2011, increasing the federal share to 53.2 percent for the first three months and to 51.2 percent for the next three months. The federal share is scheduled to return to its normal 50 percent level in July 2011. See House Research Department, *Medical Assistance*, 23.

Figure 1.1: Medical Nonemergency Transportation Spending, Fiscal Years 2000-2010

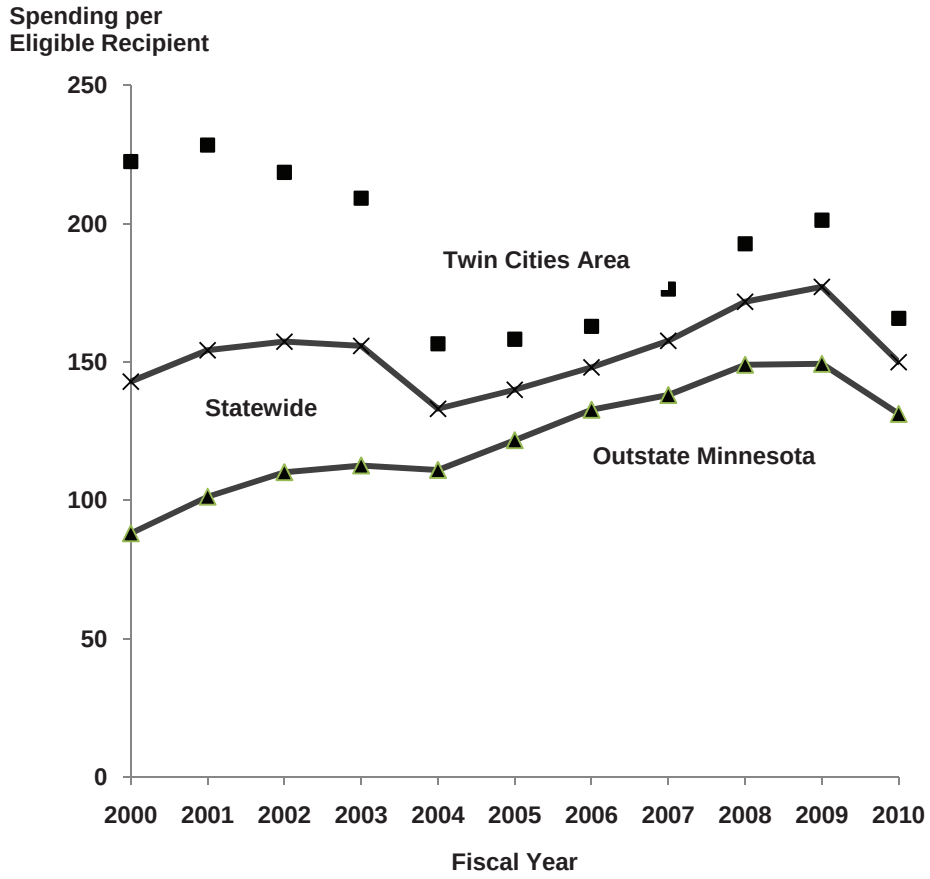


SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Despite increasing over the last several years, costs are generally lower in outstate Minnesota. Our analysis of DHS spending data for access transportation found that:

- **Outstate counties have made greater use of low-cost options to provide access transportation to Medical Assistance recipients than counties in the Twin Cities area have.**

Figure 1.2: Medical Nonemergency Transportation Spending per Eligible Medical Assistance Recipient, Fiscal Years 2000-2010



NOTE: The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Medical Assistance recipients refer to the average monthly number of public assistance recipients covered by the fee-for-service system and, thus, eligible for transportation services through Minnesota's medical nonemergency transportation program.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Outstate counties rely significantly on personal vehicles to provide access transportation, while counties in the Twin Cities area rely more on taxi-style vehicles.

In fiscal year 2010, about 69 percent of outstate counties' access transportation spending was for two low-cost options—personal mileage reimbursement and mileage reimbursement for volunteer drivers, as shown in Table 1.9. In contrast, 93 percent of access transportation spending in the Twin Cities area—excluding administrative fees—was for taxi-style vehicles, the high-cost option. Since reimbursement rates for personal and volunteer mileage are much lower than the rates paid for taxi-style vehicles, relying on volunteer drivers or recipients themselves helps keep spending lower in outstate Minnesota. For example, a ten-mile trip would cost $2 if a recipient or relative of the recipient drove and $5 if a county volunteer drove, but it would be $17 for the least expensive taxi-style vehicle.

Table 1.9: Access Transportation Spending, Fiscal Year 2010

Type of Transportation	Twin Cities Area (in thousands)	Percentage of Twin Cities Area Spending	Outstate Minnesota (in thousands)	Percentage of Outstate Minnesota Spending	Total Spending (in thousands)	Percentage of Total Spending
Taxi-style vehicles	$11,433	93%	$656	7%	$12,089	56%
Public transit	138	1	813	9	951	4
Personal mileage reimbursement	569	5	3,182	34	3,751	17
Volunteer mileage reimbursement	54	0.4	3,190	35	3,244	15
Meals and lodging	54	0.4	1,005	11	1,059	5
Other	79	1	414	4	493	2
Total	$12,310	100%	$9,250	100%	$21,560	100%
Administrative fees	$4,360		Unknown			

NOTES: The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages exclude administrative fees. Percentages may not total 100 due to rounding.

SOURCE: Office of Legislative Auditor, analysis of Department of Human Services data.

About $1 million was spent on parking, meals, and lodging in fiscal year 2010, nearly all in outstate counties where medical appointments can be far from recipients' homes. Meals and lodging are only reimbursable when medical appointments require recipients to be more than 35 miles from home and either traveling or at medical appointments during certain times of the day.

We also found that:

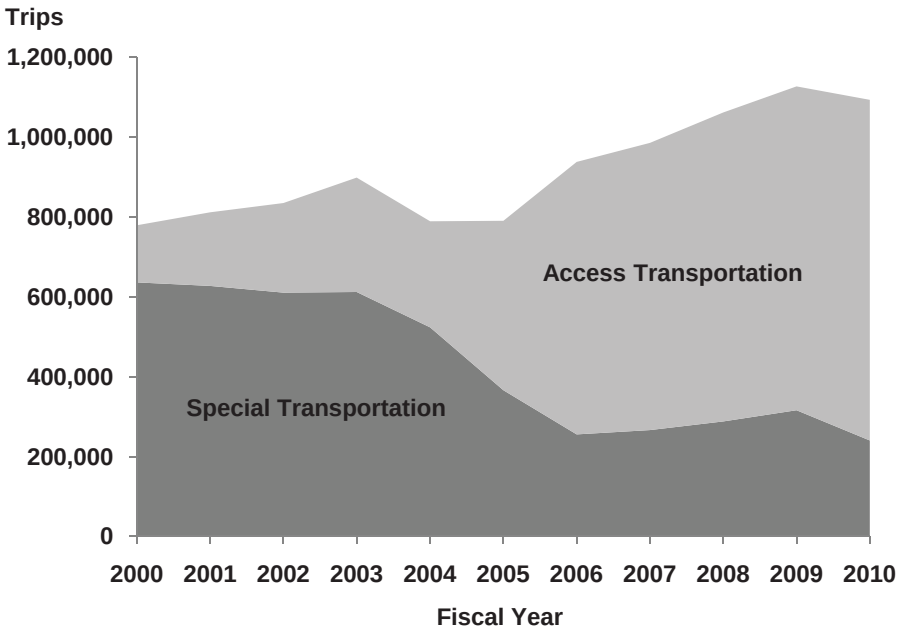
- **In the Twin Cities area, the average cost per trip for medical nonemergency transportation has declined since fiscal year 2000.**

Since 2000, average costs per trip for access transportation have fallen, partly due to the shift away from special transportation.

According to our estimates, average trip costs, excluding administrative costs, dropped from about $22 or $23 per trip in fiscal years 2000 through 2003 to about $16 in 2010. If we included administrative costs, average total costs would still fall, although by a smaller amount, going from $23 or $24 per trip in fiscal year 2000 to $21 in 2010.

This drop is partly due to the large shift in trips from special to access transportation that began in the mid-2000s. As shown in Figure 1.3, the number of special transportation trips in the Twin Cities area exceeded 600,000 in each fiscal year from 2000 to 2003, but rapidly declined to 256,000 by fiscal year 2006 and has been under 300,000 for most years since then. In contrast, the number of access transportation trips increased, going from about 300,000 to 853,000 between fiscal years 2003 and 2010. Since special transportation trips cost more than access transportation trips, average trip costs in the Twin Cities fell.

Figure 1.3: Medical Nonemergency Transportation Trips in the Twin Cities Area, Fiscal Years 2000-2010



NOTES: Each one-way trip counts as one trip. The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services and Medical Transportation Management data.

Another reason for the decline in average trip costs in the Twin Cities area is that the average cost per trip for special transportation dropped over the last several years, going from about $27 in fiscal years 2001 through 2003 to between $23 and $25 in fiscal years 2009 and 2010. Part of this drop was due to declining reimbursement rates for special transportation providers. In 2005, the Legislature decreased the base rates for most trips by $.50 to $1 and the per mile rates by $.05.[29] In addition, as we discuss in Chapter 3, the average number of miles traveled per trip declined after MTM began brokering special transportation in the Twin Cities area in October 2006. Part of this drop persisted after MTM stopped brokering the service in February 2008.

Over the last ten years, spending on special transportation declined 63 percent in the Twin Cities area, much faster than the 14 percent decline in outstate counties. During the same time period, access transportation spending increased by 1,186 percent in the Twin Cities area, compared with an increase of 188 percent in outstate counties. One reason for these differences may be that outstate counties have reported greater difficulty finding providers willing to offer taxi-style access transportation, as we discuss in Chapters 2 and 3.

[29] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 40. At the same time, the Legislature increased the base rate for stretcher rides by $24 and the per mile rate by $1. The Department of Human Services and Legislature set the maximum reimbursement rates for access transportation; rates for taxi-style vehicles within access transportation have increased slightly over the last several years.

2 Special Transportation

As we discussed in Chapter 1, Minnesota separates medical nonemergency transportation for Medical Assistance (MA) recipients into two categories: access transportation, available to all recipients, and special transportation, available only to the most seriously disabled. We begin this chapter by examining how creating a separate category for special transportation has worked overall. We then focus specifically on how the Department of Human Services (DHS) and its contractor, Medical Transportation Management, Inc. (MTM), have defined and implemented eligibility for special transportation.

MINNESOTA'S APPROACH

Minnesota has two separate administrative structures for delivering medical nonemergency transportation, one for access transportation and another for special transportation. Both, however, have essentially the same purpose—transporting MA recipients to or from medical appointments. This dual approach appears unique to Minnesota. Other states have not created separate frameworks to transport seriously disabled Medicaid recipients, although many provide different categories of service depending on recipients' needs.

Overall, we found that:

- **Minnesota's dual medical nonemergency transportation systems are duplicative and confusing.**

As we described in Chapter 1, most MA recipients in the Twin Cities area and many in outstate Minnesota use taxi-style vehicles to travel to or from medical appointments. While some of these trips are classified as access transportation and others as special transportation, the actual services provided are very similar. In both instances, drivers assist recipients in and out of vehicles and ensure that recipients are properly secured. Often, both services are provided by the same companies, using the same equipment and drivers. For taxi-style vehicles, the primary difference between access transportation and special transportation is how far into buildings drivers accompany MA recipients.[1]

Minnesota uses two separate structures to administer and deliver access and special transportation.

Despite the similarity of these two categories of transportation, Minnesota has two entirely separate structures for administering and delivering them. For example, two different payment systems are used. Counties are responsible for paying access transportation providers. Counties then submit reimbursement requests to DHS. In contrast, DHS pays special transportation providers directly, and counties are not involved.

[1] There is less overlap in services between access and special transportation for other types of transportation, such as volunteer drivers or buses.

Similarly, counties are primarily responsible for oversight of access transportation and may set standards for quality of service.[2] However, counties play no role in overseeing special transportation. Instead, oversight authority is divided between the Minnesota Department of Transportation (MnDOT) and DHS. State law requires MnDOT to set and enforce standards for special transportation providers regarding driver qualifications and training, appropriate safety equipment, inspection and maintenance of vehicles, and minimum insurance requirements.[3] None of these standards apply to access transportation providers.

The separation of the two services can produce odd and confusing changes for MA recipients who have serious health problems. Though different counties have different procedures, it is generally the county's responsibility to arrange access transportation to or from medical appointments for resident MA recipients. But if a recipient's medical condition deteriorates to the point that special transportation is necessary, the county no longer has a role in arranging transportation. At that point, it becomes the recipient's responsibility to seek eligibility for special transportation and schedule transportation directly with a special transportation provider. If the recipient improves again, transportation once again becomes the county's responsibility. Recipients can flip back and forth between the two systems in the same day—a recipient may take access transportation to a medical facility, undergo a procedure requiring sedation, and then need special transportation to return home because of the effects of the sedative.

Some MA recipients shift back and forth between access and special transportation—sometimes in the same day.

Complicating matters further, more than one definition of special transportation is used by different agencies. State law directs the Metropolitan Council to provide "special transportation" to residents of the seven-county metropolitan area, which it does through Metro Mobility.[4] This version of special transportation can be used by any individual meeting Metro Mobility's eligibility criteria for any purpose, not solely MA recipients traveling to or from medical appointments. However, Metro Mobility drivers are not required to provide the same level of service to their passengers that special transportation providers must provide to MA recipients. In contrast to the "door-through-door" service required of MA special transportation drivers, which we described in Chapter 1, Metro Mobility drivers provide "first-door-through-first-door" service. Drivers escort passengers through the outside doors of the pick-up and destination sites, but do not escort individuals further inside buildings (for example, to a medical provider's office). The Department of Human Services classifies MA recipients that travel to or from medical appointments using Metro Mobility as using access transportation, not special transportation.

[2] Because DHS reimburses counties for access transportation costs using state and federal money, DHS has ultimate authority to ensure that payments are properly made and may launch audits or investigations, as needed.

[3] *Minnesota Statutes* 2010, 174.30, subd. 2.

[4] *Minnesota Statutes* 2010, 473.386.

We also found that:

- **The Department of Human Services has administered key elements of special transportation in an ad hoc fashion.**

The department has not used rulemaking procedures, provided formal written instructions and guidelines to its contractor, or informed transportation providers, recipients, and other interested parties of procedural changes. Furthermore, DHS has not significantly changed its special transportation rules since 1987. Some of these rules no longer reflect current law, and they are silent on many important matters of interpretation.[5] The department has made key implementation decisions administratively without the public notice and comment periods required by the rulemaking process. For example, although state law sets different rates for ambulatory, wheelchair, and stretcher transportation, DHS has not promulgated rules that distinguish among these service levels.[6] Similarly, the department has never asked for public comment on its interpretations of state law that a recipient must need "driver-assisted services" to receive special transportation or that the availability of access transportation is irrelevant when determining special transportation eligibility.

Despite changes to state law, DHS has not updated its special transportation rules since 1987.

Although DHS has contracted with MTM to perform special transportation eligibility assessments for more than six years, it has given MTM little formal written guidance on how assessments should be done beyond the vague guidance contained in the contract and state law.[7] Even when the department has directed MTM to act in ways counter to contract language (as we describe later in this chapter with regard to the length of eligibility periods), it has not provided formal written guidance. Instead, the department has generally relied on informal verbal and e-mail communications to tell MTM how to perform its duties. For example, in January 2009, department staff verbally notified MTM that every minor under the age of 18 receiving medical nonemergency transportation must be accompanied by an adult. Because the accompanying adult could perform any "driver-assisted services" needed, all children therefore became ineligible for special transportation (except in unusual circumstances). The department never put this directive into a formal written document; it appeared only in MTM's meeting minutes and in later e-mail discussions between DHS and MTM staff.

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[5] For example, current rules state that eligibility for special transportation is determined by county human service agencies based on a physician's certificate. However, the 2003 Legislature changed this process by making DHS, not physicians, responsible for eligibility determinations. See: *Minnesota Rules* 2010, 9505.315, subp. 7A; and *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36.

[6] *Minnesota Statutes* 2010, 256B.0625, subd. 17(b). The department has partly defined ambulatory, wheelchair, and stretcher services in its state Medicaid plan submitted to the federal government, but the plan does not clearly explain how these levels differ between access transportation and special transportation. See Minnesota Department of Human Services, *Title XIX State Plan, 3.1(c)(1) Assurance of Transportation* (St. Paul, undated).

[7] Minnesota Department of Human Services and Medical Transportation Management, *Contract #432723*, as amended, June 15, 2004-June 30, 2006, II. H13; Minnesota Department of Human Services and Medical Transportation Management, *Contract #436466*, as amended, July1, 2006-June 31, 2011, II. 13; and *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

Implementation decisions that DHS has made administratively have changed the experiences of some special transportation applicants. However, the department has not published these changes regarding special transportation eligibility, even in cases that would make some previously denied MA recipients eligible.[8] For example, when DHS instructed its contractor in April 2010 to stop considering whether recipients would be accompanied to appointments by others, it made no public announcement of this change in practice.

ELIGIBILITY

From 1991 to 2003, MA recipients could become eligible for special transportation with written statements from their doctors. Transportation providers were required to keep a physician's authorization on file for each person they transported. However, DHS administrators told us that this system was open to fraud and abuse. Physicians had no incentive to limit authorizations to the most disabled patients, and many did not understand the distinctions among the types of transportation available.

Since 2005, DHS has contracted with a broker to determine whether MA recipients are eligible for special transportation.

In 2003, the Legislature made DHS, not physicians, responsible for determining eligibility for special transportation.[9] Beginning in January 2005, DHS contracted with MTM to meet this responsibility statewide.[10] In addition to determining eligibility, MTM also determines how long each recipient's eligibility for special transportation will last. The current contract between DHS and MTM calls for DHS to pay $35 for each eligibility determination made.[11]

To become eligible for special transportation, a recipient or a representative must contact MTM. MTM nurses assess information about the recipient's condition and determine whether the recipient needs "driver-assisted services." In some instances, the information provided in the initial phone call is sufficient to determine eligibility. At other times, MTM staff ask the recipient's medical providers to complete a form about the recipient's abilities, which is then used to reach an eligibility decision. Medical Assistance recipients that live in skilled nursing facilities do not go through this process; they are automatically eligible for special transportation under state law.[12]

An MA recipient whose request for eligibility is denied may request that MTM "reconsider" its decision. In a reconsideration, MTM generally seeks further

[8] The department is unable to directly notify individuals previously denied services because it does not keep records of denied applications.

[9] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36. Eligibility determinations are referred to in law as "level of need determinations." See *Minnesota Statutes* 2010, 256B.04, subd. 14a.

[10] Department of Human Services, *Contract #432723*, II. H13; and Department of Human Services, *Contract #436466*, II. H13.

[11] *Ibid*., Amendment 7.

[12] *Minnesota Statutes* 2010, 256B.04, subd. 14a. If a nursing facility resident or a representative requests a stretcher trip, MTM will assess the recipient to determine whether stretcher service is needed. If the request is denied, the recipient is automatically eligible for ambulatory or wheelchair special transportation.

information from one or more additional treating health providers (such as specialists or mental health professionals). All information gathered is added to the recipient's record and a new determination is made. A recipient still dissatisfied with the outcome after the reconsideration process can file a formal appeal with DHS's Appeals and Regulations Division.[13]

Reviewing information from MTM and DHS, we found that:

- **The Department of Human Services paid its contractor for nearly 4,900 special transportation eligibility determinations made from January 2009 through June 2010, approximately two-thirds of which were approvals.**

The 4,875 determinations involved 3,984 separate MA recipients. The department paid for 3,358 individuals to be assessed for eligibility once during this time period, 461 to be assessed twice, and 165 to be assessed three or more times. A handful of individuals were assessed five or more times.[14]

It is difficult to state with certainty the percentage of determinations resulting in approvals because:

- **The Department of Human Services' recordkeeping regarding special transportation applications has been poor.**

The department does not keep records of applications for special transportation status that result in denials, and it keeps incomplete records of past approvals that have expired. Despite contract language requiring MTM to report on the "disposition" of special transportation assessments, DHS has not asked for basic information about each assessment billed to the state, such as the level of service requested (ambulatory, wheelchair, or stretcher) or whether the request was approved or denied.[15] The department pays MTM based solely on the date of the assessment and the MA identification number of the person assessed. Further, MTM staff enter approvals for special transportation into a DHS database that is primarily designed to store current information. When new information is added, old information must often be discarded to make room.

Recordkeeping problems make it difficult to analyze long term trends in special transportation eligibility.

Although MTM keeps its own records, it was not possible to completely match its records to DHS's payment records. For example, MTM's assessment records did not include 59 of the 4,875 assessments paid for by DHS but did include 486

[13] The reconsideration process has evolved over time and is not outlined in DHS's contract with MTM. When applicants contest their special transportation eligibility decisions, the contract allows for a "Level II" assessment, in which applicants are evaluated by an independent third party. However, only a handful of Level II assessments have taken place in recent years. The reconsideration process is less costly because MTM does not charge DHS for reconsiderations. Importantly, the process enables applicants to make a stronger case for eligibility because decisions are based on information received from their own medical professionals.

[14] There is no limit on the number of unsuccessful applications for special transportation a single individual may make in a given time period.

[15] Department of Human Services, *Contract #436466*, II. K1(a).

assessments for which DHS recorded no payment or denied payment.[16] The dataset of assessment outcomes that MTM gave us appeared to double-count over 1,000 assessments and did not fully match MTM's own billing records.[17] Also, MTM does not systematically track the levels of service (ambulatory, wheelchair, or stretcher) requested or approved.

Consequently, it was impossible to track trends in special transportation eligibility over time. We cannot state confidently how many special transportation eligibility assessments have been conducted since DHS was given responsibility for special transportation eligibility in 2003, nor can we determine whether the percentage of approvals has changed over time.

Criteria

Some MA recipient advocates and transportation providers have contended that DHS and MTM have inappropriately denied special transportation to recipients who should receive it. We reviewed the eligibility process and found that:

- **The Department of Human Services has adopted special transportation eligibility criteria that are narrower than the criteria in state law.**

Consequently, a few MA recipients have fallen "between the cracks" of Minnesota's special transportation eligibility process. They appear eligible under state law, but they are ineligible under DHS practice.

A few MA recipients have fallen "between the cracks" in terms of eligibility for special transportation.

In setting standards for special transportation, state law describes both which recipients are *eligible* for special transportation and what *services* are to be provided to those recipients. An individual is eligible for special transportation "if the recipient has a physical or mental impairment that would prohibit the recipient from safely" using access transportation.[18] This description of eligibility makes no reference to the amount of assistance a recipient needs; it simply states that a recipient who cannot access and use commercial transportation or private automobiles is eligible. The law goes on to specify the services that must be provided to eligible individuals, including assistance into and out of medical facilities.[19]

When determining whether individuals are eligible for special transportation, DHS has combined the statute's description of eligibility with its description of services. In addition to examining whether an individual can access other forms of transportation, the department has instructed MTM to evaluate whether a recipient needs the services outlined in statute:

[16] Denials of payment were usually due to incorrect data such as wrong recipient identification numbers. In many cases, MTM later submitted corrected bills.

[17] Because we had three nonmatching data sources, our finding that two-thirds of determinations resulted in approvals is based on analyzing each data source separately.

[18] *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

[19] *Ibid.*

> To be certified as eligible for [special transportation], the client must have a physical or mental condition requiring the transportation driver to provide direct assistance to the client. The direct assistance by the driver must be required inside the residence to exit and enter and assistance into and out of the medical facility to and from the appropriate medical appointment desk.[20]

This approach to interpreting the law has left a few individuals in a gray area because they are unable to use access transportation but do not necessarily need driver assistance to reach an appointment desk. For example, practically all children are ineligible for special transportation because DHS expects parents or guardians to accompany them to appointments. The department's position is that parents or guardians can perform the services a special transportation driver would perform, so children do not need special transportation. Similarly, adult MA recipients who were often accompanied by family members, personal care assistants, or other individuals were considered ineligible for special transportation under the same reasoning. After being criticized at a legislative hearing, the department quietly reversed its direction to MTM regarding accompanying individuals in April 2010.[21] However, the practice of denying children special transportation eligibility has not changed.

Until recently, DHS had determined that MA recipients traveling with personal care attendants were not eligible for special transportation.

Some transportation providers contend that DHS has inappropriately denied special transportation eligibility to individuals who are transported in wheelchairs. We examined this claim and found that:

- **Policy decisions by the Department of Human Services, market forces, and ambiguities in state law have created barriers to medical nonemergency transportation for a small number of Medical Assistance recipients.**

The department has defined a level of access transportation for recipients who are transported in their wheelchairs.[22] These recipients can maneuver themselves into and out of medical facilities independently (for example, by using a motorized wheelchair). However, they cannot safely sit in regular automobiles or bus seats and instead must use specially-equipped vehicles that can accommodate passengers who remain in their wheelchairs during rides.

Because taxi-style access transportation costs less but is otherwise indistinguishable from special transportation (except for escorting MA recipients inside medical offices), DHS's practice of classifying these trips as access transportation has reduced costs to the state while providing recipients with transportation that meets their needs. However, some special transportation providers that serve rural areas consider the maximum access transportation rates

[20] Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, DHS Bulletin #10-21-02 (St. Paul, January 13, 2010), 2.

[21] This change in practice was not put in writing by DHS other than in an e-mail exchange with MTM staff.

[22] Department of Human Services, *Access Transportation Services (ATS) Information*, 6.

for these services too low and will only provide these services at the higher special transportation rates.[23] As a result, in some parts of the state where only one or two special transportation companies operate, access transportation is not available for wheelchair-bound recipients.[24] According to the transportation providers we spoke with, overhead costs in rural areas are higher because drivers often travel many unreimbursed miles without a recipient in the vehicle to reach pick-up points. Some providers also believe that wheelchair transportation is essentially a special transportation service and should be reimbursed as such.

Under DHS practice, availability of appropriate access transportation is irrelevant when considering whether a recipient needs special transportation. If a recipient would be able to use access transportation if it were available, then the recipient is not eligible for special transportation. Under state law, though, MA recipients are eligible for special transportation if they cannot safely access and use access transportation.[25] It is unclear whether the Legislature intended this language to include instances where appropriate access transportation does not exist. When recipients have appealed special transportation denials based on the unavailability of appropriate access transportation, some DHS administrative law judges have agreed with recipients that DHS's practice runs counter to the intent of the law. One judge wrote:

When MA recipients file appeals about special transportation eligibility, administrative law judges have issued conflicting opinions on whether DHS has interpreted state law correctly.

> There is no safe transportation option that exists in the area for the appellant and her scooter other then special transportation. The legislature certainly did not mean for special transportation to be denied because somewhere in the universe there is a common carrier vehicle that is wheelchair accessible that could accommodate the appellant's needs.[26]

However, other administrative law judges have reached the opposite conclusion. In a reconsideration of an earlier appeals decision that was partly based on the lack of access transportation, a judge wrote:

> I reject any conclusions of law that indicate lack of availability of other forms of transportation as a reason to approve special transportation. Lack of availability of other forms of transportation cannot be a reason to approve special transportation services.[27]

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[23] See Tables 1.4 and 1.7 for the reimbursement rates for access and special transportation, respectively.

[24] In some instances, county-based van services for disabled passengers are available for local trips, but recipients that travel in wheelchairs may not be able to use these services for longer trips.

[25] *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

[26] *N.C. vs. Minnesota Department of Human Services*, DHS Docket 110834, October 21, 2009, Fair Hearings Decision Database, http://appeals.dhs.state.mn.us/AppealsSearch.aspx, accessed May 20, 2010.

[27] *A.B. vs. Minnesota Department of Human Services*, DHS Docket 113042, December 18, 2009, Fair Hearings Decision Database, http://appeals.dhs.state.mn.us/AppealsSearch.aspx, accessed May 20, 2010.

Patient advocates have also raised concerns that DHS and MTM do not properly certify recipients with mental impairments as eligible for special transportation. We were unable to directly evaluate that claim because independently assessing recipients' mental impairments was beyond the scope of our evaluation. Our review of a sample of special transportation eligibility assessments did show that MTM has certified some individuals eligible for special transportation based primarily on mental impairments. However, we found that:

- **The broker's assessment forms for determining special transportation eligibility have focused mostly on physical impairments and have asked for little information about mental impairments.**

Nurses that work for MTM use a standardized form to gather information about a recipient's impairments when speaking to the recipient or a representative. A very similar form is often sent to medical providers to gather further information. Most of the questions on the two forms are related to physical mobility. For example, the forms ask if the recipient can ambulate independently, if he or she uses a mobility aid, and if assistance from others is needed for the recipient to physically move around the community. The forms have a single question that refers to mental impairments, but it is directed solely at the recipient's ability to use public transportation and does not ask whether the recipient would have difficulty using other types of access transportation. For example, the forms do not ask whether the recipient can independently find his or her way from an outside curb to the appropriate medical office within a large office building, or whether the recipient can distinguish the proper vehicle to board when exiting a building at the end of an appointment.

The department's broker has proposed changes to its special transportation eligibility forms to better assess MA recipients' mental impairments.

There is a space for "additional information, comments, or concerns" on the forms, so it is possible to convey information about a recipient's mental impairments. But the forms' direct questions would not necessarily elicit information about severe mental disabilities that could make a recipient eligible for special transportation.[28] MTM has recently proposed new versions of these forms that would, among other changes, ask more directly about mental impairments. For example, instead of asking if the recipient needs "direct physical assistance" from the driver, the proposed forms use the phrase "physical/cognitive assistance."

Various stakeholders have also raised concerns about whether conflicts of interest have affected eligibility decisions. The department uses the same contractor, MTM, to determine special transportation eligibility statewide as counties use to coordinate access transportation in the Twin Cities area.[29] To some policy makers and transportation providers, this dual role creates a conflict of interest because recipients in the Twin Cities area who are denied special transportation would most likely use access transportation that MTM arranges.

[28] By comparison, the form used by Metro Mobility to determine eligibility for its transportation services asks directly about both physical and mental impairments.

[29] The department also used MTM to coordinate access transportation in the Twin Cities area prior to July 2009.

However, we found that:

- **There was no evidence that conflicts of interest have affected the broker's decisions regarding special transportation eligibility.**

We examined a sample of special transportation assessments conducted from January 2007 through June 2010 and concluded that MTM consistently followed DHS's informal guidance in making eligibility decisions. In addition, we found no systemic differences between eligibility decisions made for recipients outside the Twin Cities area (where no conflict of interest could exist) and recipients within the Twin Cities area.[30]

The broker has followed DHS's informal guidance when making special transportation eligibility decisions.

Further, MTM and DHS staff told us that MTM has frequently consulted department staff about issues related to special transportation eligibility, and e-mails and meeting notes show that regular communication has occurred. Although we question whether the criteria MTM uses exactly match those outlined in state law, DHS developed the criteria, not MTM. Similarly, although we found that MTM's records were insufficient to fully evaluate special transportation eligibility practices, DHS has not asked MTM for more complete records.

Finally, some advocates have charged that DHS and MTM frequently deny special transportation to applicants but reverse their decisions to avoid losing when applicants file formal appeals. We did not find evidence to support this claim. Of the 117 appeals related to special transportation filed from April 2008 through September 2010, only 8 were resolved before a hearing took place. The department does not record why appeals are dismissed; some or all of these dismissals may have been due to applicants withdrawing their appeals rather than DHS reversing its stance.

Furthermore, we found that:

- **Medical Assistance recipients denied special transportation have filed relatively few appeals with the Department of Human Services.**

As stated earlier, DHS paid MTM for nearly 4,900 eligibility assessments from January 2009 through June 2010. The company denied special transportation in about one-third of the cases. During the same time period, MA recipients denied special transportation filed 83 appeals, and administrative law judges reversed the department's denials 40 percent of the time. Appeals judges' decisions overturning special transportation denials usually cited one of three reasons: (1) the recipient's impairment was more severe than MTM had found; (2) no appropriate access transportation was available in the recipient's area; or (3) the person usually accompanying the recipient could not provide "driver-assisted services" or the accompanying person did not always attend appointments.

[30] Because MTM coordinates access transportation trips within the Twin Cities area only, it would gain no advantage from funneling additional MA recipients to access transportation services outside the Twin Cities area.

Assessment Frequency and Length of Eligibility

Some policy makers and transportation providers have questioned the frequency with which MA recipients must undergo eligibility assessments for special transportation. State law and DHS's contract with MTM provide general guidance regarding the frequency of assessments.

The Legislature has specifically directed DHS to avoid frequent reassessments for special transportation eligibility. In 2007, it said that eligibility assessments "must not be performed more than semiannually on any individual, unless the individual's circumstances have sufficiently changed."[31] In 2010, it changed "semiannually" to "annually."[32] While the law gives DHS the discretion to initiate eligibility assessments more often, the statutory language anticipates that frequent assessments will be the exception, not the rule.

In addition, DHS's contract with MTM requires that special transportation certifications "generally parallel the time given for Social Security Insurance Disability redeterminations as outlined in 20 CFR 416.990."[33] Under these provisions, reassessments occur (1) between 6 and 18 months if the recipient is expected to improve, (2) at least once every 3 years for recipients with a disability not considered permanent but whose improvement cannot be accurately estimated, and (3) no more frequently than once every 5 years for those with a permanent disability.[34]

When the broker approves a request for special transportation, it also specifies how long that approval will last.

Because recipients need new assessments to receive special transportation once their previous eligibility periods expire, assessment frequency is linked to the length of eligibility periods. If eligibility periods are short, recipients must be reassessed more frequently to continue using special transportation. Conversely, if eligibility periods are long, recipients will not need reassessments—but some recipients may receive costly special transportation for longer than they need it. Statutory language does not directly address the length of eligibility periods except for stretcher transportation, for which recipients are "presumed to maintain that level of need" until otherwise determined by DHS, or for six months, whichever is sooner.[35]

We found that:

- **The Department of Human Services has frequently limited Medical Assistance recipients' eligibility for special transportation to extremely short time periods.**

Although MTM's *Operations Manual* states that special transportation approval periods will be "at least 6 months or up to 7 years," DHS and MTM have agreed

[31] *Laws of Minnesota* 2007, chapter 147, art. 5, sec. 7.

[32] *Laws of Minnesota* First Special Session 2010, chapter 1, art. 16, sec. 4.

[33] Department of Human Services, *Contract #436466,* II. H13(b).

[34] 20 CFR 416.990(d) (2010).

[35] *Minnesota Statutes* 2010, 256B.04, subd. 14a.

on procedures that limit the duration of eligibility for many MA recipients to time periods much shorter than six months.[36] As shown in Table 2.1, eligibility lasted for only a single day for about 40 percent of ambulatory and wheelchair approvals. MTM granted eligibility periods of 181 days or more in only 36 percent of ambulatory and wheelchair approvals and only 1 percent of stretcher approvals.

However, special transportation eligibility for many MA recipients lasts only a single day.

Table 2.1: Percentage of Special Transportation Eligibility Approvals by Length of Eligibility Period and Type of Eligibility, July 2007-June 2010

	Length of Eligibility Period			
Type of Eligibility	1 day	2 to180 days	181 days to 7 years	7 years or more
Ambulatory	42%	14%	36%	7%
Wheelchair	38	17	36	9
Stretcher	87	11	1	0

NOTES: Data are based on 10,457 eligibility approvals for 7,400 unique Medical Assistance recipients. Because the Department of Human Services' data are incomplete, this table likely understates the percentage of special transportation eligibility periods of short duration, particularly in earlier years. Seven years was defined as 2,525 days or more in order to capture instances where the person entering the time span rounded to the nearest month. Rows may not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Due to the high cost of stretcher transportation, DHS has been particularly aggressive in limiting eligibility periods for this level of service. The department requires that MTM preapprove each stretcher trip separately to ensure that a recipient is unable to use less expensive services. As a result, over 90 percent of stretcher special transportation approvals from January 2009 through June 2010 were limited to a single day. Stretcher eligibility periods lasting six months or more were very rare.

According to DHS, certification for special transportation and the length of the eligibility period should be based on medical necessity. If a recipient's medical condition justifying special transportation is not expected to last for a year, then MTM should not grant eligibility for a year. Consequently, some recipients require new special transportation assessments to take another trip within weeks of a previous approval, despite the statutory language saying that such reassessments should only occur if "circumstances have sufficiently changed."[37] The department's perspective is that the expiration of the eligibility period indicates that circumstances have changed.

[36] Medical Transportation Management, *Operations Manual* (St. Louis, MO, 2009), 21.

[37] *Minnesota Statutes* 2010, 256B.04, subd. 14a.

When a recipient with a recent but now expired approval requests additional eligibility for another special transportation trip, MTM may conduct an entirely new eligibility assessment for which it charges the department. In other instances, MTM may simply update the recipient's previous certification to include a new time period without charging DHS. The department has not provided MTM with any written guidelines that describe when billing is appropriate; rather, the choice appears to be at MTM's discretion.

Because many recipients do not request an additional special transportation certification shortly after being approved, short eligibility periods cause a relatively small number of special transportation applicants to need additional reassessments in less than six months. As shown in Table 2.2, in about 12 percent of the determinations made from January 2009 through June 2010, the recipient had been approved for special transportation less than 180 days previously. However, because MTM did not record the level of service each applicant sought, some recipients assessed twice may have requested a more costly level of special transportation (for example, a recipient already eligible for ambulatory service may have requested wheelchair service).

Table 2.2: Special Transportation Eligibility Assessments by Length of Time since Previous Approval, January 2009-June 2010

Time Since Previous Approval	Number	Percentage of Total	Percentage Paid for by DHS
3 days to 30 days	254	5%	93%
31 days to 180 days	363	7	93
181 days or more	1,749	33	88
No previous approval	2,950	55	92
Total	5,316	100%	91%

NOTES: Data include 486 assessments appearing in Medical Transportation Management (MTM) records for which the Department of Human Services (DHS) recorded no payment. However, data do not include 59 assessments DHS paid for during this time period that do not appear in MTM's records (because we could not determine from DHS's data alone whether the assessments resulted in approvals or denials). We also excluded 1,396 assessments appearing in MTM's records that took place less than three days after a previous approval. Most of these likely represent double-counting of single assessments; only 3 percent were paid for by DHS.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

A small number of MA recipients have had to reapply for special transportation within weeks of an earlier approval.

Because DHS does not keep complete records regarding special transportation approvals, it is difficult to determine whether its practice of limiting eligibility periods has actually been effective in managing special transportation costs. Shorter approval periods may reduce the likelihood that recipients receive more costly transportation services than they need. However, the department's current contract with MTM calls for DHS to pay $35 for each special transportation eligibility assessment. As shown earlier in Table 1.8, the difference in cost between special transportation trips and similar access transportation trips is

frequently less than $10.[38] If a recipient's medical condition improves and he or she no longer needs ambulatory or wheelchair special transportation, it costs more to reassess the recipient and deny eligibility than it would to simply allow the recipient to take an additional trip or two at special transportation rates. Further, an early reassessment of a recipient whose condition has *not* improved represents an unnecessary expense.[39]

In some cases, it makes sense to tightly limit how long MA recipients can receive special transportation without being reassessed, but in other cases it does not.

Because stretcher transportation is much more expensive than other options, requiring frequent reassessments of eligibility for stretcher transportation is more likely to lower overall costs than reassessments for other forms of special transportation—particularly if longer distances are involved. For example, as shown earlier in Table 1.8, the difference in cost between a 20 mile stretcher trip and a 20 mile wheelchair special transportation trip is $73. Thus, even if most reassessments did not change recipients' special transportation status, the savings in the minority of cases where they did change the status could justify the additional assessment costs.

Cost-effectiveness, though, is not the only criterion by which to assess DHS's actions limiting eligibility periods. Because special transportation is designed to serve recipients who are unable to use any other form of transportation, individuals who apply for special transportation status are often struggling with severe physical or mental health issues. For this population, the need to undergo repeated assessments to determine their eligibility for special transportation may be a significant burden.

RECOMMENDATIONS

Generally speaking, the evidence that we examined suggests that most MA recipients have been able to get to or from medical appointments using access or special transportation (or without assistance). The difficulties with eligibility criteria and approval periods that we describe above have likely affected a small proportion of MA recipients seeking transportation. Nonetheless, we believe some changes are necessary to simplify Minnesota's medical nonemergency transportation system, reduce unnecessary duplication, and improve services and accountability.

RECOMMENDATION

The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 Legislature.

[38] This calculation excludes administrative charges paid by some counties to contractors who arrange access transportation trips. In the Twin Cities area, this fee is currently $5.54 per trip.

[39] In practice, MTM sometimes does not bill the state for early reassessments of individuals whose condition has not changed.

Administrative structures for access and special transportation should be unified and simplified.

Minnesota's current approach to providing transportation to MA recipients is needlessly complicated. Although the two categories of service that the state uses (access and special transportation) are sometimes offered by the same providers and used by the same recipients, each category has different eligibility determination processes, scheduling arrangements, billing procedures, and oversight mechanisms. Additionally, recipients' needs are not fixed; some recipients with serious health concerns move back and forth between the two categories as their health needs change. Consolidating access and special transportation into a single administrative structure would lessen confusion, enhance coordination, and improve accountability. It would also make it easier to standardize data collection so that program performance can be evaluated and improved over time.

Separate special transportation arrangements have been in place in Minnesota for over three decades. Moving to a consolidated structure would not be easy and would require careful planning. A single structure could either require counties to take on additional special transportation responsibilities or DHS to take on additional access transportation responsibilities. Both state and local administrators would have to estimate how their costs would change and determine how to pay for any expected increases. Additionally, the definition of special transportation is used in other parts of state law, for example, in sections governing Metro Mobility, and potential statutory changes would need to be examined to prevent unintended effects on other programs.

RECOMMENDATION

As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable.

The Department of Human Services' administrative law judges have reached different conclusions when interpreting the eligibility criteria for special transportation outlined in statute. Specifically, it is unclear whether recipients who live in communities where appropriate access transportation is not available are eligible for special transportation. The Legislature should clarify its intent, bearing in mind that either approach has drawbacks. If recipients in these circumstances are considered eligible for special transportation, then special transportation providers in areas with low competition will have little incentive to also offer access transportation and costs may increase. If these recipients are not considered eligible, some rural counties may have difficulty finding appropriate transportation for some disabled recipients, particularly for longer trips.

RECOMMENDATION

The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation.

Policies regarding the frequency of assessments and the length of special transportation eligibility periods involve tradeoffs. Shorter eligibility time frames and more frequent assessments increase both inconvenience for recipients and assessment costs. However, they could lower transportation costs because recipients may be less likely to receive more costly levels of service than they need.

Although the Legislature has made a policy choice regarding assessment frequency, statutes do not directly address the length of eligibility periods. The department and MTM have granted very short eligibility periods to many recipients, a practice that appears inconsistent with the Legislature's desire for fewer assessments. While we are uncomfortable with how DHS has interpreted the statutory language, we agree that the law is vague. The department should propose replacement statutory language that more clearly reflects its current practices and seek the Legislature's endorsement of its approach.

State law regarding special transportation eligibility criteria, assessment frequency, and approval periods needs to be clarified.

In reviewing DHS's proposal, the Legislature should consider that limiting DHS's ability to reassess MA recipients may constrain the department's ability to control costs. We noted in Chapter 1 that some recipients take as many as 100 nonemergency transportation trips a year. When a recipient's health could plausibly change, it becomes increasingly cost-effective to spend money on an additional assessment as more trips are taken. Further, because the cost of a stretcher trip is much higher than any other type of nonemergency transportation, frequently reassessing eligibility for stretcher transportation also enhances DHS's ability to control costs.

However, in our view, DHS's practice of limiting many ambulatory and wheelchair eligibility periods to a single day errs too far in the other direction. Though a small number of individuals have needed reassessments within weeks of a previous approval, those reassessments represent unnecessary costs to the state and unnecessary inconvenience to recipients.

Very short eligibility periods are also inconsistent with MTM's contract, which requires the company to set eligibility periods in conformance with Social Security Disability guidelines. The department has not provided MTM with formal instructions describing when eligibility periods should deviate from the six-month minimum indicated by these guidelines, nor has it made such instructions available to recipients, transportation providers, and other interested parties.

RECOMMENDATION

The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changed.

In our discussions with transportation providers, recipient advocates, county officials, and other interested parties, we found a substantial amount of misinformation about how special transportation eligibility is determined and how access and special transportation differ from one another. While special

transportation is a small part of a much more complex MA program, it has been the subject of disproportionate scrutiny. The Legislature has made repeated changes to laws relating to special transportation.

We believe that the lack of clear information and the close scrutiny of DHS's administration of special transportation are related. Department staff told us that outside interests have sometimes mischaracterized DHS's actions. However, DHS has rarely published materials that actually describe how it administers medical nonemergency transportation. The department's ad hoc approach to program administration has meant that decisions are made and implemented behind the scenes. The department should increase transparency by publishing documentation that clarifies its special transportation eligibility process and explains changes so that recipients, advocates, providers, and legislators can better understand its policies and practices.

The department needs to make its policies and decision making more transparent to the public.

RECOMMENDATION

The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow.

Setting clear expectations is a prerequisite for effective accountability procedures. Our review led us to conclude that MTM had generally implemented DHS's directives. However, we found it surprisingly difficult to figure out what those directives were in the first place.

The department should routinely provide clear written directions to MTM about its implementation of department policies. Providing written materials would also improve overall transparency; such letters or other formal documents could be readily reviewed by interested parties such as transportation providers and disability advocates. The department should also routinely update its contract when actions outlined in the contract are substantially changed or are no longer required.

3 MANAGEMENT ISSUES

As we pointed out in Chapter 1, the federal government allows states considerable flexibility in designing their medical nonemergency transportation programs. This chapter addresses a number of concerns that legislators and other interested parties have raised about medical nonemergency transportation, including the use of brokers, state oversight practices, and recipient satisfaction.

BROKERING

Over the last several years, states have increasingly moved from operating their transportation programs themselves to contracting for such services. In fact:

- **Since the mid-1990s, the federal government has encouraged states to contract with "brokers" to manage medical nonemergency transportation for Medicaid recipients.**

The term "broker" refers to an entity that takes requests for trips and then distributes the trips among service providers.[1] Brokers act as intermediaries between Medicaid recipients and transportation providers and between providers and the state Medicaid agency.

Federal Requirements

Brokers take trip requests and distribute them among transportation providers.

When states choose to use brokers to coordinate transportation, the federal government requires that the brokers be selected through a competitive procurement process and that the programs be cost-effective.[2] State contracts must require that brokers: (1) have oversight procedures in place to monitor Medicaid recipient access and complaints; (2) use transportation personnel who are licensed, qualified, competent, and courteous; and (3) comply with federal requirements related to prohibitions on referrals and conflicts of interest.[3] Additionally, states must perform regular auditing and oversight of brokers to ensure that Medicaid recipients have access to quality transportation services.

The primary purpose of a broker is to coordinate services in a cost-efficient and effective manner. The federal government's preference for brokers grew out of

[1] Transportation Research Board, *Transit Agency Participation in Medicaid Transportation Programs* (Washington, DC, 2006), 4.

[2] 42 CFR 440.170(a)(4) (2010). Also, see U.S. Department of Human Services, Centers for Medicare & Medicaid Services, letter to State Medicaid Directors, March 31, 2006.

[3] 42 CFR 440.170(a)(4) (2010).

widespread fraud and abuse by both transportation providers and recipients, costing states and the federal government millions of dollars.[4] According to various studies, brokers can reduce or control costs by: (1) ensuring that recipients receive the most appropriate and least costly type of transportation, (2) decreasing average trip length, (3) coordinating trips and riders, (4) obtaining competitive bids from service providers, and (5) discouraging provider and recipient fraud and abuse.[5] In addition, brokers can simplify the transportation process for recipients and help ensure more consistent decision making. States using brokers generally report an increase in the number of trips provided but a reduction in cost per trip, although the rigor of the different studies varies.[6]

Widespread fraud and abuse prompted the federal government to encourage states to use brokers.

However, even well-designed broker programs can have disadvantages—disadvantages that must be weighed against brokers' abilities to control costs. First, state administrative costs may increase since, without a broker, transportation services would likely be provided locally as part of a county's overall Medicaid program. Also, states using brokers must monitor brokers' performance, which may add costs. Second, administrative costs for this single service may be too high to find economies of scale for programs providing a relatively low number of trips. Third, brokers may offer recipients less choice regarding the type of transportation or which transportation provider to use. Fourth, brokers unfamiliar with local environments or human services providers may be less efficient than local agencies when trying to coordinate Medicaid transportation with transportation services for other groups.

Other States

After reviewing relevant studies and talking with officials in several states, we found that:

- **Most states use one or more brokers to administer at least a portion of their medical nonemergency transportation programs.**

As shown in Table 3.1, at least 40 states and the District of Columbia either (1) used a broker for at least a portion of their Medicaid population in 2010 or (2) are planning to use one in 2011. Although states frequently use brokers to provide transportation for Medicaid recipients under a fee-for-service system, many states also use them for recipients in managed care plans.[7]

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[4] U.S. Department of Health and Human Services, *Controlling Medicaid Non-Emergency Transportation Costs* (Washington, DC, April 1997).

[5] For example, see The Hilltop Institute, *Non-Emergency Medical Transportation (NEMT) Study Report* (Baltimore, MD, September 26, 2008); and Joint Legislative Committee on Performance Evaluation and Expenditure Review, *A Review of the Mississippi Division of Medicaid's Non-Emergency Transportation Program* (Jackson, MS, January 7, 2008).

[6] For example, see Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, May 2004); and Public Policy Center, *Iowa Medicaid Non-Emergency Medical Transportation System Review and Options for Improvements* (Iowa City, IA: University of Iowa, September 30, 2008).

[7] In some states, transportation is carved out of managed health care plans with services coordinated by a broker rather than the health plans.

Table 3.1: Use of Brokers Nationwide, 2011

States Using One or More Brokers	
Alaska	Missouri
Arkansas	Montana
Colorado	Nebraska
Connecticut	Nevada
Delaware	New Jersey
District of Columbia	New Mexico
Florida	New York
Georgia	North Carolina
Idaho	Oklahoma
Illinois	Oregon
Indiana	Pennsylvania
Iowa	Rhode Island
Kansas	South Carolina
Kentucky	Tennessee
Louisiana	Utah
Maine	Vermont
Maryland	Virginia
Massachusetts	Washington
MINNESOTA	Wisconsin
Mississippi	West Virginia

States Not Using a Broker	
Alabama	North Dakota
Arizona	Ohio
California	South Dakota
Hawaii	Texas
New Hampshire	West Virginia

NOTES: Not all the states that we have classified as having brokers administer those programs at the state level. In some states, individual counties or groups of counties administer the brokerage programs. Illinois only uses a broker to determine eligibility for transportation assistance.

SOURCE: Office of the Legislative Auditor, analysis of various reports and studies.

Some states use a single broker statewide; others use brokers on a regional or county basis.

Brokers come in varying sizes, with differing functions and levels of responsibility. They can be for-profit companies, not-for-profit agencies, or units of government such as transit authorities. Also, brokers can operate on a statewide, regional, or county basis—or any combination thereof. These differences make it difficult to compare the effectiveness of states' experiences using brokers.

States also use a variety of methods to pay their brokers, as shown in Table 3.2. Each type of payment method comes with its own set of service-related incentives, and no method is clearly superior to another. In theory, the type of payment method used should reflect state priorities, with oversight mechanisms built into contracts to guard against the disincentives inherent in the respective payment method adopted.

Table 3.2: Types of Payment Methods States Use to Pay Brokers, 2011

Method 1: Fixed Amount per Medicaid Recipient	Fee is based on a set amount per Medicaid recipient or enrollee in the geographic area covered.
Method 2: Maximum Total Amount	Broker earns a set amount of money during the life of the contract.
Method 3: Flat Amount per Trip by Type of Trip	Broker is paid a fixed amount for each type of trip provided, with fees generally higher for trips using taxi-style vehicles and lower for trips using common carriers such as buses and cars.
Method 4: Flat Amount per Trip	Broker is paid a fixed amount for each trip provided, regardless of the type of transportation used.
Method 5: Administrative Fee	Broker is paid a flat administrative fee for each trip provided, plus an additional amount to specifically reimburse transportation providers' costs.

SOURCE: Office of the Legislative Auditor.

Different payment methods create incentives for brokers to control costs or limit access.

Payment methods 1 and 2 limit the total amount of money paid to brokers. Under both methods, brokers are paid a lump sum of money out of which they must cover their own costs and those of transportation providers. Studies suggest that these types of payment methods are the most cost-effective because they provide a direct incentive for brokers to reduce costs in order to maximize their profits.[8] Another advantage is that total costs are predictable. However, these payment methods provide incentives for brokers to inappropriately deny services or shift recipients to cheaper, but less appropriate, types of transportation.

Methods 3 and 4 are based on the number of trips brokers arrange. Brokers are paid on a per trip basis and, as with methods 1 and 2, they must use their per trip fees to cover both their costs and those of transportation providers. These payment methods provide brokers with an incentive to reduce per trip costs but not the number of trips provided. They also offer states less budget predictability than methods that limit total payments and, if certain types of transportation are more profitable than others, brokers have an incentive to assign recipients to the more profitable types of transportation.

Finally, under method 5, brokers are paid an administrative fee for each completed trip, plus they are reimbursed for the amounts paid to transportation providers. This method provides little incentive for brokers to control the number of trips or miles driven or to ensure that the least costly but most appropriate type of transportation is provided. On the other hand, with reduced

[8] For example, see The Lewin Group, *MO HealthNet NEMT Review Final Report* (Falls Church, VA, February 25, 2010); and Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, May 2004).

pressure to limit costs, recipients may be more likely to receive better, but more costly, services.

We looked at the payment methods used by states and found that:

- **Most states with brokers use payment systems that limit what brokers can earn for coordinating medical nonemergency transportation.**

Of the 19 states for which we have data, 11 paid brokers a flat amount per Medicaid enrollee (method 1), 6 paid a set administrative fee per trip plus the direct cost of transportation provider reimbursement (method 5), and 2 paid a fixed total amount (Method 2). Some states in the early phases of brokering told us that, although they are currently paying (or plan to pay) their brokers an administrative fee per completed trip, they want to switch to a method that limits total payments after their programs collect enough baseline data to set those amounts.

Minnesota

Although states vary widely in how they organize and administer their broker programs, we found that:

- **Minnesota is similar to most other states in that a private, for-profit company has been used to coordinate medical nonemergency transportation for at least a portion of its Medicaid population.**

A for-profit company has brokered access transportation in the Twin Cities area since 2004.

In Minnesota, a for-profit broker, Medical Transportation Management, Inc. (MTM), has been used to deliver portions of the state's access transportation program since mid-2004. From July 2004 through June 2009, DHS contracted with MTM to: (1) establish a network of transportation providers, (2) determine recipient eligibility, (3) schedule trips, and (4) monitor transportation providers and recipients in 11 counties in the Twin Cities area.[9] In May 2009, however, the Legislature prohibited the department from brokering access transportation.[10] Subsequently, beginning in July 2009, counties in the Twin Cities area have jointly contracted with MTM to continue brokering their access transportation programs.[11]

Since 2004, the department's contracts with MTM have required the company to determine eligibility for special transportation statewide. The contracts also

[9] Minnesota Department of Human Services and Medical Transportation Management, *Contract #432723*, as amended, June 15, 2004-June 30, 2006; and Minnesota Department of Human Services and Medical Transportation Management, *Contract #436466*, as amended, July 1, 2006-June 31, 2011.

[10] *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 34.

[11] Anoka County and Medical Transportation Management, *Contract #09-2142*, as amended, June 23, 2009-June 31, 2010; and Hennepin County and Medical Transportation Management, *Contract #A100838,* July 1, 2010-December 30, 2011. For the most part, the Twin Cities area counties have contracted for the same access transportation services previously specified in DHS's contract.

required MTM to broker special transportation in the Twin Cities area, which it did from October 2006 through January 2008. However, the 2007 Legislature prohibited DHS from brokering special transportation.[12] Consequently, since February 2008, MA recipients in the Twin Cities area who are eligible for special transportation have scheduled their own rides—just as recipients in outstate counties have done.

Brokering arrangements in Minnesota have changed several times in the last decade, due in part to legislative actions.

Table 3.3 lists major changes in how Minnesota's medical nonemergency transportation program has been administered since 2004. As shown, most program changes over the last several years have occurred in the Twin Cities area.

Table 3.3: Major Administrative Changes in Medical Nonemergency Transportation, 2004-2010

June 2004	Department of Human Services (DHS) contracts with a broker (Medical Transportation Management, Inc. [MTM]) for select services
July 2004	MTM brokers access transportation across seven Twin Cities area counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington)
February 2005	MTM determines eligibility for special transportation statewide MTM extends access transportation brokering to four additional counties (Chisago, Isanti, Sherburne, and Wright)
October 2006	MTM brokers special transportation in 11-county Twin Cities area, but participation is optional
January 2007	MTM brokers special transportation in 11-county Twin Cities area, and participation is mandatory
February 2008	DHS prohibited from brokering special transportation; MTM stops brokering the services in the Twin Cities area, but continues to determine special transportation eligibility statewide
July 2009	DHS prohibited from brokering access transportation; Anoka County contracts with MTM to jointly broker access transportation across 11 Twin Cities area counties
August 2009	Wright County drops out of the 11-county contract with MTM
February 2010	Carver and Scott counties drop out of the 10-county contract with MTM
July 2010	Hennepin County contracts with MTM to jointly broker access transportation across eight Twin Cities area counties

SOURCES: Office of the Legislative Auditor, analysis of contracts and Department of Human Services and Medical Transportation Management, Inc., data.

We looked at the payment methods used in Minnesota and found that:

- **Over the last several years, a variety of methods have been used to pay a broker to coordinate medical nonemergency transportation in the Twin Cities area.**

According to the terms of its first contract, DHS agreed to pay MTM an administrative fee, but capped what MTM could earn at a fixed amount (a

[12] *Laws of Minnesota* 2007, chapter 147, art. 5, sec. 6.

combination of methods 5 and 2) for the first two years of brokering.[13] The department switched to paying a flat amount per completed trip (method 4) for the first three years of its second contract.[14] When the Twin Cities area counties contracted with MTM in July 2009, they paid the company a fixed amount (method 2) the first year, but switched to paying an administrative fee per completed trip plus reimbursement for transportation providers' costs (method 5) in mid-2010.[15] According to officials in Hennepin County, which took the lead in negotiating the latest contract with MTM, the county wanted to emphasize participation as opposed to cost control. Hence, it favored a payment method that did not contain financial incentives for MTM to deny trips to eligible MA recipients.

Impact of Brokering

Lack of data limited our ability to measure how brokering has affected overall costs for nonemergency transportation.

Lack of data limits the extent to which we can measure the broker's impact on medical nonemergency transportation in Minnesota. Specifically, neither DHS nor counties tracked the type or amount of trips provided in the Twin Cities area before brokering began in July 2004. Consequently, we cannot compare the types of trips provided before and after MTM began brokering access transportation. Likewise, we cannot compare the costs of administering nonemergency transportation before and after brokering because counties have not tracked their administrative expenses for the program. Finally, lack of data about trips provided in outstate Minnesota prevents us from comparing counties that use brokers with those that do not. Nevertheless, we were able to examine certain ways brokering has affected program costs, participation, and service levels.

Cost Savings

In this section we examine how using a broker has affected medical nonemergency transportation costs. Overall, we found that:

- **Brokering has reduced certain medical nonemergency transportation costs, although total savings are unclear.**

We identified three ways in which using a broker has helped reduce spending: tightening special transportation eligibility, controlling reimbursable trip miles, and making greater use of the lower-cost service levels for taxi-style vehicles.

First, as we discussed in Chapter 2, the Legislature began tightening special transportation eligibility in 2003 by making DHS, not physicians, primarily

[13] Department of Human Services, *Contract #432723,* II. A. Although DHS agreed to pay MTM an administrative fee of $4.39 per completed trip, total contract costs were capped at about $1.6 million and $1.7 million for fiscal years 2005 and 2006, respectively. These amounts include other tasks assigned to MTM such as determining eligibility for special transportation and specifically authorizing access transportation trips over 30 miles.

[14] Department of Human Services, *Contract #436466*, various payment charts attached to the contract and subsequent amendments.

[15] Anoka County, *Contract #09-2142*; and Hennepin County, *Contract #A100838*.

responsible for determining eligibility.[16] The following year, the department hired MTM to make special transportation eligibility determinations on a statewide basis. Subsequently, there was a shift in trips from special transportation to less costly access transportation. As we discussed in Chapter 1, the number of special transportation trips was cut in half between fiscal years 2003 and 2006, going from about 855,000 to 417,000. During the same time period, we estimate that the number of access transportation trips increased by about 400,000 in the Twin Cities area, and spending data suggest that trips in outstate Minnesota also increased.[17]

Using a broker in the Twin Cities area has saved money because MA recipients have used less costly forms of transportation.

The shift in trips from special to access transportation appears to partially explain the reduction in average cost per trip in the Twin Cities area over the last decade that we described in Chapter 1. For example, in 2007, allowable payments to providers for special transportation trips in the Twin Cities area would have been $6.50 less per trip using access transportation rather than special transportation. Even considering the additional administrative fee for access transportation (currently $5.54 per trip), switching rides to access transportation saved money. If all of the reduction in special transportation trips (about 438,000) were shifted to access transportation, we estimate that the shift is saving about $400,000 per year.[18]

Second, using a broker to schedule special transportation trips reduced costs because MTM specified, in advance, the number of miles that providers would be reimbursed per trip. When MTM brokered special transportation in the Twin Cities area (October 2006 through January 2008), it used computerized mapping to determine trip distance rather than special transportation provider logs, which were used before and after the brokering period. From October 2006 through January 2008, special transportation trips averaged 8.2 miles per trip, compared with 9.8 miles the year before and 9.4 miles the year after this period. At a cost of $1.30 to $1.35 per mile for the most common types of special transportation, controlling mileage appears to have saved between $1.50 and $2.20 per trip. We estimate that this mileage reduction saved between $400,000 and $600,000 per year.

Third, brokering helped decrease costs by arranging less costly types of appropriate transportation.[19] MTM has reduced access transportation costs over

[16] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36.

[17] Although we do not have trip data for outstate counties, their access transportation spending increased from $4.7 million to $8.6 million between fiscal years 2003 and 2006.

[18] We based this estimate on detailed special transportation trip data for 2007 for the Twin Cities area, where about 356,000 of the total reduction in special transportation trips occurred. Lacking detailed trip data for outstate Minnesota, we assumed that savings per trip in outstate Minnesota were the same as in the Twin Cities area. Our estimate includes the reduced payments made to providers under access transportation as well as administrative fees (currently $5.54 per trip) for conducting the additional access transportation trips. We further assumed that the reduction in administrative costs for DHS to process special transportation payments offset the additional administrative cost to conduct special transportation eligibility determinations, which has averaged about $113,000 per year over the past six years.

[19] Again, data limitations hampered our ability to fully address this issue. For example, data on the type of access trips provided are not available prior to fiscal year 2005—the year MTM began brokering access transportation in the Twin Cities area.

time by increasing the proportion of taxi-style, curb-to-curb trips provided and decreasing the more expensive door-to-door trips. As we showed in Chapter 1, the percentage of wheelchair trips that provided curb-to-curb service increased from 18 to 74 percent between fiscal years 2005 and 2010. The corresponding increase for ambulatory trips was from 88 to 95 percent. Curb-to-curb service costs $2 less per trip than door-to-door service for ambulatory trips and $3 less for wheelchair trips. We estimate that the increased use of curb-to-curb trips saved about $140,000 to $200,000 in fiscal year 2010.

Taxi-style trips increased at a faster rate than other types of access transportation in the Twin Cities area. Between fiscal years 2005 (MTM's first year of brokering access transportation) and 2010, the number of access transportation trips climbed from about 424,000 to 853,000. Most of this growth was handled by using taxi-style vehicles rather than public transit or mileage reimbursement. During this time period, the number of taxi-style trips increased by 356,000, or 84 percent of the total growth. One likely reason for the increased use of taxi-style vehicles was likely to accommodate the shift from special transportation, which generally served a population that required a higher level of service.

In terms of administrative costs, we compared the compensation MTM received for brokering access transportation in the Twin Cities area before and after the Twin Cities area counties took responsibility for access transportation. We found that:

- **Counties in the Twin Cities area paid the broker less in administrative fees for fiscal year 2010 than the Department of Human Services had the previous fiscal year.**

After Twin Cities area counties took over contracting with the broker, they paid the broker about $2 million less in administrative fees than DHS had the previous year.

The Twin Cities area counties paid MTM $4.4 million in fiscal year 2010, or about $5.70 per trip; they are paying MTM $5.54 per trip for fiscal year 2011. In comparison, in fiscal year 2009, DHS paid MTM a flat fee of $22.14 per trip to cover both MTM's payments to providers and its own administrative costs. After subtracting MTM's payments to providers, we estimate that MTM's administrative compensation was about $6.7 million, or $8.30 per trip.

MTM's high compensation rate for fiscal year 2009 is partly due to certain actions that DHS took when MTM started and stopped brokering special transportation. When the company began brokering special transportation in October 2006, DHS raised the flat fee it paid MTM per completed trip from $18.06 to $21.24, about $3 per trip.[20] The increase was meant to compensate MTM for the higher rates paid to special transportation providers. However, when MTM stopped brokering special transportation in February 2008, DHS lowered the fee from $21.24 to $20.31, only about $1 per trip. In addition, DHS increased the rate paid to MTM by 9.1 percent for trips occurring after June 30, 2008, to account for cost-of-living changes.[21] These increases were made even though the payment rates for providers increased only slightly during this time period. Together, we estimate that these changes increased MTM's

[20] Department of Human Services, *Contract #436466,* Amendment 3.

[21] *Ibid.* We discuss these changes in greater detail later in this chapter.

administrative compensation from about $5.00 to $8.30 per trip, an increase of 66 percent.

Other Effects

As noted earlier, research suggests that brokering may have other benefits that affect costs, including greater control over fraud and abuse, competitive bidding, and trip coordination.[22] Regarding fraud and abuse, DHS's contract with MTM required the broker to implement procedures to guard against fraudulent activity on the part of transportation providers and recipients.[23] For example, MTM had to develop a quality control program for providers that included on-site monitoring and collecting certain performance-related data.[24] The department hoped to use this information to ultimately contract with fewer, high-quality providers. To help ensure that MA recipients had access to services, DHS invited all eligible transportation providers to contract with MTM when the department began using a broker in 2004.

The broker has also helped in monitoring the quality of transportation services and controlling for fraud and abuse.

Although we did not specifically examine MTM's activities in this area, we noted that the broker has randomly reviewed a small percentage of transportation providers' trip logs each month to check compliance with documentation and driver requirements. MTM staff have also randomly observed providers as they pick up and drop off MA recipients at their destinations and have watched recipients go into their medical appointments. Over the last several years, MTM has forwarded a few cases of possible fraud or abuse to DHS's Surveillance and Integrity Review Section for further investigation.[25] Also, as we discuss later in this chapter, MTM has used its consumer complaint system to help improve services for recipients.[26]

On the other hand, we found that:

- **Minnesota has not used two other ways to reduce costs—obtaining competitive bids from transportation providers and coordinating trips among riders.**

One of MTM's responsibilities (under both its contract with the Twin Cities area counties and its previous contracts with DHS) is to develop a network of access transportation providers. The department's contract gave MTM the authority to negotiate individual reimbursement rates with providers to help ensure that the

[22] For example, see U.S. Department of Health and Human Services, *Controlling Medicaid Non-Emergency Transportation Costs* (Washington, DC, April 1997).

[23] Department of Human Services, *Contract #436466,* II. E, I, J.

[24] *Ibid.*

[25] Surveillance and Integrity Review Section (SIRS) is DHS's post-payment review function for all Medicaid programs paid through the department's Medicaid management information system.

[26] In addition, some of the broker's up-front activities that we discussed previously are designed to help prevent fraud and abuse, for example, by acting as a transportation gatekeeper and specifying trip length in advance when scheduling rides with transportation providers.

least costly and most appropriate transportation services were provided.[27] However, MTM never utilized this strategy, opting instead to reimburse providers at the maximum rates allowed.[28] Further, the department never directed MTM to use this tool to help control costs.

According to the research literature, using a broker should make it easier to coordinate transportation trips—both among MA recipients (such as scheduling two or more MA recipients on a single trip) and between transportation programs for MA recipients and other transportation programs (such as Metro Mobility or a county-operated transportation program for senior citizens or veterans).[29] Furthermore, MTM's contracts have traditionally contained language encouraging the broker to work with other agencies.

In practice, however, few MA trips are coordinated—either among MA recipients or across programs. A major obstacle is that Minnesota gives MA recipients the ability to choose which transportation provider to use. When recipients have a preference for one provider over another, MTM must honor that request, if possible. According to MTM staff, 50 to 75 percent of MA recipients state a preference for a particular service provider. Thus, MTM's ability to save money for the state by using the same provider to deliver multiple riders to one clinic at a time (providers receive a flat rate for the first passenger and lesser amounts for additional riders) is limited.[30] MTM noted that the transportation providers it uses may serve clients from other programs and providers may be able to coordinate rides and riders. However, this does not affect the reimbursement rates that DHS pays them.

Furthermore, we found that:

- **Medicaid requirements make it difficult for the broker to use paratransit systems such as Metro Mobility to transport Medical Assistance recipients to health-related appointments.**

It costs the state more to use Metro Mobility to transport MA recipients than it does to use medical nonemergency transportation providers.

The Americans with Disabilities Act (ADA) requires transit systems that receive federal funds to operate paratransit services.[31] Paratransit consists of services complementary to fixed route transit (for example, Metro Mobility) for individuals with physical or cognitive impairments that prevent them from safely using fixed route transit either some or all of the time. In 2009, paratransit accounted for less than 2 percent of access transportation trips in the Twin Cities area; paratransit represented about 3 percent of access transportation spending in outstate Minnesota.

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[27] Department of Human Services, *Contract #438466,* II. A3(m). Also, see Hennepin County, *Contract #A100838,* Exhibit A3.2.6.

[28] As we discuss later in this chapter, MTM actually negotiated a reimbursement rate for wheelchair door-to-door service that was beyond the maximum set by DHS.

[29] For example, see Legislative Research Commission, *Human Service Transportation Delivery.*

[30] According to MTM, Minnesota is considerably more liberal than most other states in terms of recipient choice.

[31] 42 U.S.C. §§12131-12165 (2010).

Medical Assistance recipients in the Twin Cities area are generally not referred to paratransit partly because Metro Mobility, as with paratransit nationwide, is heavily subsidized by the state. Metro Mobility trips cost, on average, about $25.50 per passenger in 2008, but riders, including MA recipients, pay only $2.50-$3.50 each.[32] Consequently, state and federal government subsidies were about $22.30 per passenger in 2008.[33] In comparison, costs per trip for taxi-style vehicles in the Twin Cities area ranged from $20.31 to $22.14 in 2008, with the federal government picking up about half the cost. Medicaid regulations do not allow states to use Medicaid funds to reimburse individual transportation providers transporting Medicaid recipients at a higher rate than the general public or human service agencies would pay for such services.[34] In addition, Metro Mobility officials told us that Metro Mobility is kept busy meeting the demands for ADA service.

No Shows

Some transportation providers have questioned whether the broker has requested and received reimbursement for "no shows." No shows are trips that were scheduled but never completed because MA recipients were not at designated pick-up sites when transportation providers arrived.

One reason for transportation providers' concern is a 2007 investigation by the Department of Human Services' Surveillance and Integrity Review Section (SIRS) that found MTM improperly received nearly $84,000 in payments for trips that were not completed.[35] The department examined payments made during the first two years of its contract with MTM (July 2004-June 2006). According to DHS and MTM staff, the problem was essentially one of timing that has since been addressed. MTM returned the $84,000 and revised its management information system so it could identify and return reimbursements made by DHS for uncompleted trips, which it has periodically done over the last few years.

Contrary to claims from some transportation providers, DHS did not pay the broker when MA recipients did not show up for scheduled trips.

To investigate the no-show issue more closely, we requested data on all trips scheduled for a one-week period in March 2010 from the ten largest transportation providers, which accounted for about two-thirds of all access trips in the Twin Cities area. Specifically, we asked providers to tell us, for each trip scheduled, whether the trip was completed, cancelled, or a no show.[36] Three providers did not track no shows or were unable to provide data; the seven remaining providers reported a total of 196 no shows during this time period.

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[32] Metropolitan Council, *Twin Cities Transit System 2009 Performance Evaluation* (St. Paul, March 2010), 43.

[33] *Ibid.* State government pays for most of Metro Mobility's per passenger subsidy.

[34] 42 CFR 440.170(a)(4)(ii)(B)(4)(iii) (2010).

[35] Minnesota Department of Human Services, "Notice of Agency Action-Medical Transportation Management PID #854649500," June 12, 2007. These particular uncompleted trips were cancelled trips, which, along with no shows, are not eligible for reimbursement.

[36] We also asked for trip identification numbers so that we could match trips with data from DHS's and MTM's databases.

We examined DHS's payment records for each of the recipients who did not show up for their scheduled ride and found that:

- **There was no evidence that MTM improperly collected payments for no-show trips.**

The department's trip-by-trip payment records show that DHS did not make any payments for the nearly 200 no-show trips reported by the seven large transportation providers for a week in March 2010.

Some transportation providers were also concerned that MTM data understate the no-show problem. Transportation providers find no shows particularly irksome because the federal government does not allow states to use Medicaid funds to pay providers for miles driven when no passengers are in their vehicles. Providers waste time and money when MA recipients fail to show for scheduled trips. Although MTM has reported overall no-show rates ranging from 1 to 3 percent over the last several years, some transportation providers claimed that rates are substantially higher.[37] We found that:

- **Transportation provider data indicate no-show rates averaging about 4 percent, which is higher than the rate reported by MTM, but lower than interest group claims.**

The no-show rates reported by the seven providers ranged from 1 to 9 percent. Although these rates are higher than those shown by MTM, they are not as high as the 30 percent no-show rates sometimes cited by interest groups.

As part of its contract, DHS required MTM to develop a no-show policy to limit or deal with no shows (this provision is also in MTM's contract with the Twin Cities area counties).[38] To counteract no shows under DHS's contract, MTM encouraged transportation providers to call recipients to confirm trips beforehand. Although MTM was required to inform callers who had two or more no shows that a third no show could result in future denials for taxi-style vehicles, it has rarely done so. MTM and the eight Twin Cities area counties are currently exploring alternative options concerning no shows.

STATE OVERSIGHT

Although MA recipients receiving transportation assistance do not obtain those services directly from DHS, the department is ultimately responsible for ensuring that eligible recipients receive appropriate, cost-effective services.[39] To this end, we found that:

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[37] Medical Transportation Management, *Monthly Reports* (St. Louis, MO).

[38] Department of Human Services, *Contract #436466,* II. N2(o); and Hennepin County, *Contract #A100838,* 3.2.10.

[39] Minnesota Department of Human Services, *Title XIX State Plan, 3.1(c)(1) Assurance of Transportation* (St. Paul, undated).

- **The Department of Human Services provides little oversight of medical nonemergency transportation services statewide.**

To some extent, the program's administrative structure makes consistent oversight of medical nonemergency transportation difficult. As noted earlier, the state has set up two separate transportation categories (access and special), and each category is administered differently. Furthermore, DHS's data collection efforts vary—both across and within the two categories. For example, the department collects more detailed information on access transportation from the 8 Twin Cities area counties than from the 79 outstate counties.[40] Also, DHS does very little systematic checking to make sure that the data submitted from any county are accurate or even reasonable. The department requires special transportation providers to submit more detailed data about the rides they provide—more data than it requires from counties regarding their access transportation programs.

Data collection and staffing issues at DHS have hindered effective oversight of the nonemergency transportation program.

Limited staff resources at the department have also made oversight difficult. For the last several years, DHS has employed only one full-time staff person (plus a part-time supervisor) to monitor transportation statewide. The staff person currently overseeing the program has been employed in that capacity approximately three years; the staff person previously in that position is no longer with the department. Hence, there is limited historical knowledge or documentation about program operations prior to 2008.[41]

Access Transportation

As noted previously, from July 2004 through June 2009, DHS contracted with a broker (MTM) to provide access transportation in the 11 county Twin Cities area. In the remaining 76 counties, the counties themselves were responsible for administering the services as they saw fit. Overall, we found DHS's oversight of access transportation—regardless of how it was provided—lacking.

Twin Cities Area Counties

To assess how well DHS oversaw access transportation when it contracted with a broker, we examined the department's contractual arrangements with MTM. As noted earlier, the federal government requires that states using brokers have specific operational standards related to vehicle safety, staff competency, timeliness, access, licensing, and grievances.[42] Because it is important that Medicaid recipients arrive at medical appointments in a timely manner, the federal government also requires DHS to regularly audit the timeliness of transportation provided through the broker. Overall, we found that:

[40] The department does not require the Twin Cites area counties to submit more detailed data; they simply do because the department's former contract with MTM—and the counties current contract—require MTM to collect more detailed data.

[41] Several states with brokers, including Kansas, Kentucky, South Carolina, and Virginia, employ two to seven staff to monitor their brokers, and these states generally provide fewer transportation trips each year than does Minnesota. See The Lewin Group, *MO HealthNet NEMT Review*.

[42] 42 CFR 440.170(a)(4) (2010).

- **The Department of Human Services' most recent contract with its broker set forth numerous oversight mechanisms, including performance standards.**

For example, MTM had to submit various weekly, monthly, quarterly, and yearly reports related to local operations and annual reports regarding company finances. The department's contract allowed the department to reduce its payments to MTM for unsatisfactory performance regarding timely report submission, staffing levels, and performance goals for call center telephone abandonment rates, caller time spent on hold, customer satisfaction, and complaint rates.[43] It also laid out measurable performance objectives for MTM, including a requirement that transportation providers arrive to pick up recipients within 15 minutes of their scheduled arrival times.[44] For the most part, the department relied on MTM to monitor recipients and transportation providers and report results back to the department.

Despite the presence of these monitoring tools, we found that:

- **The Department of Human Services did not implement a formal quality assurance program to monitor its broker.**

Department oversight of its broker has been largely informal.

For the most part, department oversight of MTM consisted largely of informal communication and frequent meetings with MTM staff to discuss areas of mutual concern. The department did not consistently enforce contract reporting requirements that would have enabled policy makers to better track performance. For example, the department's contract required MTM to submit annual transportation reports beginning in fiscal year 2006, but when we asked DHS for copies of those reports, it could only locate the 2008 final report.[45] The department provided a draft report for 2007 and the report that DHS said was for 2006 was written by the department, not MTM, in March 2005—more than a year prior to its due date.[46] MTM did not complete a report for 2009, nor did DHS ask for one.

Other elements of the contract were likewise unenforced. As we discussed earlier, MTM determines whether MA recipients are eligible for special transportation and certifies their eligibility for a specific length of time. According to contract language, MTM is to make special transportation certifications that "generally parallel the time frames given for Social Security Insurance Disability redeterminations."[47] The contract also requires MTM to submit data monthly to DHS on the number and disposition of special

[43] Department of Human Services, *Contract #436466,* IV. The "call center" is MTM's main telephone number that MA recipients call to schedule rides. Abandonment rates measure the extent to which callers hang up due to busy signals or being placed on hold.

[44] *Ibid*., II. E1.

[45] *Ibid*., II. K1(d).

[46] *Ibid*. The department's contract with MTM required it to submit a draft annual report within 60 days after the end of each fiscal year, with a final report due within 30 days following receipt of the department's comments.

[47] *Ibid*., II. H13(b).

transportation assessments performed. However, despite concerns expressed by legislators and others about the frequency with which recipients were being reassessed, DHS did not enforce contract requirements regarding eligibility time frames. Likewise, DHS did not require MTM to report all required data regarding eligibility decisions, including the number of approvals and denials by the level of special transportation (ambulatory, wheelchair, or stretcher) requested.

Similarly, although MTM was responsible for monitoring transportation provider pick-up, delivery, and waiting times from July 2006 through July 2009, and DHS wrote related performance measures into its contract with MTM, DHS never required the broker to develop and implement a reliable system to collect such information, nor did the department regularly audit the timeliness of transportation provided. Finally, DHS did not periodically verify a sample of MTM's documentation to ensure that MA recipients were receiving appropriate services or that data submitted were accurate or reasonable.[48]

The department failed to enforce key provisions of its contract with the broker.

We noted earlier that DHS's contract with MTM allowed the department to reduce its payments to MTM if the company did not meet certain performance goals. However, DHS never exercised this option despite MTM's failure to submit annual reports in a timely fashion. Similarly, monthly reports that MTM submitted to DHS show that the broker consistently had problems meeting its performance goal related to call center abandonment rates, but the department never reduced its payments or set a more appropriate call abandonment goal.

Although we focused our review of DHS's oversight in relation to its second contract (July 2006 through August 2011) with MTM, the department failed to enforce one key provision in its first contract. We found that:

- **In fiscal year 2006, the Department of Human Services paid its broker about $1 million more than the amount agreed to in the contract.**

The terms of DHS's initial contract with MTM called for the department to pay MTM a $4.39 administrative fee for each access transportation trip completed. The contract capped the total amount that MTM could earn for fiscal years 2005 and 2006 at $1.6 and $1.7 million, respectively. According to contract language, administrative costs would be "monitored monthly by the STATE so as not to exceed the total compensation for administrative services in each state fiscal year."[49] However, DHS paid MTM $1.7 million in fiscal year 2005 and $2.7 million in fiscal year 2006. Department officials told us that MTM had to add staff to meet the unanticipated increase in the demand for services, and the department agreed to pay more than the amount shown in their contract. The department, however, never amended its contract with MTM. The following

[48] Many states that use brokers monitor them by auditing the broker's records, including data related to prior authorization for services, proof of medical necessity, appropriate routes taken, and verification of recipients' medical appointments. See U.S. Department of Health and Human Services, *Memorandum Report: Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services* (Washington, DC, May 2009), 6-7.

[49] Department of Human Services, *Contract #432723,* II. A1.

fiscal year DHS removed the payment caps from the contract and began paying its broker a flat amount per completed trip, combining MTM's administrative costs with transportation providers' reimbursements. Department staff told us that they did so partly because some people made negative comments about paying MTM over $4 a completed ride for its administrative costs without fully understanding the time and work involved in doing so.

We also found that:

- **The Department of Human Services frequently amended its contract with the broker to increase payment rates, even though provider reimbursement rates remained fairly stable.**

Table 3.4 shows how the rates DHS paid to MTM have changed over time. Access transportation provider reimbursement rates have remained fairly stable, increasing only $.05 for every mile traveled over the first five miles since July 2004. In contrast, DHS increased what it agreed to pay MTM for each completed access transportation trip 23 percent from fiscal years 2006 through 2009.[50]

As we noted earlier in this chapter, DHS paid MTM substantially more in administrative fees for brokering access transportation than the Twin Cities area counties paid MTM for essentially the same services. Furthermore, we found that:

- **In fiscal year 2009, the Department of Human Services overpaid its broker by about $1.5 million when the department gave the broker an inappropriate cost-of-living adjustment.**

There are three reasons why we think DHS paid MTM too much in fiscal year 2009. First, as noted earlier, when MTM began brokering special transportation in October 2006, DHS increased the flat fee it paid MTM about $3 per trip.[51] This was meant to offset the higher reimbursement rates paid to special transportation providers. However, when MTM stopped brokering special transportation in February 2008, DHS lowered the flat fee about $1 per trip, thereby giving MTM a $2 rate increase.

Second, DHS then increased MTM's new payment rate by 9.1 percent for trips occurring after June 30, 2008, to account for a cost-of-living change.[52] This adjustment further increased MTM's compensation by $1.83 per trip. We think it was unwise to build a cost-of-living adjustment into MTM's contract at a time when provider payments, MTM's principal expense, were controlled by DHS and changed little during this period. In fact, the average amount that MTM paid to providers per trip increased only 2 percent between fiscal years 2007 and 2009.

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[50] Since July 2004, DHS has increased MTM's payment rate for determining eligibility for special transportation 277 percent. With the exception of stretcher rates (which have nearly doubled), base reimbursement rates paid to special transportation providers have declined from $0.50 to $1.00 since July 2004.

[51] Department of Human Services, *Contract #436466,* Amendment 3.

[52] *Ibid.*

Table 3.4: Department of Human Services' Payment Rates to MTM for Brokering Selected Transportation Services, Fiscal Years 2005-2010

Date	Payment Rate
July 2004	$4.39 administrative fee per completed trip, up to a maximum of $1.6 million. MTM reimbursed separately for transportation providers' costs. $9.29 per Level I Level of Need Assessment $31.00 per Level II Level of Need Assessment
July 2005	$4.39 administrative fee per completed trip, up to a maximum of $1.7 million. MTM reimbursed separately for transportation providers' costs. $9.29 per Level I Level of Need Assessment $31.00 per Level II Level of Need Assessment
July 2006	$18.06 per completed trip, including transportation providers' costs, in seven-county area; $19.30 in four-county area. $25 per Level I Level of Need Assessment $75 per Level II Level of Need Assessment
October 2006	$21.09 per completed trip, including transportation providers' costs, in seven-county area; $25.51 in four-county area $25 per Level I Level of Need Assessment $75 per Level II Level of Need Assessment
July 2007	$21.24 percompleted trip, including transportation providers' costs, in seven-county area; $25.66 in four-county area
February 2008	$20.31 per completed trip, including transportation providers' costs, in 11-county area $25 per Level I Level of Need Assessment $75 per Level II Level of Need Assessment
July 2008	$22.14 percompleted trip, including transportation providers' costs in the 11-county area
July 2009	$35 per Level I Level of Need Assessment $75 per Level II Level of Need Assessment

NOTES: Except for the period form October 2006 to February 2008, completed trips refer to access transportation trips only. From October 2006 to February 2008, completed trips include both access and special transportation trips. The seven-county area covers Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. The four-county area covers Chisago, Isanti, Sherburne, and Wright counties.

SOURCES: Office of the Legislative Auditor, analysis of contracts and Department of Human Services and Medical Transportation Management data.

Third, DHS's decision to base the cost-of-living adjustment on the transportation component of the Consumer Price Index was inappropriate. The transportation component is a volatile measure because it is heavily influenced by the cost of fuel, especially for the time period on which DHS based its adjustment. The department's rate adjustment to MTM did not extend to transportation providers who are actually responsible for transporting recipients and are, thus, more affected by fuel prices. In carrying out its administrative responsibilities, MTM incurs few if any costs attributable to actually driving MA recipients to and from medical appointments. We estimate that the cost-of living adjustment increased MTM's administrative compensation by $1.5 million.

Finally, weak oversight by DHS allowed the broker—and ultimately the department—to pay some transportation providers at a slightly higher rate than permitted by department policy. As noted earlier, DHS sets the maximum reimbursement rates paid for taxi-style vehicles, and most counties pay these providers the maximum allowed. However, we found that:

- **Through the broker, the Department of Human Services has reimbursed some taxi-style providers at a slightly higher rate than its reimbursement policy allows.**

In its January 2010 bulletin to counties, the department indicated that the maximum rate counties could pay access transportation providers for wheelchair door-to-door service was $15 for the first five miles plus $1.45 per mile thereafter—rates that had not changed for several years.[53] However, MTM negotiated a slightly higher base rate for trips in the Twin Cities area—$16 rather than $15.[54] According to department staff, MTM was concerned that it would have problems finding transportation providers willing to transport recipients in wheelchairs for a base rate of $15. However, MTM did so without seeking approval from DHS. Because DHS does not routinely examine a sample of claims submitted from the broker or counties, the department was unaware that MTM was billing for the higher amount.

The department was unaware that the broker was reimbursing some transportation providers at a higher rate than DHS's policy allows.

We find the need to increase reimbursement rates for Twin Cities area providers somewhat perplexing given the problems many outstate counties have finding providers willing to provide access transportation to their MA recipients. Furthermore, the Legislature has traditionally recognized problems involved in providing services in outstate counties where recipients generally have to travel long distances to receive services. For example, since 2009, the Legislature has specified slightly higher rates for special transportation providers serving MA recipients in "rural" and "super-rural" counties than providers serving other, less rural counties.[55]

Finally, we noted that DHS made mistakes in drafting contract language. For example, when the department amended its contract with MTM in February 2009, it neglected to specify MTM's payment rate for brokering access transportation.[56] The department made a somewhat similar mistake a few months later when it failed to incorporate the payment rates it had intended to pay MTM for special transportation eligibility assessments. Department staff told us that they had meant to pay $30 per assessment rather than the $35 specified in contract amendments.[57]

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[53] Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010), 6.

[54] Medical Transportation Management, Inc., *Minnesota Schedule A to Medical Transportation Services Agreement*, July 1, 2009.

[55] *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 32.

[56] Department of Human Services, *Contract #436466,* Amendments 3-5.

[57] *Ibid.*, Amendments 6-7. As we discuss later in this chapter, MTM was not aware that the rate had increased to $35 and was only billing DHS $30 per assessment.

Overall, we found several problems with DHS's oversight of its broker, but we have not made any recommendations specifically related to the department's former contracts with MTM for access transportation. As we noted earlier, the Legislature prohibited DHS from using a broker for access transportation, and DHS severed its contractual arrangements with MTM regarding access transportation.

Outstate Counties

We also looked at DHS's oversight of counties' access transportation programs and found that:

- **The Department of Human Services has exercised little oversight of access transportation provided through counties.**

The department requires counties to file annual plans that outline how they will provide access transportation. The plans are written on department templates and many provide little insight into how services are provided or how counties monitor services. The department did not require counties to file an updated plan for 2010. According to staff, DHS allowed counties to simply extend their previous plans instead of submitting new ones pending the outcome of a federal audit that may result in counties having to change how they file for reimbursement.[58]

Furthermore:

- **The Department of Human Services collects almost no statewide data on access transportation participation, and data collected independently by outstate counties are sketchy at best.**

The department only requires counties to submit total spending by types of transportation to receive reimbursement. Consequently, DHS cannot accurately determine the number of individuals receiving access transportation in outstate Minnesota, the number of trips provided, or average costs per trip. Furthermore, the department does not routinely check the accuracy or reasonableness of the cost data that counties do submit. Department staff told us that they have no idea whether counties are adhering to DHS's policy regarding maximum reimbursement rates for transportation providers.

We asked county human services directors how they have monitored their access transportation programs. We found that county activities vary widely. Most outstate directors told us that they monitor informally, for example, through complaints and routine meetings with their providers. Few outstate counties tabulate data related to total participants, trips, and costs.

[58] The federal government does a comprehensive check once every three years to determine whether DHS is paying Medicaid claims, including transportation services, properly. Results from the latest Payment Error Rate Measurement audit, commonly referred to as PERM, were due late 2010. In conducting the review, federal auditors expressed concern over counties sending in large "group" reimbursement claims rather than individual claims for transportation reimbursement.

Due partly to lax oversight, until January 2010, DHS failed to enforce federal requirements that prohibit states from using Medicaid funds to pay for no-load miles.[59] No-load miles refer to the miles transportation providers must travel with their vehicles empty to arrive at or return from pick-up or drop-off sites. In our survey of county human services directors, 56 of the 73 outstate respondents reported being reimbursed by DHS before January 2010 for compensating volunteer drivers for no-load miles.

At the same time, we found that:

- **Failing to reimburse transportation providers for no-load miles creates a substantial burden for outstate counties.**

Transportation providers serving Minnesota's more rural areas often must drive substantial distances without recipients in their vehicle to arrive at pick-up sites or return from drop-off sites. In our survey of human services directors, 67 percent of outstate respondents strongly agreed that "the lack of state reimbursement for 'no-load' miles (when a public assistance recipient is not in the vehicle) causes problems in our county." An additional 10 percent agreed with the statement. Seventy percent of outstate directors reported difficulty in finding either for-profit or volunteer providers to transport MA recipients to medical facilities. When we asked generally what changes should be made to improve access transportation services, over half of the respondents cited the lack of reimbursement for no-load miles.

Until 2010, DHS did not enforce federal rules that prohibit using Medicaid funds to pay volunteers for certain types of mileage.

The federal government only allows states to use federal Medicaid funds to pay providers for miles traveled when a recipient is in the vehicle.[60] This restriction applies to both for-profit transportation companies and volunteer drivers. As a result, states must use different payment approaches to compensate providers in rural areas. For example, states can increase the amount paid per loaded mile to help offset the cost of no-load miles. States may also pay separately for no-load miles using non-Medicaid funds.

In Minnesota, neither of these approaches is used. Under current DHS policy, the department does not make additional funding available to help pay for no-load miles. According to DHS administrators, they have proposed increasing the per-mile amount paid to volunteers, but counties have balked because volunteers would then earn taxable income.

[59] Department of Human Services, *Access Transportation Services (ATS) Information*, 4.

[60] Verlon Johnson, Associate Regional Administrator, Center for Medicare & Medicaid Services, letter to Brian Osberg, State Medicaid Director, Minnesota Department of Human Services, May 28, 2010.

RECOMMENDATION

The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments.

The department's January 2010 reassertion of the prohibition on payments for no-load miles was received by many counties as an unexpected cost shift from the state to counties. Because DHS had not previously made any effort to deny reimbursements for no-load miles, many rural counties had used state and federal funds to compensate their volunteer drivers.

In rural areas, volunteers must often travel long distances to reach or return from rider pick-up and drop-off sites.

We agree with counties that it is unrealistic to ask volunteer drivers to pay out-of-pocket for long-distance travel. The department should allow counties to increase the compensation paid to volunteer drivers so that more of their actual expenses can be covered. One approach would be to increase the per-mile amount for loaded miles (this is the approach recommended by the federal Centers for Medicare and Medicaid Services).[61] Another approach might be to treat volunteer drivers as independent contractors instead of volunteers. MTM staff told us that they have done this in other states where the company brokers transportation services.

It is not clear why counties would object to DHS's proposal to increase mileage rates for volunteers. While it is possible that this strategy could discourage volunteers by increasing the complexity of their tax returns, simply eliminating payments for no-load miles has already been shown to discourage volunteers. The department could perhaps develop information handouts or publish information on its Web site to explain how volunteers should report reimbursement income on their tax returns.

Special Transportation

As we discussed in Chapters 1 and 2, counties are not involved in providing or overseeing special transportation—MTM determines eligibility at recipients' (or their representatives') request, recipients schedule their own rides, and transportation providers file reimbursement claims with DHS. From October 2006 through January 2008, the department contracted with MTM to broker special transportation in the 11-county Twin Cities area. As part of its contract, MTM monitored recipients and transportation providers in the same manner that it monitored access transportation. When the Legislature prohibited DHS from brokering special transportation in 2008, MTM's direct oversight responsibilities ceased. Since that time, we found that:

- **The Department of Human Services has not routinely monitored special transportation, although it has recently conducted several special investigations.**

[61] *Ibid.*

For the most part, DHS has relied on its Surveillance and Integrity Review Section (SIRS) or MTM to periodically monitor individual special transportation providers, as the need arises. In the last two years, however, department staff have examined specific issues within special transportation more closely. For example, DHS has contracted with MTM to help it determine whether reimbursement claims for special transportation were reasonable in terms of the miles driven and whether transportation providers were obtaining written documentation from health care providers as required by law.[62] The department reviewed reimbursement claims for nearly 18,200 trips provided between February and July 2008.[63] It found that most reimbursement claims were for trips of a reasonable length. About 71 percent of the claims submitted were for trips less than or within one or two miles of what DHS determined to be the proper mileage. However, 16 percent of trips were three or more miles above DHS's determination of proper mileage; an additional 13 percent did not contain enough information (which providers are required to keep) about the trip for the department to verify mileage. Lack of required signatures was a greater problem. Transportation providers either failed to obtain any signature from the health care provider or the signature was inadequate for about half of the trips.

The department recently found it had made more than $500,000 in improper payments to some special transportation providers.

The department also recently contracted with MTM to help it examine whether special transportation providers were complying with state law that allows MA recipients living in nursing homes to automatically qualify for special transportation.[64] Because there is sometimes a time lag in updating recipients' files regarding place of residence, DHS had allowed special transportation providers to transport some recipients even though the department's management information system did not show them as residing in a nursing home. The department analyzed thousands of trips made between October 2008 and July 2010. After finding more than $500,000 in provider payments for transporting MA recipients who were not living in nursing homes or eligible for special transportation, DHS retracted its practice that allowed providers to bypass certain controls built into the reimbursement system in Fall 2010. The department began collecting payments from some providers who were improperly reimbursed, and staff are pursuing payments from others.

On the other hand, despite poor monitoring by DHS, we found that:

- **There is no evidence that the broker has acted contrary to Department of Human Services' directions in carrying out the company's special transportation responsibilities.**

In fact, we found instances where MTM failed to charge DHS the full amount they were allowed. For example, when DHS and MTM amended their contract in mid-2009, the reimbursement rate for special transportation eligibility

[62] Department of Human Services, *Contract #436466,* Amendments 5-7. When transporting Medicaid recipients to health-related services, statutes require special transportation providers to obtain written documentation from health care providers indicating the time recipients arrived for their appointments. See *Minnesota Statutes* 2010, 256B.0625, subd. 16(3)(b).

[63] Transportation providers submitted sufficient documentation for the department to review 86 percent of the claims filed.

[64] Department of Human Services, *Contract #436466*, Amendments 5-7.

determinations increased from $25 to $35 per assessment.[65] However, MTM only billed DHS $30 per assessment. Also, as noted in Chapter 2, although MTM can perform Level II eligibility determinations and bill DHS $75 for each, it has instead set up an internal reconsideration process for which it does not charge the department.

Data Problems

Effective monitoring and evaluation are impossible without accurate data.

Given state and county budget problems, we think that policy makers need better information about the cost-effectiveness of transportation assistance statewide. Our evaluation was hampered by an overall lack of consistent, comparable, and reasonable data collected from counties and service providers across the state, which made it impossible to compare the cost-effectiveness of the various administrative structures in place. Improved data would give legislators and county officials better knowledge about how MA recipients are being served and would enable counties to measure their effectiveness and efficiency in relation to other counties.

RECOMMENDATION

The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data.

We think that DHS should routinely collect information such as the number of unique participants, trips by type of transportation, and costs per trip on a statewide basis, regardless of how programs are administered. In addition, DHS should ensure that its broker routinely submits more complete data on the number and type of special transportation eligibility determinations that it makes, including the number approved and disapproved by type of transportation requested. Furthermore, the department should periodically audit or check the accuracy and reasonableness of data submitted by counties as well as its broker. Routinely sampling a number of reimbursement requests would also help prevent costly mistakes on the department's part. As we noted earlier, there have been periods of time where the department was reimbursing certain transportation providers more than what the department thought it was paying them.

CUSTOMER SATISFACTION

Measuring customer satisfaction with transportation services can provide useful information to policy makers, government regulators, brokers, and transportation providers. This section looks at two separate measures of customer satisfaction, including complaints and customer satisfaction surveys.

[65] *Ibid*., Amendment 6.

Complaints

Earlier in this chapter, we noted that the federal government requires states using brokers to have oversight procedures in place to monitor Medicaid recipient access and complaints. MTM's previous contract with DHS and its current contract with the eight Twin Cities area counties require that MTM establish a complaint process regarding access transportation, which it has done.[66] We examined complaints filed with MTM over the last several years and found that:

- **Judging by the number and type of complaints filed, Medical Assistance recipients eligible for access transportation in the Twin Cities area are fairly satisfied with services.**

Over the last several years, the broker has received less than 1 complaint for every 100 trips scheduled in the Twin Cities area.

Table 3.5 shows the number of complaints that MTM has received over time compared with the number of trips scheduled. As shown, MTM has received, on average, less than 1 complaint for every 100 trips scheduled over the last several years. Furthermore, the percentage of trips with complaints has declined since July 2007.

Table 3.5: Scheduled Trips with Complaints, Twin Cities Area, Fiscal Years 2008-2010

	Number of Complaints	Number of Trips Requested	Percentage of Trips with Complaints
July 2007-December 2007	747	640,785	.12%
January 2008-June 2008	633	555,674	.11
July 2008-December 2008	406	521,424	.08
January 2009-June 2009	404	550,221	.07
July 2009-December 2009	444	560,682	.08
January 2010-July 2010	412	557,939	.07

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Comparable data are not available prior to July 2007.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Table 3.6 shows the subject matter of complaints over time. Recipients most frequently complained about timeliness, no shows, and unprofessional behavior on the part of transportation providers. Although MTM experienced an increase in the percentage of complaints involving its own operations in the first six months after the Twin Cities area counties assumed contract management in July 2009, its share of total complaints has since dropped to about 13 percent. In response to most complaints, MTM "reeducates" transportation providers by reminding them of their responsibilities, most often regarding pick-up

[66] A 2009 survey of state Medicaid agencies found that most states report using multiple techniques, including complaint investigations, to monitor the performance of their brokers. See Department of Health and Human Services, *Fraud and Abuse Safeguards*, 5-6.

requirements. MTM also uses its complaint system to routinely monitor individual transportation providers. Providers whose passengers are less satisfied may be subject to greater scrutiny by MTM and may be assigned fewer trips or dropped altogether.

Table 3.6: Percentage of Complaints by Subject Area, Twin Cities Area, Fiscal Years 2008-2010

Subject Area	7/2007-12/2007	1/2008-6/2008	7/2008-12/2008	1/2009-6/2009	7/2009-12/2009	1/2010-6/2010
Provider no-show	34%	32%	27%	28%	20%	25%
Provider timeliness	36	31	34	32	36	33
Quality of provider service	6	5	4	3	2	2
Driver behavior	13	18	18	23	23	27
MTM service	5	11	17	14	19	13
Miscellaneous	6	4	0	0	0	0

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Comparable data are not available prior to July 2007. Columns may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Assessing customer satisfaction through complaints is much more difficult in outstate counties. We found that:

- **Outstate counties generally report receiving few complaints about their access transportation programs.**

The Department of Human Services does not require counties to establish complaint systems as part of their access transportation programs. In our survey of county human services directors, we asked directors about the average number of complaints they received from MA recipients as well as transportation providers. Most respondents were unsure about the number of complaints received or they reported fewer than ten complaints a year from either recipients or providers. Many directors reported receiving more complaints from transportation providers once DHS required counties to stop using Medicaid dollars to pay volunteers for no-load miles.

It is unclear where MA recipients dissatisfied with special transportation services should complain.

On the other hand, we found that:

- **Medical Assistance recipients who receive special transportation do not have access to a formal complaint system when they have service-related problems.**

It is not entirely clear where special transportation recipients should go if they have problems related to timeliness or driver assistance. There are a number of possible options, but none are clearly responsible for service-related problems: (1) MTM, which determines whether recipients are eligible for special transportation (and has an appeals process for eligibility), (2) DHS, which pays

transportation providers and is ultimately responsible for program oversight, (3) county financial aid workers who help people as they apply for public assistance, or (4) MnDOT, which is responsible for certifying special transportation providers.[67]

RECOMMENDATION

The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation.

Complaints can be a useful tool for measuring the performance of special transportation providers. Currently, MA recipients experiencing problems regarding late pick-ups, no shows, or driver assistance can change service providers, but transportation options are limited in some parts of the state. Because MnDOT already has a complaint system in place for issues related to certification, DHS could forward certification-related issues to MnDOT. Likewise, when MnDOT receives a complaint from an MA recipient that is outside its purview, the department could forward that complaint to DHS. The Department of Human Services should also require that special transportation providers notify MA recipients of complaint procedures when they transport them. It should also require that its broker advise recipients of such procedures when it determines that MA recipients are eligible for special transportation.

User Surveys

Although a potentially important tool for monitoring the performance of MTM as well as service providers, we found that:

- **The Department of Human Services did not specifically require its broker to survey Medical Assistance recipients regarding their access transportation experiences.**

In DHS's fiscal year 2006-2009 contract with MTM, the only reference to a rider survey was in the performance standards section of the contract, which allowed DHS to deduct nine points if "customer satisfaction as measured by the monthly random survey" did not exceed 90 percent overall and 93 percent for call center

[67] While MnDOT has a complaint process in place, its authority is limited to driver, vehicle, or provider certification issues and does not extend to timeliness or driver assistance issues. *Minnesota Statutes* 2010, 174.30, subd. 9(b), requires that MnDOT prepare a biennial report for the Legislature on each complaint received and investigated. The first report showed the department receiving three complaints over a six-month period. See Minnesota Department of Transportation, *Report to the Legislature Regarding Special Transportation Service Complaints* (St. Paul, January 15, 2009).

operations.[68] The current contract MTM has with the Twin Cities area counties likewise does not specifically require MTM to conduct rider surveys (although Hennepin County staff told us they expect MTM to do so). Hennepin County officials told us that the county is planning to survey recipients about their experiences as part of its contract oversight responsibilities. Doing so will also allow the county to collect data specific to each of the participating counties; MTM's current survey procedures do not collect data concerning respondents' county of residence, level of service provided, type of transportation taken, or the transportation provider used.

Although not specifically required to do so, MTM has been surveying a sample of MA recipients who have received access transportation from taxi-style providers for the last several years. Medical Assistance recipients who use public transit or who drive themselves are excluded. Recipients are telephoned and asked to answer 12 brief questions about their transportation experience that cover areas such as the call intake process, driver and vehicle assessment, and timeliness.

We reviewed MTM's customer satisfaction surveys for access transportation and found that:

- **Methodological problems in the way the broker's customer satisfaction survey is conducted may bias results.**

The broker's customer satisfaction surveys show high approval, but too many people are excluded from the surveys.

Most notably, MTM excludes from its survey all MA recipients who receive transportation to psychiatrists, psychologists, counselors, social workers, and other mental health providers or to dialysis appointments. Such trips make up nearly one-third of the total taxi-style trips provided.[69] Because this is such a large portion of total trips and because transportation providers and MTM staff could potentially treat recipients with mental health concerns differently than individuals with physical health concerns, omitting these groups could significantly bias survey results.

MTM staff suggested that DHS had instructed them to exclude these populations several years ago, but they were unable to provide any documentation. Department staff could not confirm or deny MTM's comment, reflecting staff turnover and lack of documentation at the department. Current DHS staff were unaware that recipients receiving transportation to mental health providers and dialysis appointments were not represented in the survey results reported by MTM.

[68] Department of Human Services, *Contract #436466,* IV. B1d(iii). The contract did require MTM to develop an *Operations Manual* to detail its procedures for scheduling and delivering services. Although the contract lists numerous topics to be covered, it does not refer to customer surveys. Nevertheless, MTM's manual states that "at least 5 percent of all trips are randomly selected for a follow up customer satisfaction survey." See Medical Transportation Management, *Operations Manual* (St. Louis, MO, 2009), 19.

[69] Excluding certain groups of recipients is contrary to MTM's *Operations Manual,* which says that at least 5 percent of all trips will be randomly selected for follow up. See MTM, *Operations Manual*, 19.

Despite its methodological shortcomings:

- **The broker's customer surveys suggest high levels of satisfaction with access transportation in the Twin Cities area.**

The recipients that were surveyed were overwhelmingly pleased with the services they received. Between January 2008 and June 2010, well over 90 percent of respondents interviewed answered "yes" to questions such as "Was your call answered promptly?" "Was your trip scheduled while you were on the phone?" "Was the driver's conduct professional and courteous?" and "Did you arrive to your appointment on time?"

RECOMMENDATION

To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation.

The current method of choosing a sample of recipients for MTM's customer satisfaction survey appears to be an artifact of a long-forgotten decision. Neither MTM nor DHS could provide a reason why recipients receiving transportation to mental health and dialysis appointments are excluded from MTM's surveys. We can think of no valid reason for excluding these groups. All recipients receiving taxi-style transportation through MTM should have an equal chance of being included.

For a short time, DHS contracted with MTM to survey MA recipients receiving special transportation statewide.[70] However, this proved too difficult because, unlike access transportation trips, DHS does not know whether a special transportation trip has occurred until the provider submits a bill. Providers have up to a year to bill DHS for special transportation trips. Unless a provider has submitted its bills relatively quickly, the trips often occurred too far in the past for recipients to remember them accurately (particularly if they had taken more than one trip). Although DHS limited its surveys to providers that had sent in bills quickly, surveying individuals served only by certain providers could clearly bias results. The department concluded that the information it was receiving from the special transportation surveys was not sufficiently valuable to continue them. In the surveys that were conducted, recipients were generally positive about their special transportation experiences.

[70] Department of Human Services, *Contract #436466,* Amendments 6-7.

List of Recommendations

- The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 Legislature. (p. 32)

- As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable. (p. 33)

- The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation. (p. 33)

- The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changed. (p. 34)

- The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow. (p. 35)

- The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments. (p. 58)

- The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data. (p. 60)

- The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation. (p. 63)

- To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation. (p. 65)

Minnesota Department of **Human Services**

January 24, 2011

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

The enclosed material is the Department of Human Services response to the findings and recommendations included in the draft audit report titled Medical Nonemergency Transportation issued in January 2011. It is our understanding that our response will be published in the Office of the Legislative Auditor's final audit report.

The Department of Human Services policy is to follow up on all audit findings to evaluate the progress being made to resolve them. Progress is monitored until full resolution has occurred. If you have any further questions, please contact Gary L. Johnson, Acting Internal Audit Director, at (651) 431-3623.

Sincerely,

Lucinda E. Jesson
Commissioner

Enclosure

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

Audit Finding #1

Minnesota has two separate administrative structures for nonemergency transportation, "access" and "special," that are duplicative and confusing.

Audit Recommendation #1-1

The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 legislature.

Department Response #1-1

The Department agrees with the finding and recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 1/1/2012

Audit Recommendation #1-2

As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable.

Department Response #1-2

The Department agrees with this recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #2

Through its broker, DHS has frequently limited recipients' eligibility for "special" transportation to very short time periods—often one day—which is inconsistent with contract language.

Audit Recommendation #2

The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation.

Department Response #2

The Department agrees with this finding and recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #3

The Department of Human Services administers key elements of "special" transportation (which offers the most costly and highest levels of services) in an ad hoc fashion without using rulemaking procedures, developing formal policies, or notifying the public about changes in practice.

Recommendation #3-1

The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changes.

Department Response #3-1

The Department agrees with this finding and recommendation. We will work to improve communication of existing policies, and provide better opportunities for stakeholders to participate in the development of new policies or significant changes in existing policies.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 4/1/2011

Recommendation #3-2

The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow.

Department Response #3-2

The Department agrees with this recommendation. We will work to improve communications with our contractor. We will review current contract requirements, adherence to those requirements and add any additional duties or contract changes that may be necessary.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 4/1/2011

Auditing Finding #4

Failing to reimburse transportation providers for "no-load" miles creates a substantial burden for outstate counties.

Audit Recommendation #4

The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments.

Department Response #4

The Department agrees with this finding and recommendation. The non-payment of no-load miles has been of great concern for counties. We will work with counties to find the best solution, and are prepared to assist with a possible legislative proposal to address the no-load issue.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: **7**/1/2011

Auditing Finding #5

The Department of Human Services' oversight of nonemergency transportation has been weak, and it collects very little data on the program statewide.

Audit Recommendation #5

The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data.

Department Response #5

The Department agrees with this finding and recommendation. Currently, most counties bill access transportation in aggregate, so we do not have the detailed data necessary to generate accurate reports on key performance measures. Special transportation services are currently billed in sufficient detail to assess key performance measures. We are working with counties and other stakeholders to use a more standardized billing process for access transportation services that will enable the Department to gather relevant metrics. Our goal will be to generate consistent, reliable data that enables us to better measure and report the performance and cost effectiveness of all medical nonemergency transportation statewide.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #6

Medical Assistance recipients who receive special transportation do not have access to a formal complaint system when they have service-related problems.

Audit Recommendation #6

The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation.

Department Response #6

The Department agrees with this finding and recommendation. A formal complaint system, when used in conjunction with the Department's or contractor's ability to sanction a provider up to and including removal from the program or provider network, would be a positive adjustment to the special transportation service process. We will work with counties and other stakeholders to develop a formal complaint process.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #7

The Department of Human Services did not specifically require its broker to survey Medical Assistance recipients regarding their access transportation experiences.

Audit Recommendation #7

To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation.

Department Response #7

The Department agrees with this finding and recommendation. Satisfaction surveys should include all recipients served by the metro contract. We will work with contractors and stakeholders to expand their surveys to include all recipients.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 07/01/2011

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State Highways and Bridges, February 2008
Metropolitan Airports Commission, January 2003

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OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Managed Care Organizations' Administrative Expenses

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March 2015

Members of the Legislative Audit Commission:

At your request, we examined managed care organizations' expenses for administering Minnesota's public health care programs. We also examined the Department of Human Services' efforts to control administrative costs when setting managed care payment rates.

We found that the Department of Human Services (DHS) implemented important cost-savings initiatives for 2014, but will need to improve reporting directives to sufficiently address data complexity and variation among managed care organizations' accounting processes. DHS uses their administrative cost data for rate-setting analysis, and we found some discrepancies in their financial reports and documentation.

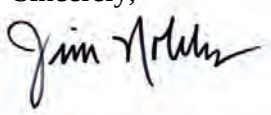
We recommend that the Legislature and the Department of Human Services be more directly involved in oversight of managed care administrative costs for Medical Assistance programs to help assure that the state does not pay for unreasonable costs. In particular, the Legislature should refine managed care reporting requirements and administrative spending limits specified in law.

This report also presents the results of our audits of managed care organizations' compliance with certain financial-related legal requirements for the year ended December 31, 2012. Our audit was conducted for the purpose of determining compliance with certain federal and state laws and rules for reporting administrative expenses and investment income. We emphasize that this has not been a comprehensive audit of all financial data of the managed care organizations, and that our work included testing their costs for the state's public programs only. Given the limited scope of our work, we do not express an overall opinion on the effectiveness of the managed care organizations' compliance with financial reporting. In addition, our work may not have identified all instances of noncompliance with legal requirements.

Our findings and recommendations for each of the four managed care organizations, including their responses, are contained in Appendices A through D of this report. The purpose of these reports is solely to describe the scope and results of our limited testing of the managed care organizations' compliance with certain financial reporting requirements. Accordingly, these reports are not suitable for any other purpose. We also did not audit the responses and we express no opinion on them.

We discussed the results of these audits with representatives of Blue Plus, HealthPartners, Medica, and UCare in December 2014. We received the cooperation of these organizations and the Department of Human Services while performing our work. Our evaluation and audits were conducted by Valerie Bombach (project manager), Tyler Billig, Carmen Marg-Patton, and Valentina Stone.

Sincerely,



James Nobles
Legislative Auditor

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Summary

The Legislature and DHS should be more directly involved in oversight of managed care administrative costs for Medical Assistance programs.

Key Facts and Findings:

- Minnesota has relied on managed care organizations (MCOs) for decades to help administer its Medical Assistance (MA) program. Administrative spending by the four largest MCOs totaled about $278 million in 2012. (p. 8)

- The Department of Human Services (DHS) determines how much to pay MCOs for these services, and relies primarily on MCOs' financial data to set the administrative portion of payment rates. (p. 40)

- In our audits of MCOs' 2012 financial reports, we sampled administrative expense records and found a small number of miscategorized transactions. Total costs related to these discrepancies ranged from $1,702 to $3.0 million. (pp. 16-18)

- We identified some opportunities for MCOs to more directly allocate administrative expenses to specific lines of business. We also questioned some costs allocated to public programs and found that MCOs did not have adequate documentation to support some subcontracted services. (pp. 22-26)

- DHS implemented important cost-savings initiatives for 2014, but its technical execution of some rate-setting options for administrative expenses was sometimes lacking during 2013. (pp. 35-39)

- Minnesota statutes, rules, state contracts, and accounting principles do not ensure consistent reporting by MCOs and compliance with policymakers' intent. (pp. 26-30)

- During 2013, DHS directives and requests to MCOs were too general to sufficiently address data complexity, data integrity, and variations among MCOs' allocation and recordkeeping processes. (pp. 46-47)

Key Recommendations:

- The Legislature should amend statutes to clarify how MCOs must allocate administrative expenses and investment income on state-required financial reports, refine managed care administrative spending limits, and further define the types of unallowable expenses for state public programs. (pp. 28, 29, 46)

- The Legislature should amend statutes to specify requirements for MCOs' subcontracts for administrative services that are expensed to Minnesota's public programs, and DHS should incorporate such language into its contracts with MCOs. (p. 30, 46)

- DHS should enhance instructions, definitions, and technical guidance to facilitate MCO compliance with administrative expense reporting requirements. (p. 47)

- DHS should implement ad-hoc audits of financial data, unallowable expenses, and other information reported to the department by MCOs under state contracts and *Minnesota Statutes* 2014, 256B.69, subd. 9c. (p. 47)

Report Summary

In 2012, the Department of Human Services (DHS) contracted with managed care organizations (MCOs) to help administer Medical Assistance (MA) services for nearly 620,000 individuals. Administrative expenses for the four largest MCOs—Blue Plus, HealthPartners, Medica, and UCare—totaled about $278 million, or about 84 percent of all managed care administrative spending.

DHS must determine how much to pay MCOs for their services and ensure that payment amounts are within limits of law. The state's current "at-risk" payment method requires DHS to work with an actuary to develop reasonable and appropriate rates using data based on Medical Assistance services for MA enrollees.

Changes in DHS rate-setting practices and initiatives by state policymakers—including competitive price bidding and legislatively imposed caps on payment rate increases—likely have limited growth in managed care administrative costs in recent years. Managed care administrative expenses per member-month in 2013 were comparable to 2009 rates for some programs, and increased about 8 percent for others. Enhancements in the financial reporting relationship between DHS and managed care organizations should advance oversight and understanding of the costs of public health care programs.

DHS implemented important cost-savings initiatives for contract year 2014, but its technical execution was sometimes lacking.

DHS modified its rate-setting methods and used competitive price bids to determine 2014 managed care payment rates. For 2014 contracts, about 16 percent of the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare payments were set through competitive price bids. However, competitive price bids from contract year 2012 had a multi-year impact on rate-setting methodology.

DHS also modified its previous rate-setting methods with a goal of reducing trends in 2014 administrative costs by $47 million. For MCOs compensated through a prepaid capitation payment method, there are few statutory restrictions on the types of expenses they may incur for public programs. Any restrictions on administrative expenses are imposed when DHS renews contracts and determines new overall payment rates.

DHS did not execute some statutory provisions related to controlling managed care administrative expenses. State law imposes limits on growth in MCO administrative spending. DHS waived this restriction in 2013, noting a lack of clarity in the law and shifting coverage in populations. DHS staff also said that the statutory provision is technically incompatible with current rate-setting methods, competitive price bidding, and aggregate limits in managed care trends specified elsewhere in law.

DHS's use of some MCO financial reports for determining managed care payment rates has been a long-standing source of controversy.

For 2014 contracts, DHS and its actuary relied primarily on data reported and certified by the MCOs—data they consider comparable to data used by the federal government and other states. These data included the MCOs' 2012 annual statutory financial filings with the Minnesota Department

of Health (MDH). MCO representatives said that the financial information is correct for purposes of reporting to MDH and that the reports were not developed to be used for DHS rate setting. This controversy supports recent legislative work to expand the direct reporting relationship between DHS and MCOs.

MCOs generally complied with accounting standards when categorizing administrative expenses, with some exceptions.

We audited MCOs' 2012 accounting practices and financial reports. Among approximately 100 samples tested for each MCO, MCOs miscategorized a small number of administrative expense transactions. However, total costs related to these discrepancies ranged from $1,702 to $3.0 million. DHS used the MCOs' reports to determine their 2014 payment rates.

We identified some opportunities for MCOs to more directly allocate administrative expenses to specific products, but MCO representatives said that this practice would increase public program costs.

MCOs have complex processes to record and allocate their administrative expenses across numerous entities, products, and programs. MCOs process tens of thousands of transactions annually for such costs as general overhead, subcontractors, intercompany fees, and capital projects. For the majority of their 2012 administrative costs, MCOs consistently allocated at least some portion of each expense across state public programs. Some MCO costs for their subcontracted administrative services could have been more directly allocated to individual state programs or to commercial products that benefitted from the service.

MCOs' accounting and allocation practices did not sufficiently restrict some unreasonable expenses from the Medical Assistance programs on state-required reports in 2012.

Among our sample transactions, we questioned some expenses allocated to the state's public programs on reports used by DHS for rate setting for contract year 2014. For each MCO, we identified between one and four cost items that we considered unreasonable, unrelated to Medical Assistance services, or out of compliance with MDH rules. We estimated the total costs of these transactions allocated among state public programs ranged from $376 to $2,144, depending on the MCO.

We also questioned some other indirect marketing and charitable contribution expenses subject to DHS review for rate-setting purposes. In total, these types of transactions for each MCO ranged from $5,198 to $8.5 million. During 2013, DHS separately requested and received from the MCOs information about these types of expenses when determining payment rates.

MCO representatives said that their allocation practices comply with federal or state law, state contracts, reporting requirements, or accounting principles. More direction from state policymakers could diminish controversy about the types of managed care administrative expenses disallowed for Medical Assistance programs. DHS's use of these MDH reports will require ongoing reconciliation of disallowed expenses.

Managed care organizations did not have adequate documentation to support expenses for some administrative service subcontracts.

For some contract-related expenses we tested, MCOs did not have adequate documentation to verify whether their subcontractors were paid appropriately, assess the reasonableness of MCOs' allocations, or determine how the costs related to public programs. Some subcontracts were not fully signed or had expired, payments did not match the contract rates, or there was no statement of work. The number of these cost items ranged from two to four, depending on the MCO.

Minnesota statutes, rules, and state contracts do not ensure consistent reporting by MCOs and compliance with policymakers' intent.

Our examination of MCOs' detailed financial data, supporting documentation, and allocation practices revealed that reporting requirements could be improved. In particular, lack of definitions, details, and conflicting language in law and state contracts do not support recent efforts by policymakers. Insufficient guidance in accounting principles contributes to these inconsistencies, too. More direction in law regarding program-specific and cost allocation requirements, and the form and content of MCOs' subcontracts for administrative services, could reduce variation and misinterpretation.

In 2013, DHS directives and requests to MCOs were too general to sufficiently address data complexity, data integrity, and variations in MCOs' recordkeeping and allocation processes.

During our audit work, DHS staff were still refining new financial reporting templates for MCOs. We think the specifications for administrative expenses were too general and likely resulted in inconsistent or incomplete data, based on our audits of MCOs. DHS contracts with MCOs require them to submit and "certify" certain filings or other financial data as requested by DHS, but we found inconsistencies among federal law, contract language, and certification documents.

Enhanced financial reporting by MCOs may have minimal value for managed care payment rate setting without independent verification of the data.

DHS and its actuary accept the MCOs' data certifications but do not independently audit their summary-level data reports. Given the significant amount of information now compiled by DHS, more rigorous, ad-hoc verification of administrative expenses by DHS would be reasonable. Absent these actions, we question the extent to which state resources needed for oversight of additional MCO financial reporting will translate into cost savings. Such work also will help assure that MCOs costs are appropriately allocated to the state's public programs.

Introduction

Since 1982, the Department of Human Services (DHS) has contracted with managed care organizations (MCOs) to help administer Minnesota's public health care programs. The cost of their involvement is significant—in 2012, managed care organizations' reported administrative expenses for public programs totaled about $332.7 million.[1] On behalf of the state, the department determines the scope of services and negotiates how much to pay managed care organizations. However, the availability and use of certain financial data for setting payment rates has been a long-standing controversy among legislators, state administrators, managed care representatives, and others. It has been frequently suggested that the department should do more to ensure a better price for administrative services and reduce the likelihood of excess payments.

The Legislative Audit Commission in March 2013 directed the Office of the Legislative Auditor to evaluate managed care organizations' administrative expenses and the Department of Human Services' efforts to develop payment rates. This assignment incorporated components of a broader legislative directive to audit managed care organizations' financial and other information.[2] Our evaluation addressed the following questions:

- **How much do managed care organizations spend to administer Minnesota's publicly funded health care programs, and for what purposes?**

- **Do the administrative expenses reported by managed care organizations comply with state and federal laws? Are administrative expenses reported consistently?**

- **Does DHS adequately review and control administrative costs when developing payment rates for managed care organizations? Does the state pay for unreasonable or unnecessary administrative costs for managed care?**

Our audit work focused on the financial data of Blue Plus, HealthPartners, Medica, and UCare, and did not include audits of county-based purchasing organizations. We also evaluated the Department of Human Services' processes and practices for determining payments for administrative services for the Medical Assistance and MinnesotaCare programs for 2014. This work did not include evaluating rate-setting methods and processes for determining payments for medical services. We did not examine DHS's competitive procurement processes for obtaining managed care services, but we briefly discuss how this approach impacts rate setting for managed care payments.

[1] Total includes general administrative and claims adjustment expenses reported by all managed care organizations under contract with the Department of Human Services. DHS payments and reimbursements to managed care organizations for all services for contract year 2012 totaled about $3.02 billion, including both state and federal monies.

[2] *Minnesota Statutes* 2014, 256B.69, subd. 9d.

We performed our audit work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[3] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

To provide context for our work, we spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of the four managed care organizations.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and partly relies on to determine payments to managed care organizations. We also reviewed select information required by the state's contracts for public health care programs or otherwise requested by DHS.

We interviewed management and employees of Blue Plus, HealthPartners, Medica, and UCare to gain an understanding of their procedures for recording and reporting administrative expenses and investment income, and how each entity allocates its costs across lines of business and programs. We obtained from each managed care organization detailed and summary financial transaction data, including general ledgers, accounts payable records, and other supporting documentation. We relied on this information to conduct our audit work.

From each entity, we selected an initial sample of more than 100 transactions to test against our objectives. We used a combination of purposive and stratified random sampling, and our sample universe generally included transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. We also selected a sample of each MCO's own contracts for administrative services and reviewed these expenses. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and supporting documentation, including purchase orders, invoices, bank statements, and other information.

We used federal and state laws, regulations, contracts, and the National Association of Insurance Commissioners (NAIC) statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for administrative services contracts.

To provide context for our evaluation, we reviewed current and historical state and federal laws and guidance for determining capitation payment rates. We also

[3] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision* (Washington, DC, 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

researched practice notes and actuarial standards promulgated by the American Academy of Actuaries, the Actuarial Standards Board, and the Society of Actuaries. To learn about alternative practices for determining capitation payment rates, we selected a sample of ten states and requested information from state agency representatives, and compiled pertinent statutes and regulations. To help with this work, we hired an actuarial consultant with expertise in this subject matter and experience working for state agencies in other states for their federal Medicaid programs.

To assess DHS's rate-setting activities, we reviewed documentation and data used to develop the administrative portion of managed care capitation payment rates. We also analyzed trends in spending using financial data and program enrollment reported by managed care organizations for 2009 and 2013.

Chapter 1 of this report provides an overview of the nature and costs of managed care administrative services for 2012 and describes background information about Minnesota's public health care programs. In Chapter 2, we briefly summarize the results of our audits of administrative expenses and financial reports for four managed care organizations and make recommendations to the Legislature. In Chapter 3, we assess how DHS determines payments for managed care administrative services and discuss recent initiatives by policymakers. We illustrate trends in managed care spending as one measure of these initiatives and of DHS's rate-setting practices. We also recommend refining state law and DHS technical guidance and contracts, based on our experience auditing managed care organizations. Lastly, Appendices A through D at the end of this report contain the findings and recommendations specific to each of the four managed care organizations we audited.

Chapter 1: Background

Minnesota's framework for providing public health care has undergone significant changes since the federal Patient Protection and Affordable Care Act of 2010 was enacted. These changes include redefining programs, benefits, and eligibility requirements, combined with alternative service arrangements, such as contracting directly with integrated health partnerships that are comprised of healthcare systems, hospitals, and providers.[1] What has not changed is the fact that the state has continued to contract with managed care organizations to help administer the state's federal Medicaid program—Medical Assistance—and MinnesotaCare programs.

In this chapter, we briefly describe the Department of Human Services' (DHS's) role in purchasing managed care services. We also present information about managed care organizations and their costs and services related to public programs. Our discussion focuses primarily on data and services for calendar year 2012 as these data were used to develop managed care payment rates for 2014.

OVERVIEW

The federal Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services oversees states' Medicaid programs. With CMS approval, states may obtain service arrangements with non-state entities to administer federally funded health care programs.[2] In Minnesota, the Department of Human Services has partially or fully delegated certain functions to managed care organizations (MCOs) as specified in federal regulations.[3]

Managed care organizations—also referred to as health maintenance organizations—are nonprofit entities that must participate in public programs as a condition of certification in Minnesota.[4] The Minnesota Department of Health (MDH) has primary regulatory authority over these entities and is responsible for ensuring their compliance with state-mandated reporting, certification, and solvency requirements.[5] As part of its oversight, MDH conducts periodic assessments of the quality of their services, including management of their provider networks. Today, each of the managed care organizations we audited—

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[1] *Minnesota Statutes* 2014, 256B.0755. See http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441, accessed March 5, 2015.

[2] *42 CFR*, sec. 438.6 (2014).

[3] *42 CFR*, secs. 438.207-438.210 (2014).

[4] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644. Pursuant to the Internal Revenue Code, Section 501(c)(4), these organizations are generally exempt from federal income taxes. Throughout this report, we refer to health maintenance organizations (HMOs) as managed care organizations (MCOs).

[5] *Minnesota Statutes* 2014, 62D.01, subd. 2b; 62D.04; and 62D.041.

Blue Plus, HealthPartners, Medica, and UCare—offer commercial products to Minnesota residents, in addition to serving public health care programs.

Managed care organizations are regulated by MDH, but also are subject to state and federal requirements through their contracts for public programs with the Department of Human Services. Minnesota law requires MDH and DHS to work together to identify and collect data on managed care administrative spending for state public health care programs.[6] Recent changes in state law also enhanced the reporting relationship between MCOs and DHS for managed care programs.[7] We discuss these requirements later in Chapter 3.

In addition to managed care organizations, Minnesota allows counties to purchase or provide health care services for the state's public programs.[8] Through their contracts with DHS, these publicly owned "county-based purchasing organizations" provide the same administrative services as health maintenance organizations and also are subject to oversight by MDH.

MANAGED CARE PROGRAMS

In 2012, Minnesota had several Medical Assistance (MA) programs that served different populations. These programs included: the Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC), and Preferred Integrated Networks (PINS). These programs are largely the same MA programs provided today. Throughout this report, we refer to these programs as the state's public programs or Medical Assistance programs.

First, PMAP served families and children, pregnant women, and adults without children that met federal Medicaid eligibility requirements. Under a federal waiver in place during 2012, expanded MA coverage and federal funding also was available for Minnesota's optional state program, called MinnesotaCare.[9] MinnesotaCare provided services to adults, parents, and caretakers with incomes higher than those covered by MA.

Other MA programs covered enrollees who typically required additional services, including enhanced care coordination and long-term care services. MSC+ and MSHO served MA recipients age 65 and over. MSHO coordinated or integrated Medicaid with Medicare services together as a way to control costs or improve access to care. Both MSHO and MSC+ provided the same services as PMAP and some added benefits that were administered under managed care, such as home and community-based services and limited nursing home care. People eligible for both Medicare and Medicaid could choose MSHO so that their

[6] *Minnesota Statutes* 2014, 256B.69, subd. 9a.

[7] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 63.

[8] *Minnesota Statutes* 2014, 256B.692. In 2012, DHS contracted with three county-based organizations—South Country Health Alliance, PrimeWest, and Itasca Medical Care—and one other health maintenance organization (HMO)—Metropolitan Health Plan dba Hennepin Health.

[9] The federal waiver for "PMAP+" covered a 2.5 year period.

benefits for the two programs were administered by the same health plan. MSC+ members eligible for Medicare could use Medicare fee-for-service or enroll in a separate federal Medicare plan for Medicare parts A and B and obtain separate Medicare prescription drug coverage.

Lastly, the SNBC program provided basic health care services to persons with disabilities, including those who were eligible for both Medicaid and Medicare. The SNBC program contracted with Medicare health plans to coordinate Medicaid and Medicare services for eligible enrollees. Most long-term care services for SNBC enrollees are not administered under managed care. As part of SNBC contracts with certain managed care organizations, DHS implemented PINS. The PINS program integrated physical and mental health services within one managed care organization and coordinated this care with social services.[10]

DHS determines which managed care organizations to contract with for each of these programs, and contracts and payment rates typically have been for one-year terms.[11] For contract year 2012, DHS used a competitive price bid process to obtain managed care services for the seven-county metro area. For the remaining 80 counties, DHS set the managed care payment rates. For contract year 2014, DHS again used a competitive bid process to obtain services for 27 other counties in other areas of the state, and set the managed care payment rates in the remaining counties, including the seven-county metro area. In Chapter 3, we briefly describe how competitive price bidding has affected DHS rate setting for managed care administrative costs for the state's public programs.

Service Areas and Costs

For 2012, DHS contracted with eight managed care entities to administer public programs across Minnesota. The great majority of managed care services were provided by Blue Plus, HealthPartners, Medica, and UCare. State reimbursement to these four entities for 2012 services totaled about $2.69 billion (out of $3.02 billion for all MCOs), including both medical and administrative costs.[12] These four MCOs accounted for about 84 percent of all administrative expenses reported for the state's public programs.[13]

In 2012, the scope and costs of managed care administrative services varied, depending on the managed care organization and specific program being administered.

[10] The PINS program is implemented through one MCO in Dakota County only.

[11] *Minnesota Statutes* 2014, 256B.69, subd. 5.

[12] State reimbursement represents DHS total payments—including both state and federal monies—for all services to these managed care organizations for contract year 2012.

[13] Services by one other MCO and the three county-based purchasing organizations comprised the remaining 16 percent of administrative costs reported for the state's public programs.

In 2012, managed care administrative expenses for Blue Plus, HealthPartners, Medica, and UCare totaled about $214.7 million, as shown in Exhibit 1.1.[14] Administrative expenses per member-month enrollment ranged from $35 per member-month (Blue Plus) to $31 per member-month (HealthPartners and Medica). When considering MCO expenses for medical and all administrative costs, the share of total expenses attributed to administrative services ranged from 6.0 percent (Medica) to 7.6 percent (UCare).

Exhibit 1.1: Managed Care Enrollment and Administrative Expenses, by Managed Cared Organization, Contract Year 2012

Managed Care Organization and Programs it Administers	Total Member-Months (in thousands)	Total Administrative Expenses (in thousands)[a]	Administrative Expenses per Member-Month (All Programs)	Administrative Expenses as Share of Total Administrative and Medical Expenses: Excluding Premium Taxes and Surcharges	Administrative Expenses as Share of Total Administrative and Medical Expenses: Including Premium Taxes and Surcharges
Blue Plus (PMAP, MNCare, MSHO, MSC+)	1,602	$ 55,427	$35	6.0%	7.4%
HealthPartners (PMAP, MNCare, MSHO, MSC+)	1,001	30,625	31	5.9%	7.5%
Medica (PMAP, MNCare, MSHO, MSC+, SNBC-MA only, PINS)	1,627	49,709	31	4.5%	6.0%
UCare (PMAP, MNCare, MSHO, MSC+, SNBC-MA only)	2,366	78,919	33	6.1%	7.6%
Total	6,596	$214,680	$33	5.6%	7.1%

NOTES: Acronyms represent the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC), and Preferred Integrated Networks (PINS).

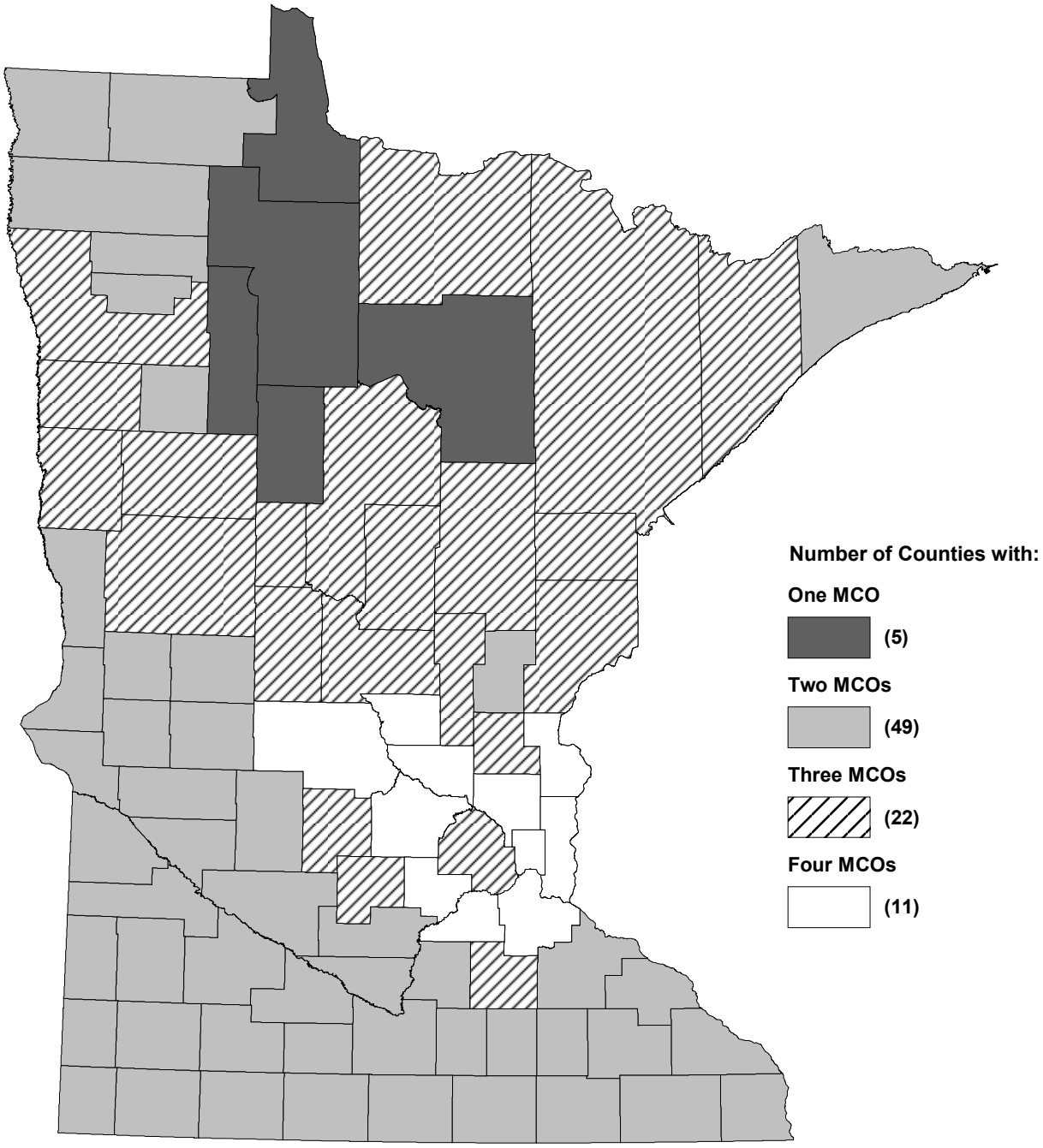
[a] Represents general administrative and claims adjustment expenses, and excludes estimated state premium taxes and surcharges on health maintenance organizations (HMOs) pursuant to *Minnesota Statutes* 2014, 297I.05, subd. 5; and 256.9657, subd. 3. Including such taxes and surcharges, 2012 administrative expenses for these four MCOs totaled about $278 million.

SOURCE: Office of the Legislative Auditor, analysis of 2012 Minnesota Supplement Report(s) #1, Statement of Revenue, Expenses, and Net Income, reported by Blue Plus, HealthPartners, Medica, and UCare.

The differences among MCOs' costs are due to a variety of factors; for example, some types of populations—such as those with special needs—require additional services and resources. Some MCOs administered more types of public programs than others. Administrative costs per program also can be affected by how an MCO estimates and allocates costs to individual programs or products, an issue we discuss in Chapter 2. Lastly, each entity's service area varied, depending on the programs it administered. Exhibit 1.2 illustrates the county service areas for these four entities during 2012, by number of managed care organizations.

[14] Totals exclude estimated state premium taxes and surcharges on HMOs pursuant to *Minnesota Statutes* 2014, 297I.05, subd. 5; and 256.9657, subd. 3. Including these taxes, reported administrative expenses totaled about $278 million.

Exhibit 1.2: Service Areas of Four Largest Managed Care Organizations Administering Minnesota Public Health Care Programs, Contract Year 2012



NOTES: Map represents counties served by Blue Plus, HealthPartners, Medica, or UCare and includes administrative services for all Medical Assistance and MinnesotaCare programs. The number and types of programs administered in each county varied by managed care organization.

SOURCE: Office of the Legislative Auditor, summary of managed cared organization service areas based on Department of Human Services' 2012 data.

Types of Administrative Services

In its contracts with MCOs, the Department of Human Services specifies the scope and nature of administrative services each MCO must provide; for example, claims processing and billing services. Federal law prescribes performance standards for certain administrative functions—for example, timely processing of claims for payment—and the department must include these requirements in its contracts.[15] DHS also specifies certain activities that the MCOs must undertake to receive performance incentive monies. DHS holds back a portion of each MCO's payments and the monies are distributed based on the MCO's performance on various standards.

Exhibit 1.3 illustrates the types of services provided for public programs by these four MCOs, collectively, and the share of total administrative costs for each service.[16] In 2012, about 26 percent of all administrative expenses was for general administrative and finance-related services. About 25 percent was for billing, enrollment, and claims processing services, and 16 percent was for medical management, quality assurance, and utilization management. Each of the remaining service categories accounted for 8 percent or less of all administrative expenses.[17]

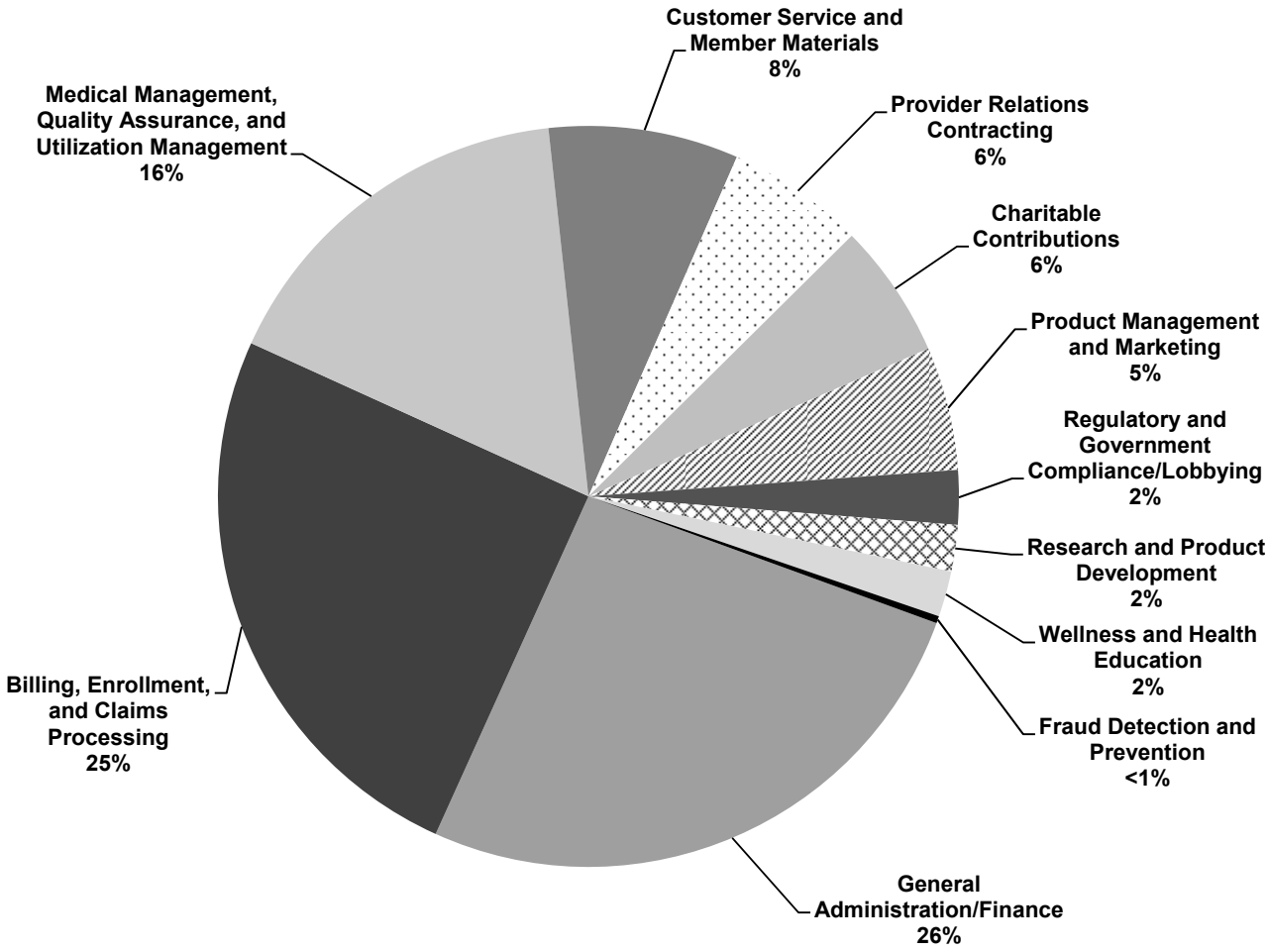
Managed care organizations can and do structure their internal functions, departments, and recordkeeping systems according to their own business models. Later in this report, we explain how state and federal law provide limited detail on the types of administrative expenses MCOs may incur to deliver services for Minnesota's federal Medicaid program. In Chapter 2, our discussion and recommendations result from our audit work at these four largest MCOs.

[15] *42 CFR*, sec. 447.46 (2014).

[16] These data exclude state premium taxes and surcharges reported by these four MCOs.

[17] The categories presented here do not necessarily align with each MCO's organizational framework, but represent common, state-mandated expense groups for reporting purposes.

Exhibit 1.3: Managed Care Administrative Expenses, by Expense Category, Calendar Year 2012



NOTES: Data exclude state premium taxes and surcharges on HMOs. Percentages do not total 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Blue Plus, HealthPartners, Medica, and UCare financial data.

Chapter 2: Managed Care Administrative Expenses

Minnesota has long required managed care organizations (MCOs) to report their administrative expenses to the state. More recently, the state has imposed additional reporting requirements in order to help the Department of Human Services (DHS) set reasonable and appropriate managed care payment rates. State regulations refer mostly to insurance industry accounting standards as guidance for MCOs to record administrative expenses in state-required reports. In this chapter, we summarize findings about MCOs' accounting practices, compliance with certain reporting requirements, and allocation of administrative costs to state public programs for 2012. We recommend legislative actions to enhance MCO financial reporting, understanding of MCO administrative expense data, and future state audits of managed care programs. We discuss DHS rate setting and its use of MCOs' financial data later in Chapter 3.

REPORTING REQUIREMENTS

The State of Minnesota contracts with Blue Plus, HealthPartners, Medica, and UCare to help administer its public health care programs. These four MCOs have complex business models that include relationships with other health insurance or health care entities.[1] The MCOs administer numerous other products and services, such as commercial health insurance for private citizens, federal and state employees, and federal health care programs.[2] These MCOs' business models also involve complex processes to estimate, track, and record financial data, such as general operating, capital, and program-specific costs.

MCOs have filed financial information about their operations with the state for more than four decades.[3] Today, some of these financial documents are not available for the public to see, but many are accessible through websites of the departments of Commerce and Health. State oversight has expanded over the years to help verify the information presented in these financial reports and assure regulators and the public about their content.

In particular, MCOs must have certain financial information certified annually by an independent public accountant.[4] The Department of Commerce oversees a

[1] These other entities may include or be referred to as an affiliate, parent, subsidiary, related entity or party, or other type of organization, depending on the nature of the business relationship.

[2] For example, a managed care organization may contract with a related entity to provide accounting and claims processing services in exchange for a fixed payment amount.

[3] See *Laws of Minnesota* 1973, chapter 670, sec. 8, "The Health Maintenance Act of 1973"; and *Minnesota Statutes* 2014, chapter 62C, "The Nonprofit Health Service Plan Corporation Act."

[4] *Minnesota Statutes* 2014, 62D.08.

periodic "financial examination" of each managed care organization.[5] These examinations are broad in scope and look at the financial condition of the entity, review their business affairs and insurance operations, and assess compliance with certain regulations.

To help state regulators assess their business operations and financial condition, managed care organizations must follow accounting principles that require consistent reporting and presentation of their finances in annual statements.

Minnesota law requires managed care organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions.[6] MDH requires MCOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. To complete this form, MCOs must interpret and consistently apply accounting standards codified as the NAIC Statements of Statutory Accounting Principles (SSAPs).[7] The NAIC provides guidance in the form of statements, instructions, issue papers, and other references.

One of the fundamental concepts of the NAIC accounting principles is to facilitate consistent reporting of meaningful, comparable financial information in order to help regulators determine an MCO's financial condition.[8] Although these principles are a primary authority for MCOs to record and report their finances, the NAIC also defers to other accounting principles.[9] Further, the NAIC SSAPs are not intended to preempt state legislative and regulatory authority.[10]

Minnesota requires MCOs to complete and submit to MDH two additional reports—Minnesota Supplement Report #1 and #1A—that present financial data of each MCO's revenues, medical and administrative expenses, and other data, summarized for each product.[11] These two reports are publicly available online at the MDH website.

MCOs participating in the state's public programs also must submit to DHS their financial statements and other information, including their MDH annual financial

[5] *Minnesota Statutes* 2014, 62D.14. The Department of Health maintains an agreement with the Department of Commerce to oversee financial examinations, to be conducted at least once every three years. The Department of Commerce has authority to conduct financial examinations of insurance companies doing business in this state. *Minnesota Statutes* 2014, 60A.031.

[6] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 2007.

[7] The NAIC annually publishes its *Accounting Practices & Procedures Manual*, Volumes I-III.

[8] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, vol. 1 (Washington, DC, 2013) P-6.

[9] *Ibid*., P-8.

[10] *Ibid*.

[11] *Minnesota Statutes* 2014, 62D.08, subd.7; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 2007. The categories are: commercial, Medicare, each of the Minnesota public programs, dental, "Other," and "Non-Minnesota" (business provided outside of Minnesota and unrelated to Minnesota products).

filings and expenses and revenues, by product.[12] DHS collects and views this and other financial data provided by MCOs for purposes of determining managed care payment rates for state public programs. The accuracy of these financial reports is important because if they are used for determining managed care payment rates, DHS must ensure compliance with federal rate-setting requirements. Further, state statutes impose limits on growth in MCOs' administrative spending for public programs.[13]

AUDIT METHODS

In the next sections, we summarize the results of our audits of MCOs' compliance with certain financial reporting requirements for reports submitted to both MDH and DHS. Specifically, we tested and relied on data the MCOs used to complete: the NAIC *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; NAIC *Exhibit of Net Investment Income*; *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *2012 Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.

For our audit work, we used a narrower, more targeted approach than typically used for either an independent annual audit or a financial examination. We tested the accuracy and reliability of 2012 general administrative, claims adjustment, and investment data contained in these three financial documents filed by each MCO. We audited each MCO's detailed financial data; however, our work was limited to transactions for which at least some part of an administrative expense was apportioned to the state's public programs, and did not include testing commercial-only or Medicare-only transactions, or transactions for medical expenses. Generally, we sampled transactions greater than $500, and some work required examining additional, related transactions.

Appendices A through D contain findings and conclusions specific to each managed care organization, along with their responses. We frame our discussion in the remainder of this report to comply with data privacy requirements. All four managed care organizations classified the majority of their data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

ADMINISTRATIVE EXPENSES AND ALLOCATION

We reviewed how MCOs classified and categorized their administrative expenses on three financial reports, and how they allocated their costs to the state's public programs. For 2012, each MCO's total administrative expenses varied greatly, depending on the number of enrollees served and programs it administered. For these four MCOs, the total 2012 administrative expenses reported for the state's

[12] *Minnesota Statutes* 2014, 256B.69, subd. 9c(b). See Minnesota Department of Human Services, *2012 Families and Children Model Contract* (St. Paul, 2012), secs. 9.10.1-9.10.2; and Minnesota Department of Human Services, *2013 Families and Children Model Contract* (St. Paul, 2013), secs. 9.10.1-9.10.3. DHS contracts for other MA programs contain similar language.

[13] *Minnesota Statutes* 2014, 256B.69, subd. 5i.

public programs were: $70.1 million (Blue Plus), $39.5 million (HealthPartners), $67.7 million (Medica), and $99.7 million (UCare).[14]

These four MCOs' reported administrative expenses represent tens of thousands of accounting transactions. During our work, we observed that accounting processes varied among the MCOs, depending on the type and amount of the expense. To the extent possible, we framed our sampling methodology to account for such differences and still meet our audit objectives.

Categorization of Administrative Expenses

As part of the Health Annual Statement filed with the state, each MCO must complete the Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses. On this exhibit, each MCO must summarize and report its total administrative expenses for all products—that is, commercial and public programs combined—by type of expense. For our work, our sample population included only expenses in which at least some portion was allocated to the state's public programs. We tested approximately 100 individual financial transactions from each MCO's data and verified whether these costs were correctly classified as "administrative" expenses on this exhibit.[15] We also tested whether these expenses were recorded to the appropriate administrative expense line (such as Rent, Salaries and Benefits, or Taxes, for example). Exhibit 2.1 illustrates certain administrative expense classes and categories on the NAIC Underwriting and Investment Exhibit, Part 3.

Among the samples we tested, managed care organizations generally complied with accounting principles when classifying transactions as administrative expenses for 2012, with one exception.

We found that each MCO had appropriately classified our sample transactions as "administrative," with one exception. One MCO classified up to $2.8 million in management and claims adjustment expenses as "medical" expenses and did not include these cost items on its 2012 Underwriting and Investment Exhibit, Part 3; in our opinion, these cost items should have been reported as administrative expenses.[16] The correct classification of these types of expenses is important because DHS handles administrative expenses differently than medical expenses when determining managed care payment rates for the state's public programs.

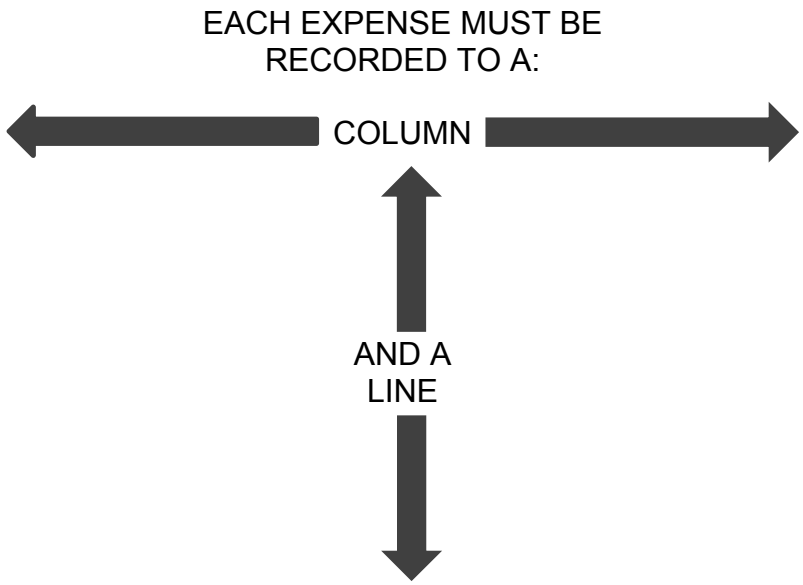
[14] Totals include state premium taxes and surcharges on HMOs. Total MA enrollment for each MCO during 2012 was: Blue Plus (1.6 million member-months), HealthPartners (1.0 million member-months), Medica (1.6 million member-months), and UCare (2.4 million member-months).

[15] We selected samples from MCO data sets containing general ledger and accounts payable data. We also looked for expenses we expected to be classified as "administrative." For purposes of our audit work, we considered "administrative" expenses to include "claims adjustment expenses," "general administrative expenses," and "investment expenses." For more detailed descriptions about these expenses, see NAIC *Statements of Statutory Accounting Principles*, No. 70 and No. 55.

[16] The total reported here represents an upper-bound estimate; we were unable to determine the precise amount in question without testing and verification of individual transactions. These expenses also were not included in the total administrative expenses reported on the MCO's 2012 Minnesota Supplement Reports #1 and #1A.

Exhibit 2.1: Types of Managed Care Organizations' Administrative Expenses, Summarized by Expense Class, 2012

Expense Classification	Claim Adjustment Expenses: Cost Containment Expenses	Claim Adjustment Expenses: Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
Rent	$	$	$	$	$
Salary, wages, and other benefits					
Commissions					
Legal fees and expenses					
Certifications and accreditation fees					
Auditing, actuarial, and other consulting services					
Traveling expenses					
Marketing and advertising					
Postage, express and telephone					
Printing and office supplies					
Occupancy, depreciation, and amortization					
Equipment					
Cost or depreciation of EDP equipment and software					
Outsourced services: EDP, claims, and other services					
Boards, bureaus, and association fees					
Insurance, except on real estate					
Taxes					
Investment expenses					
Aggregate write-ins for expenses					
Total expenses	$	$	$	$	$



NOTES: Each managed care organization (MCO) must summarize its total administrative expenses for all products and programs, collectively, on this Exhibit. MCOs complete and file this exhibit each year as part of their Health Annual Statement. The expense classifications listed here do not include all categories included on the actual National Association of Insurance Commissioners form. Minnesota Supplement Reports #1 and #1A show how these total expenses are allocated across lines of business and state public programs.

SOURCE: Office of the Legislative Auditor, summary of some categories included on the National Association of Insurance Commissioners 2012 Annual Statement—*Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*.

Based on the data we were provided by each MCO, we also reconciled each entity's detailed 2012 administrative expenses for state public programs to its internal accounting documents and its 2012 Underwriting and Investment Exhibit, Part 3. We did not observe any reportable differences in *total* expenses among these key documents and data.[17]

[17] For administrative expense allocated to the state's public programs, we tested and reconciled each MCO's 2012 data contained in general ledgers, accounts payable data, year-end trial balances, and other accounting documentation, against our three sample financial documents.

Among the samples we tested, managed care organizations miscategorized a small number of administrative expense transactions—the total costs related to each of these discrepancies ranged from $549 to $3 million.

We tested whether MCOs' administrative expense transactions were correctly categorized on our sample three financial reports; again, these expenses included transactions in which at least some portion of the expense was allocated to the state's public programs. Among approximately 100 samples tested for each MCO, the number of transactions miscategorized—that is, recorded to the incorrect line—on each MCO's Underwriting and Investment Exhibit, Part 3, ranged from 2 to 7. When including all costs likely related to these sample transactions, total miscategorized expenses for each MCO ranged from $1,702 to $3.03 million. For three MCOs, between one and four sample transactions were miscategorized on either Minnesota Supplement Report #1 or #1A. For these two supplement reports, the total discrepancies for each MCO ranged from $703 to $2.3 million. The discrepancies discussed here represented miscategorization *within* each report and did not affect the total administrative expenses reported.

For purposes of reporting financial information for the state's public programs, correct categorization or disclosure of certain administrative expenses—such as taxes—is important because some categories of data may be handled differently than others when setting managed care payment rates. Most of the MCO reporting discrepancies pertained to the following categories: Salaries, Wages, and Other Benefits; Taxes, Licenses, and Fees; Cost or Depreciation of EDP Equipment and Software; and Cost Containment. In response to our findings, some MCO representatives said that NAIC accounting principles do not sufficiently describe how to record some of the transactions we questioned. As such, the lack of specific instructions may have contributed to some inconsistencies in reporting.

Allocation Requirements

In recent years, Minnesota law imposed additional reporting requirements to enhance understanding of the costs of individual health insurance products and programs, and to develop consistency in reporting among MCOs. In response to a report by the Office of the Legislative Auditor, the 2008 Legislature directed MDH to develop guidelines to ensure that MCOs have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs.[18]

[18] The 2008 law also required the commissioner of human services to work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by MCOs under *Minnesota Statutes* 62D.08. See *Laws of Minnesota* 2008, chapter 364, secs. 5 and 12; Minnesota Department of Health, *Administrative Expenses and Investment Income for Health Plans and County-Based Purchasers: Guidelines and Recommendations, Report to the Minnesota Legislature 2009* (St. Paul, 2009); Minnesota Department of Health, *Advisory Group on Administrative Expenses: Report to the Minnesota Legislature 2012* (St. Paul, 2012), 2; and Minnesota Office of the Legislative Auditor, *Financial Management of Health Care Programs* (St. Paul, 2008).

The 2010 Legislature extended this effort by requiring in law that every managed care organization "must directly allocate administrative expenses to specific lines of business or products when such information is available."[19] The law also required MCOs to report this information to the state on a template developed by MDH. MDH did develop and require MCOs to file by April 1, 2013, this new report—Minnesota Supplement Report #1A—for the year ending December 2012.[20] Each MCO did complete and file this report with MDH mid-year 2013.

With the new reporting requirement, MCOs now must report administrative expenses and other financial information for each product, program, or line of business on two separate reports: Minnesota Supplement Report #1 and Minnesota Supplement Report #1A. (Blank copies of these two documents are contained in Appendix E of this report.) Generally accepted accounting principles provide guidance for determining how costs may be attributed to an individual product, program, or entity. Such guidance varies, depending on the authoritative source. In general, accounting principles present three scenarios for apportioning the cost of a unique transaction: (1) direct costs, (2) direct allocation, and (3) indirect allocation. Exhibit 2.2 on the next page summarizes these accounting concepts and related key NAIC accounting principles.

Depending on whether and how consistently MCOs implement this practice, more direct allocation of administrative expenses could mean that the overall cost of each state program increases or decreases from year to year. To examine how each MCO allocated administrative expenses across its lines of business in Minnesota Supplement Reports #1 and #1A for 2012, we first reviewed each MCO's accounting practices and processes.

MCO Allocation Processes

Each MCO processes tens of thousands of transactions related to their administrative costs each year. These transactions are for many types of expenses, such as general overhead, services by subcontractors, intercompany fees, and payments for capital projects. Further, managed care organizations can and do structure their internal functions, departments, and accounting according to their own business models and services.

Managed care organizations have complex allocation processes to record and apportion their administrative expenses across numerous entities, products, and programs.

[19] Further, remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. See *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2, effective January 1, 2013; and *Minnesota Statutes* 2014, 62D.08, subd. 7.

[20] The new Minnesota Supplement Report #1A reallocates general administrative expenses and investment income from Minnesota Supplement Report #1 and groups MCO "general administrative" expenses into seven general categories. Three other key requirements include: (1) each MCO must break out direct expenses from indirect expenses, (2) total indirect expenses must be reallocated across lines of business by dollars of premium income (or premium–equivalent for certain business); and (3) each MCO must allocate its investment gain by the prior five years of net income.

Exhibit 2.2: Accounting Terms and Principles for Allocating Administrative Costs, 2012

Terms	Description of Accounting Principle
Direct Cost	All costs for an item can be easily and specifically identified with or benefit a single program, product, or entity (or "cost objective"), and can be assigned with a high degree of accuracy.
Direct Allocation	Costs are considered to benefit two or more specific products, programs, or entities, and can be easily assigned. Costs are apportioned based on the relative benefits received. Direct allocation method requires some rigor of analysis—such as studies of employee activities, salaries, or claim counts—and must be "fair and reasonable."
Indirect Allocation	The allocation of costs incurred for a common or joint purpose benefitting more than one product, program, or entity, but costs are not readily assignable without effort disproportionate to the results achieved. Indirect allocation methods should still be appropriate for the type of expense allocated.
National Association of Insurance Commissioners Key Accounting Principles for Allocating Expenses	
SSAP No. 70	Any allocation of costs must be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salaries, or similar analyses.
Appendix A-440	Within a holding company system, transactions shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.
Issue Paper 94	Allocation should be based on the method that yields the most accurate results. Any basis of allocation which is found to be inappropriate should be discounted.

NOTES: These terms and principles are not always interpreted or applied in a mutually exclusive way. For example, the terms "direct cost" and "direct allocation" are sometimes used interchangeably. Some principles refer to "direct" cost and "indirect" allocation only, and do not reference "direct allocation." These definitions are for descriptive purposes only. Minnesota managed care organizations under contract for Medical Assistance programs are not subject to these federal standards.

SOURCES: Office of the Legislative Auditor, summary of National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, vol. I-III; Statements of Statutory Accounting Principles No. 70; Appendix A-440; and Issue Paper 94. See also U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A; and *48 CFR*, secs. 9904.402-30—9904.402-50 (2014).

In 2012, MCOs mostly relied on accounting systems or software programs to apportion costs across their lines of business. Generally, an MCO can preprogram into its accounting system an allocation formula or metric for each type of cost or department. Expenses then are allocated automatically to one or more specific entities, products, programs, or departments when they are entered into the system. Some of these systems are quite complicated, with multiple allocation steps or formulas. Some MCOs also manually allocate certain expense items on a case-by-case basis.

As shown in Exhibit 2.2, NAIC accounting principles require that any allocation of costs be based on a method that yields the most accurate results. Where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios, such as studies of employee activities, salaries, or similar analyses. Further, NAIC concepts require that each MCO is consistent in how it treats expenses.

Most of the allocation formulas used by each MCO in 2012 were predetermined by management, and were part of an "allocation model" that accounted for all types of administrative expenses or functions, such as legal, billing, or cost containment. Depending on the expense type, costs were allocated based on number of staff, square footage, member-months, premium revenues, claim counts, or other formulas.[21] MCOs relied on formal analysis—such as time tracking—to develop some formulas; however, for particular types of expenses or departments, management often subjectively estimated an allocation percentage. For example, management might set the percentage of marketing costs allocated to each line of business based on estimates of workload during the past year. MCO representatives told us that they periodically modify these formulas, or add cost centers or categories for new programs or expense types.

During our audit work, MCO representatives said that the Department of Commerce had reviewed and approved their allocation models as part of the department's financial examinations. Our audit work did not include evaluating each MCO's allocation model. Rather, we examined whether certain expenses could be more directly allocated to a specific product—in accordance with new state requirements—using each MCO's description of its allocation methods.

Direct Allocation

Each MCO's methods for allocating its administrative expenses across commercial and government programs in 2012 varied greatly, depending on the expense type, department, function, or entity. These methods also did not align exclusively with state public program needs as each MCO also offered commercial products or other administrative services, either within or outside of Minnesota.

For the majority of their 2012 administrative costs, managed care organizations consistently allocated at least some portion of each expense item to state public programs.

Managed care organization representatives told us that they most often spread administrative expenses across all lines of business to gain efficiencies in business operations. For more than 50 percent of all MCO administrative expense items in 2012, between 0.1 percent and 100 percent of each transaction was allocated to the state's programs on their Minnesota Supplement Reports #1 and #1A.[22] MCOs were mostly consistent in that they often treated all state

[21] For their allocation "metrics," management of some MCOs sometimes modified basic values—such as number of staff—by some factor before allocating costs (for example, number of full-time-equivalent staff X 1.2).

[22] Estimate is based on 2012 detailed financial data provided by the managed care organizations.

public programs as a single "product," and rarely tracked and directly assigned expenses solely to one individual program—such as PMAP, MSHO, or SNBC.[23] Depending on the expense type or dollar amount, some MCOs did individually review and directly allocate some expenses for one-time or specialized services.

We identified opportunities for managed care organizations to more directly allocate administrative expenses to specific products, although managed care representatives said that this practice is time-consuming and would increase costs for public programs.

Among approximately 100 transactions tested for each MCO, we identified some types of services that could have been expensed more directly to one or more state programs in each MCO's 2012 Minnesota Supplement Report #1A.[24] These items did not include day-to-day general overhead and operating expenses. Rather, these costs resulted from subcontracts for services unique to one or more lines of business. Within the contract documents, the MCO had specified products—commercial or public program—that benefitted from the service. For some of these expenses, the contract services required tracking by member eligibility, by program. As such, the MCO had information available for more direct allocation of costs.

For each MCO, the number of these contract-related services that could have been directly allocated ranged from two to five. The total sample transactions we tested ranged from $14,478 to $66,896, and we estimated the amounts allocated among the state's public programs ranged from $7,152 to $14,208.[25] When including all costs likely related to these transactions, we estimated the total costs allocated among state programs ranged from $14,068 to $206,572.

In response to the new requirements for directly allocating costs, some MCO representatives said that increased tracking of expenses would require additional administrative resources and, thus, increase the costs of the state's public programs. MCO representatives also informed us that their current allocation processes and methods are similar to those used during 2012.

Costs Allocated to Public Programs

Minnesota managed care organizations have broad discretion regarding the type of costs they may incur for their business. Generally, an MCO is paid a fixed, prepaid amount—or capitation payment—and MCO net earnings must be devoted to the nonprofit purposes of the MCO in providing comprehensive health care.[26] Minnesota law also authorizes MCOs to make payments to any

[23] Acronyms represent the Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), and Special Needs Basic Care (SNBC).

[24] *Minnesota Statutes* 2014, 62D.08, subd. 7(a).

[25] For more information, see Appendices A through D at the end of this report.

[26] *Minnesota Statutes* 2012, 62D.02, subd. 4, generally defines health maintenance organizations as entities that are paid a fixed, prepaid amount to provide comprehensive health maintenance services without regard to the frequency or extent of services furnished to any particular enrollee. See also *Minnesota Statutes* 2014, 62D.12, subd. 9.

organization(s) which are operated for charitable, education, religious, or scientific purposes, and they may not incur costs or pay for expenses that are unreasonably high in relation to the value of the services.[27]

For MCOs under contract for the Medical Assistance programs, any restrictions or limits on spending occur through the DHS rate-setting process to determine managed care payments for the upcoming contract year. This process relies in part on historical data and reports submitted to DHS by each MCO. (We discuss how DHS sets managed care payment rates later in Chapter 3.)

Managed care organizations allocated some unreasonable expenses to the Medical Assistance programs on their 2012 state-required financial reports.

Among our sample transactions we tested, we questioned some administrative expenses allocated by the MCOs to the state's public programs on their 2012 Department of Health Minnesota Supplement Reports #1 and #1A. In our opinion, these cost items were: (1) unreasonable and did not reflect the actions a prudent person would take in the circumstances, (2) unrelated to the provision of services under the state's Medical Assistance plan for Medical Assistance enrollees, or (3) did not comply with MDH rules.[28] In particular, Department of Health rules required MCOs to identify and separately report services for business outside of Minnesota and unrelated to Minnesota products.

Based on our review of MCOs' internal policies and practices, we concluded that the MCOs' accounting and allocation processes did not sufficiently identify and restrict these types of expenses from the Medical Assistance programs on their 2012 MDH supplement reports. The expenses we questioned varied for each MCO and were incurred for alcohol beverages, travel, entertainment, or activities or services outside of Minnesota and unrelated to the state's public programs. For each MCO, the number of these transactions tested ranged from one to three. The total value of the transactions ranged from $2,664 to $26,000, and we estimated total costs allocated among state public programs ranged from $376 to $2,144. As a result of our sampling methodology, these expenses were mostly small; however, we consider these transactions to be indicators of an MCO's allocation practices.

We also questioned other administrative expenses allocated by the MCOs to the state's public programs on their MDH 2012 supplement reports. These expenses were for indirect marketing activities or charitable contributions. Minnesota laws in effect at the time the MCOs filed their annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific

[27] *Minnesota Statutes* 2014, 62D.12, subd. 9a; and 62D.19.

[28] We used the following criteria as the basis for our findings: U.S. Office of Management and Budget, *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations*, subp. A, sec. 105. (We used this OMB "prudent person" standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this OMB standard.) See also *Minnesota Statutes* 2014, 62D.19; *42 CFR*, secs. 438.6(c)(4)(ii)(A) and 438.6e (2014); and *Minnesota Rules*, 4685.1930, subps. 2 and 6, posted October 2007.

purposes.[29] However, charitable contributions were included in the financial data and supplement reports submitted to DHS, and they were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[30]

Some of the costs we questioned may have benefitted individuals who happen to be enrolled in Medical Assistance, but the services were not part of the federally approved services for Minnesota's MA programs. In some cases, the MCO did not provide us with sufficient documentation to determine the details of the expense. For each MCO, the total indirect marketing and contribution transactions discussed here ranged from $47,569 to $10 million, and we estimated the amount allocated among the state's public programs ranged from $5,198 to $8.5 million. These expenses were for: marketing videos, trinkets, training for sales staff for commercial products, newspaper and television advertisements, tickets to a sporting event, promotional charity events, grants for research or employment opportunities, contributions to other nonprofit organizations, website development, and other types of expenses.[31]

Absent restrictions in state law or rule, disagreements over managed care organizations' allocation of costs to the state's public programs will persist.

Managed care representatives mostly disagreed with our findings about their allocation of costs on MDH-required reports, and our characterization of such costs as unreasonable for purposes of determining payment rates for public programs. For some costs we questioned, some representatives said that their allocation practices comply with federal and state law, state contracts, reporting requirements, and accounting standards. Some MCO representatives also said that: (1) Minnesota Supplement Reports #1 and #1A are financial reports required by MDH and were not developed nor were intended to be used for other purposes, such as by DHS for determining capitation payment rates for the state's public programs; (2) directly allocating these types of expenses exclusively to products other than the state's public programs would not be appropriate; (3) the expenses were small, benefit their organization overall, and are standard for their industry; or (4) the audit firms they employ to conduct their independent audits would not certify their financial reports if they used different allocation methods.

We questioned MCOs' indirect marketing and charitable contribution expenses because the MCOs allocated these expenses to the public programs on their MDH supplement reports, and we do not view these expenses as related to approved services under the state's Medical Assistance program. As we described earlier in this chapter, Minnesota Supplement #1A was developed to facilitate understanding of the costs for public health care programs, and DHS views the MDH supplement reports when developing payment rates for 2014.

[29] *Minnesota Statutes* 2012, 62D.12, subd. 9a.

[30] *Minnesota Statutes* 2012, 256B.69, subd. 5i.

[31] Regarding the marketing expenses we questioned, MCO representatives said that these cost items were for indirect marketing or "branding" and were not for direct marketing that would have required DHS approval.

Laws passed during the 2013 legislative session defined indirect marketing and charitable contributions as "unallowable" for purposes of determining managed care capitation payments; however, this law was passed *after* the MCOs completed and filed their 2012 annual financial filings and supplement reports.[32] Under the new law, these unallowable expenses are: fines or penalties assessed against the MCO; indirect marketing or advertising expenses; charitable contributions; and any portion of an individual's compensation in excess of $200,000. During 2013, DHS requested from MCOs and they submitted separate financial data regarding these unallowable expenses, and we attempted to reconcile these data with the MCO annual reports submitted to DHS for purposes of determining managed care payment rates. We were able to verify that some of these expenses were sufficiently disclosed to DHS. We discuss the results of our efforts and make recommendations later in Chapter 3.

Subcontract Administrative Expenses

Managed care organizations may subcontract with outside entities or individuals for the provision of services, including administrative services.[33] The state's contracts with the MCOs for public programs specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all subcontracts must be in writing.[34] During 2012, managed care organizations did subcontract for many types of administrative services, and these expenses were among the transactions we sampled.

Managed care organizations did not have adequate documentation to support costs related to some subcontracts for administrative services expensed to public programs in 2012.

For some contract-related sample transactions we tested, MCOs did not have adequate documentation to validate whether the subcontractors were paid appropriately, assess the reasonableness of the MCO's allocation, or determine how these expenses related to the state's public programs.[35] We found that invoices for subcontracted professional services sometimes lacked descriptive information. (In contrast, invoices for purchased goods generally contained descriptive data—such as price, product type, and number of units.) Under these circumstances, written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in

[32] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21, amended *Minnesota Statutes* 2012, 256B.69, subd. 5i.

[33] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[34] Department of Human Services, *2012 Families and Children, Model Contract* (St. Paul, 2012), secs. 9.1, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). Minnesota law defines a "contract" as any written instrument or electronic document containing the elements of offer, acceptance, and consideration. *Minnesota Statutes* 2014, 16C.02, subd. 6.

[35] We defined questioned costs to include "a cost that is questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation." OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

question are related to the contract and are not for other services.[36] And written amendments document any changes to the agreement between the MCO and contractor.

When verifying these expenses, we found that some MCOs' subcontracts were not signed by both parties or had expired, or payments did not match the vendor rates in the documents provided by the MCO. Some contracts had conflicting provisions or the payments we tested did not align with terms for amending the contract. In some instances, the MCO did have a general master contract, but did not execute an individual work order contract or statement of work describing payment terms and the nature of work or expected final product. For each MCO, the number of contract-related transactions that lacked adequate documentation ranged from two to four, the total transactions we tested ranged from $28,109 to $219,086, and we estimated the total costs allocated among the state's public programs ranged from $2,893 to $31,736.[37]

DISCUSSION AND RECOMMENDATIONS

Policymakers recently expanded financial reporting requirements for MCOs to improve transparency and understand costs for managed care administrative services. We focused our work to help assess implementation of these changes, and we identified issues for state policymakers and administrators to consider. The following discussion provides context for our recommendations and, if implemented, would enhance future audit work for the state's public programs.

Minnesota statutes, rules, and state contracts do not ensure consistent reporting by managed care organizations and compliance with policymakers' intent.

Our examination of managed care organizations' detailed financial data, supporting documentation, and allocation practices revealed that state financial reporting requirements should be improved. In particular, lack of detail and conflicting language in law and state contract provisions do not sufficiently support recent efforts by policymakers. Insufficient guidance in accounting principles may contribute to inconsistencies in reporting, too.

[36] We tested our contracts and samples transactions to verify: (1) the MCO had a written agreement signed by an authorized MCO representative and subcontractor, with details about the parties to the contract, duration, and terms of payment; (2) the invoice or transaction tested aligned with the terms of the contract; and (3) an amendment to the contract—as necessary—was executed to ensure the contract documents supported the transaction tested. For recommended best practices and guidelines for contracting, we referred to Minnesota Department of Administration, *State Contracting, Policies and Procedures* (St. Paul, 2000, modified May 2012), sec. 5.

[37] These totals do not include all likely related costs. Specifically, identifying all likely related costs when there is no controlling reference document—such as a contract—was too difficult to sufficiently verify. For more information, see Appendices A through D at the end of this report.

Reporting Instructions and Definitions

Some Minnesota statutes now require MCOs to report certain financial data for each individual program or product. We found that MCOs differed in their interpretation of "program" or "product," depending on the reporting requirement. As part of reviewing MCO practices for directly allocating expenses to specific lines of business or product when such information is available (as required by state statute), we considered each state public program to be a separate product.[38] Our interpretation aligns with laws passed during the 2008 legislative session, which requires direct allocation to *individual* public programs.[39] This approach also recognizes that DHS executes separate contracts and uses different methods for determining managed care payment rates, depending on the public program.[40] However, we found that MCOs most often treated all state public programs as a single "product" when directly allocating costs on Minnesota Supplement Report #1A, or otherwise allocated individual administrative expenses across all commercial and public programs (including Medicare).

We also observed that managed care representatives differed in their interpretation of terms "direct allocation" and "indirect allocation." Some considered directly allocate to mean "direct expense"; that is, 100 percent of the expense is attributed to a single entity or program.[41] One MCO representative said that because the Minnesota law does not define "directly allocate," MCOs may record costs according to internal definitions. Some said that the law does not specify the types of expenses to directly allocate (such as for items above a certain dollar amount, or for one-time projects, general operations, or contracts). Finally, one representative disagreed with the Department of Health instructions to allocate indirect costs by premium income as "there is no [relationship] between premium revenues and administrative expenses."

Several managed care representatives told us that more tracking and direct allocation of costs would be time-consuming and not cost-effective. This could be true for some types of general overhead costs; however, for contract-related expenses, MCOs already invest time in hiring subcontractors and developing a scope of work. For the sample transactions we identified as appropriate for more direct allocation, we think any measurable increase in resources needed to trace these costs more often results from a subcontractor's billing practices. Based on our review of sample transactions, subcontractors often combined costs—such as for legal services—for multiple projects into a single invoice, rather than submit a separate invoice for each project or program. Further, some higher dollar value invoices contained few references about the nature and amount of services provided.

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[38] *Minnesota Statutes* 2014, 62D.08, subd. 7(a).

[39] *Laws of Minnesota* 2008, chapter 364, sec.12.

[40] DHS combines PMAP and MinnesotaCare in a single contract, MSC+ and MSHO in a single contract, and SNBC is a standalone contract.

[41] An allocation formula which *allocates* 0 percent of costs to program A and 100 percent of costs to program B has the same effect of a *direct expense* to program B.

As directed by the Legislature, MDH developed Minnesota Supplement Report #1A and accompanying instructions. However, *Minnesota Statutes* 2014, 62D.08, does not define the term "directly allocate" or "lines of business or product," or specify types of expenses to allocate. More explicit language and definitions could help address differences in MCOs' interpretation and reporting of administrative expenses on Supplement Report #1A. To facilitate this process, the Legislature could refer to existing definitions of these terms in federal standards and regulations when defining these terms in state law.[42] Other states—such as Texas—have adopted federal definitions or specified how some types of expenses must be allocated.[43]

RECOMMENDATION

The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to include Department of Health instructions and to further specify how managed care organizations must allocate administrative expenses for Minnesota Supplement Report #1A.

State statutes and rules also do not ensure that MCOs consistently allocate and report investment income on Minnesota Supplement Report #1A. Specifically, instructions in *Minnesota Statutes* 2014, 62D.08, are very brief and require MCOs to "allocate investment income based on cumulative net income over time by business line or product" on a form required by MDH. MDH instructions are also very brief and state that MCOs "must allocate investment gain by the prior five years of net income."

Notwithstanding these differences, we found that some MCOs did not precisely comply with MDH requirements and used their own methodology. Managed care representatives interpreted these instructions differently, or said that the instructions do not ensure reported values that accurately reflect recent investment experience.

We think that *Minnesota Statutes* 2014, 62D.08, should be amended to ensure consistency in reporting requirements and compliance with policymakers' intent. In particular, reporting requirements for Minnesota Supplement #1A rely on data reported in Minnesota Supplement Report #1, and there are minimal state instructions for Minnesota Supplement Report #1. This means that each MCO could compute net income based on its internal methodology for each product; in turn, this approach can affect how much investment income is allocated to each public program on Supplement Report #1A.

[42] *48 CFR*, sec. 9904 (2014); U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004); *48 CFR,* sec. 31 (2014); and U.S. Office of Management and Budget, *Circular A-122, Cost Principles for Non-Profit Organizations* (Washington, DC, 2004). We cite these standards for reference purposes only. Minnesota managed care organizations under contract for Medical Assistance programs are not subject to these federal standards.

[43] Texas Health and Human Services Commission, *Uniform Managed Care Manual, Cost Principles for Expenses*, v. 2.2 (July 20, 2013).

RECOMMENDATION

The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to further specify how managed care organizations must allocate investment income on Minnesota Supplement Report #1A.

Requirements for Subcontracts

Managed care organizations may subcontract with other entities or individuals for administrative services for public programs; this arrangement is allowed under the state's contracts with the MCOs, as well as state law.[44] DHS contracts also require that the MCOs comply with all federal laws and regulations—including federal contract laws. Both federal law and state contracts specify that subcontracts must be in writing.

MCOs pay vendors and professional consultants for administrative services. We found that the scope of these professional services and payment terms were not always adequately documented, payments did not always align with the contract terms, and the subcontractors' invoices lacked descriptive information. For one sample without a fully signed contract, MCO total payments to its subcontractor exceeded $200,000 and the majority of costs were allocated to state public programs.

In response to our findings, some managed care representatives said that they were not required under law or through their state contracts to maintain current, fully executed contracts for the transactions we questioned. In their view, management approval of the expense is sufficient documentation, or the services were "not significant or material" to the MCO's obligation under its contract with the state and, thus, did not require a written contract.

Managed care organizations participate in administering public health care programs, a service that involves the handling of sensitive and personal information. For administrative services outsourced by the MCOs and expensed to the public programs, tight contracting requirements represent sound business practice and facilitate transparency in program costs. DHS contracts with MCOs contain more explicit provisions for some types of MCO subcontracts for health care services than for administrative services. The Legislature and DHS should directly specify that MCOs must maintain fully executed, current, written subcontracts for administrative services expensed to the public programs, including the required form and content of these documents. At a minimum, such provisions should explicitly address subcontracted administrative services that involve access to not public data.

[44] *Minnesota Statutes* 2014, 62D.05, subd. 4; and DHS, *2012 Families and Children Model Contract*, secs. 9.3.1 and 9.3.5.

RECOMMENDATIONS

The Legislature should specify in law requirements regarding managed care organizations' subcontracts for administrative services that are expensed to Minnesota's public health care programs.

In its contracts with managed care organizations, the Department of Human Services should further specify requirements regarding subcontracts for administrative services, including the required form and content.

Chapter 3: Department of Human Services Rate Setting

The relationship between managed care administrative spending and health outcomes is complicated. Absent requirements for quality of care and service performance, a lower price may, or may not, result in better value for services. Nonetheless, the state's processes and practices for determining Minnesota's costs for Medical Assistance should help ensure that payment rates for managed care administrative services are appropriate and reasonable, and neither inadequate nor excessive.

In this chapter, we make observations about the Department of Human Services' (DHS's) efforts to control managed care administrative costs through the payment rate-setting process.[1] We identify areas of concern based on our audits of managed care organizations' (MCOs') 2012 administrative expense data. We also offer recommendations to policymakers and the department to improve state oversight. Much of the analysis and data used for rate setting has been classified as not public, and we frame our discussion accordingly.

MANAGED CARE TRENDS 2009-2013

Our audits of managed care organizations' 2012 financial reports found that MCOs' overall administrative expense totals were correct, with some larger reporting exceptions that may have had an effect on DHS's rate-setting analysis for 2014. For the data we tested, MCOs generally complied with the National Association of Insurance Commissioners (NAIC) accounting principles when completing reports required by the Department of Health. However, we found that the administrative expenses that MCOs allocated to the state's public programs included some questionable or unallowable costs for purposes of determining managed care payment rates.

Our findings support recent actions by policymakers to establish a more direct reporting relationship between the MCOs and the Department of Human Services. DHS must determine how much to pay managed care organizations for administering the state's public health care programs, and ensure that payment amounts are within limits of law.[2] DHS also is responsible for controlling state expenditures for Medical Assistance—this includes ensuring against excess payments.[3]

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[1] We did not retain an actuary to review the analyses and certifications by DHS or its actuary, or to calculate a better payment rate. We also did not verify whether the 2014 managed care payment rates were "actuarially sound."

[2] *42 CFR*, sec. 438.6(c) (2014); and *Minnesota Statutes* 2014, 256B.69, subd. 5.

[3] *42 CFR*, sec. 456.3(a) (2014); and *Minnesota Statutes* 2014, 256B.69, subd. 5k.

Managed care administrative costs per member-month in 2013 were comparable to 2009 rates for some state public health care programs, but increased for others.

We examined DHS rate-setting activities during 2013 for contract year 2014, but we also considered that some state initiatives preceded this time period. For context, Exhibit 3.1 summarizes recent trends in MCO expenses, revenues, and member-months for the four largest MCOs.[4] Compared with 2009 financial data, MCO administrative expenses per member-month were about 0.5 percent lower in 2013 for the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare, but about 8.0 percent higher in 2013 for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+).[5] These differences may be due to several factors, including program requirements, care management activities, changes in MCOs' service arrangements, rate-setting methods, contract negotiations, or competitive price bids. These trends also could reflect changes in MCOs' allocation methods. In Chapter 2, we described how MCOs most often allocated administrative expenses across all public programs during 2012.

Exhibit 3.1: Minnesota Public Health Care Programs, Expenses and Enrollment, Four Managed Care Organizations, Contract Years 2009 and 2013

Programs[a]	Contract Year 2009	Contract Year 2013	Percentage of Change
Administrative Expenses (in thousands)			
PMAP, GAMC, MinnesotaCare	$156,274	$201,274	28.8%
MSHO, MSC+	$ 52,840	$ 67,843	28.4%
Total Member-Months (in thousands)			
PMAP, GAMC, MinnesotaCare	4,609	5,966	29.4%
MSHO, MSC+	401	476	18.9%
Administrative Expenses per Member-Month			
PMAP, GAMC, MinnesotaCare	$ 34	$ 34	-0.5%
MSHO, MSC+	$132	$142	8.0%
Medical Expenses per Member-Month			
PMAP, GAMC, MinnesotaCare,	$405	$408	0.6%
MSHO, MSC+	$2,189	$2,169	-0.9%

NOTES: Acronyms used in this exhibit represent the Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+)

[a] General Assistance Medical Care was a state public program in 2009, but the program was discontinued. This population was covered under other MA programs during 2013.

SOURCE: Office of the Legislative Auditor, analysis of Blue Plus, HealthPartners, Medica, and UCare financial data reported in 2009 and 2013 Minnesota Supplement Report(s) #1, Statement of Revenue, Expenses, and Net Income.

[4] Data reported in Exhibit 3.1 does not include MCOs' financial experience for contract year 2014 as these data will not be available until April 2015.

[5] Total administrative expenses for all four MCOs—Blue Plus, HealthPartners, Medica, and UCare combined—decreased from about $278 million in 2012 to $269 million in 2013.

PAYMENT METHODOLOGIES

DHS's managed care payment rates and methodology must be approved by the federal Centers for Medicare & Medicaid Services (CMS) in order for Minnesota to receive federal Medicaid funds. CMS also must approve the state's Medical Assistance (MA) plan, the scope and level of health care services, and populations covered. Federal regulations and guidelines provide the framework for developing payment rates for these services, but these directives largely defer to states and their actuaries to select payment methods and execute the details. As of March 2015, CMS approved Minnesota's 2014 managed care payment rates—including the certifying actuary's methodologies and assumptions for administrative costs—for MSHO, MSC+, and Special Needs Basic Care (SNBC). CMS's approval of PMAP and MinnesotaCare rates was still pending

Minnesota has used an "at-risk" capitation payment method for managed care services for many years. Under this approach, the price for administrative and medical services—and any additional monies for the MCO to contribute to its financial reserves—are bundled together and treated as a single payment. This means each MCO is paid a fixed, prepaid amount for each enrollee without regard to the level or amount of health care provided to any individual enrollee.[6] Under a capitation payment method, the MCO assumes the risk for paying for all services—even if the costs exceed the capitation payment amount—but also retains all monies not spent.

Under a capitation payment method, DHS must assure and provide documentation to CMS that MA payment rates are "actuarially sound."[7] That is, the rates must be:

- Developed in accordance with generally accepted actuarial principles and practices.
- Appropriate for the populations to be covered, and based only upon services covered under the state plan to Medicaid-eligible individuals (or costs directly related to providing these services, including MCO administration).
- Certified as meeting federal requirements by actuaries who meet the qualification standards of the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

[6] *Minnesota Statutes* 2014, 62D.02, subd. 4.

[7] *42 CFR*, sec. 438.6(c)(1)-(4) (2014). For contract year 2014, actuarial standards suggest that Medicaid benefit premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, the projected premiums—including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income—provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital. See American Academy of Actuaries, *Medicaid Rate Certification Work Group, Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs* (Washington, DC, 2005), 8-9.

Minnesota supplements federal law with general provisions that rates must satisfy federal requirements and be developed in accordance with generally accepted actuarial principles and practices.[8] In essence, DHS must work with and rely on an actuary to ensure compliance with Medicaid regulations. As in previous years, DHS contracted with an actuary firm during 2013 to fulfill these requirements for contract year 2014.

DHS and its certifying actuary have broad discretion to select rate-setting methods for managed care administrative costs.

Under federal Medicaid guidelines, DHS must include an adjustment to the overall capitation payment rate to account for administrative expenses, but DHS is allowed flexibility in how it determines this amount.[9] Actuarial methods to develop the administrative portion of the rate include: (1) percentage of all premium revenues; (2) fixed payment per member-month; or (3) combination of fixed payment for certain services, combined with a percentage for remaining service costs that may vary.[10] Broadly, DHS must assure that only administrative costs directly related to the provision of federally approved Medical Assistance services for MA enrollees are built into the administrative portion, and explain any incentive or risk-sharing arrangements.[11]

CMS also allows reasonable amounts for risk margin or profit levels, but has not established standards that define "reasonable" or how profit must be computed into the payment rate.[12] For Minnesota's MA program in 2014, the capitation rates did not include an explicit "profit" component, but did include a factor for "contribution to surplus"—0.75 percent for PMAP and Minnesota Care, for example—for managed care organizations' reserves.

Federal Medicaid guidelines and actuary standards require that the certifying actuary document all assumptions and methods used, including projections in future expenditures, enrollment, and utilization.[13] For example, forecasted trends

[8] *Minnesota Statutes* 2014, 256B.69, subd. 5k.

[9] Centers for Medicare & Medicaid Services, *Appendix A. PAHP, PIHP, and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting* (Washington, DC, 2003), sec. AA.3.2.

[10] Wakely Consulting Group, *Review of Medicaid MCO Administrative Rate Setting Methodology* (Minneapolis, 2014), 26.

[11] *42 CFR*, sec. 438.6(c)(3) (2014). The actuary also should include an adjustment for taxes, assessment, or fees that the MCOs must pay out of the capitation rates. Other factors considered appropriate for determining the administrative portion include: overall size, lines of business covered by the rate, age of the MCO or years of participation in Medical Assistance, organizational structure, demographic mix of enrollees, member services, interpreter services, and expenditures for marketing, claims processing, medical management, and staff overhead. Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 24-26.

[12] CMS, *Appendix A. Financial Review Documentation*, sec. AA.3.2. For Minnesota's MA program, any contribution to surplus is determined separate from the administrative and medical components of the payment rate.

[13] *42 CFR*, sec. 438.6(c)(3) (2014); and Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 29.

in administrative spending may be computed based on national indices or other measures of the health insurance industry. Minnesota statutes impose limits on future overall trend increases to MA rates paid to managed care organizations.[14] Most of these limits apply to the overall capitation payments and are not necessarily specific to administrative expenses. For example, DHS was required to limit the maximum annual trend increases in managed care payment rates to 2.0 percent for the 2014 MCO contracts for families and children.

For Minnesota managed care organizations compensated through a prepaid capitation payment method, federal and state law provide few specific restrictions on MCOs regarding the types of expenses they may incur to administer the state's Medical Assistance programs.[15] Generally, an MCO must fulfill its contractual obligations, but may use its capitation payment monies as it chooses throughout the year. Any restrictions regarding administrative expenses are imposed when DHS renews contracts and determines new overall payment rates.

2014 PAYMENT RATES

For contract year 2014, DHS determined capitation payment rates for managed care services through two separate competitive procurement processes: (1) competitive price bid, a process previously implemented through 2011 legislative session laws for contract year 2012;[16] and (2) state-set base rates (that is, DHS sets the rate and contracts with each MCO). These rate-setting processes differed depending on the Medical Assistance program, population, and geographic area. Rates for PMAP were developed separately using different data and methods than for MSHO, for example. Medical needs for these populations vary, and rate-setting methods must account for these variances. DHS's expectations for administrative services also differ for each program, which affect MCO administrative spending.

The Department of Human Services implemented important cost-savings initiatives for contract year 2014, but the department's technical execution during 2013 was sometimes lacking.

Prior to 2011, the state's actuary developed a single base rate for each program. Through a competitive price bid approach, the capitation rate-setting process is more complex but offers more flexibility for finalizing payment amounts. CMS requires that the state's actuary calculate rate ranges; that is, lower and upper

[14] *Minnesota Statutes* 2014, 256B.69, subd. 31. State law allows DHS to use competitive price bidding, payment reductions, or other methods to achieve the specified reductions and limits on an aggregate, statewide basis.

[15] *Minnesota Statutes* 2014, 62D.12, subd. 9, 9a. Federal laws impose restrictions on certain marketing by MCOs under Medicaid contracts and, thus, related administrative expenses. See *42 U.S. Code*, 1396u-2 (2012); and Department of Human Services, *2012 Model Contract*, sec. 3.2.4.

[16] *Minnesota Statutes* 2014, 256B.69, subd. 33; and *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 96.

bound rates.[17] The actuary must certify that any and all rates within the range are actuarially sound. This means that all rates in the range represent a cost reimbursement for an *average* MCO, and any single rate may be sufficient for one MCO, but perhaps not others. DHS can select any rate within the range when negotiating contracts, and the rate ranges provide parameters for evaluating competitive price bids from MCOs.

Competitive Price Bid

For contract year 2012, DHS used a competitive price bid process to procure managed care services for PMAP and MinnesotaCare for the seven-county metro area.[18] DHS again used this approach for the 2014 PMAP and MinnesotaCare contracts for 27 other counties: a "North" region comprised of 21 counties, and a "South" region comprised of 6 counties.[19] Although DHS used these processes in two different regions in two different years, the value of this approach affected payment rates for MA programs overall.

Competitive price bids for the Medical Assistance programs had a multi-year impact on DHS's managed care payment rate-setting methods.

More specifically, in its request for proposals, DHS asked each MCO to submit separate medical and administrative cost components for their bids. This included estimated prices for general cost categories, but not detailed financial records to detect unreasonable or unnecessary administrative costs. Rather, each MCO's bids were compared with the actuary's rate ranges and against other MCOs' bids. Following a DHS request for best and final offers, DHS staff scored the MCOs' final bid proposals based on cost and quality criteria (including a section scored by county representatives) and awarded the contracts.[20]

Exhibit 3.2 shows that three MCOs were awarded at least 1 county service area through competitive price bid; each award ranged from 4 to 27 counties. Capitation payment rates for these 27 counties represented MCOs' best and final offer for both administrative and medical services; actual payment rates varied for each MCO and the populations covered.[21] These payments account for about 16 percent of all capitation payments for PMAP and MinnesotaCare. As a share of all Medical Assistance payments, PMAP and MinnesotaCare represent about 88 percent of all MA enrollment, 73 percent of MA managed care payment dollars, and 73 percent of MA managed care administrative expenses.[22]

[17] CMS, *Appendix A. Financial Review Documentation*, sec. AA.1.3.

[18] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 96.

[19] *Minnesota Statutes* 2014, 256B.69, subd. 33. These 27 counties were scheduled for procurement.

[20] County representatives did not review or score the bids, and DHS awarded the final contracts.

[21] Schedules of final payment rates are contained with the managed care contracts posted to the DHS website: mn.gov/dhs/.

[22] Estimates are based on MCOs' 2012 administrative expenses and 2012 and 2013 enrollment.

Exhibit 3.2: Managed Care Organizations' Service Areas, PMAP and MinnesotaCare, Contract Year 2014

	Service Areas, by Number of Counties			Total Service Areas: Rates Set via Competitive Price Bid	
Organization	PMAP	MinnesotaCare	Total PMAP and MinnesotaCare	Number of Counties	Percentage of Total
Blue Plus	30	55	55	0	0%
HealthPartners[a]	12	14	14	4	29
Medica[a]	22	38	38	13	34
UCare[a]	63	72	72	27	38

NOTES: "Service Area" is a county. PMAP represents the Prepaid Medical Assistance Program.

[a] Managed care organization awarded some service areas through competitive price bid.

SOURCE: Office of the Legislative Auditor, summary of Department of Human Services documents.

For 2014, competitive price bids from 2012 impacted the rates set for all MCOs and county-based purchasing organizations. In 2012, 54 percent of managed care capitation payments for PMAP and MinnesotaCare were determined by competitive price bid. When setting the 2014 payment rates, the DHS actuary incorporated assumptions about efficiencies that should have been gained in a competitive price bid environment over the previous two years. That is, the actuary applied a downward adjustment to forecasted trends when calculating the rate ranges.

The impact of competitive price bids on individual MCO's 2014 administrative spending is yet unknown as MCOs do not report 2014 financial data until later in 2015. MCO representatives told us that their time and resources devoted to the competitive price bid process during 2013 for contract year 2014 were significant and added to their administrative costs. In particular, responding to some DHS technical data requests was challenging under the department's timelines and instructions. Some MCO representatives also questioned whether the state would realize the cost-savings that policymakers anticipated.

State Set Rates

Outside of the competitive price bid process, payments for the remaining PMAP and MinnesotaCare service areas were determined by DHS through direct negotiations with MCOs. DHS used the rate ranges developed for the competitive price bid process when it contracted with MCOs for the remaining PMAP and MinnesotaCare service areas. For the remaining 60 counties, DHS set and contracted for payment rates at the lower end of the 2014 rate range. For MSHO, MSC+, and SNBC, the actuary developed separate, single base rates for each program that included adjustments for the populations served, such as medical needs (or "risk" adjustment), demographics, geographic region, and enrollment for each MCO.

In 2013, the Department of Human Services modified its capitation payment rate-setting methods with the goal of limiting growth in 2014 managed care administrative costs.

For contract year 2014, DHS departed from past practices and incorporated new analysis to compute the administrative cost portion of the payment rates.[23] DHS and policymakers sought savings through the 2013 legislative session, and a 2013 law mandated a $47 million reduction in otherwise projected trend increases for administrative expenses.[24] To achieve the intended reduction in trends, DHS used a combination of methods—including analysis of costs per member-month—blended with assumptions about enrollment for 2014.[25] The intended savings were tied to estimates for certain costs classified as "unallowable" for the Medical Assistance program. (We discuss MCO reporting of these types of expenses later in this chapter.)

For contract year 2014, the trend factors applied by the DHS actuary to the administrative portion of the managed care capitation payment rates also fell within certain limits specified in state statutes.[26] Specifically, DHS must limit maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans for calendar years 2014 and 2015. The trend rate limits apply to the overall capitation payment rate and vary by state program; for example, the trend limit is 2.0 percent for medical assistance families and children. Minnesota law also requires that DHS limit aggregate administrative costs paid to managed care plans under contract for the MA programs to an overall average of 6.6 percent of total payments.[27] When considering payment rates for all programs, DHS rate-setting methods for contract year 2014 generally recognized the 6.6 percent limit for administrative expenses.

During 2013, DHS did not execute some options for controlling managed care administrative expenses.

DHS and its actuary have three other mechanisms with which to adjust their estimates for administrative expenses. First, state law requires that DHS treat MCO investment expenses in the same manner as investment income when setting capitation payments rates.[28] That is, if DHS includes MCOs' investment expenses when calculating rates, the department also must consider MCOs' investment income. However, DHS and its actuary waived this requirement for contract year 2014 in lieu of the projected $47 million required reduction in overall trend, combined with lowering the target contribution to surplus margin

[23] Based on documentation provided by DHS and its actuary.

[24] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 23.

[25] Detailed information about the methodology referenced here is classified as trade secret under *Minnesota Statutes* 2014, 13.37.

[26] *Minnesota Statutes* 2014, 256B.69, subd. 31. We did not verify whether the overall capitation payment trend rates complied with the statutory limit.

[27] *Laws of Minnesota* 2008, chapter 363, art. 18, sec. 3, subd. 5. The limit on administrative costs does not include state premium taxes and assessments.

[28] *Minnesota Statutes* 2014, 256B.69, subd. 5j.

to 0.75 percent. DHS representatives also said that a three-month delay in payments imposed by the legislature and administratively by DHS diminished the MCOs' ability to earn investment income on capitation payments received and before claims were paid.[29]

Second, DHS and its actuary did not exclude administrative costs for "non-state plan" services—services not included in the state Medical Assistance plan submitted to CMS for approval—when developing 2014 rates. Each MCO must identify and report to DHS any non-state plan costs that are otherwise included in its annual statutory financial filing.[30] This helps DHS and its actuary attest whether the new rates are based only on costs for administrative services to be furnished under the Medical Assistance plan for MA enrollees. One DHS representative said the amounts reported and certified by MCOs as non-state plan administrative costs were small.

Lastly, DHS in 2012 and 2013 did not determine MCOs' compliance with statutory limits on increases in administrative spending when determining payment rates. State statutes mandate that each MCO's administrative costs for Medical Assistance programs—as a percentage of total revenue—cannot exceed by more than 5 percent its costs for the previous year.[31] DHS must impose a penalty equal to the amount in excess of the limit, but may waive the penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

DHS staff said that this statutory provision to limit growth in MCOs' administrative spending is technically incompatible with current rate-setting methods, competitive price bidding, and aggregate limits in managed rate trends specified elsewhere in state law. Further, they said that the state's Medicaid expansion and shifting coverage of populations affected program enrollment, and the law is unclear whether the limit applies to an MCO's individual program or aggregate administrative spending. We make recommendations regarding this statute later in this chapter.

Data Sources

Determining payment rates for administrative services requires data; in particular, data determined to have the highest degree of reliability relative to other sources, and which represents costs directly related to providing services under the state's MA plan for program-eligible individuals.[32] Actuarial standards require that the certifying actuary consider and use available data that, in the actuary's professional judgment, is sufficiently current, appropriate for the intended purpose, and will

[29] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 94.

[30] See Department of Human Services, *2013 Families and Children Model Contract*, secs. 9.10.1-9.10.3.

[31] *Minnesota Statutes* 2014, 256B.69, subd. 5i.

[32] *42 CFR*, sec. 438.6(c) (2014); CMS, *Appendix A. Financial Review Documentation*, secs. AA.2.0 and AA.3.2.

allow the actuary to perform the desired analysis.[33] Further, actuaries must determine and disclose whether there are any known, material limitations to the data, but are not required to audit the data.[34] Federal guidance suggests that both the state agency and actuary are responsible for deciding which sources of data to use for rate setting.[35] DHS must document for CMS the state's compliance with rate certification requirements and actuarial standards.

DHS and its actuary relied mostly on financial data provided and certified by managed care organizations to develop 2014 administrative rate ranges; however, we found inconsistencies among data certification requirements and documentation.

Through DHS's actuary, the department defined general requirements for data analysis and work product, while any additional analyses occurred through ongoing interaction among DHS staff, its actuary, and MCO representatives. To develop the administrative rate ranges, DHS generally relied on its actuary to determine what data were appropriate, what was required from each MCO, and if there were any material limitations to the data.

According to DHS and its actuary, the primary data used to develop the administrative portion of the base rate ranges for 2014 was comparable to data used by the federal government and other states. These data included annual financial filings submitted to the departments of Health and Commerce, independent data inquiries to the MCOs, as well as national data on Medicaid and Medicare costs and trends. In considering "unallowable costs," DHS also considered findings from previous audits mandated by the Governor in 2011.

An important step in rate development and data acquisition pertains to a federal requirement for "certifying" the data used by the state. Specifically, DHS contracts with MCOs require the entities to submit certain filings or other financial data as requested by DHS, and the MCOs must complete forms in which they attest to the accuracy, completeness, and truthfulness of the data and documents.[36] DHS 2013 contracts also required that:

> The MCO shall either certify to the State that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the State

[33] Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 26-27. The Actuarial Standards Board recommends practices for the selection and use of data. Other considerations include: the reasonableness and comprehensiveness of the necessary data elements, with particular attention to internal and external consistency; the costs and feasibility of obtaining alternative data; the benefit to be gained from an alternative data set or data sources; and sampling methods. Actuarial Standard Board, *Actuarial Standards of Practice No. 23* (Washington, DC, 2011), 3.

[34] Actuarial Standard Board, *Actuarial Standards of Practice No. 23*, 3-5.

[35] CMS, *Appendix A. Financial Review Documentation*, secs. AA.2.0 and AA.3.2.

[36] *42 CFR*, sec. 438.604-606 (2014), subp. H, *Certifications and Program Integrity*. The law requires DHS to require that certification must attest to the (1) accuracy, completeness and truthfulness of the data and (2) accuracy, completeness and truthfulness of the documents specified by the state. DHS, *2013 Families and Children Model Contract*, sec. 9.10.

> Plan including the MCO's administrative costs; or the MCO must certify and report the dollar value of each specific service that is a Non-State Plan service.[37]

Managed care organizations did submit certifications of their 2012 annual financial filings to DHS in 2013. However, the language contained in the forms used for some certifications aligned with language in federal law, but did not include the additional language in DHS contracts. That is, the MCOs submitted two separate certifications. We found that the MCOs interpretation of the certification requirements varied and did not always align with the requirements under the DHS contracts. As part of our audit work, one MCO reported that in its certification of some reports, it was only certifying to its costs for non-state plan services. One MCO representative said that in its report on non-state plan service costs, the MCO only reported and certified *medical* costs not covered by the state plan, and not administrative costs.

In Chapter 2, we questioned some administrative costs allocated by MCOs to state public programs on their financial reports. Some MCO representatives said that DHS has not explicitly instructed them on which costs are non-state plan administrative costs and, thus, they did not separately disclose these expense items to DHS.

DHS's use of some MCO financial reports for rate setting has been a long-standing source of controversy.

In particular, some individuals have expressed concern that there may be deficiencies in the data presented in MCOs' annual financial filings for purposes of determining payment rates. Audits required by the Governor in 2011 raised questions about MCO costs allocated to the state's public programs on their Department of Health supplement reports, which summarizes each MCO's revenues, expenses, and net income, by product and public program. The public also views these reports assuming that the costs reported under each Medical Assistance program are for Medical Assistance enrollees, and readers are not aware that the reported amounts include other items not necessarily specific or related to Medical Assistance.

Other state-mandated audits or financial examinations do not audit the MCOs' reported administrative expenses in detail; rather, they are examined in the context of ensuring financial solvency of the MCO or the materiality of error relative to their overall financial statements. For our audit work, we found some examples of miscategorized or misclassified expenses large enough that they may have affected capitation payment rate-setting analysis. We also questioned some types of expenses—such as charitable contributions—because the MCOs allocated these expenses to the public programs on their 2012 MDH supplement reports, and we considered these costs unrelated to the MA programs.

Currently, MCOs follow NAIC accounting principles to complete the MDH supplement reports, and there are minimal instructions in state statutes or rule for

[37] The MCO must provide this certification no later than May 1st of the Contract Year.

how they must complete and allocate costs to programs on Minnesota Supplement Report #1. We found that the NAIC accounting principles provide methods and guidance to MCOs on how to allocate their costs; however, some MCO representatives said that restricting unallowable expenses from certain lines of business conflicts with NAIC allocation guidance. Further, MCO representatives assert that the Department of Health reports were not developed for DHS rate-setting purposes (an issue we discussed in Chapter 2).

Prior to 2013, there were limited alternative data sources collected by the state to inform policymakers about MCOs' detailed administrative data for public programs. Generally, there may be some MA program-specific information contained in independent audits and financial examination reports filed with the Department of Commerce; however, such data may not be pertinent to rate-setting needs. Other data sources are important checks against self-reported data and can help guide the technical execution of rate setting. Accurate data and rigorous rate-setting methods are essential for oversight of the Medical Assistance program, but there may be limits on the extent to which rate setting can control administrative costs under a capitation payment method. Other factors may have a broader impact on how much the state pays for managed care administrative services.

OTHER FACTORS AFFECTING COSTS

Reliable data and appropriate methodologies are critical for determining actuarially sound payment rates, as is the technical execution of this work. The state's use of a capitation payment method for managed care administrative services requires continued efforts towards improving financial data used for this purpose. However, actuarial rate setting represents just one element among other, complementary dynamics that influence the costs of public health care programs.

Rigorous state oversight requires sound rate-setting practices, but competitive price bids, contract negotiations, statutory requirements, expanded program needs, and involvement by state policymakers affect managed care administrative costs, too.

In recent years, initiatives by state policymakers and administrators have helped advance oversight and understanding of the costs of public health care programs. This work includes unique audits of managed care expenses, expanded data collection, specifications in state law for allocating or excluding MCO costs, and competitive price bid.

Beginning January 2014, managed care organizations must now report extensive financial data directly to DHS about all aspects of their operations—not just administrative expenses—as shown in Exhibit 3.3. The changes are intended to help address the perceived inadequacies in other data sources used for capitation payment rate setting. In the past, there has been a limited formal reporting process for MCOs to disclose, or for DHS to identify, other unallowable or unreasonable costs for Medical Assistance. These changes enhanced the reporting relationship between DHS and the MCOs.

Exhibit 3.3: Managed Care Organization Statutory Reporting to the Department of Human Services, 2014

Description of Information that Must Be Reported to the Department of Human Services

- Income statement by program
- Financial statement footnotes
- Quarterly profitability by program and population group
- Medical liability summary by program and population group
- Received but unpaid claims report by program
- Services versus payment lags by program for hospital, outpatient, physician, and other medical services, and pharmaceutical benefits
- Utilization reports that summarize utilization and unit cost information by program for hospital, outpatient, physician, and other medical services
- Pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services
- Subcapitation expenses by population group
- Third-party payments by program
- All new, active, and closed subrogation cases by program
- All new, active, and closed fraud and abuse cases by program
- Medical loss ratios by program
- Administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies
- Revenues by program, including investment income
- Nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan…to providers and vendors for administrative services under contract with the plan, including but not limited to:
  - Individual-level provider payment and reimbursement rate data
  - Provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process
  - Data on implementation of legislatively mandated provider rate changes
  - Individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process
- Data on the amount of reinsurance or transfer of risk by program
- Contribution to reserve, by program

NOTE: Managed care organizations and county-based purchasing organizations participating in Minnesota's public health programs must provide this information to DHS.

SOURCE: Office of the Legislative Auditor, summary of *Minnesota Statutes* 2014, 256B.69, subd. 9c(b).

Assessing the outcomes of any one of these recent initiatives on public programs would be complicated. Competitive price bid for managed care services brings additional data into the rate-setting analysis for payments; however, the impact on 2014 and 2015 administrative expenses is not yet known. Legislatively imposed caps on spending also lay out parameters for administrative costs, but program expansion also affects costs. DHS's change in rate-setting methods is intended to help set reasonable and appropriate payment rates, but the effectiveness of actuarially sound rate ranges in controlling costs also depends on the outcomes of contract negotiations.

Collectively, these efforts have likely contributed to the reduced trends in managed care costs illustrated earlier in Exhibit 3.1. Engagement by policymakers also has been important for maintaining oversight of public health care costs. Continued work in this area should extend these results, and some refinements are needed.

ISSUES AND RECOMMENDATIONS

From our audit of managed care organizations' administrative expenses and review of DHS rate-setting documentation and processes, we identified several issues that require policymakers' attention. We also recommend ways to improve financial information provided by MCOs to the department.

Enhanced administrative expense reporting by managed care organizations may have minimal value for rate setting without explicit statutory requirements, improved DHS technical specifications and definitions, and independent verification of rate-setting data.

In particular, without improvements in how financial information is defined, recorded, and compiled, we think the value of collecting additional managed care data will be limited. Also, without such improvements, future audits of detailed financial data may not yield useful information for administering state public programs.

Statutory Requirements

Minnesota law requires DHS to set uniform criteria, definitions, and standards for data submitted to the department, and requires MCOs to comply with these criteria.[38] To support this work, we think language in Minnesota statutes and rules regarding managed care reporting and unallowable administrative costs should be more explicit to ensure consistent data and the capture of all intended information. Managed care organizations process tens of thousands of administrative expense transactions annually, and their accounting structures and allocation models vary greatly.

When verifying managed care organizations' data, we encountered differences in how the organizations defined various terms and recorded administrative expenses.

In particular, MCO representatives interpreted the term "program" or "plan" differently; for example, it could mean one program—such as PMAP—or all Medical Assistance programs, collectively. Newly implemented law disallows certain expenses for rate-setting purposes, but we observed differences in how MCOs construed requirements for reporting compensation limits and charitable contributions. MCOs also must now report payments to "vendors for administrative services under contract with the plan." However, MCOs varied in their contracting practices and definitions as to what constitutes an acceptable

[38] *Minnesota Statutes* 2014, 256B.69, subd. 9c(a).

contract. Further, state contracts contain provisions that require MCOs to define when a subcontractor's services are "significant and material" to its contractual obligations for public programs. Some MCOs interpret and apply this provision more broadly than is specified in the DHS contracts.

More direction from state policymakers could diminish controversy about the types of managed care administrative expenses disallowed for Medical Assistance programs, and help assure that the state does not pay for unreasonable costs.

Federal regulations impose few specifics regarding administrative expenses, and generally require that only costs for services not covered by the state plan—or costs relating to providing such services—be excluded from the development of managed care capitation rates.[39] In contrast, Minnesota laws passed in 2013 identified four types of unallowable expenses: charitable contributions, fines and penalties, indirect marketing and advertising, and any portion of an individual's compensation in excess of $200,000.[40]

For contract year 2014, DHS asked the MCOs for information on these unallowable expenses as part of rate setting and competitive price bids, and we attempted to verify the data the MCOs submitted to DHS. Our ability to audit these reported costs was affected by each MCO's business model, number of products, and allocation model. In addition, the MCOs' accounting structures for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. The MCOs' allocation models are very complex, and this made it difficult to retrospectively trace and quantify these expenses. While we were able to verify that one MCO significantly disclosed these unallowable costs, verifying the other three MCOs' data would have required considerably more time. More importantly, MCO representatives said they currently use the same complex processes for recording, allocating, and reporting such costs.

Through our audit work we identified other questionable costs allocated to public programs by MCOs that were unrelated to state plan-approved services. These included costs for alcohol beverages, travel, entertainment, and activities or services outside of Minnesota and unrelated to the Medical Assistance programs. For these types of questioned costs, we also examined the MCOs' underlying policies and procedures for allocating costs. We concluded that the state does pay for unreasonable expenses for the Medical Assistance programs. MCOs disagreed with our findings and asserted that such expenses do not violate law.

If policymakers want to further exclude other types of expenses from the development of payment rates, such expenses and the reporting mechanism should be explicitly codified in statute. Any statutory language excluding certain categories of expenses should be enhanced with more precise definitions, and require direct classification and recording of expenses to specific categories in

[39] CMS, *Appendix A. Financial Review Documentation*, sec. AA.2.4.

[40] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21, amended *Minnesota Statutes* 2012, 256B.69, subd. 5i.

order to help audit efforts. To facilitate this process, the Legislature could refer to existing definitions of these terms in federal standards, regulations, and cost principles, or other states' definitions, when defining these terms in state law.[41]

Lastly, Minnesota law imposes limits on growth in managed care administrative spending; however, current language does not sufficiently specify whether the caps pertain to individual MA programs or all MA programs, collectively. Expectations for administrative services vary for each program, and some MCOs contract with DHS for more Medical Assistance programs than others. Further, the measure specified in law—administrative spending as a percent of total revenues—does not align with current DHS rate-setting methods. DHS staff told us that it would be difficult to operationalize this mandate as currently defined.

RECOMMENDATIONS

The Legislature should:

- **Amend *Minnesota Statutes* 2014, 256B.69, subd. 5i, to clarify limits on managed care administrative spending for state public programs, and to further define the terms and types of unallowable expenses for Medical Assistance rate-setting purposes.**

- **Amend *Minnesota Statutes* 2014, 256B.69, subd. 9c, to define "by program," and to further specify the types of payments that must be reported for MCOs' subcontracts for administrative services expensed to state public programs.**

Department of Human Services Reporting Requirements

As part of the rate-setting and procurement process, DHS makes numerous requests for information to the managed care organizations. To more directly address data needs specific to public health care programs, DHS also implemented new reporting requirements, shown previously in Exhibit 3.3.

DHS directives and requests to managed care organizations were too general to sufficiently address data complexity, data integrity, and variations among MCOs' recordkeeping and allocation processes.

During 2014, DHS staff were still refining the new MCO financial reporting templates, and this work required several iterations of data requests to managed care organizations. We did not evaluate all aspects of the new MCO reporting template. However, we think the specifications regarding administrative expenses were too general and likely resulted in inconsistent or incomplete data, based on our audits of MCOs' accounting data and allocation processes.

[41] *48 CFR*, sec. 9904 (2014). U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local and Indian Tribal Governments* (Washington, DC, 2004); *48 CFR*, sec. 31 (2014); and U.S. Office of Management and Budget, *Circular A-122, Cost Principles for Non-Profit Organizations* (Washington, DC, 2004). See also California Code of Regulations, 28 CCR, sec. 1300.78 (2014); 10 CRR New York, parts 1002.1-1002.3 (2014); and Texas Health and Human Services Commission, *Uniform Managed Care Manual, Cost Principles for Expenses*, v. 2.2 (July 20, 2013).

DHS's contracts with MCOs require the entities to submit certain filings or other financial data as requested by DHS, and attest to the accuracy, completeness, and truthfulness of the data and documents. For some 2012 data used for rate setting, MCO certification documents addressed language in federal law, but did not precisely align with DHS contract language. On the other hand, language contained within other certifications aligned with DHS contract requirements. During our audit work, MCO representatives reported different interpretations of the intent and purpose of their certifications. There also was disagreement from some MCO representatives regarding instructions on "non-state plan" administrative services and expenses. More comprehensive, documented guidance by DHS on these requirements could reduce misinterpretation and help assure that payment rate setting is based only on data representing approved services for the Medical Assistance programs and related administrative costs.

RECOMMENDATIONS

The Department of Human Services should enhance instructions, definitions, and technical guidance to managed care organizations to facilitate compliance with reporting instructions.

The Legislature should amend state law to require that managed care organization certifications align with federal law and the Department of Human Services (DHS) contract language. DHS should develop and require managed care organizations to use such templates with certifying their data.

Data Verification

The value of enhanced data collection by DHS will depend on complete and consistent reporting, both within and among managed care organizations. DHS can rely solely on the audit or examination work of others for insight into the quality of the data it receives. For our audit samples, we found that MCOs mostly complied with accounting principles for classifying administrative expenses, but we also found opportunities for more direct allocation of expenses, a lack of documentation for some contract expenses, and some questioned costs allocated to public programs. Without unique requests by DHS, it is unlikely audits by other entities—such as the departments of Health and Commerce—will sufficiently incorporate data verification needs specific to rate setting or competitive procurement for Medical Assistance programs.

RECOMMENDATION

The Department of Human Services should implement ad-hoc audits of data reported by managed care organizations; in particular, data reported pursuant to *Minnesota Statutes* 2014, 256B.69, subd. 9c.

Currently, DHS and its actuary accept but do not independently audit the summary-level administrative expense data reported and certified by the MCOs. During 2013, their review of MCO administrative expense data involved questioning discrepancies in high-level summary data. Given the vast amount of

information now compiled by DHS, more rigorous, ad-hoc verification of administrative expense data by DHS would be reasonable. This work should directly target data analysis needed for controlling administrative spending and to support its contracting processes. In particular, DHS should be more directly involved in verifying data classified in state statutes as unallowable for rate-setting purposes. Such efforts would help enhance DHS's understanding of the data and its own reporting instructions to MCOs, and also ensure against overpayment in the development of managed care payment rates. Absent these actions, we question the extent to which state resources devoted to additional reporting of MCO administrative expenses will translate into cost savings for the Medical Assistance programs.

List of Recommendations

- The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to include Department of Health instructions and to further specify how managed care organizations must allocate administrative expenses for Minnesota Supplement Report #1A. (p. 28)

- The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to further specify how managed care organizations must allocate investment income on Minnesota Supplement Report #1A. (p. 29)

- The Legislature should specify in law requirements regarding managed care organizations' subcontracts for administrative services that are expensed to Minnesota's public health care programs. (p. 30)

- In its contracts with managed care organizations, the Department of Human Services should further specify requirements regarding subcontracts for administrative services, including the required form and content. (p. 30)

- The Legislature should:

  - Amend *Minnesota Statutes* 2014, 256B.69, subd. 5i, to clarify limits on managed care administrative spending for state public programs, and to further define the terms and types of unallowable expenses for Medical Assistance rate-setting purposes. (p. 46)

  - Amend *Minnesota Statutes* 2014, 256B.69, subd. 9c, to define "by program," and to further specify the types of payments that must be reported for MCOs' subcontracts for administrative services expensed to state public programs. (p. 46)

- The Department of Human Services should enhance instructions, definitions, and technical guidance to managed care organizations to facilitate compliance with reporting instructions. (p. 47)

- The Legislature should amend state law to require that managed care organization certifications align with federal law and the Department of Human Services (DHS) contract language. DHS should develop and require managed care organizations to use such templates with certifying their data. (p. 47)

- The Department of Human Services should implement ad-hoc audits of data reported by managed care organizations; in particular, data reported pursuant to *Minnesota Statutes* 2014, 256B.69, subd. 9c. (p. 47)

Minnesota Department of **Human Services**

March 5, 2015

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review the findings and recommendations from your audit of *Managed Care Organization (MCO) Administrative Expenses* for public health care programs. We appreciate the diligent and professional work of your staff on this important issue.

As you are aware, the Department of Human Services has focused for the last four years on getting better value for in our managed care contracts. The report recognizes the progress we have made on containing costs and improving the oversight and transparency in our managed care contracting process. However, the report findings also highlight the need for continued improvements in reporting and oversight of MCOs expenses. We support the recommendations, which we believe will help provide the tools for DHS to continue its progress on this effort.

DHS began its efforts to reform the managed care contracting process in 2011 by implementing competitive bidding for public health care program contracts, starting January 1, 2012 in the seven-county metropolitan area. This was the first time DHS placed its contracts out for bid and resulted in substantial savings to the state budget. DHS was also successful in reducing costs in the existing 2011 contracts by negotiating a one percent cap on MCO profits. DHS has continued this successful procurement process by competitively bidding an additional 27 counties for calendar year 2014 referenced in the audit and recently released a statewide procurement for managed care for calendar year 2016.

As the audit documents, in addition to the reforms made to the procurement process, DHS has also implemented significant changes to its rate-setting practices and worked closely with the Legislature to pass meaningful financial reporting, quality assurance and independent audit requirements to provide more detailed financial data directly to DHS. DHS conducted an independent audit of past rate-setting practices that informed these administrative and legislative changes.

Some of these changes have just begun implementation and were after the time period of the audit. Specifically, DHS implemented the enhanced quarterly and annual financial reporting in mid-2014 that requires detailed breakdown of medical and administrative expenses. DHS has already made revisions to this requirement for 2015 reporting to require additional information and instruction. DHS has also clarified the definition of "allowable expenses" in the current statewide procurement for the 2016 contract year. We will continue to monitor the implementation, results, and identify additional areas for improvement.

Our responses to specific recommendations in the audit report are included below.

Audit Findings

The audits of the 2012 MCO financial reports found a small number of miscategorized transactions. Total costs related to these discrepancies ranged from $1,702 to $3.0 million, and some exceptions may have affected DHS managed care payment rate-setting analysis.

The audits identified opportunities for MCOs to more directly allocate administrative expenses to specific lines of business. Findings indicated that MCOs did not have adequate documentation to support some subcontracted services.

DHS' technical execution of some rate-setting options for administrative expenses was lacking during 2013.

Minnesota statutes, rules, state contracts, and accounting principles do not ensure consistent reporting by MCOs and compliance with policymakers' intent.

2013 DHS directives to the MCOs were too general to sufficiently address data complexity, data integrity, and variations among MCOs' allocation and recordkeeping processes.

Audit Recommendation

The Legislature should amend statutes to specify requirements for MCOs' subcontracts for administrative services that are expensed to Minnesota's public programs, and DHS should incorporate such language into its contracts with MCOs.

Response to Audit Recommendations

The Department supports legislative efforts that would define MCO requirements for subcontracts that allocate administrative services to Minnesota's public health care programs. Upon enactment of new legislation, DHS would incorporate any new requirements into the MCO contracts.

Responsible Person:	Nathan Moracco
Estimated Completion Date:	Contingent on new legislation

Audit Recommendations

DHS should enhance instructions, definitions, and technical guidance to facilitate MCO compliance with administrative expense reporting requirements.

DHS should implement ad-hoc audits of data reported to the department by MCOs under state contracts and required by Minnesota Statutes 2014, 256B.69, subd. 9c.

Response to Audit Recommendation

In January of 2015, the Department issued an improved financial reporting template for collection of financial information and provided further detailed guidance and instructions to the MCOs in the price bid instructions for the 2016 statewide procurement referenced above. For example, the Department is working to better standardize the definition of managed care "product" and "program" to improve the allocation of administrative expenses, such as compensation above $200,000, and provide further definition to specific categories of unallowable expenses such as charitable contributions.

The Department will continue to refine the financial reporting template to incorporate administrative expense information at a more granular level and provide further guidance and definition on unallowable expenses in response to the findings of this audit. Revised instructions will be clearly documented in the financial reporting template and in the contract and future procurements.

The Department supports the recommendations and will develop a process to perform ad-hoc audits of the MCOs' financial data to ensure compliance with legislation, existing state and federal law, and contract requirements. DHS will develop a process between its Internal Audits and Health Care Administration staff to identify audit requirements and incorporate audit findings into contract requirements, rate-setting analyses, and financial reporting. Additional program and audit staff resources will be needed for the department to fully implement this recommendation in a timely manner.

Responsible Person:	Nathan Moracco, DHS; Gary Johnson, DHS
Estimated Completion Date:	December 31, 2014

Thank you again for the professional and dedicated efforts of your staff during this audit. The Department of Human Services policy is to follow up on all audit findings to evaluate the progress being made to resolve them. Progress is monitored until full resolution has occurred. Moving forward, the Department is committed to be more directly involved in the oversight of managed care administrative costs for Minnesota Health Care Programs.

If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at (651) 431-3623.

Sincerely,

Lucinda E. Jesson
Commissioner

Appendix A: Blue Plus
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

Conclusions

Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, Blue Plus either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.
- Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services.
- Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of Blue Plus' administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

BLUE PLUS

BACKGROUND

Blue Plus is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Blue Plus is an affiliate of Blue Cross Blue Shield of Minnesota (BCBSM), and Blue Plus sustains its operations through management agreements with BCBSM. Specifically, BCBSM provides and charges Blue Plus for general and administrative services necessary for its operations, including its accounting systems and processes for recording and allocating expenses across products.

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with Blue Plus to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). Blue Plus also provided other health insurance products and services unrelated to these programs during this period.[3]

Blue Plus' reported expenses to administer the state's programs in 2012 totaled approximately $70.1 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 82 counties statewide. Blue Plus' program enrollment for this period totaled about 1.6 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with Blue Plus also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), Blue Plus is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] Blue Plus also provided commercial products and contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs.

[4] Blue Plus, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, HMO Minnesota, DBA Blue Plus* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of Blue Plus' administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by Blue Plus to the State of Minnesota for Minnesota public health care programs?

- Did Blue Plus report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by Blue Plus for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who conduct audits of health insurance entities to gain an understanding of their scope

[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133: Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of Blue Plus.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from Blue Plus' 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expense*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenues, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of Blue Plus to gain an understanding of Blue Plus procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

From Blue Plus' financial data, we selected an initial sample of 103 transactions to test against our objectives.[11] We used a combination of random and purposive

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, HMO Minnesota, DBA Blue Plus*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

[11] The total number of transactions we actually reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on Blue Plus' *2012 Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of Blue Plus' own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, bank statements, contracts, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for Blue Plus' administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled Blue Plus' 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against Blue Plus' publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by Blue Plus at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. Blue Plus classified the great majority of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, Blue Plus either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

FINDINGS AND RECOMMENDATIONS

Finding 1

Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.[12]

Among 103 samples we tested, Blue Plus generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Annual Statement, Underwriting and Investment Exhibit, Part 3, with some exceptions.[13] Blue Plus recorded certain tax-related expenses totaling $919,748 on this exhibit, but it did not fully disclose the nature of these expenses. Instead of categorizing these tax-related expenses as "Taxes, Licenses, and Fees," Blue Plus categorized these costs as "Other Expenses" on the line "Aggregate Write-ins."

Blue Plus miscategorized expenses for seven transactions totaling at least $87,784 on this exhibit.[14] Specifically, Blue Plus miscategorized expenses related to four of these transactions as "Equipment"; in our opinion, these expenses should be categorized as "Cost or Depreciation of EDP Equipment and Software." Blue Plus miscategorized two transactions that should have been recorded as "Outsourced Services," but were recorded on different lines of this exhibit. Blue Plus misclassified one transaction as "Other Claims Adjustment," instead of "General Administrative." Blue Plus' miscategorization of these items did not impact the sum total of administrative expenses reported on this exhibit. For three of these samples totaling $8,759, the discrepancies affected the totals reported for the corresponding category—but not the overall totals—on Blue Plus' 2012 Minnesota Supplement Report #1A.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] NAIC instructions for the Underwriting and Investment Exhibit, Part 3, direct entities to record taxes and assessments to the line "Taxes, Licenses, and Fees."[16] Disclosure of these types of expenses informs regulators and others about the MCO's actual service costs and expenses required by federal and state authorities. For transparency

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[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] These totals represent a lower-bound estimate based on information provided by Blue Plus. Calculating the precise amount related to these samples is difficult due to the complexity of the BCBSM/Blue Plus accounting system.

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, chapter 4685, subparts 1910-1980, posted October 11, 2007.

[16] National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*, (Washington, DC, 2012), 80-92.

purposes, entities reporting items as "Aggregate Write-Ins" should provide more detailed description of major expenses at the bottom of this exhibit. NAIC instructions also define the types of expenses to record to "Outsourced Services" and "Cost or Depreciation of EDP Equipment and Software."[17]

NAIC accounting principals define claims adjustment expenses as "costs expected to be incurred in connection with the adjustment and recording of managed care claims."[18] The sample transaction we discuss here does not meet the NAIC criteria.

Recommendation

Blue Plus should report administrative expenses, taxes, and assessments in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

Finding 2

Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.[19]

Expenses for Blue Plus' administrative services—including contract-related expenses—are allocated across Blue Plus product lines through the Blue Cross Blue Shield accounting system and allocation model. Blue Plus uses an allocation model with numerous statistics to apportion costs, depending on the type of administrative expense. For some larger transactions, Blue Plus does not process expenses through its allocation model, but directly designates the items to specific programs or products.

Among the samples we tested, we identified two cost items for which Blue Plus could have allocated expenses more directly to individual products that benefitted from the services. In 2012, Blue Plus paid one contractor for work performed on behalf of two state programs, and paid a different contractor for work specific to its commercial and Medicare-related products; however, Blue Plus used an "indirect" approach to allocate these expenses across these products and additional programs, too. In its directives to its contractors, Blue Plus specified which programs were within the scope of work. For these samples, the transactions we tested totaled $66,896, and we estimated $14,209 was allocated

[17] NAIC, *Official NAIC Annual Instructions—Health*, 81-84. Outsourced services include expenses for administrative services, claim management services, new programming, membership services, and other similar services. Costs for EDP equipment and software include depreciation and amortization expense for electronic data processing equipment, operating software, and nonoperating software.

[18] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol. 1 (Washington, DC, 2012) *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and NAIC *Official NAIC Annual Instructions—Health*, 80-92.

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

among all state public programs on Blue Plus' Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. Blue Plus could use its contract documents and statements of work as resources to discern costs incurred for specific lines of business and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, Blue Plus should directly allocate administrative expenses to specific lines of business or products when such information is available.*

[20] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

Finding 3

Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services.[26]

Among the samples we tested, Blue Plus paid one contractor for work in 2012, but for one project did not have a written schedule or statement of work that detailed the scope and duration of work, payment terms, and signatures by both parties. Blue Plus' payments to a different contractor exceeded the amount specified in the contract.[27] For these two samples, the transactions we tested totaled $60,558; we estimated $5,789 was allocated among all state public programs.[28]

Without adequate supporting documentation, we were unable to validate whether Blue Plus' contractors were paid appropriately, assess the reasonableness of Blue Plus' allocation, or determine how these expenses related to the state's public programs. Specifically, we defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[29]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[30] Blue Plus' contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[31] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[32] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence

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[26] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[27] Blue Plus representatives advised us that they reconciled these expenses against the contracted amount with the contractor, after we detected the issue during our field audit work.

[28] Totals reported here represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model. Estimating the precise amount allocated is very difficult due to the complexity of the Blue Cross Blue Shield/Blue Plus cost allocation processes and accounting system.

[29] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[30] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[31] DHS, *2012 Families and Children Contract, Blue Plus*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6. DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. Minnesota law defines a "contract" as any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[32] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

Blue Plus should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. Blue Plus' payments should be in accordance with the terms of such contracts.

Finding 4

Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[33]

Among 103 samples tested, Blue Plus allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs on its 2012 Minnesota Supplement Reports #1 and #1A. The value of these three sample transactions totaled $53,896. We estimated the allocated value totaled $2,144, and the transactions were for alcohol beverages ($13), and activities or services that occurred outside of Minnesota and were unrelated to services for the state's public programs ($2,131).[34] In our view, Blue Plus did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[35] We defined questioned costs to include: …where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[36] Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[37]

In its contracts with DHS, Blue Plus must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO

[33] For Finding 4, we considered a single questioned cost to be a finding.

[34] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model. These cost items represent the individual transactions we tested only.

[35] Some of these types of expenses would be considered "unallowable" expenses based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[36] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[37] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

must certify and report the dollar value of each specific service that is a non-state plan service.[38] Blue Plus did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by Blue Plus to the state's public programs on its financial reports. These eight sample transactions totaled $188,938 and were for marketing activities and contributions. We estimated the allocated costs totaled $18,528. Minnesota laws in effect at the time Blue Plus filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[39] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[40]

During 2013, DHS separately requested and Blue Plus provided DHS and its actuary with 2012 summary financial data regarding the types of unallowable expenses specified in the 2013 law—including marketing and contribution expenses—and how much was allocated to state public programs. We tested but were unable to sufficiently verify the extent to which Blue Plus fully disclosed these expenses to DHS, for several reasons. First, the BCBSM/Blue Plus accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, the BCBSM/Blue Plus allocation model is very complex; this made it difficult to retrospectively trace and quantify these expenses. Lastly, verifying these financial records against the data Blue Plus submitted would have required significantly more time beyond the scope of this audit.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary

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[38] *42 CFR*, sec. 438.604, subp. H (2014) Program Integrity and Certification; and DHS, *2012 Families and Children Contract, Blue Plus*, sec. 9.10. (Other DHS contracts with Blue Plus contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR*, secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO…"

[39] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[40] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

ratios, or similar analyses.[41] Blue Plus should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. Blue Plus also could implement accounting practices that identify such expenses—perhaps by specific type or account code—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs in when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure Blue Plus costs are appropriately allocated to the state's public programs.

Recommendation

Blue Plus should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

[41] NAIC, *Accounting Practices & Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

Blue Cross and Blue Shield of Minnesota and Blue Plus
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BlueCross BlueShield Minnesota

February 19, 2015

VIA ELECTRONIC MAIL

Valerie Bombach
Program Evaluation Coordinator
Office of the Legislative Auditor
Room 140
658 Cedar Street
St. Paul, MN 55155

Re: Blue Plus, Audit of Compliance with Financial Reporting
January 1, 2012 to December 31, 2012

Dear Ms. Bombach:

HMO Minnesota d/b/a Blue Plus ("Blue Plus") appreciates the opportunity to provide comments on the report dated February 16, 2015 in which the Office of the Legislative Auditor made certain conclusions, findings and recommendations regarding its review of the administrative expenses and investment income reported by Blue Plus on its 2012 annual financial reports and the allocation of certain administrative expenses to Minnesota's public programs.

The report found that Blue Plus generally complied with legal requirements and accounting standards for reporting administrative expenses on its annual report. However there were limited exceptions and Blue Plus' responses to those items are contained herein. This document should be read in conjunction with the Final Report to give a complete and comprehensive understanding of the observations and findings.

The report states that "Blue Plus' reported expenses to administer the state's programs in 2012 totaled approximately $70.1 million." As noted in footnote 4, this amount is from Blue Plus' 2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses and Net Income. The report state that "administrative expenses reported here include general administrative and claims adjustment expenses." Blue Plus notes that the administrative expenses reported also include estimated premium taxes and surcharges.

Findings and Blue Plus Responses:

Finding 1: Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.

L02R05 Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

Brief description

The report states that Blue Plus "generally complied with legal requirements and accounting standards for reporting administrative expenses on its 2012 Annual Statement, Underwriting and Investment Exhibit, Part 3." However the report identifies two exceptions to this conclusion. The first exception involves the recording of certain tax-related expenses and the second involves the miscategorization of certain other expenses. The report notes that "Blue Plus' miscategorization of these items did not impact the sum total of administrative expenses reported on this exhibit." Three of the samples tested affected the totals reported for the corresponding categories on Minnesota Supplement Report #1A, "but did not affect the overall total expenses recorded."

Blue Plus response:

Blue Plus follows Statutory Accounting Principles and state law. Under Finding 1, regarding the recording of certain tax-related assessments, Blue Plus believes that the recording of $919,748 in the "Other" Category was a reasonable interpretation of the NAIC instructions. This amount related to the Minnesota Comprehensive Health Association (MCHA) Assessment pursuant to Minnesota Statutes section 62E.11, subd. 6. Regarding the recording of Equipment instead of Cost or Depreciation of EDP Equipment and Software (the four transactions referenced on page 12), Blue Plus provided an explanation of its interpretation of the instructions relative to SSAP 16.

Regarding the miscategorization of the remaining three transactions sampled, Blue Plus notes that these items did not impact the total overall expenses reported.

Finding 2: Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial reports.

Brief description

This finding relates to two out of 103 transactions tested in which the auditor identified two cost items for which Blue Plus could have allocated expenses more directly to individual products that benefitted from the services. These two samples totaled $66,896 and the auditor estimated that $14,209 was allocated across all public programs on the supplement reports in lieu of being allocated directly to the individual products.

Blue Plus response:

Blue Plus follows Statutory Accounting Principles and its internal corporate allocation policies. When possible, specific identification of expenses is recorded and in all cases a reasonable methodology is employed.

Finding 3: Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services

Brief description

The auditor's threshold for Finding 3 constitutes two or more exceptions, or any single exception greater than $10,000 to be a finding. In this case, the report identifies two contracts in which one was not properly documented in scope, payment terms and signature and the second in which the payment to the contractor exceeded the amount specified. The two transactions tested totaled $60,558, of which $5,789 was allocated among state public programs.

Blue Plus response:

The lack of documentation to support expenses was inadvertent and is inconsistent with Blue Plus' standard business practices to maintain documentation to support contracts for administrative services.

Finding 4: Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs in its 2012 financial report.

Brief description

In this section of the report, the auditor states that a single questioned cost is considered to be a finding. The report states that of the 103 samples tested, "Blue Plus allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs in its 2012 Minnesota Supplement Reports #1 and #1A." The report lists the total value of the three sample transactions at $53,896, of which the auditor estimated $2,144 was allocated to public programs.

The report states that the auditor also questioned some other costs allocated by Blue Plus to state public programs. Of the eight sampled transactions, the auditor estimated that $18,528 were allocated to public programs. The costs questioned included payments to charitable, educational, religious or scientific purposes. As the report notes, it is permissible for health maintenance organizations to make these payments.

Blue Plus response:

The report states that Blue Plus did not report these identified costs to the Department of Human Services as part of its annual statutory financial certification to DHS. Blue Plus provided documentation to the auditor regarding the non-allowable 2012 costs and administrative expenses that it had reported to DHS as required by its contracts with DHS during the time period at issue. As also noted in the report, laws later passed in 2013 classified several expenses including charitable contributions as unallowable for rate-setting purposes, and subsequent changes in reporting requirements have clarified the reporting of these expenses.

Blue Plus is committed to compliance with requirements relating to reporting of administrative expenses for managed care rate-setting purposes. Blue Plus has policies and procedures in place to identify and report administrative expenses to DHS that are not allowable for rate-setting purposes as required by its contracts with DHS.

Blue Plus' Summary Comments

The OLA performed specific tasks under its April 2013 Managed Care Organizations' Administrative Expenses Topic Selection Background Paper and as provided in applicable Minnesota Statutes. The OLA found that Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports with some limited exceptions. Blue Plus appreciates the opportunity to provide these comments and is committed to serving all of the members enrolled in its programs.

Thank you for the opportunity to comment.

Sincerely,

Frank Fernandez
President & Chief Executive Officer
HMO Minnesota d/b/a Blue Plus

Appendix B: HealthPartners, Inc.
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

CONCLUSIONS

HealthPartners generally complied with certain financial-related legal requirements for reporting its administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, HealthPartners either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- HealthPartners did not fully comply with some requirements for reporting administrative expenses and investment income on its 2012 annual financial reports.
- HealthPartners did not adequately identify administrative expenses for five samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- HealthPartners did not have adequate documentation to support expenses related to four HealthPartners contracts for administrative services.
- HealthPartners allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of HealthPartners' administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

HEALTHPARTNERS, INC.

BACKGROUND

HealthPartners, Inc., (HealthPartners) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] HealthPartners conducts its operations and is supported through service agreements with numerous other affiliates and related entities under the HealthPartners system of companies. In particular, Group Health Plan, Inc.—a wholly owned subsidiary of HealthPartners—provides administrative and management services to HealthPartners. HealthPartners' administrative expenses as reported in its financial statements are initially allocated from Group Health Plan, Inc.

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with HealthPartners to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). HealthPartners also provided other health insurance products and health care services unrelated to these programs during this period.[3]

HealthPartners' reported expenses to administer the state's programs in 2012 totaled approximately $39.5 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 14 counties statewide. HealthPartners' program enrollment for this period totaled about 1.0 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with HealthPartners also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), HealthPartners is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] HealthPartners also provided commercial insurance products and contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs.

[4] HealthPartners, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, HealthPartners, Inc*. (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of HealthPartners' administrative expenses and investment income focused on the following audit objectives for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by HealthPartners to the State of Minnesota for Minnesota public health care programs?

- Did HealthPartners report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by HealthPartners for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of HealthPartners.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from HealthPartners' 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of HealthPartners to gain an understanding of HealthPartners' procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, HealthPartners, Inc.*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From HealthPartners' financial data, we selected an initial sample of 104 transactions to test against our objectives.[11] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of HealthPartners' own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, contracts, bank statements, and other information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for HealthPartners' administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled HealthPartners' 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against HealthPartners' publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by HealthPartners at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. HealthPartners classified the great majority of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

HealthPartners generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, HealthPartners either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota's public health care programs.

[11] The total number of transactions we actually reviewed exceeded 104 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on HealthPartners' *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

HealthPartners did not fully comply with some requirements for reporting administrative expenses and investment income on its 2012 annual financial reports.[12]

Among 104 sample transactions we tested, HealthPartners generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with exceptions.[13] For three transactions, HealthPartners misclassified expenses totaling $34,586 as "Cost Containment"; in our opinion, these transactions should be classified as "General Administrative."[14] HealthPartners also miscategorized employer-paid federal payroll taxes totaling about $3 million to the line item "Salaries, Wages, and Benefits," rather than to the correct line (Taxes, Licenses, and Fees). The discrepancies discussed here did not affect the sum total of administrative expenses reported on this exhibit.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] NAIC statements of statutory accounting principles provide guidance to managed care organizations for recording expenses on their annual financial statements. NAIC defines cost containment expenses as "expenses that actually serve to reduce the number of health services provided or the cost of such services."[16] The three sample transactions we tested do not meet the NAIC criteria for cost containment expenses. NAIC instructions for the Underwriting and Investment Exhibit, Part 3, also direct entities to record payroll taxes to the category "Taxes, Licenses, and Fees."[17] HealthPartners' employer-paid taxes discussed here meet the definition of a payroll tax.

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[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] One of these transactions also could have been classified as "Other Claims Adjustment." HealthPartners also categorized these three transactions as "claims adjustment" expenses for purposes of reporting its data on 2012 Minnesota Supplement Report #1 and Supplement Report #1A.

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, chapter 4685, subparts 1910-1980, posted October 11, 2007.

[16] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol.1, (Washington, DC, 2012); *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health*, *Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC, 2012).

[17] NAIC, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses.*

HealthPartners did not fully comply with requirements for reporting administrative expenses and investment experience (or gains and losses) on its 2012 Minnesota Supplement Report #1A. HealthPartners miscategorized "Board, Bureau, and Association Fees" totaling $419,000 as "General Business/Office Expense," rather than to the correct line (Consulting and Professional Fees). HealthPartners also miscategorized federal payroll taxes totaling $1.9 million as "Employee Benefit Expenses," rather than to the line "General Business and Office Type Expenses." These discrepancies did not affect the sum total of administrative expenses, or the expenses allocated to individual product lines, on this report. When allocating net investment income across its lines of business, HealthPartners used a method that differed from state requirements and factored in the MCO's long-term investment experience for each product. The discrepancies discussed here did not affect the total investment experience stated on this report.

Minnesota Department of Health (MDH) instructions for completing Supplement Report #1A specify the types of expenses to record in each of seven categories. Minnesota also has two separate instructions for reporting investment income and gains for each product or program on this financial report. *Minnesota Statutes* 2014, 62D.08, subd. 7(b) requires that:

> Every health maintenance organization must allocate investment income *based on cumulative net income over time* by business line or product and must submit this information…using the reporting template provided by the commissioner of health.

The Minnesota Department of Health's instructions for completing Minnesota Supplement #1A state that "investment gain must be allocated *by the prior five years of net income*."[18]

Recommendations

HealthPartners should report administrative expenses and payroll taxes in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

HealthPartners should report administrative expenses and investment income and gains in accordance with Minnesota Statutes *2014, 62D.08, subd. 7.*

Finding 2

HealthPartners did not adequately identify administrative expenses for five samples that could have been directly allocated to specific programs on its 2012 annual financial report.[19]

HealthPartners uses a complex allocation model to apportion administrative expenses to specific departments (or accounting units) within the organization.

[18] See http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm.

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

Most of HealthPartners' administrative departments support all product lines and are not unique to one particular product. If HealthPartners has a department whose only function is to provide services for a particular product, HealthPartners directly allocates those expenses to the particular product. For example, all state and federal public programs are supported by HealthPartners' "government programs" accounting unit. With some exceptions, HealthPartners does not further discern among the state's government programs to directly allocate costs. Under this model, HealthPartners classified all general administrative expenses as "directly" allocated its 2012 Minnesota Supplement Report #1A submitted to the Minnesota Department of Health in 2013.

Among the samples we tested, we identified five cost items for which HealthPartners could have allocated expenses more directly to individual products that benefitted from the services. In 2012, HealthPartners paid one of its contractors for work performed on behalf of its Medicare-related products, and paid a different contractor for work related to its commercial and government programs. HealthPartners also sponsored and paid for two other initiatives that required verifying member eligibility for just two state programs. In directives to its contractors, HealthPartners specified which products were within the scope of work; however, HealthPartners allocated some costs from each of these five samples to all government programs. For these cost items, the transactions we tested totaled $45,039; we estimated $7,153 was allocated across all state public programs on HealthPartners' Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

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[20] We estimated that these transaction expenses and likely related costs allocated to the state's public programs totaled $69,844. These estimates were developed based on information provided by HealthPartners about its allocation model.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. HealthPartners could use its contract documents, statements of work, and member eligibility, as resources to discern costs incurred for specific lines of business and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, HealthPartners should directly allocate administrative expenses to specific lines of business or products when such information is available.*

Finding 3

HealthPartners did not have adequate documentation to support expenses related to four HealthPartners contracts for administrative services.[26]

Among the samples we tested, HealthPartners did not have adequate contracts or current work orders that detailed the scope and duration of work, payment terms, and signatures by both parties, for three contracts for administrative services. HealthPartners also paid another contractor a rate that differed from the payment terms of the contract. The transactions we tested totaled $28,109; we estimated $2,893 was allocated among all state public programs.[27]

Without adequate supporting documentation, we were unable to validate whether HealthPartners' contractors were paid appropriately, assess the reasonableness of HealthPartners' allocation, or determine how these expenses related to the state's public programs. We defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[28]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[29] HealthPartners'

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[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

[26] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[27] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using HealthPartners' allocation model. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $19,327.

[28] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[29] *Minnesota Statutes* 2014, 62D.05, subd. 4.

contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[30] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[31] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

HealthPartners should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. HealthPartners' payments should be in accordance with the terms of such contracts.

Finding 4

HealthPartners allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[32]

Among 104 samples we tested, HealthPartners allocated unreasonable costs for three items to Minnesota's Medical Assistance programs on its 2012 Minnesota Supplement Reports #1 and #1A. These three sample transactions totaled $5,129, and were for entertainment, and for activities or services occurring outside of Minnesota and unrelated to services for the state's public programs.[33] We estimated the costs allocated to the state's public programs totaled $578. In our view, HealthPartners did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[34] We considered questioned costs to include: …where the costs incurred appear

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[30] DHS, *2012 Families and Children Contract, HealthPartners, Inc.*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[31] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

[32] For Finding 4, we considered a single questioned cost to be a finding.

[33] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using HealthPartners' allocation model. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $3,351.

[34] Some of these expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 14; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

unreasonable and do not reflect the actions a prudent person would take in the circumstances.[35] Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[36]

In its contracts with DHS, HealthPartners must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[37] HealthPartners did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by HealthPartners to the state's public programs on its financial reports. These seven sample transactions totaled $47,569 and were for marketing and contributions. We estimated the allocated costs totaled $5,198. Minnesota laws in effect at the time HealthPartners filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[38] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[39]

During 2013, DHS separately requested and HealthPartners provided DHS and its actuary with 2012 summary financial and other data regarding the types of unallowable expenses specified in the 2013 law—including the marketing and contribution expenses—and the amount allocated to state public programs. We tested but were unable to sufficiently verify the extent to which HealthPartners fully disclosed these expenses to DHS, for several reasons. First, HealthPartners'

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[35] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[36] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

[37] *42 CFR*, sec 438.604, subpart H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, HealthPartners*, sec. 9.10. (Other DHS contracts with HealthPartners contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR,* secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[38] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[39] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, HealthPartners' processes for allocating costs are quite complex; this made it difficult to retrospectively trace and reconcile these expenses. Lastly, verifying these financial records against the data HealthPartners submitted to DHS would have required significantly more time beyond the scope of this audit.

NAIC accounting principles direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[40] HealthPartners should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. HealthPartners also could implement accounting practices that identify such expenses—perhaps by specific type, account code, or amount—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data in accordance with DHS contracts and state law. These approaches would help assure that HealthPartners costs are appropriately allocated to the state's public programs.

Recommendation

HealthPartners should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

[40] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these standards for general references purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

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February 19, 2015

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Saint Paul, MN 55101

Dear Mr. Nobles:

Thank you for the opportunity to respond to the report *HealthPartners, Inc., Audit of Compliance with Financial Reporting* ("Report"), completed by the Office of the Legislative Auditor ("OLA"). We appreciate the thoroughness and professionalism of the OLA team members who conducted the audit. Moreover, we recognize the helpful role that a thorough review, like that conducted by the OLA, can play in highlighting opportunities for improvement. We believe this audit affirms our effective processes and controls.

As you may know, we provide extensive financial reporting to many different regulators at the state, federal, and accreditation levels for commercial plans as well as state and federally funded programs, and the requirements we are subject to can be inconsistent or in conflict. We work hard to comply with all of these requirements while keeping in mind the need to minimize administrative costs and complexity so that our focus can be on improving the health of our members and patients. That's the expectation Minnesotans have of our organization, and we take that responsibility seriously.

Again, thank you for the opportunity to respond your Report. Before providing specific responses to individual findings, I would like to share some general points about our administrative allocation model:

- HealthPartners allocates costs across product lines using an administrative allocation model (Model) that was developed over 25 years ago and is continually updated for changes in our organization and products.
- The Model uses multiple cost drivers to allocate the administrative costs for our different departments. Examples of these cost drivers are direct allocations, FTEs, square footage, numbers of members, effort certification and claims. HealthPartners always attempts to allocate costs directly to specific product lines when practical.
- The Model has been audited by numerous regulators including the Minnesota Department of Commerce, Minnesota Department of Health, Internal Revenue Service, Centers for Medicare and Medicaid Services, Office of Personnel Management, and our independent auditors.
- In each of those audits the Model was closely examined and determined to be an acceptable approach to allocate costs between organizations and products within HealthPartners.

Finally, it's important to note that none of the findings made by OLA pertained to issues that would have a material effect on the accuracy of our overall financial reporting or on the amounts paid by the State of Minnesota for its public health care programs. This demonstrates that we have instituted effective controls and systems to assure reasonable compliance with financial reporting requirements. Our allocation method provides an accurate and reliable portrayal of our finances. This method not only directly reduces administrative expense, but, we believe, also reduces cost of care by allowing staff who work in cost containment areas, such as medical management and case management, to maximize the time they spend assuring our members receive appropriate and effective care by minimizing the time staff are required to devote to administrative paperwork.

Our responses to each of the individual findings follow.

Finding 1:

We are pleased that the Report noted that the observations leading to this finding had no impact on either the amount of our administrative expenses or their allocation among product lines. While we acknowledge and are grateful that the OLA has looked so closely at the subcategorization of several of our administrative expenses, we question the need for a formal finding on an issue with no impact. Moreover, HealthPartners does not agree with all elements of Finding 1.

HealthPartners reports administrative expenses in accordance with National Association of Insurance Commissioners ("NAIC") instructions for the Health Annual Statement. We report them under the proper breakout classification on the Statement of Revenue, Expenses, and Net Income, whether they are Cost Containment expenses, Claims Adjustment expenses or General Administrative expenses. Because certain of HealthPartners' departments are engaged solely in activities properly classified as Cost Containment, HealthPartners does not agree that certain expenses within those departments should be allocated to General Administrative expenses.

HealthPartners agrees and will change the line item where employer-paid FICA tax is recorded on the Health Annual Statement, Underwriting and Investment Exhibit Part 3 from the Salaries and Benefits line to the Payroll Taxes line. HealthPartners will also make the same change on Supplemental Report #1A. This change, as noted by the OLA, would not have had any impact on the administrative expenses charged to any HealthPartners product lines.

HealthPartners disagrees with Finding 1 as it relates to reporting of investment income. HealthPartners allocates investment income across product lines in accordance with Minnesota Statutes, section 62D.08, subdivision 7, paragraph (b), which provides that investment income must be allocated based on "cumulative net income over time by business line or product." HealthPartners acknowledges that the instructions for Supplement 1A say investment income must be allocated based on net income for the past five years. If we were to prepare Report 1A using the past-five-year method, the net incomes for all product lines, including State-funded products, would be different between the two reports. The amounts reported on Supplemental Report 1A are required to tie back to Supplemental Report 1. Therefore, we follow Minn. Stat. § 62D.08, subd. 7(b) for the allocation of investment income so that net income by product lines will be consistent between the reports.

Finding 2:

HealthPartners sells multiple products that cross all lines of businesses—whether commercial, Medicare or Medicaid; fully or self-insured; group or individual; medical or dental. Most administrative departments of HealthPartners support all product lines and are not unique to one particular product. If HealthPartners has a department whose only function is to provide services for one particular product line, HealthPartners' administrative allocation model, as described above, directly allocates those expenses to the particular product it is supporting in accordance with Minn. Stat. § 62D.08, subd. 7(a). If a department provides services to multiple lines of businesses, the Model properly allocates the costs of the whole department to each product line it supports based on the cost driver that provides the most reasonable allocation for that department. While this approach may result in a particular invoice that related, for example, to commercial-only to be allocated across all products, it is balanced out by other invoices that may have related only to the State's public programs being similarly allocated.

HealthPartners will continue to evaluate its allocation model as well as how it sets up its departments to facilitate allocating directly to lines of business or products when information is available to directly allocate expenses.

Finding 3:

HealthPartners has processes and procedures in place to support all contracted services that are provided to HealthPartners. However, contract management is a complex process and one that HealthPartners will continue to work on improving. In the specific instances where the OLA found deficiencies, we would note that all expenses were supported by invoices and documentation of approval for the expenses by department leaders. Also, in the instance where the rate paid did not match that in the contract, it should be noted that, due to an increase in volume, the vendor had agreed to discount its services below the contracted rate, so that the cost of services was actually lower.

Finding 4:

HealthPartners files Supplemental Report 1 and Supplemental Report 1A in accordance with instructions for filing these reports with the Minnesota Department of Health. In submitting these reports, we are also required to follow NAIC, SSAP, and GAAP accounting principles. These two reports are designed to show how each product line within HealthPartners is performing and require us to allocate all costs incurred by HealthPartners to each product. These two reports are not intended to break apart or exclude any costs from product lines that may be classified for rate setting purposes by DHS as unallowable costs. DHS's understanding of this is clear as they require separate reports of unallowable costs so that they can be backed out of rate setting processes. HealthPartners has complied with all DHS requests and instruction for reports to show the costs within Report 1 and Report 1A that would be classified as unallowable costs for rate setting purposes. Moreover, when using these reports for other rate reporting or submission of bids to, for example, CMS or the federal employee health benefit program, we make adjustments to remove unallowable cost, such as lobbying, charitable contributions, marketing, etc. It would be inconsistent with accepted financial reporting protocols to not allocate these costs to Reports 1 and 1A in the first place.

HealthPartners complies with all contractual certification requirements with respect to the data it submits to DHS. Section 9.10.2 of our 2012 Families and Children Contract requires that we either (1) certify

that the statutory filing only reflects State Plan services or (2) "certify and report the dollar value of each specific service that is a non-State Plan service." In 2012 and for 2012 in 2013, HealthPartners has complied with this section of the contract by certifying and reporting on each specific non-State Plan service in the manner requested and specified by DHS. In addition, HealthPartners has responded fully and accurately to all requests for further information from DHS concerning administrative costs, including those that break out costs related to lobbying, charitable contributions, marketing, and others.

Conclusion

Once again, we appreciate the efforts of OLA and the auditing team to closely examine our financial reporting as it relates to Minnesota's public health care programs. While there are some very minor opportunities to improve, overall we believe this report affirms that we are an effective administrator of medical assistance and MinnesotaCare managed care programs for the State of Minnesota. We strongly support making these programs as robust and sustainable as possible, but this must be undertaken in the context of the programs' ultimate goal of providing the best health care and experience to program recipients in an efficient and cost-effective manner. HealthPartners has sound financial practices in place to help the State of Minnesota achieve these goals. We are proud to serve public program members, and look forward to continuing to work with the State to improve the system for the good of all Minnesotans.

Sincerely,

David A. Dziuk
Senior Vice President and Chief Financial Officer

Appendix C: Medica Health Plans
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

CONCLUSION

Medica generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, Medica either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- Medica did not fully comply with some requirements for reporting administrative expenses on its 2012 annual financial reports.
- Medica did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- Medica did not have adequate documentation to support expenses related to four Medica contracts for administrative services.
- Medica allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of Medica's administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

MEDICA

BACKGROUND

Medica Health Plans (Medica) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Medica is an affiliated entity of Medica Holding Company (MHC), and provides and charges for administrative services to other MHC affiliates as specified through management agreements. Medica also contracts with and pays United Health Group (UHG) for administrative services, including accounting, billing, claims processing, network, and general administration.[2]

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[3] The Minnesota Department of Human Services (DHS) contracted with Medica to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC). Medica also provided other health insurance products unrelated to these programs during this period.[4]

Medica's reported expenses to administer the state's programs in 2012 totaled approximately $67.7 million (including management fees paid to UHG).[5] These expenses represented managed care general administrative and claims adjustment services for two or more programs in 33 counties statewide. Medica's program enrollment for this period totaled about 1.6 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with Medica also specify that the entity is subject to audits by OLA.[6] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), Medica is generally exempt from federal income taxes.

[2] Medica's payments to UHG in 2012 totaled $14.5 million.

[3] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[4] Medica contracted directly with the Centers for Medicare & Medicaid Services to provide services for Medicare programs. Medica also provided commercial insurance products, and administrative and management services.

[5] Medica Health Plans, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[6] Minnesota Department of Human Services, *2012 Families and Children Contract, Medica Health Plans* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of Medica's administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by Medica to the State of Minnesota for Minnesota public health care programs?

- Did Medica report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by Medica for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[7] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[8]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

[7] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[8] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of Medica.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[9] Specifically, we used the following documents from Medica's 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[10]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[11]

We interviewed management and employees of Medica to gain an understanding of Medica's procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[9] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[10] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[11] DHS, *2012* and *2013 Families and Children Contract, Medica Health Plans*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5(i). A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From Medica's financial data, we selected a sample of 103 transactions to test against our objectives.[12] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of Medica's own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, contracts, bank statements, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for Medica's administrative services contracts. We also examined the extent to which certain "unallowable" expenses were disclosed to DHS for purposes of determining capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled Medica's 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against Medica's publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by Medica at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. Medica classified most of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

Medica generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 financial reports, with exceptions. In addition, for several sample transactions, Medica either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota's public health care programs.

[12] The total number of transactions we reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on Medica's *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

Medica did not fully comply with some requirements for reporting administrative expenses on its 2012 annual financial reports.[13]

Among 103 sample transactions we tested, Medica generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with some exceptions. Medica did not include in this exhibit certain management and claims adjustment expenses; rather, Medica classified these expenses elsewhere in its annual statement as "medical" expenses. These expenses may have totaled up to $2.8 million.[14] Similarly, these administrative expenses were not included in the total general administrative and claims adjustment expenses on its 2012 Minnesota Supplement Reports #1 and #1A.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] In its instructions and accounting principles, NAIC instructs MCOs to record management and claims adjustment expenses as "General Administrative" or "Claims Adjustment," and not as "medical."[16] (Federal reporting requirements for the Affordable Care Act also classify these expenses as administrative.[17]) Medica incurs other costs for similar types of services, but Medica correctly classifies these transactions as administrative expenses in its financial reports. These reporting discrepancies represent inconsistent interpretation and application of accounting principles, contrary to NAIC guidance.[18]

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[13] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[14] This finding is based on supporting documentation provided by Medica during the audit. Verifying the precise impact of this reporting discrepancy was not possible without extensive testing and review of all transactions related to this service. Some of these expenses may have been appropriately classified as "medical."

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted Oct. 11, 2007.

[16] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol.1 (Washington, DC, 2012), *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health*, *Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC, 2012). NAIC, *Accounting Practices & Procedures Manual*, Vol. 1, *Statements of Statutory Accounting Principles, No. 70, Allocation of Expenses*, classifies expenses within principal groupings as claims adjustment expenses and general administrative expenses.

[17] *45 CFR,* secs. 158.150(c) and 158.160 (2014).

[18] Consistency in the application of statutory accounting practices is a fundamental concept on which NAIC standards are based. NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, *Preamble*: P-5.

Recommendation

Medica should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

Finding 2

Medica did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs in its 2012 annual financial report.[19]

Medica allocates expenses for administrative services—including contract-related expenses—across product lines and among its affiliates using both direct and indirect allocation methods. Medica uses an allocation model with numerous statistics to apportion costs, depending on the types of administrative expense. For some larger transactions, Medica does not record expenses through its allocation model, but directly designates the items to specific products.

Among the samples we tested, we identified two cost items for which Medica could have allocated the expenses more directly to individual products that benefitted from the services. During 2012, Medica paid one of its contractors for work specific to two state programs; however, Medica used an "indirect" approach to allocate these expenses across all state programs based on a combination of statistics. Medica also paid a different contractor for work on behalf of commercial lines of business through Medica's affiliates, but Medica indirectly allocated the expenses across commercial and all state programs. In its directives to its contractors, Medica specified which programs were within the scope of work. For these samples, the amount of transactions tested totaled $14,478, and we estimated $14,068 was allocated among all state public programs on Medica's Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[20] The totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004) attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. Medica could use its contract documents and statements of work as resources to discern costs incurred for specific lines of business and, thus, to more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, Medica should directly allocate administrative expenses to specific lines of business or products when such information is available*.

Finding 3

Medica did not have adequate documentation to support expenses related to four Medica contracts for administrative services.[26]

Among the samples we tested, Medica paid two different contractors rates that did not align with the payment terms in its contracts. One consultant was paid less than the contract payment rate, and one consultant was paid more than the contract payment rate. For these two samples, the transactions tested totaled $2,200, and we estimated $326 was allocated among all state public programs.[27]

Medica also paid two other contractors for administrative services in 2012, but did not provide us with adequate contracts or current work orders detailing the full scope and duration of work, payment terms, and signatures by both parties. For these contracts, the transactions tested totaled $216,886, and we estimated $31,410 was allocated among all state public programs.

Without adequate supporting documentation, we were unable to validate whether the contractors were paid appropriately, assess the reasonableness of Medica's allocation, or determine how these expenses related to public programs. We defined questioned costs to include:

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[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

[26] For Finding 3, we considered two or more exceptions of any single exception greater than $10,000 to be a finding.

[27] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods. We estimated the amount of these transactions and likely related expenses as allocated to the state's public programs totaled $7,298.

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[28]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[29] Medica's contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[30] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[31] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

Medica should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. Medica's payments should be in accordance with the terms of such contracts.

Finding 4

Medica allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[32]

Among 103 samples we tested, Medica allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs in its 2012 Minnesota Supplement Reports #1 and #1A. These three transactions totaled $18,306. We estimated the allocated costs totaled $1,340, and included expenses for alcohol beverages ($19), travel ($1,236), and activities or services occurring outside of Minnesota and unrelated to the state's public programs ($86).[33] In our view,

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[28] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[29] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[30] DHS, *2012 Families and Children Contract, Medica Health Plans*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[31] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

[32] For Finding 4, we considered a single questioned cost to be a finding.

[33] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods. Due to the complexity of Medica's allocation model, we could not more precisely estimate the amount reported here. We estimated all known and likely related costs as allocated to the state's programs totaled $3,813.

Medica did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[34] We defined questioned costs to include: …where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[35] In its guidance for completing financial reports, Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[36]

In its contracts with DHS, Medica must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[37] Medica did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by Medica to the state's public programs on its financial reports. These nine transactions we tested totaled $6,988,488, and were for marketing expenses and charitable contributions. We estimated the allocated costs totaled $6,135,701.[38] Minnesota laws in effect at the time Medica filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner

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[34] Some of these expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[35] OMB, *Circular A-133*, subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[36] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

[37] *42 CFR,* sec. 438.604, subpart H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, Medica Health Plans*, sec. 9.10. (Other DHS contracts with Medica contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR,* secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[38] For two transactions we tested, Medica allocated 100 percent of the costs ($609,575) to the state's public programs. In our view, a share of these costs should have been allocated to Medica commercial products as they also would have benefitted from the intended purpose of these costs.

of human services.[39] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[40]

During 2013, DHS separately requested and Medica provided DHS and its actuary with 2012 summary financial and other data regarding the types of unallowable expenses specified in the 2013 law—including marketing and contribution expenses—and the amount that was allocated to state public programs. We tested but were unable to sufficiently verify the extent to which Medica fully disclosed these expenses to DHS, for several reasons. First, Medica's accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, Medica's processes for allocating costs are very complex; this made it difficult to retrospectively trace and reconcile these expenses. Lastly, verifying these financial records against the data Medica submitted would have required significantly more time beyond the scope of this audit.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[41] Medica should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. Medica also could implement accounting practices that identify such expenses—perhaps by specific type, account code, or amount—and: (1) directly expense such costs to non-state plan products, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure Medica costs are appropriately allocated to the state's public programs.

Recommendation

Medica should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or are unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

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[39] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[40] *Laws of Minnesota* 2013, chap. 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expense, charitable contributions, and any individual's compensation in excess of $200,000.

[41] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

MEDICA.

February 19, 2015

Mr. James Nobles
Legislative Auditor
Centennial Office Building, Room 140
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to submit a letter for inclusion in your Audit of Compliance with Financial Reporting. We appreciate the attention your staff gave to the comments we have provided throughout the process. A number of them were taken into account in finalizing the findings. Some of them were not and are noted here for the record.

Finding 1

Medica files a number of standard and custom reports for our various regulators. The guidance we rely on is not always clear or consistent. For example, NAIC guidance does not specify the classification between the administrative and medical expenses cited here. We rely on instruction from the Minnesota Department of Commerce in determining these classifications. Our filings have been built using a consistent methodology over the years, and have been reviewed and audited quarterly by the Department of Commerce.

It is worth noting that the classification we have used, if relied upon for setting rates, would likely have the effect of lowering our premiums rates from the state.

Finding 2

The invoice cited in this finding for approximately $14,000 was appropriately allocated to State Public Programs. However, the finding notes that details within the invoice would have allowed us to further directly allocate expenses to specific programs. While the statute states that expenses should be allocated directly when such information is available – and our guiding principle is to allocate directly when practicable – we believe that a standard of reasonableness needs to apply. The items in the invoice that could have been allocated directly ranged from $27 to $1,700. If there is no standard of reasonableness, we would need to increase both staff and administrative expense – with the promise of little or no benefit to the state.

Finding 3

Medica has a robust contract management system that ensures the expenditures are appropriately authorized and that written contracts are in place prior to receiving services. Occasionally, changes to contracts, including contract extensions, are not reflected in contract extensions on a timely basis, as this audit has shown. We will strive to ensure current documentation is in place for all contracts.

Finding 4

The finding points to three invoices with allocations totaling $1,340 that are considered unreasonable. We continue to believe that these expenses were appropriately allocated. For example, the largest portion of this expense was for travel to an out-of-state location to oversee operations that directly affect our public programs business. There will always be an element of judgment in determining reasonableness. More importantly, the salient point here is that this disagreement is not material.

We will continue to work with DHS to provide any and all information needed for rate setting.

We value our partnership with the state, and the coverage and service we are able to provide for our members. To that end, we are dedicated to following all regulatory requirements for financial reporting and in producing filings that are accurate and complete. Given the complexity of this work, we know that small errors will occur and that there will be areas of disagreement. We view this audit, and all those we participate in, as an opportunity to improve our performance and strengthen our partnerships.

Sincerely,

Glenn Andis
Senior Vice President
Medica Government Programs

Appendix D: UCare Minnesota
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

Conclusions

UCare generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, UCare either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- UCare generally complied with certain requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.
- UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.
- UCare allocated unreasonable costs for one sample transaction to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of UCare's administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

UCARE

BACKGROUND

UCare Minnesota (UCare) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with UCare to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Special Needs Basic Care (SNBC), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). UCare also provided other health insurance products and services unrelated to these programs during this period.[3]

UCare's reported expenses to administer the state's programs in 2012 totaled approximately $99.7 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 80 counties statewide. UCare's program enrollment for this period totaled nearly 2.4 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with UCare also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(3), UCare is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] UCare contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs. UCare also provided administrative and management services via an agreement with UCare Wisconsin, a UCare subsidiary.

[4] UCare Minnesota, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, UCare Minnesota* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of UCare's administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by UCare to the State of Minnesota for Minnesota public health care programs?

- Did UCare report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by UCare for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision* (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of UCare.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from UCare's 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expense*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of UCare to gain an understanding of its procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See: *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, UCare Minnesota*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From UCare's financial data, we selected an initial sample of 103 transactions to test against our objectives.[11] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of UCare's own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, bank statements, contracts, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for UCare's administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled UCare's 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against UCare's publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by UCare at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. UCare classified much of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

UCare generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, UCare either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

[11] The total number of transactions we actually reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on UCare's *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

UCare generally complied with certain requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.[12]

Among 103 sample transactions we tested, UCare generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with two exceptions.[13] UCare miscategorized expenses for one transaction to "Printing and Office Supplies," instead of to the correct line (Cost or Depreciation of EDP Equipment and Software). UCare also miscategorized expenses for a second transaction to "Traveling Expenses"; in our opinion, these expenses should be categorized as "Outsourced Services." These two transactions totaled $1,702. UCare's miscategorization of these items did not impact the sum total of administrative expenses on this exhibit.

Minnesota requires managed care organizations to complete and file the National Association of Insurance Commissioners (NAIC) Health Annual Statement.[14] NAIC instructions for the Underwriting and Investment Exhibit, Part 3, direct where to record expenses on this exhibit.[15]

UCare did not fully comply with requirements for reporting investment experience (or gains and losses) on its 2012 Minnesota Supplement Report #1A. UCare used a method for allocating net investment income and gains across its lines of business that differed from state reporting requirements and factored in recent earnings generated relative to current lines of business. UCare's allocation method did not impact the total amount of investment income reported on its 2012 Minnesota Supplement Report #1A.

Minnesota has two separate instructions for reporting investment income and gains for each product or program on Supplement Report #1A. *Minnesota Statutes* 2014, 62D.08, subd. 7(b) requires that:

> Every health maintenance organization must allocate investment income *based on cumulative net income over time* by business

[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[15] National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC: September 2012).

> line or product and must submit this information…using the reporting template provided by the commissioner of health.

The Minnesota Department of Health's instructions for completing Minnesota Supplement Report #1A state that "investment gain must be allocated *by the prior five years of net income*."[16]

Recommendations

UCare should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

UCare should report investment income and gains in accordance with Minnesota Statutes *2014, 62D.08, subd. 7.*

Finding 2

UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.[17]

UCare uses both direct and indirect allocation methods to record and allocate administrative costs across its lines of business. Generally, expense transactions are reviewed for attributing costs to a specific product or program. UCare directly allocates certain expenses to specific products. Expenses related to more than one product are most often indirectly allocated across products based on premium revenue.

Among the samples we tested, we identified two cost items for which UCare could have allocated expenses more directly to individual programs that benefitted from the services. During 2012, UCare sponsored and paid for two health care cost containment initiatives that required direct tracking of member eligibility, by state program. UCare contracted with outside vendors for these services and specified in each statement of work the state programs that would benefit from these efforts. UCare did not directly allocate these costs to the designated state programs. Instead, UCare indirectly allocated these expenses across all products. These sample transactions totaled $16,289; we estimated $10,046 was allocated among all state public programs on UCare's Minnesota Department of Health supplement reports.[18]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project

[16] See http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm.

[17] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[18] The totals reported in this paragraph represent OLA estimates of expenses allocated to the state's public programs using UCare's allocation methods. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $206,572.

or service.[19] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[20] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[21] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[22]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[23] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. UCare could use its contract documents and statements of work as resources to discern costs incurred for specific programs and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, UCare should directly allocate administrative expenses to specific lines of business or products when such information is available.*

Finding 3

UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.[24]

Among the samples we tested, UCare paid a contractor for one project in 2012, but did not have an executed contract or statement of work that detailed the scope and duration of work, payment terms, and signatures by both parties. UCare's total payments to a different contractor exceeded the agreed upon amount in the contract. These two sample transactions totaled $38,291, and we estimated the

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[19] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes, only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[20] *Ibid.* Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[21] National Association of Insurance Commissioners, *Accounting Practices and Procedures Manual*, Vol. 1, *Statements of Statutory Accounting Principles, SSAP No. 70.* (Washington, DC, 2012).

[22] *Ibid.*, Appendix A-440.

[23] *Laws of Minnesota* 2010, First Special Session, Chapter 1, art. 20, sec. 2.

[24] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

costs that lacked adequate documentation and allocated to the state's public program totaled $4,408.[25]

Without adequate supporting documentation, we were unable to validate whether UCare's contractors were paid appropriately, assess the reasonableness of UCare's allocation, or determine how these expenses were related to the state's public programs. We defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[26]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[27] UCare's contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[28] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

UCare should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. UCare's payments should be in accordance with the terms of such contracts.

Finding 4

UCare allocated unreasonable costs for one transaction to the Medical Assistance programs on its 2012 financial reports.[29]

Among 103 samples, we identified one sample in which UCare allocated about $376 for alcohol beverages and related costs to Minnesota's Medical Assistance

[25] Totals reported in this section represent OLA estimates of allocated expenses to the state's public programs using UCare's allocation methods.

[26] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[27] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[28] DHS, *2012 Families and Children Contract, UCare, Minnesota,* secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR,* sec 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[29] For Finding 4, we considered a single questioned cost to be a finding.

programs on its 2012 Minnesota Supplement Reports #1 and #1A.[30] In our view, UCare did not sufficiently consider and restrict this type of expense from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[31] We considered questioned costs to include: …where costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[32]

In its contracts with DHS, UCare must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[33] UCare did not consider this cost item to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by UCare to the state's public programs. These seven sample transactions totaled $10,044,568, and included expenses for marketing and contributions. We estimated the costs allocated to the state's public programs totaled about $8,512,112. Minnesota laws in effect at the time UCare filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[34] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as

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[30] The totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using UCare's allocation methods. The transaction tested totaled $2,664.

[31] These expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[32] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[33] *42 CFR*, sec. 438.604, subp. H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, UCare*, sec. 9.10. (Other DHS contracts with UCare contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR* secs. 438.6(c)(4)(ii)(A), and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[34] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[35]

During 2013, DHS separately requested and UCare provided DHS and its actuary with 2012 summary financial data regarding the types of unallowable expenses specified in the 2013 law—including the marketing and contribution expenses. We tested documentation supplied by both UCare and DHS regarding these types of expenses, and the amount allocated to state public programs. We found that UCare did substantially disclose these expenses to DHS and its actuary as part of the rate-setting process for contract year 2014.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[36] UCare should identify and disclose all unreasonable costs to DHS for purposes of determining managed care payments for state programs. UCare should implement accounting practices that identify such expenses—perhaps by specific type or account code—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure UCare costs are appropriately allocated to the state public programs.

Recommendation

UCare should fully identify and segregate administrative expenses that are unreasonable or otherwise unrelated to providing services for the Medical Assistance programs when reporting and certifying financial data to the Department of Human Services.

[35] *Laws of Minnesota* 2013, chap. 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

[36] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

February 18, 2015

Mr. James Nobles, Legislative Auditor
Office of the Legislative Auditor
Room 140, Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Re: Response to Appendix D of the OLA Audit of Compliance with Financial Reporting

Dear Mr. Nobles:

UCare appreciates the opportunity to respond to the Office of the Legislative Auditor's review of UCare's administrative and investment expenses for 2012 and related financial reporting. Although the report shows we can always improve our documentation and reporting, we are pleased by the minor findings and high level of compliance described in the report. Over 98% of the audited transactions in each finding area were compliant. In addition, the net financial impact of the findings on UCare's financial reporting is only $1,459 in under-reported expenses out of a total $99.7 million in UCare administrative expenses for state public health care programs.

We note below specific responses to the findings which will provide readers helpful context for understanding the report. Before proceeding to these detailed responses, we believe it is important to emphasize that UCare shares the Legislature's interest in ensuring we as a State are cost-effectively providing coverage and care to our most vulnerable individuals and families. Although audits constitute one necessary approach for confirming managed care's value and compliance, we hope that they do not distract policy makers and stakeholders from richer discussions about how managed care can strengthen performance, accountability, and quality in the delivery of public health care program services.

Finding 1: UCare generally complied with certain requirements for administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.

Recommendations

UCare should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

UCare should report investment income and gains in accordance with Minnesota Statutes 2014, 62D.08, subd. 7.

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As recommended in the report, we will continue to report administrative expenses in accordance with applicable NAIC requirements. We acknowledge that the two identified exceptions (totaling $1,702) out of the 103 sampled transactions could have been categorized more precisely. We appreciate that the report noted that the less refined categorization did not affect the sum total of reported administrative expenses.

We accept the report's clarification of how investment income should be reported under Minnesota Statutes, section 62D.08, subdivision 7(b), and look forward to implementing the recommended approach for 2014 annual reporting. We also appreciate that the report noted our prior method did not affect the total amount of reported investment income.

Finding 2: UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.

Recommendation: Pursuant to Minnesota Statutes 2014, 62D.08, subd. 7, UCare should directly allocate administrative expenses to specific lines of business or products when such information is available.

Although we would have preferred to learn that all of the 103 tested transactions reflected the most accurate possible allocation, we accept that two of the transactions could have been directly allocated to a product or program. It is worth highlighting here that the transactions in question resulted in **under-allocation** of administrative expenses to state public programs in the amount of $6,243. We will take greater care in reviewing potential costs for direct allocation of administrative expenses when information is available.

Finding #3: UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.

UCare should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed (sic) contracts and statements of work that specify the scope, duration, and payment rates. UCare's payments should be in accordance with the terms of such contracts.

We agree that in one of the 103 tested transactions we could not produce a signed statement of work, and we regret this lack of documentation. However, we respectfully disagree that we lacked documentation for the other transaction described in this finding. We produced documentation showing that the UCare business leader for the contract approved the relatively small amount of expenses that exceeded the contracted amount. This is consistent with our policy, and we do not understand the basis for the

apparent implication that a contract amendment would have been required. In any event, we will continue to strive for appropriate contract documentation and we have instituted even more robust contracting review processes since 2012.

Finding #4: UCare allocated unreasonable costs for one transaction to the Medical Assistance programs on its 2012 financial reports.

Recommendation

UCare should fully identify and segregate administrative expenses that are unreasonable or otherwise unrelated to providing services for the Medical Assistance programs when reporting and certifying financial data to the Department of Human Services.

In this finding, the report describes $376 in alcohol and related expenses that UCare spent as part of a recognition dinner for physicians who demonstrated high-quality care for our members. We do not understand how this expense should have been segregated in our financial reports. Neither the Department of Human Services nor the Department of Health has provided any direction or imposed any restrictions about how such expenses should be reported. We reported such expenses in compliance with applicable laws and contract requirements, and will continue to follow any revised or clarified standards issued by our government partners and regulators.

At UCare, we take our mission as a nonprofit organization seriously, and are proud of our efforts to provide community benefit. We appreciate that the report confirmed that UCare appropriately reported our charitable contributions and fully complied with the specific reporting requirements for these expenses recently implemented by the Department of Human Services.

Thank you for your office's professional efforts in this audit and report.

Sincerely,

Nancy J Feldman

Nancy J. Feldman
President & CEO

Appendix E: Sample Financial Reports

Managed care organizations must complete and file with the Minnesota Department of Health two reports that summarize their revenues, health care expenses, administrative expenses, and other information, by lines of business. Blank copies of these two reports—*Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income;* and *Minnesota Supplement Report #1A, Reallocation of Administrative Expenses*—are provided in the following pages. For a sample of administrative expense transactions, we tested the accuracy of each managed care organization's financial data recorded on their 2012 reports. The results of our audit work are summarized in Chapter 2. Our findings and recommendations for each of the managed care organizations are contained in Appendices A through D.

<Name of HMO>
Minnesota Supplement Report #1
STATEMENT OF REVENUE, EXPENSES AND NET INCOME
For the year ending December 31, 2012
Public Information, Minnesota Statutes § 62D.08

NAIC #	NAIC Description	1	2	3	4
	As found on page 4 of the Annual Statement	NAIC Totals	Non-Minnesota Products (Eliminations)	Total Minnesota Products	Commercial
1	Member Months				
REVENUES:					
2	Net Premium Income (including $ [redacted] non-health premium income)				
3	Change in unearned premium reserves and serve for rate credits				
4	Fee-for-service (net of $ [redacted] medical expenses)				
5	Risk revenue				
6	Aggregate write-ins for other health care related revenues (Line 699)	NR	NR	NR	NR
7	Aggregate write-ins for other non-health revenues (Line 799)	NR	NR	NR	NR
8	TOTAL REVENUES (Lines 2 through 7)	NR	NR	NR	NR
EXPENSES:					
9	Hospital/medical benefits				
10	Other professional services				
11	Outside referrals				
12	Emergency room and out-of-area				
13	Prescription drugs				
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)	NR	NR	NR	NR
15	Incentive Pool and Withhold Adjustments				
16	TOTAL EXPENSES (Lines 9 through 15)	NR	NR	NR	NR
LESS					
17	Net reinsurance recoveries				
18	Total hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR
19	Non-health claims				
20	Claims adjustment expenses				
21	General administrative expenses				
22	Increase in reserves for life, accident and health contracts (including $ [redacted] increase in reserves for life only)				
23	Total underwriting deductions (Lines 18 through 22)	NR	NR	NR	NR
24	Net underwriting gain or (loss) (Lines 8 minus 23)	NR	NR	NR	NR
25	Net investment income earned				
26	Net realized capital gains or (losses)				
27	Net investment gains or (losses) (Lines 25 plus 26)	NR	NR	NR	NR
28	Net gain or (loss) from agents' or premium balances charged off				
29	Aggregate write-ins for other income or expenses (Line 2999)	NR	NR	NR	NR
30	Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	NR	NR	NR	NR
31	Federal and foreign income taxes incurred				
32	Net income (loss) (Lines 30 minus 31)	NR	NR	NR	NR

Minnesota Supplement Report #1 (Continued)

5	6	7	8	9	10	11	12	13	14
Medicare + Choice	Medicare Cost	Minnesota Senior Health Options (MSHO)	SNBC (MA Only)	SNBC (Integrated)	Prepaid Medical Assistance Program (PMAP)	MNCare	Dental	Other Please Specify	Administrative Services Only
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

SOURCE: Minnesota Department of Health, http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm, accessed March 2, 2015.

<Name of HMO>
Minnesota Supplement Report #1A
REALLOCATION OF EXPENSES AND INVESTMENT INCOME
For the year ending December 31, 2012
Public Information, Minnesota Statutes § 62D.08

		1	2	3	4
Line	**Direct Non-Claim Expenses**	**Total**	**Non MN**	**Total MN**	**Commercial**
1	Employee benefit expenses	0		0	
2	Sales expenses	0		0	
3	General business/office expense	0		0	
4	State premium taxes and assessments	0		0	
5	Consulting and professional fees	0		0	
6	Outsourced services	0		0	
7	Other expenses	0		0	
8	**Total Direct Expenses**	**0**	**0**	**0**	**0**

		1	2	3	4
Line	**Reallocated Indirect Non-Claim Expenses**	**Total**	**Non MN**	**Total MN**	**Commercial**
9	Employee benefit expenses	0		0	
10	Sales expenses	0		0	
11	General business/office expense	0		0	
12	State premium taxes and assessments	0		0	
13	Consulting and professional fees	0		0	
14	Outsourced services	0		0	
15	Other expenses	0		0	
16	**Total Indirect Expenses**	**0**	**0**	**0**	**0**

		1	2	3	4
Line	**Direct plus Indirect Non-Claim Expenses**	**NAIC Total**	**Non MN**	**Total MN**	**Commercial**
17	Employee benefit expenses	0	0	0	0
18	Sales expenses	0	0	0	0
19	General business/office expense	0	0	0	0
20	State premium taxes and assessments	0	0	0	0
21	Consulting and professional fees	0	0	0	0
22	Outsourced services	0	0	0	0
23	Other expenses	**0**	**0**	**0**	**0**
24	**Total Non-Claim Expenses = Sum of Lines 17 to 23**	**0**		**0**	
25	**Claims Adjustment Expenses**	0		0	
26	**Revenues (Supp Report #1, Line 8)**	0		0	
27	**Incurred Claims (Supp Report #1, Line 18 + Line 22)**	0		0	
28	**Net Investment Gain/(Loss) (Allocated)**	0		0	
29	**Aggregate Write Ins for Other Income or (Expenses)**	0		0	
30	**Federal and Foreign Income Taxes Incurred**	0		0	
31	**Net Income = Lines 26+28+29-24-25-27-30**	**0**	**0**	**0**	**0**

Minnesota Supplement Report #1A (Continued)

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	0	0	0	0	0	0	0	0	0

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	0	0	0	0	0	0	0	0	0

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0

SOURCE: Minnesota Department of Health, http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm, accessed March 2, 2015.

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Helping Communities Recover from Natural Disasters, March 2012

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Home- and Community-Based Services: Financial Oversight

2017
EVALUATION REPORT

Program Evaluation Division

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Program Evaluation Division

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OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2017

Members of the Legislative Audit Commission:

Minnesota provides a variety of home- and community-based services (HCBS) through its Medical Assistance program. These services are intended to help the elderly and adults with disabilities live in the community rather than institutions.

Minnesota spent about $2.4 billion in Fiscal Year 2015 to provide these services to approximately 64,000 individuals. The median cost per recipient was about $22,000.

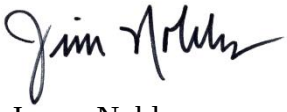
Despite the significant amounts of money spent for HCBS, we found that the Minnesota Department of Human Services does not provide adequate financial oversight of all HCBS providers.

To improve financial accountability, we recommend that the Legislature and department increase reporting requirements for HCBS providers. We also recommend that the Legislature require the department to periodically collect certain workforce-related data on HCBS workers.

Our evaluation was conducted by Jo Vos (project manager), Ellen Dehmer, Jennyfer Hildre, and Jolie Wood, with assistance from Emily Wiant.

The Minnesota Department of Human Services cooperated fully with our evaluation, and we thank the department for its assistance.

Sincerely,



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THE GREAT SEAL OF THE STATE OF MINNESOTA
L'ETOILE DU NORD
1858

Summary

Key Facts and Findings:

- The federal government gives states considerable flexibility to design and administer their Medicaid programs, including the home- and community-based services (HCBS) they choose to offer. (pp. 4-8)
- The Minnesota Department of Human Services (DHS) provides a variety of HCBS to Medical Assistance (MA) recipients with disabilities and the elderly through its state MA plan and five federally approved waivers. (pp. 3, 21-24)
- It is difficult to put a comprehensive price tag on HCBS, mainly due to differing financial reporting requirements and payment methods. (pp. 17-18)
- Medical Assistance expenditures to provide HCBS to about 64,000 adults with disabilities and the elderly totaled $2.4 billion in Fiscal Year 2015; the median cost per recipient was $21,993. (p. 19)
- The median cost per MA recipient with disabilities that received HCBS through the state MA plan was $2,713 in Fiscal Year 2015. For those who received HCBS through a waiver, median costs ranged from $4,191 to $158,554 per recipient in 2015. (pp. 19-21)
- A little more than half of MA spending for HCBS in 2015 was for supported living and foster home/ assisted living services, generally provided to people in residential settings to help them live more independently. (pp. 23-24)
- In Fiscal Year 2015, 10 percent of all providers accounted for 70 percent of MA payments for HCBS. (pp. 34-36)
- While Minnesota spends more per capita on HCBS than other states, other measures suggest that it has not been overly successful in helping people with disabilities live or work alongside people without disabilities. (pp. 13-16)
- The Department of Human Services does not collect adequate information to conduct financial oversight of all HCBS providers. (pp. 39-40, 47-48)
- The Department of Human Services has more stringent reporting requirements for personal care attendants than it does for other workers who do similar work. (pp. 50-51)
- Demographic changes, staff shortages, low wages, and demanding work complicate HCBS providers' ability to hire enough staff to respond to the demand for services, both in Minnesota and across the nation. (pp. 53-58)
- Wages for some types of direct care staff are generally higher in Minnesota than in other states, and they are comparable to the payment rates used by DHS under its waivers. (pp. 55-56)

Key Recommendations:

- The Legislature should increase its regulation over some types of direct care workers who provide HCBS in recipients' own homes. (p. 51)
- The Legislature should require the Department of Human Services to periodically collect data on direct care staffing in HCBS settings. (p. 57)
- The Legislature and Department of Human Services should adopt a common set of financial reporting requirements and menu of services for HCBS. (p. 61)

To improve financial accountability, the Legislature and Department of Human Services (DHS) should increase requirements for home- and community-based services (HCBS) providers.

Tracking the full cost of HCBS is difficult due to different reporting and payment requirements.

Report Summary

The federal Medicaid program requires states to develop statewide programs for people who do not have the resources to pay for their medical care. Medical Assistance (MA) is Minnesota's Medicaid program. It served, on average, just over 1 million people monthly in 2015 at a total cost of about $10.5 billion.

The Minnesota Department of Human Services (DHS) is the state's lead Medicaid agency and, as such, is responsible for administering MA. It has, in turn, delegated various responsibilities to counties, tribal governments, and managed care organizations.

Medical Assistance provides home- and community-based services (HCBS) to people with disabilities and the elderly.

Home- and community-based services help people with limited abilities live more independently. They offer an alternative to nursing homes, hospitals, or other long-term care settings.

Home- and community-based services may include: assistance with eating, dressing, mobility, or obtaining and keeping a job; transportation getting to and from various community settings; residential supervision; physical, occupational, and speech therapies; personal care and home health services; house or yard work; and respite for caretakers.

Minnesota provides HCBS to MA recipients in two ways. First, all MA recipients, regardless of whether they have disabilities, are eligible to receive certain types of HCBS as part of the state's overall MA plan.

Second, MA recipients "certified" as disabled may receive special or expanded HCBS through one of the state's five federally approved waivers. Being certified as having a disability means that an individual is unable to engage in substantial work activities due to a medically determined impairment expected to result in death or last continuously for at least 12 months. To be eligible for a waiver, certified recipients further need the level of care provided in long-term care institutions. The elderly and those diagnosed with developmental disabilities must only meet the latter criteria to be eligible for a waiver.

It is difficult to put a comprehensive price tag on HCBS.

There are a variety of reasons for this. First, there are differing reporting requirements and payment methods for HCBS. The amount or type of financial data that DHS collects to oversee HCBS varies, depending on (1) whether MA recipients receive HCBS through the state MA plan or waivers, (2) the type of health plan in which recipients are enrolled, (3) the type of HCBS provided, and (4) the type of HCBS provider. To help address this, DHS should adopt a common set of financial requirements for HCBS, regardless of how the services are delivered.

Second, programs other than MA, both inside and outside of DHS, provide similar services for which MA recipients may be eligible. For example, the Minnesota Department of Employment and Economic Development provides vocational services to individuals with disabilities that are similar to the services provided by DHS.

Third, state and national laws, rules, and guidelines for HCBS that have evolved over time have become increasingly complex and confusing. This may make it difficult for DHS to collect adequate financial data from HCBS providers in an efficient manner.

Medical Assistance expenditures for HCBS for adult recipients with disabilities and the elderly totaled $2.4 billion in Fiscal Year 2015.

About 64,000 adult MA recipients with disabilities and the elderly received HCBS through MA in Fiscal Year 2015. Median and average costs per recipient were $21,993 and $37,438, respectively.

Expenditures on behalf of recipients through the state MA plan were much lower than spending through waivers. For the most part, state plan HCBS may serve a population with less debilitating conditions or those who are able to obtain the assistance they need from sources other than MA, such as family members or other caregivers. Median and average MA costs for HCBS to recipients with certified disabilities through the state MA plan (27,500 recipients) were $2,713 and $12,986, respectively.

For recipients who received HCBS through waivers (41,959), median and average costs were $35,116 and $48,485, respectively. Costs varied widely, however, depending on the type of waiver. For example, annual median cost per recipient in Fiscal Year 2015 was $158,554 for those with chronic health conditions. Annual median costs for the two waivers enrolling the largest number of adult MA recipients were $24,213 for those with physical and other disabling conditions (19,642 enrollees) and $73,166 for those with developmental disabilities (15,226 enrollees).

The majority of MA spending for HCBS in 2015 was for services provided to people with disabilities in residential settings, including foster homes and recipients' own homes.

Supported living services, which are provided to people with developmental disabilities living in foster homes or their own homes, accounted for the largest share of total MA expenditures for HCBS ($742.5 million or 31 percent). These services focus on providing and teaching recipients to perform daily activities, such as eating, dressing, and bathing. Spending for foster home/assisted living services provided largely to people with other types of disabilities, accounted for 22 percent of HCBS expenditures ($536.9 million). Services provided mainly to recipients in their own homes by personal care attendants and home health aides accounted for 19 percent ($462.2 million). Day training and habilitation services, generally provided to people with developmental disabilities in nonresidential settings, accounted for 8 percent ($183.1 million). All other types of services, including medically related services such as nursing and therapeutic services, each accounted for 3 percent or less of HCBS spending.

The Department of Human Services does not collect adequate financial documentation from HCBS providers.

The Minnesota Department of Human Services began licensing providers of many types of services for people with developmental disabilities in 1997 and expanded to other types of HCBS providers in 2014. As part of its licensing process, however, DHS does not require or collect financial documentation. In addition, the department does not conduct routine financial investigations of HCBS providers. It only does so when problems come to its attention through processing payment claims or complaints.

In 2014, DHS began setting statewide payment rates for most HCBS. The department's system for processing claims has checks to prevent providers from fraudulently altering payment rates and the services included in recipients' service agreements. (Service

Services to train adults to live independently and provide basic care in recipients' homes account for most HCBS spending.

While DHS does not conduct routine financial audits of HCBS providers, it should improve financial accountability with increased regulation of some types of direct care staff.

agreements are documents counties develop that identify providers and the type, intensity, and frequency of HCBS they agree to provide to individual MA recipients.) However, according to DHS, some providers have found ways to bypass these safeguards to increase their overall payments.

The Legislature should more closely regulate some types of HCBS direct care staff.

A 2009 report by our office documented numerous instances of fraud by personal care attendants—those who help MA recipients maintain their independence in the community. We issued several recommendations for greater oversight by DHS, some of which have been enacted into law. These changes helped DHS identify over $1.6 million in personal care overpayments between 2014 and 2015. However, the changes adopted only apply to personal care attendants. They do not cover other types of direct care staff, such as home health aides and homemakers, who perform similar work in recipients' homes—generally unsupervised.

At a minimum, we recommend the Legislature extend personal care attendant requirements to other types of direct care staff that perform similar work in recipients' own homes. This would involve: (1) requiring additional types of HCBS direct care workers to enroll with DHS, (2) limiting the number of hours that these workers can bill DHS, and (3) requiring documentation of the provision of services.

The Legislature should require DHS to regularly collect data on direct care staff in HCBS settings.

Providers of HCBS in Minnesota—and across the nation—are facing several staffing issues. First, the number of individuals entering the workforce is growing at a much slower rate than the number of people who may need HCBS in the future. The Minnesota Department of Employment and Economic Development predicts that the number of home health care jobs will increase 30 percent between 2014 and 2024, while the number of people age 65 and older will increase more than 50 percent. It estimates 16,000 job openings for home health aides in Minnesota through 2022.

Second, relatively low wages for many types of direct care staff make it difficult for HCBS providers to compete with other employers. Although hourly wages for home health, nursing, and personal care aides in Minnesota ($11.51 to $12.22) are generally higher than in other states, they are far below the national average across all occupations ($23.23). Moreover, HCBS providers must compete with other healthcare employers, such as hospitals and nursing homes, that provide similar services but pay higher wages. They must also compete with other types of employers, such as grocery stores and gas stations, which can pay employees the same or more for work that is considerably easier than HCBS work.

The department needs to collect data on direct care staff specific to HCBS providers to better understand their workforce problems. These data should include: (1) the number of direct care workers employed by HCBS providers, both full and part time; (2) turnover; (3) the number of job vacancies; (4) average hourly wage; (5) the average benefit package; and (6) advancement opportunities. This type of information is necessary for state policy makers to develop appropriate strategies to address workforce issues confronting HCBS. The information is also needed to assess the impact of those strategies over time and make whatever changes may be necessary.

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Introduction

Over the last several years, the state of Minnesota has been under increased pressure to ensure that all Minnesotans with disabilities are afforded the opportunity to live and participate in their local communities rather than in institutional settings. Services provided in institutional settings, such as nursing homes and hospitals, segregate people with disabilities from the rest of society.

To this end, the Department of Human Services (DHS) provides a variety of services through its Medical Assistance (MA) program to help low-income adults achieve as much independence as possible. These services, commonly referred to as home- and community-based services (HCBS), cover a wide range of activities, including training to help individuals live independently; 24-hour emergency assistance; homemaker, personal care, and home health aide services; specialized equipment and technology; and vocational support. Services are provided in a variety of settings, including recipients' own homes; provider controlled residential settings, such as foster homes or assisted living; or daytime settings, such as adult day care centers or sheltered workshops.

In March 2016, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate HCBS for MA recipients with disabilities. Our evaluation addressed the following research questions:

- **What types of HCBS are provided to adult MA recipients with disabilities and the elderly, and in what settings are they delivered?**

- **How much does the state spend, in terms of MA, to provide HCBS, what types of organizations provide HCBS, and what do the different types of HCBS cost?**

- **To what extent has DHS developed the necessary tools to provide financial oversight of HCBS providers?**

We used a variety of methods to answer these questions. First, we reviewed state and federal laws, rules, and regulations, and district and federal court rulings related to HCBS. Second, we examined DHS policies, procedures, reports, and other documents, and we reviewed the national literature on HCBS. Third, we used DHS's management information systems to analyze all claims paid to provide HCBS to adult MA recipients with disabilities during Fiscal Year 2015. We supplemented these data with other DHS data on housing assistance and data from the Department of Employment and Economic Development regarding vocational rehabilitation services provided to the same group of HCBS recipients. Fourth, we talked with state and county staff, HCBS providers, and representatives from various advocacy organizations.[1] Finally, we attended various task force and advisory group meetings as well as information and training sessions for the public and other stakeholders.

[1] We spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount MA paid them for HCBS in Fiscal Year 2015 and the types of services they delivered. We tried to focus on providers that received relatively high amounts of MA payments relative to their geographic area. Once we selected our provider sample, we talked with the counties where those providers were based. Our two samples are not representative of either population, and their comments cannot be generalized to all counties or providers.

Our evaluation took a broad look at HCBS, and there are several important issues that we did not examine, including: HCBS housing concerns (including the moratorium on corporate foster care homes); eligibility; the availability of services (including waiting lists); program quality; or effectiveness.[2] Although we discuss providers' concerns about DHS's methodology for determining HCBS payment rates, we did not fully analyze the various factors going into the formula. Finally, although some legislators wanted us to examine HCBS providers' profit margins, lack of financial reporting requirements and inconsistent data collection across providers prevented us from doing so.

[2] The 2009 Minnesota Legislature authorized a moratorium on the growth of licensed corporate foster care settings beyond a predetermined threshold. The moratorium remains in effect. *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 8. Regarding waiting lists, the number of people with disabilities waiting for HCBS has decreased since May 2014, due in part to additional funding from the Legislature. Currently, there is only a waiting list for people with developmental disabilities. Minnesota Department of Human Services, *Disability Waiver Financial Management and Waiting Lists* (St. Paul, December 2016), 5.

Chapter 1: Background

With the nationwide shift away from institutional care that began in the late 1960s, providing services to people with disabilities in community-based settings has become a more commonly used approach to long-term care. Minnesota provides a variety of home- and community-based services (HCBS) through its publicly funded healthcare programs to help low-income people with disabilities remain in their local communities. This chapter discusses the major legal provisions that guide the state's approach to providing HCBS, funding sources, and how Minnesota compares with other states in overall HCBS spending and service delivery.

The federal government has given states considerable flexibility to design and administer their HCBS systems. This includes the specific services states choose to offer and the groups of individuals eligible for them. Minnesota was one of the first states to take advantage of this flexibility, with some of its HCBS programs dating back more than 25 years. More recent federal requirements and court cases, however, question the adequacy of the state's efforts to ensure equal opportunities to low-income people with disabilities.

Definitions

Home- and community-based services help people with limited abilities live more independently. They offer an alternative to care in nursing homes, hospitals, or other institutional settings providing long-term care and support.

Minnesota provides a variety of home- and community-based services (HCBS) to help low-income people with disabilities live and participate in local communities rather than institutions.

These services may include: assistance with eating, dressing, mobility, or obtaining and keeping a job; transportation to community events or one's place of employment; residential supervision; physical, occupational, and speech therapies; training in living skills; house or yard work; and respite for caretakers. Chapter 2 more explicitly defines HCBS and provides detailed cost and utilization data for specific types of HCBS provided to a subset of low-income individuals.

Providing HCBS has many purposes: helping people with disabilities live in the most integrated settings of their choice and as independently as possible; honoring people's preferences; and promoting cost effective options to institutional care and services. Individuals considered to be living "in the community" may reside in their own homes; with their families; or in certain types of regulated residential facilities, including assisted living and foster care homes (both family and corporate).[1]

[1] In family foster care, the licensed provider actually lives in the home alongside residents. For the most part, this individual is considered the primary caregiver. In corporate foster care, the licensed provider hires workers to provide care in a home where he or she does not live.

Institutional settings include nursing homes, hospitals, treatment centers, intermediate care facilities for people with developmental disabilities, and other state-licensed residential facilities. For the most part, state- and federally funded HCBS are not available to individuals living in these settings, unless the services are provided to help transition individuals from an institution to the community. In addition, in the last few years, federal regulations caution states that some individual foster homes can be considered institutional if their environments are too restrictive.[2]

Legal Framework

State and federal laws, Centers for Medicare and Medicaid Services (CMS) regulations, and judicial rulings authorize and guide Minnesota's HCBS system. Exhibit 1.1 provides an overview of this legal framework, which we discuss in greater detail below.

Medicaid

In 1965, Congress established Medicaid as part of the *Social Security Act*.[3] The Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services administers the program by issuing regulations and guidelines that states must follow to receive federal funding. Medicaid requires participating states to offer basic healthcare services to certain categories of low-income individuals, including people age 65 and older, adults who are permanently and totally disabled, pregnant women, and children.[4] Mandatory services include physician care, inpatient and outpatient hospital care, and certain home health services, among others.

The federal government gives states considerable flexibility in how they design and administer their Medicaid programs, including the HCBS they choose to offer.

Medicaid allows states to include additional services and categories of individuals in their programs if they so choose. Optional services may include mental health services, physical and occupational therapies, and HCBS, among others. Further, if states choose to offer HCBS, the federal government allows them to decide (1) who will be eligible for their state HCBS programs and (2) the different types of services they will offer.

Over the last several years, the federal government has given states a variety of options for administering these "extra" services. One of the first options available allows states to simply choose to offer some HCBS as part of their overall state Medicaid plans, which generally makes all Medicaid recipients eligible to receive the HCBS if needed. Minnesota has chosen to expand its public healthcare plans in this way to make some HCBS available to all health plan enrollees. For example, HCBS available to all health plan enrollees include personal care attendants, physical and occupational therapies, and certain types of case management services.[5]

[2] 42 *CFR*, sec. 441.301 (2014).

[3] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396.

[4] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396d.

[5] The federal government requires states to include certain home health services as part of their overall benefit packages.

Exhibit 1.1: Legal Framework for Providing Home- and Community-Based Services

Year Enacted	Provision	Authority	What it Does
1965	*Social Security Act* (Title XIX)	U.S. Congress	• Establishes the federal Medicaid program • Requires participating states to offer basic healthcare services to certain categories of low-income individuals
1967	*Minnesota Statutes* 2016, Chapter 256B	MN Legislature	• Establishes a statewide program for people who do not have the resources to pay for medical care • Is the basis for Minnesota's Medicaid program, Medical Assistance (MA)
1981	*Omnibus Budget Reconciliation Act* (OBRA)	U.S. Congress	• Allows states to use Medicaid to provide home- and community-based services (HCBS) to people who would otherwise require Medicaid-covered services in an institutional setting • Establishes federal waiver program
1990	*Americans with Disabilities Act* (ADA)	U.S. Congress	• Landmark civil rights legislation that guarantees equal opportunity for people with disabilities in public accommodations, employment, services, and telecommunications
1999	*Olmstead v. L.C.*	U.S. Supreme Court	• Ruled that unjustified segregation of people with disabilities violates Title II of the 1990 *Americans with Disabilities Act* • Requires states to provide community-based services to persons with disabilities when (1) such services are appropriate, (2) affected individuals do not oppose it, and (3) the services can be reasonably accommodated
2011	*Jensen v. DHS*, Jensen Settlement	U.S. District Court (MN)	• Requires that the state of Minnesota and Department of Human Services (DHS) develop and implement a plan to help ensure that people with disabilities receive services that effectively meet their needs in the most integrated settings possible, in compliance with Olmstead • Led to creation of Minnesota's Olmstead Plan, which was approved in 2015
2012	*Minnesota Statutes* 2016, 245D	MN Legislature	• Adds additional types of HCBS to DHS's licensing authority • Establishes additional licensing standards
2013	*Minnesota Statutes* 2016, 256B.4914	MN Legislature	• Requires DHS to determine payment rates for certain HCBS and sets forth a rate-setting methodology
2014	42 *CFR*, secs. 441.301 and 441.530 (2014)	Centers for Medicare and Medicaid Services	• Establishes new requirements for HCBS financed through several Medicaid programs, including HCBS waivers • Requires that HCBS be provided in integrated settings that allow recipients full access to their communities • Mandates person-centered planning
2014	*Workforce Innovation and Opportunity Act* (WIOA)	U.S. Congress	• Helps people with barriers to employment have access to services they need to succeed in the labor market

SOURCE: Office of the Legislative Auditor, review of state and federal laws, regulations, and court rulings.

States can also choose to limit HCBS or certain types of HCBS to distinct groups of Medicaid recipients or to certain geographic areas. To do so, states must apply for one or more federal "waivers." Receiving a waiver allows states to forgo certain Medicaid requirements concerning service comparability and availability.[6] Authorized in 1981, the provision allows states to provide HCBS to individuals who would otherwise require Medicaid-covered hospital, nursing home, or other long-term institutional care.[7] Using this option requires "cost-neutrality," which means that states must show it is no more expensive, on average, to provide HCBS than to provide institutional care to comparable Medicaid recipients.[8] Almost all states, including Minnesota, use this option to provide at least some HCBS.

Medical Assistance

Medical Assistance (MA) is the state's response to the federal Medicaid program. Passed in 1967, state law establishes MA as a statewide program for people who do not have the resources to pay for their medical care.[9] It served, on average, just over 1 million people monthly during Fiscal Year 2015 at a total cost of about $10.5 billion.[10]

The federal government and states share in financing MA according to a formula known as the Federal Medical Assistance Percentage. This formula determines the federal share based on each state's per capita income in relation to the national per capita income—the higher a state's income, the lower the federal share. In Fiscal Year 2015, the federal government paid about 57 percent ($5.9 billion) of Minnesota's total MA costs, with the state paying 42 percent ($4.3 billion) and counties 1 percent ($154 million).[11]

Over one-quarter of Medical Assistance expenditures paid for HCBS in Fiscal Year 2015.

As noted above, MA spending in Fiscal Year 2015 totaled about $10.5 billion.[12] About $2.8 billion of this amount—27 percent—went toward providing HCBS to MA recipients.[13] The Department of Human Services estimates that the proportion of MA expenditures going to HCBS will continue to increase.

[6] Generally, state plans must be in effect throughout the entire state, with the same scope of coverage statewide. *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c).

[7] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c). These waivers are commonly referred to as Section 1915(c) waivers.

[8] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c)(2)(D).

[9] *Laws of Minnesota* 1967, Extra Session, chapter 16, sec. 1, codified as *Minnesota Statutes* 2016, 256B.

[10] Minnesota Department of Human Services, "Background Data Tables for November 2016 Forecast," https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp, accessed February 9, 2017.

[11] *Ibid.*

[12] *Ibid.*

[13] Expenditures for HCBS include MA payments for waivers, home health agency services, personal care, and home care nursing services.

The Minnesota Department of Human Services is the state's lead Medicaid agency and, as such, is responsible for administering the program. The department has, in turn, delegated various responsibilities to counties, tribal governments, and managed care organizations.

Like other states, Minnesota has chosen to expand its Medicaid program to provide HCBS to people with disabilities and the elderly.

Minnesota provides HCBS to MA recipients in two major ways.[14] First, low-income Minnesotans enrolled in MA may receive state- and federally funded HCBS as part of the state's overall MA plan. By using this option, Minnesota makes certain types of HCBS generally available to all MA recipients, regardless of whether they have disabling conditions. For example, nonemergency transportation, certain medical equipment and supplies, personal care assistance, and various types of therapies such as physical and occupational therapies, are available to all MA recipients, if needed.[15]

Second, MA recipients with disabilities, including the elderly, may receive special or expanded HCBS through one of the state's five federally approved waivers, which we describe in Exhibit 1.2. As an early adopter of HCBS waivers, Minnesota established all five waivers under a federal option that requires eligible recipients to need a level of care provided in long-term care facilities. Consequently, it must show that providing HCBS through waivers is no more costly than institutional care for comparable individuals. As shown earlier in Exhibit 1.1, the federal government made this option available to states in 1981.

As a first step to determining waiver eligibility, MA recipients must generally be (1) "certified" as having a disability, (2) diagnosed with a developmental disability, or (3) at least 65 years old and need the level of care provided in nursing homes. Being certified as having a disability means that people are unable to engage in substantial gainful activities due to any medically determined physical or mental impairment.[16] In addition, the impairment must be expected to result in their death or last continuously for at least 12 months.[17] The U.S. Social Security Administration sets the criteria for these determinations based on individuals' work status, the severity of their conditions, and whether their conditions are included on a federal list of disabilities.[18]

[14] We describe these services in more detail in Chapter 2.

[15] Throughout this report, we refer to HCBS generally available to all MA recipients, regardless of whether they have disabling conditions, as "state MA plan services."

[16] The Social Security Administration uses the term "substantial gainful activity" to describe a level of work activity and earnings. Work is "substantial" if it involves doing significant physical or mental activities or a combination of both. Work is "gainful" if it is generally performed for pay or profit, regardless of whether a profit is realized. Social Security Administration, *2016 Red Book* (Washington, DC, 2016), 5.

[17] *Social Security Act of 1965,* 42 *U.S. Code* 1382c, 1396a, and 1396d.

[18] The Social Security Administration also makes all decisions on whether individuals qualify for Social Security benefits on the basis of a disability.

Exhibit 1.2: Minnesota's Home- and Community-Based Services Waivers

Name of Waiver	Eligibility
Brain Injuries	People certified as disabled and have acquired or traumatic brain injuries who would otherwise require the level of care provided in a specialized nursing facility or neurobehavioral hospital
Chronic Health Conditions and Medically Fragile	People certified as disabled and are chronically ill or "medically fragile" who would otherwise need the level of care provided in a hospital
Physical and Other Disabling Conditions	People certified as disabled and have physical or other types of disabilities, including cognitive or behavioral conditions, who would otherwise require the level of care provided in a nursing facility
Developmental Disabilities	People diagnosed with developmental disabilities who would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities
Elderly	People ages 65 and older who require the level of care provided in a nursing facility and choose to live in the community

SOURCE: Minnesota Department of Human Services, *Community-Based Services Manual: Disability Services Program Manual* (St. Paul, 2016).

In Minnesota, a disability must be certified by the Social Security Administration or the State Medical Review Team (SMRT). Individuals seeking certification may be referred to SMRT if they have applied for Social Security benefits and are awaiting a decision.[19] The review team is part of DHS.

Medical Assistance recipients who have been certified as having a disability, diagnosed with a developmental disability, or are 65 years or older do not automatically qualify to receive HCBS through waivers.

Once an MA recipient is certified as having a disability or diagnosed with a developmental disability, or is at least 65 years of age, the recipient's home county, tribal organization, or, in some cases, his or her managed care organization uses a DHS-developed assessment tool known as MnCHOICES to determine whether that recipient is eligible to receive HCBS through one of the state's five waivers. To be eligible to participate in a waiver, MA recipients must also need the level of care provided in long-term care institutions, such as hospitals, nursing homes, or intermediate care facilities. Local staff conduct a needs assessment to determine which HCBS the individual needs and how many hours of services he or she will receive. The needs assessment forms the basis of a waiver recipient's coordinated services and support plan that staff must develop.

[19] *Minnesota Statutes* 2016, 256.01, subd. 29; and 256B.055, subd. 7(b); and Minnesota Department of Human Services, *Minnesota Health Care Programs Eligibility Policy Manual* (St. Paul, 2016), sec. 2.3.2.2, 24-25.

The Home- and Community-Based Settings Rule

In January 2014, CMS issued its final regulations establishing new requirements for HCBS funded through waivers.[20] The regulation, effective March 2014, is sometimes referred to as the "HCBS Settings Rule." It establishes quality requirements for the settings where Medicaid recipients receive HCBS through waivers.

To receive federal funding, states must provide HCBS in the most integrated settings possible—ones that allow individuals full access to their communities.

Any residential or nonresidential setting where Medicaid recipients live or receive HCBS must be integrated into the community. This means that HCBS sites must offer recipients opportunities for competitive employment, civic involvement, and control of their personal resources. Furthermore, service settings must ensure individuals' rights of privacy, dignity, respect, and freedom from coercion and restraint. Recipients must have the opportunity to make their own decisions about the HCBS they receive, including how, when, and where they receive those services.

While previous regulations banned providing HCBS in institutions such as nursing homes, hospitals, and other types of large care facilities, some settings, such as corporate foster homes, have been considered appropriate. The new HCBS Settings Rule, however, requires that HCBS be provided in settings that do not have the "qualities of an institution."[21] This means that individuals living in foster homes must enjoy the same types of freedoms that people without disabilities typically have in their homes—going to bed when they choose, watching television programs of their choosing, and having snack food available. It also means that HCBS recipients should have the opportunity to work alongside people without disabilities.

States must be fully compliant with the new rule by March 2019. The rule requires that states develop "transition" plans that address how they will ensure compliance by 2019.[22] Minnesota submitted its plan to CMS in December 2016 and is currently awaiting federal approval.[23]

The Workforce Innovation and Opportunity Act

In 2014, Congress passed the *Workforce Innovation and Opportunity Act*.[24] It is designed, in part, to help individuals with barriers to employment, including those with disabilities, have access to the training and support services they need to succeed in the labor market.

[20] 42 *CFR*, Parts 430, 431, 435, 436, 440, 441, and 447 (2014). In Minnesota, this applies to MA recipients receiving HCBS through the state's five waivers.

[21] 42 *CFR*, sec. 441.301 (2014).

[22] *Ibid.*

[23] Minnesota Department of Human Services, *Minnesota's Home and Community-Based Services Final Rule Statewide Transition Plan* (St. Paul, 2016).

[24] *Workforce Innovation and Opportunity Act,* 29 *U.S. Code*, sec. 3101 (2014).

Recent federal workforce requirements focus on giving people with disabilities opportunities to have jobs that pay at or above minimum wage.

Although the law pertains to a much larger population than Medicaid recipients, two provisions are especially relevant to HCBS. First, the Act requires that state workforce agencies spend at least 15 percent of their federal vocational rehabilitation funds for pre-employment transition services for special education high school students.[25] Many of these students may be receiving HCBS through MA. The goal is to help them move into regular jobs that pay at least minimum wage, rather than work in sheltered workshops. The Department of Employment and Economic Development (DEED) is Minnesota's lead workforce agency.

Second, effective July 2016, DEED must play a more active role in assisting people with disabilities already in subminimum wage jobs explore other options. It must provide career counseling and information and referral services to any disabled individual currently employed or seeking employment in a job paying less than minimum wage.[26] Again, many of these individuals may be receiving HCBS through Minnesota's MA plan or one of its waivers.

Judicial Requirements

In addition to legislation, two major court cases have set forth new expectations for HCBS in Minnesota: the 1999 U.S. Supreme Court ruling, *Olmstead v. L.C.*, and the 2011 *Jensen v. DHS* settlement in U.S. District Court.[27]

The courts have directed state agencies to (1) move people with disabilities out of restrictive settings and into their communities and (2) provide them with the services they need to live independently.

Olmstead v. L.C. involved two women with disabilities who were confined to an institution, even though health professionals determined they were ready to move into a community-based setting. In 1999, the U.S. Supreme Court upheld the Eleventh Circuit Court's decision that the unjustified segregation of people with disabilities violates Title II of the 1990 *Americans with Disabilities Act*.[28] Title II regulations require that public entities provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[29] The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[30] The ruling requires Minnesota (and all other states) to provide HCBS to persons with disabilities when (1) such services are appropriate; (2) the individuals affected do not oppose it; and

[25] 29 *U.S. Code*, sec. 419d(1) (2014).

[26] 29 *U.S. Code*, sec. 794g (2014).

[27] *Olmstead v. L.C.*, 527 U.S. 581 (1999); and Final Approval Order for Stipulated Class Action Settlement Agreement, *Jensen v. Minnesota Department of Human Services*, No. 09-1775 (D. Minn. Dec. 5, 2011).

[28] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[29] 28 *CFR*, 35.130(d) (1991).

[30] 28 *CFR*, Appendix B, Part 35, subpart B, sec. 35.130 (2010).

(3) the services can be reasonably accommodated, taking into account state resources and the needs of others receiving disability services from the state.[31]

About ten years later, in July 2009, a federal class-action lawsuit against DHS was filed in U.S. District Court. In this case, *Jensen v. DHS*, the plaintiffs alleged that people with developmental disabilities living in a DHS-operated intermediate care facility were unlawfully and unconstitutionally secluded and restrained.[32] In December 2011, the court approved the *Jensen Settlement Agreement*.[33] Among other things, the agreement requires the state of Minnesota and DHS to develop and implement a comprehensive plan to help ensure that people with disabilities can build and maintain relationships with their family and friends, live more independently, work at regular jobs, and participate in community life.

About a year later, in January 2013, Governor Mark Dayton established the Olmstead Subcabinet.[34] With representatives from nine state agencies, the subcabinet has several responsibilities. First, the subcabinet was to develop and implement Minnesota's *Olmstead Plan* in accordance with the Supreme Court decision in *Olmstead v. L.C.* The subcabinet successfully completed this task; in September 2015, the courts accepted the third draft of Minnesota's *Olmstead Plan*.[35] This document sets forth measurable goals to increase the number of people with disabilities receiving appropriate services in the most integrated settings possible.

The subcabinet has several other continuing responsibilities.[36] For example, it is to provide ongoing recommendations regarding the *Olmstead Plan* and how it may be improved. It must convene public meetings to discuss plan implementation. Also, the subcabinet must create a plan for developing quality of life measurements for people with disabilities.

More recently, a 2016 class-action lawsuit filed by the Minnesota Disability Law Center accuses DHS of violating the Olmstead ruling by forcing individuals with disabilities to live in segregated corporate foster homes, where they are cut off from mainstream society and deprived of basic autonomy.[37] The Department of Human Services has challenged the case for a number of reasons, including contending that statutes do not impose the standard of care or require the level of services the Plaintiffs request. As of December 2016, the case had not been heard.

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[31] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[32] Amended Class Action Complaint and Request for Injunctive Declaratory Relief, Demand for Jury Trial, *Jensen v. Minnesota Department of Human Services*, No. 09-CV-1775 (D. Minn. Jul. 30, 2009).

[33] Final Approval Order for Stipulated Class Action Settlement Agreement, *Jensen v. Minnesota Department of Human Services*, No. 09-1775 (D. Minn. Dec. 5, 2011).

[34] Mark Dayton, Executive Order 13-01, "Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Creation of Minnesota's Olmstead Plan," January 28, 2013.

[35] Olmstead Subcabinet, *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan* (St. Paul, June 2016).

[36] Mark Dayton, Executive Order 15-03, "Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Implementation of Minnesota's Olmstead Plan," January 28, 2015.

[37] Complaint, *Gordon v. Minnesota Department of Human Services*, No. 16-2623 (D. Minn. Aug. 3, 2016).

Other Programs

While our evaluation focused on HCBS provided through Minnesota's MA program, other state and federal programs may provide similar services to help people with disabilities live as independently as possible. This section highlights a few of those programs that, while focused on other groups of individuals with disabilities or low-income people in general, may also provide similar services to the same recipients with disabilities as MA.[38]

It is important to note that state agencies do not necessarily define a disability in the same manner as DHS. Some state agency programs, such as some of Minnesota Housing Finance Agency's mortgage programs, report participation rates for people with disabilities, but they identify people as having disabilities if the individuals say they do. Others agencies may require a doctor's assessment, while still others, such as DHS, may require certification by the Social Security Administration or a medical team convened by DHS. For example, certain benefits available to veterans with disabilities require that they have their conditions documented by their doctors, while regulations regarding certain housing supports for people with disabilities may not require review by a physician.

Although Medical Assistance pays for most HCBS, several other programs help low-income adults with disabilities live more independently.

Several programs provide cash and food assistance to people with disabilities. For example, Supplemental Security Income (SSI) and Social Security Disability Income (SSDI), both federal programs, provide recipients with basic incomes, which is an essential component for independent living. In Minnesota, SSI recipients may qualify for additional cash assistance through the Minnesota Supplemental Assistance Program, and MA recipients may qualify for food assistance through the Supplemental Nutrition Assistance Program. In a similar vein, the Minnesota Department of Veterans Affairs provides short-term financial assistance (for up to six months) to veterans unable to work due to temporary disabilities and those waiting to receive permanent disability benefits.

Various state and federal housing programs help people with disabilities live in their communities. For example, MA recipients with disabilities may qualify for Group Residential Housing, a state-funded program designed to help recipients pay for certain living expenses, such as room and board. In addition, people with disabilities who meet certain income requirements may qualify for Section 8 Housing Choice Vouchers. The vouchers provide federal subsidies that allow renters to pay reduced rents equivalent to a fixed portion of their incomes. The Minnesota Housing Finance Agency's Bridges Program provides subsidies through local housing organizations for temporary rental assistance and security deposits for people with serious mental illnesses. The Minnesota Housing Partnership administers the DHS-funded Crisis Housing Fund, which assists people receiving mental health or chemical health treatment with temporary rental, mortgage, and utility assistance. Finally, the Legislature funds the Housing Access Services program, which is administered by DHS, to help eligible people with disabilities locate suitable, affordable, and accessible housing.

[38] Appendix A provides more detail on state and federal programs that may serve MA recipients with disabilities.

Finally, several state programs address the educational and vocational needs of people with disabilities. The Minnesota Department of Education oversees special education services, including transitional programs for students with disabilities ages 18 to 21 to prepare them for integrated employment, independent living, community participation, and postsecondary education or training. The Department of Employment and Economic Development provides job counseling and placement services, training opportunities, and on-the-job supports to people with disabilities. In addition, the Minnesota departments of Veterans Affairs and Employment and Economic Development partner with one another to provide employment assistance to veterans with service-connected disabilities.

Minnesota and the Nation

By some measures, Minnesota compares well with other states in providing HCBS to low-income people with disabilities. At the same time, other measures suggest room for improvement. However, comparing states in terms of spending and outcomes is difficult for two major reasons. First, states have structured their HCBS programs differently, providing different services to different populations. Some states provide HCBS through managed care programs, so detailed spending for specific services may be unavailable. They may also categorize their spending differently. Second, states have taken different approaches to moving people with disabilities from institutions into community-based settings. Minnesota began this process, called deinstitutionalization, by closing most of its state hospitals and moving many people into smaller group home settings. However, evolving state and federal requirements have raised the standards for the settings in which people with disabilities live and work.

While Minnesota ranks high among states in spending for HCBS, it ranks lower in helping people with disabilities live or work in integrated settings.

Minnesota's spending on HCBS has grown over the last few years, and a large share of MA spending goes for HCBS. While Minnesota's growing HCBS spending reflects a nationwide trend, it has also devoted a far higher proportion of its MA spending to HCBS than the nation as a whole. According to a 2016 report compiling CMS data through Fiscal Year 2014, Minnesota spent nearly twice as much of its Medicaid expenditures on HCBS (31 percent) than the nation as a whole (17 percent).[39]

At 31 percent, Minnesota also spent a higher share of its Medicaid spending on HCBS than several other states, including Wisconsin (28 percent), Alaska (25 percent), Oregon (23 percent), Vermont (17 percent), and Washington (17 percent).[40] Furthermore, as shown in Exhibit 1.3, Minnesota ranked third nationally in terms of Fiscal Year 2014 HCBS expenditures per state resident ($571 per resident). Only New York and the District of Columbia spent more per resident ($651 and $637, respectively).

It is important to note that Minnesota's high spending levels for HCBS do not necessarily mean that Minnesota is "more successful" than lower spending states. Other measures suggest that Minnesota is lacking in two areas: housing and employment. In Minnesota, a relatively low proportion of people with disabilities live at home. About 44 percent of

[39] *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014* (Ann Arbor, MI: Truven Health Analytics, 2016), 33 and 201.

[40] *Ibid*., 201, 383, 47, 299, 355, and 369 (respectively).

people with intellectual or developmental disabilities live with their families or in their own homes in Minnesota.[41] This is much lower than the national average of 67 percent, as Exhibit 1.3 shows. While the goal is to have people living in the most integrated settings possible, Minnesota ranks 35th among 49 states and the District of Columbia.

In addition, Minnesota lags in the proportion of people with disabilities provided integrated employment services.[42] As shown in Exhibit 1.3, the state serves a very low proportion of people with intellectual and developmental disabilities (13 percent) with integrated employment services, ranking 34th among 45 states and the District of Columbia.

While Minnesota has relatively high employment rates among people with disabilities, data suggest that it has one of the more segregated workforces for people with disabilities in the country. A 2014 report shows that Minnesota places a high proportion of people receiving employment services in "facility-based work," commonly known as sheltered workshops.[43] This is a far higher percentage than most other states—only Ohio, Oklahoma, and South Dakota segregate a higher proportion of workers with developmental disabilities in sheltered workshops than Minnesota.[44] The majority of employees in these settings have disabilities, and employees—often referred to as clients—earn subminimum wages.

In October 2016, the U.S. Justice Department released guidance to state agencies providing employment services to people with disabilities, which could have legal ramifications for DHS. This guidance advised that "unnecessary segregation" of people with disabilities in sheltered workshops may represent a violation of the *Americans with Disabilities Act*.[45] In 2016, the Minnesota Department of Human Rights issued a charge of discrimination against a nonprofit organization that employs people with disabilities. According to the department, because the organization had a policy of not hiring people it served with supported employment services for permanent positions, it likely discriminated on the basis of disability.[46] The organization and the human rights department reached a settlement in November 2016.[47] As a result of the settlement, the company agreed to change its hiring policies to allow anyone who receives job supports or other services to be considered for regular employment.

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[41] Sheryl Larson, Libby Hallas-Muchow, Faythe Aiken, Brittany Taylor, Sandy Pettingell, Amy Hewitt, Mary Sowers, and Mary Lee Fay, *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2013* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2016).

[42] Competitive integrated employment is defined as work performed for paid wages consistent with those paid to people without disabilities; at least minimum wage; benefits-eligible; in an environment where people with disabilities can interact with people without disabilities; and with opportunities for advancement. See 29 *U.S. Code*, sec. 705 (2014).

[43] Institute for Community Inclusion, *StateData: The National Report on Employment Services and Outcomes* (Boston: University of Massachusetts, 2014), 21.

[44] Data from other states may include duplicate counts of individuals who are served in multiple settings. Minnesota's data, however, do not include duplicate counts.

[45] U.S. Department of Justice, *Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. to State and Local Governments' Employment Service Systems for Individuals with Disabilities* (Washington, DC, 2016).

[46] Minnesota Department of Human Rights, *Charge of Discrimination: Opportunity Partners* (St. Paul, April 2016).

[47] Chris Serres, "Minn. Nonprofit to Reform Hiring Practices in Major Disability Rights Settlement," *StarTribune*, November 21, 2016.

Exhibit 1.3: State Rankings on Selected Measures

State	Fiscal Year 2014 HCBS Expenditures per Capita	Percentage of People Living in Family or Own Home[a]	State Rank: Living in Family or Own Home	Percentage of People Receiving Integrated Employment Services[b]	State Rank: Integrated Employment Services
New York	$651	70%	13	13%	34
District of Columbia	637	35	42	12	38
Minnesota	**571**	**44**	**35**	**13**	**34**
Rhode Island	468	54	26	33	8
Alaska	446	47	32	26	17
Massachusetts	442	52	29	29	12
Vermont	421	58	22	38	6
Connecticut	407	32	47	49	3
Oregon	393	63	18	33	8
Maine	392	37	40	28	15
West Virginia	369	52	30	41	4
Wisconsin	364	69	15	21	22
New Mexico	335	34	44	33	8
Arkansas	335	42	37	–	–
Iowa	333	–	–	17	31
Ohio	322	82	4	21	22
North Dakota	314	70	14	–	–
Pennsylvania	297	60	20	18	26
New Hampshire	291	44	34	38	6
Missouri	284	73	10	12	38
Maryland	277	34	43	40	5
California	254	83	3	12	38
Washington	251	79	6	86	1
Montana	245	39	38	12	38
Delaware	232	58	21	29	12
New Jersey	230	56	25	11	42
Wyoming	227	53	27	18	26
Colorado	224	57	23	27	16
Nebraska	206	47	33	–	–
Kansas	198	33	46	13	34
Tennessee	198	70	12	19	25
Idaho	190	63	19	–	–
Louisiana	186	76	8	31	11
Virginia	186	18	50	24	18
Texas	182	32	48	8	43
North Carolina	176	68	16	22	21
South Dakota	173	52	3	18	26
Kentucky	172	32	49	18	26
Arizona	171	87	2	21	22
Illinois	167	38	3	6	44
Indiana	164	65	17	15	32
Oklahoma	153	56	2	62	2
Alabama	147	36	41	4	45

Continued on next page.

Exhibit 1.3: State Rankings on Selected Measures (continued)

State	Fiscal Year 2014 HCBS Expenditures per Capita	Percentage of People Living in Family or Own Home[a]	State Rank: Living in Family or Own Home	Percentage of People Receiving Integrated Employment Services[b]	State Rank: Integrated Employment Services
Mississippi	$137	34%	45	–	–
Hawaii	137	71	11	2%	46
South Carolina	125	75	9	29	12
Georgia	115	43	36	13	34
Michigan	105	82	5	23	19
Florida	99	78	7	14	33
Nevada	90	94	1	18	26
Utah	85	52	28	23	19
United States	257	67	–	19	–

[a] This percentage is based on people with intellectual or developmental disabilities with a reported living arrangement who received one or more funded long-term supports and services from the state's intellectual and developmental disability agency. In Minnesota this would be the Department of Human Services, Disability Services Division. Data reported through June 30, 2013.

[b] This percentage is based on people with intellectual or developmental disabilities who received say and employment services from the state's intellectual and developmental disability agency. It does not measure the number of people actually employed in integrated employment settings. Integrated employment takes place in a community setting and pays wages to the participant. It includes competitive employment, individual supported employment, group supported employment, and self-employment supports. Data reported for Fiscal Year 2013.

SOURCES: *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending* (Ann Arbor, MI: Truven Health Analytics, 2016), Table J; Sheryl Larson, Libby Hallas-Muchow, Faythe Aiken, Brittany Taylor, Sandy Pettingell, Amy Hewitt, Mary Sowers, and Mary Lee Fay, *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2013* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2016), 16 and 177; and Institute for Community Inclusion, *StateData: The National Report on Employment Services and Outcomes* (Boston: University of Massachusetts, 2014), 17 and 21.

Chapter 2: Cost and Use of Home- and Community-Based Services

Over the last several decades, Minnesota—and other states across the country—has been working to help low-income residents with disabilities live in their communities rather than institutions. Since the 1960s, Minnesota has made tremendous strides toward achieving this goal by closing most of its large institutions housing people with disabilities and moving them instead into small foster care homes. As discussed in Chapter 1, Minnesota spends more per capita on home- and community-based services (HCBS) than most other states. Other measures, however, suggest the state may not be doing enough to ensure that people with disabilities have sufficient opportunities to fully integrate into their communities.

This chapter looks at how much Minnesota spends to provide HCBS to Medical Assistance (MA) recipients with disabilities and the elderly.[1] We describe the specific HCBS they receive; the cost to deliver these services; and the businesses, agencies, and organizations providing the services.

Overall, we found that MA expenditures to provide HCBS to adult MA recipients with disabilities varied widely in Fiscal Year 2015. Much of the variation can be explained by the specific types and intensity of services recipients received. For those receiving HCBS through one of the state's five federal waivers, the majority of expenditures paid for supported living and foster home/assisted living services provided in residential settings.[2] For those served under the state MA plan, personal care attendant/home health aide services, generally provided in residential settings that are private homes, accounted for the largest share of costs.

Overall Expenditures

Although MA recipients may receive assistance from a variety of funding sources across several state and federal agencies, we focused our analysis on MA expenditures for HCBS provided in community settings.

It is difficult to put a comprehensive price tag on the home- and community-based services (HCBS) provided to Medical Assistance recipients with disabilities.

There are a variety of reasons for this. Most important, though, are the different financial reporting requirements and payment methods across or within the managed care or fee-for-

[1] Having a certified disability means that an individual has a physical or mental condition that significantly limits his or her ability to perform daily living activities such as dressing, eating, or walking. Further, the disabling condition must be expected to last continuously for at least 12 months or result in that person's death. For the sake of simplicity, whenever we refer to "individuals with disabilities served through the state MA plan" in this and subsequent chapters, we mean individuals with certified disabilities who may need HCBS.

[2] As we discussed in Chapter 1, Minnesota has four waivers that address HCBS for MA recipients with developmental disabilities, brain injuries, chronic health conditions, and physical and other disabling conditions. The state's fifth waiver covers elderly MA recipients who need the level of care provided in nursing homes.

service health plans that enroll MA recipients.[3] In addition, state and national laws, rules, and guidelines that have evolved over time to improve the lives of people with disabilities have become increasingly complex and confusing, which may make them more difficult to administer.

Our analysis focuses on a subset of HCBS recipients and costs: adults (18 years of age and over) at or below the poverty line with certified disabilities or who were enrolled in one of the state's five waivers and who received HCBS in Fiscal Year 2015. We define HCBS broadly to include services offered as part of the state's overall MA plan and through waivers.

It should be noted that this includes only some HCBS provided to MA recipients enrolled in managed care health plans. For example, our data include personal care attendants, nursing services, and nonemergency transportation for managed care health plan enrollees with certified disabilities who received HCBS through the state MA plan. Our data also include HCBS for managed care health plan enrollees who participated in four of the state's five waivers. With the exception of services provided through the elderly waiver, HCBS provided through waivers are paid for separately by the state on a fee-for-service basis, regardless of whether recipients are enrolled in a managed care or fee-for-service health plan. Most elderly MA recipients are enrolled in managed care health plans.[4] Our data capture only about 11 percent of HCBS expenditures through the elderly waiver. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations (MCOs) receive a capitated payment from DHS as part of their public healthcare contracts. Managed care organizations then pay for waiver services for the elderly themselves. Finally, our data capture all adult MA recipients with disabilities receiving HCBS through fee-for-service health plans.

We chiefly relied on two management information systems in DHS for our data: MAXIS and Medicaid Management Information System (MMIS).[5] We used these systems to identify MA recipients with disabilities and the providers that serve them, categorize the different types of HCBS available to them, and calculate the utilization and cost of providing those services. Medical Assistance expenditures for HCBS include federal, state, and county shares.[6]

For the most part, MA expenditures for HCBS are based on individual service rates established or approved by DHS—they do not necessarily reflect providers' costs or expenditures. The Department of Human Services' Disability Waiver Rate System

[3] Over the last several years, the state has been gradually moving more MA recipients, including the elderly and those with disabilities, to managed care as opposed to fee-for-service health plans. Under managed care health plans, managed care organizations (MCOs) provide healthcare for a flat rate, regardless of how many services recipients may receive. Under fee-for-service plans, enrollees can generally access any healthcare providers who have agreed to participate in MA. Participating providers submit bills to DHS, which in turn pays them. In Fiscal Year 2015, about 1 million individuals were eligible for MA each month. As of August 2016, about 814,000 recipients were enrolled in managed care plans and 236,000 in fee-for-service plans. Minnesota House of Representatives Research Department, *Medical Assistance: An Overview* (St. Paul, November 2016), 2.

[4] The Department of Human Services has two managed care health plans for MA recipients who are elderly: Minnesota Senior Care Plus and Minnesota Senior Health Options.

[5] Medical Assistance is funded by federal, state, and local governments and pays for the bulk of HCBS in Minnesota. MAXIS is a computer system used by state and county workers to determine eligibility for various public assistance and healthcare programs, including MA. The Medicaid Management Information System stores data on MA services and expenditures at the individual recipient level; HCBS providers submit payment claims to MMIS.

[6] As we discussed in Chapter 1, the federal government paid for about 57 percent of MA costs in 2015, the state 42 percent, and counties 1 percent.

calculates many payment rates for HCBS. Implemented in January 2014, the system is designed to provide consistent statewide methodologies for establishing payment rates for most HCBS.[7] However, the system is being phased in gradually, and payment rates for most HCBS providers will not be fully implemented until 2019 or 2020.

Medical Assistance expenditures to provide HCBS to adults with disabilities and the elderly were approximately $2.4 billion in Fiscal Year 2015.

As Exhibit 2.1 shows, 63,878 adult MA recipients with disabilities and the elderly received HCBS through MA in Fiscal Year 2015. The overall median cost for providing these services was $21,993 for Fiscal Year 2015. Partly because MA provides HCBS to a wide range of recipients with disabling conditions, average costs per recipient were substantially higher—$37,438.

Exhibit 2.1: Adult Medical Assistance Recipients with Disabilities Receiving Home- and Community-Based Services, Fiscal Year 2015

	Fiscal Year 2015			
Source of HCBS	Number of Recipients	Cost (in $1,000s)	Median Cost	Average Cost
State Medical Assistance plan	27,500	$ 357,110	$ 2,713	$ 12,986
Waiver				
Developmental disabilities	15,226	$1,128,639	$73,166	$ 74,126
Physical and other disabilities	19,642	717,619	24,213	36,535
Brain injuries	1,428	103,898	66,610	72,758
Elderly[a]	5,595	47,910	4,191	8,563
Chronic health conditions	214	36,315	158,554	169,696
Waiver Subtotal	41,959[b]	$2,034,381	35,116	48,485
Total	63,878[b]	$2,391,491	$21,993	$ 37,438

[a] These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015.

[b] These figures refer to the subtotal and total number of MA recipients receiving HCBS paid for by DHS for the fiscal year shown. Because some recipients received services through both the waiver and state plan or through more than one waiver during the year, the waiver subtotal and total do not equal the number of recipients served by individual waivers and the state plan.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota Department of Human Services.

State Plan Expenditures

As shown previously, nearly 64,000 adults with disabilities received at least one HCBS through MA in Fiscal Year 2015. Of these, 27,500 received HCBS through the state MA plan.

[7] We discuss DHS's rate payment system in greater detail in Chapter 3.

The median expenditure for HCBS for recipients with certified disabilities through the state Medical Assistance plan was $2,713 in Fiscal Year 2015.

Average per recipient spending for HCBS was much higher than median spending—$12,986 in Fiscal Year 2015. Both median and average HCBS expenditures on behalf of recipients through the state plan, though, were much lower than spending through waivers. State plan recipients generally do not need the level of care provided in long-term institutions, or they may be able to obtain the assistance they need from sources other than MA, such as family members or other caregivers. As we will see later in this chapter, state plan recipients tend to receive services in their own homes rather than foster homes. Finally, the state plan does not offer the full array of services available through waivers, nor does it always provide the same level of intensity or frequency of services.

Waiver Expenditures

For the most part, waivers are intended to serve populations that are more at risk than state plan recipients and whose needs cannot be met through state plan services alone. Not only must most waiver recipients be severely limited in their abilities to live independently, but they must also be at risk of institutionalization in hospitals, nursing homes, or intermediate care facilities for people with developmental disabilities if they do not receive HCBS.[8]

Most of the nearly 64,000 adults with disabilities who received HCBS in Fiscal Year 2015 did so through waivers, rather than the state Medical Assistance plan.

As shown in Exhibit 2.1, 41,959 MA recipients received HCBS through one of Minnesota's five waivers in Fiscal Year 2015. As discussed in Chapter 1, to be eligible for a waiver, MA recipients must generally be unable to engage in substantial activity by reason of any medically determined physical or mental impairment expected to last for a continuous period of at least 12 months; be diagnosed with a developmental disability; or be at least 65 years old. They must also be at risk of institutionalization if they do not receive HCBS.

Of the nearly 42,000 adults receiving HCBS through waivers in Fiscal Year 2015, 47 percent were enrolled in the waiver designed for people with physical or other disabilities, 36 percent in the waiver for those with developmental disabilities, 13 percent in the waiver for the elderly, and 3 percent in the waiver for those with brain injuries. About 1 percent was enrolled in the waiver for those with chronic health conditions.

Medical Assistance expenditures for HCBS for recipients through waivers varied widely, with annual median spending of $35,116 per person in Fiscal Year 2015.

The median annual cost to provide HCBS to recipients through waivers was considerably higher than the cost to provide HCBS through the state MA plan. Average costs per recipient were also higher—$48,485. Expenditures varied widely, however, across the individual waivers. For example, annual median costs per recipient in Fiscal Year 2015

[8] Intermediate care facilities are residential facilities licensed as health care institutions by the Minnesota Department of Health and certified by the federal government to provide health or rehabilitative services to persons with developmental disabilities who require active treatment.

ranged from a low of $4,191 for those receiving services through the elderly waiver to a high of $158,554 for those with chronic health conditions.[9] Annual median costs for the two waivers enrolling the largest number of adult MA recipients were $24,213 for those with physical and other disabling conditions (19,642 enrollees) and $73,166 for those with developmental disabilities (15,226 enrollees).

Expenditures by Type of Service

As we have discussed, HCBS are designed to help recipients live as independently as possible in the community.[10] In this section, we first examine the specific types of HCBS that accounted for the bulk of total expenditures, regardless of whether those services were provided through the state MA plan or waivers. We then examine expenditures for specific types of services provided through the state plan and each individual waiver.

We grouped the various types of HCBS available to eligible MA recipients into the categories shown in Exhibit 2.2.[11] Classifying the different types of services identified as HCBS is difficult for a variety of reasons. First, DHS sometimes uses different terms to describe similar services. For example, although DHS makes distinctions among personal care attendants and home health aides, the services they perform overlap considerably. Department documents say that personal care attendants and home health aides can help clients perform daily living activities, such as eating, toileting, grooming, dressing, and mobility, among others.[12] Both types of workers can also perform various health-related tasks, such as changing wound dressings.

Likewise, services classified as "foster home" and "supported living" involve some similar tasks. The former is aimed at *providing* basic services, such as helping with dressing, walking, and eating, while the latter also tries to *teach* recipients to do the tasks themselves. Foster home and supported living are both performed in residential settings. While foster care is only provided in foster homes, supported living may be provided in recipients' own homes or in foster homes. When recipients with developmental disabilities live in foster homes, the HCBS services they receive in those homes is not called foster care, but rather supported living (also referred to as residential habilitation). Personal care attendants/home health aides generally perform some of the same types of services (helping with daily living skills) for those with other types of disabilities in recipients' own homes. Services aimed at helping people with developmental disabilities develop and maintain living skills that are provided in nonresidential settings (that is, separate from a person's own home or foster home) are called day training and habilitation.

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[9] As we explained in Exhibit 2.1, our data capture only a small portion of HCBS expenditures through the elderly waiver.

[10] MAXIS and MMIS do not provide definitive information on where HCBS recipients lived at the time of service (that is, in their own homes, family homes, foster care homes, or other regulated settings). When HCBS providers submit payment claims, they are given a variety of residence options to check (including other) that are not mutually exclusive. Consequently, we do not provide data on recipients' living arrangements.

[11] Home- and community-based services are provided in a variety of settings that generally exclude institutions such as nursing homes, hospitals, and intermediate care facilities. Furthermore, as we discussed in Chapter 1, CMS regulations that become effective in 2019 require that sites where HCBS are provided through waivers be "noninstitutional" in nature. However, some transitional HCBS may be provided to MA recipients living in institutions, with the goal being to move the recipients into community settings.

[12] Minnesota Department of Human Services, *Personal Care Assistance Fact Sheet* (St. Paul, undated); and Minnesota Department of Human Services, *Provider Manual: Home Health Aide Services* (St. Paul, revised September 26, 2012).

Exhibit 2.2: Home- and Community-Based Services Available to Adult Medical Assistance Recipients with Disabilities and the Elderly

Type of Service	Description
Adult day services	Various support and leisure services provided to recipients in licensed day facilities
Behavioral therapy/education	Specific interventions designed to decrease severe maladaptive behavior
Case management/home assessments/ transition services	Activities aimed at coordinating recipients' services, including activities to help move them from one setting to another
Companion/peer/night supervision services	Nonmedical care, assistance, supervision, and socialization
Consumer directed community supports	Services that help recipients take more responsibility for arranging and managing their own services
Crisis intervention	Short-term medical and behavioral care and intervention strategies to alleviate stress
Day training and habilitation	Services to help recipients acquire, retain, and improve the skills needed for community living; generally provided in non-residential settings
Emergency response systems/technology	Devices, such as remote sensors, to improve recipients' physical safety by alerting caregivers about recipients' movements
Financial management	Services to assist recipients manage their own services, such as budgeting and payroll
Foster home/assisted living	Regular supportive services provided in licensed or regulated residential settings
Home care training	Training and consultation to family and non-family caregivers to support participants' placement in the community
Homemaker services/meals/chores	General household activities, such as cleaning, meal preparation, and yard maintenance
Home/vehicle modifications	Modifications made to homes or cars to help individuals maintain their independence
Medical supplies/equipment	Supplies or devices that improve recipients' physical health or safety, such as automatic pill dispensers, respiratory equipment, and wheelchairs, among others
Nonemergency transportation	Individual assistance getting to or from community settings, including reimbursement for mileage, taxis, or bus fares
Nursing services	Services provided by licensed or certified health specialists, such as nurses, speech therapists, or occupational therapy assistants; does not include home health aides
Personal care attendant/home health aide services	Wide range of direct care services provided in individuals' own homes to help them live independently
Prevocational training/supported employment/education	Services to help individuals obtain and keep employment, regardless of the wage level
Relocation support	Services to help recipients move from institutional living to a community setting (also referred to as Moving Home Minnesota)
Respite/crisis respite	Services provided on a short-term basis to provide relief to regular caregivers
Speech/physical/occupational/respiratory/ activity therapy	Specific therapeutic services provided in recipients' homes to improve their functioning
Supported living (residential habilitation)	Services to help recipients acquire, retain, and improve the skills needed for community living; generally provided in residential settings

NOTE: Not all services may be available to all recipients with disabilities or the elderly.

SOURCE: Office of the Legislative Auditor, analyses of Minnesota statutes and documents from the Department of Human Services.

Simply having a service available, however, does not mean that an individual with a disability is entitled to receive that service. Managed care organizations, tribal governments, or county human services agencies must first determine that eligible recipients need particular services before they authorize provision of those services.

A little more than half of Medical Assistance expenditures for HCBS in Fiscal Year 2015 were for supported living and foster home/assisted living services.

Exhibit 2.3 shows MA expenditures for specific HCBS for MA recipients with disabilities in Fiscal Year 2015. Overall, supported living services—provided to recipients with developmental disabilities in residential settings—accounted for the largest share of total MA expenditures—31 percent. As discussed earlier, these services focus on both *providing* and

Exhibit 2.3: Cost of Home- and Community-Based Services by Type of Service, Fiscal Year 2015

Type of Service	Number of Recipients		Cost	Percentage of Total Cost
	State Plan	Waivers		
Supported living (residential habilitation)	0	10,668	$ 742,525,000	31%
Foster home/assisted living	0	12,579	536,874,000	22
Personal care attendant/home health aide services	13,811	8,407	462,208,000	19
Day training and habilitation	0	10,850	183,053,000	8
Nursing services	7,015	3,524	77,190,000	3
Consumer directed community supports	0	2,131	71,280,000	3
Case management/home assessments/transition services	84	40,777	70,394,000	3
Companion/peer/night supervision services	196	1,801	47,407,000	2
Speech/physical/occupational/respiratory/activity therapy	896	5,956	46,849,000	2
Prevocational habilitation/supported employment/education	0	4,611	35,516,000	1
Homemaker services/home delivered meals/chores	0	9,335	25,109,000	1
Respite/crisis respite	0	2,650	24,828,000	1
Nonemergency transportation	10,986	16,361	23,881,000	1
Adult day services	0	2,112	17,139,000	1
Crisis intervention	3	877	9,304,000	<1
Home/vehicle modifications	0	1,367	8,014,000	<1
Behavioral therapy/education	0	579	5,375,000	<1
Medical supplies/equipment	161	4,570	2,296,000	<1
Emergency response systems/technology	1	4,075	1,546,000	<1
Relocation support	4,323	0	402,000	<1
Home care training	0	82	260,000	<1
Financial management	0	324	42,000	<1
Total	27,500[a]	41,959[a]	$2,391,491,000	100%

NOTES: These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015. Percentages and totals may not sum to the totals shown due to rounding.

[a] These figures refer to the total number of MA recipients receiving HCBS paid for by DHS. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

teaching recipients to perform daily activities (for example, eating, dressing, and moving about). Medical Assistance expenditures for foster home/assisted living services—similar services provided largely to people with other types of disabilities in regulated residential settings—accounted for 22 percent of HCBS expenditures. Services provided largely to recipients in their own homes by personal care attendants/home health aides comprised 19 percent, and day training and habilitation accounted for 8 percent of expenditures. All other types of services, including more medical-related services such as nursing and therapeutic services, each comprised 3 percent or less of total MA spending on HCBS.

State Plan Expenditures by Service

Medical Assistance recipients with certified disabilities who receive HCBS through the state MA plan do not have access to the full array or intensity of HCBS described in Exhibit 2.2. For example, the state does not use MA to provide vocational services to this group. Exhibit 2.4 shows the specific HCBS that MA recipients with certified disabilities received through the state MA plan in Fiscal Year 2015.

Exhibit 2.4: Costs of Home- and Community-Based Services through the State Medical Assistance Plan to Adults with Certified Disabilities, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Personal care attendant/home health aide services	13,811	$298,698,000	84%	$21,628
Nursing services	7,015	47,471,000	13	6,767
Nonemergency transportation	10,986	8,884,000	2	809
Speech/physical/occupational/respiratory therapy	896	1,280,000	<1	1,428
Relocation support	4,323	402,000	<1	93
Companion/peer/night supervision services	196	298,000	<1	1,518
Medical supplies/equipment	161	43,000	<1	268
Case management/home assessments/ transition services	84	35,000	<1	412
Crisis intervention	3	<1,000	<1	184
Emergency response systems/technology	1	<1,000	<1	155
Total	27,500[a]	$357,110,000	100%	$12,986

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of MA recipients receiving HCBS through the state Medical Assistance plan. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Personal care attendant/home health aide services accounted for 84 percent of the cost of HCBS for adults with certified disabilities through the state Medical Assistance plan in Fiscal Year 2015.

Personal care attendant/home health aide services accounted for the majority of HCBS spending under the state plan—84 percent, while licensed nurses accounted for 13 percent. Most of the remaining costs involved transportation and various types of therapies, although each comprised only a small share of costs—2 percent or less.

HCBS through the State MA Plan, Fiscal Year 2015

Total MA Expenditures	$357,110,000
Number of Recipients	27,500
Median Cost	$2,713
Average Cost	$12,986

While average costs to provide HCBS to MA recipients through the state plan are relatively low in comparison to waiver costs, annual per recipient costs varied widely—ranging from less than $100 to a high of $372,000. To examine the factors explaining the wide variation, we looked at the specific services recipients received by quintile—for example, the services provided to the 20 percent of recipients incurring the highest costs. At the high end, recipients typically incurred significantly more costs for nurses and less for personal care attendants than did recipients in lower-cost quintiles. At the most extreme end, 85 percent ($316,600) of the total costs incurred by one individual ($372,000) was for nurses, while 6 percent ($21,800) was for personal care attendants. In comparison, for recipients in the middle cost quintile (40th to 60th percentile), most costs incurred were for personal care attendants.

Waiver Expenditures by Service

The type and extent of HCBS provided to MA recipients through the state's five waivers varied considerably across the individual waivers. Below we discuss specific service costs incurred under each waiver, starting with the waiver that accounted for the largest share of MA expenditures in Fiscal Year 2015: the developmental disabilities waiver.

Developmental Disabilities Waiver

As discussed earlier, Minnesota's waiver for MA recipients with developmental disabilities served about 15,000 recipients in Fiscal Year 2015. Exhibit 2.5 shows the specific HCBS provided to them along with the average cost for each type of service.

Medical Assistance expenditures to provide HCBS through the developmental disabilities waiver totaled about $1.1 billion in Fiscal Year 2015, most of which paid for supported living and day training and habilitation services.

As shown, nearly all of the 15,226 MA recipients enrolled in the developmental disability waiver received services to help them live independently—at an average cost of $69,603 for supported living services and $17,170 for day training and habilitation services per recipient. All other HCBS each made up 4 percent or less of total expenditures, the most significant of which were consumer

HCBS through the Developmental Disabilities Waiver, Fiscal Year 2015

Total MA Expenditures	$1,128,639,000
Number of Recipients	15,226
Median Cost	$73,166
Average Cost	$74,126

directed community supports, companion/peer/night supervision services, and personal care attendant/home health aide services.

While the same types of services were often provided to most of the recipients in the developmental disabilities waiver, they were provided in varying degrees of frequency. For example, recipients at the lowest cost quintile (20th percentile and below) had individual costs ranging from less than $100 to slightly more than $35,000 in Fiscal Year 2015.[13] These recipients tended to incur most of their costs for day training and habilitation services.

At the high end of the scale (80th cost percentile and above), recipients received the same set of services, but costs to do so were more than $104,000 per individual. At the most extreme, MA expenditures to provide HCBS to one individual with developmental disabilities came to about $1.1 million in 2015, with almost all costs allocated to supported living services. Eight other recipients with developmental disabilities each received waiver services costing MA more than $500,000 per recipient. Together, MA expenditures for these nine MA recipients came to $6.1 million in Fiscal Year 2015. For the most part, these individuals were all relatively young (between the ages of 22 and 35), with complex health needs generally involving multiple disabling conditions.

Exhibit 2.5: Costs of Home- and Community-Based Services through the Developmental Disabilities Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Supported living (residential habilitation)	10,668	$ 742,525,000	66%	$69,603
Day training and habilitation	10,308	176,993,000	16	17,170
Consumer directed community supports	1,258	49,415,000	4	39,281
Companion/peer/night supervision services	1,588	46,437,000	4	29,242
Personal care attendant/home health aide services	2,398	40,922,000	4	17,065
Case management/home assessments/transition services	14,900	26,907,000	2	1,806
Respite/crisis respite	2,305	22,243,000	2	9,650
Prevocational/supported employment/education	1,328	7,683,000	1	5,785
Nonemergency transportation	8,099	5,718,000	1	706
Adult day services	345	4,663,000	<1	13,515
Crisis intervention	161	2,064,000	<1	12,821
Home/vehicle modifications	235	1,581,000	<1	6,726
Homemaker services/meals/chores	341	685,000	<1	2,009
Nursing services	127	533,000	<1	4,195
Medical supplies/equipment	158	120,000	<1	757
Emergency response systems/technology	101	78,000	<1	774
Home care training	35	57,000	<1	1,627
Financial management	222	16,000	<1	72
Total	15,226[a]	$1,128,639,000	100%	$74,125

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

[13] Waiver recipients at the very low end of the quintile may not have received HCBS for the entire year or may not have been enrolled in MA for the entire year.

Physical and Other Disabling Conditions Waiver

Exhibit 2.6 shows the specific services MA recipients received through the waiver for those with physical and other disabilities in Fiscal Year 2015. This waiver can cover a broad range of disabling conditions, including conditions such as multiple sclerosis, spinal cord injuries, and mental illness.

Foster home/assisted living and personal care/home health aide services accounted for almost three-fourths of the cost to provide HCBS through the physical and other disabilities waiver in Fiscal Year 2015.

Exhibit 2.6: Costs of Home- and Community-Based Services through the Physical and Other Disabling Conditions Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	7,642	$416,029,000	58%	$54,440
Personal care attendant/home health aide services	5,116	110,923,000	15	21,682
Speech/physical/occupational/respiratory/activity therapy	5,573	42,047,000	6	7,545
Case management/home assessments/transition services	19,370	35,473,000	5	1,831
Prevocational/supported employment/education	3,281	27,826,000	4	8,481
Homemaker services/meals/chores	7,728	22,176,000	3	2,870
Consumer directed community supports	718	14,678,000	2	20,443
Adult day services	1,524	11,319,000	2	7,427
Nursing services	2,516	8,735,000	1	3,472
Nonemergency transportation	7,385	8,200,000	1	1,110
Crisis intervention	656	6,570,000	1	10,015
Home/vehicle modifications	1,011	5,652,000	1	5,590
Respite/crisis respite	290	2,087,000	<1	7,197
Behavioral therapy/education	244	2,046,000	<1	8,386
Medical supplies/equipment	3,483	1,814,000	<1	521
Emergency response systems/technology	3,299	1,324,000	<1	401
Companion/peer/night supervision services	156	533,000	<1	3,414
Home care training	39	184,000	<1	4,712
Financial management	58	3,000	<1	46
Total	19,642[a]	$717,619,000	100%	$36,535

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Departments of Human Services.

As Exhibit 2.6 shows, of the 19,642 MA recipients receiving HCBS through this waiver, 7,642 recipients (39 percent) received foster home/assisted living services. These costs—about $416 million—accounted for 58 percent of MA expenditures for this group, averaging about $54,000 per recipient. Another 5,116 recipients (26 percent) received personal care attendant/home health aide services, which accounted for 15 percent of total expenditures ($111 million). These costs averaged $21,682 per recipient.

HCBS through the Physical Disabilities and Other Conditions Waiver, Fiscal Year 2015

Total MA Expenditures	$717,619,000
Number of Recipients	19,642
Median Cost	$24,213
Average Cost	$36,535

As with the other waivers, services and costs varied widely. Waiver recipients at the more costly end of the spectrum tended to receive more foster home services in licensed settings and less personal care services in unlicensed settings. For example, the individual most costly to serve under this waiver in Fiscal Year 2015 incurred practically all of his or her total cost of $406,479 for residential care services. Recipients less costly to serve tended to receive more services from personal care attendants as well as various homemaker services, such as housekeeping and meal preparation—services largely provided in private residences.

Brain Injuries Waiver

As shown in Exhibit 2.7, 1,428 MA recipients with brain injuries received waiver services in Fiscal Year 2015. Brain injuries can be the result of physical injuries from sport-related concussions, car accidents, or military combat. Common symptoms can include anger, memory loss, or depression.

Almost three-fourths of Medical Assistance expenditures to provide HCBS through the brain injuries waiver were for foster home/assisted living services in Fiscal Year 2015.

The most significant cost driver for MA recipients with brain injuries was for services provided in licensed residential settings—generally foster homes, which cost $77 million in Fiscal Year 2015. A large number of recipients (542) also received day training and habilitation services. These services totaled about $6.1 million and averaged $11,181 per recipient. Fewer recipients (138) received personal care/home health aide services.

Services and costs varied widely within the brain injury waiver—from less than $1,000 dollars to a little more than half a million dollars per recipient. Waiver recipients in the top cost quintile (80th to 100th percentile) incurred most of their costs for foster home services. Per recipient costs to provide HCBS to these individuals generally fell between $117,000 and $518,000. At the low end (0 to 20th percentile), costs ranged from less than $1,000 to slightly more than $22,000 per recipient. These individuals generally received a wider variety of services, including assisted living, activity therapy, personal care attendants, homemaking services, and meal delivery.[14]

HCBS through the Brain Injuries Waiver, Fiscal Year 2015

Total MA Expenditures	$103,898,000
Number of Recipients	1,428
Median Cost	$66,610
Average Cost	$72,758

[14] The Department of Human Services' glossary of terms and acronyms does not define activity therapy.

Exhibit 2.7: Costs of Home- and Community-Based Services through the Brain Injuries Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	964	$ 77,066,000	74%	$79,944
Day training and habilitation	542	6,060,000	6	11,181
Personal care attendant/home health aide services	138	3,938,000	4	28,539
Case management/home assessments/transition services	1,417	3,608,000	3	2,546
Speech/physical/occupational/respiratory/activity therapy	379	3,377,000	3	8,911
Behavioral therapy/education	334	3,328,000	3	9,964
Consumer directed community supports	56	2,034,000	2	36,325
Nonemergency transportation	633	986,000	1	1,558
Adult day services	124	883,000	1	7,124
Homemaker services/meals/chores	227	691,000	1	3,043
Crisis intervention	60	669,000	1	11,153
Nursing services	100	453,000	<1	4,527
Respite/crisis respite	31	379,000	<1	12,226
Home/vehicle modifications	41	163,000	<1	3,986
Companion/peer/night supervision services	13	129,000	<1	9,924
Medical supplies/equipment	142	86,000	<1	603
Emergency response systems/technology	65	28,000	<1	437
Home care training	8	19,000	<1	2,406
Financial management	6	<1,000	<1	46
Total	1,428[a]	$103,898,000	100%	$72,758

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Elderly Waiver

As shown in Exhibit 2.8, 5,595 MA recipients received HCBS through the elderly waiver in Fiscal Year 2015, at an average cost of $8,563 per recipient.[15]

Services provided in foster home/assisted living settings accounted for about three-fourths of Medical Assistance expenditures to provide HCBS through the elderly waiver in Fiscal Year 2015.

Medical Assistance costs to provide services in regulated facilities (either foster home or assisted living settings) totaled about $36.2 million in Fiscal Year 2015 and averaged $9,212 per recipient. The next largest category of expenditures was for personal care attendant/home health aide services, which totaled about $4 million, for an average of $6,011 per recipient.

[15] Our expenditure data do not capture all HCBS provided to elderly MA recipients who were enrolled in managed care health plans in Fiscal Year 2015.

As with the other waivers, services and costs varied widely. Waiver recipients at the 80th to 100th percentile of spending incurred most of their costs for assisted living services. Per recipient costs to provide HCBS to these recipients ranged from about $15,000 to nearly $60,000. At the lowest cost quintile, per person costs were less than $1,200 per recipient. The most costly HCBS provided to these recipients involved case management and assisted living services. Similarly, the most costly services provided to recipients in highest cost quintile involved assisted living, personal care attendants, and case management services.

HCBS through the Elderly Waiver, Fiscal Year 2015	
Total MA Expenditures	$47,910,000
Number of Recipients	5,595
Median Cost	$4,191
Average Cost	$8,563

Exhibit 2.8: Costs of Home- and Community-Based Services through the Elderly Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	3,929	$36,194,000	76%	$9,212
Personal care attendant/home health aide services	671	4,034,000	8	6,011
Case management/home assessments/transition services	4,878	3,961,000	8	812
Homemaker services/meals/chores	1,009	1,476,000	3	1,463
Nursing services	639	1,137,000	2	1,779
Consumer directed community supports	47	314,000	1	6,678
Adult day services	119	274,000	1	2,302
Medical supplies/equipment	732	182,000	<1	249
Emergency response systems/technology	600	113,000	<1	188
Nonemergency transportation	239	90,000	<1	378
Home/vehicle modifications	38	75,000	<1	1,971
Respite/crisis respite	20	26,000	<1	1,301
Financial management	35	23,000	<1	666
Companion/peer/night supervision services	44	11,000	<1	248
Total	5,595[a]	$47,910,000	100%	$8,563

NOTES: These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015. Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of MA recipients who are enrolled in fee-for-service plans and receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

As noted in Exhibit 2.8, our data capture only about 11 percent of HCBS expenditures through the elderly waiver in Fiscal Year 2015. Most elderly MA recipients are enrolled in one of two managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs receive a capitated payment from DHS as part of their public healthcare contracts. Managed care organizations then pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient) in Fiscal Year 2015. About 40 percent of these costs were for various health-related and support

services provided to recipients living in certain types of regulated residential settings, and 29 percent were for personal care attendant/home health aide services generally provided in recipients' own homes.

Chronic Health Conditions Waiver

As discussed in Chapter 1, MA waiver recipients with chronic illnesses or who are medically fragile may have a broad array of disabling conditions, such as congestive heart failure, chronic kidney disease, or lung cancer. Exhibit 2.9 shows the specific services received by adult MA recipients through this waiver in Fiscal Year 2015.

Nursing services accounted for slightly more than half of Medical Assistance expenditures to provide HCBS through the chronic health conditions waiver in Fiscal Year 2015.

Exhibit 2.9: Costs of Home- and Community-Based Services through the Chronic Health Conditions Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Nursing services	142	$18,862,000	52%	$132,829
Foster home/assisted living	44	7,585,000	21	172,397
Consumer directed community supports	52	4,838,000	13	93,041
Personal care attendant/home health aide services	84	3,693,000	10	43,961
Home/vehicle modifications	42	543,000	1	12,926
Case management/home assessments/transition services	212	410,000	1	1,934
Speech/physical/occupational/respiratory/activity therapy	4	146,000	<1	36,386
Respite/crisis respite	4	93,000	<1	23,315
Homemaker services/meals/chores	30	81,000	<1	2,694
Medical supplies/equipment	55	51,000	<1	920
Prevocational/employment support/education	2	7,000	<1	3,358
Emergency response systems/technology	10	4,000	<1	362
Nonemergency transportation	5	2,000	<1	415
Behavioral therapy/education	1	1,000	<1	1,327
Financial management	3	<1,000	<1	58
Total	214[a]	$36,315,000	100%	$169,696

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

While average expenditures were $169,696 per recipient, individual recipient costs ranged from less than $500 to nearly $450,000 in Fiscal Year 2015. Almost two-thirds of the 214 recipients receiving HCBS through this waiver received nursing services in 2015 at a total cost of $18.9 million. Although a high-cost item on a per person basis, relatively few recipients (44 recipients or 21 percent) received foster home/assisted living services, which made up 21 percent of total costs and averaged $172,397 per recipient. Nearly one-fourth of waiver recipients received consumer directed community supports, at an average cost of $93,041 per recipient. (As explained in Exhibit 2.2, this service helps recipients take more responsibility for managing their own services.)

HCBS through the Chronic Health Conditions Waiver, Fiscal Year 2015

Total MA Expenditures	$36,315,000
Number of Recipients	214
Median Cost	$158,554
Average Cost	$169,696

Related Services from Other Sources of Funding

In addition to HCBS reimbursed by DHS through MA, we looked at expenditures for similar or complimentary services from two other funding sources: (1) Group Residential Housing, a state-funded program in DHS designed to help low-income Minnesotans pay certain living expenses that MA does not cover, such as room and board; and (2) Vocational Rehabilitation Services, a jobs program for people with disabilities funded through the Minnesota Department of Employment and Economic Development (DEED) and the federal government.

For the most part, DHS sets the housing rate using a federal and state standard of what an individual needs, at a minimum, to live in the community. As of July 1, 2015, the rate was $891 per month.[16]

Expenditures for related services from some non-Medical Assistance sources for adult Medical Assistance recipients with certified disabilities or enrolled in waivers came to $41.4 million in Fiscal Year 2015.

As shown in Exhibit 2.10, 13,271 MA recipients (21 percent of total HCBS recipients) were served by DHS's Group Residential Housing program in Fiscal Year 2015, and 1,003 (2 percent) were served by DEED's Vocational Rehabilitation Services program. The housing program spent $38.7 million on MA recipients receiving HCBS through MA in 2015, while the Vocational Rehabilitation Services program contributed $2.7 million. Expenditures for DEED's jobs program reflect costs the department pays outside contractors to serve people with disabilities. They do not include costs incurred when its own staff provide the same types of services.

Of the 13,271 MA recipients receiving Group Residential Housing assistance in Fiscal Year 2015, about 12,000 (90 percent) received HCBS through waivers. Half of them (about 6,000) received HCBS through the developmental disability waiver and about 5,000 through the waiver for recipients with physical and other disabling conditions.

[16] In some cases, for example, when group residential housing recipients do not receive HCBS through waivers, DHS may supplement this amount with an additional $483. Supplemental services include, but are not limited to: oversight and up to 24-hour supervision; medication reminders; assistance with transportation; and setting up various meetings and appointments.

Exhibit 2.10: Selected Non-Medical Assistance Expenditures for Related Services to Medical Assistance Recipients Receiving Home- and Community-Based Services, Fiscal Year 2015

	Fiscal Year 2015			
	Number of MA Recipients[a]	Cost (in $1,000s)	Median Cost	Average Cost
Group Residential Housing	13,271	$38,657	$2,940	$2,913
Vocational Rehabilitation Services	1,003	2,726	2,076	2,718
Total	14,018	$41,382	$2,940	$2,952

[a] These figures refer to the total number of MA recipients with certified disabilities receiving HCBS for the fiscal year shown that also received HCBS through the Department of Human Services' Group Residential Housing program or the Department of Employment and Economic Development's Vocational Rehabilitation Services program. The figures do not sum to the total shown because some recipients received both housing and vocational rehabilitation services.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota departments of Employment and Economic Development and Human Services.

About 1,000 MA recipients who received HCBS in Fiscal Year 2015 also received vocational rehabilitation services from DEED. Vocational services help recipients seek and maintain employment. Department of Employment and Economic Development expenditures totaled about $2.7 million in 2015. Most of the MA recipients that DEED served received HCBS from DHS through the waiver for individuals with a physical or other disabling conditions (516) or developmental disabilities (154).

Although both the departments of Employment and Economic Development and Human Services provide vocational services to Medical Assistance recipients with disabilities, there is little overlap in clients served.

Because both DEED and DHS provide vocational services, we looked at the extent to which the two departments provided job-related services to the same clientele. Available to all waiver recipients but the elderly, relatively few recipients received vocational services from DHS through MA. As we showed earlier in Exhibit 2.3, 1 percent of MA expenditures was spent on job-related activities for 4,611 recipients in Fiscal Year 2015. Overall, only 117 of DEED's clients received similar services from DHS in 2015 (about 3 percent).

Payments to Providers

Each year, DHS pays a wide variety of organizations, businesses, and public agencies for providing HCBS to MA recipients with disabilities through the MA program. Providers include county social services agencies, home health agencies, corporations providing a variety of foster care and other services, personal care attendants, transportation companies, restaurants, and yard service companies, among others.

In Fiscal Year 2015, over 4,000 organizations, mostly for-profit businesses, received about $2.4 billion from Medical Assistance for providing HCBS to adults with certified disabilities and waiver recipients.

As Exhibit 2.11 shows, for-profit businesses represented the majority of providers of HCBS for MA recipients with disabilities in Fiscal Year 2015. They accounted for 66 percent of all providers receiving payments (2,661), and they received 65 percent of the total payments in Fiscal Year 2015 ($1.6 billion). In comparison, nonprofit organizations accounted for 25 percent of HCBS providers, and their payments came to 29 percent of total costs ($703 million in Fiscal Year 2015). Public agencies—often county social services departments that provide individual case management to waiver recipients—comprised about 8 percent of providers and 6 percent of payments.

Exhibit 2.11: Providers of Home- and Community-Based Services to Adult Medical Assistance Recipients with Disabilities, Fiscal Year 2015

	Fiscal Year 2015		
Type of Provider	Number	Recipients Served	Payments (in $1,000s)[a]
For profit	2,661	50,324	$1,554,369
Nonprofit	1,027	35,440	702,808
Public	321	38,515	132,150
Other	69	419	2,164
Total	4,062[b]		$2,391,491

[a] Payments refer to the amount the Department of Human Services (DHS) paid providers through the Medical Assistance (MA) program for services delivered. These data do not include payments made to providers serving managed care enrollees who received HCBS through the elderly waiver. Most elderly MA recipients are enrolled in managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million in Fiscal Year 2015.

[b] In the Medicaid Management Information System, 16 providers had multiple identification numbers reflecting different types of ownership for Fiscal Year 2015. Consequently, the total shown does not equal the sum of provider types.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota Department of Human Services.

Nearly half of all providers (44 percent) delivered foster home/assisted living services in residential facilities, as shown in Exhibit 2.12. Seventeen percent of all providers delivered supported living services to MA recipients with developmental disabilities. These two services made up about 53 percent of Fiscal Year 2015 payments to providers. Finally, 20 percent and 5 percent of all providers delivered personal care attendant/home health aide and day training and habilitation services, respectively.

In Fiscal Year 2015, 10 percent of all providers accounted for 70 percent of total Medical Assistance payments for HCBS.

Exhibit 2.12: Payments to Providers for Specific Home- and Community-Based Services, Fiscal Year 2015

Type of Service	Number of Providers	Percentage of Providers	Payments[a]	Percentage of Payments
Supported living (residential habilitation)	701	17%	$ 742,525,000	31%
Foster home/assisted living	1,799	44	536,874,000	22
Personal care attendant/home health aide services	814	20	462,208,000	19
Day training and habilitation	215	5	179,723,000	8
Nursing services	319	8	77,190,000	3
Consumer directed community supports	13	<1	71,280,000	3
Case management/home assessments/transition services	194	5	70,394,000	3
Companion/peer/night supervision services	178	4	47,407,000	2
Speech/physical/occupational/respiratory/activity therapy	322	8	46,849,000	2
Prevocational training/supported employment/education	258	6	38,845,000	2
Homemaker services/meals/chores	583	14	25,109,000	1
Respite/crisis respite	403	10	24,828,000	1
Nonemergency transportation	568	14	23,881,000	1
Adult day services	147	4	17,139,000	1
Crisis intervention	52	1	9,304,000	<1
Home/vehicle modifications	140	3	8,014,000	<1
Behavioral therapy/education	29	1	5,375,000	<1
Medical supplies/equipment	178	4	2,296,000	<1
Emergency response systems/technology	93	2	1,546,000	<1
Relocation support	77	2	402,000	<1
Home care training	28	1	260,000	<1
Financial management	24	1	42,000	<1
Total	4,062[b]		$2,391,491,000	100%

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] Payments refer to the amount the Department of Human Services (DHS) paid providers through the Medical Assistance (MA) program for HCBS. These data do not include payments made to providers serving managed care enrollees who received HCBS through the elderly waiver. Most elderly MA recipients are enrolled in managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of $400.5 million in Fiscal Year 2015.

[b] This figure refers to the total number of providers. Because they typically provide more than one type of service, the total does not equal the number of providers delivering individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Service.

The amount each provider was paid varied widely, from a few dollars to millions of dollars. In fact, ten providers (about 0.25 percent of all HCBS providers) accounted for about 14 percent of expenditures, each receiving from $16.5 million to $142.4 million in payments in Fiscal Year 2015. As Exhibit 2.13 shows, the ten providers generating the most in MA payments generally provided a wide range of services, including foster home/assisted living and supported living services.

For the most part, MA recipients—especially those receiving services through waivers—are often served by more than one provider, and typically more than one type of service provider. For example, MA recipients receiving HCBS through the waiver for those with physical and other disabling conditions generally can receive case management services from their home county (or their agent) and foster home services from another type of

organization. If they live in their own homes, they may receive personal care services to help in dressing or moving about from other service providers. Of the nearly 64,000 MA recipients receiving HCBS in Fiscal Year 2015, 79 percent were served by one or more for-profit businesses, 60 percent by public agencies (largely for case management services), and 55 percent by nonprofit organizations.

Exhibit 2.13: Top Ten Providers of Home- and Community- Based Services to Medical Assistance Recipients with Disabilities, Fiscal Year 2015

Provider	Number of Recipients Served	Medical Assistance Payments[a]	Major Services Provided[b]
REM Minnesota	2,636	$142,442,000	Supported living; foster care; activity therapy; care attendants; crisis intervention; respite; companion services; transportation; transition services; and comprehensive community support services
Dungarvin Minnesota LLC	1,228	38,219,000	Supported living; foster care; crisis intervention; case management; care attendants; activity therapy; assisted living; vocational support; transportation; respite; and companion services
Accra Care	1,456	29,770,000	Personal care services; companion services; respite; homemaking services; nursing care; home health aides; and activity therapy
Divine House Inc.	416	23,046,000	Supported living; foster care; respite; personal care services; activity therapy; care attendants; vocational support; companion services; and assisted living
Habilitative Services	466	21,980,000	Supported living; foster home/assisted living; personal care/care attendants; activity therapy; respite; companion services; homemaking services; and vocational support
ACR Healthcare Services	198	21,170,000	Supported living; foster home; respite; home modifications; and transportation
Thomas Allen Inc.	2,947	18,592,000	Supported living; case management; foster home; activity therapy; care attendants; and respite
Prairie Community Services, Inc.	334	17,200,000	Supported living; foster care; activity therapy; care attendants; and respite
ResCare Minnesota	914	16,877,000	Supported living; foster home; activity therapy; case management; care attendants; vocational support; crisis intervention; and transportation
Community Living Options Inc.	200	16,453,000	Supported living; foster care; personal care/care attendants; activity therapy; respite; assisted living; and homemaking services

[a] Payments refer to those made by the Department of Human Services. They do not include payments made by managed care organizations that enroll Medical Assistance recipients who received HCBS through the elderly waiver.

[b] Services are in descending order in terms of payments received and only includes services generating at least $5,000 in Fiscal Year 2015.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Chapter 3: Financial Oversight

As discussed in Chapter 2, expenditures for home- and community-based services (HCBS) for Medical Assistance (MA) recipients are significant and, therefore, should be subject to routine financial oversight. The Department of Human Services (DHS) provides financial oversight of HCBS through licensing, rate setting and provider payments, and fraud and abuse investigations. These oversight responsibilities are managed largely by two separate DHS units, the Disability Services Division and the Office of the Inspector General (OIG). The Disability Services Division oversees HCBS policies and programs, including setting rates for services. The department's OIG investigates financial fraud and abuse, licenses providers, and conducts background checks on staff who work with vulnerable people. In this chapter, we focus on the Disability Services Division's rate setting and the OIG's licensing authority and fraud and abuse investigations as financial oversight tools. Although DHS holds primary responsibility for oversight, other state agencies, counties, and tribal governments also play a role.

Overall, we think that HCBS financial oversight should be improved to ensure HCBS providers deliver the services for which they are responsible. The Legislature and DHS should establish more extensive regulations and require more systematic data collection of HCBS providers and their staff.

Licensing

One way in which DHS provides program oversight is by requiring that HCBS providers be licensed, certified, or approved. To license a provider, DHS staff may conduct a site visit, as well as review a provider's policies and procedures and conduct background checks on its HCBS staff.

Not all providers must be licensed. Those who are not licensed may be *certified* by a state agency or approved by DHS or a county.[1] Providers who predominantly offer programs or services to the general public rather than MA recipients, such as restaurants, lawn services, and personal care agencies, need certification or approval. Generally, to become certified or approved, a provider must meet certain criteria and agree to the terms of participation. Compared with licensing, certifications and approvals are less intensive reviews. An individual may also seek DHS's approval to indicate he or she meets certain criteria to provide services, including HCBS. In this section, we discuss state agencies' and counties' licensing, certification, and approval practices for HCBS providers.

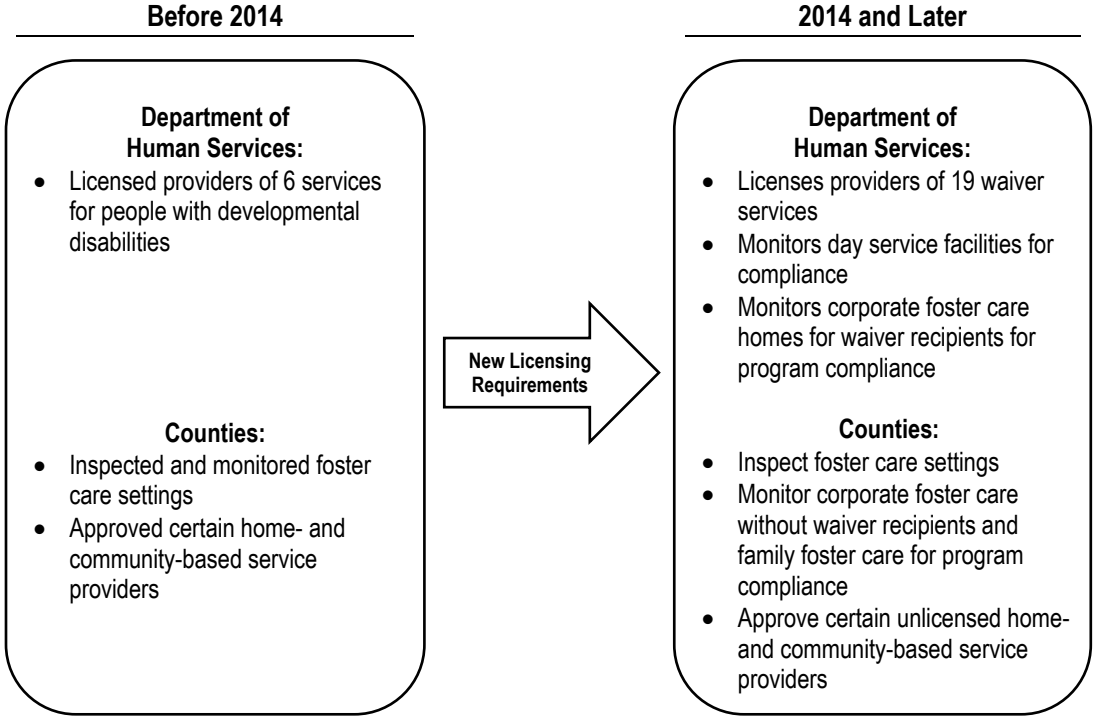
Department of Human Services

According to DHS, in 2008, the Centers for Medicare and Medicaid Services (CMS) determined that Minnesota's waiver programs were out of compliance with federal

[1] For clarity and readability purposes, we use the term "certify" to describe a less intensive process state agencies use to review some HCBS providers. The departments of Human Services and Transportation use the term "certify," while the Department of Health uses "register." We describe the certification process in general, not specific to one agency.

regulations.[2] The centers said that counties held too much authority, which created inconsistencies in how Medicaid was administered. To increase statewide consistency and comply with federal standards, DHS assumed licensing authority for some HCBS providers. The department previously licensed only six types of HCBS providers who served individuals with developmental disabilities.[3] The Legislature passed a law in 2012, which it amended in 2013, expanding DHS's authority to license many (but not all) HCBS providers, as shown in Exhibit 3.1.[4] The department began issuing licenses in 2014, when its licensing authority took effect.[5]

Exhibit 3.1: The Department of Human Services' and Counties' Roles Before and After New Licensing Requirements



NOTES: Waiver recipients qualify to receive Medicaid-funded services in home- and community-based settings. Minnesota offers five home- and community-based service waivers that serve people with: brain injuries; chronic illnesses; developmental disabilities; physical or other disabilities, including mental illness; and those who are 65 years or older.

SOURCE: Office of the Legislative Auditor, based on review of *Minnesota Statutes* 2012, 245B.03; *Minnesota Statutes* 2016, 245D.03, subd. 1; *Minnesota Rules* 9555.9640; and Department of Human Services' documents.

[2] As noted in Chapter 1, CMS administers the federal Medicaid program and issues regulations and guidelines that states must follow to receive federal funding. Minnesota Department of Human Services, *Changing County and Tribal Roles Home and Community-Based Services Waiver Provider Oversight* (St. Paul, 2013), 8-9.

[3] *Minnesota Statutes* 2012, 245B.03, subd. 1.

[4] *Laws of Minnesota* 2012, chapter 216, art. 18, sec. 18; and *Laws of Minnesota* 2013, chapter 109, art. 8, sec. 23.

[5] *Laws of Minnesota* 2013, chapter 108, art. 8, sec. 23 (effective January 1, 2014).

The Department of Human Services does not license all home- and community-based services (HCBS) providers, and not all licensed providers have been reviewed under the new licensing standards.

The Department of Human Services licenses many waiver service providers.[6] For example, DHS licenses providers of foster home and supported living services. Other entities, including counties and the departments of Health and Transportation, also license or oversee certain kinds of HCBS providers.[7]

The Department of Human Services also certifies HCBS providers who are not otherwise licensed. Specifically, personal care agencies and the staff employed by those agencies do not need to be licensed.[8] However, the department enrolls personal care agencies and ensures that personal care attendants have fulfilled training and employment requirements, including passing background checks.[9]

When DHS assumed authority for licensing many providers of HCBS waiver services in 2014, it began by reviewing new applications from previously unlicensed providers. Due to the newness of the licensing laws, some HCBS providers with existing licenses have yet to be reviewed using the new standards. The department completed reviews of new provider licenses in 2014 and 2015 and began reviews of existing licenses in 2016.

As part of its licensing requirements, the Minnesota Department of Human Services does not require or collect financial documentation or engage in any routine financial auditing of HCBS providers.

Before issuing a license, DHS ensures licensees have developed policies and procedures to protect the health and well-being of clients. Policies and procedures involve sanitary practices, coordination of health services and care, medication administration, and emergency plans, among other things.[10] To be approved for a license, applicants must demonstrate that their facilities are safe and sanitary; for example, buildings must be free of peeling paint, mold, and vermin.[11] In addition, corporate foster care and day service providers have more specific standards in that they must ensure that buildings meet code requirements, have adequate space for activities, and have the necessary furniture.[12]

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[6] Minnesota offers five HCBS waivers that serve people with: brain injuries; chronic illnesses; developmental disabilities; physical or other disabilities, including mental illness; and those who are 65 years or older.

[7] The Department of Human Services delegates some licensing oversight to counties, although the department issues the licenses. For example, DHS instructs counties to implement health-related inspections of foster homes.

[8] In Fiscal Year 2015, 846 personal care agencies, which accounted for 20 percent of all HCBS providers, received payments from DHS for HCBS.

[9] The Department of Human Services "enrolls" some HCBS providers and some individual workers. Enrollment involves a review, similar to certification, in which DHS completes background checks and assesses completion of training requirements. We use the term "enrollment" and its derivatives later in the chapter to describe reviews of individual workers.

[10] *Minnesota Statutes* 2016, 245D.11, subd. 2.

[11] *Minnesota Statutes* 2016, 245D.22.

[12] *Minnesota Statutes* 2016, 245D.21, 245D.24, and 245D.28.

Neither statutes nor rules require DHS to review HCBS licensees regularly; however, statute does allow DHS to review HCBS licensees biennially.[13] When it does review licensed providers, DHS verifies that providers have complied with the policies and procedures that the department approved during the licensure application process. The department determines compliance through site visits, document reviews, and interviews. If DHS finds a licensee non-compliant with regulations, it may require corrective action, levy a fine, apply a conditional status to the license, or suspend or revoke the license. For example, if a HCBS licensee fails to provide annual training to its employees, DHS may require the licensee to provide the training or it will impose a fine.

However, the department does not require providers to submit any routine financial documentation, such as profit and loss statements, as part of its licensing process. Although many providers with whom we spoke undergo regular financial audits, the department neither requires nor reviews them.[14] Without standardized financial reports from HCBS providers, DHS's financial oversight is limited.

While HCBS providers need not submit detailed financial documentation for DHS to have thorough financial oversight of providers, we think DHS can improve its financial oversight of HCBS through other means. As a condition of certification or licensure, DHS should require worker identification on claims submissions, place limits on hours for certain types of HCBS workers, and require workers to document their provision of services. We discuss these recommendations later in this chapter.

Other State Agencies

At least two state agencies, in addition to DHS, have responsibility to regulate and oversee some types of service providers that often provide HCBS to MA recipients with disabilities and the elderly. Regardless of which agency monitors the provision of services, DHS has ultimate responsibility for MA funds.

The departments of Health and Transportation have regulatory authority over some HCBS providers.

As of March 2016, the Minnesota Department of Health (MDH) had licensed 1,303 home care providers and 200 home health agencies.[15] Home care providers assist with activities of daily living, such as dressing, toileting, bathing, and giving medication reminders.[16] Home health agencies provide medical-related services in one's home, such as nursing; speech, physical, or occupational therapy; nutritional services; social services; and home health aide tasks.

[13] *Minnesota Statutes* 2016, 245A.09, subd. 7(e).

[14] As described in the Introduction, we spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount MA paid them for HCBS in Fiscal Year 2015 and the types of services they delivered. We tried to focus on providers that received relatively high amounts of MA payments relative to their geographic area. Once we selected our provider sample, we talked with the counties where those providers were based. Our two samples are not representative of either population, and their comments cannot be generalized to all counties and providers.

[15] Minnesota Department of Health, *2016 Directory Licensed, Certified, and Registered Health Care Facilities and Services* (St. Paul, 2016), I.

[16] As we discuss in Chapter 2, home care services are similar to personal care services and those provided by some types of direct care staff in foster home settings.

If a home care provider is licensed by MDH but is also providing HCBS to MA recipients, that provider may choose to receive an "integrated license" from MDH.[17] This means the home care provider may provide a limited selection of services without needing a separate license from DHS for services that would otherwise be licensed by that department. However, as the HCBS licensing law is still relatively new, some providers have decided to continue seeking separate licenses from MDH and DHS as they have done in the past.

The Department of Health also certifies providers of home management services. Home management services include housekeeping, meal preparation, and shopping. These services do not require advanced training or expertise, but staff must attend an orientation discussing matters related to people who are elderly or have disabilities.

The Department of Transportation certifies some providers of HCBS transportation services.[18] These services include ambulatory and non-ambulatory nonemergency transportation.[19] Home- and community-based transportation services help MA recipients with disabilities access community resources.

Counties

Before DHS took over licensing responsibilities, counties contracted with providers and negotiated HCBS rates. The department allowed counties to develop their own contracts but required that they address providers' responsibilities; waiver requirements; monitoring and evaluation duties; and terms of payment, among other things. Counties used contracts to help ensure countywide consistency in service delivery as well as compliance with waiver regulations. Providers could not be reimbursed if they did not have some type of agreement with a county.

Counties no longer contract with most HCBS providers. If county staff have concerns about the health and safety of their clients, they may recommend that DHS take a negative licensing action.[20] The Department of Human Services, as the primary licensing authority, may take action against the licensee, for example, revoke or suspend its license.

While DHS licenses foster care homes, it delegates health-and safety-related inspections of the homes to counties. Counties inspect sanitary practices, the safety of the environment, as well as availability of safe food and water. For foster homes that do not provide waiver services, counties perform inspections in addition to other monitoring responsibilities.

Counties also oversee some services that do not require a DHS license. Some county staff said they encourage vendors of chore services, such as lawn mowing and home modification services, who do not need to be licensed, to enroll with the department. If a vendor does not enroll, it must be approved by a county. Some county staff with whom we met indicated that they did not use a standardized process to evaluate vendors before or after the provision of services.[21]

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[17] *Minnesota Statutes* 2016, 144A.484, subd. 1(b).

[18] *Minnesota Statutes* 2016, 174.30.

[19] When individuals can get into and out of a vehicle independently, with or without a wheelchair, it is considered ambulatory transportation. When they need assistance, it is considered non-ambulatory.

[20] *Minnesota Rules*, 9555.6145, subp. 2, published electronically October 15, 2013.

[21] The Department of Human Services publicized a required, standardized form for counties to use when approving vendors in December 2016.

With their role in licensing HCBS providers recently limited, counties reported unclear lines of authority and only vague guidance from the Department of Human Services.

Statutes do not clearly delineate counties' roles in monitoring the financial or quality aspects of the HCBS providers they use. County staff with whom we met viewed DHS as the lead monitoring agency, in the absence of any explicit county oversight authority. However, on its website, DHS identifies counties as being responsible for monitoring provider performance, yet the county staff with whom we met did not have a clear understanding of their role.[22]

Some county representatives said that DHS expects counties to monitor providers but does not grant them the authority or funding to do so. In addition, counties do not have direct authority to affect providers' licenses, which limits their ability to take disciplinary action. With these limitations, counties often provide oversight on a client-by-client basis rather than evaluating providers as a whole. They rely on county case managers to oversee services provided to individuals enrolled in the waiver program.

In terms of financial monitoring, representatives from a few counties said they lacked the information and authority to provide financial oversight of HCBS providers. Staff from some counties said they do not have aggregate financial information for each provider, and it would take too much staff time to put it together. Staff from a few counties said they do not have the capacity to routinely monitor individual claims for fraudulent billing and, even if they found fraud, they would have little recourse.

Rate Setting

Similar to licensing, DHS's system for establishing standardized HCBS payment rates is relatively new. The department monitors providers' payments through the system's regulation of rates and quantity of services. More broadly, DHS oversees the funding it allocates to counties to provide HCBS.

Rates

The Minnesota Legislature established statewide rates for HCBS waiver services effective January 1, 2014.[23] The new rates override previous service rates set through counties' contracts with providers. However, to ease providers' transitions to the new system, many individual payment rates are being adjusted gradually until the rate management system is fully implemented in 2019 or 2020. Most providers will not receive the full effect of the new rates during the transition period. However, rates for recipients starting new residential services are affected immediately.

Although the rates only pertain to waiver and state plan MA recipients, some providers said they use the same rates for their other clients. Waiver and state plan services subject to DHS's rate management system include: foster care, supported living, and day training and

[22] Minnesota Department of Human Services, *State and Lead Agency Oversight Responsibilities* (St. Paul, 2014), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000723, accessed January 3, 2017.

[23] *Laws of Minnesota* 2013, chapter 108, art. 13, sec. 11-12.

habilitation, and services provided by personal care attendants, home health aides, companions, and homemakers, among others.

The Department of Human Services considers the following items when it sets payment rates: supervision costs, staff compensation, staffing/supervisory patterns, program-related expenses, and general and administrative expenses.[24] The department is charged with making recommendations to the Legislature on adjusting the terms and values associated with the rate management system, as any adjustments require a change in law. In 2017 and every five years thereafter, DHS must update rate components, including base wages, administrative costs, and vacation and sick leave.[25] The department must adjust rate components using data from the Bureau of Labor Statistics and Consumer Price Index.

Although DHS and the Legislature, working with stakeholders, developed the rate formulas, counties make final spending determinations by developing individual clients' service agreements.[26] Each service agreement has day or hour limits on services to be provided, as well as inputs that describe the extent to which services will be provided. Before entering service inputs into the rate system, county staff consult with providers to determine staffing ratios and hours of services to meet clients' assessed needs. County staff ultimately enter all inputs that may affect clients' final rates, such as staffing ratios or transportation needs, into the rate system.

The rate management system prevents HCBS providers from fraudulently altering payment rates.

When submitting claims, providers may only enter hours of services provided; they do not have access to the rates used to calculate the payment. Providers receive screenshots of the rates produced by the rate management system and can access a public framework to determine what rate the system will produce with the inputs provided to the county. If changes need to be made to service agreements or rates, only counties have the authority and access to make those changes. By limiting who can adjust rates, DHS may be preventing fraud. In this way, DHS is providing financial oversight through its standardized rate and payment systems. However, according to DHS, some providers have found ways to bypass these safeguards.

Staff from a few counties we visited spoke positively of the rate management system and standardized HCBS rates. They said the system prevents providers from submitting duplicate hours of service for the same day. It also prohibits providers from claiming service hours beyond what is specified in service agreements. County staff expressed appreciation for not having to negotiate HCBS rates with providers, because the system uses standardized rates. They described the system's controls as being advantageous for counties and DHS in terms of financial oversight.

However, as we discuss in Chapter 4, both county staff and providers expressed concern with the rate management system and the rates it produces. First, they said the system does

[24] *Minnesota Statutes* 2016, 256B.4912, subd. 3.

[25] *Minnesota Statutes* 2016, 256B.4914, subd. 5(i).

[26] The Department of Human Services routinely monitors counties' and tribal governments' HCBS waiver programs to assess quality and compliance. In these reviews, DHS audits samples of clients' case files for content but does not evaluate the appropriateness of individual clients' services.

not account for all state and federal regulations. Moreover, because there is not a profit margin built into the system, providers must make up for any shortfalls in major cost drivers, such as wages for direct care staff, elsewhere in their businesses.[27] This can be problematic for providers who need to pay staff for overtime to make up for staffing shortages, which are becoming common as workers leave direct care positions for less difficult, higher-paying jobs. Additionally, the system does not easily accommodate the difficulty of the client or the skill level needed to care for clients when it determines wages, so providers must seek special approval to receive higher payment rates for difficult clients.

Rate Exceptions

Service needs for individuals who qualify for waiver services vary, depending on their functional abilities, cognition, behavior needs, and health status. Working with some MA recipients can be dangerous or require very staff-intensive services. For example, some waiver recipients have disabilities that are characterized by challenging behaviors, such as biting, hitting, running away, or injuring themselves. Some providers told us that more difficult HCBS recipients often require staff with more training or experience.

Unlike some other payment systems, the system for HCBS does not adjust wage rates for direct care staff to account for different levels of disability or assistance needed.[28] All direct care staff are reimbursed at the same rate, regardless of the complexity of recipients' conditions, needs, or behaviors. This creates a disincentive for providers to serve those with high needs when they could serve individuals with less complex needs for the same payment amount. It also presents problems for counties trying to find placements for more difficult-to-serve MA recipients.

To account for this, HCBS providers can ask for rate exceptions by submitting requests to counties. Providers must document and submit information on costs that go over, or are not included in, the system's calculated rates. Counties, in turn, recommend whether DHS should approve or deny providers' requests.[29] To qualify for a rate exception, a recipient must meet one of the following criteria: (1) additional service hours will not address the individual's needs, (2) a provider has warned that it will stop providing services under the current rate, or (3) an individual's behavioral needs require a change in care.[30] According to statute, county staff may deny rate exception requests that clearly do not meet the criteria described above.[31] For example, if client needs can be addressed through additional service hours, a county representative may make the final decision to deny the rate exception request and instead approve more service hours.

Counties interpret their role in requesting rate exceptions differently, which leads to inconsistent practices.

[27] In most instances, providers are not required to spend payments in any particular manner. For example, providers are not required to pay their employees the wage rates that DHS uses to calculate their payments. Providers may pay their employees higher or lower wages. However, the rate system is not fully implemented, so many providers are not yet fully affected by the system's rates.

[28] The formula only pays higher rates for staff who work with blind or hearing-impaired clients.

[29] *Minnesota Statutes* 2016, 256B.4914, subd. 14(b).

[30] *Minnesota Statutes* 2016, 256B.4914, subd. 14(c).

[31] *Minnesota Statutes* 2016, 256B.4914, subd. 14(f).

Counties must forward all requests that meet the exception criteria to DHS for final action, regardless of counties' recommendations.[32] Some county staff with whom we spoke said they send all provider requests to DHS, while others only submit those that meet the criteria and have the county's approval. Some outstate counties said they are so desperate to find providers that they feel compelled to recommend approval of any requests.

In 2016, DHS received 979 exception requests; staff approved 764 of them (78 percent) and denied 26.[33] Of the remaining 189, counties themselves denied 26 and withdrew 125 for a variety of reasons, such as the individual's needs could be met in other ways.[34] In some instances, counties authorized additional units of services rather than approving rate exceptions. Half of the approvals were for residential services, such as foster care.

County staff told us that providers generally suggest the amount of the rate exception, which could create inconsistencies. Staff expressed concern about the rates some providers have requested to serve high-needs recipients. The Department of Human Services predicted that the average rate exception, when final rates are in effect, could be as high as 82 percent above the payment system level.[35]

The Department of Human Services does not provide additional funding to counties when it approves rate exceptions, so counties must use their existing waiver allocations to cover the higher rates. According to department projections, MA spending to accommodate rate exceptions is likely to be more than $58.8 million in Fiscal Year 2020.[36]

Some county staff commented on the high number of exception requests they received from providers. According to DHS, even when the final rates go into effect in 2019 or 2020, HCBS providers will still request rate exceptions.[37]

When the department asked providers why they would request an exception, many responded that the staff person serving the client would need a higher wage.[38] In the future, DHS projects that rate exceptions for corporate foster home, supported living services, and day training and habilitation will have the greatest financial impact on the state.[39]

Allocations

The Department of Human Services oversees waiver costs through its allocations to counties and tribal governments. The allocation acts as a budget, indicating the total amount of funding county or tribal governments will receive in a year to cover waiver costs.

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[32] Counties must submit providers' cost driver information as well as descriptions of recipients' extraordinary needs in their exception requests.

[33] The Department of Human Services and counties review and monitor rate exceptions. Vicki Kunerth, Minnesota Department of Human Services, e-mail message to Jo Vos, "Follow-up OLA's Audit of HCBS," January 6, 2017.

[34] By the end of the year, 38 requests did not have a final status.

[35] Minnesota Department of Human Services, *Disability Waivers Rate System Report* (St. Paul, January 2016), 35.

[36] *Ibid.*

[37] *Ibid.*

[38] *Ibid.*, 36-37.

[39] *Ibid.*, 35.

The allocation formula reflects historic costs with occasional adjustments made by the Legislature.

Counties and tribal governments manage their HCBS allocations by approving waiver enrollments and individual service agreements.

Counties and tribal governments must ensure they have sufficient funding to support new waiver enrollments and service agreements, as they are generally ongoing expenses. Counties and tribal governments are also responsible for confirming that HCBS recipients are receiving only necessary services, which includes being enrolled in suitable waivers. However, some DHS staff and HCBS advocates with whom we met felt that case managers sometimes enroll participants in the waiver for which they have more funding, rather than the waiver that best meets their needs.

The Department of Human Services developed an online tool, called the Waiver Management System, to assist counties and tribal governments in managing their allocations. The system tracks claims paid through the Medicaid Management Information System (MMIS). The Waiver Management System allows counties and tribal governments to identify who is currently in or eligible for their waiver programs. It also has a simulation feature that allows counties and tribal governments to predict the cost of modifying service agreements or adding waiver recipients.

Department staff monitor counties' and tribal governments' expenditures by examining their allocations quarterly. Staff also assess trends in service authorizations on a monthly basis and provide guidance to counties and tribal governments if spending is far greater or less than the allocation. The system gives providers a one-year window to submit payment claims for the HCBS they provide. Having such a long period for submitting claims could interfere with a county or tribal government's ability to make budget projections. For example, if providers delay claims submissions and counties are not aware of the delays, the counties may underestimate actual service use and therefore overestimate available funding. Moreover, the system shuts down monthly to update MMIS data; a few counties mentioned that the lack of real-time claims data was problematic for managing their allocations.

Fraud Investigations and Prevention

The federal government provides financial oversight of Medicaid, including HCBS, through audits and investigations. At the state level, DHS completes financial fraud and abuse investigations, most of which are brought to its attention through analyzing payment claims or complaints.

Federal Audits and Investigations

The Centers for Medicare and Medicaid Services (CMS) and the federal Office of the Inspector General (OIG) monitor HCBS on behalf of the federal government. The Centers for Medicare and Medicaid Services monitors providers by reviewing Medicaid payments, and the federal OIG monitors federal Department of Health and Human Services' programs for fraud, waste, and abuse. Most often, the OIG's work involves overseeing Medicare and Medicaid, which account for a large portion of federal funding.

The Centers for Medicare and Medicaid Services monitors Medicaid payments through the Payment Error Rate Measurement (PERM) program, which audits each state and the District of Columbia every three years. The PERM audit may assess all types of Medicaid claims, which CMS regards as being susceptible to erroneous payments. The audit requires providers to submit supporting documentation for a limited number of claims, which may include HCBS. The PERM report does not specify the number of audited claims that fall within the purview of HCBS.

The Center for Medicare and Medicaid's most recent audit of states' payment systems included DHS claims from Fiscal Year 2012.[40] The federal government reports states' results in the aggregate, so it does not permit comparison of Minnesota's Medicaid payment system with those of other states.

For Medicaid fraud investigations, the federal OIG reports some criminal conviction data by state. Additionally, the reports indicate the type of provider, some of which administer HCBS.

Many of the Medicaid fraud convictions reported by the federal Office of Inspector General involve HCBS providers.

Although the federal OIG investigates all Medicaid fraud, many of the convictions involve HCBS providers.[41] Of the 1,097 total Medicaid fraud criminal convictions reported nationwide, 439 (40 percent) involved personal care attendants or other home care aides. In response to the prevalence of personal care attendant fraud, the federal OIG issued recommendations for prevention, which we discuss later in this chapter.

In its Fiscal Year 2015 report, the federal OIG stated that Minnesota had 417 open Medicaid fraud investigations; some of the investigations likely involved HCBS. In that year, the state also had 22 criminal indictments or charges and 17 criminal convictions.

State Investigations

As stated at the beginning of this chapter, the Minnesota Department of Human Services' Office of Inspector General (OIG) completes financial fraud and abuse investigations for the state. Within OIG is the Surveillance and Integrity Review Section (SIRS), which is federally mandated to oversee the state's Medicaid program. This unit reviews all MA services, not just HCBS, through its three units: Provider Investigations, Minnesota Restricted Recipient Program, and Provider Screening.

The Minnesota Department of Human Services does not routinely conduct financial investigations of HCBS providers unless problems come to its attention through processing payment claims or complaints.

[40] The Centers for Medicare and Medicaid Services reviewed Fiscal Year 2015 claims across several states, including Minnesota, but the updated aggregated results have not been published. The Centers for Medicare and Medicaid Services, *Medicaid and CHIP 2015 Improper Payments Report* (Washington, DC, 2015).

[41] U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Fraud Control Units Fiscal Year 2015 Annual Report* (Washington, DC, 2016).

The Department of Human Services' waiver agreements with CMS assert that SIRS will monitor the delivery and use of waiver services by providers and participants by: (1) routinely analyzing claims data for unusual patterns, (2) periodically reviewing selected providers, and (3) investigating identified or reported fiscal integrity issues.

Inspector General staff told us that they receive more complaints against providers than they have the resources to investigate. Some waiver services lack statutory documentation requirements, making investigations into waiver service more time consuming and less fruitful. The most timely and cost-effective way to determine if services actually occurred is to compare documentation to other verifiable resources, such as outside employment, hospitalizations, school attendance, or other medical appointments. Without documentation requirements for some waivered services, SIRS is limited in its ability to recover overpayments or remove fraudulent waivered providers.

In 2015, SIRS investigated 218 personal care providers, 37 home and community service providers, 11 day training and habilitation centers, and 10 home health agencies.[42] Investigations may result in: referral to a prosecuting authority; suspension or termination of the provider's enrollment in Minnesota's health care program; education for the provider to prevent further overpayment; recovery of overpayments; or withholding further payment to the provider.

While screening providers that CMS or DHS considers at high or moderate risk of fraud, SIRS investigators make unscheduled visits to ensure that the organizations exist. Investigators focus on the organizations as a whole, rather than evaluating the services.

The Department of Human Services does not collect adequate information to conduct financial oversight of all HCBS providers.

Although DHS is able to do some monitoring of providers, financial monitoring could be improved if additional information were routinely collected. For example, DHS does not receive information about workers who provided services or documentation about services provided for most types of HCBS. Both pieces of information would give DHS more information about the provision of services. If DHS had more information, at least in regard to those services most susceptible to fraud, it could provide better financial oversight and, thereby, help prevent fraud.[43]

Fraud Prevention

As Minnesota provides more opportunities for people with disabilities and the elderly to live independently in the community, more people will receive services in their homes from direct care staff. This shift increases the opportunity for fraud, because workers who provide in-home services, such as personal care attendants and home health aides, often do not have direct supervision.

[42] Minnesota Department of Human Services, Office of Inspector General, *2015 Annual Report* (St. Paul, 2016), 13.

[43] We address this issue in a recommendation later in this chapter.

In our 2009 report on personal care assistance, we found that Minnesota's personal care program was vulnerable to fraud and abuse.[44] In our report, we discussed issues with personal care attendants not providing the services for which they billed. We also identified numerous cases in which DHS paid claims that indicated that personal care attendants worked more than 24 hours in a day. Additionally, we found that personal care agencies did not always maintain documentation to support their claims submissions.

To address these problems, we issued recommendations, some of which involved greater oversight from DHS. To identify potentially fraudulent or erroneous claims, we recommended that DHS regularly analyze claims data. We recommended that personal care service providers make periodic visits or phone calls to verify that their personal care attendants are actually providing the expected services.[45] We acknowledged problems with inadequate documentation, although we did not make any explicit recommendations requiring additional documentation.

The federal OIG also found that personal care attendants sometimes bill for services that are improbable, such as serving multiple clients at one time. The federal OIG issued guidance to address fraud among personal care services, with an additional recommendation to enroll personal care assistants with a state agency.[46] The federal OIG recommended that states enroll personal care attendants and give them unique identification numbers to prevent fraud in claims submissions.[47]

State legislation regarding the personal care program has addressed many recommendations from our 2009 report and the federal OIG. Although DHS began requiring personal care attendants to enroll in 2005, the Legislature did not enact legislation to that effect until 2009.[48] In 2009, the Legislature adopted legislation requiring personal care attendants to document daily activity for each day they provided services to recipients.[49] This information must be submitted on a monthly basis to the agencies for which the personal care attendants are working. The Legislature enacted legislation in 2010 that prevents personal care attendants from billing for more than 275 hours in a month.[50] The 2015 Legislature adopted our 2009 recommendation, requiring that for each service recipient, personal care providers make at least one unscheduled telephone call every 90 days to verify that a personal care attendant is present on site.[51]

These changes have helped the state OIG identify over $1.6 million in personal care overpayments between 2014 and 2015.[52] However, the changes do not apply to other in-

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[44] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009).

[45] *Ibid.*, 72.

[46] Gary Cantrell, Deputy Inspector General for Investigations, Office of Inspector General, memorandum to Vikki Wachino, Deputy Administrator and Director, Centers for Medicare & Medicaid Services, Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services, October 3, 2016.

[47] *Ibid.*, 7.

[48] Office of the Legislative Auditor, *Personal Care Assistance* (St. Paul, 2009), 77; and *Laws of Minnesota*, 2009, chapter 79, art. 8, sec. 31, subd. 11(a)(3).

[49] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, subd. 12.

[50] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 15, sec. 7.

[51] *Laws of Minnesota* 2015, chapter 78, art. 4, sec. 53.

[52] Minnesota Department of Human Services, Office of Inspector General, *2015 Annual Report* (St. Paul, 2016), 20.

home service providers. Other types of HCBS direct care workers, such as home health aides, companions, and homemakers, also work in recipients' homes; however, DHS puts forth less monitoring and fewer requirements for them. Similar to personal care attendants, other direct care staff have limited supervision in clients' homes, making them just as susceptible to fraud.

The Department of Human Services does not routinely monitor all HCBS direct care staff to ensure that they are providing the services for which they are billing, nor does it direct counties or providers to do so.

Staff from the state's OIG suggested that the best way to ensure that HCBS staff are present in clients' homes is to make unscheduled phone calls or visits to the homes. With the exception of personal care attendants, DHS does not use this approach to monitor other types of HCBS direct care staff, nor does it require it of all HCBS providers or counties.[53] However, some county staff and providers told us they make calls and visits anyway.

Some case managers make scheduled or unscheduled visits to recipients to ensure HCBS workers are providing the expected services. However, case managers' workloads can affect their ability to provide thorough oversight. In interviews, staff from some counties said their workloads are too heavy or they spend too much time traveling to meet with their clients residing in other counties.

Some providers told us that they have taken it upon themselves to monitor their employees' service delivery. A few providers use technology to track employees' locations and their notes of services provided. Although not required, some HCBS providers make unannounced visits or phone calls to ensure staff are present. As noted previously, statute requires personal care, but not other types of HCBS providers, to make unscheduled phone calls.[54]

Currently, if a case manager or provider does not make unscheduled visits or phone calls to the client's home, there is no oversight mechanism to ensure HCBS workers are actually providing services. Additionally, MA recipients with disabilities who receive HCBS through the state MA plan may not have case workers to oversee their services, so they would have to self-report if workers do not show up. Given the current HCBS worker shortages, recipients may not report workers' absence in fear that they would not find a replacement.[55]

Aside from personal care attendants, the Department of Human Services does not (1) require other types of direct care staff to enroll with the department, (2) limit the number of hours for which workers can bill, or (3) require documentation supporting the provision of services.

Personal care attendants must submit their personal enrollment information on claims, which helps DHS identify fraudulent billing. By tracking the individual personal care

[53] Providers must supervise, assist, and train direct care staff to ensure their competency in delivering services; however, providers are not specifically required to confirm that services were actually delivered.

[54] *Minnesota Statutes* 2016, 256B.0705, subd. 2.

[55] We discuss staffing issues in Chapter 4.

attendant, DHS can look across clients and agencies to identify if a personal care attendant claims too many hours. Without enrollment information for other HCBS workers, DHS is limited in its ability to track individual workers' claims submissions.

When individual direct care workers are not enrolled with the department, DHS's system cannot detect when the workers bill for an unreasonable number of hours in a month. While the system does not monitor individual workers' hours, it does detect discrepancies in providers' billing submissions. It compares providers' submissions to service agreements to prevent a provider from billing for more than the total hours listed in a service agreement. For example, if a client's service agreement dictates he or she can receive 1,040 hours of a service in a year, a provider cannot bill for more than 1,040 hours.

Documentation of services provided helps DHS investigate complaints or suspected fraud. Since DHS does not require other HCBS providers to maintain documentation of the provision of services, providers may not require their employees to keep notes on the services they provide. The department cannot verify the provision of services without supporting documentation.

RECOMMENDATION

The Legislature should increase its regulation over some types of direct care workers who provide HCBS in recipients' own homes.

Overall, as shown in Exhibit 3.2, financial oversight of some types of direct care staff could be improved by extending current regulations for personal care attendants to other types of direct care staff who do similar work. At a minimum, we think these regulations should be extended to other direct care staff who provide services in clients' own homes, because with limited supervision, they pose a greater risk for fraud.

We think legislation is especially needed in three areas. First, comparable to personal care attendant legislation, the Legislature should consider requiring HCBS providers to make unscheduled phone calls or visits to staff working in recipients' homes to ensure their provision of services.[56] Alternatively, the Legislature could require either county or DHS staff to make these phone calls or visits. Although we did not evaluate the effectiveness of the personal care model, we think periodic check-ins could improve HCBS oversight.

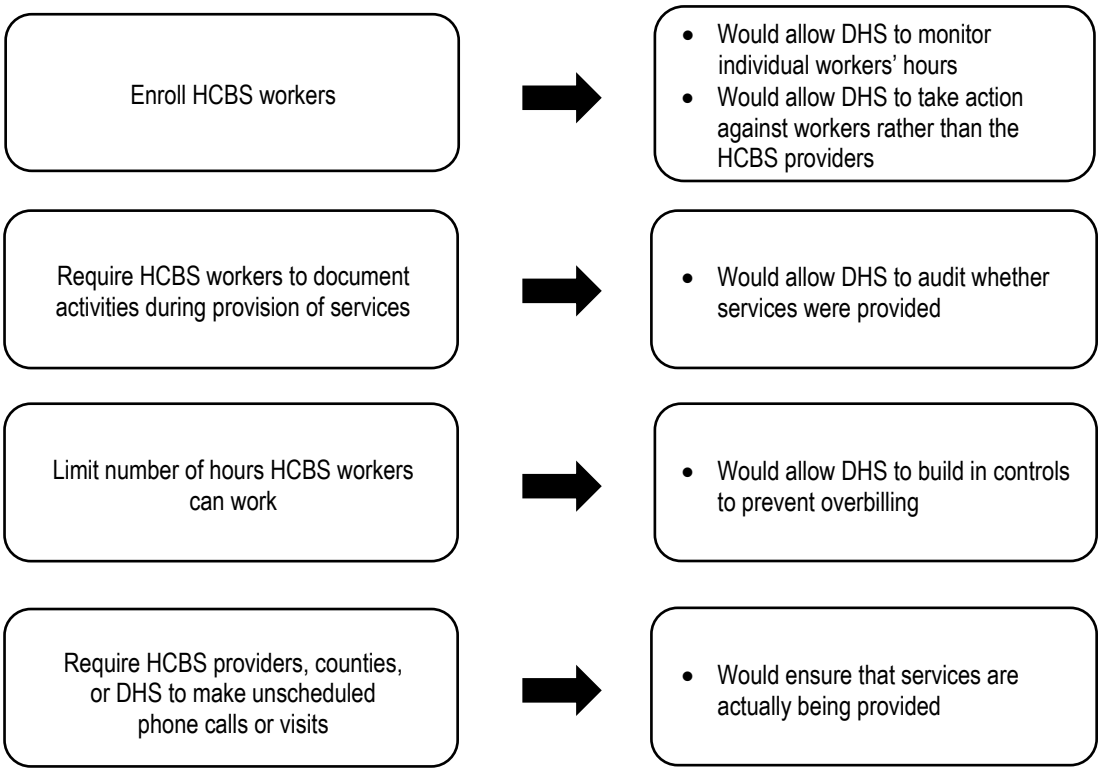
Second, the Legislature should limit the number of hours some types of HCBS direct care workers can work in a month. Implementing monthly hour caps and documentation requirements, such as daily activity notes, for workers (similar to the personal care program) could increase DHS's ability to detect fraud and monitor HCBS finances. Again, at a minimum, we think these requirements should be applied to services provided in recipients' own homes. While it may not be necessary for DHS to routinely collect documentation, providers should have it available upon the department's request.

Third, the Legislature should require some HCBS direct care workers to enroll with DHS and require that certain staff information be provided when providers file claims for payment. Department staff emphasized that personal care attendant enrollment is one of the

[56] *Minnesota Statutes* 2016, 256B.0705.

most powerful tools they have to prevent personal care attendant fraud.[57] We think it would be just as powerful for overseeing other HCBS. With the exception of personal care attendants, DHS does not enroll other HCBS workers or require them to provide identifying information on claims. Again, enrollment is particularly needed for HCBS direct care workers providing services in recipients' own homes.

Exhibit 3.2: Actions to Prevent Fraud among Home- and Community-Based Services Workers



NOTES: DHS refers to the Minnesota Department of Human Services and HCBS refers to home- and community-based services.

SOURCE: Office of the Legislative Auditor.

[57] The FY 18-19 Governor's Budget Recommendations include a recommendation to enroll some other types of in-home direct care staff and include their identification on claims submissions. Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services* (St. Paul, January 2017), 89-91.

Chapter 4: Other Issues

While Minnesota has made significant progress over the last several years in moving Medical Assistance (MA) recipients with disabilities out of large institutions and into their own homes or foster homes, much work still remains. As we saw in previous chapters, in comparison with other states, Minnesota relies more heavily on foster home settings, many operated by for-profit businesses. Also, Minnesota's MA expenditures for home- and community-based services (HCBS) are sizeable compared with other states' spending.[1] At the same time, the state has implemented few oversight mechanisms to ensure that HCBS are being delivered as planned.

During the course of our evaluation, we learned about other challenges and issues, aside from financial accountability, facing policy makers, people with disabilities, and those that work with or for them. This final chapter discusses some of those issues.

Additional Challenges

As part of our research, we asked representatives from several counties, HCBS providers, and advocacy organizations about the biggest issues facing the HCBS system.[2] This section identifies two of providers' biggest concerns: workforce staffing and payment rates. Counties were also concerned about these issues.

Direct Care Workforce

Direct care staff, such as home health aides, nursing assistants, and personal care attendants, provide much of the routine nonmedical care people with disabilities and the elderly need to live in community settings. They help with activities people without disabilities may take for granted, such as eating, walking, bathing, or dressing. Currently, providers who employ these types of direct care staff are confronting several interrelated workforce issues that are not easily resolved: demographic changes, staff shortages, low wages, and demanding work. Some issues, such as demographics, are beyond the state's control.

In Minnesota and across the nation, the number of individuals entering the workforce is growing at a much slower rate than the number of people needing assistance.

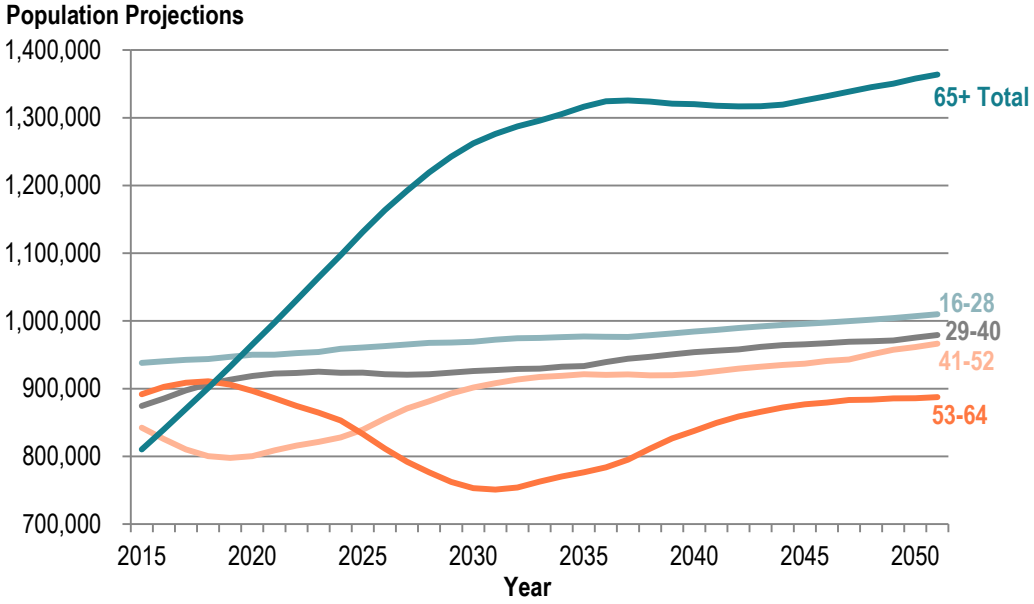
As Exhibit 4.1 shows, the number of Minnesotans ages 16 to 24 in the workforce will be relatively stagnant over the next several years. At the same time, the population of people ages 65 and older (who may need HCBS) will increase dramatically. The Minnesota State

[1] While the federal government requires that participating states provide basic healthcare services to low-income people, it generally does not require them to provide all types of HCBS. Consequently, states vary considerably regarding the HCBS they provide and the specific groups of individuals eligible to receive those services. This, in turn, affects their spending.

[2] As we explained in our Introduction, we spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount of MA payments they received for HCBS in Fiscal Year 2015, geographic location, and the types of services they delivered. Once we selected our provider sample, we talked with the counties where those providers were based. Because our two samples are not representative of either population, their comments cannot be generalized to all counties or providers.

Demographer estimates that, between 2019 and 2028, Minnesota's population ages 25 to 64 will experience a net loss of about 40,800 people.[3] The demographer predicts that the ten years following 2019 will likely be the most severe in terms of labor supply shortage in Minnesota, barring major changes in immigration or migration patterns.

Exhibit 4.1: Population Projections for Minnesota by Age Group, 2015 through 2050



SOURCE: Office of the Legislative Auditor, based on data from the Minnesota State Demographic Center.

According to the Department of Employment and Economic Development (DEED), the number of home health care jobs will increase 30 percent between 2014 and 2024, and the number of people age 65 and older will increase more than 50 percent.[4] The department lists home health aides sixth in terms of jobs with the highest projected number of openings between 2014 and 2024.[5] The department predicts that there will be 16,000 job openings for home health aides in Minnesota through 2022.[6]

Minnesota is not alone. Americans in general are living longer. Baby boomers are getting older, and medical advances are allowing more people with chronic illnesses and disabilities to live longer and more independently in the community. According to The Henry J. Kaiser Family Foundation, the number of Americans age 65 years and older is expected to more than

[3] Minnesota State Demographic Center, *Demographic Considerations for Long-Range and Strategic Planning* (St. Paul, September 2015), 8.

[4] Minnesota Department of Employment and Economic Development, *H is for Home Health Aide* (St. Paul, 2016), 1. The department defines home health care jobs as work typically done in clients' homes or nursing facilities as opposed to hospitals or clinics. In addition to administering some basic medical care, home health aides help recipients with daily activities, such as eating or dressing.

[5] Minnesota Department of Employment and Economic Development, *Employment Outlook Projections: Occupations with the Most Job Openings from Employment Growth and Replacement Needs 2014-2024* (St. Paul, 2016).

[6] Minnesota Department of Employment and Economic Development, *H is for Home Health Aide*, 1.

double between 2012 and 2050, while the number of people 85 years and older will more than triple.[7] It is estimated that, among people age 65 and older, 70 percent will use long-term services and supports.[8] Individuals age 85 and older—the fastest growing segment of the U.S. population—are four times more likely to need long-term services compared with people ages 65 to 84. Approximately seven in ten people age 90 and older have a disability, and among people between the ages of 40 and 50, almost one in ten, on average, will have a disability that may require long-term services. Meanwhile, with fewer people entering the national workforce (barring major changes in immigration or relocation patterns), competition for workers in all segments of the nation's economy is expected to be fierce.[9]

Low wages for some types of direct care staff, both in Minnesota and across the nation, further complicate home- and community-based services (HCBS) providers' ability to hire enough staff to respond to the demand for services.

In our interviews, HCBS providers told us about their current difficulties hiring some types of direct care staff, which they attribute, at least in part, to overall workforce shortages coupled with low wages. They said they compete with other healthcare employers, such as hospitals and nursing homes, which provide similar services but pay higher wages. Home- and community-based service providers also compete with other types of employers, such as grocery stores, gas stations, and hotels, for staff. They said it is difficult to compete with other types of employers that can pay the same or more for work that is considerably easier than being a direct care worker in an HCBS setting. Some providers told us they have stopped or reduced certain types of services due, in part, to staff shortages. Counties also expressed concern that some providers have stopped or will stop providing services in response to staff shortages.

Wages for some types of direct care staff are generally higher in Minnesota than in most other states, and they are generally comparable to the wage rate used by the Department of Human Services to pay HCBS providers.

Exhibit 4.2 shows wage rates for home health, nursing, and personal care aides in Minnesota compared with other states, as of May 2015.[10] Home health aides in Minnesota earned, on average, $12.22 per hour, while personal care aides averaged $11.51. These two job titles are frequently used in HCBS settings in Minnesota. The average hourly wage for nursing assistants, generally employed in nursing homes, was higher ($13.79).

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[7] *Medicaid and Long-Term Services and Supports: A Primer* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 2015), 3-4.

[8] Long-term services and supports are broadly defined as the paid and unpaid medical and personal care assistance needed when people experience problems taking care of themselves due to aging, chronic illness, or disability. Services may be provided in a variety of settings, including nursing homes and hospitals as well as in recipients' own homes.

[9] Several studies have documented the shortage of certain types of direct care workers nationwide and the growing gap between available workers and an aging population. For example, see Commission on Long-Term Care, *Report to the Congress* (Washington, DC: Government Printing Office, September 30, 2013); and *Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers* (Washington, DC: Government Accountability Office, August 2016).

[10] These figures include staff employed in a variety of settings, not just HCBS settings. For example, statewide rates reflect pay scales in hospitals, nursing homes, and treatment facilities, among other settings.

Exhibit 4.2: Mean and Median Hourly Wages of Direct Care Workers by State, May 2015

State	Home Health Aides		Nursing Assistants		Personal Care Aides	
	Mean	Median	Mean	Median	Mean	Median
Alabama	$ 9.48	$ 9.07	$10.65	$10.37	$ 8.73	$ 8.64
Alaska	14.50	14.80	17.93	17.70	14.84	15.22
Arizona	11.18	10.70	13.89	13.66	10.35	10.19
Arkansas	9.05	8.64	10.61	10.41	9.06	8.73
California	13.26	11.42	14.96	14.01	11.12	10.47
Colorado	12.59	11.54	14.12	13.80	10.63	10.39
Connecticut	12.95	12.90	15.33	14.79	12.69	12.24
Delaware	13.90	13.06	13.63	13.47	11.17	10.92
District of Columbia	12.55	12.61	15.71	15.38	12.01	12.00
Florida	11.02	10.62	11.78	11.43	10.46	10.02
Georgia	10.08	9.52	10.89	10.61	9.64	9.13
Hawaii	12.70	12.72	14.80	14.62	11.53	10.61
Idaho	10.44	9.51	11.70	11.39	9.73	9.44
Illinois	11.36	10.71	12.54	11.76	10.60	10.51
Indiana	10.62	10.51	11.70	11.31	9.51	9.39
Iowa	11.50	11.17	12.64	12.07	11.05	10.83
Kansas	11.12	10.90	11.54	11.21	10.14	10.29
Kentucky	11.36	10.54	11.77	11.53	10.29	9.83
Louisiana	9.69	9.02	10.05	9.68	8.70	8.63
Maine	11.50	10.99	12.12	11.76	10.48	10.37
Maryland	11.67	11.32	13.82	13.47	11.56	11.08
Massachusetts	13.78	13.47	14.48	14.00	13.05	13.01
Michigan	10.68	10.04	13.46	13.38	10.39	9.95
Minnesota	**12.22**	**11.87**	**13.79**	**13.39**	**11.51**	**11.15**
Mississippi	10.23	10.44	10.23	9.64	8.51	8.56
Missouri	10.73	10.82	11.48	11.06	9.68	9.33
Montana	10.82	10.72	12.12	11.71	10.69	10.57
Nebraska	11.69	11.26	12.18	11.60	11.07	10.86
Nevada	12.35	10.98	15.73	14.92	10.49	10.53
New Hampshire	12.82	12.61	14.30	13.96	11.22	11.01
New Jersey	11.07	10.71	13.61	13.30	13.50	11.50
New Mexico	11.23	9.97	12.86	12.44	9.54	9.17
New York	11.23	10.85	16.06	16.20	11.98	11.17
North Carolina	9.46	9.12	11.07	10.84	9.79	9.48
North Dakota	14.50	14.13	14.19	13.98	14.64	14.37
Ohio	10.09	9.83	12.09	11.61	10.35	9.71
Oklahoma	11.32	10.61	11.01	10.81	9.09	8.85
Oregon	11.33	10.88	14.49	14.12	11.30	10.98
Pennsylvania	10.58	10.26	13.68	13.46	10.65	10.54
Rhode Island	12.79	11.55	13.99	13.60	11.16	10.88
South Carolina	9.75	9.59	11.59	10.90	9.22	9.09
South Dakota	12.74	12.60	11.68	11.21	10.30	10.16
Tennessee	9.35	9.15	11.02	10.77	9.13	8.99
Texas	9.59	8.85	11.80	11.23	8.65	8.61
Utah	11.76	10.90	11.52	11.23	10.52	9.98
Vermont	12.71	12.73	13.27	13.13	–	–
Virginia	10.77	10.50	12.07	11.75	9.28	8.95
Washington	12.37	11.51	14.15	13.68	12.01	11.44
West Virginia	9.19	8.91	11.58	11.07	9.10	8.89
Wisconsin	11.67	11.11	13.18	12.95	10.29	10.32
Wyoming	12.88	13.18	13.47	13.29	10.85	10.64

SOURCE: *Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers* (Washington, DC: Government Accountability Office, August 2016), 33-34.

According to a recent report from the Government Accountability Office, these types of direct care workers in long-term care industries nationwide were paid, on average, $11.21 per hour in 2015.[11] Personal care aides in long-term care industries had the lowest hourly wage of direct care workers at $10.42, while psychiatric aides had the highest at $12.62. This is in the bottom quartile of all U.S. wages. The average hourly wage across all occupations nationwide was $23.23—more than twice that of these types of direct care workers.

As we discussed in Chapter 3, the Department of Human Services (DHS) collects very little financial data from HCBS providers, including wage data. This may be due, in part, to the fact that DHS does not require HCBS providers to pay certain wage rates. The department factors statewide wage rates for various types of direct care staff, including foster home staff, home health aides, homemakers, and personal care attendants, into its payment system. Payment levels for HCBS direct care staff, such as personal care attendants, home health aides, and companions, ranged from $11.86 to $12.41 in 2015—depending on the type of service. These rates are basically the same as the statewide wage rates for comparable jobs, as shown previously.

At the same time, DHS pays its own direct care staff considerably more than what is built into its payment formula, and its wage rates are higher than wage rates statewide.[12] For example, the hourly wage rate for human services technicians in state-operated foster homes ranged from $13.28 to $21.06 in Fiscal Year 2015.[13] Statewide, home health aides averaged $12.22 in 2015, as Exhibit 4.2 showed.

In recognition of HCBS workforce problems, DHS convened a workforce "summit" in July 2016 to search for possible solutions. Participants focused their attention in four areas: recruitment and use of technology, retention and compensation, training and credentialing, and career ladders and work environment. Five possible strategies emerged from the conference: (1) increase compensation, (2) expand the worker pool, (3) enhance training, (4) increase job satisfaction, and (5) raise public awareness.[14]

RECOMMENDATION

The Legislature should require the Department of Human Services to periodically collect data on current and future direct care staffing needs in HCBS settings.

[11] Government Accountability Office, *Long-Term Care Workforce: Better Information Needed*, 9-10. Wages for direct care staff reflect wages across all industries and are not exclusive to HCBS settings.

[12] The department itself is a licensed provider of HCBS in that it operates several adult foster care homes for people with disabilities.

[13] Jeffrey Schmidtman, Minnesota Management and Budget, e-mail message to Jo Vos, "MSOCS Data," October 4, 2016. The hourly wage rate for human services technicians in state-operated foster homes was, on average, $19.00 in October 2016. Human services technician is the job title the department uses to identify the majority of staff employed in its foster homes. Their duties are similar to those of home health aides, nursing assistants, and personal care attendants—helping foster home residents with their daily needs, such as dressing, eating, and bathing.

[14] Minnesota Department of Human Services, *Direct Care/Support Workforce Summit Summary Report Draft* (St. Paul, October 2016), 5.

State law requires DHS to adjust the wage rates it uses to set payment rates every five years, beginning in 2017.[15] As the law dictates, DHS uses statewide wage rates for selected job classifications, as collected by the Bureau of Labor Statistics. Although we do not object to using statewide data to set payment rates, the data do not provide sufficient insight into HCBS providers' experiences for the state to address broader workforce issues. Minnesota's HCBS system is, to a large extent, dependent on direct care staff working in recipients' own homes or foster homes. The work environment for these staff is quite different than that of direct care staff working in hospitals and nursing homes. For example, HCBS staff working in recipients' own homes are more likely to work without direct supervision, have unpredictable work schedules, and be more isolated from coworkers. Direct care staff working in foster homes are also more likely than hospital or nursing home staff to find themselves, at times, working without direct supervision.

The department needs additional data specific to HCBS providers on direct care staffing to develop effective strategies to address the problems faced by the HCBS system. These data should include: (1) the number of direct care workers employed by HCBS providers, on both a full- and part-time basis; (2) turnover; (3) the number of job vacancies; (4) average hourly wage; (5) the average benefit package, and (6) advancement opportunities. As a first step, the department should determine the extent to which other state agencies already collect related data that may be of use. To the extent that this occurs, the department should seek data sharing agreements with the agencies.

Various state and national groups and legislative bills introduced in Minnesota have made similar recommendations over the years.[16] Most recently, the Governor's 2018-2019 biennial budget recommended requiring that HCBS providers submit data on their workforce to DHS to help analyze staffing issues.[17] As has been argued, such information is necessary for state policy makers to develop appropriate strategies to address workforce issues. The information is also needed to assess the impact of those strategies over time and make whatever changes may be required.

Payment Rates

As discussed in Chapter 3, the 2013 Legislature adopted a statewide rate-setting methodology for HCBS.[18] It is intended to ensure that DHS uses uniform processes to determine payment rates. The Department of Human Services began implementing the system in January 2014, and it should be fully operational in 2019 or 2020. It is a complex system and represents a substantial change from 2012, when each county negotiated its own rates for HCBS providers. All parties involved—counties, providers, DHS, and recipients—are adjusting to the change.

Some HCBS providers with whom we talked favored having one uniform methodology to calculate rates, rather than negotiating them with each county. However, most providers expressed frustration regarding various elements of the methodology. While some county

[15] *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5h.

[16] National Direct Service Workforce Resource Center, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection* (Washington, DC: Government Printing Office, February 2009), iv; Government Accountability Office, *Long-Term Care Workforce: Better Information Needed*, 20; and H.F. 3838 and S.F. 3332, 2016 Leg., 89th Sess. (MN), art. 3, sec. 6.

[17] Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services* (St. Paul, January 2017), 47.

[18] *Laws of Minnesota* 2013, chapter 108, art. 13, sec. 12.

staff that we talked with also favored having statewide rates for HCBS, some cited problems with the system.

Some HCBS payment rates do not fully reflect state and federal requirements.

The Department of Human Services is responsible for adjusting payment rates to reflect HCBS costs affected by changes in state or federal laws.[19] Most providers that we talked with said that this has not always happened. For example, recent changes to federal Fair Labor Standards Act regulations require HCBS providers to pay minimum wage for some direct care staff who are allowed to sleep during their time on the job.[20] Because some staff must be available at night, providers pay them while they sleep onsite. The Department of Human Services pays providers a lower rate for "sleep" staff than it does for staff that must stay awake. The current sleep rate—$7.66—is below the minimum wage rate of $7.75 per hour for small employers and $9.50 per hour for large employers.[21]

Federal labor regulations also require that certain staff be compensated at no less than time and a half for overtime hours.[22] However, DHS's payment formula does not adjust rates for overtime. Many providers that we talked with expressed frustration over the amount of money they have to put toward overtime costs due to staffing shortages.

Finally, state law requires that medical professionals, such as licensed nurses, periodically provide onsite direct supervision of some direct care staff who visit HCBS recipients in their homes.[23] But DHS does not always recognize indirect supervisory costs that providers may incur when calculating payment rates. While day and foster home service rates incorporate some administrative activities, other services do not fully account for work time spent away from clients.[24] For example, for some recipient training activities, staff must document a recipient's progress, even though these types of administrative costs are not fully reflected in the rate for this service.

RECOMMENDATION

The Legislature and the Department of Human Services should ensure that HCBS payment rates adequately account for changes or requirements in state and federal regulations.

Given concerns about workforce shortages, it is important that DHS be timely about incorporating regulatory changes into its rate-setting system. The department's payment formula does not include a profit margin for HCBS providers. Consequently, providers

[19] *Minnesota Statutes* 2016, 256B.4914, subd. 10(d).

[20] 29 *CFR*, secs. 785.21 and 785.22 (2011); and 29 *CFR*, sec. 552.3 (2013).

[21] *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5a(3); and 177.24, subd. 1. As noted earlier, state law requires DHS to adjust the base wage rates used in its rate management system once every five years, beginning in 2017. *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5h.

[22] 29 *CFR*, sec. 552 (2013), effective January 2015.

[23] *Minnesota Statutes* 2016, 144A.4797, subd. 3.

[24] *Final Report: Non-Wage Provider Costs in Home and Community-Based Disability Waiver Services* (Ann Arbor, MI: Truven Health Analytics, May 31, 2016), 12.

must incur losses when the payment formula does not cover their expenses or make up for losses elsewhere in their operations. Small providers may not have the necessary cushion in their budgets to either incur losses or make up for them elsewhere in their budgets.

Framework for Delivering Home- and Community-Based Services

As we discussed in Chapters 2 and 3, the amount or type of data that DHS collects to provide financial oversight of the HCBS program vary, depending on (1) whether MA recipients with disabilities receive HCBS through the state MA plan or waivers, (2) whether recipients are enrolled in managed care or fee-for-service health plans, (3) the type of HCBS provided, and (4) the type of HCBS provider.[25] This makes it difficult for DHS to provide adequate financial oversight of HCBS providers. It also makes it difficult to understand how HCBS operates.

Overall, Minnesota's system for providing HCBS to Medical Assistance recipients with disabilities and the elderly is complex, confusing, and, at times, poorly communicated to interested parties.

For example, MA recipients with disabilities may receive HCBS as a service covered under the state's MA plan and available to all MA recipients, or as a service available only to recipients who are enrolled in one of the state's waiver programs. The same types of services are often available under both approaches, although they may differ in terms of frequency or intensity. Also, recipients may receive HCBS through either a managed care or fee-for-service health plan. As we explained in Chapter 2, DHS does not pay for HCBS in a consistent manner across both types of plans. Furthermore, different terms are sometimes used for the same or similar services across individual waivers.

In addition, information on DHS's website about HCBS is not always accurate or available in a timely manner. For example, DHS's website contains conflicting information about whether recipients who had been receiving services before the new rate system went into effect are eligible for a rate exception.[26] In another instance, counties noted that it took DHS two months to notify them about errors in certain types of transportation claims.[27] Although the claims were being submitted properly, system edits prevented them from processing correctly. Counties had to ask HCBS providers to void the affected claims and refile them once adjustments were made.

[25] As discussed in Chapter 1, Minnesota offers five HCBS waivers. They serve people with: brain injuries; chronic illnesses; developmental disabilities; physical and other disabling conditions, including mental illnesses; and recipients who are 65 years and older.

[26] Minnesota Department of Human Services, "DWRS frequently asked questions–April 2014" (April 2014), http://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/disability-waiver-rates-system/frequently-asked-questions/, accessed January 13, 2017.

[27] Minnesota Department of Human Services, "Edit 437 incorrectly posting for waiver transportation code," Disabilities Services Division eList, electronic mailing, September 1, 2016.

RECOMMENDATION

The Legislature and Department of Human Services should adopt a common set of financial reporting requirements and menu of services for HCBS, regardless of how those services are delivered.

To better understand overall spending on HCBS, there should be greater consistency in financial data collection and reporting across health plans, waivers, and the different populations of recipients with disabilities eligible for HCBS. As we discussed in Chapter 2, DHS has different data collection requirements for managed care and fee-for-service health plans—both of which enroll MA recipients with disabilities. Further, as we discussed in Chapter 3, there are different requirements for different types of direct care staff—even though they do similar work and represent similar types of financial risk. This makes it difficult for DHS to oversee HCBS providers and the services they offer. It also hampers legislative oversight because there is no way of knowing how much the state is spending for HCBS across health plans or the types of HCBS services being delivered. As a result, it is difficult for legislators and state policy makers to know whether HCBS funds are being spent in a cost-effective manner.

Having a common menu of HCBS for MA recipients with disabilities and the elderly—using uniform and consistent definitions—would make the system easier to understand. We do not think that this change would increase the amount or type of HCBS that individual recipients receive. The needs assessment process, performed by counties, would remain the main determinant of the specific services each recipient should receive via their individual service agreements. In developing its common set of services, we encourage the department to use terms and phrases that are easily understood by policy makers, counties, providers, and the public.

A recent report from the Government Accountability Office likewise recommended that the federal government do more to standardize policies, programs, and reporting requirements across programs.[28] The accountability office noted that more consistency would help "the federal government and states better manage risks to beneficiaries and protect the integrity of the program."[29]

One way Minnesota may be able to accomplish this would be by consolidating its five waivers into a single waiver. Over the last several years, the federal government has given states a variety of options for administering HCBS. For example, it has expanded states' abilities to establish more innovative service-delivery systems to improve care, increase efficiency, and reduce costs. In response, some states have made broad changes in how they administer their waivers. For example, Rhode Island received federal approval to operate its entire Medicaid program under a single demonstration waiver. It covers all Medicaid participants, including people with disabilities. Arizona also manages its entire Medicaid program under a demonstration waiver, as does Vermont. According to The Henry J. Kaiser Family Foundation, these three states "administer statewide Medicaid

[28] *Medicaid Personal Care Service: CMS Could Do More to Harmonize Requirements across Programs* (Washington, DC: Government Accountability Office, November 2016), 45-46.

[29] *Ibid*., unpaginated.

capitated managed care programs that include all HCBS covered for all populations."[30] Unlike Minnesota, they do not have individual waivers for people with certain types of disabilities.

We think combining Minnesota's five HCBS waivers into a single waiver could make the system easier to understand and administer.[31] For example, counties are currently limited in how many MA recipients can receive services under the developmental disability waiver by the amount of money they receive from DHS for that waiver. When counties run out of money, they must either (1) petition DHS for an adjustment, (2) wait until they have sufficient money, or (3) enroll recipients with more than one disabling condition in another waiver where funds are available.

Combining Minnesota's five HCBS waivers into a single waiver—with one menu of services available to all waiver participants—could help counties better address clients' needs. It could also make the entire HCBS system easier to understand for policy makers, people with disabilities and their families, and the general public.

[30] *Medicaid Home and Community-Based Services Programs: 2013 Data Update* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October 2016), 10.

[31] As part of his 2018-2019 biennial budget proposal, the Governor recommended hiring an outside contractor to study whether the state should combine its four disability-based waivers into a single waiver. Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services*, 37.

List of Recommendations

- The Legislature should increase its regulation over some types of direct care workers who provide home- and community-based services (HCBS) in recipients' own homes. (p. 51)

- The Legislature should require the Department of Human Services (DHS) to periodically collect data on current and future direct care staffing needs in HCBS settings. (p. 57)

- The Legislature and DHS should ensure that HCBS payment rates adequately account for changes or requirements in state and federal regulations. (p. 59)

- The Legislature and DHS should adopt a common set of financial reporting requirements and menu of services for HCBS, regardless of how those services are delivered. (p. 61)

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Appendix A

Several state and federal programs aside from Medical Assistance and Medicaid support people with disabilities. Some of these programs provide assistance primarily to low-income households, where people with disabilities may live, while others are directed more generally at people with disabilities.

Other State and Federal Programs

Program	Agency	Description	Eligibility
Bridges Rental Assistance Program	Minnesota Housing Finance Agency (MHFA) and Minnesota Department of Human Services (DHS)	Temporary rental assistance payments and security deposits paid directly to landlords on behalf of qualified participants	People with very or extremely low incomes and a serious mental illness, who are waiting for Housing Choice Voucher or another rental subsidy
Crisis Housing Fund	Minnesota Housing Partnership, under contract with DHS	Rental, mortgage, and utility assistance to retain current housing	Low- and moderate-income adults with a serious mental illness, residing in community-based housing, who are receiving facility-based mental health or chemical dependency treatment for 90 days or less
Disabled Veterans Program	Minnesota Department of Employment and Economic Development (DEED)	Job search counseling and assistance, including resume development; skills-building in interviewing, networking, and use of social media; and direct referral to employers with available jobs	Veterans who have left the service in the last three years, have significant challenges finding or keeping a job, or have service-connected disabilities
Energy Assistance Program	Minnesota Department of Commerce	Financial assistance to pay for various energy related items, including bills, utility disconnections, fuel deliveries, or repair or replacement of broken heating systems	Households with income at or below 50 percent of the state median income; other criteria include energy cost and household size
Extended Employment Program	DEED	Ongoing employment support services necessary to maintain and advance employment	People with significant disabilities
Group Residential Housing	DHS	Living expenses such as room and board	Low-income adults with disabilities and low-income seniors
Housing Access Services	DHS	Assistance in seeking and applying for accessible and suitable housing, including negotiating with landlords, moving, furnishing one's home, and developing a household budget	Adults who have been assessed as eligible for Medical Assistance (MA) state plan home care or waiver services, who want to move into their own homes in the community

Continued next page.

Other State and Federal Programs (continued)

Program	Agency	Description	Eligibility
Medical Assistance for Employed Persons with Disabilities	DHS	Medicaid buy-in program covering all or part of certain health care services, depending on income	People with disabilities who are working and who earn too much to qualify for MA, and who meet the asset limit
Minnesota Supplemental Aid (MSA)	DHS	Supplemental cash assistance to help Social Security recipients pay for basic needs	Adults who receive Social Security; some people who are blind, have a disability, or are older than 65, who qualify for Social Security except for the income limit, may be eligible for supplemental aid if they meet income limit
Minnesota Supplemental Aid (MSA) Housing Assistance	DHS	Cash assistance to help cover housing costs	Adults under 65 who are eligible for MSA, with housing costs over 40 percent of income and either (1) living in their own home or apartment and receiving HCBS waiver services, (2) moving to the community from an institution or treatment facility for people with serious mental health problems, or (3) eligible for personal care assistance under MA state plan
Section 8 Housing Choice Vouchers	U.S. Department of Housing and Urban Development	Provides vouchers for housing that allows renters to pay a fixed portion of their income for rent	People who meet income limits; preference may be given to people with disabilities or people aged 62 and older
Short Term Financial Assistance (Subsistence)	Minnesota Department of Veterans' Affairs (MDVA)	Income- and asset-based temporary assistance with shelter payments (rent/mortgage), utility bills, and health insurance premiums, up to six months	Veterans unable to work due to a temporary disability, or who are permanently disabled and waiting to receive a permanent benefit
Special Education	Minnesota Department of Education	Special education services individualized to the student's needs and goals	Students who have a disability and are in need of specialized education services
Social Security Disability Income	U.S. Social Security Administration	Monthly income	Those who cannot work because they have a medical condition expected to last at least one year or result in death
Supplemental Nutrition Assistance Program	U.S. Department of Agriculture	Assistance to purchase approved food items for the household from approved retailers	Low-income households that meet certain resource/asset limits

Continued next page.

Other State and Federal Programs (continued)

Program	Agency	Description	Eligibility
Supplemental Security Income	U.S. Social Security Administration	Monthly income	Low-income seniors and adults with disabilities and/or blindness; pays benefits based on financial need
Telephone services assistance including the Telephone Equipment Distribution (TED) program, Minnesota Telephone Assistance Plan (TAP), Telecommunications Access Minnesota (TAM), Lifeline, and Link-Up	DHS, Minnesota Public Utilities Commission, Minnesota Department of Commerce, local service providers, and the Federal Communications Commission (Lifeline and Link-Up)	TED loans telephone equipment; TAP provides monthly credits to low-income households; TAM provides telecommunications relay service between communication-impaired persons and conventional telephone subscribers; Lifeline provides monthly telephone service discounts; Link-Up provides discounts on telephone service installations	Low-income households, except for TED and TAM, which are designed for people with disabilities
Vocational Rehabilitation Services	DEED	Vocational rehabilitation assistance including job counseling, guidance, and search services; occupational/vocational training; and other forms of training	People with significant disabilities

SOURCE: Office of the Legislative Auditor, analyses of state and federal laws and regulations and agency documents, budgets, and websites.

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DEPARTMENT OF HUMAN SERVICES

February 16, 2017

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the program evaluation report from the Office of The Legislative Auditor on the financial oversight of Home and Community Based Services (HCBS). Home and community based services are the backbone of supports for people with disabilities and older adults, enabling Minnesota to close state hospitals and dramatically reduce more expensive institutional care, while providing services that help people live, work, and enjoy life in their communities. While we have much to be proud of, we agree that the recommendations in the report highlight areas for continued improvement.

Home and community based services developed over time, and were developed through the conversion of investments that had been made in institutional services such as nursing homes and intermediate care facilities for persons with intellectual and developmental disabilities. In fact, Minnesota, at one time, had the highest per capita capacity in these institutional services. We have worked hard to change that, and now have 94% of people with disabilities receiving home and community based services rather than institutional care. Minnesota has been ranked first in a national scorecard for services for older adults and people with disabilities by the Scan Foundation.

While we have been successful at building a system of flexible and preferred home and community based services that can adapt over different life stages, we concur we should improve how we manage these programs into the future. We spend over $2.4 billion on these services annually, involving dozens of different services and thousands of providers, and need improved tools to ensure proper oversight. The Governor's budget and the Department's policy bill include a number of proposals, which align closely with the recommendations in the report, including:

1. **Authority to collect more and better information** to improve oversight of the system, specifically for rate setting, workforce planning, and service verification.
    - Collecting workforce information from providers annually, such as rates of pay, benefits, staff turnover, and other labor measures. This will help us to plan and respond to workforce issues, with the goal of increasing the recruitment and retention of a viable home and community based services workforce.
    - Obtaining documentation from providers of their costs to deliver services to ensure rate setting methodologies accurately reflect provider costs over time.
    - Increasing required documentation by providers to verify that services billed were delivered and to enable appropriate investigations into any questionable billings

2. **Expanding provider enrollment requirements** for certain home and community based services, including personal care assistance, qualified professional services by nurses, and consumer directed community supports, so the Department can verify required qualifications and service delivery.

3. **Studying a more streamlined system**.
    - Researching and developing recommendations for the consolidation of the four disability home and community based services waivers into one program to make the system easier to understand and administer so that people are able to access the right service at the right time.
    - Studying and recommending an individual budgeting model for disability waiver recipients to increase choice in the authorization and purchasing of home and community based services, which will be even more important in determining appropriate service levels for waiver recipients if the four disability waivers are consolidated into one waiver program.

4. **Preventing fraud** by requesting ten additional staff for our Medical Assistance fraud investigation unit.
    - The additional staff will increase our capacity to investigate complaints and use data analytics to better target investigations.
    - The Department is also examining administrative options, such as additional edits in the Medicaid Management Information System to ensure services are authorized and delivered appropriately.

Thank you again for the professional and dedicated efforts of your staff during this program evaluation. These are complex programs, and we appreciate the time and diligence your staff took to complete their analysis and prepare the recommendations.

The Department's policy is to evaluate, monitor, and track until final resolution the progress being made in response to the recommendations in the report. If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at 651-431-3623.

Sincerely,

Emily Piper

Emily Piper
Commissioner

Forthcoming OLA Evaluations

Clean Water Fund Outcomes
Minnesota State High School League
Standardized Student Testing

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Iron Range Resources and Rehabilitation Board (IRRRB), March 2016
JOBZ Program, February 2008

Education, K-12 and Preschool
Perpich Center for Arts Education, January 2017
Minnesota Teacher Licensure, March 2016
Special Education, February 2013
K-12 Online Learning, September 2011
Alternative Education Programs, February 2010
Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008

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Preventive Maintenance for University of Minnesota Buildings, June 2012
MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009

Energy
Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources
Department of Natural Resources: Deer Population Management, May 2016
Recycling and Waste Reduction, February 2015
DNR Forest Management, August 2014
Sustainable Forest Incentive Program, November 2013
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
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Minnesota Board of Nursing: Complaint Resolution Process, March 2015
Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014
Helping Communities Recover from Natural Disasters, March 2012
Fiscal Notes, February 2012
Capitol Complex Security, May 2009

Health
Minnesota Department of Health Oversight of HMO Complaint Resolution, February 2016
Minnesota Health Insurance Exchange (MNsure), February 2015
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Nursing Home Inspections, February 2005

Human Services
Home- and Community-Based Services: Financial Oversight, February 2017
Managed Care Organizations' Administrative Expenses, March 2015
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Consolidation of Local Governments, April 2012

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State Protections for Meatpacking Workers, 2015
State Employee Union Fair Share Fee Calculations, July 2013
Workforce Programs, February 2010
E-Verify, June 2009
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Miscellaneous
Minnesota Film and TV Board, April 2015
The Legacy Amendment, November 2011
Public Libraries, March 2010
Economic Impact of Immigrants, May 2006
Liquor Regulation, March 2006

Transportation
MnDOT Highway Project Selection, March 2016
MnDOT Selection of Pavement Surface for Road Preservation, March 2014
MnDOT Noise Barriers, October 2013
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State Highways and Bridges, February 2008

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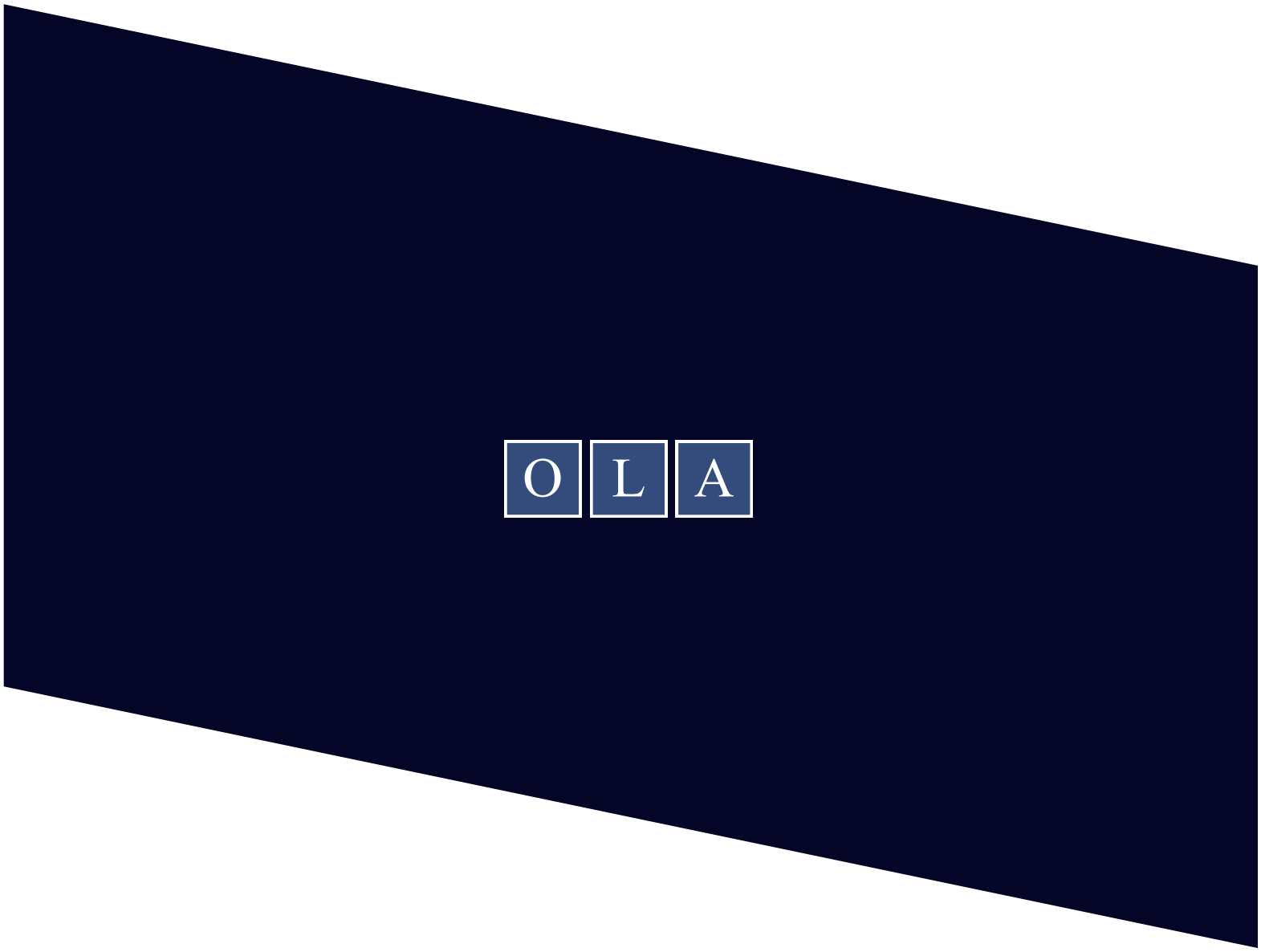

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

FINANCIAL AUDIT DIVISION REPORT

Department of Human Services

Information Verification in Eligibility Determinations

Special Review

March 26, 2013 **Report 13-05**

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OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

March 26, 2013

Senator Roger Reinert, Chair
Legislative Audit Commission

Members of the Legislative Audit Commission

Lucinda Jesson, Commissioner
Department of Human Services

This report presents the results of our special review of the Department of Human Services' compliance with federal and state requirements to use electronic file matches to verify information provided by public assistance participants and its assessment of the effectiveness of electronic file matches to validate reported income amounts for fiscal years 2012 and 2013 (through February 2013).

This special review was conducted by David Poliseno, CPA, CISA, CFE (Audit Manager) and Laura Wilson, CPA, CISA (Auditor-in-Charge), Tyler Billig, CPA, and Jordan Bjonfald, CPA (Auditors).

We received the full cooperation of the Department of Human Services' staff while performing this special review.

James R. Nobles
Legislative Auditor

Cecile M. Ferkul, CPA, CISA
Deputy Legislative Auditor

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Report Summary

Background

In December 2012, the Office of the Legislative Auditor (OLA) decided to follow up on previous OLA concerns about the process used by the Minnesota Department of Human Services to verify social security numbers and incomes reported by recipients of the state's Medical Assistance program. Our review focused on Medical Assistance and other public assistance programs, including the MinnesotaCare program, a state-created, subsidized health insurance program funded from a state tax on health care providers, federal matching funds, and enrollee premiums. We are reporting the result of our review separate from other findings that may emerge from our audit of the department's public assistance programs because we think there is a need for the department to resolve long-standing deficiencies noted in this and previous reports.

Findings

- The Department of Human Services did not comply with federal and state requirements to verify the social security numbers and income reported by participants in MinnesotaCare. (Finding 1, page 5)

- The Department of Human Services did not effectively monitor resolution of income discrepancies for several public assistance programs. (Finding 2, page 6)

Audit Scope

We audited the Department of Human Services' compliance with federal and state requirements to verify reported social security numbers and income through electronic file matches with other government data for fiscal years 2012 and 2013 (through February 2013).

Department of Human Services

Background

In December 2012, the Office of the Legislative Auditor (OLA) decided to follow up on previous OLA concerns about the process used by the Minnesota Department of Human Services to verify social security numbers and incomes reported by recipients of the state's Medical Assistance program. Our review focused on Medical Assistance and other public assistance programs, including the MinnesotaCare program, a state-created, subsidized health insurance program funded from a state tax on health care providers, federal matching funds, and enrollee premiums. We are reporting the result of our review separate from other findings that may emerge from our audit of the department's public assistance programs because we think there is a need for the department to resolve long-standing deficiencies noted in this and previous reports.

The department requires applicants for medical, cash, and food benefits to provide their social security numbers and to report their income. Federal regulations require the department to verify this information to ensure program eligibility and deter fraud.[1] In addition, state statutes require the department to use electronic file matches as the "primary method" to verify income reported by MinnesotaCare participants.[2]

The federal government requires that the state resolve 80 percent of its social security number and income discrepancies within 45 days of detection.[3] According to the department's records, county eligibility workers routinely met that requirement, averaging a resolution rate of 88 percent for fiscal years 2010, 2011, and 2012. For the Medical Assistance program, the federal government restricts the department from pursuing recovery of overpayments unless those claims are supported by a court order.[4]

In 2003, the Office of the Legislative Auditor evaluated the MinnesotaCare program and noted that the department did not use electronic file matching to verify income for MinnesotaCare participants.[5] At the time, the department asserted that the development of a planned web-based computer system would resolve the concern. The new system, referred to as HealthMatch, would provide automated eligibility determinations for nearly all its health care programs, including Medical Assistance and MinnesotaCare, and would include the ability to electronically verify income to other government databases. However, as noted

[1] Social Security Act, Section 1137 (United States Code 1320b-7).
[2] *Minnesota Statutes* 2012, 256L.05, subd. 2.
[3] 42 Code of Federal Regulations, section 435.952, and 45 Code of Federal Regulations, section 205.56.
[4] Social Security Act, section 1917(a).
[5] Office of the Legislative Auditor, Program Evaluation Division Report 03-03, *MinnesotaCare,* issued January 21, 2003.

in a follow-up evaluation in 2007, HealthMatch's development took much longer than expected due to increases in the system's scope and missteps by the contractor and the department, among other factors.[6] The evaluation noted that successful implementation of HealthMatch still faced serious risks and that a first version of the system was not likely to be released before 2009—four years later than initially expected. Ultimately, in 2008, after spending about $40 million, the department cancelled the HealthMatch contract and abandoned the project.

In 2005, the Office of the Legislative Auditor conducted an information technology audit focused on computerized file matches designed to validate the social security numbers and income of program recipients.[7] Among other weaknesses, the report noted that the department was not resolving 80 percent of the file match discrepancies within 45 days, as required by federal regulations, and that it was not analyzing how county eligibility workers resolved the discrepancies or quantifying the financial impact of benefits provided to ineligible Medical Assistance recipients.

Objectives, Scope, and Methodology

The objectives of this special review were to answer the following questions for fiscal years 2012 and 2013 (through February 2013):

- Did the Department of Human Services comply with federal and state requirements to use electronic file matches to verify information provided by MinnesotaCare participants, including social security numbers and reported income amounts?

- Did the Department of Human Services effectively use discrepancy information resulting from electronic file matches to limit public assistance benefits to eligible recipients?

To answer these questions, we interviewed department staff to discuss the income verification process and reviewed documentation supporting income verification discrepancies and records related to resolution of those discrepancies.

The following *Findings and Recommendations* provide further explanation about compliance issues with federal and state requirements.

[6] Office of the Legislative Auditor, Program Evaluation Division Report, *Follow-up Review: MinnesotaCare Eligibility Determination*, issued April 12, 2007.
[7] Office of the Legislative Auditor, Financial Audit Division Report 05-13, *Department of Human Services Medical Assistance, Temporary Assistance for Needy Families, and Food Stamp Programs - Eligibility Data Validation Controls*, issued February 24, 2005.

Findings and Recommendations

Finding 1

The Department of Human Services did not comply with federal and state requirements to verify the social security numbers and income reported by participants of MinnesotaCare.

The department did not verify social security numbers or income reported by participants of the MinnesotaCare program. The federal government requires the state to have a data exchange process that cross-checks social security numbers and income for recipients of federal programs.[8] In addition, state statute requires the department to use electronic file matches as the "primary method" to verify income reported by MinnesotaCare participants.[9] The department did not include MinnesotaCare participants in the file matches it performed for other cash, food, and medical benefit programs because it could not easily integrate MinnesotaCare data, recorded on one computer system, with the information for those programs, recorded on another computer system.

Although department management has known since at least 2003 that it was not in compliance with the federal or state file match requirements for MinnesotaCare participants, it did not develop a way to effectively validate reported social security numbers and income to other government data, such as from the Internal Revenue Service, Social Security Administration, and the Department of Employment and Economic Development. Department management had believed HealthMatch would fix the problem; the department now anticipates it will comply with the file matching requirements through implementation of the Minnesota Health Insurance Exchange.

During fiscal year 2012, the state paid about $526 million for medical benefits on behalf of about 129,000 participants in the MinnesotaCare program; the federal government funded about 44 percent of the costs, or $234 million.

Recommendation

- *The department should verify social security numbers and income reported by MinnesotaCare participants to other government data.*

[8] Social Security Act, section 1137; 42 CFR sections 435.948 and 435.953.
[9] *Minnesota Statutes* 2012, 256L.05, subd. 2.

Finding 2

The Department of Human Services did not effectively monitor resolution of income discrepancies for several public assistance programs.

The department did not effectively monitor how county eligibility workers resolved discrepancies identified by electronic file matches of reported income amounts to other government data for participants of Medical Assistance, Temporary Assistance for Needy Families, and Supplemental Nutrition Assistance programs. The number of discrepancies between information reported by program participants and data recorded in federal and state databases rose from about 165,000 in fiscal year 2010 to nearly 240,000 in fiscal year 2012. Although reports indicated that the department complied with federal requirements to resolve at least 80 percent of the discrepancies within 45 days, the department had not monitored whether the file matching process was effective in ensuring that participants were eligible for the benefits they received.

Following are some deficiencies in the file matching and discrepancy resolution process:

- The department did not assess how effective the file matching process was in identifying valid discrepancies that resulted in changes to benefits. Other than tracking that the discrepancy was resolved, to show that it had satisfied the federal requirement, it did not measure the number of discrepancies found to be invalid (resulting in no change to the benefits provided) or the number of valid discrepancies that resulted in benefit changes. The department had not adjusted criteria used in the file matching process since 2005.[10]

- Until recently, the department did not monitor whether county eligibility workers took appropriate action to determine the validity of the discrepancy and to adjust, as necessary, a participant's eligibility.[11] For example, the department did not use resolution data to identify county eligibility workers who had higher than normal rates of invalid discrepancies, perhaps indicating a lack of effort to appropriately resolve the discrepancy and resulting in a continuation of benefits to ineligible recipients.

- Also, for the Medical Assistance program, the department did not effectively quantify the benefit overpayments identified by valid file matching discrepancies. Although the department required county eligibility workers to report Medical Assistance overpayments identified as a result of the file matching process, the department did not know whether this information was complete or accurate. The department did

[10] With federal approval, 42 Code of Federal Regulations, section 435.948, allows the department to establish discrepancy thresholds for each of its verification data matches.

[11] In November 2012, the department began a study on the income verification process. At the time of this report, the department had not completed that study.

not use the information to monitor if counties assessed whether valid discrepancies were attempts by program participants to fraudulently obtain benefits.

Recommendation

- *The department should assess the effectiveness of the electronic file matching process and county eligibility workers' resolution of discrepancies to verify the eligibility of public assistance and medical program participants.*

Minnesota Department of **Human Services**

March 20, 2013

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the recommendations included in the draft audit report documenting your special review of the Department of Human Services' (department) compliance with federal and state requirements to use electronic file matches to verify information provided by public assistance program recipients. We believe this report identifies critical issues facing the department as we work to accurately determine eligibility for Minnesota's public assistance programs.

The department agrees with and supports the findings and recommendations of this report. The key weaknesses found in our processes to verify income for applicants of our public assistance programs are issues we take very seriously. We will work diligently to correct them.

The Affordable Care Act requires states to have an online eligibility application process for their Medicaid programs starting in January 2014. States must rely on electronic verification sources to the greatest extent possible in determining eligibility, and must use the verification available through the federal data hub sponsored by the Secretary of the U.S. Department of Health and Human Services. To meet these requirements the department is building a new IT platform. The department is working to determine whether the federal hub will provide all needed verification or whether continued use of additional sources through the Income Eligibility Verification System (IEVS) will be necessary.

Thank you again for the work of your office and the professionalism shown by your staff in conducting this special review.

Sincerely,

Lucinda E. Jesson
Commissioner

Enclosure

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Department of Human Services
Response to the Legislative Audit Special Review and Report on
Compliance with Income Eligibility Verification System

Audit Finding #1
The Department of Human Services did not comply with federal and state requirements to verify the social security numbers and income reported by participants of MinnesotaCare.

Audit Recommendation #1
The department should verify social security numbers and income reported by MinnesotaCare participants to other government data.

Agency Response to Recommendation #1
The department agrees with the finding and recommendation. The department will work to develop the needed IT capacity and related policies and procedures in this area.

Person Responsible: Karen Gibson, Director of Health Care Eligibility and Access
Estimated Completion Date: January 1, 2014

Audit Finding #2
The Department of Human Services did not effectively monitor resolution of income discrepancies for several public assistance programs.

Audit Recommendation #2
The department should assess the effectiveness of the electronic file matching process and county eligibility workers' resolution of discrepancies to verify the eligibility of public assistance and medical program participants.

Agency Response to Recommendation #2
The department agrees with the finding and recommendation. We will evaluate the income eligibility verification process and procedures, including thresholds used for identifying discrepancies, and make the necessary adjustments. Additionally, we will work to identify and implement controls that provide proper oversight on the county's efforts to resolve identified income discrepancies.

Person Responsible: Erin Sullivan-Sutton, Assistant Commissioner for Children and Family Services
Scott Leitz, Assistant Commissioner for Health Care Administration
Estimated Completion: September 30, 2013

DHS Oversight of Personal Care Assistance

2020
EVALUATION REPORT

Program Evaluation Division

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Program Evaluation Division

The Program Evaluation Division was created within the Office of the Legislative Auditor (OLA) in 1975. The division's mission, as set forth in law, is to determine the degree to which state agencies and programs are accomplishing their goals and objectives and utilizing resources efficiently.

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For more information about OLA and to access its reports, go to: www.auditor.leg.state.mn.us.

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OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2020

Members of the Legislative Audit Commission:

Personal care assistance (PCA) helps individuals with disabilities, chronic diseases, or mental illness live independently in their homes. PCA is available to eligible individuals enrolled in certain publicly funded health care programs, including Minnesota's Medicaid program. The Department of Human Services (DHS) is responsible for overseeing PCA in Minnesota.

Over the past eleven years, DHS and the Legislature have made changes to strengthen the oversight of PCA. However, opportunities for improvement remain. In this report, we make several recommendations to the department and the Legislature to improve DHS's oversight of PCA.

Our evaluation was conducted by Jodi Munson Rodríguez (project manager), Scott Fusco, and Katherine Theisen, with assistance from Mark Mathison and Joe Sass. DHS cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

James Nobles
Legislative Auditor

Judy Randall
Deputy Legislative Auditor

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THE GREAT SEAL OF THE STATE OF MINNESOTA
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Summary
DHS Oversight of Personal Care Assistance

Key Facts and Findings:

- Personal care assistance (PCA) helps individuals with disabilities, chronic diseases, or mental illness live independently in their homes. (p. 3)
- The number of individuals who received PCA increased by more than 10 percent between fiscal years 2015 and 2018, to a total of more than 43,700 in 2018. In Fiscal Year 2018, PCA cost about $1.03 billion. (pp. 6, 9)
- To receive PCA, individuals must have an assessment. DHS allows the use of two different assessment tools to identify need and determine eligibility for PCA. (p. 14)
- DHS has not evaluated whether the use of the two tools has produced systematically different results, and some assessors expressed concern about differences. (p. 20)
- Through its initial provider enrollment process, DHS has generally ensured that PCA agencies meet state and federal requirements, but there is room for improvement. (p. 42)
- When enrolling personal care assistants, DHS does not verify that they meet all requirements in state law. (p. 60)
- PCA agencies are required to document services provided, but state law does not specify how—or even whether—DHS must regularly ensure that agencies comply with documentation requirements. (p. 55)
- DHS has improved its ability to prevent payments to PCA agencies for impossible or implausible hours. (p. 70)
- DHS did not take timely action to fully investigate some cases in which preliminary investigation identified issues with compliance. (p. 83)
- The 2013 Legislature established Community First Services and Supports, which will replace the PCA program. The Legislature did not require DHS to implement the change by a certain date, and DHS has not yet implemented the program. (pp. 89, 91)

Key Recommendations:

- DHS should develop a firm timeline for requiring the use of the MnCHOICES assessment tool for PCA. (p. 21)
- The Legislature should require DHS to regularly evaluate the consistency of assessment results across assessors. (p. 32)
- DHS should review all required documentation to ensure compliance with legal requirements during PCA agencies' initial enrollment. (p. 47)
- DHS should ensure that PCA agencies' staff complete training as required by law. (p. 44)
- The Legislature should clarify DHS's responsibilities for monitoring PCA documentation requirements. (p. 57)
- DHS should develop a plan for investigating suspected fraud and abuse cases in a more timely way. (p. 84)
- The Legislature should review the oversight requirements in Community First Services and Supports. (p. 91)

DHS and the Legislature have made changes to strengthen the oversight of PCA, and opportunities for improvement remain.

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MARCH 2020
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Report Summary

Personal care assistance (PCA) helps individuals with disabilities, chronic diseases, or mental illness live independently in their homes and communities. PCA is available to eligible individuals enrolled in certain publicly funded health care programs, including Minnesota's Medicaid program. Lead agencies—which include counties and tribal governments—are responsible for assessing individuals to determine the activities for which they need assistance and how much assistance with those activities they are eligible to receive.

Personal care assistants may help PCA recipients with activities of daily living (such as eating and dressing), observe and redirect behaviors, or perform health-related tasks. Personal care assistants must be affiliated with PCA agencies that maintain financial records and evaluate services, among other responsibilities. Personal care assistants and PCA agencies do not need licenses, but they must enroll with the Department of Human Services (DHS). DHS is responsible for overseeing the PCA program.

More than 43,700 individuals received PCA in Fiscal Year 2018 at a cost of about $1.03 billion split nearly evenly between federal and state funding.

DHS has not evaluated whether the two assessment tools used for PCA produce systematically different results.

Since 2009, DHS and the Legislature have made changes to the PCA program in an effort to strengthen program integrity.

In 2009, OLA released an evaluation report in which it concluded that PCA was unacceptably vulnerable to fraud and abuse.[1] For example, OLA found that DHS had reimbursed PCA agencies for impossible or implausible hours, including hundreds of personal care assistants who were paid for more than 24 hours of service provided in one day or consecutive 24-hour days.

Since then, DHS has implemented electronic controls in its claims payment system that improved its ability to prevent these types of improper payments. We analyzed data on PCA claims processed in fiscal years 2015 through 2019, and found that they were generally effective in preventing payments for claims that asserted personal care assistants worked more than 24 hours per day or consecutive 24-hour days.

In addition, OLA recommended that the Legislature require DHS to implement mandatory training requirements for PCA assessors. In 2009, the Legislature passed a law that required DHS to include PCA in a broader assessment of long-term needs.[2] Assessors using this assessment are required to complete a mandatory training and certification program.[3] DHS developed the MnCHOICES tool to complete these assessments for long-term needs. It is a Web-based assessment tool and will replace the previous paper-based assessment tool, referred to as the "legacy" PCA assessment tool.[4]

More than six years have passed since DHS launched MnCHOICES, yet the department does not require lead agencies to use that assessment tool for all PCA assessments.

DHS launched MnCHOICES in November 2013 and made the tool available to most lead agencies across the state over the following 13 months. In early 2020, DHS still did not have a firm timeline for requiring lead agencies to use MnCHOICES for all PCA assessments. DHS is developing a revised version of MnCHOICES, and officials told us they plan to require lead agencies to use it for all PCA assessments after it is finished. DHS

[1] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 43.

[2] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 37, codified as *Minnesota Statutes* 2019, 256B.0911, subd. 3a(a).

[3] *Minnesota Statutes* 2019, 256B.0911, subds. 2b(a) and 2c.

[4] The legacy PCA assessment tool is called the Personal Care Assistance Assessment and Service Plan, form DHS-3244.

does not expect to roll out the new version until at least 2021.

DHS has not evaluated whether MnCHOICES and the legacy PCA assessment tool produce systematically different results; however, some assessors we surveyed and interviewed expressed concern about differences. One assessor stated, "I think the use of two different tools which create significantly different outcomes of the same person is just unfair to the people receiving the assessment."

We recommend that DHS establish a firm timeline for requiring assessors to use MnCHOICES for all PCA assessments. Allowing assessors to use two different tools without studying potential systematic differences in the results may lead to unequal access to PCA for individuals assessed with one tool rather than the other.

Through its initial provider enrollment process, DHS has generally ensured that most PCA agencies meet requirements to provide services, but there is room for improvement.

Statutes require certain PCA agency staff to complete training and background studies.[5] DHS ensured that most, but not all, PCA agencies it enrolled in Fiscal Year 2018 complied with these requirements. For example, DHS data indicate that the department did not ensure that all appropriate staff in 24 of the 93 agencies that enrolled that year completed required training according to timelines established in law.

In addition, DHS does not require PCA agencies to submit all documentation required by state law for initial enrollment. Instead, a DHS official told us that DHS requires providers to attest to meeting numerous requirements by signing a provider assurance statement. This approach does not comply with the law, and it does not allow DHS to fully execute its responsibility to oversee the enrollment of PCA agencies.

We recommend DHS ensure PCA agency staff comply with training requirements before enrolling agencies. We also recommend DHS review all required documentation to ensure compliance with legal requirements during PCA agencies' initial enrollment.

PCA agencies are required to document services provided, but state law does not specify how—or even whether—DHS must regularly ensure that all agencies comply with those requirements.

Statutes require PCA agencies to keep employee and recipient files that include specific documents, such as records of supervisory visits and PCA care plans.[6] Rules contain additional requirements to document recipients' health services and agencies' financial records.[7]

Statutes do not specify how DHS should regularly monitor PCA agencies' compliance with all requirements. Statutes require PCA agencies to revalidate their enrollment with DHS every three years but do not specify which documents DHS must review during that process.[8] Statutes also require DHS to establish a process to monitor program integrity, including random reviews of documentation.[9] However, statutes do not state how often or to what extent DHS should review service documentation.

A DHS official told us staff typically review recipient and employee files during certain site visits to PCA agencies. However, DHS policies and procedures do not clearly indicate which documents staff are expected to review.

We recommend the Legislature clarify DHS's responsibilities for monitoring ongoing PCA documentation requirements. If the Legislature, in an effort to prevent fraud and abuse, wishes for DHS to be more

DHS should do more to ensure all PCA agencies meet requirements to provide PCA.

[5] *Minnesota Statutes* 2019, 256B.0659, subds. 13(a), 13(c), 21(c), and 25.

[6] *Minnesota Statutes* 2019, 256B.0659, subd. 28(a).

[7] *Minnesota Rules*, 9505.2175, subps. 2 and 7; and 9505.2180, subp. 1, published electronically August 12, 2008.

[8] *Minnesota Statutes* 2019, 256B.04, subd. 21.

[9] *Minnesota Statutes* 2019, 256B.0651, subd. 15.

comprehensive in its oversight activities, it should make that explicit in law.

DHS did not take timely action to fully investigate some cases in which a preliminary investigation identified issues with compliance.

DHS's Office of the Inspector General (OIG) conducts investigations into potential fraud, theft, abuse, or error in Medicaid programs, including PCA. Fraud complaints go through a triage process to determine whether a full investigation is warranted. We analyzed DHS data for all preliminary investigations that were open as of November 2019. There were 317 cases in which the preliminary investigation resulted in a recommendation to open a full investigation, but DHS had not yet assigned the case to an investigator. Those cases had been waiting for an investigator to be assigned an average of more than 270 days; two cases had been waiting more than two years for assignment.

We also reviewed reports for 80 site visits completed in fiscal years 2017 through 2019. We found ten cases that were passed back and forth between different units in OIG for more than two years without taking action on the compliance issues identified.

We recommend DHS create a plan for investigating suspected fraud and abuse cases in a more timely way to ensure providers cannot engage in fraudulent practices over long periods of time.

The 2013 Legislature established a new program to replace the PCA program, but DHS has not yet implemented the new program.[10]

Community First Services and Supports, which will eventually replace the PCA program, has different oversight requirements than PCA.

While the new program—Community First Services and Supports (CFSS)—and PCA are similar in some respects, the type of oversight CFSS requires is different from PCA in several ways. For example, in PCA, qualified professionals must visit all recipients to oversee the delivery of PCA at specified intervals.[11] In CFSS, this type of direct oversight by a qualified professional is not required. However, in CFSS, consultation services providers must approve recipients' service delivery plans and provide recipients with other support.[12]

Nearly seven years have passed since the Legislature passed the law authorizing CFSS, and the Legislature has made changes to PCA that may reflect changing opinions about the level and type of oversight necessary for these services. As such, we recommend the Legislature review the oversight requirements in CFSS.

[10] *Laws of Minnesota* 2013, chapter 108, art. 7, sec. 49, codified as *Minnesota Statutes* 2019, 256B.85.

[11] *Minnesota Statutes* 2019, 256B.0659, subds. 14 and 19(a)(4).

[12] *Minnesota Statutes* 2019, 256B.85, subd. 17. Consultation services providers must approve service delivery plans for CFSS recipients that do not have a case manger or care coordinator responsible for authorizing services.

Summary of Agency Response

In a letter dated March 11, 2020, Department of Human Services Commissioner Jodi Harpstead noted that DHS is "proud of the strides we have made in overseeing [PCA] services" and that many of the recommendations from OLA's 2009 evaluation "have been operational for many years." "And," she stated, "there is always room for improvement." The commissioner went on to say that it is the department's policy "to follow up on all findings to evaluate the progress made to resolve them." The commissioner included a department response and designated a responsible person for each OLA recommendation in the report. She stated, "If there is a theme to the areas where the Department objects to the recommendations, it is in expectations suggested in the report that seem more appropriate for fully licensed services than for these intentionally unlicensed services."

The full evaluation report, *DHS Oversight of Personal Care Assistance*, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2020/pcaoversight.htm

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THE GREAT SEAL OF THE STATE OF MINNESOTA
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Chapter 1: Background

4 1.1 Eligible individuals may access personal care assistance through certain public health care programs.

7 1.2 Most Medical Assistance fee-for-service personal care assistance recipients in Fiscal Year 2018 were adults, and most were either White or Black or African American.

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Appendix A: DHS and Legislative Changes in Response to OLA Recommendations

97 A.1 Status of OLA's 2009 Recommendations

THE GREAT SEAL OF THE STATE OF MINNESOTA
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Introduction

Personal care assistance (PCA) helps eligible individuals with disabilities, chronic diseases, or mental illness complete tasks such as bathing, dressing, and remembering to take their medication. The Department of Human Services (DHS) is responsible for overseeing PCA in Minnesota. It is an important service that can enable recipients to live independently in their homes. It is also a service that is vulnerable to fraud and can create challenges in protecting recipients' safety, as it is often delivered in private homes without independent supervision.

The Office of the Legislative Auditor (OLA) completed an evaluation of PCA in 2009 in which we concluded that PCA lacked sufficient state oversight and accountability.[1] In that evaluation, OLA made numerous recommendations for the Legislature and DHS to improve oversight of PCA. In 2019, the Legislative Audit Commission directed the office to complete the current evaluation to determine how well DHS currently oversees the program. Our primary research questions were:

- **To what extent has DHS promoted consistency and provided effective guidance for completing assessments to determine an individual's need for PCA?**

- **To what extent has DHS complied with requirements related to PCA agency and personal care assistant enrollment?**

- **What procedures has DHS established for identifying fraud and abuse in PCA, and what were the results of those efforts?**

We used various research methods to answer these questions. We reviewed relevant state and federal laws, as well as DHS policies, procedures, manuals, guides, and forms. To learn about issues recipients raised about assessments, we reviewed a sample of judges' recommended orders issued in Fiscal Year 2019 related to appeals of PCA assessment results. We also reviewed a sample of reports from DHS site visits to PCA agencies from fiscal years 2017 through 2019 and shadowed a screening investigator during a site visit to learn more about DHS's PCA agency screening process.

We reviewed numerous types of data. We analyzed payment claims—and enrollment, recipient, appeals, and site visit data—from fiscal years 2015 through 2019 to learn about the scope of PCA and determine the extent to which DHS complied with state and federal requirements for administering the PCA program. We also analyzed investigations data from fiscal years 2016 through 2019.

Finally, we sought feedback from many individuals knowledgeable about PCA. We interviewed PCA recipients, parents of recipients, staff, and others with The Arc Minnesota and the Governor's Council on Developmental Disabilities. We also interviewed individuals at the Minnesota Disability Law Center, the Office of Ombudsman for Mental Health and Developmental Disabilities, SEIU Healthcare

[1] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), ix.

Minnesota, Minnesota First Provider Alliance, the Minnesota Home Care Association, and the Medicaid Fraud Control Unit in the Minnesota Office of the Attorney General. We interviewed assessors in two counties and surveyed all certified assessors in the state. We also spoke with many DHS staff throughout the agency.

Our evaluation focused on DHS's oversight of the PCA program. As such, there were several issues that we determined were outside the scope of this review. For example, we did not evaluate the quality of the services provided to recipients, nor did we determine whether individual assessment results for PCA were accurate or appropriate. Additionally, we did not examine workforce issues, such as pay for personal care assistants or the availability of personal care assistants throughout the state.

Chapter 1: Background

Thousands of Minnesotans need assistance to complete essential tasks, such as eating, bathing, and dressing on their own each day. Some individuals depend on others for assistance with getting out of bed or moving around their home. Individuals may qualify for public programs that help them obtain the assistance they need to remain in their homes and communities. One such type of assistance is called personal care assistance (PCA).[1] In Minnesota, the Department of Human Services (DHS) oversees PCA.

In this chapter, we provide an overview of PCA in Minnesota. We explain the requirements for receiving and providing PCA. We also discuss funding and oversight of the program. Finally, we provide a brief update on program changes since the Office of the Legislative Auditor (OLA) completed its last evaluation of PCA in 2009.

Personal care assistance includes help with:

Activities of Daily Living: Grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

Instrumental Activities of Daily Living: Meal planning and preparation, basic assistance paying bills and shopping for essential items, performing certain household tasks, communication, and traveling.

Observation and Redirection of Behaviors: (1) Physical aggression towards self or others, or destruction of property that requires the immediate response of another person; (2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or (3) increased need for assistance due to verbal aggression or resistance to care.

Health-related Procedures and Tasks: Tasks—such as exercise to maintain a recipient's strength and assistance with self-administered medication—that can be delegated by a licensed health professional to a personal care assistant.

— *Minnesota Statutes* 2019, 256B.0659, subds. 1, 2, and 4.

Overview

PCA is regulated by both federal and state laws. These laws describe the services that constitute PCA, eligibility criteria to receive PCA, and requirements for providers of PCA, among other things.

Personal care assistance helps individuals with disabilities, chronic diseases, or mental illness live independently in their homes.

PCA is designed to help individuals in four main areas: activities of daily living, instrumental activities of daily living, observation and redirection of certain behaviors, and health-related procedures and tasks. Individuals may access PCA in their homes or in the community, including at work, when their normal activities take them outside their homes.[2] PCA cannot be provided to individuals living in hospitals or other health care facilities.

In the following section, we describe the requirements for receiving and providing PCA. We also provide information about PCA recipients and providers.

[1] Throughout the report, when we reference PCA, we are referring to publicly funded services.

[2] *Minnesota Statutes* 2019, 256B.0625, subd. 19a.

Eligibility

Individuals that wish to receive PCA must qualify for (1) health coverage through certain publicly funded health care programs, and (2) assistance with tasks specified in law.

Personal care assistance is available to eligible individuals enrolled in certain publicly funded health care programs.

Individuals can qualify to receive PCA through public health care programs with distinct eligibility criteria intended to serve different populations. Exhibit 1.1 briefly describes the eligibility criteria for relevant programs.

Exhibit 1.1: Eligible individuals may access personal care assistance through certain public health care programs.

Program	Eligibility Criteria
Medical Assistance State Plan (Minnesota's Medicaid Program)	• Be a U.S. citizen or qualifying noncitizen • Be a Minnesota resident • Meet income and asset limits
Medical Assistance (Medicaid) Home and Community-Based Services Waivers	
Brain Injury Waiver	• Be eligible for Medical Assistance • Have an assessed need for supports and services over and above those available through the Medical Assistance state plan • Be under age 65 • Be certified disabled • Determined to need a nursing facility or neurobehavioral hospital level of care • Be diagnosed with a brain injury or neurological condition that meets certain conditions • Meet criteria for having the potential to benefit from rehabilitative services • Have an assessed need for either a specialized provider to meet cognitive or behavior impairment needs and/or higher amount of PCA time or rate for services due to cognitive or behavior impairments
Community Access for Disability Inclusion Waiver	• Be eligible for Medical Assistance • Have an assessed need for supports and services over and above those available through the Medical Assistance state plan • Be under age 65 • Be certified disabled • Determined to need a nursing facility level of care
Community Alternative Care Waiver	• Be eligible for Medical Assistance • Have an assessed need for supports and services over and above those available through the Medical Assistance state plan • Be under age 65 • Be certified disabled • Determined to meet hospital level of care criteria and certified by primary physician to need the level of care provided in a hospital

Continued on next page.

Exhibit 1.1: Eligible individuals may access personal care assistance through certain public health care programs (continued).

Program	Eligibility Criteria
Medical Assistance (Medicaid) Home and Community-Based Services Waivers (continued)	
Developmental Disabilities Waiver	• Be eligible for Medical Assistance based on a disability diagnosis • Have an assessed need for supports and services over and above those available through the Medical Assistance state plan • Determined to meet the criteria for intermediate care facility for persons with developmental disabilities (ICF/DD) level of care criteria • Have a developmental disability or a related condition as defined in rules • Require daily interventions, daily service needs, and a 24-hour plan of care specified in the community support plan • Assessed to need a residential habilitation service included in the community support plan • Have made an informed choice of waiver services instead of alternative services
Elderly Waiver	• Be eligible for payment of long-term care under Medical Assistance • Be age 65 or older • Be assessed to need a nursing facility level of care • Have a community support plan that can reasonably assure health and safety within a specified budget • Pay waiver obligation (if applicable)
Alternative Care Medicaid Waiver Demonstration Program	• Not be eligible for Medical Assistance • Be a U.S. citizen or qualifying noncitizen • Be a Minnesota resident • Be age 65 or older • Be assessed to need a nursing facility level of care • Have income and assets to sustain no more than 135 days of nursing facility services • Have a community support plan that can reasonably assure health and safety within a specified budget • Have no other payer for needed community-based services • Be able to pay a fee (if applicable)
MinnesotaCare	• Be a U.S. citizen or qualifying noncitizen • Be a Minnesota resident • Not be enrolled in or have access to Medicare Part A • Not be enrolled in Medicare Part B • Not be incarcerated, unless awaiting disposition of charges • Meet income limits • Be a pregnant woman or a child under the age of 19 to receive PCA

NOTES: "PCA" refers to personal care assistance. Individuals must meet all eligibility criteria in order to qualify for the public health program listed. Individuals may also access personal care services through other public health care programs.

SOURCES: Office of the Legislative Auditor, review of the Department of Human Services Community-Based Services Manual and the Department of Human Services MinnesotaCare and Medical Assistance Web pages, https://mn.gov/dhs/.

Minnesota primarily provides PCA through Medical Assistance, the state's Medicaid program. Minnesota has two payment models for Medical Assistance: a fee-for-service model and a Medical Assistance managed care model. In the fee-for-service model, providers submit bills to DHS for reimbursement of actual services provided, and DHS pays

for covered services. In the managed care model, DHS makes fixed payments to managed care organizations (MCOs) based on the number of individuals enrolled with the MCO. The MCO is responsible for paying providers for covered services provided to its enrollees.

To qualify for PCA based on activities of daily living, an individual must:

- Need assistance with the activity every day or on each day the activity is completed.
- Need cuing and constant supervision or hands-on assistance to complete the task.

To qualify for PCA based on behavior, an individual must:

- Demonstrate physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

— *Minnesota Statutes* 2019, 256B.0625, subd. 19a; and 256B.0659, subds. 1(c) and 4(b).

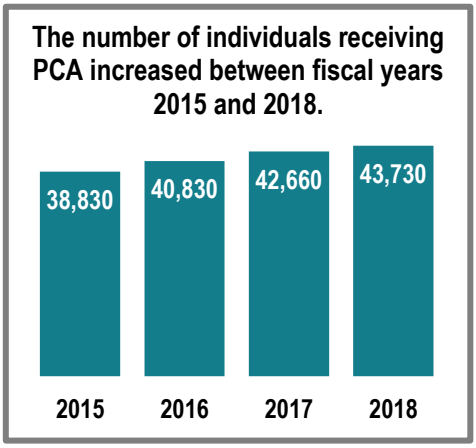
In addition to qualifying for one of the public health care programs described in Exhibit 1.1, individuals must separately qualify for PCA. Individuals must receive an assessment from their "lead agency"—counties, county alliances, tribal governments, or managed care organizations—to determine their need and eligibility for PCA. To receive PCA, the assessor must determine that the individual needs assistance with at least one activity of daily living or a qualifying behavior, as described in the box to the left.[3] In addition, the assessor must find that the individual is able to direct their own care or has a responsible party that can help them direct their care.[4] The assessor determines the amount of PCA individuals are qualified to receive based on their needs and statutory guidance.[5] We describe the assessment process in more detail in Chapter 2.

Recipients

PCA is an important service that has enabled thousands of Minnesotans to live in their homes and community. For example, a child with a behavior disorder may need help from a personal care assistant to redirect their behaviors to avoid harming themselves or others. As another example, an adult with a physical disability may need assistance with getting in and out of bed, bathing, combing their hair, and dressing.

The number of individuals who received personal care assistance increased by more than 10 percent from Fiscal Year 2015 through Fiscal Year 2018.

PCA has served an increasing number of individuals in recent years. About 38,830 individuals received PCA in Fiscal Year 2015. By Fiscal Year 2018, that number increased to about 43,730 people.[6]



[3] *Minnesota Statutes* 2019, 256B.0625, subd. 19a.

[4] Statutes define "responsible party" as "an individual who is capable of providing the support necessary to assist the recipient to live in the community." *Minnesota Statutes* 2019, 256B.0659, subd. 1(o). Responsible parties have certain responsibilities listed in law; see *Minnesota Statutes* 2019, 256B.0659, subd. 10.

[5] *Minnesota Statutes* 2019, 256B.0652, subd. 6; and 256B.0659, subd. 3a.

[6] We do not present Fiscal Year 2019 data because they were not complete at the time of our analysis. DHS allows health care providers to submit fee-for-service claims up to one year from the date of the service. Fiscal Year 2019 ended on June 30, 2019, and we received data from DHS on August 16, 2019.

The growth of individuals receiving PCA in recent years has outpaced the growth of the state's population. According to data from the Minnesota State Demographic Center, the state's population increased by about 3 percent between 2015 and 2018.

In Fiscal Year 2018, nearly two-thirds of PCA recipients received services through the Medical Assistance fee-for-service model. We examined demographic data for these individuals and found that about 69 percent of the nearly 27,800 individuals who received PCA through the Medical Assistance fee-for-service model in Fiscal Year 2018 were adults between the ages of 19 and 64, as Exhibit 1.2 shows. Forty percent of the individuals who received PCA through the Medical Assistance fee-for-service model in Fiscal Year 2018 were White, and 39 percent were Black or African American.

Exhibit 1.2: Most Medical Assistance fee-for-service personal care assistance recipients in Fiscal Year 2018 were adults, and most were either White or Black or African American.

	Percentage of Medical Assistance Fee-for-Service PCA Recipients
Age	
0-18	24%
19-64	69
65+	6
Race	
White	40
Black or African American	39
Asian	10
American Indian or Alaskan Native	5
Not reported	3
Two or more races	2
Pacific Islander or Native Hawaiian	< 1
Ethnicity	
Non-Hispanic or Latino	96
Hispanic or Latino	3
Not reported	1

NOTES: In Fiscal Year 2018, about 27,800 individuals received PCA through the Medical Assistance fee-for-service model. "PCA" refers to personal care assistance. In some cases, the percentages in the table do not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Over two-thirds (68 percent) of individuals who received PCA through the Medical Assistance fee-for-service model in Fiscal Year 2018 lived in the seven-county Twin Cities metropolitan area.[7] Thirty-one percent who received PCA through that model were located in Greater Minnesota, and about 1 percent lived in both the Twin Cities metropolitan area and in Greater Minnesota at some point during Fiscal Year 2018.

[7] The seven counties are Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Providers

PCA is provided by personal care assistants who typically perform their duties in recipients' homes or in the community. Personal care assistants must meet certain criteria in law, including minimum age and training requirements.[8] Personal care assistants are not required to be licensed, but they must enroll with DHS.

Personal care assistants must be affiliated with personal care assistance agencies that maintain financial records and evaluate services, among other responsibilities.

Like personal care assistants, PCA agencies are not required to be licensed but must enroll with DHS.[9] During the enrollment process, providers must submit documents and complete background studies and training. We describe the provider enrollment process in Chapter 3. PCA agencies have numerous administrative responsibilities.[10] These include verifying hours worked by personal care assistants, billing for services provided and paying personal care assistants for hours worked, and maintaining appropriate insurance and bonds, among other duties.[11] In addition, PCA agencies must employ a "qualified professional"—a registered nurse, licensed social worker, or other qualified individual—to periodically evaluate services provided by personal care assistants.[12]

Between fiscal years 2015 and 2018, the number of PCA agencies and personal care assistants that were enrolled with DHS increased.

Fiscal Year	Number of Enrolled PCA Agencies	Number of Enrolled Personal Care Assistants
2015	510	61,030
2016	550	73,840
2017	600	85,990
2018	680	97,240

NOTE: The numbers of enrolled personal care assistants and PCA agencies reported in this table reflect enrolled assistants and agencies listed on at least one PCA claim paid by DHS in fiscal years 2015 through 2019.

At the end of Fiscal Year 2015, 61,030 personal care assistants and about 510 PCA agencies were enrolled with DHS to provide PCA.[13] The number of personal care assistants increased to about 97,240 at the end of Fiscal Year 2018, and the number of agencies increased to about 680.

PCA agencies varied greatly in the total amount of time that they had been enrolled with DHS as of the end of Fiscal Year 2018. Some had been actively enrolled with DHS for less than 1 year, while others had been enrolled with the department for a total of more than 30 years, with a median enrollment of nearly 5 years. There was a median of 54 personal care assistants affiliated with each PCA agency that was enrolled at the end of Fiscal Year 2018.

About 84 percent of the roughly 680 PCA agencies enrolled with DHS at the end of Fiscal Year 2018 were located in the seven-county Twin Cities metropolitan area. The remaining

[8] *Minnesota Statutes* 2019, 256B.0659, subd. 11.

[9] *Minnesota Statutes* 2019, 256B.04, subd. 21(b); and 256B.0659, subds. 11(a)(3) and 24(1).

[10] *Minnesota Statutes* 2019, 256B.0659, subds. 19(b) and (c); 21(b), (c), and (d); and 24.

[11] *Ibid*.

[12] *Minnesota Statutes* 2019, 256B.0659, subds. 13(a) and (b), 14, and 19(a)(4); and 256B.0625, subd. 19(c).

[13] The numbers of enrolled personal care assistants and PCA agencies reported in this section reflect enrolled assistants and agencies listed on at least one PCA claim paid by DHS in fiscal years 2015 through 2019.

16 percent of PCA agencies were located in Greater Minnesota, except for three agencies that were located outside the state.

Personal care assistance agencies may offer two distinct service options: traditional or Choice.

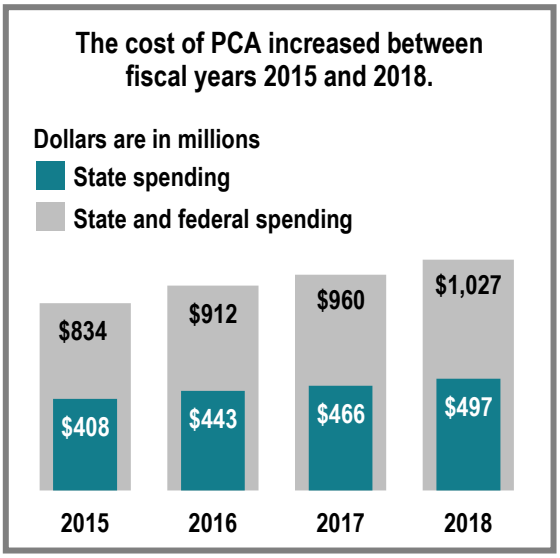
PCA recipients must choose a PCA agency and the service option through which they would prefer to receive their services. PCA agencies may offer traditional PCA, PCA Choice, or both types of services. In the traditional option, the agency is responsible for typical employer tasks, such as recruiting, hiring, training, scheduling, and firing personal care assistants. Under the PCA Choice option, recipients take on those and several of the other responsibilities assigned to PCA agencies in the traditional option.

There are some similarities between the two service options. Under both, personal care assistants must submit their time sheets to a PCA agency that is responsible for verifying and keeping records of hours personal care assistants work and paying the personal care assistant.[14] PCA agencies are responsible for billing for services and keeping most required documentation in both service options, and DHS oversees traditional and Choice services much the same way.

Funding

The cost of providing PCA increased as the number of PCA recipients grew in recent years.

From Fiscal Year 2015 through Fiscal Year 2018, the total cost of personal care assistance in Minnesota increased from about $830 million to over $1 billion.



Total spending increased by more than 20 percent during the four-year period. Federal funds generally covered about 51 percent of PCA costs each year, while state funding covered about 49 percent.

In fiscal years 2015 through 2018, about 97 percent of PCA was paid for by the Medical Assistance state plan. As we noted in Exhibit 1.1, Minnesota covers PCA through its Medical Assistance state plan, as well as Medical Assistance Home and Community-Based Services waivers. The state plan covers a specified level of PCA services, while Medical Assistance Home and Community-Based waivers can pay for services that exceed the amount available through the Medical Assistance state plan. The Medical Assistance Home and

[14] *Minnesota Statutes* 2019, 256B.0659, subds. 12(a), 19(c), and 24.

Community-Based waivers paid for only a small portion—2 percent—of PCA expenditures in fiscal years 2015 through 2018.[15]

Within the Medical Assistance state plan program, DHS paid for about two-thirds of PCA in fiscal years 2015 through 2018 through fee-for-service payments. In Fiscal Year 2018, $628 million of the $994 million Minnesota spent on Medical Assistance state plan PCA was paid for on a fee-for-service basis. This evaluation focused primarily on PCA provided through the fee-for-service Medical Assistance state plan, as this funding model served the largest number of recipients and received the highest level of funding.

Oversight

Program integrity is an important issue in PCA, both to ensure that PCA recipients are safe from harm and receiving appropriate services, and to protect state and federal resources. Because PCA is often provided in recipients' homes without direct supervision, it is a program that various government agencies have identified as having a high risk for fraud or abuse. To mitigate that risk, certain government agencies have responsibilities for overseeing PCA.

Both federal and state agencies have oversight responsibilities for the personal care assistance program.

As previously noted, most PCA is provided through Minnesota's Medicaid program, Medical Assistance. Medicaid benefits, including PCA, are administered by states through an approved Medicaid state plan and waivers. The U.S. Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for overseeing states' Medicaid plans. CMS approves changes to state plans and issues regulations and guidance to assist states in following federal law, among other responsibilities. In addition, the HHS Office of the Inspector General conducts audits, investigations, and inspections of health and human services programs, including PCA. That office also provides recommendations intended to strengthen program integrity and protect recipients.

DHS is designated as Minnesota's Medicaid administrator and has numerous oversight responsibilities articulated in state and federal law, briefly outlined below. Another entity, the Minnesota Office of the Attorney General's Medicaid Fraud Control Unit, prosecutes PCA agency owners and personal care assistants for fraudulent activity.

[15] The remaining 1 percent of PCA was paid for by other publicly funded health care programs, including the Alternative Care Medicaid Waiver Demonstration Program and MinnesotaCare. While Medical Assistance Home and Community-Based Services waivers paid for a small percentage of PCA expenditures in Fiscal Year 2018, about 41 percent of the individuals who received PCA through the Medical Assistance state plan that year were waiver recipients. If these individuals were determined to need more PCA services than the Medical Assistance state plan covered, their services that exceeded the state plan limit were paid for by their Medical Assistance Home and Community-Based Services waiver.

DHS is required to oversee the personal care assistance program through several processes.

Federal and state laws establish oversight processes intended to prevent, deter, and detect fraud and abuse in PCA, and DHS is responsible for carrying out most of those processes. For example, DHS is responsible for developing standard assessment forms for determining individuals' need for PCA.[16] The department also must enroll both PCA agencies and personal care assistants.[17]

DHS oversight responsibilities include:

- Developing PCA assessment tools
- Enrolling PCA providers
- Conducting quality assurance activities
- Paying claims
- Conducting investigations

DHS is a large agency, and its PCA oversight duties are spread across numerous divisions and work units. We describe DHS's oversight responsibilities related to PCA assessments, provider enrollment, and provider investigations in greater detail in the remainder of this report.

Legislative Changes

In response to legislative concerns, the Legislative Audit Commission directed OLA to evaluate PCA administration in 2008. In 2009, OLA released a report in which it concluded that PCA was unacceptably vulnerable to fraud and abuse.[18]

DHS and the Legislature made numerous changes in an effort to strengthen personal care assistance program integrity following a 2009 Office of the Legislative Auditor report.

The Legislature made several changes to the laws governing PCA that corresponded to recommendations in OLA's 2009 report. For example, OLA recommended the Legislature require that qualified professionals periodically supervise PCA provided through the Medical Assistance state plan.[19] In addition, OLA recommended the Legislature require all agencies providing PCA to obtain background studies on their qualified professionals.[20] The 2009 Legislature enacted both of these requirements.[21]

DHS also made numerous changes, both in response to OLA recommendations and legislative changes. For example, OLA recommended that DHS define topics on which

[16] *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a).

[17] *Minnesota Statutes* 2019, 256B.04, subd. 21(a); and 256B.0659, subds. 11(a)(3) and 24(1).

[18] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 43.

[19] *Ibid*., 70.

[20] *Ibid*., 79.

[21] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, codified as *Minnesota Statutes* 2019, 256B.0659, subds. 13 and 25.

personal care assistants should receive training.[22] The 2009 Legislature defined the topics for the personal care assistants' training in law, and DHS developed standard training all personal care assistants must complete.[23] We provide additional information about changes made in response to OLA's 2009 recommendations in Appendix A and throughout this report.

In 2013, the Legislature established a new program that will replace the PCA program.[24] Community First Services and Supports (CFSS) is intended to provide recipients with greater flexibility and choice in how they use personal care services. While PCA and CFSS share many characteristics, CFSS is different from PCA in numerous ways. We discuss CFSS in more detail in Chapter 5.

[22] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 87.

[23] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(8).

[24] *Laws of Minnesota* 2013, chapter 108, art. 7, sec. 49, codified as *Minnesota Statutes* 2019, 256B.85.

Chapter 2: Assessments

Assessments determine an individual's need and eligibility for personal care assistance (PCA).[1] By law, they must include a review of an individual's health needs, a determination of need for PCA, and identification of appropriate services, among other things.[2] Assessments are also an important tool for protecting PCA program integrity. They are a mechanism through which individuals can advocate for the supports they need to live independently in their home and community. Assessments also provide an opportunity for medical or social work professionals to speak with recipients, observe their condition, and ensure they have access to needed support. Simultaneously, they provide assessors the opportunity to direct individuals that do not qualify for PCA to more appropriate services.

Key Findings in This Chapter

- DHS allows the use of two different assessment tools to identify individuals' need and determine eligibility for personal care assistance.
- DHS has not evaluated whether the use of two tools produces systematically different results, and some assessors expressed concern about differences.
- MnCHOICES, one of the assessment tools, standardizes certain assessment processes but can still lead to inconsistent results.
- DHS has established guidance documents and standard training for MnCHOICES assessors, but many assessors indicated there is room for improvement.

In this chapter, we describe the assessment process, the assessment tools currently used to identify individuals' need for PCA, and the guidance and training the Department of Human Services (DHS) has provided to assessors. We also discuss the consistency and accuracy of assessments and explain the process for appealing assessment results. Based on our review, we make recommendations for DHS to improve its oversight of the PCA assessment process.

Assessment Process

Individuals who believe they may benefit from PCA, or their responsible party, may request a PCA assessment from their lead agency. Lead agencies include counties, county alliances, or tribal governments that administer assessment and support planning services for PCA.[3] Unlike PCA agencies, lead agencies are not involved in the provision of PCA.

[1] Throughout the report, when we reference PCA, we are referring to publicly funded services. In this chapter, we focused on PCA provided through the Medical Assistance fee-for-service state plan.

[2] *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a); and 256B.9011, subds. 2b(a) and 3a(c).

[3] The term "lead agency" can also refer to managed care organizations. However, this chapter focuses on the assessment process for PCA provided through the Medical Assistance fee-for-service state plan.

Assessor: An individual who arranges for and completes an assessment for PCA, authorizes assessment results, and provides required documentation to appropriate entities.

Lead agency: An entity that administers assessments for PCA, including a county, county alliance, or tribal government.

Responsible party: An individual who can provide the support necessary to assist a recipient to live in the community and direct a recipient's care when the recipient is unable to do so on their own. Their responsibilities include monitoring the PCA services provided and reviewing and signing time sheets.

By law, lead agencies must send an assessor to conduct an assessment within a specified timeframe.[4] Assessors typically conduct the assessment in an individual's residence, the location where services will be provided, or a health care facility when the individual is planning to move from a facility to a home setting. During an assessment, an assessor asks the individual a series of questions. Based on the individual's responses, the assessor identifies (1) whether an individual is able to direct their own care, or needs a responsible party to do so on their behalf; and (2) whether the individual needs PCA. After completing the assessment, the lead agency assessor enters the results into the state's Medicaid data system and authorizes services when applicable.

DHS sends the individual a letter to notify them of any services authorized. The letter states how much PCA time an individual may receive based on the needs identified by the assessor during the assessment and statutory guidance. Lead agencies must reassess individuals' need and eligibility for PCA every 12 months.[5]

Assessors must also develop a service plan.[6] The service plan summarizes the assessment results, describes the services needed by the individual, and identifies the expected goals of these services. For example, an assessor may record that the individual has a goal to live more independently or obtain employment. The lead agency assessor must provide a copy of the service plan to the individual or responsible party within a specified timeframe of the assessment.[7]

DHS allows lead agencies to use two different assessment tools to identify need and determine eligibility for personal care assistance.

Lead agencies may use a paper-based assessment tool commonly referred to as the "legacy" PCA assessment or the Web-based MnCHOICES assessment tool.[8]

State law contains different requirements for the two assessment tools, as shown in Exhibit 2.1. For example, while MnCHOICES assessors must complete DHS's training

[4] The timeframe to complete an assessment is different for the different assessment tools (*Minnesota Statutes* 2019, 256B.0659, subd. 3a(a); and 256B.0911, subd. 3a(a)). We describe the two types of assessment tools later in the chapter.

[5] *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a); and 256B.0911, subd. 3f(a).

[6] Assessors develop a service plan or a community support plan, depending on which assessment tool they use (*Minnesota Statutes* 2019, 256B.0659, subd. 6; and 256B.0911, subd. 2b(a)(4)). We explain the different assessment tools in the following section. The service plan must be developed in consultation with the individual or responsible party.

[7] The timeframe to provide either the service plan or the community support plan is different for the different assessment tools (*Minnesota Statutes* 2019, 256B.0659, subd. 6; and 256B.0911, subd. 3a(e)).

[8] When we refer to the "legacy" PCA assessment, we are referring to the Personal Care Assistance Assessment and Service Plan, form DHS-3244.

and become certified, legacy assessors are not required to complete DHS training.[9] In addition, assessors who use the legacy PCA assessment tool must be a public health nurse or a MnCHOICES certified assessor; an assessor who uses MnCHOICES can have a degree in social work, nursing, or a closely related field with a specified level of relevant experience.[10]

Exhibit 2.1: State law contains different requirements for the two assessment tools used to determine eligibility for personal care assistance.

Legacy PCA assessments must be:	MnCHOICES assessments must be:
• Completed by a public health nurse or a certified MnCHOICES assessor. • Completed within 30 days of a request for services. • An assessment for only PCA. • Completed face-to-face for initial assessments, when there is a significant change in condition, when there is a change in need for PCA, or at least every three years. Service updates, which may be completed by telephone, may substitute for annual reassessments under specific circumstances. • Used to develop a service plan within ten working days from the time of the assessment.	• Completed by an individual that completed the DHS training and certification process. • Completed by an individual who, at minimum, (1) has a bachelor's degree in social work, (2) has a bachelor's degree in nursing with a public health nursing certificate, (3) has a bachelor's degree in a closely related field with at least one year of home and community-based experience; or (4) is a registered nurse with at least two years of home and community-based experience. • Conducted within 20 calendar days of a request. • Used to assess a broad range of needs to support community-based living through several programs. • Completed face-to-face for all assessments and reassessments. • Used with best practices, including person-centered planning principles. • Completed by a member of a lead agency's team of certified assessors, which must include a social worker and either a public health nurse or a registered nurse. • Used to develop a community support plan that is provided to an individual within 60 calendar days of the assessment visit.

NOTES: "PCA" refers to personal care assistance. Requirements listed are only those that pertain to the assessment tools.

SOURCE: *Minnesota Statutes* 2019, 256B.0659, subds. 3a and 6; and 256B.0911, subds. 2b, 2c, 3, 3a, and 3f.

[9] *Minnesota Statutes* 2019, 256B.0911, subd. 2c.

[10] *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a); and 256B.0911, subd. 2b(b). The 2019 Legislature passed a law allowing MnCHOICES certified assessors to conduct PCA assessments using the legacy PCA assessment tool (*Laws of Minnesota* 2019, First Special Session, chapter 9, art. 5, sec. 35, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a)). Previously, legacy PCA assessments could only be conducted by public health nurses.

Legacy Personal Care Assistance Assessment

As noted in Chapter 1, the Office of the Legislative Auditor (OLA) completed an evaluation of PCA in 2009. In that evaluation, we found a lack of controls to ensure reasonably consistent assessments of individuals' needs for PCA.[11] The 2009 Legislature passed a law that modified aspects of the PCA assessment and service authorization processes.[12] As part of the reform, DHS developed the legacy PCA assessment tool.

The legacy PCA assessment tool was designed specifically to assess individuals' need for PCA. It includes questions with "Yes/No" answer options to record an individual's need for a specified level of assistance with an activity. The tool primarily uses open-ended comment sections to capture information about each individual's unique situation, as shown in Exhibit 2.2. For example, an assessor might ask an individual to describe their process for getting dressed and record the response in the blank space in the assessment tool. Based on the individual's response, the assessor determines if the individual has a dependency (needs a specified level of assistance) in the activity of dressing and chooses "Yes" or "No." The assessor also indicates whether the information recorded in the assessment is self-reported by the individual or observed by the assessor. The assessor calculates how much PCA time the individual is eligible to receive, based on the number and types of activities and behaviors for which they qualify to receive assistance and statutory guidance.[13]

MnCHOICES

In addition to modifying the PCA assessment and service authorization processes, the 2009 Legislature required DHS to include PCA in a broader assessment of individuals' needs for long-term supports and services.[14] DHS developed the MnCHOICES tool to complete these assessments of long-term needs. MnCHOICES not only assesses an individual's eligibility for PCA services, it also assesses their eligibility for multiple programs, including PCA and Medical Assistance Home and Community-Based Services waivers. In the past, individuals received separate assessments for different types of services or waivers. Now, during the MnCHOICES assessment, individuals are assessed concurrently to determine eligibility and support planning across multiple programs. MnCHOICES is a Web-based assessment tool which will replace the legacy PCA assessment tool. MnCHOICES is intended to provide more consistency in eligibility determinations by using a computer program to determine (1) individuals' eligibility for PCA and (2) the amount of PCA individuals are eligible to receive. MnCHOICES is also intended to promote equal access to services, eliminating the need to request separate assessments for different programs.

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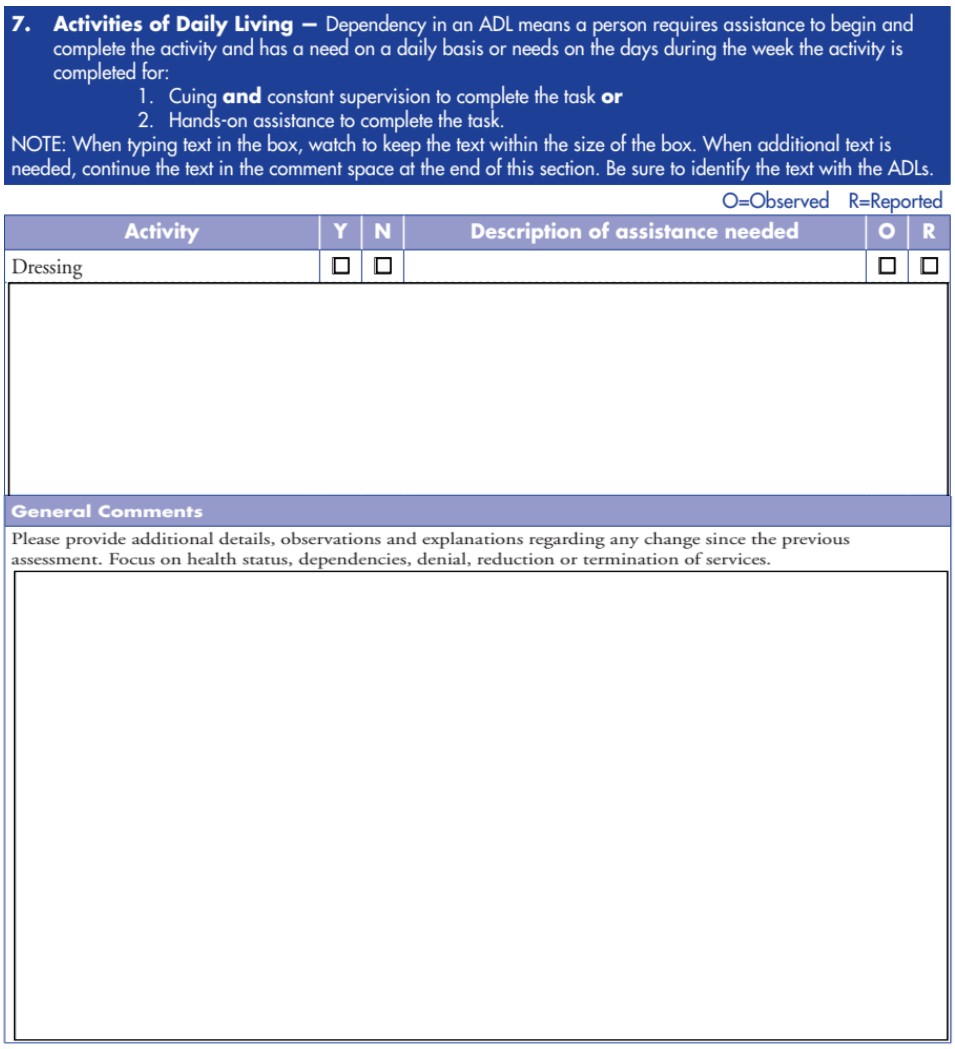
[11] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 31.

[12] *Laws of Minnesota* 2009, chapter 79, art. 8, secs. 20, 21, 23, 24, 27, 28, and 31.

[13] *Minnesota Statutes* 2019, 256B.0652, subd. 6.

[14] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 37. The 2009 Legislature required PCA to be included in this broader assessment by January 1, 2011. Subsequent legislative action removed a specific implementation date. *Laws of Minnesota* 2012, chapter 216, art. 11, sec. 11, codified as *Minnesota Statutes* 2019, 256B.0911, subd. 3a(a).

Exhibit 2.2: The legacy personal care assistance assessment tool includes open-ended comment sections to describe an individual's need for personal care assistance.



7. Activities of Daily Living – Dependency in an ADL means a person requires assistance to begin and complete the activity and has a need on a daily basis or needs on the days during the week the activity is completed for:

1. Cuing **and** constant supervision to complete the task **or**
2. Hands-on assistance to complete the task.

NOTE: When typing text in the box, watch to keep the text within the size of the box. When additional text is needed, continue the text in the comment space at the end of this section. Be sure to identify the text with the ADLs.

O=Observed R=Reported

Activity	Y	N	Description of assistance needed	O	R
Dressing	☐	☐		☐	☐

General Comments

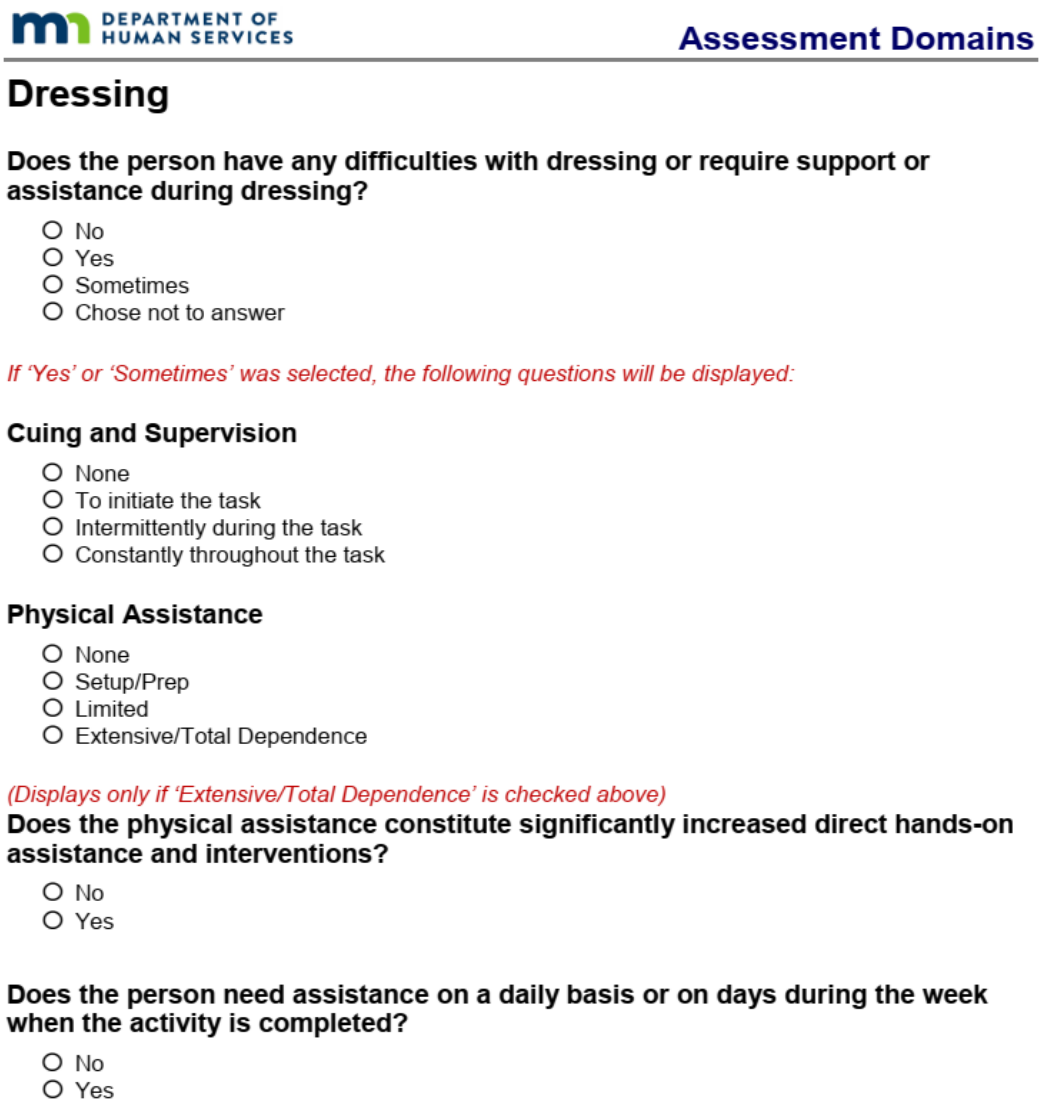
Please provide additional details, observations and explanations regarding any change since the previous assessment. Focus on health status, dependencies, denial, reduction or termination of services.

NOTE: The image contains all questions in the legacy personal care assistance assessment tool for determining a need for assistance with dressing.

SOURCE: Department of Human Services, form DHS-3244-ENG, *Personal Care Assistance Assessment and Service Plan,* February 2014.

MnCHOICES prompts assessors to ask individuals questions in more than a dozen different categories. Questions in MnCHOICES are generally close-ended, as shown in the example in Exhibit 2.3. Assessors select one of the answer options provided in MnCHOICES based on individuals' responses and their own professional judgment. As Exhibit 2.3 shows, there are more questions in MnCHOICES than in the legacy PCA assessment tool, with additional questions appearing if the assessor selects certain answers.

Exhibit 2.3: The MnCHOICES assessment tool contains mostly close-ended questions to determine a need for personal care assistance.



DEPARTMENT OF HUMAN SERVICES

Assessment Domains

Dressing

Does the person have any difficulties with dressing or require support or assistance during dressing?

- ○ No
- ○ Yes
- ○ Sometimes
- ○ Chose not to answer

If 'Yes' or 'Sometimes' was selected, the following questions will be displayed:

Cuing and Supervision

- ○ None
- ○ To initiate the task
- ○ Intermittently during the task
- ○ Constantly throughout the task

Physical Assistance

- ○ None
- ○ Setup/Prep
- ○ Limited
- ○ Extensive/Total Dependence

(Displays only if 'Extensive/Total Dependence' is checked above)

Does the physical assistance constitute significantly increased direct hands-on assistance and interventions?

- ○ No
- ○ Yes

Does the person need assistance on a daily basis or on days during the week when the activity is completed?

- ○ No
- ○ Yes

NOTE: The image contains only 5 of 12 potential questions in the MnCHOICES assessment tool for determining a need for support with dressing.

SOURCE: Department of Human Services, MnCHOICES Assessment, *Activities of Daily Living*, 12, updated June 12, 2017.

DHS launched MnCHOICES in November 2013. After testing the tool with select counties, the department made MnCHOICES available to all county, county alliance, and tribal government lead agencies over the next 13 months. Lead agencies that used MnCHOICES provided DHS with feedback, and DHS is currently in the process of incorporating lead agencies' feedback into a second version of MnCHOICES. The department has not established a firm launch date for the revised MnCHOICES tool.

More than six years have passed since DHS launched MnCHOICES, yet the department does not require lead agencies to use that assessment tool for all personal care assistance assessments.

While DHS officials told us that they generally require lead agencies to use MnCHOICES for *initial* PCA assessments, they also told us that DHS leadership determined that there are exceptions to this requirement. For example, department officials said they allowed lead agencies to use the legacy PCA assessment tool to assess individuals switching from receiving PCA through managed care organizations to fee-for-service in 2019 because some lead agencies were experiencing issues with staffing.

DHS allows lead agencies to determine whether they will conduct *reassessments* for PCA with MnCHOICES or the legacy PCA assessment tool. In addition, the PCA Program Manual states that assessors should use the legacy PCA assessment tool to document service updates.[15] A DHS official told us that the department currently has no mechanisms in place to enforce the use of MnCHOICES for initial assessments or reassessments for PCA.

Additionally, DHS does not track whether PCA assessments are completed with MnCHOICES or the legacy PCA assessment tool. DHS officials told us they asked lead agencies to self-report progress toward full implementation of MnCHOICES at one point, but the department did not have current data on the number of PCA assessments completed with each type of assessment tool when we requested it.

A DHS official told us the department has postponed requiring all PCA assessments to be completed using MnCHOICES for several reasons. State law directs DHS to work with lead agencies to modify the MnCHOICES tool and assessment policies to create efficiencies.[16] A DHS official told us DHS has extended the implementation timeline for MnCHOICES, in part, to meet this requirement to create efficiencies. In addition, the same DHS official noted that some lead agencies have struggled to secure an adequate number of certified assessors.

[15] Minnesota Department of Human Services, Personal Care Assistance Manual, *Eligibility, Assessment: Assessment for PCA Services*, updated July 9, 2018, https://www.dhs.state.mn.us/main/idcplg?IdcService =GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=PCA_01, accessed June 18, 2019. Service updates may be done in place of reassessments if (1) an individual's need for PCA has not changed, (2) an individual's condition has not significantly changed, and (3) the individual does not participate in the PCA Choice service option. Service updates may substitute for two consecutive reassessments if followed by a face-to-face reassessment. Unlike reassessments, which must occur in person, service updates may be completed by telephone. During a service update, assessors must review an individual's baseline data; evaluate the effectiveness of services; redetermine service need; provide consumer education; and modify the service authorization, service plan, appropriate referrals, and initial forms (*Minnesota Statutes* 2019, 256B.0659, subds. 3a(a) and 19(a)(6)).

[16] *Minnesota Statutes* 2019, 256B.0911, subd. 5(b).

DHS officials also told us the department does not plan to require lead agencies to use MnCHOICES for all PCA assessments until the revised MnCHOICES tool rolls out; one official told us DHS expects lead agencies to complete all PCA assessments with MnCHOICES approximately six months after the launch of the revised MnCHOICES tool. Although DHS originally planned to roll out the revised MnCHOICES tool in the second half of 2019, DHS has pushed the launch date for the revised MnCHOICES tool back by at least two years.

DHS has not evaluated whether MnCHOICES and the legacy personal care assistance assessment tools produce systematically different results for personal care assistance; however, some assessors expressed concern about differences.

One DHS official told us that the legacy PCA assessment tool and the MnCHOICES tool use the same eligibility criteria, so it should not matter which assessment a recipient receives; the results should be the same. A DHS official also told us that they have not heard of systematic differences between the two types of assessments.

However, the two assessment tools are different, and they can be completed by individuals with different professional backgrounds and training. Numerous assessors, advocates, and others told us that they believe the two assessment tools produce different results. We surveyed all certified MnCHOICES assessors as of July 2019 and asked them about the MnCHOICES assessment tool and DHS's oversight of the PCA assessment process.[17]

> "I am more concerned about assessors using the legacy tool and the variation that creates than those only using MnCHOICES. I think the use of two different tools which create significantly different outcomes of the same person is just unfair to the people receiving the assessment. If you happen to get a legacy assessment you are likely to get more PCA. If you get a MnCHOICES you're likely to get less. In my experience it seems that the MnCHOICES assessment results in [a] more accurate assignment of hours while the legacy tends to be heavy on the hours approved.
>
> **— MnCHOICES assessor**

In our survey, we asked certified MnCHOICES assessors what, in their experience, have generally been the results when they assessed individuals' eligibility for PCA with MnCHOICES after the individuals were assessed using the legacy PCA assessment tool. More than 40 percent of respondents indicated that individuals generally were eligible for *less* PCA time after being assessed with MnCHOICES. Less than one quarter of respondents indicated that individuals generally were eligible for the same amount of PCA time after being assessed with MnCHOICES; more than one-quarter of respondents indicated that they did not know.[18] Among the reasons provided for differences in

[17] We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of certified MnCHOICES assessors, as of July 2019, in their jurisdiction. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed.

[18] The remaining respondents indicated that individuals generally were eligible for more PCA time after being assessed with MnCHOICES.

assessment results was that the legacy PCA assessment tool allows for more subjectivity than MnCHOICES. For example, as one assessor shared,

> Having used the legacy PCA assessment in the past and now using the MnCHOICES assessment I have found that with the Legacy it was much easier to manipulate the total approved hours based on the assessor's opinion of what the person may need. …. While there is still room for interpretation in the MnCHOICES assessment it is a much more standard way to determine PCA hours….

We interviewed eight assessors from two counties and individuals from advocacy and provider organizations. Five of the assessors told us that the legacy PCA assessment tool is subjective and it is easy to increase PCA service time when using the tool. These five assessors also mentioned that the legacy PCA assessment tool often gives the individual being assessed more PCA time than MnCHOICES. Several individuals from different advocacy and provider organizations also told us that legacy PCA assessments typically provide recipients more hours than MnCHOICES.

RECOMMENDATION

DHS should establish a firm timeline for requiring assessors to use the MnCHOICES assessment tool for all personal care assistance assessments.

DHS has allowed the use of two separate assessment tools to determine PCA eligibility for more than six years without studying potential systematic differences in the results of these assessments. We understand that DHS has encountered difficulties in the implementation of MnCHOICES and that the transition has been difficult for lead agencies. But, the use of two tools may lead to unequal access to PCA for recipients who are assessed using one tool rather than the other. It is important to have reasonably consistent PCA assessment results throughout Minnesota so that individuals have equal access to PCA.

We acknowledge that some members of the public have concerns about MnCHOICES, and we express concerns as well in the following section of this report. The Legislature could determine that MnCHOICES is unworkable and direct DHS to develop a different system. However, no assessment process will be perfect. Each individual being assessed for PCA has unique needs and each individual conducting an assessment has a unique background that influences their professional judgment.

While not perfect, we believe DHS can mitigate many concerns about the MnCHOICES tool by continuing to engage in a process of ongoing improvement. DHS has already taken steps to improve MnCHOICES and continues to do so with the forthcoming revised MnCHOICES tool. For instance, DHS solicited feedback on the assessment process from hundreds of assessors during regional meetings in 2016. Through that process, the department identified changes necessary for the current version of MnCHOICES and changes to make in the revised MnCHOICES tool. As an example of those changes, DHS reported that it has reduced the number of required questions in MnCHOICES and reorganized the assessment to reduce the time required to complete assessment interviews. We believe that continuing to improve upon the MnCHOICES tool is a better use of resources than the alternatives.

MnCHOICES Assessment Integrity

In this section, we discuss the guidance DHS provides to lead agencies and MnCHOICES assessors, as well as the training the department provides to MnCHOICES assessors. We also discuss the consistency and accuracy of the MnCHOICES assessment tool. We focus on MnCHOICES because the Legislature mandated that MnCHOICES be used for all PCA assessments in the future, and DHS has committed significant resources to creating and revising the tool.[19]

DHS Guidance to Lead Agencies

DHS and lead agencies share legal responsibility for the assessment process. For example, DHS is responsible for creating the assessment form, and lead agencies are responsible for using the form to conduct an assessment to determine individuals' need and eligibility for PCA. Lead agencies must also develop a community support plan, as shown below.

Lead agencies must:

- Use certified assessors who completed DHS training to assess individuals for health concerns and support needs, among other things. Certified assessors must use person-centered planning principles to fulfill responsibilities listed in law.
- Visit individuals within 20 calendar days after an assessment was requested.
- Maintain sufficient numbers of certified assessors.
- Use a team of certified assessors to provide input upon request when assessing individuals.
- Develop a community support plan within 60 calendar days of the assessment.
- Provide a copy of the community support plan to the individual or responsible party.
- Provide materials and forms regarding the individual's service options and appeal rights, among other things, to the individual.
- Determine level of care and eligibility for PCA.

— *Minnesota Statutes* 2019, 256B.0911, subds. 2b(a), 2c, 3(b), and 3a(a), (e), and (j).

DHS must:

- Provide training and a certification process for MnCHOICES assessors.
- Establish timelines to provide an individual or individual's legal representative a written community support plan.
- Allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint teams of certified assessors.
- Provide an assessment form.
- Supply materials and forms regarding an individual's service options and appeal rights, among other things, to the lead agency.
- Develop mechanisms for providers to share information with the assessor to facilitate reassessments and support planning tailored to a person's needs and preferences.
- Streamline the assessment process and modify the MnCHOICES tool to create efficiencies.

— *Minnesota Statutes* 2019, 256B.0911, subds. 2c, 3(c), 3a(c), (e), and (j), 3f(b), and 5.

DHS provides direction to lead agencies about conducting assessments for personal care assistance.

One way in which DHS provides lead agencies with direction on their MnCHOICES assessment responsibilities is through an assurance agreement. Lead agencies must sign

[19] *Minnesota Statutes* 2019, 256B.0911, subd. 3a(a) and (c).

the agreement, which outlines DHS's basic performance expectations for the implementation and administration of MnCHOICES. For example, the assurance agreement states that lead agencies must maintain an adequate number of certified assessors to complete assessments within required timelines. The assurance agreement does not specify administrative sanctions DHS could impose for lead agencies' noncompliance.

Additionally, DHS provides guidance to lead agencies through policy manuals. Lead agencies may access these manuals to review legal requirements and department policies and procedures. These manuals also provide a platform for DHS to communicate expectations and responsibilities. We reviewed these manuals and the MnCHOICES assurance agreement and determined that DHS's guidance generally included lead agencies' legal responsibilities.

Assessor Guidance and Training

As we noted previously, statutes require DHS to develop a training and certification process for MnCHOICES assessors.[20]

DHS has established guidance documents and standard training for MnCHOICES assessors, but many assessors indicated there is room for improvement.

Guidance

In addition to formal training, DHS provides guidance to assessors through websites, policy manuals, and designated mentors in each lead agency, among other resources. For example, DHS operates a website through which lead agency staff can submit questions about assessments or PCA. DHS staff answer these questions and make the questions and answers available for others to reference. In addition, DHS encourages each lead agency to designate mentors to offer guidance to other certified assessors. Mentors also act as liaisons between the agency and DHS to raise concerns or questions. DHS staff said they use these resources to help ensure assessors are assessing individuals according to the same standards or rules.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we reported that DHS had insufficient guidance and training for PCA assessors.

DHS has established guidance documents, and the Legislature mandated standard training for MnCHOICES assessors.

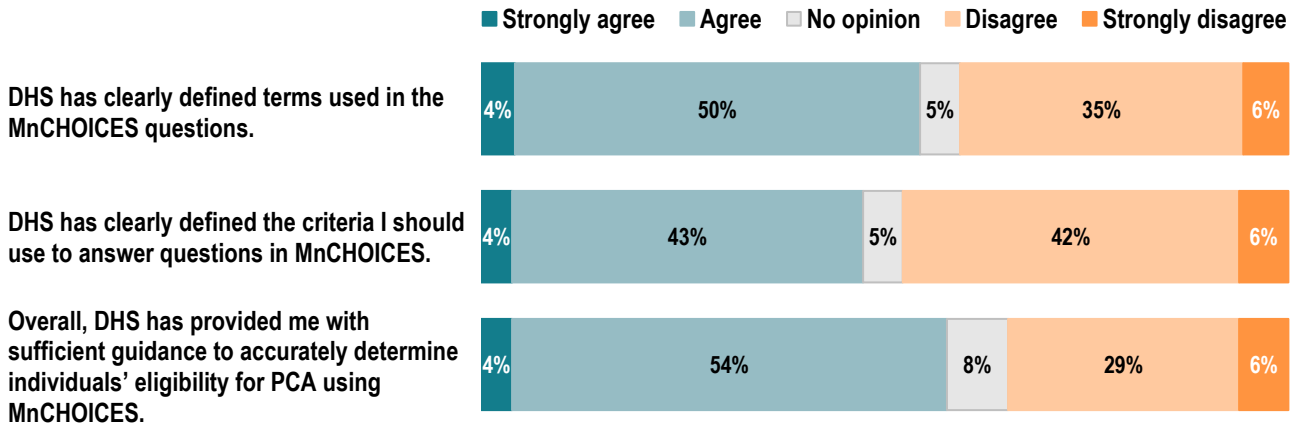
— *Minnesota Statutes* 2019, 256B.0911, subd. 2c.

[20] *Minnesota Statutes* 2019, 256B.0911, subd. 2c.

Although DHS has made efforts to provide assessors with guidance on how to use the MnCHOICES assessment tool to determine eligibility, a number of assessors we surveyed and spoke with indicated it was insufficient. For example, in our survey of MnCHOICES assessors, we asked if they received sufficient guidance from DHS to accurately determine individuals' eligibility for PCA. While 58 percent of assessors who responded to our survey indicated they agreed or strongly agreed that DHS provided sufficient guidance to accurately determine eligibility, 35 percent of respondents disagreed or strongly disagreed. In addition, as shown in Exhibit 2.4, only about half of assessors who responded to our survey indicated that DHS clearly defined other aspects of the MnCHOICES tool.

> When assessing for PCA, using the [MnCHOICES] tool, we have received different instructions from DHS. …. Different supervisors instruct differently based on the incongruous answers they have each received from DHS at various times. We would benefit from some instructions in writing added to the tool....
>
> **— MnCHOICES assessor**

Exhibit 2.4: About half of assessors who responded to our survey said that DHS has clearly defined certain aspects of the MnCHOICES tool.



NOTES: We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of certified MnCHOICES assessors in their jurisdiction as of July 2019. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed. For these survey questions, *N* = 934, 934, and 936, respectively. In some cases, the percentages in the charts do not sum to 100 percent due to rounding. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor, survey of certified MnCHOICES assessors.

One common theme we heard from assessors we interviewed and surveyed was that they need more guidance to better understand how they should answer the questions in the MnCHOICES tool. One assessor noted that without more guidance or standards, assessors may select different responses to MnCHOICES questions, which could result in a different outcome for the same PCA recipient. They said this is particularly true if different assessors reassess the PCA recipient each year. The assessor said that differences in assessment results year to year can be difficult for families because the amount of PCA time could vary.

> Too much room for professional opinion - the answer options should be clearly defined.
>
> **— MnCHOICES assessor**
>
> It would be extremely helpful if MnCHOICES had definitions built into the assessment that the assessor could click on to read what is meant by terms such as "limited assistance," "constant supervision" vs "intermittent supervision," etc., and the whole behavior section could use some definitions and better explaining.
>
> **— MnCHOICES assessor**

Six of the eight assessors we interviewed indicated that DHS does not provide sufficient guidance on how to interpret and answer questions in MnCHOICES. For example, the MnCHOICES assessment tool prompts assessors to answer questions about individuals' need for assistance with certain activities as "limited," "extensive," "intermittently during the task" or "constantly throughout the task," among other answer options. Two of the assessors we interviewed said that there were no clear definitions for these terms. Another assessor said these categories are problematic because some people fall in between them.

Training

State law requires assessors to complete a standard MnCHOICES training curriculum created by DHS.[21] The training is not specific to PCA, but rather focuses on using person-centered approaches and interview techniques to allow an individual to explain their needs. DHS's Disability Services Division developed training that includes interactive Web-based training sessions and learning modules to provide information needed to conduct assessments. Lead agencies are responsible for ensuring that assessors complete DHS's training. At the end of the training, assessors must complete a practice assessment in MnCHOICES using a story about a fictitious person. In the final step for certification, assessors must pass a test with at least 80 percent proficiency.

Each certified assessor must complete continued learning units and become recertified every three years.[22] State law requires lead agencies to ensure that certified assessors renew their certification and that agencies have sufficient numbers of certified assessors to provide assessments and support planning.[23]

In our survey, we asked certified MnCHOICES assessors to describe the quality of the training they received from DHS to accurately complete assessments using MnCHOICES.

---

[21] *Minnesota Statutes* 2019, 256B.0911, subds. 2b(a) and 2c.

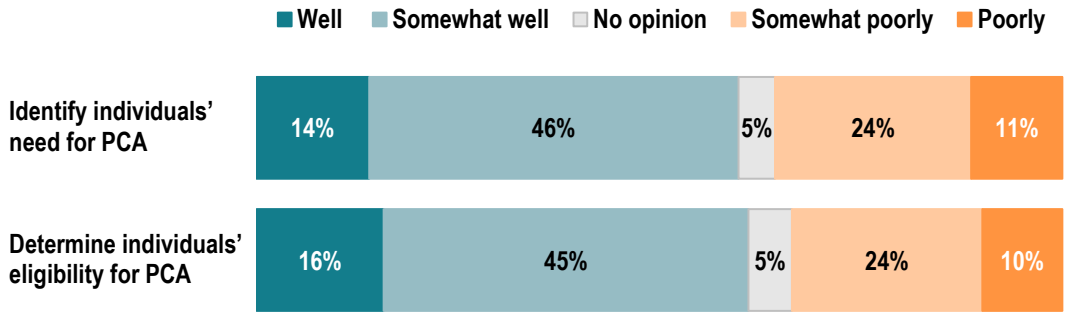
[22] *Ibid.*

[23] *Ibid.*

Only about 40 percent of assessors responded that the training was "good" or "very good." We also asked certified MnCHOICES assessors to rate how well the training they received from DHS prepared them to accurately identify individuals' need for PCA and determine individuals' eligibility. Most assessors who responded to our survey indicated that DHS's training prepared them at least somewhat well to accurately identify need and determine eligibility for PCA, as shown in Exhibit 2.5.

Exhibit 2.5: Most assessors who responded to our survey indicated that DHS's training prepared them at least somewhat well to accurately identify need and determine eligibility for personal care assistance.

Rate how well you were prepared from DHS's training to accurately:



NOTES: We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of currently certified MnCHOICES assessors in their jurisdiction as of July 2019. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed. For these survey questions, *N* = 945 and 944, respectively. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor, survey of certified MnCHOICES assessors.

> I am not a nurse. Nurses may have additional knowledge relating to medical conditions and understand terminology that I may not understand. I may not ask the same questions as someone with a medical background. I may miss medical complications that could affect a PCA determination.
>
> **— MnCHOICES assessor**

MnCHOICES assessors we spoke with and surveyed offered a variety of suggestions on how DHS could improve its training. For example, a few assessors we surveyed shared a desire to receive some training on medical conditions prior to conducting assessments for PCA services. This type of training is not currently part of MnCHOICES training. Two assessors we interviewed said that without advanced medical knowledge, especially when assessing an individual with complex health needs, it is difficult to assess the individual. One assessor we surveyed said, "DHS provided little information about Complex Health needs. It would be beneficial for the medical terms to be defined and explained [in an] in person training and/or a guide…."

Some assessors we surveyed noted that the mandatory training does not cover eligibility criteria well for PCA services or the PCA program in general. One assessor wrote, "More training would be helpful, especially for new assessors, in what the different levels of assistance means for [activities of daily living] and what qualifies a person for additional time."

RECOMMENDATION

DHS should regularly consult with assessors to improve its MnCHOICES training program, including guidance available to assessors, and make timely use of the feedback.

DHS reports that it has requested feedback from assessors and begun incorporating more guidance and definitions into the revised MnCHOICES tool. However, as we noted previously, a DHS official said the department has delayed the roll-out of the revised MnCHOICES tool for at least two years. Until that time, assessors may be left with unanswered questions and recipients may be receiving inconsistent assessment results based on assessors' varying interpretations of questions and answers. DHS should improve efforts to provide increased guidance in a timely way.

DHS has developed a training and certification process for MnCHOICES assessors but does not require that all personal care assistance assessments be completed by certified assessors.

DHS's training and certification process has the potential to help standardize assessors' use of MnCHOICES and improve the consistency of assessment results.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that the Legislature require DHS to implement mandatory training requirements for persons conducting assessments of individuals' need for PCA.

Statutes require all MnCHOICES assessors to complete training.

—*Minnesota Statutes* 2019, 256B.0911, subd. 2b(a).

However, DHS's efforts to provide standardized training are weakened by its use of two assessments—one of which can be completed by assessors that may not have received standard training. Assessors who use the legacy PCA assessment tool are not required to complete standard training or to become certified. MnCHOICES assessors can have different professional backgrounds than legacy assessors and are trained to use the MnCHOICES tool. However, the 2019 Legislature passed a law allowing certified MnCHOICES assessors to also complete PCA assessments using the legacy PCA assessment tool.[24] As we noted previously, there are differences between the two tools, and this change could create variation in results. As we recommended earlier, DHS should set a firm timeline for requiring the use of MnCHOICES for all PCA assessments to reduce the possibility for variation in eligibility determinations.

[24] *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 5, sec. 35, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 3a(a).

Consistency in MnCHOICES Assessments

As we noted previously, OLA's 2009 report, *Personal Care Assistance*, highlighted a number of issues with the PCA assessment process.[25] OLA found that Minnesota had "not established sufficient guidance and controls to ensure reasonably consistent, sound assessments" for personal care assistance.[26] OLA concluded that inconsistent assessment practices were a possible explanation for variation in the use of PCA across the state and differences in the extent to which counties assessed individuals for certain needs.[27] Consequently, the legislature and DHS made several changes to the PCA assessment process. Two of the Legislature's and DHS's efforts to address inconsistent assessment results included (1) standardizing the methodology for determining the amount of PCA time individuals may receive and (2) establishing electronic controls in the Medicaid data system.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we reported that there were insufficient guidance and controls to ensure reasonable levels of consistency in assessments.

The Legislature and DHS have introduced controls in the PCA assessment process to help standardize results.

The 2009 Legislature revised the home care rating system, which is the basis for determining how much PCA time an individual may receive.[28] The amount of PCA time an individual may receive varies based on the number and types of dependencies for which the assessor identified a need for assistance. For example, if an individual only needs assistance with one activity of daily living, such as dressing, they would qualify to receive 30 minutes of PCA each day. If an individual needs assistance with two activities of daily living, such as bathing and dressing, they would qualify for 75 minutes each day. If an individual needs assistance with two activities of daily living and one behavior, they could be eligible for 105 minutes of PCA each day.

In an effort to consistently authorize PCA time in accordance with individuals' home care ratings and prevent billing for unauthorized services, DHS incorporated electronic controls into its Medicaid data system. For example, some electronic controls are designed to prevent assessors from entering service authorizations with incorrect home care ratings based on assessment results. Another electronic control denies payment for claims that exceed authorized amounts of PCA.

As we previously noted, in an effort to produce more consistency in eligibility determinations, DHS also developed the MnCHOICES assessment tool.

MnCHOICES standardizes certain assessment processes but can still lead to inconsistent results.

DHS designed MnCHOICES to reduce inconsistency across assessors by automating the process of determining PCA eligibility. However, assessors still must use their

[25] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009).

[26] *Ibid.*, 31.

[27] *Ibid.*, 27-29 and 31-33.

[28] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 28, codified as *Minnesota Statutes* 2019, 256B.0652, subd. 6.

professional judgment when using MnCHOICES. Three key ways in which they use their judgment is by: (1) varying the order and phrasing of questions in the assessment tool, (2) asking follow-up questions to fully understand an individual's responses, and (3) interpreting an individual's responses and selecting appropriate answer options in MnCHOICES.

> I believe that when determining PCA it is all based [on] the assessor's perception. As a nurse, my perception of an individual's needs may differ from a social worker as we may view their level of assistance in different perspectives.
>
> **— MnCHOICES assessor**

According to state law, certified assessors must conduct assessments as a conversation with the individual about their needs.[29] A DHS official told us the questions in the MnCHOICES tool are not meant to be asked exactly as they are written. This allows assessors to tailor the questions in MnCHOICES and ask follow-up questions so that individuals can fully understand what the assessor is asking and provide an accurate response. This type of flexibility can be important for assessors to accurately determine individuals' needs, but it can also introduce inconsistency due to different assessors asking questions in different ways. As a result, one individual could receive different amounts of PCA if they were assessed by two different assessors using the MnCHOICES tool.

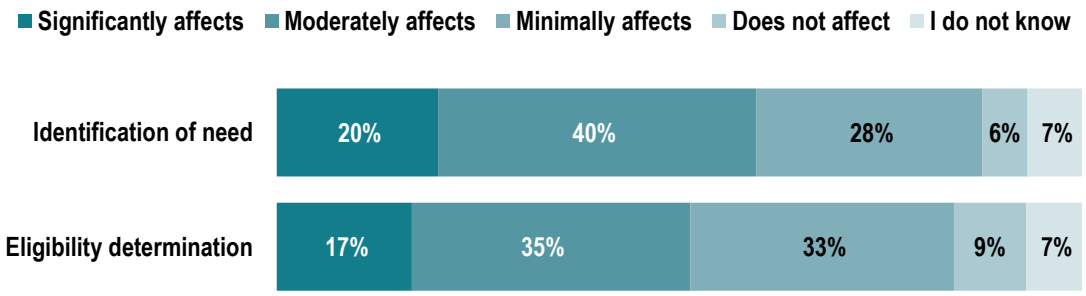
Inconsistency can also occur based on how individuals respond to questions and how assessors record those responses. DHS trains assessors to use their professional judgment when choosing among the set of answers in the MnCHOICES assessment tool. Additionally, assessors we interviewed told us that they are instructed to answer the questions in MnCHOICES based only on what individuals tell them rather than their own observations. For example, an assessor said they may observe an individual answer the door or move from the couch to a chair on their own. However, if the individual describes a need for help with moving around their home, the assessor told us DHS has instructed assessors to use the self-reported data rather than their own observations when answering questions in MnCHOICES. This can be important for individuals whose needs may change throughout the day; for example, an individual may have a medical condition that makes it impossible to get out of bed on their own in the morning, but can move independently during a window of time after taking pain medication. Therefore, the information provided by an individual during the assessment can also affect the assessment results.

In our survey of MnCHOICES assessors, we asked if the way in which assessors ask questions during an assessment can affect PCA assessment results. Most assessors who responded to our survey answered that it has at least a slight affect on the identification of individuals' need and determination of eligibility, as shown in Exhibit 2.6.

[29] *Minnesota Statutes* 2019, 256B.0911, subd. 3a(d).

Exhibit 2.6: Most assessors who responded to our survey indicated that the way in which assessors ask questions during a MnCHOICES assessment can affect assessment results.

To what extent do you think variation in the way in which assessors ask questions during a MnCHOICES assessment affects their:



NOTES: We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of currently certified MnCHOICES assessors in their jurisdiction as of July 2019. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed. For these survey questions, *N* = 944 and 935, respectively. The percentages in the chart do not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, survey of certified MnCHOICES assessors.

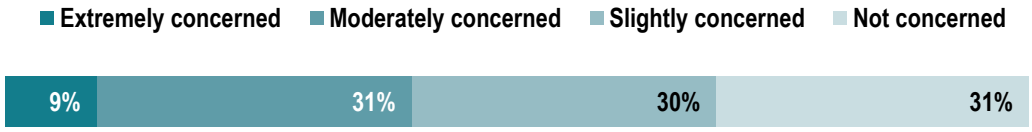
> The primary problem I see now is when a previous assessor answered questions in ways that utterly do not match my assessment, especially when the previous assessor did so in a way that gave a person more hours than I can justify. It is usually hard to tell if this is due to a change in the person's condition, or if the assessor interpreted the questions differently, or if the client gave different answers.
>
> **— MnCHOICES assessor**

As stated previously, the MnCHOICES assessment tool is intended to produce consistent and equitable access for individuals who may need PCA. But, some of the assessors we interviewed and surveyed told us that there are differences across counties in how assessors determine assessment results. One assessor told us that when they have performed reassessments for individuals that were previously assessed in other counties, assessors from other counties completed the assessment "totally different" from how the assessor we spoke with completed the assessment.

We asked assessors how concerned they were about variation in eligibility determinations when using MnCHOICES. Nearly 70 percent of assessors who responded to our survey indicated that they were at least slightly concerned, as shown in Exhibit 2.7.

Exhibit 2.7: Most assessors who responded to our survey indicated they were concerned with variation in eligibility determinations using MnCHOICES.

How concerned are you about variation in assessors' eligibility determinations for publicly funded PCA when using the MnCHOICES assessment tool?



NOTES: We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of currently certified MnCHOICES assessors in their jurisdiction as of July 2019. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed. For this survey question, *N* = 924. The percentages in the chart do not sum to 100 percent due to rounding. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor, survey of certified MnCHOICES assessors.

Several advocates and provider representatives we spoke with also expressed concern about the consistency of assessment results. One provider representative told us that the amount of PCA time an individual receives depends upon the assessor who conducts the assessment.

DHS has not evaluated the consistency of MnCHOICES assessment results across assessors.

> There is a great amount of variance between assessors within our own unit; across multiple units within the same organization; and across lead agencies.
>
> **— MnCHOICES assessor**

DHS does not have a mechanism in place to regularly review assessments for individuals that receive PCA through the fee-for-service Medical Assistance state plan. This is despite the fact that, as we stated in Chapter 1, that plan pays for the majority of PCA and the majority of individuals receive services through the Medical Assistance state plan. A DHS official told us that the department does conduct reviews for Medical Assistance Home and Community-Based Services waiver programs. This review process began in 2006 and involves case file reviews and interviews with lead agency staff.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that the Legislature require DHS to periodically review samples of PCA assessments to ensure reasonable levels of consistency.

The Legislature has not required DHS to review a sample of PCA assessments, and the department has not established a method for doing so.

In addition, DHS has not conducted a reliability study for the version of MnCHOICES currently in use. The department completed a reliability study of an early version of the revised MnCHOICES tool, but that study had numerous limitations that affected the usefulness of its results. For example, the study was conducted using an early draft of the revised MnCHOICES tool, before revisions were completed. In addition, the study was not

conducted with MnCHOICES assessors working in the field; instead, the evaluation firm hired interviewers and required them to complete MnCHOICES training. It is unclear whether those interviewers met the qualifications for MnCHOICES assessors.

RECOMMENDATION

The Legislature should require DHS to regularly evaluate the consistency of assessment results across assessors.

It would be impossible and undesirable to remove all use of professional judgment from the assessment process. Each individual that receives an assessment has unique needs that they may not be able to fully communicate if assessors were required to use overly rigid assessment methods. However, DHS should ensure that results are reasonably consistent among assessors to guarantee equal access to PCA across the state.

A DHS official told us that the department plans to evaluate the reliability and validity of data collected with MnCHOICES, including consistency across assessors. We recommend DHS and the Legislature work together to establish reasonable timelines and expectations for this work. As we explain further in Chapter 5, DHS has taken many years to implement several changes to the PCA program; the Legislature should hold the department accountable for completing evaluation work within set timelines. Establishing, in law, an expectation for DHS to conduct regular, robust evaluations of MnCHOICES assessment results can help ensure that individuals across Minnesota have equal access to services. It can also ensure that these evaluations take place consistently.

Accuracy of the MnCHOICES Assessment

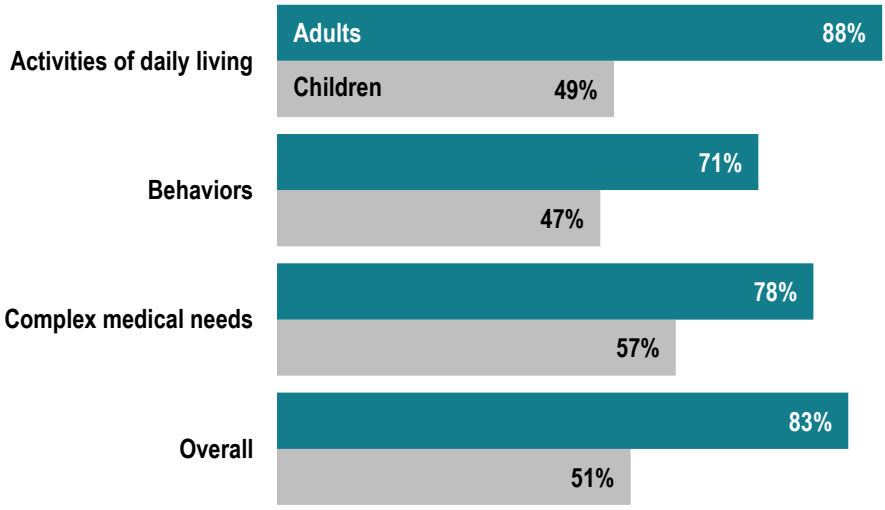
In addition to having reasonably consistent results, it is important that PCA assessments accurately capture individuals' need for PCA. An accurate assessment would correctly determine (1) the activities for which an individual is eligible to receive PCA and (2) the amount of PCA time that the individual is eligible to receive. We asked MnCHOICES assessors, separately, if MnCHOICES helps them accurately determine adults' and children's eligibility for PCA.

Most assessors we surveyed indicated that MnCHOICES was accurate when used to determine adults' eligibility for personal care assistance, but there was less agreement on its accuracy when used with children.

More than 80 percent of the assessors we surveyed responded that, overall, MnCHOICES helped them accurately determine an *adult's* eligibility for PCA. On the other hand, about half of respondents indicated that MnCHOICES helped them accurately determine *children's* eligibility for PCA, as shown in Exhibit 2.8.

Exhibit 2.8: Most assessors who responded to our survey indicated that MnCHOICES was accurate for determining an adult's eligibility for personal care assistance; fewer assessors indicated it was accurate for children.

MnCHOICES helps me accurately determine eligibility for publicly funded assistance with:



NOTES: In the survey, we noted that the questions above referred to personal care assistance. We contacted lead agencies (counties, county alliances, and tribal governments) and asked them to provide a complete list of currently certified MnCHOICES assessors in their jurisdiction as of July 2019. We received responses from 1,047 of the 1,404 assessors (75 percent) we were able to contact. We received at least one response from a certified MnCHOICES assessor from 83 counties and all five county alliances, representing all 87 counties. We also received at least one response from three of four tribal governments that we surveyed. For these survey questions, responses shown are "strongly agree" and "agree." For adults, *N* = 943, 922, 942, and 904, respectively. For children, *N* = 934, 927, 933, and 914, respectively.

SOURCE: Office of the Legislative Auditor, survey of certified MnCHOICES assessors.

A number of the assessors we surveyed noted in their open-ended comments that the MnCHOICES assessment tool does not capture children's needs well. Some assessors wrote that MnCHOICES is not age-appropriate and that DHS does not offer sufficient guidance on what to consider as age-appropriate behaviors for children. For example, assessors we spoke with told us that throwing temper tantrums can be an age-appropriate behavior for toddlers because they are learning to control their emotions and reactions. One assessor noted that there are no clear age restrictions to receive PCA for behaviors, so a toddler could be eligible to receive PCA because they throw tantrums. A DHS official told us that assessors receive training on what constitutes typical behavior for children, and typical tantrums would not qualify a toddler for PCA. However, the official acknowledged that more training in this area may be necessary.

At the same time, some advocates we spoke with expressed concern about the overall accuracy of MnCHOICES. One advocate told us they do not think it identifies individuals' needs well. Another advocate said that it is not culturally sensitive and can make it difficult for individuals who do not speak English to effectively communicate their needs. Additionally, a provider representative told us that participants may not

understand the questions, and then they end up with reduced PCA time. As we noted previously, we believe DHS can address many concerns about MnCHOICES by continuing to engage in a process of ongoing improvement. DHS should ensure it regularly incorporates feedback from assessors and recipients during this process.

Appeals of Assessment Results

In addition to the oversight activities described previously in this chapter, DHS can also oversee the assessment process through appeals of assessment results. Recipients may appeal the results of their assessments, and human services judges in DHS's Appeals Division conduct administrative fair hearings for these appeals.[30] During a hearing, a human services judge listens to the arguments and testimony from the lead agency and recipient and reviews the evidence presented to them. After the hearing, the human services judge writes a recommended order, generally affirming or modifying the results of the assessment. Chief human services judges review the recommended order and issue a final decision on behalf of the DHS commissioner.[31]

To learn more about recipients' use of the appeals process, we reviewed DHS data and a sample of recommended orders.[32] We reviewed DHS data on recommended orders issued in fiscal years 2015 through 2019, and we found that the number of appeals related to PCA decreased during that time. In Fiscal Year 2015, DHS issued more than 780 recommended orders related to PCA, but in Fiscal Year 2019, it issued about 650. An average of about 41,900 individuals received PCA—and therefore PCA assessments—each year during that five-year period, so recipients appealed less than 2 percent of assessment decisions. This may indicate that few recipients disagreed with the results of the assessment; however, it could also indicate that few were able or willing to go through the appeal process. To gain a better understanding of the reasons recipients appealed their assessment results, we also reviewed 43 recommended orders issued in Fiscal Year 2019 from appeals related to PCA.

As we explained in Chapter 1, to qualify for PCA, an assessor must determine that an individual is dependent on assistance in an activity of daily living (ADL) or a qualifying behavior.[33] Assessors determine how many minutes of PCA a recipient is eligible to receive based on the number and types of ADLs, behaviors, and complex health-related needs the assessor identifies. Complex health-related needs are interventions—such as administering intravenous medication, dressing wounds, or inserting a catheter—that are ordered by a physician and meet other criteria in law. The amount of PCA time an individual is eligible to receive is based on their assessed dependencies and statutory guidance.[34]

[30] *Minnesota Statutes* 2019, 256.045, subds. 1 and 3(a)(1).

[31] If a PCA recipient disagrees with the DHS commissioner's final order, they may appeal the order to the district court of the county in which they receive services. *Minnesota Statutes* 2019, 256.045, subd. 7.

[32] The data we reviewed pertained to fee-for-service PCA appeals.

[33] *Minnesota Statutes* 2019, 256B.0625, subd. 19a.

[34] *Minnesota Statutes* 2019, 256B.0652, subds. 6(b) and 6(c).

The appeals we reviewed most commonly involved disagreements over the appellants' needs regarding toileting, eating, mobility, and transferring.

Most of the appeals we reviewed resulted from an assessor determining a recipient was ineligible for assistance with an ADL, and the recipient disagreeing. Of the eight ADL categories, toileting was the area with the largest number of recipients disagreeing with their assessment results. Seventeen of the 43 cases we reviewed involved a disagreement about an appellant's toileting needs. Other common disagreements over ADL assessment results included eating, mobility, and transferring (moving from one seated or reclining area to another).

About one-third of the appeals we reviewed indicated that the recipient disagreed with assessment results related to behaviors or complex health-related needs. Minnesota law defines three types of behaviors for which individuals may be eligible to receive PCA, as listed in the box to the right.[35] We reviewed cases that involved each of the three areas; the most common disagreement (seven appeals) involved verbally aggressive behavior and resistance to care. There was one case in which the appellant disputed the assessment of their complex health-related need.

Dependency	Number of Appeals
Activities of Daily Living	38
Toileting	17
Eating	14
Mobility	12
Transferring	12
Positioning	7
Grooming	4
Bathing	3
Dressing	3
Behaviors	15
Verbal aggression/resistance	7
Increased vulnerability	6
Physical aggression	3
Complex Health-Related Needs	1

NOTE: Appeals often related to more than one dependency, so the data in the table do not sum to 43, the number of recommended orders we reviewed.

Nearly two-thirds of the appeals we reviewed involved a disagreement with an assessment that resulted in reduced time for PCA. In many of these cases, the assessor determined that the recipient was not eligible for assistance with a dependency in which they had previously been evaluated as eligible, so their allotted PCA time decreased. In several other cases, PCA time was not reduced, but appellants asserted that the assessment was inaccurate in determining their dependencies or that the amount of PCA time allotted for their dependencies was not sufficient to meet their needs.

[35] *Minnesota Statutes* 2019, 256B.0659, subd. 4(d).

Example: Assessment Result Affirmed

The responsible party for a PCA recipient with autism and a developmental delay appealed an assessment determination that the recipient was not dependent when toileting. The responsible party reported that the recipient was able to transfer on and off the toilet and clean themselves independently. But, the responsible party stated that the recipient needed reminders to use the toilet before bed and assistance to clean occasional accidents. The judge determined that the assessment was correct in the conclusion that the recipient did not meet the statutory criteria for a dependency in toileting because the recipient did not require (1) hands-on assistance throughout the activity or (2) step-by-step instructions to start and complete all steps of the task. The judge recommended affirming the assessment results.

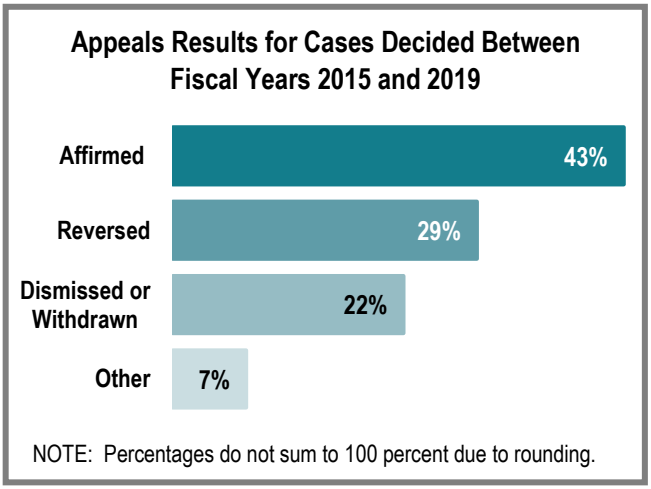
Example: Assessment Result Reversed

A PCA recipient received an assessment after a spinal fusion surgery and was found eligible for assistance with eating because they had difficulty feeding themselves. The recipient was reassessed several months later, and the assessor determined that the recipient was no longer eligible for assistance with eating because the recipient was able to feed themselves. The recipient contended that they were dependent on outside assistance because they needed someone to cut all but very soft foods for them. Meal preparation is not considered when assessors evaluate an individual's eligibility for assistance with eating, but the judge determined that cutting food is an activity that occurs after food preparation and throughout the meal, so the recipient was eligible for assistance with eating. The judge recommended reversing the assessor's determination.

We examined the extent to which human services judges concurred or disagreed with assessors' conclusions about individuals' eligibility.

DHS human services judges reversed less than one-third of the personal care assistance assessment results appealed in fiscal years 2015 through 2019.

According to DHS data, about 30 percent of the PCA appeals decided by DHS human services judges from Fiscal Year 2015 through Fiscal Year 2019 resulted in a reversal of the assessment results. More than 40 percent of appeals from fiscal years 2015 through 2019 were affirmed by a human services judge.[36]



In our review of recommended orders, we oversampled appeals in which judges reversed the assessment results in order to better

[36] Appeals that were dismissed or withdrawn have not had a decision on the merits of the case. These appeals were dismissed due to a procedural issue, such as an untimely appeal, or because the appellant cancelled the appeal. The "other" category includes appeals where (1) the chief human services judge modified the human services judge's original decision; (2) a new docket was incorrectly opened on a case that already existed; (3) the appeal was dismissed without a decision on the merits of the appeal because the appellant failed to appear at the hearing; and (4) there was not enough information in the record to make a decision, so the case was sent back to the lead agency to take further action (such as to complete a new assessment).

understand issues that judges identified with the assessments they reviewed. Twenty-one of the 43 appeals we reviewed resulted in a reversal of the assessment results. Given our small sample, it was difficult to find commonalities among judges' determinations, but there were some. For example, in four cases, the judge reversed the assessor's determination that the appellant did not need assistance with eating; instead, the judge found that the appellant's food must be cut into pieces for them at each meal. In each of those cases, the judge determined that the appellant qualified for assistance with eating. As another example, in four other cases, the judge reversed the assessment result because they found that the appellant provided credible testimony about their need and the appellant had been previously determined eligible for the dependency in question.

Although judges reversed a relatively small percentage of assessment results, the number was not insignificant. We interviewed three human services judges and they told us they had not spoken with DHS officials about their observations on the assessment process. One judge said that this could compromise the independence and objectivity of the Appeals Division. A DHS official in another division told us that staff read decisions from the Appeals Division to implement the result of the appeal in the DHS's data system. It is unclear whether DHS uses the information learned during appeals to improve the consistency of the assessment process.

RECOMMENDATION

DHS should regularly review appeals and recommended orders to identify and respond to inconsistencies in personal care assistance assessments.

Appeals of assessment results can serve as an important check on the consistency of PCA assessments. Some of the appeals we reviewed indicated that judges and assessors sometimes reached very different conclusions when reviewing similar information about a recipient. Because human services judges' decisions provide an independent review of the recipient's assessment, cases that are reversed for similar reasons could indicate that assessors may need more guidance or training in certain areas. Or, as another example, patterns in appeals could indicate that questions and response options in the MnCHOICES assessment tool lead to incorrect or inconsistent assessment results. By regularly reviewing appeals and recommended orders, DHS could identify and respond to issues that come up in appeals.

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Chapter 3: Provider Enrollment

As we stated in Chapter 1, personal care assistance (PCA) is provided by personal care assistants typically working without direct supervision in recipients' homes or in the community.[1] The lack of direct supervision can create risks to recipients' safety from neglect, abuse, or theft, and to public funds from improper or fraudulent billing.

One way to prevent and deter fraud and abuse in the PCA program is to ensure that only qualified PCA agencies and personal care assistants provide services to recipients. Because federal and state laws do not require PCA agencies or personal care assistants to be licensed, PCA agencies and personal care assistants receive less oversight of the services they provide when compared to licensed entities, such as licensed home care providers.[2] Instead, state law requires both PCA agencies and personal care assistants to enroll with the Department of Human Services (DHS) to provide publicly funded services.[3] As a result, a robust enrollment process is critical for ensuring the integrity of the PCA program.

Key Findings in This Chapter

- DHS's initial provider enrollment process has generally ensured that personal care assistance agencies meet requirements to provide personal care assistance services, but there is room for improvement.
- Personal care assistance agencies are required to document services provided, but state law does not specify how—or even whether—DHS must regularly ensure that all agencies comply with those requirements.
- When enrolling personal care assistants, DHS does not verify that they meet all requirements in state law.
- Based on our review, some personal care assistance agencies have not billed for qualified professional services, which has affected DHS's ability to monitor whether personal care assistants are adequately supervised.

In this chapter, we explain DHS's responsibilities related to PCA agency and personal care assistant enrollment. We also describe DHS's oversight responsibilities after PCA agencies and personal care assistants have enrolled with the department. We recommend that DHS improve its enrollment policies and practices so that it ensures all PCA agencies and personal care assistants meet enrollment requirements upon initial enrollment and throughout their enrollment with DHS.

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[1] Throughout the report, when we reference PCA, we are referring to publicly funded services.

[2] For example, unlike home care providers, PCA agencies do not have regular inspections, called "surveys." State law requires the Minnesota Department of Health to conduct surveys of licensed home care providers at least once every three years (*Minnesota Statutes* 2019, 144A.474, subd. 1). During these surveys, which may last several days, surveyors evaluate the care and services provided to determine whether they meet state standards. They also review the provider's staffing, policies, and procedures.

[3] *Minnesota Statutes* 2019, 256B.04, subd. 21(a); and 256B.0659, subds. 11(a)(3) and 24(1). Federal regulations also require providers to enroll with the Medicaid program when providing services funded by that program. 42 *CFR*, sec. 455.410 (2019).

Agency Enrollment

DHS's Provider Eligibility and Compliance unit is primarily responsible for enrolling PCA agencies. After PCA agencies are enrolled, the unit is responsible for ensuring DHS's information about the agency is up to date. DHS's Office of the Inspector General (OIG) also plays a key role in ensuring that PCA agencies meet enrollment requirements during their initial enrollment, as well as determining whether PCA agencies meet ongoing requirements for providing PCA services.

Owner: A person or corporation with an ownership interest of 5 percent or more in the PCA agency, or who is an officer or director of an agency organized as a corporation or a partner in an agency organized as a partnership.

— 42 *CFR*, sec. 455.101 (2019).

Managing employee: A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, a PCA agency.

— 42 *CFR*, sec. 455.101 (2019).

Qualified professional: A mental health professional, registered nurse, licensed social worker, or other professional that meets certain requirements. Qualified professionals provide supervision of PCA services and staff.

— *Minnesota Statutes* 2019, 256B.0625, subd. 19c; and 256B.0659, subd. (1)(k).

Initial Enrollment

When an agency wishes to provide PCA, it must apply for enrollment with DHS. As Exhibit 3.1 shows, the first step in the enrollment process is attending DHS training. State law requires (1) owners of the agency who are active in the day-to-day management and operations of the agency, (2) all employees in management and supervisory positions, and (3) qualified professionals to complete this training.[4]

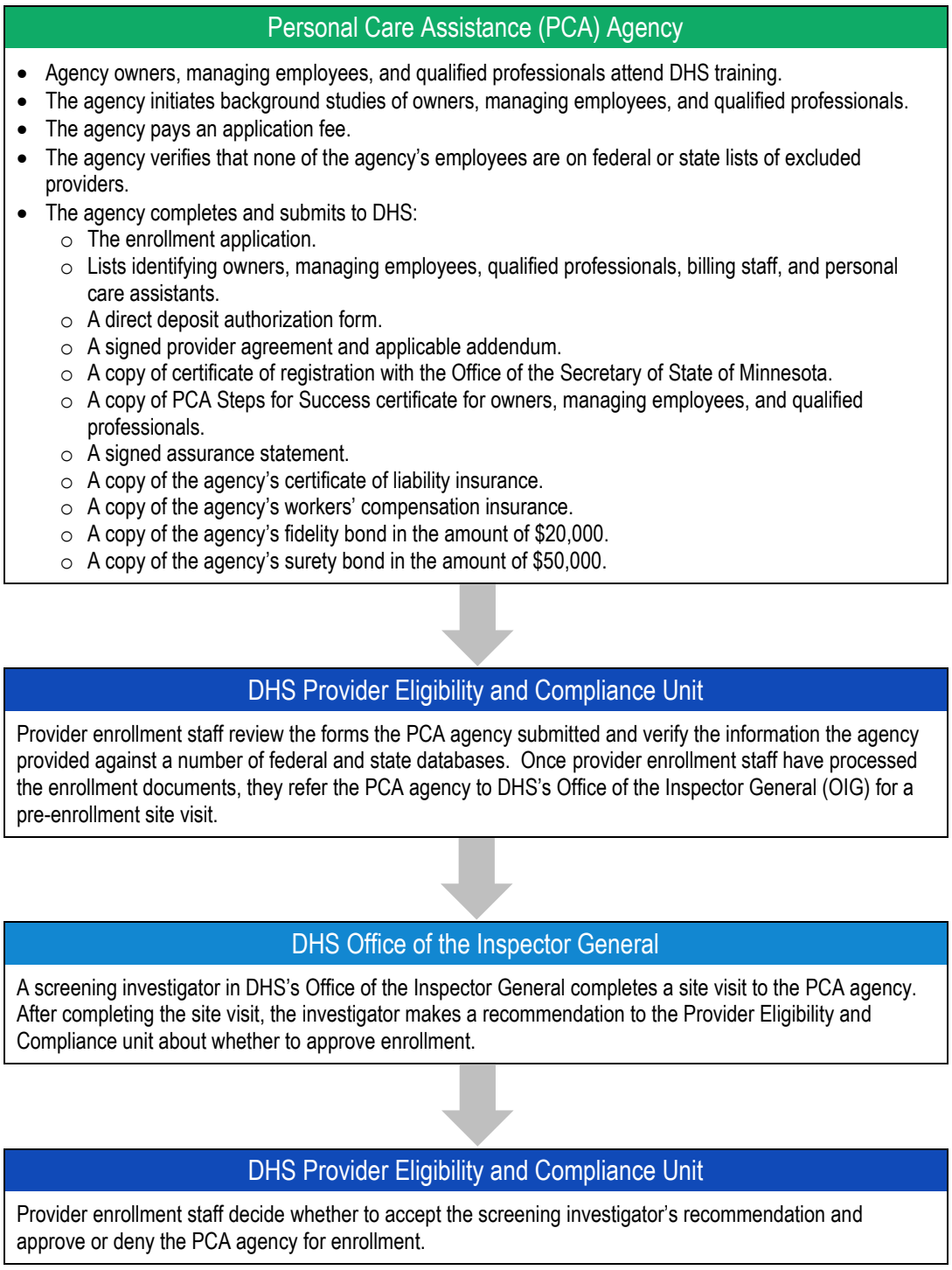
After owners, managing employees, and qualified professionals complete their training, the PCA agency pays an application fee, initiates background studies for its staff, and submits several documents to DHS's Provider Eligibility and Compliance unit. For example, PCA agencies must complete a form that collects basic information about the agency, such as the agency's address and its federal and state tax identification numbers. On other forms, PCA agencies are required to provide information on agency owners, managing employees, and qualified professionals.

After receiving the agency's enrollment application, provider enrollment staff review the forms and verify the information the agency provided against a number of federal and state databases. As an example, provider enrollment staff confirm the identity of PCA agency owners, managing employees, and qualified professionals and determine whether those individuals are excluded from providing federally funded health care services.[5] Once provider enrollment staff process the enrollment documents, they refer the PCA agency to DHS's OIG for a pre-enrollment site visit.

[4] *Minnesota Statutes* 2019, 256B.0659, subds. 13(c) and 21(c).

[5] Individuals and entities may be excluded from participation in federally funded health care programs for several reasons, such as a conviction for Medicare or Medicaid fraud. Excluded individuals and entities cannot receive payment from federal health care programs, and anyone who hires an excluded individual or entity may be subject to a civil monetary penalty. Provider enrollment staff check a list of excluded individuals and entities maintained by the U.S. Department of Health and Human Services Office of the Inspector General.

Exhibit 3.1: Personal care assistance agencies complete an enrollment process involving two DHS divisions.



SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services policies and procedures.

Screening investigators in DHS's OIG complete site visits to PCA agencies. During a site visit, the screening investigator is expected to interview owners or managing employees and review documents to verify that the information the PCA agency submitted to DHS is accurate and complies with federal and state enrollment requirements. After completing the site visit, the screening investigator makes a recommendation to the Provider Eligibility and Compliance unit about whether to approve enrollment. Finally, provider enrollment staff decide whether to accept the screening investigator's recommendation and approve or deny the PCA agency for enrollment.

DHS's initial provider enrollment process has generally ensured that personal care assistance agencies meet requirements to provide personal care assistance, but there is room for improvement.

To evaluate the extent to which DHS complied with requirements related to PCA agency enrollment, we reviewed DHS policy manuals, internal procedures, and enrollment forms. We also analyzed DHS data on PCA agency enrollment and site visits. While DHS's initial enrollment process has generally ensured compliance, we found some issues with its oversight at key points in the process. Below we discuss our findings related to PCA agency staff training and background studies, the documentation DHS requires for enrollment, the screening site visits DHS conducts, and the guidance DHS provides to PCA agencies.

Training

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that the Legislature require PCA agency staff to periodically complete comprehensive state training on PCA standards and practices.

Minnesota law now requires PCA agency staff to complete training. Certain staff must complete training before the agency enrolls with DHS. These staff must repeat training based on changes to their employment.

— *Minnesota Statutes* 2019, 256B.0659, subds. 13(c) and 21(c).

As we stated earlier in this chapter, Minnesota law requires all (1) owners of the agency who are active in the day-to-day management and operations of the agency, (2) employees in management and supervisory positions, and (3) qualified professionals to complete training.[6] This training, called "Steps for Success," is a three-day workshop that covers statutory requirements for providing PCA and PCA agencies' responsibilities, among other things. Agency staff may attend the workshop in person or participate in an online webinar, and they must complete the training before the agency submits its application for enrollment.[7] DHS requires the agency's designated billing person to attend a separate one-day training on PCA billing within six

[6] *Minnesota Statutes* 2019, 256B.0659, subds. 13(c) and 21(c).

[7] *Minnesota Statutes* 2019, 256B.0659, subd. 21(c). The 2019 Legislature required PCA agencies to ensure qualified professionals complete training before the agency submits its application for enrollment (*Laws of Minnesota* 2019, First Special Session, chapter 9, art. 7, sec. 33). Prior to that, qualified professionals were required to complete training within six months of their hiring. Owners, managing employees, and qualified professionals that have completed the Steps for Success training as an employee of another PCA agency do not need to repeat the training when hired by another PCA agency, as long as they completed the training within the past three years (*Minnesota Statutes* 2019, 256B.0659, subds. 13(c) and 21(c)).

months after the agency successfully enrolls with DHS.[8] Billing staff may attend DHS's training in person or through an online webinar.

DHS ensured that most, but not all, of the personal care assistance agencies it enrolled in Fiscal Year 2018 complied with training requirements.

To evaluate whether DHS ensured that PCA agency staff completed training according to state law, we reviewed DHS data on training for the owners, managing employees, qualified professionals, and billing staff employed by each of the 93 PCA agencies that enrolled with DHS in Fiscal Year 2018.

According to DHS's data, DHS did not ensure that all owners, managing employees, qualified professionals, and billing staff employed by 24 of the 93 agencies we reviewed completed training according to the timelines established in law. For example, at least one owner, managing employee, or qualified professional in 13 of the 93 agencies we reviewed completed Steps for Success training before the agency enrolled, but more than three years before they were hired by the agency. In these cases, the individuals should have repeated the training. As another example, DHS did not have a record that 11 of the 93 agencies ensured that any of their staff completed DHS's billing training as required.

We also found a few cases where owners or managing employees completed training *after* the agency enrolled with DHS, contrary to state law. Three individuals who were listed as owners or managing employees in five PCA agencies did not complete DHS's Steps for Success training before the agencies enrolled with DHS. These individuals were hired before the agencies enrolled, so in these cases, DHS should not have approved the PCA agencies' applications for enrollment.

An official in the state's Medicaid Fraud Control Unit (MFCU), housed in the Minnesota Office of the Attorney General, told us that the unit has concerns about training for PCA agency staff.[9] The MFCU official said that DHS should better enforce training requirements for agency staff. They said staff can simply view training online or sign up, but not attend.

In a 2017 letter from an MFCU official to a DHS official, and a 2019 letter from the former attorney general to the former DHS commissioner, MFCU provided recommendations to deter and prevent fraud in PCA. Among other things, MFCU recommended that "PCA agency owners, managing employees, and [qualified professionals] be required to attend Steps for Success in person, check in using a government-issued identification card, and remain present during the entire Steps for

[8] Statutes require PCA agency billing staff to complete training on PCA program financial management (*Minnesota Statutes* 2019, 256B.0659, subd. 21(c)).

[9] Medicaid Fraud Control Units employ teams of investigators, attorneys, and auditors to investigate and prosecute Medicaid provider fraud. Federal law requires each state to have a Medicaid Fraud Control Unit, with exceptions. These units must be a separate and distinct entity from the state Medicaid agency (such as Minnesota's DHS). 42 *CFR*, sec. 1007 (2019).

Success training."[10] However, we note that statutes require the training to be "available online or by electronic remote connection."[11]

RECOMMENDATION

DHS should ensure that personal care assistance agency staff complete training as required by law.

PCA agencies have many administrative duties, and it is important for agency owners, managing employees, qualified professionals, and billing staff to understand those duties. We also think training is an important tool for preventing improper payments and fraud. Training is especially necessary because, as we explain in the following sections, DHS is not required to regularly review agencies' compliance with all requirements. In addition, it is important that staff repeat training as required to ensure they have the most up-to-date information on program requirements.

DHS's internal procedures for PCA agency enrollment direct staff to check that owners, managing employees, and qualified professionals completed the Steps for Success training as required. The procedures clearly state that staff should deny an agency's application for enrollment if training is not completed within statutory guidelines. This indicates that DHS has appropriate guidance for staff, but management must ensure that staff follow that guidance. When DHS reviews PCA agencies' applications for enrollment, DHS managers should ensure that all staff review whether the agencies' owners, managing employees, and qualified professionals have completed DHS's Steps for Success training in accordance to statutes. If agency staff have not completed the training, DHS should not approve the agency's enrollment. In addition, DHS should ensure that staff hired by enrolled PCA agencies complete training within required timelines.

Background Studies

Minnesota law requires PCA agency owners who have a 5 percent interest or more in the agency, managing employees, and qualified professionals to undergo a background study.[12] In order to enroll with DHS, agencies must *initiate* a background study for owners and managing employees, and *initiate* and *complete* a background study for qualified professionals.[13] Agencies initiate a background study by entering information about the individual into an online DHS system. Background studies are complete when DHS notifies the PCA agency of the results of the study.

DHS's Background Studies Division, housed within DHS's OIG, conducts background studies by reviewing various records to determine whether an individual is disqualified

[10] Kirsi Poupore, Manager, Medicaid Fraud Control Unit, Minnesota Office of the Attorney General, memorandum to Jennifer Hasbargen, Manager, Office of the Inspector General, Department of Human Services, July 13, 2017; and Lori Swanson, Attorney General, Minnesota Office of the Attorney General, letter to Tony Lourey, Commissioner, Department of Human Services, January 3, 2019.

[11] *Minnesota Statutes* 2019, 256B.0659, subd. 21(c).

[12] *Minnesota Statutes* 2019, 256B.0659, subd. 25.

[13] *Ibid*.

Background Studies

Background studies include reviews of:

- Information on criminal history kept by the Minnesota Bureau of Criminal Apprehension.
- Information on substantiated maltreatment of minors and vulnerable adults from investigations completed by DHS, the Minnesota Department of Health, and counties' child protection and adult protection units.
- Minnesota's Predatory Offender Registry.

In some cases, background studies may also include reviews of records from:

- Courts, law enforcement agencies, and other agencies in Minnesota and other states.
- The Federal Bureau of Investigation.

from direct contact with PCA recipients. Owners, managing employees, or qualified professionals may be disqualified for several reasons. For example, they may be disqualified if they were convicted of committing, admitted to committing, or filed an "Alford plea" for certain crimes, such as assault, fraud, or murder.[14] Individuals who have been found to have committed serious and/or recurring maltreatment of a minor or vulnerable adult may also be disqualified.[15]

We examined DHS data on background studies for the owners, managing employees, and qualified professionals employed by each of the 93 PCA agencies that enrolled with DHS in Fiscal Year 2018. Because DHS collects data on when these agency staff *completed* background studies, we were unable to determine whether PCA agencies *initiated* background studies on owners and managing employees before being enrolled by DHS. However, because Minnesota law requires PCA agencies to complete background studies on qualified professionals before enrolling with DHS, we were able to assess PCA agencies' compliance with background study requirements for qualified professionals.

In Fiscal Year 2018, DHS ensured that nearly all personal care assistance agencies complied with background study requirements for their qualified professionals before enrolling the agencies.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that the Legislature amend Minnesota statutes to require all agencies providing PCA to obtain background checks on their qualified professionals.

Minnesota law now requires PCA agencies to complete background studies of qualified professionals.

— *Minnesota Statutes* 2019, 256B.0659, subd. 25(2).

Only 1 of the 93 PCA agencies that enrolled with DHS in Fiscal Year 2018 did not have all qualified professionals complete background studies before DHS approved their enrollment. In this case, the agency had one qualified professional that was hired by the agency *before* it enrolled, but passed their background study *after* the agency enrolled. Notably, the PCA agency had more than one qualified professional, and the other qualified professionals passed their background studies before the agency enrolled. Nevertheless, to enroll with DHS, statutes require PCA agencies to complete background studies on all qualified professionals.[16]

[14] *Minnesota Statutes* 2019, 245C.14 and 245C.15. Under an Alford plea, a defendant maintains their innocence but pleads guilty because the defendant "reasonably believes, and the record establishes, the state has sufficient evidence to obtain a conviction" if the case were to go to trial. *State v. Ecker*, 524 N.W.2d 712, 716 (Minn. 1994) (citing *North Carolina v. Alford*, 400 U.S. 25, 37, 91 S. Ct. 160, 167 (1970)).

[15] *Minnesota Statutes* 2019, 245C.15, subd. 4(b)(2).

[16] *Minnesota Statutes* 2019, 256B.0659, subd. 25(2).

Documentation Required for Enrollment

State law requires PCA agencies to submit a number of documents in order to enroll with DHS as a PCA provider.[17]

DHS does not require personal care assistance agencies to submit all documentation required by state law for initial enrollment.

Despite the requirements in law, DHS mandates that PCA agencies submit only some of the required documentation. As Exhibit 3.2 shows, DHS does not require agencies to submit a copy of the agency's written policies and procedures or a list of all training and classes the PCA agency requires its personal care assistants to complete, among other things.

Exhibit 3.2: DHS does not require agencies to submit all documents required by statutes to enroll as a personal care assistance provider.

According to statutes, at the time of enrollment, all agencies must provide:	Does DHS require the document for enrollment?	
• Agency's current contact information	✓	
• Proof of surety bond coverage	✓	
• Proof of fidelity bond coverage	✓	
• Proof of workers' compensation insurance	✓	
• Proof of liability insurance	✓	
• Written policies and procedures		**X**
• All forms used in daily business, including: o Time sheet, if it varies from the standard, approved time sheet o Template for PCA care plan o Template for PCA Choice service option agreement		**X**
• List of all training and classes the agency requires of personal care assistants		**X**
• Documentation of required training completion	✓	
• Documentation of marketing practices		**X**
• Disclosure of ownership, leasing, or management of all residential properties that are used or could be used for home care services	✓	
• Documentation that the agency will use 72.5 percent of revenue generated from Medical Assistance for PCA services for employee personal care assistant wages and benefits		**X**
• Documentation that the agency does not burden recipients' free exercise of their right to choose a provider		**X**

NOTES: A ✓ indicates that DHS requires PCA agency owners to submit the document during the enrollment process and an **X** indicates DHS does not require the document. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor, assessment of the Department of Human Services' compliance with *Minnesota Statutes* 2019, 256B.0659, subd. 21(a).

[17] *Minnesota Statutes* 2019, 256B.0659, subd. 21(a).

Instead of requiring the aforementioned documentation, a DHS official told us that DHS requires providers to attest to meeting most of the requirements by signing a provider assurance statement. (We discuss the provider assurance statement and other provider agreements in more detail below.) However, this approach does not comply with the law, and it does not allow DHS to fully execute its responsibility to oversee the enrollment of PCA agencies.

RECOMMENDATION

DHS should review all required documentation to ensure compliance with legal requirements during personal care assistance agencies' initial enrollment.

As we previously noted, PCA agencies are already subject to less oversight than licensed entities, such as licensed home care providers. Some of the DHS officials and PCA agency representatives we spoke with indicated that DHS's PCA agency enrollment process might be too simple. For example, two DHS officials described the enrollment requirements as a low barrier to entry and the enrollment process as a simple paperwork process. One PCA agency representative stated that PCA agencies are often not set up well from the beginning, and they struggle to comply with legal requirements. Another noted that agencies do not need to show proof that they complied with all of DHS's enrollment requirements. A third representative said DHS should increase PCA agency enrollment standards to make it more difficult for "bad actors" to enroll.

The Legislature may determine that there should be more requirements to enroll as a PCA agency. At present, however, DHS must ensure that PCA agencies at least meet the current requirements in law. This includes exercising its responsibility to review all required documentation during PCA agencies' initial enrollment. If DHS determines that some of the enrollment requirements do not contribute to a safer, more effective provision of services, DHS should work with the Legislature and suggest statutory changes.

Screening Site Visits

During initial enrollment, federal regulations require state Medicaid agencies to screen Medicaid providers based on three categorical risk levels: limited, moderate, or high.[18] Risk levels are based on the risk of fraud, waste, or abuse each type of provider presents. State Medicaid agencies are required to determine the risk level of certain provider types, including PCA agencies. DHS has designated PCA agencies as high risk for fraud, waste, or abuse of the Medicaid program. Federal regulations require states to perform more screening activities for provider types designated as medium and high risk than for low-risk provider types, including pre-enrollment site visits to the provider's practice location.[19]

[18] 42 *CFR*, sec. 455.450 (2019).

[19] *Ibid*.

DHS completed screening site visits to nearly all personal care assistance agencies that enrolled with the department in Fiscal Year 2018.

As we previously noted, DHS enrolled 93 PCA agencies in Fiscal Year 2018. Based on department data, screening investigators completed pre-enrollment site visits to 91 of the 93 agencies on or prior to their enrollment date. In one case, screening investigators completed a site visit the day after the PCA agency's enrollment date. In another case, screening investigators visited an agency's existing location in Greater Minnesota, but not its newly enrolled location in Minneapolis. Federal regulations state that all new practice locations must receive site visits.[20] The Provider Eligibility and Compliance unit approved that provider to enroll without a site visit to the Minneapolis location.

Screening investigators recommended approving most enrollment applications, and the Provider Eligibility and Compliance unit generally followed their recommendations. Screening investigators recommended approving 85 of the 92 agencies they visited after completing the first pre-enrollment site visit. Screening investigators recommended denying enrollment to seven agencies after the first visit. The Provider Eligibility and Compliance unit initially denied enrollment to six of those agencies and later approved the enrollment application following a subsequent site visit in which screening investigators recommended approval. The Provider Eligibility and Compliance unit approved enrollment for one of the agencies screening investigators recommended denying. DHS officials told us that screening investigators identified an issue with ownership documentation, which they were able to resolve without an additional site visit.

DHS policies do not specify which documents screening investigators must review for accuracy and compliance.

Federal regulations state that the purpose of site visits is to ensure that information submitted to the department is accurate and to determine whether the provider complies with federal and state enrollment requirements.[21] These visits are particularly important since, as we noted previously, DHS does not require PCA agencies to submit all required paperwork to DHS's Provider Eligibility and Compliance unit.

DHS policies indicate that screening investigators are expected to verify that information submitted in the enrollment application is accurate. Policies direct screening investigators to verify that ownership information is correct, but they do not specifically direct screening investigators to review most other required documentation listed in Exhibit 3.2.

Screening investigators use a template to complete the site visit, but the template does not direct screening investigators to review supporting documentation. For example, the template only prompts them to ask whether the agency has up-to-date policies and procedures manuals. It does not direct the screener to review the policies and procedures manuals for required elements and record that information in their report. A

[20] *Ibid*. This requirement pertains to providers designated as moderate or high risk.

[21] 42 *CFR*, sec. 455.432 (2019). Federal regulations refer to the state Medicaid administrator, which in Minnesota is DHS.

DHS official told us screening investigators are not expected to document all information they review in reports they write after site visits. This makes it difficult to determine whether site visits comply with their stated purpose: to ensure enrollment documentation is accurate. We make a recommendation for DHS to standardize its site visit protocols later in this chapter.

Guidance to Personal Care Assistance Agencies

In addition to state and federal laws, DHS has two online policy manuals PCA agencies can use to learn about their responsibilities as PCA agencies. DHS also requires that PCA agencies sign multiple provider agreements and an assurance statement prior to enrolling as a PCA provider. The box below provides more information about the policy manuals, provider agreements, and assurance statement.

Policy Manuals, Provider Agreements, and Assurance Statement for PCA Agencies

Minnesota Health Care Programs Provider Manual: Outlines policies for providers of services available through the Minnesota Health Care Programs (such as Medical Assistance) administered by DHS. The manual also includes general instructions regarding enrollment and billing, among other things.

PCA Program Manual: Outlines policies specific to the Medical Assistance PCA program, including covered services, recipient eligibility, PCA agency and personal care assistant requirements and responsibilities, and PCA service options.

Minnesota Health Care Programs Provider Agreement: Lists general requirements for participating in the Minnesota Health Care Programs (such as Medical Assistance) administered by DHS. PCA agencies must sign the agreement to certify they will comply with the agreement.

Provider Agreement Addendum – Traditional PCA Provider: Serves as an addendum to the Minnesota Health Care Programs Provider Agreement. This addendum lists requirements specific to PCA agencies that provide traditional PCA services.

Provider Agreement Addendum – PCA Choice Provider: Serves as an addendum to the Minnesota Health Care Programs Provider Agreement. This addendum lists requirements specific to PCA agencies that provide PCA Choice services.

PCA Agency Applicant Assurance Statement: Serves as an addendum to the Minnesota Health Care Programs Provider Agreement. PCA agencies attest that they will comply with certain requirements, such as maintaining required documentation at the PCA agency and/or at the recipient's home.

We reviewed DHS's policy manuals, provider agreements, and assurance statement to determine whether they contained state and federal requirements for providing PCA services.

DHS has provided inconsistent and incomplete guidance to personal care assistance agencies through its numerous policy manuals, provider agreements, and assurance statement.

DHS did not list certain legal requirements in its policy manuals, provider agreements, or assurance statement for PCA agencies. This could make it difficult for PCA agencies to have a complete understanding of the requirements for enrolling with DHS and providing PCA. For example, Minnesota law required PCA agencies to conduct at least one random, unscheduled telephone call to each recipient every 90 days to verify that PCA services were being provided as scheduled.[22] During these telephone calls, agencies were required to speak with personal care assistants to verify they were present. DHS's policy manuals, provider agreements, and assurance statement did not mention requirements for telephone verification of services.

As another example of incomplete guidance, statutes outline a number of requirements for providing PCA to recipients that are dependent on ventilators to help them breathe.[23] Among other things, statutes prohibit personal care assistants from conducting any "clinical services, patient assessment, patient evaluation, or clinical education regarding the ventilator or the patient on the ventilator."[24] Instead, these services must only be provided by licensed or registered health care professionals. During our review of DHS's policy manuals, provider agreements, and assurance statement, we found that these documents did not specify these requirements. After receiving our draft report, DHS updated its PCA Program Manual to include the aforementioned prohibition.

Additionally, it could be difficult for agencies to understand requirements when they are listed differently across DHS's policy manuals and provider agreements. For example, Minnesota law requires PCA agencies that offer the PCA Choice service option to annually enter into a written agreement with the PCA Choice recipient.[25] Among other things, the PCA agency-PCA Choice recipient agreement must specify (1) the duties of the recipient, qualified professional, personal care assistant, and agency; and (2) documentation requirements including time sheets, activity records, and the PCA care plan.[26] While DHS's PCA Program Manual indicates that the PCA agency must have a written agreement in place before services are provided, it does not indicate what must be included in the agreement. On the other hand, DHS's assurance statement specifies the items for the PCA agency-PCA Choice recipient agreement, but not the required parties of the agreement or that it must be executed annually.

[22] *Minnesota Statutes* 2018, 256B.0705, subds. 1(d) and 2. The 2019 Legislature repealed this requirement, effective January 1, 2020 (*Laws of Minnesota* 2019, First Special Session, chapter 9, art. 6, sec. 94).

[23] *Minnesota Statutes* 2019, 256B.0659, subd. 27.

[24] *Minnesota Statutes* 2019, 256B.0659, subd. 27(b).

[25] *Minnesota Statutes* 2019, 256B.0659, subd. 20. As we explained in Chapter 1, PCA agencies may offer two distinct service options: traditional PCA and PCA Choice. In the PCA Choice option, recipients take on many of the responsibilities assigned to PCA agencies in the traditional option.

[26] *Minnesota Statutes* 2019, 256B.0659, subd. 20(a)(1) and (6).

Another example of inconsistent guidance relates to when PCA agency owners, managing employees, and qualified professionals must complete required training. Although Minnesota law and DHS's internal procedures indicate the training must be completed *before* submitting an application for enrollment, DHS's PCA Program Manual states that providers must complete the training *after* submitting their application.[27]

RECOMMENDATION

DHS should revise its policy manuals and provider agreements so that they reflect state law and provide comprehensive and consistent references to personal care assistance agencies' responsibilities.

DHS officials told us they support PCA agencies in meeting requirements by answering policy and process questions received through call centers and other sources. They said they are beginning to analyze the questions they receive with a goal of identifying policies that need clarification. These are important activities that may help improve available guidance, but DHS should also perform its own review of its documents. As we discuss in the following section, DHS provides limited direct oversight of PCA agencies. Because of this, it is important that agencies understand their responsibilities related to providing PCA. One way DHS can help agencies fulfill their responsibilities is by providing complete and consistent guidance in its policy manuals and provider agreements.

There are a number of requirements for personal care assistance in Minnesota rules that conflict with statutes and DHS's policy manuals.

Differences between rules and DHS policy manuals and Minnesota statutes could further complicate PCA agencies' understanding of their responsibilities for providing PCA. For example, Minnesota rules outline eligibility criteria for PCA agencies that are different from the enrollment requirements specified in statutes.[28] Among other things, rules state that PCA agencies must "demonstrate the financial ability to produce a cash flow sufficient to cover operating expenses for 30 days" and "demonstrate an accounting or financial system that complies with generally accepted accounting principles."[29] Neither statutes nor DHS's policy manuals include these or most of the other eligibility criteria outlined in rules.

As another example, rules state that PCA must be provided under the supervision of a registered nurse.[30] In contrast, statutes require that PCA services be supervised by a qualified professional, who does not have to be a registered nurse.[31] There are also

[27] *Minnesota Statutes* 2019, 256B.0659, subd. 21(c).

[28] *Minnesota Statutes* 2019, 256B.0659, subd. 21; and *Minnesota Rules*, 9505.0335, subp. 5, published electronically October 16, 2013.

[29] *Minnesota Rules*, 9505.0335, subp. 5H and J, published electronically October 16, 2013.

[30] *Minnesota Rules*, 9505.0335, subp. 4, published electronically October 16, 2013.

[31] *Minnesota Statutes* 2019, 256B.0625, subd. 19c.

differences between rules and statutes regarding the nature and frequency of supervision visits. For example, rules state that the registered nurse must evaluate PCA by directly observing the personal care assistant or consulting with the recipient (1) within 14 days after the personal care assistant is placed with the recipient, (2) at least once every 30 days during the first 90 days of services, and (3) at least once every 120 days thereafter.[32] Statutes require direct observation of the personal care assistant within 14 days; the qualified professional then is required to visit the recipient to evaluate services at least every 90 days during the first year of services, and every 120 days thereafter.[33] DHS's PCA Program Manual lists only the requirements in statutes.

Rules also state that PCA agencies must document a physician's initial order for PCA services.[34] DHS's PCA Program Manual states that documentation of a physician's order is not required. Statutes are silent on whether a physician's order is required for PCA.

When we asked DHS about these inconsistencies, a DHS official told us that the rules are outdated or obsolete; they were promulgated prior to the Legislature passing current PCA statutes. However, DHS has not taken steps to repeal the outdated or obsolete rules specified above. Statutes require state agencies to submit a list each year of obsolete rules to policy committees, among others, along with a timetable for repealing the obsolete rules.[35] DHS indicated in a 2007 report that some of the rules pertaining to PCA were obsolete. But, a DHS official told us that the department has not had adequate resources to follow through with the repeal of obsolete rules.

RECOMMENDATION

DHS should repeal or revise outdated or obsolete administrative rules so that they align with statutes and DHS's current administration of the personal care assistance program.

One of DHS's statutory duties is to "make uniform rules, not inconsistent with law, for carrying out and enforcing" requirements related to the Medical Assistance program.[36] While statutes take precedence over rules when they conflict, one purpose of administrative rules is to make the law a state agency enforces or administers more specific.[37] When rules are inconsistent with statutes or contain requirements not included in statutes, PCA agencies may have difficulty determining which requirement to follow.

When we spoke with PCA agency representatives about DHS oversight of PCA, one representative referenced resource issues they had meeting supervision requirements outlined in *rules*. They said that it is difficult to recruit qualified professionals because

[32] *Minnesota Rules*, 9505.0335, subp. 4D, published electronically October 16, 2013.

[33] *Minnesota Statutes* 2019, 256B.0659, subd. 14(c). These requirements pertain only to traditional PCA services. Qualified professionals are required to visit recipients participating in the PCA Choice option every 180 days; see *Minnesota Statutes* 2019, 256B.0659, subd. 19(a)(4).

[34] *Minnesota Rules*, 9505.2175, subp. 7A, published electronically February 18, 2013.

[35] *Minnesota Statutes* 2019, 14.05, subd. 5. In place of a timetable for repeal, agencies may submit a bill for the repeal of obsolete rules.

[36] *Minnesota Statutes* 2019, 256B.04, subd. 2.

[37] *Minnesota Statutes* 2019, 14.02, subd. 4.

they have to be registered nurses, and it is difficult to compete with other health care organizations on wages and benefits. As we explained previously, statutes and rules list different requirements for qualified professionals.

To avoid these issues, DHS should systematically review the rules that pertain to PCA and repeal or revise outdated or obsolete rules so that they accurately reflect statutes and the department's current administration of PCA.

Ongoing Requirements

Federal and state laws require DHS to perform specific, ongoing oversight activities after PCA agencies' initial enrollment. Certain activities are intended to ensure that agencies' enrollment documentation remains up-to-date and in compliance with applicable laws. Other activities are meant to confirm that agencies document financial transactions and the services they provided. These requirements can help to ensure recipients receive the services they need and prevent public resources from being used improperly.

Annual Reviews of Enrollment

Until repealed by the 2019 Legislature, statutes required PCA agencies to submit enrollment documentation detailed in Exhibit 3.2, as well as agencies' grievance policies and a written record of grievances submitted in the previous year and their resolutions, on an annual basis.[38]

DHS did not comply with a statutory requirement for annual reviews.

DHS did not track in its Medicaid data system whether agencies completed the annual review process, and a DHS official told us the Provider Eligibility and Compliance unit could not enforce the requirement every year given its resources. DHS officials told us they most recently completed annual reviews for all PCA agencies in 2016.

Although the Legislature removed the annual review requirement from the PCA program, Community First Services and Supports (CFSS) will require PCA agencies to submit documents for annual review.[39] As we noted in Chapter 1, CFSS will replace PCA. Unlike PCA, CFSS statutes do not indicate which documents PCA agencies must submit as part of the annual review; however, given that the department did not complete annual reviews in the past, we question its ability to do so moving forward. In Chapter 5, we offer a recommendation for the Legislature to review oversight requirements in CFSS statutes.

Revalidation of Enrollment

Annual reviews were not DHS's only required, routine oversight mechanism. Both federal and state law require periodic revalidation of agencies' enrollment.[40] During

[38] *Minnesota Statutes* 2018, 256B.0659, subd. 22, repealed by *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 7, sec. 47.

[39] *Minnesota Statutes* 2019, 256B.85, subd. 12(d).

[40] 42 *CFR*, sec. 455.414 (2019); and *Minnesota Statutes* 2019, 256B.04, subd. 21.

this process, DHS must review certain documentation and conduct a screening site visit.[41] Since 2011, federal law has required DHS to revalidate agencies' enrollment at least every five years to remain eligible for Medicaid funding.[42] More recently, the 2019 Legislature passed a law requiring DHS to revalidate PCA agencies' enrollment every three years.[43]

DHS revalidated personal care assistant agencies' enrollment as required for most, but not all, agencies enrolled at the end of Fiscal Year 2019.

During revalidation, DHS must verify that PCA agencies meet federal and state requirements.[44] As noted in Exhibit 3.2, statutes require PCA agencies to submit numerous documents, including policies and procedures and proof of insurance. As is true for initial enrollment, the Provider Eligibility and Compliance unit is responsible for ensuring agencies meet revalidation requirements, whereas DHS's OIG conducts site visits.

We reviewed data on all PCA agencies enrolled at the end of Fiscal Year 2019 to determine whether they had complied with revalidation requirements. We found that 375 agencies had been enrolled continuously for at least five years, and therefore should have gone through revalidation between fiscal years 2015 and 2019. We found that DHS reviewed documentation, as required, for 358 (95 percent) of those agencies. DHS did not ensure the remaining 17 agencies submitted required documentation.

DHS data also indicated that screening investigators conducted site visits to the majority of the 375 PCA agencies that had been enrolled for at least five years as of the end of Fiscal Year 2019. DHS conducted site visits to 369 of those agencies in the five-year span of fiscal years 2015 through 2019. Although the remaining six agencies required a site visit at least once during that five-year period, DHS data show that screening investigators did not conduct visits to them.

RECOMMENDATION

DHS should ensure it revalidates enrollment of all personal care assistance agencies, as required by law.

Based on our review, DHS failed to revalidate the enrollment of only a small percentage of PCA agencies. But, a lack of supervision of even one agency could permit fraudulent or abusive practices to persist. MFCU has prosecuted single PCA agencies for over a million dollars in fraudulent claims. Revalidation is the principal

[41] As we previously noted, federal regulations require enhanced screening—including site visits—for all providers designated as high risk of fraud, waste, or abuse of the Medicaid program. DHS designated PCA agencies as high risk.

[42] 42 *CFR*, sec. 455.414 (2019).

[43] *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 7, sec. 15, codified as *Minnesota Statutes* 2019, 256B.04, subd. 21(b).

[44] 42 *CFR*, sec. 455.450 (a)(1) and (c)(1) (2019).

routine mechanism DHS uses to ensure PCA agencies comply with legal requirements. It is important to ensure that every agency goes through the revalidation process.

Key Recipient Documentation

- Emergency back-up plan
- PCA care plan
- Month-to-month service use plan
- Supervision of PCA by qualified professional

Key Employee Documentation

- Background study results
- Training with demonstration of competence
- Supervisory visits
- Evaluations of employment

Review of Service Documentation

Statutes and rules outline numerous documentation requirements for PCA. Statutes require PCA agencies to keep employee and recipient files that include specific documents, such as records of supervisory visits and PCA care plans, among other requirements.[45] Rules contain additional requirements to document recipients' health services and agencies' financial records, including payroll ledgers and relevant contracts.[46] These documentation requirements can help ensure that personal care assistants provide the services for which PCA agencies bill DHS.

Personal care assistance agencies are required to document services provided, but state law does not specify how—or even whether—DHS must regularly ensure that all agencies comply with those requirements.

While statutes identify required documentation, they do not explicitly lay out a process through which DHS must regularly monitor agencies' compliance with all requirements. Prior to 2019, statutes required agencies to go through an annual review, but the review required agencies to submit initial enrollment documents, rather than PCA service documentation. Further, statutes requiring (1) annual reviews when PCA is changed to CFSS and (2) revalidation every three years do not specify which documents DHS must review during those processes. Federal regulations require state Medicaid agencies to "verify the provider meets any applicable…State requirements for the provider type…" but does not provide further direction.[47]

Beyond the annual review and revalidation processes, statutes provide broad direction for DHS to monitor Medical Assistance services. For example, statutes require DHS to establish a process to monitor program integrity, including random reviews of documentation.[48] However, statutes do not state how often or to what extent DHS should review documentation.

Statutes also direct DHS to establish criteria and procedures for identifying and investigating suspected fraud, theft, and abuse of the Medical Assistance program.[49] But, these procedures pertain to certain claims only—those in which DHS has reason to suspect fraud, theft, or abuse occurred. They do not require routine investigations of all

[45] *Minnesota Statutes* 2019, 256B.0659, subd. 28(a).

[46] *Minnesota Rules*, 9505.2175, subps. 2 and 7; and 9505.2180, subp. 1, published electronically August 12, 2008.

[47] 42 *CFR*, sec. 455.450 (a)(1) and (c)(1) (2019).

[48] *Minnesota Statutes* 2019, 256B.0651, subd. 15.

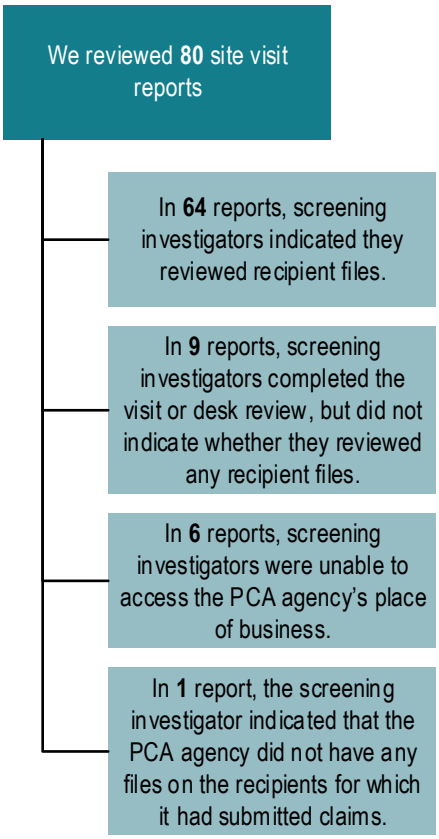
[49] *Minnesota Statutes* 2019, 256B.04, subd. 10.

PCA agencies. We provide more information about DHS's fraud investigations procedures in Chapter 4.

Based on a lack of detail in DHS policies and site visit reports, it was difficult to determine which documents screening investigators reviewed, and therefore, the extent to which DHS ensured personal care assistance agencies complied with documentation requirements.

DHS officials told us the department monitors PCA program integrity through revalidation site visits. An official told us that screening investigators typically review a sample of claims, recipient files, and employee files during these visits.

However, revalidation site visits have limitations. For example, DHS policies do not explicitly direct investigators to determine whether PCA agencies comply with all documentation requirements. Policies state that screening investigators will review the "enrollment record" to ensure agencies reported any changes. They also state that screening investigators *may* review a sample of claims, recipient files, and employee files during routine revalidation site visits. Policies do not mention whether screening investigators should review required financial records at all. As mentioned previously, DHS policies do not clearly indicate which documents screening investigators are expected to review during site visits. DHS officials told us that screening investigators use their training and experience, as well as DHS manuals, to decide what to review during site visits.



A DHS official told us screening investigators are not expected to list every document they review in their reports. Screening investigators are also not expected to indicate which elements of each document they reviewed in their site visit reports. The official told us screening investigators only make notes in their reports if a document they reviewed did not comply with requirements.

To better understand the depth and breadth of reviews screening investigators perform during site visits, we reviewed a sample of 80 site visit reports from fiscal years 2017 through 2019.[50] Based on our review, screening investigators indicated that they reviewed 243 recipient files during the 64 site visits in which they reportedly reviewed recipient files. This was typically a small percentage of all recipients served by the PCA agency. Screening investigators indicated they reviewed an average of 4 recipient files per visit, and each of the agencies reportedly served an average of nearly 60 recipients. A DHS official told us that

[50] We reviewed reports for all 12 routine revalidation site visits completed in fiscal years 2018 and 2019, as well as a random sample of reports for 27 revalidation site visits from Fiscal Year 2017. We also reviewed a random sample of reports for 41 discretionary site visits completed in Fiscal Year 2019. The department's process for completing these types of visits is nearly identical to the process for revalidation visits. We provide more information about discretionary site visits in Chapter 4.

screening investigators typically review three recipient files per visit; if screening investigators find issues with those files, they may review additional files.

Screening investigators did not always specify which documents they reviewed in recipients' files. For example, screening investigators indicated they reviewed care plans for only 161 of the 243 files (66 percent). They did not indicate that they reviewed certain other required items, such as authorization for the recipient's PCA services, for any file.

Screening investigators noted that they reviewed employee files in site visit reports for only 9 of the 80 site visits we reviewed.[51] None of the site visit reports indicated the screener reviewed certain required financial records, such as payroll ledgers or schedules for supervision.

RECOMMENDATION

DHS should develop standard protocols for personal care assistance agency pre-enrollment and revalidation site visits to ensure agencies comply with legal requirements.

A DHS official told us that screening investigators visit many types of providers, so creating a list of documents they must review for each type of provider would be a huge undertaking. However, nearly half of all site visits screening investigators performed in fiscal years 2015 through 2019 were to PCA agencies. Because PCA agencies constitute a large portion of screening investigators' work and PCA receives a high level of state and federal funding, we believe more detailed protocols are warranted.

Site visit protocols will help ensure that screening investigators hold all PCA agencies to the same standards and review all relevant legal requirements. They will also promote consistency in site visit procedures as staff change and demands on screeners' time change. As noted previously, the 2019 Legislature required PCA agencies to be revalidated every three years, rather than every five years as required by federal law. This change may strain DHS's resources and cause the department to scale back on the comprehensiveness of site visits if standards are not in place.

RECOMMENDATION

The Legislature should clarify DHS's responsibilities for monitoring personal care assistance documentation requirements.

We noted at the beginning of this chapter that, due to the nature of PCA, there are inherent risks to the safety of recipients and financial integrity of the program. With individual personal care assistants often providing services to recipients in their homes, there is little direct oversight of services. The Legislature has tried to mitigate this risk by requiring personal care assistants and PCA agencies to clearly document services

[51] As noted in the figure on the previous page, in six of these site visit reports, screening investigators indicated that they were unable to access the PCA agency.

and financial transactions, but it has not specified in law an equally robust oversight program.

The Legislature gave PCA agencies many administrative duties, but has not clearly outlined expectations for how the department should ensure they meet these requirements. We noted that DHS has performed limited documentation reviews during site visits. If the Legislature, in an effort to prevent fraud and abuse, wishes for DHS to be more comprehensive in its oversight activities, it should make that explicit in law and ensure DHS has appropriate resources to carry out those activities. In fall 2019, DHS employed four screening investigators that had the responsibility to complete site visits to almost 30 types of providers.

Electronic Visit Verification

The U.S. Congress enacted the 21st Century Cures Act in 2016. Under this act, by January 1, 2020, state Medicaid agencies must require that providers use an electronic visit verification (EVV) system to document that individuals received PCA services billed to the state.[52] EVV systems must electronically verify certain data on PCA services performed during an in-home visit. These data include the date and location of the service and the individuals providing and receiving the service.

Electronic verification of personal care assistance visits may improve service documentation, but DHS has not yet established an implementation date for this required technology.

Electronic visit verification systems must capture the following information:

- Type of service performed
- Individual receiving service
- Date of service
- Location of service delivery
- Individual providing service
- Time service begins and ends

— Public Law 114-255, sec. 12006 (a)(5)(A).

EVV systems may eliminate the need for paper time sheets, help increase time sheet and billing accuracy, and facilitate fraud detection and audits. For example, PCA agencies are currently required to document services on a DHS-approved time sheet form that may be Web-based, electronic, or paper format.[53] PCA agencies do not submit these time sheets to DHS; they keep them in recipients' records. When DHS needs to review time sheets, it requests them from agencies or reviews them onsite at the agency. DHS intends for data captured by EVV to be aggregated in a central repository, which would facilitate reviews.

States that fail to require EVV for PCA by the federal deadline will have federal Medicaid funding reduced. For the first year of noncompliance, federal funding is reduced by one-quarter of 1 percentage point; it will be reduced incrementally up to

[52] 21st Century Cures Act, Public Law 114-255, sec. 12006, December 13, 2016; and Public Law 115-222, July 30, 2018. If a state Medicaid agency does not comply, the state will face a penalty, as described later in this section.

[53] *Minnesota Statutes* 2019, 256B.0659, subd. 12(a).

1 percentage point in 2023 and beyond.[54] States may request that the federal government delay reducing federal Medicaid funding until January 2021 if they show they have made a "good faith effort" to comply with EVV requirements but encountered unavoidable delays.[55]

To date, Minnesota has not developed an EVV system. The 2017 Legislature directed DHS to consult with stakeholders, including PCA providers and recipients, to develop EVV requirements.[56] The Legislature also directed DHS to report back on its findings, which it did in January 2018. As of February 2020, DHS had not yet issued a request for proposal for its EVV system. DHS officials told us the implementation was delayed due to a lack of funding for new positions at the department. They said DHS staff were required to develop the EVV requirements on top of their regular duties, which prolonged the timeline.

DHS submitted a request for a delay in reduction of Minnesota's federal Medicaid funding, and that request was approved in December 2019. This means that Minnesota's federal Medicaid funding will not be reduced in calendar year 2020. At the time this report was published, the reduction was scheduled to take effect January 2021 if DHS is not in compliance. Given that DHS has not yet selected a vendor to develop its EVV system or established a timeline for implementation of the requirement, it is unclear how DHS could meet the federal deadline.

RECOMMENDATION

DHS should comply with federal requirements for electronic visit verification as soon as possible to avoid a reduction in federal funding.

The 2019 Legislature required PCA agencies to implement EVV by a date established by the commissioner and required that reimbursement rates to providers not be reduced as a result of the federal government reducing funding.[57] This means DHS would have to absorb any potential reduction in federal Medicaid funding due to delayed implementation of the EVV requirement. Minnesota receives billions of dollars in federal Medicaid funding each year; even a small reduction could have a significant impact on DHS's resources and its ability to effectively administer and oversee Minnesota's Medicaid program.

Personal Care Assistant Enrollment

Similar to PCA agency enrollment, DHS's Provider Eligibility and Compliance unit is primarily responsible for enrolling personal care assistants. However, PCA agencies also play a large role in ensuring personal care assistants meet initial enrollment requirements.

[54] Federal law states that the federal medical assistance percentage will be reduced. This is the federal government's share of most Medicaid expenditures.

[55] Public Law 114-255, sec. 12006, (a)(4)(B), December, 13, 2016; and Public Law 115-222, sec. 1, (a)(2), July 30, 2018.

[56] *Laws of Minnesota* 2017, First Special Session, chapter 6, art. 3, sec. 49.

[57] *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 5, sec. 82.

Additionally, PCA agencies—rather than DHS—are primarily responsible for ongoing oversight of the services personal care assistants provide to their clients.

Initial Enrollment

DHS's provider manual indicates that it only reimburses agencies for PCA if a personal care assistant enrolled with DHS provides those services. PCA agencies enroll personal care assistants with DHS by submitting an application to the department on behalf of the personal care assistants. Prior to sending personal care assistants' enrollment applications to DHS, PCA agencies must ensure that each personal care assistant (1) meets statutory requirements for personal care assistants, (2) successfully completes an online training, (3) does not appear on state or federal exclusion lists, and (4) successfully completes a background study. We describe these requirements in more detail later in this chapter.

After receiving a personal care assistant's enrollment application, staff in DHS's Provider Eligibility and Compliance unit review the application and verify the information provided against a number of federal and state databases. Provider enrollment staff also check that the personal care assistant has completed their required training and a background study. After DHS enrolls a personal care assistant, the personal care assistant can begin providing care to recipients.

To evaluate the extent to which DHS complied with requirements related to personal care assistant enrollment, we reviewed DHS policy manuals, internal procedures, and enrollment forms. We also analyzed DHS data on personal care assistant enrollment.

When enrolling personal care assistants, DHS does not verify that personal care assistants meet all requirements in statutes.

Minnesota law requires personal care assistants to meet numerous requirements. For example, statutes dictate that personal care assistants may not themselves be consumers of PCA.[58] According to DHS, the Provider Eligibility and Compliance unit runs a daily report to ensure that recipients are also not personal care assistants.

However, based on our review of DHS's enrollment policies and procedures, DHS does not ensure assistants meet all other requirements, as Exhibit 3.3 shows. For example, personal care assistants must not have certain relationships to the recipient, such as being a parent of a minor child receiving PCA.[59] A DHS official confirmed that DHS does not determine during the enrollment process the relationship between personal care assistants and recipients.

[58] *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(6).

[59] *Minnesota Statutes* 2019, 256B.0659, subd. 11(c).

Exhibit 3.3: DHS does not verify that personal care assistants meet all statutory requirements before enrolling them with the department.

According to statutes, a personal care assistant must:	According to DHS procedures, does DHS check?	
• Be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements: o Supervision by a qualified professional every 60 days o Employment by only one PCA agency responsible for compliance with current labor laws	✓	
• Be employed by a PCA agency	✓	
• Enroll with the department as a personal care assistant after clearing a background study	✓	
• Be able to effectively communicate with the recipient and PCA agency		**X**
• Be able to provide covered PCA services according to the recipient's PCA care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician		**X**
• Not be a consumer of PCA services	✓	
• Maintain daily written records including, but not limited to, time sheets		**X**
• Complete DHS standardized training before completing enrollment	✓	
• Complete training and orientation on the needs of the recipient		**X**
• Be limited to providing and being paid for up to 275 hours per month of PCA regardless of the number of recipients being served or the number of PCA agencies with which the personal care assistant is enrolled	✓	
• Not be parents, stepparents, or legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers (with an exception); or staff of a residential setting		**X**

NOTES: A ✓ indicates that DHS policies and procedures direct staff, or there is an automated process, to check whether the personal care assistant meets the enrollment requirement. An **X** indicates that DHS policies and procedures do not direct staff to check the enrollment requirement. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor, assessment of the Department of Human Services' compliance with *Minnesota Statutes* 2019, 256B.0659, subd. 11(a) and (c).

We analyzed DHS data on personal care assistants' enrollment records to more closely examine whether DHS ensures personal care assistants meet enrollment requirements. Specifically, we determined whether personal care assistants (1) met requirements related to their age and (2) completed required background studies and training.

Personal Care Assistants' Age at Enrollment

Minnesota law allows individuals who are 16 or 17 years of age to enroll as personal care assistants, as long as they and the PCA agency they are affiliated with meet two requirements.[60] First, 16- and 17-year-old personal care assistants must be supervised by qualified professionals every 60 days. (In contrast, qualified professionals must evaluate services provided by personal care assistants who are 18 years of age or older

[60] *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(1).

at least every 120 days).[61] Second, 16- and 17-year-old personal care assistants must be affiliated with only one PCA agency. We focused our analysis on the latter requirement, as DHS's data on qualified professional supervision are incomplete. We discuss qualified professional supervision later in this chapter.

We analyzed DHS's data on personal care assistants' enrollment records to determine individuals' age upon enrollment as a personal care assistant. Of the roughly 67,600 personal care assistants who enrolled with DHS in fiscal years 2015 through 2019, only about 5,000 (7 percent) were under 18 years of age when they were enrolled as personal care assistants.[62]

While most of the personal care assistants under 18 years of age who enrolled with DHS in fiscal years 2015 through 2019 complied with requirements related to their age, some did not.

We found 48 personal care assistants who enrolled before their 16th birthday, which is not allowed under state law. We also found 178 personal care assistants under 18 years of age who, at some point before their 18th birthday, were affiliated with at least two PCA agencies at the same time. As stated above, Minnesota law requires 16- and 17-year-old personal care assistants to be affiliated with only one PCA agency.

RECOMMENDATION

DHS should ensure that the personal care assistants it enrolls who are under 18 years of age meet statutory requirements related to their age.

While the issues we identified pertained to only a small percentage of the personal care assistants who were under 18 years of age when they enrolled in fiscal years 2015 through 2019, it is important to note that a single unqualified personal care assistant can cause harm to the PCA recipient or abuse state and federal resources. As a result, it is important for DHS to ensure that *all* personal care assistants meet requirements related to their enrollment.

When DHS reviews personal care assistants' applications for enrollment, it should ensure that they are at least 16 years old. If they are not, DHS should not approve the personal care assistants' enrollment. Moreover, when DHS receives an application for a 16- and 17-year-old personal care assistant, DHS should ensure that the personal care

[61] *Minnesota Statutes* 2019, 256B.0659, subd. 14(c). This requirement applies to recipients who participate in traditional PCA. If the recipient participates in the PCA Choice option, the qualified professional is responsible for supervising the personal care assistant with the recipient (or their responsible party), and the qualified professional must visit the recipient every 180 days (*Minnesota Statutes* 2019, 256B.0659, subd. 19(a)(4)).

[62] The counts of personal care assistants in this sentence include individuals who provided PCA at some point in fiscal years 2015 through 2019. However, the data DHS provided to us also contained individuals who provided services through the Consumer Directed Community Supports and Consumer Support Grant programs, even though a DHS official told us those individuals have to meet different enrollment requirements than personal care assistants. As a result, the numbers of personal care assistants we report are likely an over count.

assistant is not currently affiliated with another agency. If they are, DHS should decline the personal care assistants' application.

DHS's internal procedures for personal care assistant enrollment clearly state these requirements. As a result, managers in DHS's Provider Eligibility and Compliance unit should ensure that their staff consistently follow internal procedures.

In addition, a DHS official told us that, until October 2018, DHS's Medicaid data system contained electronic controls to prevent its staff from (1) enrolling personal care assistants under 16 years of age, and (2) allowing personal care assistants under age 18 to be affiliated with multiple PCA agencies. The official said the electronic controls were turned off when DHS began implementing a new enrollment data system, and the department plans to restore the controls in June 2020. After restoring the electronic controls, DHS should conduct regular checks of the controls to determine whether they are functioning properly and address issues as they occur.

Background Studies and Training

State law requires personal care assistants to complete background studies before they begin providing services.[63] As we stated earlier in this chapter, background studies are record reviews conducted by DHS's Background Studies Division to determine whether an individual is disqualified from direct contact with PCA recipients.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that DHS define a set of topics on which personal care assistants should receive training.

The 2009 Legislature passed a law that requires personal care assistants to complete standardized training. State law defines the topics to be covered during the training.

— *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(8).

State law also requires personal care assistants to complete standardized training administered by DHS before completing enrollment.[64] According to DHS, the online-only training covers (1) basic first aid, (2) basic roles and responsibilities of a personal care assistant, (3) universal precautions from the Occupational Safety and Health Administration, and (4) how to report vulnerable adult and child maltreatment. At the end of the training, personal care assistants take a competency test, for which they need a score of 80 percent or more to pass.

We examined the enrollment records of the nearly 13,600 personal care assistants DHS enrolled in Fiscal Year 2018 to determine whether DHS ensured that they (1) passed background studies before they began providing services, and (2) completed DHS training before completing enrollment.

[63] *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(3).

[64] *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(8).

DHS ensured that most, but not all, personal care assistants it enrolled in Fiscal Year 2018 complied with requirements related to background studies and training.

Of the nearly 13,600 personal care assistants DHS enrolled in Fiscal Year 2018, DHS paid claims for services provided by about 12,200 personal care assistants that year.[65] However, we found ten personal care assistants who provided PCA *before* they passed a background study for their Fiscal Year 2018 enrollment.[66] This is not allowed under state law.

Similarly, DHS ensured that the vast majority of personal care assistants it enrolled in Fiscal Year 2018 completed mandated state training. However, according to DHS's data, 33 of the nearly 13,600 personal care assistants enrolled that fiscal year did not complete mandated training. Another 149 personal care assistants completed training only after they enrolled with DHS.

RECOMMENDATION

DHS should ensure that all personal care assistants meet statutory requirements related to background studies and training.

As we stated at the beginning of the chapter, personal care assistants provide services to PCA recipients in their homes or in the community with little direct supervision. If background studies are not completed in a timely manner, PCA services could be provided by an individual who has been convicted of a crime or has a history of abusing a vulnerable adult. Additionally, DHS training for personal care assistants contains information on their responsibilities as a personal care assistant.

When DHS reviews personal care assistants' applications for enrollment, it should ensure that they have passed a background study and completed required training. If they have not, DHS should not approve the personal care assistants' enrollment. DHS's internal procedures for personal care assistant enrollment clearly state these requirements. As a result, managers in DHS's Provider Eligibility and Compliance unit should ensure that their staff consistently follow internal procedures.

Ongoing Requirements

DHS and PCA agencies are responsible for performing specific oversight activities after personal care assistants' initial enrollment. Federal and state laws require DHS to revalidate personal care assistants' enrollment every five years.[67] Revalidation is

[65] The count of personal care assistants DHS enrolled in Fiscal Year 2018 includes individuals who provided PCA at some point in fiscal years 2015 through 2019. However, as stated earlier, the data DHS provided to us also contained individuals who provided services through the Consumer Directed Community Supports and Consumer Support Grant programs. As a result, the total number reported in this sentence is likely an over count.

[66] This is likely a conservative estimate. Due to the structure of DHS's data, we focused only on the personal care assistants that enrolled for the first time in Fiscal Year 2018.

[67] 42 *CFR*, sec. 455.414 (2019); and *Minnesota Statutes* 2019, 256B.04, subd. 21(b)(1).

intended to ensure that agencies' and assistants' enrollment documentation remains up-to-date and in compliance with applicable laws. PCA agencies are responsible for supervising personal care assistants' work.

We focused our analysis on the supervision of personal care assistants' work. The data we received from DHS did not allow us to examine the extent to which the department complied with federal and state requirements for revalidation.

Supervision of Personal Care Assistant Services

Supervision of personal care assistants is an important component to ensuring PCA recipients receive services and that the services they receive are appropriate for their needs. In Minnesota, all personal care assistants are required to be supervised by individuals called qualified professionals.[68] As we stated earlier in this chapter, qualified professionals must be mental health professionals, registered nurses, licensed social workers, or other specified professionals.[69]

In addition to supervising and evaluating personal care assistants, qualified professionals may also develop care plans with recipients and train personal care assistants to provide the care specified in those plans.[70] State law also requires qualified professionals to evaluate PCA services at regular intervals.[71] See Exhibit 3.4 for a list of qualified professionals' statutory duties and requirements.

PCA agencies may bill DHS for qualified professional services, and billing provides DHS with one mechanism to monitor whether PCA agencies are providing these services.[72] We analyzed claims for payments for qualified professional services provided in Fiscal Year 2018 to determine whether (1) PCA agencies billed for qualified professional services and (2) qualified professional services occurred according to the timelines established in law.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we recommended that the Legislature clarify statutes to ensure that all Medical Assistance state plan PCA recipients have their services periodically supervised by a qualified professional.

The 2009 Legislature passed a law that requires all personal care assistants to be supervised by qualified professionals.

— *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 14(a).

[68] *Minnesota Statutes* 2019, 256B.0659, subd. 14(a).

[69] *Minnesota Statutes* 2019, 256B.0625, subd. 19c; and 256B.0659, subd. 1(k).

[70] Qualified professionals are required to complete these tasks if the recipient participates in the traditional PCA service option. If the recipient participates in the PCA Choice option, the qualified professional is responsible for assisting the recipient or responsible party with completing these tasks only when requested by the recipient or responsible party.

[71] *Minnesota Statutes* 2019, 256B.0659, subds. 14(c) and 19(a)(4).

[72] Statutes allow PCA agencies to bill for up to 24 hours per year of qualified professional services for each recipient, with exceptions (*Minnesota Statutes* 2019, 256B.0652, subd. 6(e)). Statutes state that the duties of PCA agencies providing PCA Choice services include billing for qualified professional services (*Minnesota Statutes* 2019, 256B.0659, subd. 19(c)(2)).

Exhibit 3.4: Qualified professionals can play an important role in overseeing personal care assistance.

Qualified professionals must:

- Be a mental health professional, registered nurse, licensed social worker, or a qualified designated coordinator as defined in statutes.
- Work for a PCA agency.
- Enroll with DHS after clearing a background study.
- Complete DHS training either (1) before a new PCA agency submits an application for enrollment, or (2) within six months of the date hired by a PCA agency for newly hired qualified professionals, unless the qualified professional completed the required training within the last three years while employed by a different PCA agency.

Qualified professionals are responsible for:

- Developing with the recipient a PCA care plan based on the service plan and individualized needs of the recipient.[a]
- Developing with the recipient a monthly plan for the use of PCA services.
- Training personal care assistants in providing services that meet the individual needs of the recipient.[a]
- Ensuring through supervision and consultation with the recipient that the personal care assistant is:[a]
  1. Capable of providing the required PCA services.
  2. Knowledgeable about the PCA care plan before performing services.
  3. Able to identify conditions that should be immediately brought to the attention of the qualified professional.

Qualified professionals must visit the recipient:

- For traditional PCA services:
  - Within the first 14 days of starting to provide regularly scheduled services to a recipient to directly observe and evaluate the personal care assistant's work.
  - At least every 90 days during the first year of a recipient's PCA services.
  - At least every 120 days after the first year of a recipient's PCA service or whenever requested by the PCA recipient.
- For PCA Choice services:
  - Every 180 days.
- For 16- and 17-year-old personal care assistants, traditional PCA and PCA Choice services:
  - Every 60 days.

At each visit, the qualified professional must:

- Evaluate the recipient's satisfaction with their PCA services.
- Review the month-to-month plan for use of PCA services.
- Review documentation of the services provided.
- Evaluate whether the PCA services are meeting the goals of the services as stated in the PCA care plan and service plan.
- Document evaluations and needed actions to improve performance of the personal care assistant.
- Revise the PCA care plan as necessary, in consultation with the recipient or responsible party, to meet the needs of the recipient.

NOTE: "PCA" refers to personal care assistance.

[a] If the recipient participates in the PCA Choice option, the qualified professional is responsible for assisting the recipient or responsible party with completing this task only when requested by the recipient or responsible party.

SOURCE: *Minnesota Statutes* 2019, 256B.0625, subd. 19c; and 256B.0659, subds. 1(k), 11(a)(1)(i), 13, 14, 19, and 21(c).

Based on our review, some personal care assistance agencies have not billed for qualified professional services, which has affected DHS's ability to monitor whether personal care assistants are adequately supervised.

At the end of Fiscal Year 2018, 606 PCA agencies were enrolled with DHS that had submitted at least one payment claim for PCA services provided in that fiscal year. We found that 123 of the 606 PCA agencies (20 percent) did not bill DHS for *any* qualified professional services in Fiscal Year 2018.

When we looked at the frequency of qualified professional services among the 483 PCA agencies that *did* submit payment claims, we found that the agencies did not always bill for qualified professional services according to the timelines established in law. We estimate that between 9 and 13 percent of the qualified professional supervision visits for which PCA agencies submitted bills in Fiscal Year 2018 occurred at an interval greater than 120 days.[73]

DHS officials told us that staff in DHS's OIG conducted a review of qualified professional service claims for calendar years 2012 through 2014, but it has not continued this work. As a result of that review, the Surveillance and Integrity Review Section (SIRS) in DHS's OIG opened investigations of some PCA agencies. DHS officials told us that qualified professional services were being provided in a majority of the cases they reviewed, but the PCA agencies chose not to bill for the services. One official said the agencies decided that billing for these services was not worth their time or effort.

RECOMMENDATION

DHS should regularly monitor whether personal care assistance agencies bill for qualified professional supervision as a way of determining whether agencies are providing services as required.

We believe that qualified professional supervision is important for ensuring that recipients receive needed services in a safe and appropriate manner. As part of our evaluation, we spoke with several representatives from PCA agencies and provider advocacy organizations. Most of the PCA agency representatives believed that qualified professional visits helped their agencies better serve their clients. For example, one agency representative said that qualified supervision visits helps their

[73] We focused on the 120-day interval—the largest interval between qualified professional supervision visits for PCA recipients participating in the traditional PCA service option—because it was difficult to identify PCA recipients that began receiving PCA services in Fiscal Year 2018. (These individuals would have required more frequent supervision, as outlined in Exhibit 3.4.) In addition, we present a range because it was difficult to identify PCA recipients that stopped receiving PCA services after only one qualified professional supervision visit in Fiscal Year 2018. We also examined the data based on the 180-day requirement specific to PCA Choice recipients. DHS does not track which payment claims were for traditional PCA or PCA Choice. As a result, we looked at claims that were associated with the PCA agencies DHS has enrolled as PCA Choice providers. We estimated that 4 to 7 percent of qualified professional supervisions claims that *could* have been PCA Choice claims occurred at an interval greater than 180 days.

agency understand the client's circumstances, such as where medicine is located and the cleanliness of their living space.

DHS does not regularly monitor whether PCA agencies bill for qualified professional supervision. As a result, it cannot ensure that qualified professional visits are occurring according to statutory requirements.

DHS should create a process in which staff regularly review data on qualified professional services claims to determine whether PCA agencies bill for the services. If staff find PCA agencies that do not bill for the services, DHS could send a letter to the agencies to remind them about their duty to provide qualified professional services. DHS could also open investigations into providers that consistently fail to bill for qualified professional services to determine whether they are providing the services as required.

Chapter 4: Program Integrity

In chapters 2 and 3 we described two processes that may help to prevent fraud and abuse in the personal care assistance (PCA) program: assessments and provider enrollment. The Department of Human Services (DHS) also engages in efforts specifically designed to detect fraud, waste, abuse, and error in the provision of PCA.

The program integrity efforts described in this chapter are meant to prevent, identify, and end practices ranging from unintentional error to outright fraud. In some cases, errors may occur due to PCA agency administrators' lack of attention to requirements or careless paperwork. In others, fraud may occur through individuals'—recipients', personal care assistants', or PCA agency staff's—intentional efforts to bill DHS for services that were unnecessary, or necessary but never provided.

Key Findings in This Chapter

- DHS has improved its ability to prevent payments to personal care assistance agencies for impossible or improbable hours.
- DHS reported taking administrative action on over three-quarters of the personal care assistance investigation cases it completed in fiscal years 2016 through 2019.
- DHS did not take timely action to fully investigate some cases in which preliminary or screening investigators identified issues with compliance.
- The Medicaid Fraud Control Unit provided numerous recommendations to DHS to improve fraud prevention and detection efforts, but the department has not acted on many of those recommendations.

In this chapter, we discuss two of the department's efforts to deter, detect, and halt improper PCA payments: electronic payment controls and investigations. We also discuss criminal prosecution of PCA fraud cases. Based on our review, we make several recommendations to strengthen DHS's investigations process.

Electronic Payment Controls

As noted in Chapter 1, the great majority of PCA in Minnesota is provided through Minnesota's Medicaid program, Medical Assistance. To receive federal Medicaid funding, states must implement an automated claims processing system. The Centers for Medicare and Medicaid Services (CMS) is responsible for overseeing states' implementation of Medicaid, and it has defined requirements for these claims processing systems, including electronic controls that compare claims data to Medicaid program requirements before issuing payments.

In addition, DHS has implemented several PCA-specific controls in its claims payment system. We noted in Chapter 1 that the Office of the Legislative Auditor (OLA) completed an evaluation of PCA in 2009. During that evaluation, we reviewed a sample of claims and found that DHS had reimbursed PCA agencies for impossible or implausible hours. For example, we found that hundreds of personal care assistants were paid for more than 24 hours of service provided in one day. We also identified personal care assistants who were paid for multiple consecutive 24-hour work days.

UPDATE TO 2009 REPORT

In OLA's 2009 report, *Personal Care Assistance*, we reported that DHS had not found effective ways to stop payments in cases in which personal care assistants claimed to work more than 24 hours per day or consecutive 24-hour days.

DHS has implemented electronic controls in its claims payment system that have effectively prevented these types of improper payments.

Since then, DHS has implemented controls in its electronic claims payment system that are intended to (1) deny payments for claims that asserted that a personal care assistant worked more than 24 hours in a day and (2) suspend payments for claims of 48 consecutive hours. Suspended payments should be individually reviewed by DHS staff.

DHS has improved its ability to prevent payments to personal care assistance agencies for impossible or implausible hours.

We analyzed data on the more than 39 million fee-for-service PCA claims DHS processed in fiscal years 2015 through 2019 to determine whether the PCA-specific electronic controls worked as intended. We determined that the control to limit payments to 24 hours per day functioned for nearly all paid claims. We found only 14 instances in which DHS paid claims in which a personal care assistant claimed to work more than 24 hours in one day. The highest claim was for 32 hours in one day. DHS's controls on claims for consecutive 24-hour work days also generally worked to prevent DHS from paying implausible claims. We found only two instances in which personal care assistants claimed to work consecutive 24-hour days.

DHS implemented additional electronic payment controls to comply with statutes, and these controls were also generally effective. Statutes limit the number of hours for which personal care assistants may be paid for providing care to 275 hours each month.[1] This averages to roughly nine hours each day of the month. DHS implemented a control to deny claims for more than 275 hours in a month for a single personal care assistant, and we found that the control is generally working. We found that only four paid claims in the five-year period exceeded 275 hours. These claims exceeded the limit by a maximum of two hours. A DHS official told us that they review all claims for personal care assistants that were paid for 275 hours or more on a monthly basis and recover excess payments if necessary.

Investigations

Investigations into potential fraud, theft, abuse, or error in PCA are carried out by DHS's Office of the Inspector General's (OIG) Financial Fraud and Abuse Investigation Division. Within that division, the Surveillance and Integrity Review Section (SIRS) Provider Investigations unit reviews cases, analyzes information, and determines whether DHS should take administrative action on a case.[2] That unit also determines whether to refer cases for criminal investigation and prosecution. The SIRS Screening unit performs more limited reviews of PCA agency documentation. While its primary function is to review PCA agency enrollment or revalidation documentation for accuracy and

[1] *Minnesota Statutes* 2019, 256B.0659, subd. 11(a)(10).

[2] Administrative actions include suspending or terminating a PCA agency or personal care assistant's participation in PCA. We provide more information about administrative actions later in the chapter.

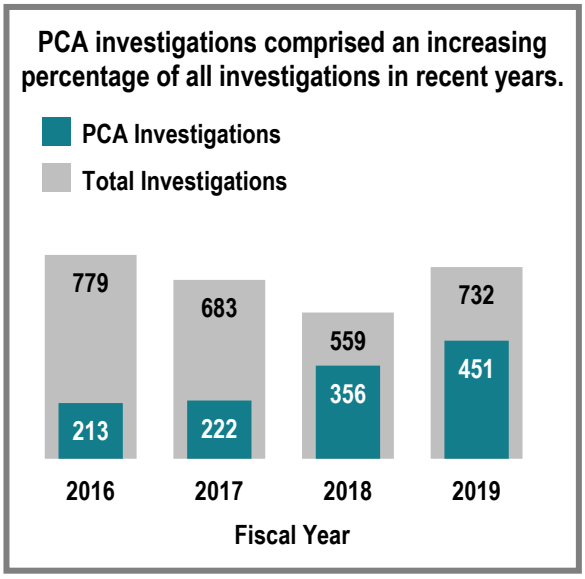
recommend whether to approve an agency's enrollment, the Screening unit may also refer cases to the Provider Investigations unit for more in-depth investigation.

In this section, we provide an overview of the provider investigations process, the results of investigations, and the timeliness in which investigations are completed. We also discuss appeals of administrative actions taken as a result of investigative findings.

Provider Investigations

Under federal regulations, states that receive Medicaid funds must establish "methods and criteria for identifying suspected fraud cases."[3] Minnesota rules established SIRS to identify and investigate fraud, theft, abuse, or error in publicly funded health care programs.[4] Minnesota rules define which activities constitute fraud, theft, and abuse, and both state law and federal regulations outline DHS's responsibilities for fining, sanctioning, or otherwise acting when SIRS uncovers fraud or abuse in Medicaid services.

SIRS is responsible for investigating potential fraud and abuse by more than 100 different types of providers, including PCA agencies, hospitals, and medical transportation providers. We reviewed DHS's investigations data for fiscal years 2016 through 2019 and determined that the Provider Investigations unit completed investigations of nearly 50 different provider types during that time period.[5]



Investigations related to personal care assistance comprised nearly half of the total number of cases DHS completed in fiscal years 2016 through 2019.

PCA cases comprised 45 percent of the more than 2,700 investigations the Provider Investigations unit completed from fiscal years 2016 through 2019. The number of PCA cases increased each year, from roughly 200 in Fiscal Year 2016 to more than 450 in Fiscal Year 2019.

The second most prevalent provider type the unit investigated was hospitals, which comprised nearly 30 percent of the total. All other provider types, including home and community-based services providers, physicians, and pharmacies, each accounted for less than 5 percent of total cases.

[3] 42 *CFR*, sec. 455.13(a) (2019).

[4] *Minnesota Rules*, 9505.2160, published electronically August 12, 2008.

[5] "Completed" cases include cases that the Provider Investigations unit independently investigated as well as cases on which the unit took action, such as suspending a provider, based on information received from other entities.

DHS relied primarily on external complaints to identify cases of potential personal care assistance fraud or abuse.

The majority (nearly 65 percent) of PCA investigations completed from fiscal years 2016 through 2019 originated from external sources, including PCA agencies, county agencies, citizens, managed care organizations, and the Minnesota Office of the Attorney General's Medicaid Fraud Control Unit. About 10 percent came from DHS units other than the Provider Investigations unit, and about 25 percent were opened based on provider investigators' findings in related cases. For example, if an investigator identified an overpayment to an individual personal care assistant, they opened a separate case for the PCA agency to recover the overpayment.[6]

DHS has performed limited proactive analysis to identify potential fraud and abuse in PCA. For example, a DHS official told us the OIG Financial Fraud and Abuse Investigation Division's Data Analytics unit does not engage in data mining to detect possibly improper or fraudulent PCA activity. Officials told us a SIRS manager regularly reviews a report on providers whose claims have increased significantly in order to identify outliers and determine whether their claims were legitimate. However, one DHS official told us it is uncommon for PCA agencies to appear on the report, and another official said that SIRS had never opened an investigations case based on those reviews.

DHS officials indicated that limited resources prevent them from performing more proactive analysis. One official said SIRS already receives too many complaints for provider investigators to investigate them all in a timely way. Another official said that the Data Analytics unit is extremely busy providing data reports to DHS staff, the Medicaid Fraud Control Unit, and others, and data analysts must prioritize requests because there is already too much work for the unit to complete. We discuss the volume of complaints awaiting investigation later in this chapter.

SIRS Preliminary Investigator:
Conducts a limited review of fraud and abuse allegations by reviewing post-payment claims information, requesting documents, and conducting a desk review. Recommends whether to open a full investigation.

SIRS Provider Investigator:
Conducts a full investigation onsite or through a desk review of documents and post-payment claims information. Determines, with management, what action to take, if any.

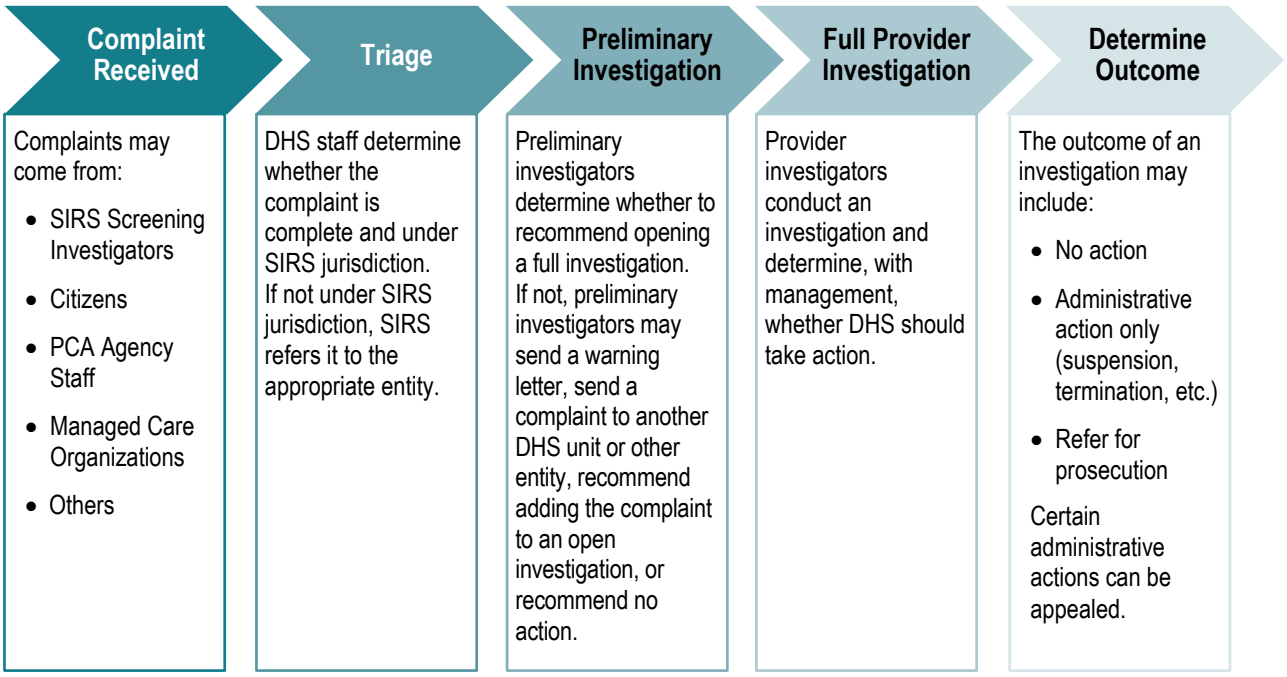
Provider Investigations Process

Federal regulations require DHS to perform preliminary investigations of reports of potential fraud or abuse and determine whether a full investigation is necessary.[7] In the SIRS Provider Investigations unit, *preliminary investigators* perform this function. If, after reviewing a complaint, they recommend opening a full investigation and SIRS managers agree with the recommendation, SIRS managers assign the case to a *provider investigator*. As we noted previously, SIRS receives complaints from a variety of sources, and those complaints generally go through a process of review outlined in Exhibit 4.1.

[6] In the PCA program, PCA agencies are the "pay-to" provider, meaning DHS pays agencies and agencies pay individual personal care assistants. If DHS determines that a personal care assistant fraudulently claimed to work hours they did not, DHS would not recover the overpayment directly from the personal care assistant. Rather, DHS would open a separate case for the PCA agency that billed for the personal care assistant's services and recover the overpayment from the PCA agency.

[7] 42 *CFR*, sec. 455.14 (2019).

Exhibit 4.1: Fraud and abuse complaints received by DHS may pass through several stages of review.



NOTES: "SIRS" refers to the Surveillance and Integrity Review Section within DHS's Office of the Inspector General. "PCA" refers to personal care assistance.

SOURCE: Office of the Legislative Auditor.

Statutes require DHS to establish, in rule, general criteria and procedures for identifying and investigating potential cases of fraud, theft, and abuse in Minnesota's Medicaid program.[8] Rather than establish detailed procedures, DHS promulgated rules that provide broad authority for provider investigators to contact individuals and organizations and examine documents pertinent to an investigation.[9]

Clear policies and procedures are important for several reasons. They promote consistency in decision-making processes, they establish clear expectations for individuals' work, and they create standards to which work can be held accountable.

DHS has not developed written criteria for determining when to recommend opening a full investigation.

A DHS official told us that no fraud tip or complaint is the same, so SIRS has not developed "cut and dry" criteria for opening a full investigation. However, DHS receives enough of certain types of cases to develop informal guidelines. For example, a DHS

[8] *Minnesota Statutes* 2019, 256B.04, subd. 10.

[9] *Minnesota Rules*, 9505.2200, published electronically August 12, 2008.

official said a common complaint involves a personal care assistant claiming to have worked hours they did not. In these cases, preliminary investigators look for evidence that the hours the personal care assistant claimed to have worked overlapped with hours worked at another job. The official told us preliminary investigators typically recommend opening a full investigation if there are more than five instances of overlap.

A preliminary investigator told us their goal is to recommend opening cases on which provider investigators can take an action; based on preliminary investigators' experience, they may believe that DHS will not be able to take action on certain deficiencies. Investigators also said that some complaints simply do not have merit. For example, one investigator noted that a person may complain about personal care assistants' actions, but the complaint demonstrates that the person does not understand the PCA program. A DHS official told us SIRS supervisors review all recommendations made by preliminary investigators. However, without written criteria, different supervisors may not make consistent decisions, particularly as staff change.

The Provider Investigations unit completed more than 2,100 preliminary investigations related to PCA complaints in fiscal years 2016 through 2019. Preliminary investigators recommended taking no action in 40 percent of complaints, while they recommended opening new investigations in about 30 percent. In about 12 percent of cases, preliminary investigators recommended referring the case to other entities—including managed care organizations, counties, or other DHS units—for further review.

Preliminary investigators most often recommended taking no action on complaints in fiscal years 2016 through 2019.

Outcome	Percentage of Cases
No action taken	40%
Open new investigation	30
Include complaint in ongoing investigation	12
Refer to other entity	12
Warning letter	6

NOTE: These data reflect preliminary investigations closed in fiscal years 2016 through 2019.

DHS has adopted some formal policies to guide its investigations.

The Provider Investigations unit is in the process of creating a manual of processes and procedures preliminary and provider investigators can use for reference or guidance while conducting investigations. For example, the department has established procedures for conducting site visits to PCA agencies. It has also outlined procedures for implementing sanctions and developed templates for conducting interviews and certain types of analysis.

At the same time, DHS has not adopted policies for some other research tasks, such as determining who to interview and how to document those interviews. In addition, DHS has not established formal timelines for investigative activities, which means PCA agencies and personal care assistants may continue to engage in fraudulent or abusive behavior during prolonged investigations. For example, DHS does not have a policy that establishes a timeline within which preliminary investigators must make a recommendation on whether to open a full investigation into a complaint. DHS also does not have a policy that states how quickly after being assigned to a case provider investigators are expected to begin investigative activities. Due to how DHS tracks

case activity, it is difficult to determine how long provider investigations take, on average. However, we found cases in which provider investigators performed no investigative activity on cases for months or even years after they were assigned. A DHS official also told us that the department is in the process of formalizing additional policies. The official also told us DHS is working towards establishing timelines for some investigative activities but does not currently require investigators to meet timeliness standards.

DHS's provider investigations procedures follow several—but not all—recommended practices compiled by the Centers for Medicare and Medicaid Services.

In 2018, CMS published a report with recommended practices for mitigating vulnerabilities in PCA.[10] The report included recommended practices for PCA investigations. After reviewing DHS manuals and policies and speaking with SIRS staff, we determined that investigators follow some recommended practices, as shown in Exhibit 4.2. For example, one recommended practice is to check state employment records when a personal care assistant is suspected to be working elsewhere when services were billed. SIRS has broad authority to review documentation relevant to their investigations, and an investigator told us they check Minnesota Department of Employment and Economic Development reports when they suspect a personal care assistant may have worked elsewhere during hours they claimed to provide PCA.[11]

On the other hand, the Provider Investigations unit does not consistently follow a number of other recommended practices. For example, as we noted previously, the unit does not regularly conduct data analytics to identify PCA agencies with suspicious billing practices. It also frequently conducts desk reviews, in which it requests documents from PCA agencies, rather than conducting recommended unannounced site visits to review documents.

RECOMMENDATION

DHS should further develop policies and procedures to formalize aspects of its investigations processes and incorporate best practices.

A DHS manager and investigators told us it would be difficult to create manuals or guidelines for every aspect of SIRS's investigative work. We agree, but believe that by formalizing additional policies and procedures, DHS can ensure that investigators understand what is expected of them, promote consistency as staff changes occur, and provide greater guidance to new investigators. This is particularly important because SIRS has not typically provided formal training to new investigators; instead, it has assigned mentors to assist new investigators during their first few months in the position. Investigators we spoke with reported mixed experiences with mentors, with some mentors providing more guidance than others.

[10] Centers for Medicare and Medicaid Services, *Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services* (Woodlawn, MD, 2018).

[11] *Minnesota Rules*, 9505.2200, subp. 3, published electronically August 12, 2008.

To the extent possible, DHS should align its formal policies and procedures with recommended practices. DHS's ability to implement some recommended practices may be limited by available resources, but some practices may require a smaller commitment of resources. For example, DHS and the Medicaid Fraud Control Unit could use their own staff to conduct interagency training on topics relevant to both entities.

Exhibit 4.2: DHS investigation practices are in line with some recommended practices.

Recommended Practices	Practices in Line	DHS Practices
Based on results of data analytics, audit cases of suspicious billing.	No	SIRS does not regularly perform data analytics on PCA data.
Work with the state's or Center for Medicare and Medicaid's audit contractors to audit PCA agencies.	No	DHS contracts with audit contractors for other types of work, but not to audit PCA.
Organize interagency training on policies, functions, and provider interactions related to fraud referral and investigations.	No	DHS reports it has not regularly organized joint training for SIRS and MFCU.
Conduct unannounced on-site inspections for providers under investigation.	Partial	As a condition of enrollment as a Medical Assistance provider, statutes require PCA agencies to allow DHS to conduct unannounced on-site inspections; most investigations do not involve site visits.
If a personal care assistant is suspected of working elsewhere, check state employment records.	Yes	SIRS has broad authority to review documentation necessary to complete its investigations.
Audit a small sample of claims and provide focused education to PCA agencies.	Yes	DHS policies state screening investigators may review a sample of claims during site visits; DHS management reports that investigators provide education to PCA agencies when needed.
Meet regularly with MFCU.	Yes	SIRS management reports that they hold regular meetings with MFCU management.

NOTES: "SIRS" refers to DHS's Surveillance and Integrity Review Section. "PCA" refers to personal care assistance. "MFCU" refers to the Medicaid Fraud Control Unit at the Minnesota Office of the Attorney General. This is not an exhaustive list of recommended practices related to investigations.

SOURCES: Office of the Legislative Auditor, review of Centers for Medicare and Medicaid Services, *Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services* (Woodlawn, MD, 2018); DHS policies and procedures; *Minnesota Statutes* 2019, 256B.04, subd. 21(j); and *Minnesota Rules*, 9505.2200, subp.3, published electronically August 12, 2008.

Screening

In Chapter 3, we described the two types of routine screening site visits that the SIRS Screening unit is required to perform for all PCA agencies: pre-enrollment and revalidation.[12] Screening investigators also perform discretionary screening site visits in response to issues identified by DHS.

SIRS Screening Investigator:
Interviews PCA agency owner or managing employee and conducts a limited review of documentation on-site. Recommends whether the Provider Eligibility and Compliance unit should approve agency for enrollment. May refer case to the Provider Investigations unit for review.

The purpose of discretionary screening visits is similar to the purpose of routine visits: to verify the accuracy of information the PCA agencies provide to DHS and to determine whether PCA agencies are complying with legal requirements. Discretionary visits, however, may focus more specifically on reviewing issues identified in complaints or previous site visits. These issues may include an agency failing to properly document hours worked by qualified professionals or to maintain recipients' PCA care plans as required.

Screening investigators provided increased support to the Provider Investigations unit in recent years by completing discretionary site visits.

In fiscal years 2018 and 2019, screening investigators began performing screening site visits at the request of the Provider Investigations unit. The Screening unit also increased the number of site visits it performed at its own discretion in recent years.[13] A DHS official told us that screening investigators generally target PCA agencies for these discretionary site visits when they believe they could add value; for example, screening investigators may choose to visit agencies where they identified issues during pre-enrollment site visits.

In fiscal years 2018 and 2019, about 40 percent of the site visits the Screening unit performed were discretionary, rather than routine pre-enrollment or revalidation, site visits. This was an increase from less than 1 percent in Fiscal Year 2015.[14]

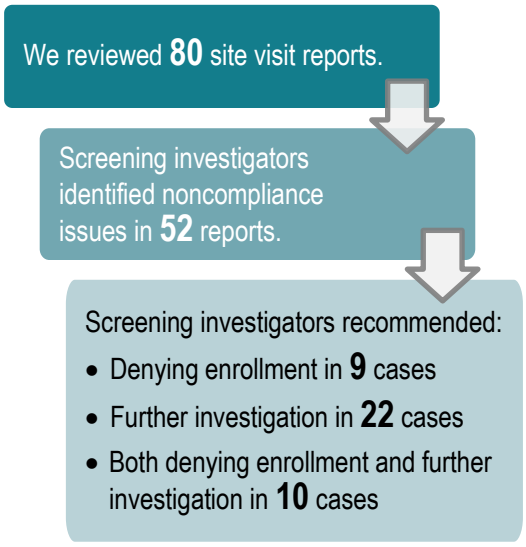
Screening site visits are generally limited in scope, and screening investigators do not implement administrative actions when they find issues of noncompliance during their investigations. Instead, they may (1) recommend that DHS's Provider Eligibility and Compliance unit deny a PCA agency's enrollment and/or (2) refer the case to the Provider Investigations unit for further investigation.

[12] The Screening unit completes site visits to many other types of providers in addition to PCA agencies. In fiscal years 2015 through 2019, it completed about 3,100 visits. During that five-year period, 46 percent of total site visits were completed at PCA agencies.

[13] A DHS official told us that there are not many differences between the visits that provider investigators refer to the Screening unit and the ones the Screening unit chooses to make, although the Screening unit may not always target PCA agencies for a visit due to issues identified during previous visits. In some cases, they may choose to conduct a more routine follow-up visit with a provider because the unit has capacity to do so.

[14] This change coincided with a sharp decrease in the number of revalidation site visits performed between fiscal years 2015 and 2019.

DHS has not established written criteria for screening investigators to recommend further review of problematic cases.



We reviewed site visit reports for 80 screening visits completed in fiscal years 2017 through 2019, and it was not always clear why screening investigators did not recommend DHS take action on the information they found.[15] Although screening investigators noted at least one instance of noncompliance in most of the site visit reports we reviewed, they did not recommend further action for all of those visits. In addition, it was not always clear why screening investigators referred cases to the Provider Investigations unit for further review, but recommended approving the PCA agency to remain enrolled as a PCA provider.

DHS has not developed written criteria for when screening investigators should refer a case to Provider Investigations, and officials gave us differing opinions on when cases should be referred. One DHS official told us that screening investigators typically refer cases to the Provider Investigations unit for further review when they believe that unit can pursue action against a provider. However, another DHS official told us they were not aware of any criteria cases must meet for screening investigators to send cases to the Provider Investigations unit. The second official said if screening investigators find the PCA agency is not following documentation requirements, they should refer the case to the Provider Investigations unit.

Criteria for recommending that a PCA agency's enrollment be terminated are clearer, but they also leave some room for interpretation. Federal and state law require DHS to terminate agencies' enrollment in certain cases, with exceptions. For example, in the site visit reports we reviewed, screening investigators recommended denying enrollment if (1) they were unable to access the PCA agency's place of business, or (2) the agency had not disclosed all owners or managing employees. Federal regulations require termination in both of these cases, unless the state Medicaid agency (DHS) finds that termination is not in the best interests of the Medicaid program.[16]

Other criteria are less clear. For example, statutes state that DHS has the authority to request proof of documentation of "meeting provider standards" and failure to comply with laws and rules may result in suspension, denial, or termination of an agency's enrollment.[17] However, in cases where certain required documentation—such as PCA

[15] About one-half of these site visit reports were for routine revalidation site visits and about one-half were for discretionary screening investigation site visits. We present results of both types of visits here because the site visit process is very similar for both. Screening investigators were able to complete the visit in 71 of the 80 cases; in 3 cases, screening investigators conducted a desk review; and in 6 cases, the PCA agency did not provide access to their site of business.

[16] 42 *CFR*, sec. 455.416(d) and (f) (2019).

[17] *Minnesota Statutes* 2019, 256B.0651, subd. 16.

care plans or qualified professional supervision notes—were deficient, screening investigators often recommended approving agencies' enrollment.

RECOMMENDATION

DHS should establish written guidelines for determining when screening investigators should (1) recommend that a personal care assistance agency's enrollment be approved or denied, and (2) refer a case to the Provider Investigations unit for further review.

The Screening unit should work with the Provider Eligibility and Compliance and Provider Investigations units to develop written criteria for the actions it recommends based on information investigators collect during site visits. In some cases, the law clearly requires that DHS terminate an agency's enrollment. In others, DHS has more discretion in the actions it takes. Given the number of DHS units that work to protect the integrity of the PCA program, it is important that they all agree on each unit's responsibilities. They should also understand the ramifications of those decisions.

Investigations Results

DHS has the authority—and the responsibility—to take administrative action against individual personal care assistants and PCA agencies under certain circumstances. Under federal law, DHS must terminate PCA agencies' enrollment if individuals with 5 percent or more ownership interest do not provide DHS with timely and accurate information.[18] As another example, state law allows DHS to suspend PCA agencies' enrollment if they make a pattern of false claims.[19]

Statutes require DHS to consider "the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served" by the provider when taking certain administrative actions.[20] DHS has established broad criteria investigators must consider when imposing certain administrative actions. For example, when determining the chronicity of an action, provider investigators should determine (1) the number of identified violations, (2) the length of time violations occurred, and (3) the length of the period of time reviewed.

A DHS official told us that SIRS management reviews all cases with provider investigators prior to closing them without action or imposing administrative actions. In these reviews, investigators are expected to present evidence related to the nature, chronicity, and severity of the conduct they investigated, and decisions are made on a case-by-case basis.

[18] 42 *CFR*, sec. 455.416(a) (2019).

[19] *Minnesota Statutes* 2019, 256B.064, subds. 1a(a)(2) and 1b.

[20] *Minnesota Statutes* 2019, 256B.064, subd. 1b.

DHS reported taking administrative action on over three-quarters of the personal care assistance investigations cases it completed in fiscal years 2016 through 2019.

As shown in Exhibit 4.3, DHS can implement a variety of administrative actions when it uncovers fraud, theft, abuse, or error in PCA. The Provider Investigations unit reported taking at least one administrative action against over 1,000 providers—both PCA agencies and individual personal care assistants—in fiscal years 2016 through 2019.[21] According to DHS data, the unit took at least one administrative action in about 80 percent of the cases it completed during those four fiscal years.

Exhibit 4.3: State law gives DHS the authority to take several types of administrative action when providers commit fraud, theft, abuse, or errors in the provision of personal care assistance.

Administrative Action	Description	Number of Cases Fiscal Years 2016-2019
Payment Withhold	Stop claims for PCA from being processed and payments from being sent to the PCA agency	147
Suspend or Terminate Participation in Program	PCA agency or personal care assistant is prohibited from being paid as a PCA provider for a specified period of time, or in the case of termination, until the basis for termination no longer exists	463
Fine	Fines issued for failing to keep proper documentation, repeated violations, and employing an excluded provider	6
Identify Overpayment for Recovery	Issue "Notice of Agency Action" to the PCA agency to collect an identified overpayment	238
Provider Agreement	Require provider agreement that states specific conditions of participation	71
Warning	Letter is sent to provider warning them of conduct that had the potential to warrant an administrative action	281

NOTES: This table does not present all actions available in law; there were additional actions that DHS did not impose. "PCA" refers to personal care assistance.

SOURCES: Office of the Legislative Auditor, based on *Minnesota Statutes* 2019, 256B.064; *Minnesota Rules*, 9505.2210, subp. 2; and 9505.2215, subps. 1A and 2, published electronically August 12, 2008; and correspondence with and data provided by the Department of Human Services.

[21] Until spring 2019, the Provider Investigations unit did not track whether cases pertained to a PCA agency or a personal care assistant within its case management system. The Provider Investigations unit determines the administrative action to take and communicates the action to the Provider Eligibility and Compliance unit. The Provider Eligibility and Compliance unit implements the action in applicable databases.

In fiscal years 2016 through 2019, DHS most commonly imposed suspensions and terminations on providers. Suspensions last for a specified period of time; terminations are effective until the basis for termination no longer exists. A DHS official told us that when a provider whose participation in the program was terminated seeks reinstatement, DHS considers many factors to determine whether the basis for termination still exists. For example, department officials determine whether the provider fully repaid overpayments and restitution ordered by the court. DHS is required to identify the length of time providers are excluded from participation in the PCA program when they are suspended or terminated.[22] The average suspension length was 23 months, while the average termination length was 63 months.

DHS also commonly identified overpayments in fiscal years 2016 through 2019. DHS identified a total of nearly $6.2 million in overpayments in the four-year period and reported recovering more than $4.7 million. When the Provider Investigations unit identifies overpayments, it coordinates with other DHS units to recover those overpayments by accepting payments from PCA agencies, reducing future claims payments to PCA agencies, or recovering surety bonds, among other actions. As the "pay-to" provider—the entity that receives money from DHS for services provided—DHS only recovers overpayments from PCA agencies. It does not recover overpayments from personal care assistants. A DHS official told us that it may take several years to recover an overpayment, particularly if the PCA agency goes out of business. In some cases, after taking all actions available to the department, DHS must classify the overpayment as unrecoverable.

Appeals of Administrative Actions

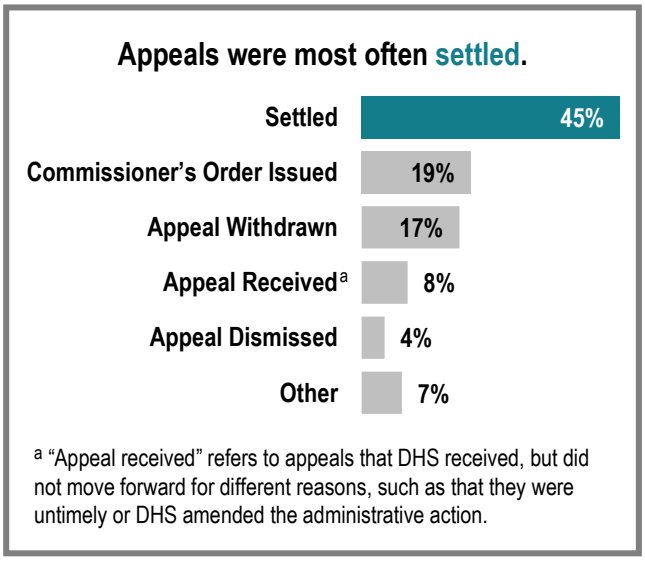
Personal care assistants and PCA agencies may appeal certain administrative actions, including certain suspensions, terminations, and identification of overpayments.[23] To do so, they must file the appeal with DHS within 30 days of the date that DHS mailed a notification of action. Administrative law judges in the Office of Administrative Hearings preside over these types of appeal cases. When the hearing concludes, the judge issues a report with conclusions about the facts of the case and recommendations as to whether DHS's administrative action should be affirmed, modified, or reversed. The judge's recommendation is not necessarily binding. The commissioner has 90 days from when the hearing record is closed to issue a final order; if they do not issue an order, the judge's recommendation becomes the final order.[24]

[22] *Minnesota Rules*, 9505.2230, subp. 1B(1), published electronically August 12, 2008.

[23] *Minnesota Statutes* 2019, 256B.064, subd. 2(e). These appeals lead to "contested case hearings."

[24] *Minnesota Statutes* 2019, 14.62, subds. 1 and 2a.

Personal care assistance providers appealed less than 20 percent of eligible administrative actions taken by DHS in fiscal years 2016 through 2019.



DHS received just under 140 appeals for the approximately 700 appealable administrative actions it took in fiscal years 2016 through 2019. Nearly half of these appeals were resolved when the appellant and DHS reached a settlement agreement.

When DHS and the appellant do not reach a settlement, there are several other possible outcomes. As previously noted, the appeal may go through a hearing in the Office of Administrative Hearings, and the commissioner may issue an order on the judge's recommendation. In some cases, the appellant withdraws the appeal. In others, the appeal is received, but it was not timely, and so it does not move forward.

Timeliness of Investigations

Statutes and rules do not require DHS to complete investigative activities within established timeframes. For example, there is no limit on the amount of time DHS can take to conduct a preliminary investigation or assign a provider investigator to a case once a preliminary investigator determines that the case has merit. In addition, as we noted previously, DHS has not established internal policies that specify timeframes for investigative activities. Timeliness is important in DHS's investigations because the longer DHS takes to investigate a provider and take administrative action, the longer the provider can potentially participate in abusive or fraudulent practices.

As noted previously, a DHS official told us DHS receives too many complaints to investigate them all in a timely way. To review the total number of complaints received by the department and its timeliness in reviewing them, we analyzed data, not only related to PCA, but on *all* preliminary investigations that were open at the beginning of November 2019.

DHS data showed that there were more than 620 preliminary investigations open at that time.[25] About half (310) of those cases were actively under review or waiting for review. In these cases, preliminary investigators had not yet determined the merit of the complaint and recommended how to proceed with the case, or their recommendation was waiting for management review. Preliminary investigators had finished reviewing the other 317 open cases and had recommended that provider investigators conduct a full investigation.

[25] Sixty-three percent of these cases were related to PCA.

DHS did not take timely action to fully investigate some cases in which preliminary or screening investigators identified issues with compliance.

The 317 cases for which preliminary investigators recommended a full investigation had been waiting for assignment to provider investigators for an average of more than 270 days, as of November 2019. Two cases had been waiting more than two years for assignment.

There were several reasons for the delay in assigning provider investigators. At the time of our review, the Provider Investigations unit had 18 provider investigators. A DHS official told us they have been working to reduce high caseloads for provider investigators, which they stated were at an average of 50 cases per investigator in January 2019. To reduce investigators' caseloads, management must assign fewer cases to each investigator, meaning cases may wait longer for assignment.

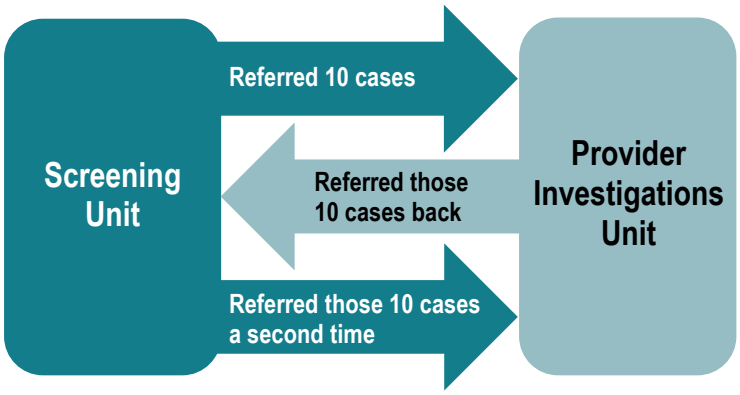
In addition, some cases are assigned to a provider investigator more quickly than others. DHS does not have a case prioritization policy, but a DHS official told us that the unit has developed unwritten priorities for assignment to provider investigators. For example, they said that SIRS' top priority is to investigate complaints in which there are concerns about an individual's health or well-being. Cases deemed a lower priority could wait for years to be assigned to an investigator. By the time a provider investigator finishes their investigation of these cases and DHS takes an action, several years may pass in which a PCA agency or personal care assistant continued to provide services after a preliminary investigator identified compliance issues.

Prioritization for Assignment of Provider Investigators

1. Cases in which there is concern for an individual's health or well-being.
2. Cases DHS sent to the Medicaid Fraud Control Unit that require the department to take administrative action.
3. Cases for which DHS received multiple complaints against a provider.
4. Cases from oldest to newest.

The Provider Investigations unit was also slow to act on many cases referred by screening investigators. In 32 of the 80 site visit reports we reviewed, screening investigators referred the case to the Provider Investigations unit for further investigation.[26] To better understand investigation timelines, we reviewed data on those 32 cases. As of September 2019, DHS had taken action against a provider in only 5 of the 32 cases we reviewed, 15 of which screening investigators had referred in fiscal years 2017 and 2018. In three additional cases, preliminary investigators recommended taking no further action after reviewing documentation and determining the PCA agency had taken steps to comply with requirements.

[26] As previously noted, we reviewed 80 site visit reports from visits completed in fiscal years 2017 through 2019.



We found that screening investigators conducted 10 of the 32 visits we reviewed at the request of the Provider Investigations unit *after* previously referring the case to that unit due to noncompliant documentation. The Screening unit received the follow-up request an average of two years and five months after that unit's original referral to the Provider Investigations unit. In all ten of these cases, screening investigators referred the case to the Provider Investigations unit a second time for continued documentation deficiencies. This means that that these ten cases were passed between SIRS units without action for more than two years.

RECOMMENDATION

DHS should create a plan for investigating suspected fraud and abuse cases in a more timely way.

Statutes state that DHS must establish general criteria and procedures for the "prompt investigation" of suspected fraud, theft, and abuse in the Medical Assistance program.[27] However, we found that DHS's investigations are not always prompt. This is due, at least in part, to the high volume of complaints received by DHS compared to its limited workforce. The 2019 Legislature provided funding for an additional four investigators.[28] This may help address the Provider Investigation unit's workload, but some of the delays may also be related to DHS's practices—including passing cases back and forth between SIRS units without taking action to address issues identified.

As DHS further develops its investigative policies and procedures, it should devise a plan for addressing cases of suspected fraud and abuse in a timely manner. In particular, it should explore ways to act more quickly on issues of noncompliance that preliminary and screening investigators uncover. For example, it could increase preliminary investigators' use of warning letters or expand the scope of preliminary investigators' work to include recommending fines for incomplete documentation. As we showed in Exhibit 4.3, DHS rarely used its authority to fine providers. It should also formalize timeframes within which it expects key tasks, such as beginning investigative activity on a case after assignment, to be completed. DHS should present this plan to the Legislature for review.

[27] *Minnesota Statutes* 2019, 256B.04, subd. 10.

[28] *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 14, sec. 2.

Criminal Prosecutions

Federal law generally requires states that participate in the Medicaid program to operate a Medicaid Fraud Control Unit (MFCU) to investigate and prosecute individuals that commit fraud in federal health care programs.[29] As we noted previously, in Minnesota, MFCU is part of the Minnesota Office of the Attorney General. If the SIRS Provider Investigations unit determines that a case involves a credible allegation of fraud, the Provider Investigations unit must refer the case to MFCU for further investigation and possible prosecution.[30]

The Medicaid Fraud Control Unit and DHS's Surveillance and Integrity Review Section have important, but distinct, roles in protecting the integrity of the personal care assistance program.

While MFCU's responsibilities are focused on investigating and prosecuting fraud in court, SIRS is more broadly responsible for investigating fraud, abuse, or error and imposing appropriate administrative actions.[31] As shown in the examples below, SIRS does not always determine that a case involves a credible allegation of fraud. In some cases, for example, investigators may determine that the case simply involves error on the part of the provider.

Example: SIRS Case Referred to MFCU

The owner of a PCA agency reported to SIRS that they believed a personal care assistant they employed had billed for time that overlapped with the assistant's other job. A provider investigator found that the personal care assistant had submitted multiple time cards for PCA that overlapped with times that the assistant worked at a second job. SIRS referred the case to MFCU, which further investigated. MFCU filed a criminal complaint, and the personal care assistant was found guilty of theft by swindle and theft by false representation and ordered to pay restitution of $20,000.

Example: Case Investigated by SIRS Only

The mother of a child receiving PCA reported to SIRS that her PCA agency had billed for services that her child did not receive. A provider investigator reviewed timecards and other documentation and identified an overpayment of approximately $1,300. The provider investigator determined the claims were mistakenly submitted, and DHS recovered the overpayment by reducing payments to the PCA agency.

Along with different responsibilities, MFCU and SIRS have different investigative priorities. An MFCU official told us that unit is more inclined to investigate cases with large monetary implications, and the unit's cases tend to encompass years-long timeframes. In contrast, they said that SIRS' investigations tend to be for smaller dollar values, and the timeframe SIRS reviews is short. The MFCU official told us they would not characterize SIRS' investigative work as thorough. A DHS official said that,

[29] 42 *U.S. Code*, sec. 1396b(q) (2018).

[30] 42 *CFR*, secs. 455.15(a)(1) and 1007.11(a) (2019).

[31] *Minnesota Rules*, 9505.2160, subp. 1, published electronically August 12, 2008.

for practical reasons, SIRS investigates the tips it receives and does not generally expand the scope of a review once investigators find the evidence necessary to support an administrative action. A SIRS investigator told us DHS management focuses on overall program integrity and encourages investigators to ensure providers comply with requirements, not pursue only high-dollar cases.

From fiscal years 2016 through 2019, DHS reported referring more than 320 cases to MFCU for what the SIRS Provider Investigations unit concluded were credible cases of fraud. MFCU determined it would pursue a criminal investigation, or "accepted," about three-quarters of those cases. An MFCU official told us that MFCU may not accept a case for numerous reasons, including that MFCU determined (1) the case did not meet the required standard for a credible allegation of fraud, (2) SIRS did not gather enough information for MFCU to pursue the case, or (3) the case warranted administrative action but not criminal action.

Stay of Imposition: The imposition of a prison sentence is delayed as long as the offender complies with conditions of the court. If conditions are met, the case is discharged and, for civil purposes, the offender receives a misdemeanor, rather than felony, conviction on their record.

Stay of Adjudication: The offender pleads guilty or nolo contendere (no contest), but the judge does not enter a judgment of guilt. If the offender complies with conditions of the court, charges are dismissed and the offender does not have a record of conviction.

According to DHS data, MFCU filed charges in court for just over half of the cases the unit accepted from SIRS.[32] The court ordered action in over 90 percent of those cases. The most common actions were stay of imposition (35 percent) and stay of adjudication (27 percent). Courts ordered about $5.7 million in restitution for cases SIRS referred to MFCU.

While DHS is the principal entity that refers allegations of fraud to MFCU, the unit opens cases based on referrals from other agencies and individuals and its own investigative work. According to MFCU data, the unit received more than 530 referrals related to PCA from all sources in fiscal years 2016 through 2019, and it filed more than 200 criminal charges. The unit reported 178 convictions during the four-year period and $14 million ordered in restitution.

The Medicaid Fraud Control Unit provided numerous recommendations to DHS to improve fraud prevention and detection efforts, but the department has not acted on many of those recommendations.

The former attorney general sent a letter to the former DHS commissioner in January 2019 providing recommendations for how DHS could deter and prevent fraud in PCA. The attorney general indicated that MFCU had sent similar recommendations to DHS in previous years. OLA requested information about DHS's response to MFCU's recommendations and found that the letter had not been shared with relevant officials in the department. The former interim manager of OIG stated that "the letter was sent during a period of transition, and this correspondence did not reach our current SIRS

[32] An MFCU official told us that, in some cases in which MFCU did not file criminal charges, the unit entered into civil settlements which required repayment of Medicaid funds and suspension of a provider for a specified period of time.

management team."[33] The former interim manager went on to say that MFCU and SIRS had discussed much of the content of the letter in the past.

In a 2017 letter to MFCU, the former Inspector General stated that "some of MFCU's suggestions appear to arise out of a misunderstanding of the organization of DHS and administration of the Medical Assistance program in Minnesota."[34] One recommendation MFCU provided was for DHS to identify which PCA agencies "always bill for recipients' *maximum authorized*" amounts of PCA "instead of the *actual services* provided" and review those agencies' claims to determine whether they are legitimate.[35] The former interim manager of OIG stated that individuals may need the amount of services authorized. In fact, that is what these service authorizations are designed to do. As we explained in Chapter 2, recipients must complete an annual assessment to determine their need and eligibility for PCA. Based on that assessment, assessors authorize the amount of PCA recipients may receive. One advocate we spoke with indicated that the number of individuals that do not access the amount of PCA they are authorized to receive is problematic and that some recipients cannot find personal care assistants to provide needed services.

At the same time, DHS did not adequately address some of MFCU's other recommendations in its response. For example, MFCU provided a number of recommendations to review billing for qualified professionals' visits. In OIG's 2017 letter, the former Inspector General noted that the Legislature would need to pass legislation to enroll qualified professionals in order for DHS to perform the data analytics suggested. The 2019 Legislature *did* require qualified professionals to enroll with DHS.[36] However, in their October 2019 letter, the interim manager for OIG did not indicate how this change would affect OIG's ability to implement MFCU's recommendations; instead, they referred to the response provided in the office's 2017 letter. A DHS official later told us that the department would need additional staff to complete enrollment for qualified professionals.

As another example, MFCU recommended that SIRS use the data DHS maintains to identify claims for services provided by individuals ineligible to bill for PCA, including parents of minors receiving PCA and recipients of PCA. In addition, MFCU recommended that DHS create controls within its billing system to prevent payment of claims for providers or recipients living outside Minnesota. DHS did not address these specific recommendations in communication with MFCU or OLA.

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[33] Bob Jacobson, Interim Manager, Office of the Inspector General, Department of Human Services, letter to Jodi Rodríguez, Office of the Legislative Auditor, October 18, 2019.

[34] Carolyn Ham, Inspector General, Office of the Inspector General, Department of Human Services, letter to Kirsi Poupore, Director, Medicaid Fraud Control Unit, Minnesota Office of the Attorney General, July 24, 2017.

[35] Lori Swanson, Attorney General, Minnesota Office of the Attorney General, letter to Tony Lourey, Commissioner, Department of Human Services, January 3, 2019; referring to Melanie Leslie, Investigator Auditor, Medicaid Fraud Control Unit, Minnesota Office of the Attorney General, e-mail to Bob Cooke, Supervisor, Office of the Inspector General, Department of Human Services, January 27, 2015.

[36] *Laws of Minnesota* 2019, First Special Session, chapter 9, art. 5, sec. 37, codified as *Minnesota Statutes* 2019, 256B.0659, subd. 13(a).

RECOMMENDATION

DHS should work more closely with the Medicaid Fraud Control Unit to prevent, deter, and detect fraud in personal care assistance.

Transition occurs in all state agencies and is not an excuse for failing to provide important communication to relevant leaders. In the future, DHS should ensure that not only OIG, but other divisions that have relevant roles in overseeing the PCA program, receive communications from MFCU and take concrete action to respond to recommendations. It may not always be possible or appropriate for DHS to implement MFCU's recommendations, but department officials should consider each recommendation and communicate with MFCU about them.

DHS has recently taken steps toward building a closer working relationship with MFCU. For example, a DHS official reported that MFCU and SIRS recently held a joint meeting for MFCU and SIRS investigators to meet and share information. In addition, the OIG Financial Fraud and Abuse Investigation Data Analytics unit recently began working with MFCU to address that unit's requests for data analytics and plan to select one project each quarter to complete. A DHS official reported that the first project was focused on dental data. We recommend DHS continue to strengthen its working relationship with MFCU to find new and innovative ways to protect PCA recipients and tax dollars from abusive and fraudulent practices.

Chapter 5: Program Changes

Throughout this report, we highlighted changes that the Legislature and the Department of Human Services (DHS) have made to the personal care assistance (PCA) program since 2009. The largest modification came in the form of a legislative mandate in 2013 to replace the PCA program with a new program. In this chapter, we provide a brief overview of the new program and discuss our overarching observations of DHS's efforts to implement changes to the PCA program. We recommend that the Legislature review statutory oversight requirements for the new program.

Community First Services and Supports

As we noted in Chapter 1, Minnesotans who need assistance with dressing, bathing, certain health-related procedures, and other specified activities may qualify for public programs that provide assistance with those activities. Currently, Minnesotans can receive assistance with these types of activities through PCA.

The federal Patient Protection and Affordable Care Act, passed in 2010, created a new option for states to provide these types of services through Medicaid.[1] To participate in this option, states must amend their state Medicaid plans and meet numerous criteria, such as providing services through a person-centered plan and providing back-up support to ensure continuity of services for recipients. States must also establish a Development and Implementation Council that includes elderly members and members with disabilities, and must collaborate with the council. States that are approved to offer services through this option are eligible to receive increased federal funding. Minnesota decided to participate in this new Medicaid option by creating a new program.

The 2013 Legislature established the Community First Services and Supports program to replace the PCA program.[2]

Like PCA, Community First Services and Supports (CFSS) requires individuals to complete an assessment and be determined to need assistance with at least one activity of daily living or qualifying behavior in order to be eligible for the program.[3] Also like PCA, the amount of services an individual receives is based on statutory guidance.[4]

While PCA and CFSS share many characteristics, CFSS is different from PCA in numerous ways. For example, "support workers," rather than personal care assistants, will provide services to recipients of CFSS. CFSS can pay for support workers to help recipients learn, enhance, or maintain skills necessary to perform certain tasks, such as dressing or eating.[5] It can pay for goods that may reduce a recipient's need for human

[1] The Patient Protection and Affordable Care Act of 2010, Public Law 111-148, sec. 2401, March 23, 2010.

[2] *Laws of Minnesota* 2013, chapter 108, art. 7, sec. 49, codified as *Minnesota Statutes* 2019, 256B.85.

[3] *Minnesota Statutes* 2019, 256B.0625, subd. 19a; 256B.0659, subd. 4; and 256B.85, subd. 3(b)(1).

[4] *Minnesota Statutes* 2019, 256B.0652, subd. 6(b); and 256B.85, subd. 8(b).

[5] *Minnesota Statutes* 2019, 256B.85, subd. 7(2).

assistance.[6] For example, an individual could purchase a microwave to enable them to prepare their own meal, rather than relying on assistance from a support worker with that task. In addition, individuals who are unable to act as personal care assistants through PCA, including spouses and parents of minor children, may act as support workers in CFSS.[7]

Similar to the PCA program, CFSS provides recipients with two service options. Recipients may choose to use a provider agency that employs, trains, and supervises support workers.[8] Or, recipients may instead choose to participate in the "budget model." Under this model, recipients receive a budget and control their own services and supports within that budget according to their service delivery plan.[9] They hire, train, and supervise their own support workers and work with a financial management service to ensure they pay applicable taxes, keep track of their spending, and perform other duties.

The type of oversight CFSS requires is different from PCA in several ways. While in CFSS, provider agencies must meet enrollment requirements that are very similar to the current requirements for PCA agencies, the enrollment requirements are different for financial management services. In addition, in PCA, qualified professionals must visit all recipients to oversee the delivery of PCA at regular intervals.[10] In CFSS, this type of direct oversight by a qualified professional is not required. Instead, under the provider agency model, the agency must evaluate services at regular intervals, but statutes do not specify qualifications for individuals that conduct those evaluations.[11] The budget model does not have a similar provision for regular outside supervision visits.

All CFSS recipients must have a plan for support worker training, which must include direct observation and monitoring of the support worker's skills.[12] However, statutes indicate that this type of monitoring must occur when services begin or when a new support worker starts working with a recipient, not on an ongoing basis. Statutes also do not specify who must conduct the monitoring activities or their qualifications; statutes only indicate that monitoring activities must be conducted by "an appropriate professional."[13] In CFSS, consultation service providers must also approve recipients' service delivery plans and provide recipients with other support.[14]

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[6] *Minnesota Statutes* 2019, 256B.85, subd. 7(3).

[7] *Minnesota Statutes* 2019, 256B.0659, subd. 3(a)(1); and 256B.85, subd. 7(8).

[8] *Minnesota Statutes* 2019, 256B.85, subds. 11(a) and 11b.

[9] *Minnesota Statutes* 2019, 256B.85, subd. 13(a).

[10] *Minnesota Statutes* 2019, 256B.0659, subds. 14(a) and (c) and 19(a)(4). Qualified professionals must be mental health professionals, registered nurses, licensed social workers, or other qualified individuals (*Minnesota Statutes* 2019, 256B.0625, subd. 19c).

[11] *Minnesota Statutes* 2019, 256B.85, subds. 11a and 11b.

[12] *Minnesota Statutes* 2019, 256B.85, subds. 6(c)(15) and 18a(c)(3).

[13] *Minnesota Statutes* 2019, 256B.85, subd. 18a(c)(3).

[14] *Minnesota Statutes* 2019, 256B.85, subd. 17. This requirement does not apply to individuals enrolled in Medical Assistance Home and Community-Based Services waiver programs or Alternative Care, whose plans must be approved by their case manager or care coordinator. Consultation services providers are required to provide recipients with information about CFSS service options, service planning, and other things when they begin participating in CFSS and at least annually thereafter.

The Legislature did not require DHS to implement Community First Services and Supports by a certain date, and DHS has not yet implemented the program.

Nearly seven years have passed since the Legislature passed the law authorizing CFSS, and DHS only recently established a target implementation date of July 2021. DHS officials told us that several factors have contributed to the delay in implementing CFSS. For example, they told us that different divisions within DHS needed to review current eligibility for PCA under the various public health care programs to understand how individuals would access services under CFSS. They also said they must make changes to two data systems and had to adapt the program to changes in federal rules. Minnesota must receive approval from the Centers for Medicare and Medicaid Services (CMS) to implement CFSS, but DHS officials did not tell us this was a factor in the delayed implementation. They told us CMS was waiting for DHS to provide them with a proposed implementation date before they could approve the amendment to Minnesota's state plan.

RECOMMENDATION

The Legislature should review the oversight requirements in Community First Services and Supports.

We believe that sufficient time has passed since the Legislature established CFSS that it should review the language in that section of law and determine whether it continues to reflect the Legislature's vision for the program. The Legislature significantly modified the program's statutes in 2015, but there have been changes to PCA since then. As we noted in Chapter 3, the 2019 Legislature removed the requirement for annual reviews in PCA, but that requirement continues to exist for agencies that provide services under CFSS. As another example, the 2019 Legislature required qualified professionals to enroll with DHS. However, CFSS does not require qualified professionals to evaluate services provided through that program. These changes may reflect changing opinions about the level and type of oversight the Legislature believes is necessary for the services offered through PCA and CFSS.

In addition, we found some issues in DHS's oversight of the current PCA program that the Legislature should consider as it reviews CFSS. For example, in Chapter 3, we noted that DHS had not ensured that all personal care assistants and relevant PCA agency staff had completed training as required. We also found that DHS had not reviewed all required documentation for PCA agency enrollment. In CFSS, the Legislature may want to consider requiring DHS to regularly report on its efforts to comply with statutory requirements.

As the Legislature reviews the oversight requirements in CFSS, it should ensure it takes into account feedback from recipients and advocates, including Minnesota's Development and Implementation Council. Some of the advocates we spoke with indicated stronger oversight of PCA is necessary. One advocate characterized the oversight of PCA as "terrible." During another interview, advocates told us that qualified professional services help protect the most vulnerable populations, but DHS needs to do a better job of ensuring PCA agencies provide these services. Additionally,

an advocate told us that when there is no mechanism for reviewing the quality of service, it leaves the door open for abuse.

At the same time, several advocates indicated that PCA oversight should be balanced. One advocate stated that oversight should not limit a person's choices about their care. Another said that compliance measures put in place do not always align with the intention to provide flexibility for recipients. A third said that increased focus on oversight or penalizing a few perpetrators could negatively affect individuals' ability to access services they need.

Discussion

PCA is a large, complex program that has provided billions of dollars in services to tens of thousands of Minnesotans in recent years. It must comply with numerous federal and state requirements, and its administration is complicated. In this report, we noted three DHS divisions with primary responsibilities for overseeing assessor training, enrolling PCA agencies and personal care assistants, and investigating fraud and abuse; many separate units within the three large divisions we discussed in this report have specific responsibilities. For example, in the Office of the Inspector General, three separate units complete screening site visits, provider investigations, and data analytics.

With such broad reach across the department, it was difficult and time consuming for us to understand how DHS carries out its administrative responsibilities for PCA. It was also difficult to determine who ultimately ensures that the PCA program complies with its many requirements. CMS completed a focused program integrity review of Minnesota's PCA program in January 2019 and, after noting the different divisions within DHS that provide oversight of PCA, recommended that DHS consider developing an internal memorandum of understanding or similar agreement to specify each unit's oversight responsibilities. DHS completed a memorandum of understanding in response to the recommendation. The memorandum provides important information about many units' roles, but it does not include information about all units involved in PCA oversight and contains limited information about certain processes, such as revalidation.

The complicated structure of PCA administration may have contributed to the prolonged timelines to enact changes to the program in the last decade. In Chapter 2, we explained that the 2009 Legislature required DHS to include PCA in a broader assessment process for long-term services and supports; DHS developed the MnCHOICES tool to complete these assessments. While DHS launched MnCHOICES in 2013, the department did not require the use of that assessment tool for all PCA assessments as of early 2020. In Chapter 3, we noted that, under federal law, states must require that PCA providers use an electronic visit verification system by January 2020 or receive a decrease in federal Medicaid funding. Minnesota received a one-year delay in the reduction of federal funding, but DHS has yet to implement such a system. In this chapter, we noted that the 2013 Legislature established CFSS to replace PCA, but nearly seven years after the legislation was enacted, the department has not yet implemented the program.

It is unclear why it has taken so long to implement these changes. It may be due to the structure of DHS's administration and oversight of the program, the size of the PCA

program, a lack of sufficient resources to dedicate to these efforts, or all of the above. We do not offer a recommendation to change the structure of PCA's administration, because we have no evidence that a particular change would improve its administration. At present, units and divisions specialize in specific policy areas or tasks; it may be sufficient for DHS to modify its internal memorandum of understanding to more clearly outline each unit's responsibilities for ensuring the PCA program complies with all legal requirements. However, recent events have caused the Governor and some legislators to contemplate changing DHS's administrative structure. As they discuss possible changes to the department, the breadth of PCA administration—and eventually CFSS administration—should be kept in mind.

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List of Recommendations

- DHS should establish a firm timeline for requiring assessors to use the MnCHOICES assessment tool for all personal care assistance assessments. (p. 21)
- DHS should regularly consult with assessors to improve its MnCHOICES training program, including guidance available to assessors, and make timely use of the feedback. (p. 27)
- The Legislature should require DHS to regularly evaluate the consistency of assessment results across assessors. (p. 32)
- DHS should regularly review appeals and recommended orders to identify and respond to inconsistencies in personal care assistance assessments. (p. 37)
- DHS should ensure that personal care assistance agency staff complete training as required by law. (p. 44)
- DHS should review all required documentation to ensure compliance with legal requirements during personal care assistance agencies' initial enrollment. (p. 47)
- DHS should revise its policy manuals and provider agreements so that they reflect state law and provide comprehensive and consistent references to personal care assistance agencies' responsibilities. (p. 51)
- DHS should repeal or revise outdated or obsolete administrative rules so that they align with statutes and DHS's current administration of the personal care assistance program. (p. 52)
- DHS should ensure it revalidates enrollment of all personal care assistance agencies, as required by law. (p. 54)
- DHS should develop standard protocols for personal care assistance agency pre-enrollment and revalidation site visits to ensure agencies comply with legal requirements. (p. 57)
- The Legislature should clarify DHS's responsibilities for monitoring personal care assistance documentation requirements. (p. 57)
- DHS should comply with federal requirements for electronic visit verification as soon as possible to avoid a reduction in federal funding. (p. 59)
- DHS should ensure that the personal care assistants it enrolls who are under 18 years of age meet statutory requirements related to their age. (p. 62)
- DHS should ensure that all personal care assistants meet statutory requirements related to background studies and training. (p. 64)
- DHS should regularly monitor whether personal care assistance agencies bill for qualified professional supervision as a way of determining whether agencies are providing services as required. (p. 67)

- DHS should further develop policies and procedures to formalize aspects of its investigations processes and incorporate best practices. (p. 75)

- DHS should establish written guidelines for determining when screening investigators should (1) recommend that a personal care assistance agency's enrollment be approved or denied, and (2) refer a case to the Provider Investigations unit for further review. (p. 79)

- DHS should create a plan for investigating suspected fraud and abuse cases in a more timely way. (p. 84)

- DHS should work more closely with the Medicaid Fraud Control Unit to prevent, deter, and detect fraud in personal care assistance. (p. 88)

- The Legislature should review the oversight requirements in Community First Services and Supports. (p. 91)

DHS and Legislative Changes in Response to OLA Recommendations

APPENDIX A

In response to legislative concerns, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate PCA administration in 2008. In 2009, OLA released a report that included a number of recommendations directed to the Legislature and the Department of Human Services (DHS).[1]

Since 2009, DHS and the Legislature have made numerous changes in an effort to strengthen PCA program integrity. In this appendix, we outline the recommendations relevant to the scope of our current evaluation, and describe the actions DHS and the Legislature have taken in response to those recommendations.

Exhibit A.1: Status of OLA's 2009 Recommendations

2009 OLA Recommendation	Implemented	Description
The Legislature should require DHS to develop a process for periodically reviewing samples of PCA assessments for the purpose of ensuring reasonable levels of consistency.	No	As of the end of the 2019 legislative session, the Legislature had not required DHS to review samples of PCA assessments.
The Legislature should amend state law to prohibit the same person from serving as both the qualified professional and personal care assistant for a recipient on an ongoing basis.	No	Statutes define qualified professionals as individuals who evaluate PCA services and supervise PCA staff. However, the law does not explicitly state that a person cannot serve as both the qualified professional and the personal care assistant for a recipient.
DHS should post relevant documents from its quality assurance reviews of PCA agencies on its public website.	No	A DHS official told us the department does not post information on quality assurance reviews of PCA agencies on its website.
DHS should ensure that its Medicaid Management Information System contains accurate reporting about which PCA recipients have elected to get services under Minnesota's PCA Choice option.	No	A DHS official told us that the data system does not capture which service model PCA recipients use.
To the extent possible, DHS should reallocate existing resources to conduct more PCA-related investigations.	Unclear	Close to half of DHS's investigations in fiscal years 2016 through 2019 involved PCA, but a DHS official told us that DHS prioritizes assigning cases to investigators based on factors other than provider type.

Continued on next page.

[1] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 97-99.

Exhibit A.1: Status of OLA's 2009 Recommendations (continued)

2009 OLA Recommendation	Implemented	Description
The Legislature should require DHS to implement mandatory training requirements for persons conducting assessments of individuals' need for PCA services.	Partially	The 2009 Legislature required assessors that conduct certain assessments for PCA (now called MnCHOICES) to be certified and complete required training. However, DHS has not required training for all assessors that complete PCA assessments.
The Legislature should require representatives of new and existing PCA agencies to periodically complete comprehensive state training on PCA standards and practices.	Partially	Statutes require certain PCA agency staff to attend DHS training before the agency enrolls with the department. However, staff must repeat training only if they are hired by another agency and have not completed training within the past three years.
DHS should strengthen its Quality Assurance Review program by: (1) increasing resources devoted to it; (2) expanding the number and types of reviews; and (3) improving documentation.	Partially	A DHS official told us DHS has conducted two reviews of PCA agencies, one to determine compliance with standards, and the other to review service delivery. DHS also offers guidance documents and technical assistance to promote program integrity. In addition, DHS is required to conduct site visits to PCA agencies at initial enrollment and revalidation.
The Legislature should direct DHS to propose more specific policies regarding which PCA activities are (and are not) reimbursable.	Yes	The Legislature has more explicitly defined covered and noncovered services.
The Legislature should require DHS to develop guidance to help assessors determine the PCA service needs of persons with behavior issues.	Yes	The 2009 Legislature redefined behaviors. DHS provides some guidance regarding behavior definitions in instructions for completing assessments with one assessment tool.
The Legislature should require counties and managed care agencies that arrange for PCA assessments to provide timely copies of the assessment reports to PCA agencies that will be providing services, if they request them.	Yes	The 2009 and 2012 Legislatures specified that copies of reports that summarize the assessments be provided to the recipient within a specified timeframe.
DHS should develop a stand-alone document for PCA assessors and PCA agencies to distribute that clearly and concisely states the duties of a responsible party.	Yes	Statutes and DHS's PCA Program Manual define the duties of responsible parties. A responsible party must sign an agreement with the PCA agency to indicate their understanding of their role.
The state's chief human services judge should periodically review summary data showing the outcomes of PCA appeals for individual judges. Where appropriate, the chief judge should take steps to reduce inconsistencies—for example, through the development of increased training or clearer guidelines for judges.	Yes	According to a DHS official, the Appeals Division does not currently review summary data. However, the division has taken a number of steps to reduce inconsistencies, including developing training for new human services judges and expanding the process for reviewing judges' decisions.
The Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency's owners or administrators have previously documented violations of federal or state regulations.	Yes	Statutes prohibit PCA agencies and all owners and managing employees affiliated with the agency from enrolling with DHS for two years following termination after having been found in violation of regulations.

Continued on next page.

Exhibit A.1: Status of OLA's 2009 Recommendations (continued)

2009 OLA Recommendation	Implemented	Description
The Legislature should amend Minnesota statutes to require all agencies providing PCA to obtain background checks on their qualified professionals.	Yes	The 2009 Legislature amended state law so that all qualified professionals must complete a background study.
DHS should define a set of topics on which personal care assistants should receive training.	Yes	The 2009 Legislature specified training topics that personal care assistants must receive.
The Legislature should clarify state statutes to ensure that all Medical Assistance State Plan PCA recipients have their services periodically supervised by a qualified professional.	Yes	The 2009 Legislature required that all personal care assistants be supervised by qualified professionals, who must visit PCA recipients at specific intervals.
DHS should amend its provider manual to require PCA agencies providing traditional PCA services to periodically make visits or phone calls to recipients' residences to verify that scheduled services are actually being provided.	Yes	Statutes and DHS's PCA Program Manual list responsibilities for qualified professionals, which include visits or phone calls.
The Legislature should amend statutes to explicitly require unlicensed PCA agencies to provide Minnesota's Home Care Bill of Rights to the recipients they serve. DHS should incorporate discussion of the bill of rights into its training program for PCA agencies.	Yes	Statutes require PCA agencies to provide recipients a copy of the Home Care Bill of Rights. DHS reviews the requirement to provide the document during training.
DHS should develop a concise, useful document that indicates whom PCA recipients can contact with service-related concerns. The department should require all PCA agencies to distribute this to recipients.	Yes	The Home Care Bill of Rights lists contacts for recipients to call if they have a complaint about their services. PCA agencies are required to provide recipients with a copy of the Home Care Bill of Rights.
DHS should regularly and promptly analyze its data on paid claims for PCA services to identify and recoup payment of improper claims.	Yes	DHS has implemented electronic payment controls to prevent certain improper claims.

NOTES: This appendix includes only recommendations relevant to the scope of our current evaluation. OLA made an additional six recommendations in its 2009 report, *Personal Care Assistance*. "PCA" refers to personal care assistance. "DHS" refers to the Department of Human Services.

SOURCES: The Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009), 97-99; Office of the Legislative Auditor review of the Department of Human Services Personal Care Assistance Manual, department forms and procedures, and communication with the Department of Human Services; *Laws of Minnesota* 2009, chapter 79, art. 8; *Laws of Minnesota* 2012, chapter 216, art. 11; *Laws of Minnesota* 2015, chapter 78, art. 6; *Minnesota Statutes* 2008, 256B.0655; and *Minnesota Statutes* 2019, 144A.471; 256B.04; 256B.0625; 256B.064; 256B.0652; 256B.0659; and 256B.0911.

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Minnesota Department of Human Services
Elmer L. Andersen Building
Commissioner Jodi Harpstead
Post Office Box 64998
St. Paul, Minnesota 55164-0998

March 11, 2020

James Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Legislative Auditor Nobles:

Thank you for the opportunity to review and comment on your office's report titled *DHS Oversight of Personal Care Assistance*. We appreciate the professionalism of your staff as they completed their work on this project.

We are proud of the strides we have made in overseeing Personal Care Assistance (PCA) services across Minnesota since the last audit of this program by your office in 2009. The PCA program has long been a flexible staple of the continuum of care serving people with disabilities, older adults, and mental illness to live independently in their communities. When Minnesota had moratoriums on growth in foster care, nursing home and waiver services, PCA was available and has since grown to serving over 43,000 people per year. Audits such as these are an important trail marker in our efforts to implement program integrity measures while also ensuring the service remains affordable and accessible.

As your report notes, many of the recommendations made by the legislature after the 2009 report have been operational for many years. In fact, just last year, at the request of CMS, the DHS provider enrollment team presented at the national Medicaid Provider Enrollment Seminar Conference on the procedures in place in Minnesota to enroll PCA providers. Further, in the area of investigations, we have more than doubled the number of PCA investigations between 2017 and 2019 with more than 60 percent of the investigations we completed in 2019 on PCA providers. We continue to strengthen program controls, including launching an Electronic Visit Verification system and additional reviews of our assessment tools in the coming year.

And, there is always room for improvement in our systems and processes.

PCA is a critically important part of the continuum of services that help people to live full lives in their communities. However as PCA has been growing, so too has the workforce shortage that poses many challenges for people using PCA and other services. While we support continuous improvement efforts, we

are concerned that additional requirements could make it more difficult for people to find assistance and for providers to stay in business. An addendum to this letter comments on every recommendation in the report.

If there is a theme to the areas where the Department objects to the recommendations, it is in expectations suggested in the report that seem more appropriate for fully licensed services than for these intentionally unlicensed services. Once again, these services were designed to be affordable and accessible while managing state spending. Some of your recommendations expand oversight in a way that could compromise the character that makes PCA so valuable to the people using services. We are ready to work with the legislature to find the right balance of regulatory oversight that allows PCA to remain a flexible option for Minnesotans across the state.

Thank you again for the professional and dedicated efforts of you and your staff during this audit. The Department's policy is to follow up on all findings to evaluate the progress made to resolve them. If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at (651) 431-3623.

Sincerely,

/s/
Jodi Harpstead
Commissioner

PCA Audit Recommendation 1

The Department of Human Services (DHS) should establish a firm timeline for requiring assessors to use the MnCHOICES assessment tool for all personal care assistance assessments.

Response to PCA Audit Recommendation 1

If a qualified vendor is selected through the MnCHOICES RFP process, the legacy tool will be discontinued six months after implementation of the revised MnCHOICES. This timeframe will allow lead agencies to end contracts with legacy PCA assessors and ensure appropriate lead agency assessor staff resources to conduct PCA assessments in MnCHOICES.

Responsible Person: Natasha Merz and Mary Lenertz
Estimated Completion Date: January 1, 2022 or six months post revised MnCHOICES implementation

PCA Audit Recommendation 2

DHS should regularly consult with assessors to improve its MnCHOICES training program, including guidance available to assessors, and make timely use of the feedback.

Response to PCA Audit Recommendation 2

By state law, certified assessors are required to be either a public health nurse, registered nurse, or social worker. In cases with complex medical needs, certified assessors are required to consult with a multidisciplinary team that includes at a minimum a social worker and a public health or registered nurse when a person has complex health care needs that impact service delivery. Training for specific medical conditions is outside the scope of DHS's role in training assessors.

The MnCHOICES team, in collaboration with the lead agency project team, is currently developing an on-demand guidance document to be incorporated into the revised MnCHOICES application. This document will be tested in paper form and included in the revised MnCHOICES application upon implementation. MnCHOICES RFP demonstrations from potential vendors for the revised MnCHOICES application were conducted in February and March 2020. The demonstrations included subject matter experts from lead agencies to ensure their insights into potential vendors were included in the selection process.

MnCHOICES facilitates several on-going lead agency and assessor groups to answer questions, gain feedback and enhance MnCHOICES.

The feedback gained from these groups informs training and application improvements by prioritizing the changes with greatest impact for lead agencies.

MnCHOICES currently uses an on-line training and certification process required for all assessors prior to conducting any assessments. In addition, they must be re-certified every three years. The MnCHOICES training team continues to update and enhance the certification training as needed.

Responsible Person: Natasha Merz and Mary Lenertz
Estimated Completion Date: July 30, 2021 or when revised MnCHOICES is implemented

PCA Audit Recommendation 3

DHS should regularly review appeals and recommended orders to identify and respond to inconsistencies in personal care assistance assessments.

Response to PCA Audit Recommendation 3

DHS will develop a process to use information from appeals to identify and respond to inconsistencies in the implementation of assessments for PCA services.

Responsible Person: Natasha Merz
Estimated Completion Date: December 31, 2020

PCA Audit Recommendation 4

DHS should ensure that personal care assistance agency staff complete training as required by law.

Response to PCA Audit Recommendation 4

DHS will reevaluate and make the necessary changes to the process used to track and maintain records of training completed by personal care assistants and verify that they comply with applicable laws.

Responsible Person: Lori Shimon
Estimated Completion Date: December 31, 2020

PCA Audit Recommendation 5

DHS should review all required documentation to ensure compliance with legal requirements during personal care assistance agencies' initial enrollment.

Response to PCA Audit Recommendation 5

DHS will coordinate responsibilities within the agency to ensure all personal care assistance agencies have the required documentation that complies with legal requirements during initial enrollment. Additional FTEs and legislative initiatives will be explored and may be necessary to ensure compliance.

Responsible Person: Lori Shimon and JJ Hasbargen
Estimated Completion Date: December 31, 2020

PCA Audit Recommendation 6

DHS should revise its policy manuals and provider agreements so that they reflect state law and provide comprehensive and consistent references to personal care assistance agencies responsibilities.

Response to PCA Audit Recommendation 6

DHS will revise its policy manuals and provider agreements to reflect state law and provide comprehensive and consistent reference to the responsibilities of PCA agencies.

Responsible Person: Lori Shimon and Natasha Merz
Estimated Completion Date: February 28, 2021

PCA Audit Recommendation 7

DHS should repeal or revise outdated or obsolete administrative rules so that they align with statutes and DHS' current administration of the personal care assistance program.

Response to PCA Audit Recommendation 7

DHS will identify and revise or repeal outdated or obsolete PCA administrative rules as part of the annual rule review process.

Responsible Person: Natasha Merz

Estimated Completion Date: July 1, 2021

PCA Audit Recommendation 8

DHS should ensure it revalidates enrollment of all personal assistance agencies, as required by law.

Response to PCA Audit Recommendation 8

PCA agencies are currently undergoing revalidation in phases. We continue to run reports to identify providers who need to be revalidated and then initiate those revalidation processes.

DHS plans to make enhancements to the revalidation process, including the automation of the revalidation management process, as part of the Minnesota Provider Screening and Enrollment portal (MPSE) project.

Responsible Person: Lori Shimon
Estimated Completion Date: Ongoing; MPSE enhancements for automating the revalidation process are scheduled for January of 2023.

PCA Audit Recommendation 9

DHS should develop standard protocols for personal care assistance agency pre-enrollment and revalidation site visits to ensure agencies comply with legal requirements.

Response to PCA Audit Recommendation 9

DHS will develop standard pre-enrollment and revalidation site visit protocols to assure compliance with legal requirements.

Responsible Person: Lori Shimon and JJ Hasbargen
Estimated Completion Date: December 31, 2020

PCA Audit Recommendation 10

DHS should comply with federal requirements for electronic visit verification (EVV) as soon as possible to avoid a reduction in federal funding.

Response to PCA Audit Recommendation 10

DHS will work to minimize the risk of federal financial penalties but in balance with the need to prioritize guidance from Centers for Medicare and Medicaid Services and other states about how to avoid the challenges other states have experienced as they attempt to implement EVV. Their guidance has emphasized the need to continue to gather stakeholder input, base our implementation on what we learn, work across the business areas in our agency impacted by EVV implementation, ensure that our requirements for the EVV system reflect the needs of these business areas and use pilots during implementation to achieve successful implementation.

Responsible Person: Natasha Mertz
Estimated Completion Date: July 1, 2021

PCA Audit Recommendation 11

DHS should ensure that the personal care assistants it enrolls who are under 18 years of age meet statutory requirements related to their age.

Response to PCA Audit Recommendation 11

DHS will ensure personal care assistants under age 18 meet the requirements prior to enrollment by adding additional information to the Minnesota Provider Screening and Enrollment portal (MPSE).

Responsible Person: Lori Shimon
Estimated Completion Date: June 1, 2020

PCA Audit Recommendation 12

DHS should ensure that all personal care assistants meet statutory requirements related to background studies and training.

Response to PCA Audit Recommendation 12

DHS will ensure all personal care assistants meet statutory requirements related to background studies and training. With the implementation of MPSE, requirements for background studies and trainings must be met prior to enrollment. DHS has also developed a quality metrics process. Our quality team will audit a sampling of work from each enrollment specialist for accuracy on an ongoing basis.

Responsible Person: Lori Shimon
Estimated Completion Date: June 1, 2020

PCA Audit Recommendation 13

DHS should regularly monitor whether personal care assistance agencies bill for qualified professional supervision as a way of determining whether agencies are providing services as required.

Response to PCA Audit Recommendation 13

With the assistance of data analytics, DHS will develop tools to help evaluate a PCA agency's billing for qualified professional supervision against billing for PCA services as a means of identifying inconsistencies that could indicate irregularities in providing services as required. DHS will use these results to assist in identifying providers at risk for failing to provide qualified professional services and initiate investigations as appropriate.

Responsible Person: Elizabeth Oji
Estimated Completion Date: August 1, 2020

PCA Audit Recommendation 14

DHS should further develop policies and procedures to formalize aspects of its investigation processes and incorporate best practices.

Response to PCA Audit Recommendation 14

In the past year, DHS has engaged in a continuous improvement (CI) process in the Child Care Assistance Program (CCAP) Investigations unit that includes many components that are transferable and/or able to be adapted for use in the PCA program. DHS will evaluate the applicability of these best practice process improvement workflows and, when appropriate, use them to develop and/or document, through policies and procedures, a formalized, consistent and well-defined investigation processes.

Responsible Person: Elizabeth Oji
Estimated Completion Date: December 31, 2020

PCA Audit Recommendation 15

DHS should establish written guidelines for determining when screening investigators should (1) recommend that a personal care assistance agency's enrollment be approved or denied, and (2) refer a case to the Provider Investigations unit for further review.

Response to PCA Audit Recommendation 15

DHS will create an inter-departmental working group to write guidelines.

Responsible Person: Lori Shimon and JJ Hasbargen
Estimated Completion Date: September 30, 2020

PCA Audit Recommendation 16

DHS should create a plan for investigating suspected fraud and abuse cases in a more timely way.

Response to PCA Audit Recommendation 16

DHS is committed to evaluating lessons learned in the continuous improvement process in its CCAP Investigations unit in order to identify opportunities for process and system improvement. The objective is to ensure processes and systems are designed to streamline investigations to make them as effective and efficient as possible. However, to fully address the issue of timely investigations, DHS may require additional resources dedicated to the investigation of fraud and abuse.

Responsible Person: Elizabeth Oji
Estimated Completion Date: December 31, 2020.

PCA Audit Recommendation 17

DHS should work more closely with the Medicaid Fraud Control Unit to prevent, deter, and detect fraud in personal care assistance.

Response to PCA Audit Recommendation 17

DHS and the Medicaid Fraud Control Unit are separate and distinct entities of state government with joint and complementary responsibility for the prevention, detection and investigation of fraud in the Medicaid program. We have a common interest and recognize that effective administration of the Medicaid program is a prerequisite to the effective delivery of health services and maintaining the fiscal integrity of the state. We further agree that Medicaid program integrity can be best accomplished by full, frequent, and complete communication and cooperation between the two entities.

Responsible Person: Elizabeth Oji
Estimated Completion Date: Ongoing

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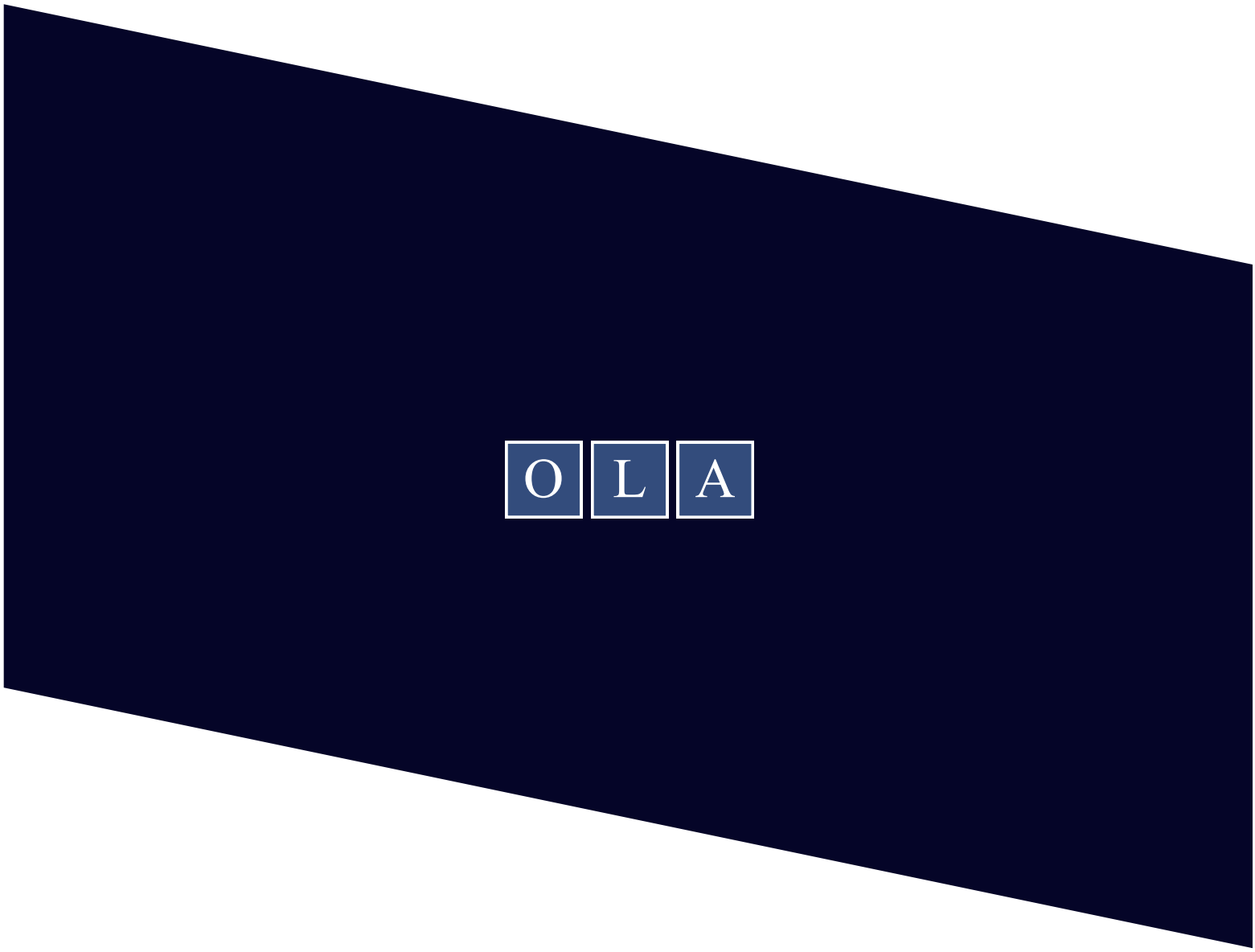

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Minnesota Department of Education: Oversight of Feeding Our Future

Special Review

June 2024

Office of the Legislative Auditor
State of Minnesota

State of Minnesota
Office of the Legislative Auditor

Special Reviews

We conduct special reviews in response to requests from legislators and other public officials, or to address a government issue that has come to our attention in some other way.

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

Judy Randall, Legislative Auditor
State of Minnesota

June 13, 2024

Legislative Audit Commission Members

Willie L. Jett II, Commissioner
Minnesota Department of Education

The Minnesota Department of Education (MDE) oversees two federally funded nutrition programs that were defrauded during the COVID-19 pandemic. These programs provide reimbursements for meals and snacks served at participating child-care centers, afterschool care programs, summer camps, and adult day care centers, among other locations. However, taxpayer funds intended to support these programs were allegedly used instead for 70 individuals' personal gain. According to the federal government, the scheme centered on a Minnesota nonprofit organization, Feeding Our Future.

Federal regulations required MDE to monitor and enforce Feeding Our Future's compliance with program requirements. MDE's responsibilities under federal law ranged from providing guidance and training to Feeding Our Future staff, to terminating the organization's participation in the programs if warranted. However, we found MDE's oversight of Feeding Our Future to be inadequate. In fact, we believe MDE's actions and inactions created opportunities for fraud. In our report, we describe how MDE:

- Failed to act on warning signs known to the department prior to the onset of the COVID-19 pandemic and prior to the start of the alleged fraud.

- Did not effectively exercise its authority to hold Feeding Our Future accountable to program requirements.

- Was ill-prepared to respond to the issues it encountered with Feeding Our Future.

This special review was conducted by Katherine Theisen, Special Reviews Director; Lucas Lockhart, Lead Special Reviews Auditor, CFE, CAMS; and Libby Wallace, Special Reviews Auditor. MDE cooperated fully with our review, and we thank them for their assistance.

Sincerely,

Judy Randall
Legislative Auditor

Katherine Theisen
Special Reviews Director

OLA

Summary

June 2024

Minnesota Department of Education: Oversight of Feeding Our Future

MDE's inadequate oversight of Feeding Our Future created opportunities for fraud.

Report Summary

Application and Administrative Review

Under federal law, MDE is responsible for conducting regular oversight of sponsors participating in CACFP and SFSP. Two key oversight activities include (1) reviewing and approving annual sponsor applications, and (2) conducting monitoring visits and compliance reviews, called "administrative reviews."

- MDE's inaction to strengthen and exercise its authority to deny applications put the CACFP and SFSP programs' integrity at risk. Most notably, MDE failed to address what it sees as limits to its authority years before the start of the COVID-19 pandemic. And, MDE approved Feeding Our Future's program applications despite unaddressed concerns. (pp. 22, 24, 25)

  Recommendation ► The Legislature should either establish criteria in statute or give MDE the authority to conduct rulemaking to establish criteria that the department must consider when determining whether to approve organizations for CACFP or SFSP. (p. 33)

- MDE did not always take steps to verify statements made by Feeding Our Future prior to approving its program applications. (pp. 30, 32)

  Recommendation ► MDE should take additional steps to verify information provided in support of sponsorship applications submitted by high-risk applicants. (p. 34)

- MDE's only administrative review of Feeding Our Future's CACFP operations—conducted in 2018—resulted in serious findings that required follow-up, but MDE never conducted a follow-up review. (p. 37)

  Recommendation ► MDE should conduct follow-up reviews, as needed, to ensure sponsors fully implement corrective action plans that result from administrative reviews. (p. 42)

- COVID-19-pandemic-related waivers that modified monitoring requirements for state agencies and sponsors encouraged offsite reviews and alternative forms of oversight, but MDE's offsite monitoring of Feeding Our Future was limited. (p. 46)

  Recommendation ► MDE should place a greater emphasis on program integrity and risk-based monitoring if oversight requirements are waived again in the future. (p. 48)

Background

Between September 2022 and February 2024, the U.S. Department of Justice charged 70 individuals with various financial crimes related to their suspected roles in a $250 million fraud scheme. The defendants allegedly exploited two federally funded nutrition programs during the COVID-19 pandemic. According to the federal government, the scheme centered on a Minnesota nonprofit organization, Feeding Our Future.

Until early 2022, Feeding Our Future was a "sponsor" for two federal nutrition programs—the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP). The Minnesota Department of Education (MDE) is responsible for administering these programs in Minnesota.

Sponsors—which include school districts, child care programs, and nonprofit organizations, such as Feeding Our Future—manage "sites." Sites are the places where meals and snacks are served.

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Complaint Investigations

Between June 2018 and December 2021, MDE received at least 30 complaints involving Feeding Our Future or its sites. By law, state agencies must promptly investigate complaints received or irregularities noted in connection with CACFP and SFSP.

- Many of MDE's complaint investigation procedures and practices were inappropriate or of limited usefulness, particularly in the context of the alleged fraud. While MDE had written complaint investigation procedures, their limited scope and failure to address important issues undermined their ability to promote good investigative practices. And, MDE inappropriately asked Feeding Our Future to investigate complaints about itself. (pp. 49, 51, 55)

- MDE did not investigate some complaints about Feeding Our Future, despite their frequency or seriousness. When MDE decided to investigate complaints about Feeding Our Future, the investigations were inadequate. (pp. 53, 57)

  Recommendations ► MDE should revise its CACFP and SFSP complaint investigation procedures, prioritize independent fact-finding in response to complaints, and limit the information it shares with the subject of a complaint in an effort to protect complainants from retaliation. (pp. 59-61)

  Recommendation ► MDE should evaluate the implementation of recent statutory changes related to its investigative authority, and promptly propose needed changes to the Legislature. (p. 61)

Serious Deficiency Process

If MDE finds a sponsor noncompliant with federal law in its administration of CACFP or SFSP, it must declare the sponsor "seriously deficient." The resulting process gives sponsors the opportunity to correct the deficiencies. However, if a sponsor is unwilling or incapable of correcting the problems, this process gives MDE the ability to terminate the sponsor's participation in CACFP and SFSP.

- MDE found Feeding Our Future seriously deficient on two occasions, but ultimately deferred all serious deficiencies without taking reasonable steps to ensure the organization implemented corrective actions. (p. 65)

  Recommendation ► MDE should conduct more active follow-up to ensure sponsors and sites fully implement corrective action plans that result from serious deficiency processes. (p. 75)

Summary of Agency Response

In a letter dated June 7, 2024, Willie L. Jett II, Commissioner of Education, said "MDE disputes the OLA's characterization regarding the adequacy of MDE's oversight – MDE's oversight of these programs met applicable standards and MDE made effective referrals to law enforcement." He said, "What happened with Feeding Our Future was a travesty – a coordinated, brazen abuse of nutrition programs that exist to ensure access to healthy meals for low-income children. The responsibility for this flagrant fraud lies with the indicted and convicted fraudsters."

Commissioner Jett stated that MDE "is committed to program integrity and strong fiscal oversight of [its] programs and the important work [MDE does] on behalf of children and adults across the state." The Commissioner further noted that the department has "independently implemented changes to strengthen the Department's oversight," including establishing an Office of Inspector General, adding a General Counsel's Office, providing training to staff on the department's updated fraud-reporting policy, and contracting with a firm to conduct financial reviews of certain sponsors, among other things.

The full special review report, *Minnesota Department of Education: Oversight of Feeding Our Future*, is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/sreview/2024/mdefof.htm**

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Introduction

Between September 2022 and February 2024, the U.S. Department of Justice charged 70 individuals with various financial crimes related to their suspected roles in an alleged $250 million fraud scheme.[1] The defendants allegedly exploited two federally funded nutrition programs during the COVID-19 pandemic. According to the federal government, the scheme centered on a Minnesota nonprofit organization, Feeding Our Future.

Until early 2022, Feeding Our Future was a "sponsor" for two federal nutrition programs—the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP). CACFP provides reimbursements for meals and snacks served to eligible children and adults enrolled at participating child-care centers, afterschool care programs, and adult day care centers, among other locations. SFSP typically operates during the summer months when students are not in school, and provides reimbursements for meals and snacks served to eligible children and teens in low-income areas. In these programs, sponsors, which include school districts, child-care programs, and nonprofit organizations, oversee "sites." Sites are the places where meals and snacks are served.[2] The Minnesota Department of Education (MDE) is responsible for administering CACFP and SFSP in Minnesota.

A **sponsor** is an organization that enters into an agreement directly with the administering state agency to oversee sites' provision of food.

A **site** enters into an agreement with a sponsor and serves food to eligible children and adults, depending on the program.

In response to widespread legislative and public concern about the alleged fraud, we initiated a special review to examine MDE's oversight of Feeding Our Future. The primary questions addressed in our review were:

- **To what extent did MDE meet federal requirements for monitoring Feeding Our Future's participation in CACFP and SFSP?**

- **What, if anything, could MDE have done differently to prevent or stop the alleged fraud?**

To conduct this review, we examined documents related to MDE's oversight of Feeding Our Future, such as records concerning MDE's review of the organization's applications, meal claims, and monitoring activities. We also reviewed documents

[1] As of May 2024, 18 of the 70 defendants had pleaded guilty. Federal criminal trials for seven of the remaining defendants began in April 2024.

[2] Sponsors can be affiliated with their sites, meaning they oversee sites that are owned or operated by their organization (such as a child-care organization that has multiple locations), or unaffiliated, meaning the sponsor does not own or operate the site. CACFP sites can also be "independent sites"; these sites enter into an agreement directly with the administering state agency.

related to the administrative actions MDE took against Feeding Our Future. The documents we reviewed were provided to us by MDE and Feeding Our Future's executive director.

Further, we evaluated MDE's responses to the complaints it received about Feeding Our Future and its sites. We reviewed MDE's communications with the U.S. Department of Agriculture (USDA) and federal law enforcement agencies. Additionally, we interviewed MDE staff, analyzed data on meal claims and reimbursements, reviewed USDA guidance on CACFP and SFSP, and examined state and federal laws and court records.

This was a limited review, and we did not examine some topics that may be of interest to legislators and the public. For example, we did not evaluate the legal merits of Feeding Our Future's lawsuits against MDE or MDE's legal strategy in that litigation. Because the fraud scheme allegedly began around the start of the COVID-19 pandemic, we assessed the impact of MDE's implementation of federal pandemic-era waivers on its oversight practices. However, we did not evaluate whether these waivers were justified.

Finally, our review focused solely on MDE's oversight of one sponsor—Feeding Our Future—and not on MDE's broader implementation of federal nutrition programs. While this review's focus was driven by the federal criminal charges filed against Feeding Our Future's executive director, staff, and associates, the Office of the Legislative Auditor is not expressing an opinion on the guilt or innocence of the individuals or entities discussed in this report.

Conclusion

The Minnesota Department of Education (MDE) has publicly stated that the department's "fast action and diligence launched the investigation that stopped the fraud and led to dozens of indictments."[1] However, given the size of the alleged fraud scheme, it is reasonable to question what else MDE *could* have done, or *should* have done, to prevent or stop the alleged misappropriation of public funds.

When we questioned its oversight of Feeding Our Future, MDE officials explained that five key factors prevented the department from acting on its concerns about Feeding Our Future's participation in federal nutrition programs:

- **Operational challenges caused by the COVID-19 pandemic-related waivers.** Waivers issued by the U.S. Department of Agriculture (USDA) in response to the COVID-19 pandemic gave sites and sponsors significant flexibility in how to distribute meals and snacks. However, according to an MDE official, these waivers made some prepandemic oversight activities—such as observing meal service—difficult. And, an MDE official told us that things that might once have been clear indicators of fraud or noncompliance, such as perfect attendance at a child-care center with infants and young children, became more ambiguous due to the waivers.

- **Lack of clear, written guidance from USDA.** According to MDE officials, when MDE asked questions of USDA about how the department should interpret certain federal regulations and implement pandemic-era waivers, USDA sometimes responded verbally or did not respond in a timely manner. MDE officials also said the guidance MDE received from USDA at times did not fully address the department's questions. For example, one MDE official told us that in communications between MDE and USDA about initiating administrative action against Feeding Our Future, USDA pushed responsibility back to MDE, telling the department that it should make decisions consistent with federal regulations.

- **Feeding Our Future's litigation and public relations campaign regarding MDE's disapproval of site applications.** Feeding Our Future began threatening to sue MDE in April 2020, and in November 2020, it filed a lawsuit against the department. MDE officials said the department had to be particularly clear and intentional in its oversight of Feeding Our Future in light of its legal risks. Further, when MDE and Feeding Our Future were engaged in the lawsuit, court filings included accusations by Feeding Our Future that MDE was discriminating against it because it served minority communities. Feeding Our Future also alleged, in court filings and in news media, that MDE was preventing tens of thousands of hungry children from accessing food by refusing to approve Feeding

[1] Minnesota Department of Education, *NEWS RELEASE: MDE Files Legal Claim Against Feeding Our Future to Recover State Funds* (Minneapolis, September 21, 2022), https://content.govdelivery.com /accounts/MNMDE/bulletins/32e3cf0, accessed February 15, 2024.

Our Future's site applications. According to MDE officials, the threat of legal consequences and negative media attention affected MDE's decisions about the regulatory actions it did and did not take against Feeding Our Future.

- **Lack of rulemaking authority under state law.** According to MDE officials, the department believes it does not have authority in Minnesota law to create rules for federal nutrition programs. As such, MDE has not promulgated administrative rules defining, for example, how it should evaluate organizations' applications to participate in federal nutrition programs. Without rulemaking authority, the department determined it could not establish additional program requirements that could provide guardrails against waste and abuse.

- **Lack of investigatory authority under state and federal law.** MDE officials told us federal guidance indicated that MDE had to prove a sponsor knowingly submitted false or fraudulent claims in order for it to take administrative action. An MDE official said MDE lacked the investigative authority to meet that standard at the time the alleged fraud was occurring. For example, MDE did not have the authority to subpoena bank records necessary to track the movement of funds across bank accounts.

While we acknowledge these factors created challenges for the department, we also believe MDE could have taken more decisive action sooner in its relationship with Feeding Our Future.

MDE's inadequate oversight of Feeding Our Future created opportunities for fraud.

In our review, we identified numerous instances when MDE did not provide adequate oversight, especially given information it either had in its possession or should have obtained but did not. These instances span all of MDE's key oversight mechanisms, including its review of Feeding Our Future's annual sponsor applications, investigations of complaints involving Feeding Our Future, and oversight of an administrative "serious deficiency" process initiated due to deficiencies in Feeding Our Future's operations. Further, these instances span the nearly four years (2018 to 2022) during which Feeding Our Future received public funds to administer nutrition programs.

MDE officials told us that the department began to have concerns about Feeding Our Future only after the start of the COVID-19 pandemic. However, we think **MDE failed to act on warning signs known to the department prior to the onset of the COVID-19 pandemic and prior to the start of the alleged fraud.** As we describe in Chapter 2, Feeding Our Future was an outlier in terms of its large size in the years preceding the pandemic. At the same time, Feeding Our Future's annual applications, which we discuss in Chapter 3, reflected an organization that did not appear to have the staffing or procedures needed to manage the millions of dollars that passed through the organization annually. And, as we discuss in Chapter 4, by March 2020, MDE had received a number

of complaints about Feeding Our Future—including an allegation that the organization had solicited a kickback from a vendor in order to participate in the program.

Despite signs that Feeding Our Future might not be in full compliance with program requirements both before and after the start of the COVID-19 pandemic, **MDE did not effectively exercise its authority to hold Feeding Our Future accountable to program requirements.** For example, in this report, we describe how MDE:

- Repeatedly approved Feeding Our Future's annual applications despite identifying serious concerns about the organization's ability to administer federal nutrition programs. (pp. 25, 31)

- Did not follow up on serious findings from its only in-depth monitoring review of the organization that began in late 2018. (p. 37)

- Did not appropriately investigate complaints involving Feeding Our Future. (pp. 53, 55)

- Did not verify information provided by Feeding Our Future prior to approving its annual applications, closing investigations, or deferring administrative actions taken in response to deficiencies MDE identified in Feeding Our Future's operations. (pp. 30, 32, 57, 65)

No additional authority would have been needed to take these steps. MDE had the authority—and the obligation—to take each of these steps, regardless of any lack of detail in law or USDA guidance, and regardless of a threat of litigation or negative press.[2] To the extent that MDE believed that additional regulatory authority would have strengthened its ability to take these actions, MDE had an obligation to seek legislative action to obtain that authority.

More broadly, the failures we highlight in this report are symptoms of a department that was ill-prepared to respond to the issues it encountered with Feeding Our Future. MDE did not have a general counsel until January 2022 to advise the department on how to interpret and implement complex federal regulations and identify policy changes to bolster the department's regulatory authority. As we discuss further in Chapter 3, even after the Minnesota Court of Appeals put MDE on notice in 2017 that it needed to codify certain procedures in state administrative rules, MDE neither requested changes to statutes nor pursued rulemaking authority. As we explain in Chapter 4, MDE relied on child-nutrition program staff—not trained investigators—to investigate allegations of fraud, waste, and abuse. And, according to one MDE official, the department lacked the staff it needed to respond to the COVID-19 pandemic.

Chapter 1 of this report provides background information on federal nutrition programs and the oversight requirements for state agencies and sponsors. Chapter 2 focuses on Feeding Our Future and the alleged fraud scheme. In Chapter 3, we outline concerns

[2] For example, federal regulations require that MDE only approve the applications of sponsors that meet certain performance standards, target sponsors with a history of operational deficiencies for more frequent in-depth monitoring reviews, and promptly investigate complaints or irregularities (7 *CFR*, secs. 225.6(d); 225.7(e)(4)(iii); 225.11(b); and 226.6(b)(1)(xviii), (b)(2)(vii), (m)(2), and (n) (2023)).

we have about MDE's review of Feeding Our Future's sponsor applications, administrative review of the organization, and implementation of federal waivers issued in response to the COVID-19 pandemic. We criticize MDE's handling of complaints it received involving Feeding Our Future in Chapter 4, and in Chapter 5, we explain how MDE's oversight was undermined by decisions it made when the organization was subject to a serious deficiency process. Finally, Appendix A provides a detailed history and timeline of MDE and Feeding Our Future's relationship, and Appendix B provides a summary of litigation between MDE and Feeding Our Future.

Chapter 1: Federal Nutrition Programs

From 2020 to 2022, approximately 7 percent of Minnesota households were, at times, uncertain of having or unable to acquire enough food to meet their needs due to a lack of money or other resources.[1] Through the U.S. Department of Agriculture (USDA), the federal government provides funding to states for several programs to address childhood hunger and promote the health and well-being of children and dependent adults. For example, one program reimburses schools and other designated institutions for providing free or low-cost lunches to children each day, and another program helps schools and early care sites to incorporate local foods in the meals and snacks they serve. The Minnesota Department of Education (MDE) administers these programs in Minnesota.

Two federal nutrition programs—the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP)—were allegedly defrauded during the COVID-19 pandemic by a Minnesota nonprofit organization and its associates.

- **CACFP** provides reimbursements for meals and snacks provided to eligible children and adults who are enrolled for care at participating child-care centers, day care homes, and adult day care centers. CACFP also provides reimbursements for meals and snacks served to children and youth participating in afterschool care programs and children residing in emergency shelters.

- **SFSP** reimburses providers who serve free healthy meals and snacks to children and teens in low-income areas when school is not in session. The program operates primarily during the summer months, but it may also be used during unanticipated school closures due to natural disasters, labor-management disputes, or other events.

Overview of CACFP and SFSP

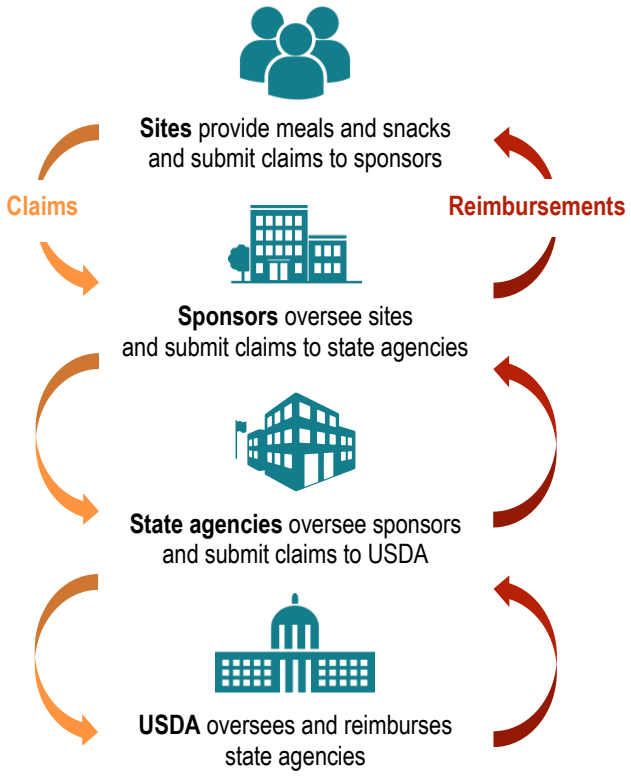
In CACFP and SFSP, food is served to eligible children and adults at locations called "**sites**," such as schools, child-care centers, and adult day care centers. Sites are responsible for verifying eligibility of participants, taking attendance, serving meals and snacks, and counting the number of meals and snacks served. CACFP and SFSP sites may prepare food themselves or contract with outside vendors to provide meals and snacks.

As Exhibit 1.1 depicts, sites submit claims for reimbursement to "**sponsors**" that reflect the number of meals and snacks served on a given day. Sponsors, which include school districts, child-care programs, and nonprofit organizations, are responsible for overseeing their sites, including monitoring their sites for compliance with program requirements.

[1] U.S. Department of Agriculture, Economic Research Service, *Food Security in the U.S., Interactive Charts and Highlights* (Washington, DC), https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/interactive-charts-and-highlights/#childtrends, accessed January 9, 2024.

Exhibit 1.1

Sites, sponsors, state agencies, and USDA have roles in administering CACFP and SFSP.



Source: Office of the Legislative Auditor.

Sponsors contract with **state agencies** to administer CACFP and SFSP, and state agencies are responsible for overseeing sponsors' compliance with applicable federal and state laws. Sponsors submit claims for reimbursement on behalf of their sites to state agencies on a monthly basis, and in turn, state agencies submit those claims to **USDA**.

USDA then reimburses state agencies, and state agencies reimburse sponsors. Sponsors, in turn, reimburse the sites under their sponsorship. Sponsors retain a percentage of reimbursements to cover the costs of providing or facilitating food service and ensuring compliance with federal program rules, among other responsibilities.

Typically, a child or adult's eligibility for food funded through CACFP is determined by their household income. For example, participating child-care centers are reimbursed based on enrolled children's eligibility for free or reduced-price meals, meaning their household income is at or below 185 percent of the federal poverty level. Generally, sites are eligible for reimbursement through SFSP if at least 50 percent of households in the school district or census tract in which they are located are eligible for free or reduced-price school meals.

Program Participation

In recent years, hundreds of Minnesota school districts, child-care programs, and nonprofit organizations have participated in CACFP and SFSP. During the 2018 through 2022 CACFP program years, a total of 442 sponsors participated in CACFP.[2] During the 2018 through 2022 SFSP program years, 714 sponsors participated in SFSP.[3] In fiscal years 2018 to 2022, MDE distributed a total of $845 million in federal funds through CACFP and SFSP to nonprofit organizations.[4]

[2] CACFP program years begin on October 1 and end on September 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2018 began on October 1, 2017, and ended on September 30, 2018.

[3] SFSP program years begin on May 1 and end on April 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2018 began on May 1, 2017, and ended on April 30, 2018.

[4] The state's fiscal year begins on July 1 and ends on June 30 of the following year and is designated by the calendar year in which it ends; thus, Fiscal Year 2021 began on July 1, 2020, and ended on June 30, 2021. For simplicity, we use "fiscal year" to refer to the state's fiscal year. Nonprofit organizations included charter schools and child-care organizations, among other entities. Sponsors that were public school districts or other public entities (such as local or tribal governments) received nearly $545 million in federal funds during this same time period.

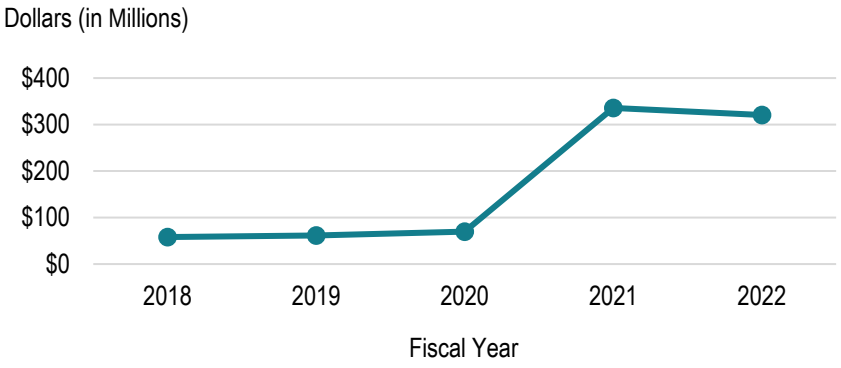
Most sponsors operate one site. In the 2022 CACFP and SFSP program years, 72 percent of CACFP sponsors and 53 percent of SFSP sponsors operated only one site. Only a small percentage of all sponsors operated 20 or more sites; 3 percent of CACFP and SFSP sponsors operated 20 or more sites in the 2022 CACFP and SFSP program years.

Reimbursements for and participation in CACFP and SFSP increased substantially in response to the COVID-19 pandemic.

The amount of money MDE distributed to nonprofit sponsoring organizations through CACFP and SFSP increased substantially between fiscal years 2020 and 2021.[5] In Fiscal Year 2020, MDE reimbursed CACFP and SFSP nonprofit sponsors nearly $70 million. In Fiscal Year 2021, however, MDE distributed almost $336 million, a 382 percent increase from the prior year.

Exhibit 1.2

MDE distributed 382 percent more funds to CACFP and SFSP nonprofit sponsors in Fiscal Year 2021 than in the year prior.



Source: Office of the Legislative Auditor, analysis of expenditure data from StateWide Integrated Financial Tools (SWIFT).

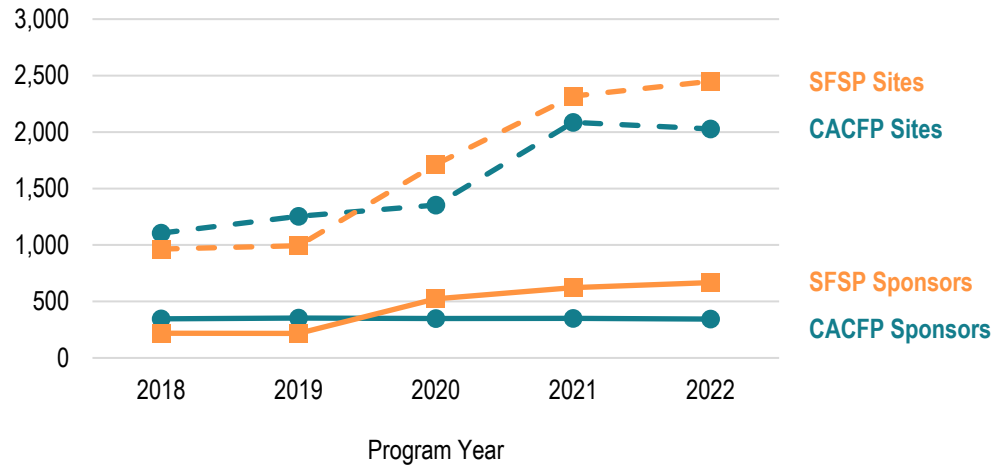
The number of CACFP and SFSP sites approved by MDE also increased dramatically after the start of the pandemic in 2020. For example, site participation in SFSP increased 73 percent between the 2019 and 2020 SFSP program years, from 993 sites to 1,713 sites. SFSP sponsor participation also increased following the onset of the pandemic; 141 percent more sponsors participated in SFSP in program year 2020 (523) than in program year 2019 (217).

In the years prior to the pandemic, SFSP sites typically opened for food service beginning in May and operated throughout the summer. However, when schools across the nation closed in response to the COVID-19 pandemic in the spring of 2020, USDA used SFSP to provide meals and snacks to children who were previously served through school-based nutrition programs. During the 2020 SFSP program year, which ended on April 30, 2020, MDE approved over 1,100 sites in March and April 2020 alone.

[5] The World Health Organization declared COVID-19 a pandemic in March 2020.

Exhibit 1.3

More sites and sponsors began participating in CACFP and SFSP around the start of the COVID-19 pandemic.



Source: Office of the Legislative Auditor, analysis of Minnesota Department of Education data.

Oversight

The integrity of CACFP and SFSP relies on state agencies and sponsors fulfilling their oversight responsibilities.

Federal regulations that govern both CACFP and SFSP require state agencies to administer and monitor the programs, including conducting oversight of sponsors.[6] In Minnesota, MDE is responsible for:

- Approving applications for all sponsors and sites participating in the programs.
- Entering into program agreements that govern the rights and responsibilities of MDE and sponsors.
- Monitoring program participants to ensure compliance with recordkeeping requirements, nutritional and food service requirements, and other program requirements.
- Reviewing and approving claims for reimbursement and making payments to sponsors for valid claims.
- Providing training and technical assistance to program participants to help them comply with federal regulations and guidance.

[6] 7 *CFR*, secs. 225.6(a)(1) and 226.6(a) (2023).

In fiscal years 2020 through 2022, MDE dedicated roughly 15 full-time-equivalents to overseeing CACFP and SFSP. MDE pays for its oversight activities through an indirect rate charged to several federal funding sources.

Sponsors also have important oversight responsibilities under federal regulations.[7] Sponsors are responsible for enrolling sites into the program, training site staff, receiving the sites' reimbursement claims, and distributing reimbursements for valid claims. Through regular site visits and off-site "desk" reviews, sponsors are responsible for monitoring sites' compliance with program requirements. Further, sponsors are required to maintain records documenting the meals and snacks served at their sites.

If sponsors do not comply with federal program requirements, MDE may issue a notice of "serious deficiency" and require sponsors to take corrective actions.

Federal regulations require CACFP and SFSP sponsors to demonstrate financial viability, administrative capability, and program accountability; maintain detailed records; and have adequate personnel to monitor sites for compliance, among other obligations.[8] If MDE finds serious violations of federal requirements during a sponsors' participation in CACFP or SFSP, the department must notify the sponsor that it is "seriously deficient."[9] Sponsors must take corrective action to address noncompliance.[10] If the sponsor does not adequately address MDE's concerns, MDE must move to terminate the sponsor from program participation.[11] Sponsors can appeal MDE's decision to deny an application or terminate their participation in CACFP or SFSP, but they cannot appeal MDE's serious deficiency determinations.[12]

Examples of Serious Deficiencies

- Misrepresentation of information submitted on applications.
- Submission of false claims for reimbursement.
- Noncompliance with requirements related to the nutritional content of meals and snacks.
- Failure to keep required records.

Other violations prompt a more immediate response from MDE. If MDE were to find a violation that threatens the health or safety of program participants, it must immediately take steps to terminate either the sponsor or the site, depending on the program.[13] Finally, if MDE finds that a sponsor submitted an invalid claim, it may not reimburse the sponsor for the portion of the claim that MDE knows to be invalid.[14]

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[7] 7 *CFR*, secs. 225.14-15 and 226.15-16 (2023).

[8] 7 *CFR*, secs. 225.6(d); 225.15(c)(1); 226.6(b)(1)(xviii)(A)-(C) and (b)(2)(vii)(A)-(C); 226.15(e); and 226.16(b)(1) (2023).

[9] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(iii)(A), (c)(2)(iii)(A), and (c)(3)(iii)(A) (2023).

[10] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(iii)(B), (c)(2)(iii)(B), and (c)(3)(iii)(B) (2023).

[11] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(iii)(C), (c)(2)(iii)(C), and (c)(3)(iii)(C) (2023).

[12] 7 *CFR*, secs. 225.13(a); and 226.6(k)(2)(i), (k)(2)(iii), and (k)(3)(ii) (2023).

[13] 7 *CFR*, secs. 225.11(f)(3) and 226.6(c)(5)(i) (2023).

[14] 7 *CFR*, secs. 225.9(d)(4) and 226.7(k) (2023). If MDE determines that a sponsor in CACFP has "knowingly submitted a false or fraudulent claim," it may suspend the sponsor's participation in the program and must initiate action to terminate the sponsor (7 *CFR*, sec. 226.6(c)(5)(ii) (2023)).

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Chapter 2: Feeding Our Future

Feeding Our Future, a nonprofit organization, was established in November 2016.[1] Feeding Our Future's mission was to help youth and seniors access healthy foods by sponsoring community organizations' participation in federal nutrition programs. At its height, the organization employed dozens of individuals to manage its programs and prepare and serve food at its sites.

On January 20, 2022, federal authorities executed search warrants at Feeding Our Future's office and several other locations affiliated with the nonprofit organization, including the home of its executive director. On the same day, the Minnesota Department of Education (MDE) terminated Feeding Our Future's participation in two federal nutrition programs. Between September 2022 and February 2024, the U.S. Department of Justice charged 70 individuals associated with Feeding Our Future with various crimes, including bribery, money laundering, and wire fraud. According to the U.S. Department of Justice,

> The defendants obtained, misappropriated, and laundered millions of dollars in program funds that were intended as reimbursements for the cost of serving meals to children. The defendants exploited changes in the program intended to ensure underserved children received adequate nutrition during the COVID-19 pandemic. Rather than feed children, the defendants enriched themselves by fraudulently misappropriating millions of dollars in Federal Child Nutrition Program funds.[2]

In this chapter, we describe Feeding Our Future's participation in federal nutrition programs and summarize the criminal charges filed against Feeding Our Future's executive director, staff, and associates.

Participation in Federal Nutrition Programs

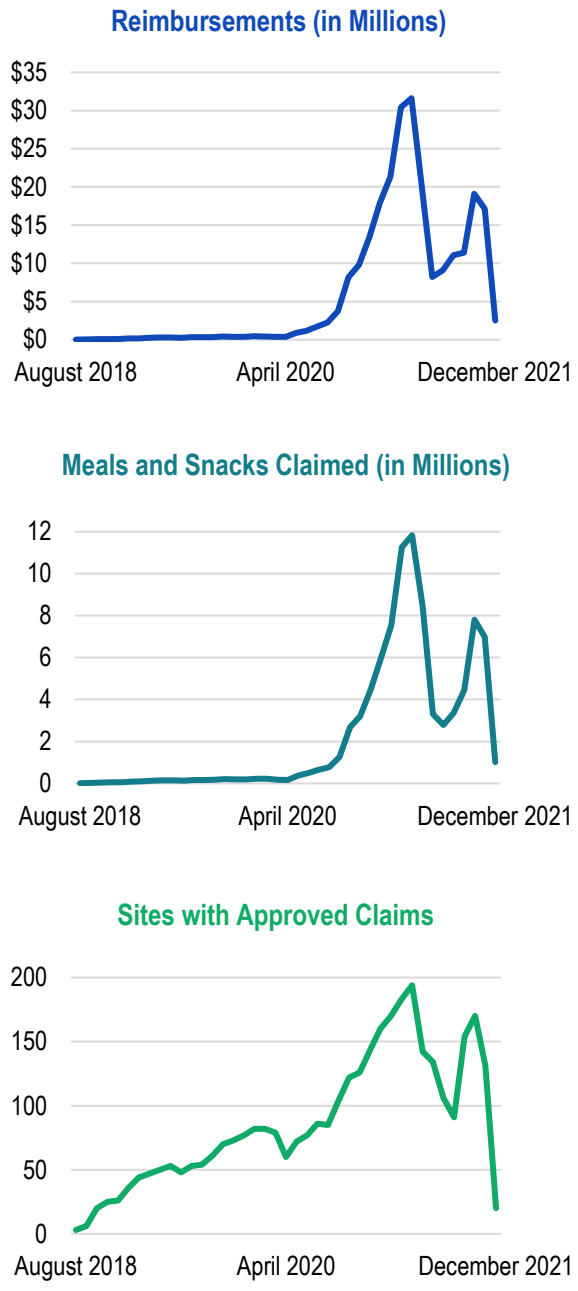
Feeding Our Future first secured MDE's approval to be a sponsor in the Child and Adult Care Food Program (CACFP) in 2017. Despite being an approved sponsor, Feeding Our Future remained inactive until mid-2018. The organization received its first reimbursements for meals and snacks served through CACFP in August 2018. Later, in 2020, MDE approved Feeding Our Future as a sponsor in the Summer Food Service Program (SFSP). Feeding Our Future received its first reimbursements for meals and snacks served through SFSP in June 2020.

[1] According to one of Feeding Our Future's founding members, Feeding Our Future was created to be a backup organization in case an existing CACFP sponsor, Partners in Nutrition, was unable to continue operating. As we discuss in Chapter 3, in 2016, MDE denied Partners in Nutrition's request to expand from a sponsor of a single site to being a sponsor of multiple sites in CACFP. Partners in Nutrition appealed MDE's determination to the Minnesota Court of Appeals, and in the summer of 2017, the court ruled in Partners in Nutrition's favor. In 2017, MDE also approved Feeding Our Future's application to be a CACFP sponsor.

[2] U.S. Department of Justice, Office of Public Affairs, *PRESS RELEASE: U.S. Attorney Announces Federal Charges Against 47 Defendants in $250 Million Feeding Our Future Fraud Scheme* (Washington, DC, September 20, 2022), https://www.justice.gov/opa/pr/us-attorney-announces-federal-charges-against-47-defendants-250-million-feeding-our-future, accessed January 17, 2024.

Exhibit 2.1

For CACFP and SFSP combined, the reimbursements Feeding Our Future received, the number of meals and snacks it claimed, and sites under its sponsorship per month ballooned in 2020.



Source: Office of the Legislative Auditor, analysis of Minnesota Department of Education data.

Between 2018 and 2021, Feeding Our Future's operation grew at a significant rate.

Over its first year in operation, Feeding Our Future grew at a relatively steady rate when compared to its growth after the start of the COVID-19 pandemic.[3] Feeding Our Future went from receiving roughly $307,000 in total **reimbursements** in the last five months of 2018 (approximately $61,500 per month on average) to roughly $1.8 million in total reimbursements in the last five months of 2019 (approximately $361,000 per month on average), an increase of 487 percent.

As Exhibit 2.1 shows, for CACFP and SFSP combined, the **number of meals and snacks** Feeding Our Future claimed to have served—and the reimbursements it received from MDE—increased dramatically in the year following the beginning of the COVID-19 pandemic. At its peak, Feeding Our Future claimed to have served 11.8 million meals and snacks in April 2021, a 7,104 percent increase from the same month a year prior. MDE paid Feeding Our Future nearly $32 million for the meals and snacks the organization served in April 2021—87 times more than what MDE paid Feeding Our Future in April 2020. The **number of sites** that received payment under Feeding Our Future's sponsorship also increased during the same time, reaching a high of 194 sites in April 2021.

As we discuss in Chapter 5, in March 2021, MDE temporarily stopped accepting and paying Feeding Our Future's meal claims. Further, as we explain in Appendix B, from late 2020 to mid-2021, MDE delayed its approval of over 100 of Feeding Our Future's sites. This caused a sudden drop (seen in Exhibit 2.1) in the reimbursements Feeding Our Future received, the number of meals and snacks it claimed, and sites under its sponsorship.

[3] The World Health Organization declared COVID-19 a pandemic in March 2020.

Compared to other sponsors, Feeding Our Future was an outlier in the amount of reimbursements it received and the number of sites under its sponsorship.

Due to the COVID-19 pandemic, the amount of federal funds MDE distributed to all CACFP and SFSP sponsors combined nearly quintupled in Fiscal Year 2021 when compared to the previous year.[4] However, as Exhibit 2.2 shows, the total funds received by Feeding Our Future increased by roughly 2,800 percent over the same period. In Fiscal Year 2021, roughly four out of every ten dollars distributed to nonprofit CACFP and SFSP sponsors and independent sites went to Feeding Our Future.

Exhibit 2.2

Between Fiscal Year 2020 and Fiscal Year 2021, MDE's payments to Feeding Our Future increased by about 2,800 percent.

	Payments to All CACFP and SFSP Nonprofit Sponsors		Payments to Feeding Our Future	
Fiscal Year	Dollars (in Millions)	Percentage Change from Previous Fiscal Year	Dollars (in Millions)	Percentage Change from Previous Fiscal Year
2018	$ 58.1	–	–	–
2019	61.3	6%	$ 1.4	–
2020	69.6	14	4.8	252%
2021	335.7	382	140.3	2,818
2022	320.4	-5	98.4	-30

Source: Office of the Legislative Auditor, analysis of expenditure data from StateWide Integrated Financial Tools (SWIFT).

Growth in the number of Feeding Our Future's CACFP sites was significantly larger than other CACFP sponsors with multiple sites. While the total number of CACFP sites across Minnesota grew by 54 percent in the 2021 CACFP program year, the number of Feeding Our Future CACFP sites more than tripled during the same period.[5] Even before the COVID-19 pandemic, Feeding Our Future was an outlier in terms of the number of CACFP sites it sponsored. By the end of the 2019 program year, Feeding Our Future already had more than six times the number of CACFP sites than the average multisite sponsor. [6]

[4] The state's fiscal year begins on July 1 and ends on June 30 of the following year and is designated by the calendar year in which it ends; thus, Fiscal Year 2021 began on July 1, 2020, and ended on June 30, 2021. For simplicity, we use "fiscal year" to refer to the state's fiscal year.

[5] CACFP program years begin on October 1 and end on September 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2021 began on October 1, 2020, and ended on September 30, 2021.

[6] In the 2019 CACFP program year, 25 percent of approved sponsors operated more than one CACFP site. Between the 2018 and 2022 program years, the percentage of sponsors approved to operate more than one CACFP site ranged from 24 to 30 percent, peaking at 30 percent in the 2021 CACFP program year.

Exhibit 2.3

Between program year 2020 and program year 2021, Feeding Our Future more than tripled the number of CACFP sites under its sponsorship.

	Multisite CACFP Sponsors		Feeding Our Future	
Program Year	Average Number of Sites Per Sponsor	Percentage Change from Previous Program Year	Number of Sites	Percentage Change from Previous Program Year
2018	10	–	8	–
2019	12	12%	73	813%
2020	12	3	116	59
2021	18	50	384	231
2022	19	4	312	-19

Notes: The number of sites listed above represents sites approved by MDE to operate in a given CACFP program year. Some sites approved by MDE did not receive reimbursements during the program year in which they were approved to operate. For example, during the 2019 CACFP program year, MDE approved 73 Feeding Our Future sites, but only 68 of those sites received reimbursement for claimed CACFP meals and snacks during the program year. Exhibit 2.1 presents the number of Feeding Our Future sites that received reimbursements for CACFP or SFSP meals and snacks served in a given month.

Source: Office of the Legislative Auditor, analysis of Minnesota Department of Education data.

The number of SFSP sites also grew significantly after the onset of the COVID-19 pandemic, but Feeding Our Future's growth was especially dramatic. Feeding Our Future did not participate in SFSP prior to the pandemic, but received approval to open 81 sites during the 2021 SFSP program year (May 1, 2020, to April 30, 2021). The number of sites Feeding Our Future sponsored in 2021 was roughly 12 times the average number of sites sponsored by other multisite SFSP sponsors during the same program year.

Criminal Indictments

Between September 2022 and February 2024, the federal government indicted 70 individuals associated with Feeding Our Future, alleging they used federal food aid for personal gain.

In September 2022, the U.S. Department of Justice announced federal criminal charges against 47 individuals for allegedly defrauding the government of $250 million from federal nutrition programs. In October 2022, March 2023, and February 2024, the U.S. Department of Justice announced additional indictments, naming a total of 23 more defendants. The following box provides a description of some of the criminal charges used in this case.

The defendants include Feeding Our Future's executive director, other Feeding Our Future employees, and individuals who operated various sites affiliated with Feeding Our Future and/or another federal nutrition program sponsor.

According to the federal indictments, Feeding Our Future employees allegedly recruited individuals and entities to open illegitimate CACFP or SFSP sites throughout Minnesota, knowingly submitted fraudulent claims for reimbursement, and solicited and received bribes and kickbacks from the sites it sponsored, among other things. Further, the government alleged that Feeding Our Future's executive director gave false assurances to MDE that the nonprofit organization was monitoring the sites it sponsored and that the sites served the meals and snacks they claimed to be serving.

The defendants who operated the sites named in the charging documents allegedly claimed meals and snacks that were never served, falsified attendance records, and created fake invoices intended to document the purchase of food purportedly served to children at their sites. The government alleged some of the defendants created dozens of shell companies to receive, misappropriate, and launder the proceeds of their fraud scheme. After allegedly laundering the proceeds of their scheme, the defendants allegedly used their shell companies to pay off debts; travel; and purchase commercial and residential real estate (in Minnesota, other states, and other countries), businesses, luxury cars, boats, and other personal items such as electronics, clothing, and jewelry.

Criminal Charges Related to the Alleged Scheme

- **Wire fraud:** Interstate electronic communications are used in furtherance of a criminal act.
- **Conspiracy to commit wire fraud:** An agreement between two or more people to intentionally commit wire fraud.
- **Federal programs bribery:** Soliciting, accepting, or transferring anything of value in exchange for an action of an agent of an entity that receives $10,000 or more annually in federal assistance.
- **Conspiracy to commit federal programs bribery:** An agreement between two or more people to intentionally commit federal programs bribery.
- **Money laundering:** A financial transaction scheme that aims to conceal the identity, source, and destination of illicitly obtained money.
- **Conspiracy to commit money laundering:** An agreement between two or more people to intentionally commit money laundering.
- **Theft of government funds:** Willfully and knowingly stealing funds from a government program.

As of May 2024, 18 of the 70 defendants had pleaded guilty. Federal criminal trials for seven of the remaining defendants began in April 2024.

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Chapter 3: Application and Administrative Reviews

Under federal law, the Minnesota Department of Education (MDE) is responsible for overseeing sponsors participating in the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP).[1] Some of these oversight responsibilities, including reviewing and approving applications and conducting monitoring visits and compliance reviews, must occur on a regular schedule outlined in federal regulations.[2]

In Minnesota, sponsors must apply annually to participate in CACFP and SFSP.[3] Federal regulations require MDE to review sponsors' (1) applications to ensure that they can comply with financial and operational standards, and (2) administrative budgets to ensure that applicants will have the financial means to comply with program regulations.[4]

Key Events in the Timeline: Application and Administrative Reviews

November 2016 – Feeding Our Future was established.

June 2017 – Feeding Our Future received MDE approval to become a CACFP sponsor.

February 2019 – MDE completed its only administrative review of Feeding Our Future.

June 2020 – Feeding Our Future received MDE approval to become an SFSP sponsor.

January 2022 – MDE terminated Feeding Our Future's sponsorship in CACFP and SFSP.

See Appendix A for additional information.

Federal regulations require MDE to conduct periodic compliance monitoring, known as administrative reviews, of a specified percentage of all CACFP sponsors and a specified number of SFSP sponsors each year.[5] Administrative reviews include visits to a specified percentage of a sponsor's sites; observations of meal and snack services; and reviews of the sponsor's records, including meal claims, financial records, and documentation of the sponsor's monitoring efforts.

In this chapter, we discuss MDE's review of Feeding Our Future's annual sponsor applications, its administrative reviews of Feeding Our Future's operations, and the impact of COVID-19 pandemic-era waivers on these processes.

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[1] 7 *CFR*, secs. 225.6(a)(1) and 226.6(a) (2023).

[2] 7 *CFR*, secs. 225.6(b)(1) and (b)(3); 225.7(d)(1) and (e)(4); and 226.6(b), (f), and (m)(6) (2023).

[3] Federal regulations require CACFP sponsors to reapply at least once every three years, but MDE requires sponsors to reapply for CACFP participation annually (7 *CFR*, sec. 226.6(f)(2)(i) (2023)). In contrast, federal regulations establish an explicit deadline for annual SFSP applications (7 *CFR*, sec. 225.6(b)(1) (2023)). CACFP program years begin on October 1 and end on September 30 of the following year. SFSP program years begin on May 1 and end on April 30 of the following year. For both CACFP and SFSP, the program year is designated by the year in which it ends; thus, CACFP program year 2018 began on October 1, 2017, and ended on September 30, 2018.

[4] 7 *CFR*, secs. 225.6(b)-(e); 226.6(b); 226.6(f)(1)(iv); and 226.7(g) (2023).

[5] 7 *CFR*, secs. 225.7(e)(4)(ii) and 226.6(m)(6) (2023).

Annual Application Reviews

MDE's review of new and renewing sponsors' annual applications is one of the key ways in which the department exercises oversight of CACFP and SFSP sponsors. During these reviews, MDE has the opportunity to evaluate sponsor applicants' detailed plans for managing their food programs, including information on the organizations' budgets and staffing.

If MDE determines that a sponsor's application is incomplete, the department provides technical assistance to help it complete its application. If, despite this technical assistance, MDE believes the sponsor cannot meet standards found in law, MDE must deny the application.[6] Further, if MDE identifies in the application certain serious concerns outlined in federal regulations, MDE has the authority to initiate an administrative "serious deficiency" process, which could result in the sponsor's termination from CACFP or SFSP.[7]

In this section, we first describe the information sponsors are required to submit to MDE during the annual application process. Then, we discuss concerns we have about MDE's review and approval of Feeding Our Future's annual applications.

Application Requirements

To participate in CACFP and SFSP, each new or renewing sponsor must submit an application to MDE. Among other things, the application must demonstrate how the sponsor meets certain performance standards, including that it is financially viable and administratively capable of operating CACFP or SFSP in compliance with federal regulations.[8] Sponsors must also provide policies and procedures (called a "program management plan") documenting how they will manage their operations and monitor their sites, while complying with legal requirements and operating within their budgets.[9] The boxes on the following page provide a summary of the performance standards for CACFP and SFSP found in federal regulations.[10]

[6] 7 *CFR*, secs. 225.6(d); and 226.6(b)(1)(xviii), (b)(2)(vii), (c)(1)(i), and (c)(2)(i) (2023).

[7] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(i) and (c)(2)(i) (2023). As we explained in Chapter 1, if MDE finds serious violations of federal requirements during a sponsor's participation in CACFP or SFSP, the department notifies the sponsor that it is "seriously deficient." If the sponsor does not adequately correct its serious deficiencies, MDE must move to terminate the sponsor from program participation. Sponsors can appeal MDE's decisions to deny an application or terminate a sponsor from program participation, but they cannot appeal MDE's serious deficiency determinations.

[8] 7 *CFR*, secs. 225.6(d); and 226.6(b)(1)(xviii) and (b)(2)(vii) (2023).

[9] 7 *CFR*, secs. 225.6(e); and 226.6(b)(1)(iv), (b)(1)(xviii)(C)(4), (b)(2)(i), and (b)(2)(vii)(C)(4) (2023).

[10] 7 *CFR*, secs. 225.6(d)(1)-(3); and 226.6(b)(1)(xviii)(A)-(C) and (b)(2)(vii)(A)-(C) (2023). In the years Feeding Our Future participated in SFSP, federal regulations did not require the organization to submit an SFSP management plan or comply with the SFSP-specific performance standards shown in the boxes on page 21. The regulations were amended in October 2022 to add these requirements, more than eight months after MDE terminated Feeding Our Future's participation in SFSP.

CACFP and SFSP Performance Standard 1: Financial Viability and Management

Sponsors must be financially viable and must:

- Have adequate resources to operate on a daily basis (CACFP only).
- Have appropriate site recruitment practices.
- Have adequate resources to pay debts, employees, and suppliers during temporary interruptions in program payments.
- Document their financial viability, such as through financial statements and audits.
- Have budgets that contain necessary, reasonable, allowable, and documented costs.

CACFP and SFSP Performance Standard 2: Administrative Capability

Sponsors must be capable of administering CACFP or SFSP and must have:

- Appropriate and effective management practices to ensure compliance with federal law.
- Adequate numbers and types of staff, including monitoring staff.
- Written policies and procedures that (1) assign program responsibilities and duties and (2) ensure compliance with civil rights regulations.

CACFP and SFSP Performance Standard 3: Program Accountability

Sponsors must have internal controls and other management systems in place to guarantee fiscal accountability and other program operational requirements. For example, they must have:

- An independent governing board (CACFP only).
- Written management controls to ensure fiscal integrity and accountability.
- A system of safeguards and controls to prevent and detect improper financial activities by employees.
- Recordkeeping systems to account for and retain program records.

Along with the application, both CACFP and SFSP sponsors must provide an administrative and operating budget that includes projected administrative expenses and reimbursements. Among other things, sponsors provide salary and benefit information, expenses associated with training staff, and food costs.

Further, new and renewing SFSP sponsor applicants must demonstrate that they and their sites meet eligibility criteria found in law.[11] Sponsor applicants must also provide information about each of their proposed sites, such as the types of meals and snacks the sites will serve and for new sites, how the sites plan to store food.[12]

Federal regulations direct MDE to use information submitted in sponsors' applications to determine the eligibility of new and renewing CACFP and SFSP sponsors, the reasonableness of sponsors' budgets, and the capability of sponsors to manage program funds in accordance with federal requirements.[13] MDE must use its discretion to determine whether the sponsors' applications demonstrate that they can meet CACFP

[11] 7 *CFR*, secs. 225.6(g) and 225.14 (2023). Typically, to be eligible for SFSP participation, sites must be either (1) located in an area in which at least 50 percent of the children are from households with incomes that make them eligible for free or reduced-price school meals under the National School Lunch Program and the School Breakfast Program; or (2) at least 50 percent of the children enrolled at the site are from households with incomes that make them eligible for free or reduced-price school meals under the National School Lunch Program and the School Breakfast Program.

[12] 7 *CFR*, secs. 225.6(c)(2)(iii), (c)(3)(ii), and (g) (2023).

[13] 7 *CFR*, secs. 225.6(b)(4), (b)(7), (c)(2)(iv), (c)(2)(vii), (c)(3)(v), and (d); 225.14(c) and (d); 226.6(b), (b)(1)(xviii), (b)(2)(vii), and (f)(1)(iv); and 226.16(b) (2023).

and SFSP performance standards.[14] MDE must review and approve or disapprove sponsors' applications and budgets within 30 days of receiving complete applications.[15]

In addition to reviewing application documents, federal regulations require MDE to conduct "pre-approval visits" of new CACFP and SFSP sponsors, as well as renewing SFSP sponsors that the department determines need additional oversight.[16] The purpose of these visits is to verify the accuracy of the information in the application and assess sponsors' ability to successfully operate the program.[17]

Shortcomings in MDE's Oversight

MDE reviewed each of Feeding Our Future's annual applications for CACFP and SFSP, identified concerns, and provided technical assistance to the organization. Nevertheless, we identified several shortcomings in MDE's review of Feeding Our Future's applications.

MDE's inaction to strengthen and exercise its authority to deny applications put the CACFP and SFSP programs' integrity at risk.

In this section, we discuss how the department:

- Failed to address what it sees as limits to its authority years before the start of the COVID-19 pandemic in March 2020.[18]
- Did not deny applications or take timely administrative action when Feeding Our Future did not address some serious and repetitive concerns MDE raised during its review of the organization's applications.

[14] 7 *CFR*, secs. 225.6(d); and 226.6(b)(1)(xviii) and (b)(2)(vii) (2023). In addition to information in sponsor applications, federal regulations also direct MDE to consider sponsor applicants' past performance in child nutrition programs when determining their ability to meet performance standards.

[15] CACFP regulations specify "30 calendar days" (7 *CFR*, sec. 226.6(b)(3) (2023)). SFSP regulations state "30 days" (7 *CFR*, sec. 225.6(b)(3) (2023)). As permitted by law, sponsors can appeal MDE decisions to deny sponsor applications (7 *CFR*, secs. 225.13(a) and 226.6(k)(2)(i) (2023)). In Minnesota, appeals are made to an MDE panel, which consists of three MDE employees who were not involved in the action being appealed. After reviewing relevant documentation; analyzing relevant legal requirements; and if requested, holding a hearing, the panel issues a decision on whether to uphold MDE's denial. Although the appeal panel's decision is considered MDE's final administrative determination, state statutes permit that decision to be appealed directly to the Court of Appeals (*Minnesota Statutes* 2023, 14.69).

[16] 7 *CFR*, secs. 225.7(d) and 226.6(b)(1) (2023). Federal regulations require MDE to conduct preapproval visits of "All applicant [SFSP] sponsors that had operational problems noted in the prior year; and…All sites that the State agency has determined need a pre-approval visit" (7 *CFR*, secs. 225.7(d)(2) and (d)(3) (2023)). MDE has discretion to determine whether to conduct preapproval visits of (1) sponsors proposing to operate during unanticipated school closure; and (2) sponsors that are a school food authority, were reviewed by MDE under the National School Lunch Program during the preceding 12 months, and had no significant deficiencies noted in that review (7 *CFR*, sec. 225.7(d)(1) (2023)).

[17] 7 *CFR*, secs. 225.7(d) and 226.6(b)(1) (2023).

[18] The World Health Organization declared COVID-19 a pandemic in March 2020. As we explained in the Introduction, the federal government alleges that the individuals charged in relation to the alleged fraud scheme exploited CACFP and SFSP during the COVID-19 pandemic.

- Did not take steps to verify statements made by Feeding Our Future prior to approving its program applications, particularly during the time when MDE had serious concerns about the ability of Feeding Our Future to manage its growth and maintain the integrity of its nutrition program operations.

MDE Did Not Seek Timely Legislative Action

Requirement to Establish Procedures for CACFP Application Review

Each State agency must establish application review procedures…to determine the eligibility of new [sponsors], renewing [sponsors], and [sites] for which applications are submitted by sponsoring organizations.

— 7 *CFR*, sec. 226.6(b) (2023)

As the state agency administering CACFP, federal regulations require MDE to establish a number of program procedures, including application review procedures to determine the eligibility of new and renewing sponsors.[19] Federal regulations also require MDE to establish factors it will consider in determining whether a new or renewing CACFP sponsor has sufficient staff to perform required monitoring responsibilities at all of its sites.[20] Further, regulations require MDE to "develop criteria for determining whether a new sponsoring organization's participation will help ensure the delivery of benefits to otherwise unserved [sites] or participants."[21]

Requirement for CACFP Staffing Factors

The State agency must establish factors…that it will consider in determining whether a new [or renewing] sponsoring organization has sufficient staff to perform required monitoring responsibilities at all of its sponsored [sites]. As part of the review of the…sponsoring organization's management plan, the State agency must determine the appropriate level of staffing for each sponsoring organization, consistent with the staffing range of monitors set forth [in law] and the factors it has established.

— 7 *CFR*, secs. 226.6(b)(1) and (b)(2) (2023)

MDE has some internal procedures to guide its review of CACFP sponsor applications.[22] According to MDE officials, staff used these procedures—and the criteria within them—to review Feeding Our Future's applications and provide technical assistance to the organization. However, a 2017 court decision involving a different sponsoring organization indicated that for MDE to be permitted to apply the procedures, they needed to be established in state administrative rules. Because the criteria did not exist in state law when MDE reviewed Feeding Our Future's applications, MDE believed it had limited authority to require Feeding Our Future to take specific actions or to outright deny the organization's applications.[23]

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[19] 7 *CFR*, sec. 226.6(b) (2023).

[20] 7 *CFR*, secs. 226.6(b)(1) and (b)(2) (2023). By law, a sponsor overseeing centers must employ the equivalent of one full-time staff person to monitor each of the 25 to 150 sites it sponsors (7 *CFR*, sec. 226.16(b)(1) (2023)).

[21] 7 *CFR*, sec. 226.6(b)(1)(xi) (2023).

[22] MDE has not developed factors that it considers when determining whether sponsors have sufficient monitoring staff. When we asked MDE if it had established the factors required by law, MDE officials provided a document that contained no factors beyond the CACFP performance standards already found in federal regulations.

[23] The 2023 Legislature established some criteria in law on which MDE must evaluate applicant sponsors' eligibility (*Laws of Minnesota* 2023, chapter 55, art. 9, sec. 2, codified as *Minnesota Statutes* 2023, 124D.111, subd. 2a). These criteria primarily relate to the financial viability performance standard, and not to the administrative capability or program accountability performance standards.

MDE did not seek legislative changes or rulemaking authority to codify application review criteria after a 2017 decision by the Minnesota Court of Appeals encouraged it to do so.

In 2016, MDE denied another nonprofit organization's—Partners in Nutrition's—request to expand from being a sponsor of a single site to being a sponsor of multiple sites because MDE determined that it could not demonstrate its financial viability. After an MDE administrative appeal panel upheld the department's denial, Partners in Nutrition appealed MDE's decision to the Minnesota Court of Appeals.[24]

In July 2017, the Minnesota Court of Appeals ruled that MDE could not deny Partners in Nutrition's application on the basis of the financial-viability criteria it had imposed.[25] Specifically, the court held that the criteria MDE used to evaluate Partners in Nutrition's financial viability were not specified in the federal regulations and were inconsistent with U.S. Department of Agriculture (USDA) guidance.

The court also noted that MDE's financial-viability criteria had not been approved by USDA. However, even if the criteria had been approved by USDA, the court noted that they would have needed to be promulgated through the state rulemaking process.[26] More specifically, the court included the following footnote in its 2017 decision:

> MDE has not promulgated any administrative rules in relation to the CACFP. Although staffing levels is a topic for which promulgation appears necessary, both MDE and other stakeholders may benefit from rules governing MDE's application procedure generally.[27]

According to MDE officials, the department believes that it does not have rulemaking authority under state law. As a result, it did not attempt to adopt rules related to CACFP after the 2017 decision, nor did it request that the Legislature give it specific rulemaking authority. However, Minnesota statutes direct MDE to identify and propose needed legislative changes.[28] Given the federal requirement for application procedures, the urging by the Minnesota Court of Appeals to adopt rules for CACFP, and MDE's

[24] In early 2016, Partners in Nutrition appealed MDE's initial denial of its application to an MDE administrative appeal panel. That panel determined that MDE's initial denial resulted from not following federal regulations, failing to set specific financial viability criteria, using inconsistent methodology, confusingly communicating, and impermissibly using financial projections. The appeal panel directed MDE to reassess Partners in Nutrition's application. On this reassessment, MDE again denied Partners in Nutrition's application, on the basis that the organization did not submit sufficient financial viability documentation. Partners in Nutrition again appealed this to an MDE administrative appeal panel; in August 2016, this panel upheld MDE's denial. Partners in Nutrition then appealed to the Minnesota Court of Appeals.

[25] *Partners in Nutrition's Appeal of Disapproval of Site Expansion in the CACFP Program*, 904 N.W.2d 223, 232-234 (Minn. Ct. App. 2017). MDE did not appeal the case to the Minnesota Supreme Court and eventually approved the nonprofit organization's expansion.

[26] *Ibid.*, 232 (Minn. Ct. App. 2017).

[27] *Ibid.*, 231 n. 5 (Minn. Ct. App. 2017).

[28] *Minnesota Statutes* 2023, 127A.06, requires that MDE recommend to the Legislature and the governor legislation relating to the state system of education that would make its laws "more readily understood and more effective in execution."

obligation in state law to identify and propose needed legislation, we believe MDE should have raised this issue for a legislative fix before the start of the alleged fraud in 2020.

As we discuss in the following section, MDE had, at times, significant concerns about Feeding Our Future's ability to meet CACFP performance standards. However, because MDE had not proactively sought changes to state law, it was ill-prepared to address issues it later encountered with Feeding Our Future.

MDE Approved Applications Despite Concerns

As noted above, federal regulations state that MDE "should use its discretion in determining whether the [sponsor's] application, in conjunction with its past performance in CACFP," adequately demonstrates the sponsor's ability to meet the performance standards found in law.[29] Federal regulations also require MDE to deny a sponsor's application if it does not meet the standards.[30]

Requirement for Application Approval

The State agency must only approve the applications of those new and renewing sponsors that meet these performance standards, and must deny the applications of those new and renewing sponsors that do not meet the standards.

— 7 *CFR*, secs. 226.6(b)(1)(xviii) and (b)(2)(vii) (2023)

MDE approved Feeding Our Future's CACFP sponsor applications, even after the organization did not address the department's concerns.

MDE reviewed Feeding Our Future's annual CACFP sponsor applications and budgets, as required by federal law.[31] As Exhibit 3.1 shows, in most reviews, MDE raised concerns about Feeding Our Future's finances and staffing. MDE also raised concerns regarding the feasibility of Feeding Our Future's food service operations. These concerns related directly to the performance standards for CACFP sponsors (as outlined on page 21).

[29] 7 *CFR*, secs. 226.6(b)(1)(xviii) and (b)(2)(vii) (2023). Since SFSP did not have performance standards until 2023, this discussion focuses primarily on Feeding Our Future's CACFP applications, not SFSP applications.

[30] *Ibid*.

[31] 7 *CFR*, secs. 226.6(b) and 226.7(g) (2023). As we mentioned above, MDE must annually review sponsors' budgets to determine "the allowability, necessity, and reasonableness of all proposed expenditures," and to assess sponsors' capabilities to manage, expend, and account for program funds in compliance with regulatory requirements and federal guidance (7 *CFR*, sec. 226.6(f)(1)(iv) (2023)).

Exhibit 3.1

MDE raised numerous concerns nearly every time it reviewed Feeding Our Future's CACFP applications or budget revisions.

Despite its concerns, MDE approved each application or budget revision.

CACFP Program Year[a]	Type of Review	MDE's Concerns
2017[b]	Initial Application	• Inadequate financial resources (such as net assets and income) to meet financial viability performance criteria • Financial reports failed to meet generally accepted accounting principles • Board members' independence was undermined by their role as volunteer employees • Volunteer employees who were responsible for monitoring and administering CACFP also had full-time outside employment
2018	Annual Application	• Lack of financial or operational history to demonstrate financial viability (repeat concern)
2019	Annual Application	• No documented concerns
2019	Budget Revision[c]	• All 80 of Feeding Our Future's sites reportedly were preparing their own meals and snacks • Feeding Our Future's staff salaries were above average • Cash flow was insufficient to cover staff salaries and office space rental costs • Uncertainty about projected revenue from unnamed sites • Uncertainty about how administrative costs should be allocated given nonprogram revenue
2020	Annual Application	• Feeding Our Future's staff salaries were above average (repeat concern) • Lack of dedicated financial or accounting staff • Lack of information provided about compliance manager contract • Staff time allocated 100 percent to CACFP despite claims of nonprogram revenue • Lack of information on how the organization ensures CACFP funds are not spent on non-CACFP activities • Additional documentation and prior MDE approval needed before hiring two additional staff • Insufficient information about travel expenses • Higher-than-expected costs for training materials

Continued on the next page.

CACFP Program Year[a]	Type of Review	MDE's Concerns
2021	Annual Application	• Lack of dedicated financial or accounting staff (repeat concern) • Lack of information provided about compliance manager contract (repeat concern) • Projected income growth from sponsored sites was 176 percent • Large growth in meal claims for seven specific sites when compared to the previous program year • Lack of information about financial internal controls • Additional documentation and prior MDE approval needed before hiring 14 additional staff (repeat concern) • Inadequate justification for costs of office lease and office space expansion • Inadequate justification for some administrative expenses • Federal single audit not yet submitted
2021	Budget Revision[d]	• Larger number of sites than provided in application estimates
2022	Annual Application	• Unreasonable and noncompliant enrollment numbers for some CACFP sites • Uncertainties about site compliance with attendance, occupancy limit, Minnesota Department of Health food service licensing, and meal and snack service requirements • Lack of clarity about the location of some sites, including a proposed site already participating under another sponsor, and another site located at a private residence • Lack of clarity about the type of business (for profit or nonprofit) of some sites • Issues with forms for sites transferring between Feeding Our Future and other sponsors

[a] CACFP program years begin on October 1 and end on September 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2017 began on October 1, 2016, and ended on September 30, 2017.

[b] In April 2017, MDE denied Feeding Our Future's 2017 CACFP sponsor application because it did not meet CACFP performance standards. Feeding Our Future appealed the denial. In June 2017, after receiving additional information from Feeding Our Future and clarification from the Minnesota Court of Appeals about the financial-viability performance standard, MDE's appeal panel approved Feeding Our Future's 2017 program year application.

[c] USDA guidance indicates that sponsors can submit budget revisions at any time after their budget is approved, as sponsors are "prohibited from spending CACFP funds in accordance with [amended budgets] until the amendments have been reviewed and approved by the State agency" (U.S. Department of Agriculture, Food and Nutrition Service, *Guidance for Management Plans and Budgets, A Child and Adult Care Food Program Handbook* (Washington, DC, December 2013), 43). Feeding Our Future initiated the 2019 budget revision.

[d] MDE required Feeding Our Future to submit a revised budget when the department found the organization "seriously deficient" in its operation of CACFP in March 2021. We discuss MDE's administrative action against Feeding Our Future and the serious deficiency process more broadly in Chapter 5.

Source: Office of the Legislative Auditor, analysis of Minnesota Department of Education documents.

Given the number of concerns MDE had when it reviewed many of Feeding Our Future's CACFP sponsor applications or budget revisions, MDE was right to question whether Feeding Our Future met performance standards provided by federal regulations. However, Feeding Our Future did not always make changes in response to MDE's concerns or provide all the information MDE requested. In these cases, we think MDE should have denied Feeding Our Future's applications or budgets, or taken other administrative actions, as a way to require the organization's compliance with federal regulations.[32]

One of the applications we believe MDE could have denied—or used as a basis for serious deficiencies—was Feeding Our Future's sponsor application for the 2021 CACFP program year, which MDE approved in October 2020. As Exhibit 3.1 shows, MDE raised a number of concerns when reviewing the application, many of which pertained directly to the extent to which the organization met CACFP performance standards and budget requirements. For example, MDE noted that the organization's application did not adequately document financial internal controls, as required under federal regulations.[33] (Internal controls are the policies and procedures an organization implements to safeguard funds to minimize incidences of fraud, waste, and abuse, and ensure that it administers programs in compliance with applicable laws and rules.) Further, MDE found that the organization lacked dedicated financial or accounting staff—a repeat concern and one that we think is reasonable given the size of Feeding Our Future's operation.[34]

In its application review, MDE noted that this lack of financial staff undermined internal controls related to fiscal integrity and prevented a reasonable separation of duties for an organization of its size. In September 2020, MDE requested information on how Feeding Our Future managed its finances and internal controls. Feeding Our Future did not provide this information to MDE. MDE approved Feeding Our Future's 2021 CACFP application anyway.

We asked MDE officials why the department approved some of Feeding Our Future's applications despite the organization's failure to respond to MDE's concerns. MDE repeatedly highlighted a lack of detail in federal law concerning CACFP program requirements, a lack of USDA guidance and support for MDE actions, and its own lack of rulemaking authority under Minnesota law. Additionally, MDE officials told us that the department thought Feeding Our Future would challenge the legality of its application review in court if it denied any of the organization's sponsorship applications.[35]

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[32] While MDE approved all of Feeding Our Future's budgets, it did deny budget items related to a contract for a compliance manager in program years 2020 and 2021.

[33] 7 *CFR*, secs. 226.6(b)(1)(xviii)(C)(2) and (b)(2)(vii)(C)(2) (2020).

[34] In the 2020 CACFP program year (October 2019 through September 2020), Feeding Our Future served roughly 2.6 million CACFP meals and snacks at 105 sites and managed roughly $5.3 million in reimbursements. In addition, from June 2020 through September 2020, Feeding Our Future served 2.4 million SFSP meals and snacks at 33 SFSP sites worth $7.2 million in reimbursements. Feeding Our Future estimated in its 2021 CACFP program year application that it would serve nearly 7.2 million CACFP meals and snacks at 138 sites worth $15.6 million in reimbursements.

[35] As we describe in Appendix B, Feeding Our Future sued MDE in Ramsey County District Court in November 2020 alleging, among other things, that the department delayed its approval of the organization's site applications beyond time limits found in federal law. In 2021, Feeding Our Future twice appealed MDE's denials of its site applications to the Minnesota Court of Appeals, claiming that MDE's site application review was arbitrary, capricious, and in one of its two appeals, sometimes based upon misrepresentations made by MDE.

A lack of detail in federal law or USDA guidance does not relieve MDE of its legal duty to deny a sponsor's application if it believes the sponsor cannot meet CACFP performance standards.[36] As we explain in Chapter 5, MDE declared Feeding Our Future seriously deficient in March 2021 for failing to meet all three CACFP performance standards. MDE based its determination on Feeding Our Future's lack of financial or accounting staff and several other concerns it raised about Feeding Our Future's operations when it reviewed the organization's 2021 CACFP application in the fall of 2020. It is difficult to understand how concerns serious enough to prompt administrative action in March 2021 were not serious enough to justify denying the organization's CACFP application (or initiating a more timely serious deficiency process) in the fall of 2020.[37]

Finally, had MDE pursued state-specific "additional requirements" permitted under federal regulations, MDE could have strengthened its ability to hold Feeding Our Future to program requirements and protect the integrity of the program.[38] If MDE truly believed it could not defend a denial of Feeding Our Future's CACFP application in court, it should have taken steps to clarify its interpretation of CACFP performance standards in state law, as we discussed above.

Lack of Application Verification

Federal regulations provide several ways MDE can verify information sponsors submit in their applications and ensure renewing sponsors continue to meet program requirements.[39] For example, regulations require MDE to conduct preapproval visits of certain CACFP and SFSP sponsor applicants to (1) verify the accuracy of the information provided in their applications and (2) assess applicants' ability to manage their nutrition programs.[40] As another example, federal regulations require participating

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[36] 7 *CFR*, secs. 226.6(b)(1)(xviii) and (b)(2)(vii) (2023).

[37] Federal regulations and USDA guidance highlight application renewal as a time at which state agencies can find sponsors seriously deficient, including for failure to meet the performance standards found in law (7 *CFR*, sec. 226.6(c)(2)(i) (2023)); and U.S. Department of Agriculture, Food and Nutrition Service, *Serious Deficiency, Suspension, & Appeals for State Agencies & Sponsoring Organizations, A Child and Adult Care Food Program Handbook* (Washington, DC, February 2015), 10-11).

[38] Federal regulations permit states to impose additional participation requirements for CACFP, as long as they are not inconsistent with federal regulations and are approved by USDA (7 *CFR*, sec. 226.25(b) (2023)). Further, federal guidance for CACFP states that "State agencies may not deny an application, disallow meals that are otherwise reimbursable, assess an overclaim, declare a sponsor seriously deficient, or terminate a sponsor based solely on the violation of an additional State agency requirement. Instead, such a violation may result in a finding, whereby the State agency may require corrective action." (U.S. Department of Agriculture, Food and Nutrition Service, Memorandum CACFP 09-2013, *Additional State Agency Requirements in the Child and Adult Care Food Program* (Washington, DC, March 2013), 2.)

[39] As stated earlier in this chapter, federal regulations direct MDE to consider CACFP sponsor applicants' past performance in the program, "in conjunction with" its application, when determining if a sponsor meets performance standards (7 *CFR*, secs. 226.6(b)(1)(xviii) and (b)(2)(vii) (2023)). For SFSP sponsor applicants, federal regulations require MDE to consider applicants' past performance in *all* federal child nutrition programs when assessing their ability to meet SFSP performance standards (7 *CFR*, sec. 225.6(d) (2023)). The Minnesota Court of Appeals recently affirmed MDE's authority to consider a CACFP sponsor applicant's past performance in SFSP when assessing its ability to meet CACFP performance standards (*Re: Youth Leadership Academy dba Gar Gaar Family Services Appeal of Denial of Application for the Child and Adult Care Food Program (CACFP*), A22-0378 (Minn. Ct. App. 2023)).

[40] 7 *CFR*, secs. 225.7(d) and 226.6(b)(1) (2023).

sponsors to maintain records demonstrating their compliance with federal regulations, including documentation of meals and snacks served.[41] Federal regulations require sponsors to make these records available to MDE upon request.[42]

MDE did not always take steps to verify statements made by Feeding Our Future prior to approving its CACFP sponsor applications.

At times, MDE took steps to verify assertions Feeding Our Future made in application materials. For example, MDE questioned the organization's financial viability when reviewing its 2017 CACFP sponsorship application. MDE initially denied the application, in part because Feeding Our Future's application materials did not demonstrate that it had adequate financial resources to operate CACFP on a daily basis. After Feeding Our Future appealed MDE's decision and continued to insist that it was financially viable, MDE required the organization to submit additional financial documentation as a condition of approving its application for the 2018 CACFP program year.

However, in subsequent years, MDE did not always verify information Feeding Our Future submitted in its annual applications. We think such steps would have been appropriate in the context of Feeding Our Future's dramatic growth, and, as we discuss later in this chapter, documented weaknesses in the organization's operations.[43]

For example, during its review of Feeding Our Future's revised budget for the 2019 CACFP program year, MDE noted that Feeding Our Future did not have catering contracts in its budget for any of its 80 proposed sites. In effect, Feeding Our Future was claiming that all 80 of its sites had the food preparation equipment, available space, physical layout, and trained staff necessary to prepare meals and snacks that met complex program requirements, including those related to meal and snack portions, nutrition, preparation, and food safety. During the previous CACFP program year (the organization's first year in operation), six of Feeding Our Future's sites received reimbursements. Only two of these sites prepared food onsite. Despite the authority to do so, MDE did not request documentation that could have confirmed whether or not these 80 proposed sites had the ability to prepare food onsite, nor did it visit a selection of sites to assess the reasonableness of Feeding Our Future's claim.

[41] 7 *CFR*, secs. 225.15(c)(1); 226.10(d); and 226.15(e) (2023).

[42] 7 *CFR*, secs. 225.15(c)(1) and 226.10(d) (2023). MDE's CACFP and SFSP sponsor applications also require sponsors to certify their understanding that USDA and MDE may verify the information they provided in sponsor applications and related supporting documentation.

[43] This issue is not unique to MDE. In 2018, USDA's Office of Inspector General found that the California Department of Education did not adequately or independently verify some sponsor-provided application information, including information related to sponsors' eligibility and financial management and accountability (U.S. Department of Agriculture, Office of Inspector General, *California's Controls Over Summer Food Service Program*, Audit Report 27004-0001-41 (Washington, DC, November 2018), 5-7). Similarly, in 2019, USDA's Office of Inspector General found that Florida's Department of Agriculture and Consumer Services approved sponsors' site applications without first confirming whether sponsors performed corrective actions proposed during the application review process (U.S. Department of Agriculture, Office of Inspector General, *Florida's Controls Over Summer Food Service Program*, Audit Report 27004-0001-31 (Washington, DC, August 2019), 7-9).

As another example, during its review of Feeding Our Future's 2021 CACFP application, MDE raised concerns about the organization's projected growth, among other things. MDE requested additional information about the growth of seven specific sites.[44] (For one of the seven sites, MDE asked Feeding Our Future to explain how the site had the capacity to serve "a comparable number of meals" as "the entire St. Paul Public School District provides" through federal nutrition programs.[45]) Even after Feeding Our Future did not provide justification for these sites' significant growth, MDE did not visit the sites virtually or in person to observe CACFP meal and snack service.[46] MDE also did not request documentation—such as attendance, meal and snack counts, or food preparation records—to determine if these rapidly growing sites were in compliance with CACFP regulations.

Despite inaccuracies in Feeding Our Future's initial SFSP sponsorship application, and MDE's concerns about its participation in CACFP, MDE approved the organization as a sponsor in SFSP.

Feeding Our Future first applied to be an SFSP sponsor in the spring of 2020. According to MDE application review documentation, the organization planned to begin operations with 9 sites and then expand to 15 sites during the remainder of the program year. After reviewing the organization's application, MDE conducted a virtual preapproval visit in June 2020 of Feeding Our Future's headquarters.

MDE's preapproval visit produced "action items" related to all nine of Feeding Our Future's initial SFSP sites. MDE found that Feeding Our Future's application, as originally submitted, failed to accurately describe meal and snack service (such as which meals and snacks the sites would serve, meal and snack service times, and how the sites would serve meals and snacks) at eight sites. MDE also requested that Feeding Our Future provide new or updated meal vendor contracts for eight of its sites.

Feeding Our Future was generally responsive to MDE's requests to fix these errors. For example, Feeding Our Future corrected the catering contracts for its proposed sites and updated site documentation so that they indicated that the sites would be receiving meals and snacks from a vendor rather than preparing food onsite. However, given Feeding Our Future's lack of responsiveness to MDE's concerns with its CACFP operations, we expected MDE to have conducted more preapproval visits of Feeding Our Future's SFSP sites, in addition to its virtual visit of Feeding Our Future's headquarters. MDE visited only 2 of the 18 sites that received reimbursements during the first three months of the organization's SFSP operations. MDE observed meal service at only one of the two sites, and both visits were scheduled in advance and conducted virtually.

MDE approved Feeding Our Future's SFSP application for the 2021 program year in June 2020.

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[44] As of May 2024, the U.S. Department of Justice had named four of these seven sites in the charging documents related to the alleged fraud. See Chapter 2 for more information.

[45] CACFP Financial Analyst, Minnesota Department of Education, letter to Executive Director, Feeding Our Future, *RE: FY21 Budget Review for Child and Adult Care Food Program (CACFP)*, September 28, 2020.

[46] MDE conducted virtual visits of two of the seven sites for SFSP in August 2020, prior to its September 2020 review of Feeding Our Future's 2021 CACFP program year application.

MDE originally denied Feeding Our Future's SFSP application for the 2022 program year, but then approved the application without having complete information.

According to federal regulations, MDE may not approve an SFSP application for a sponsor who has been deemed to have serious deficiencies in its operation of a federal nutrition program.[47] As we discuss further in Chapter 5, MDE found Feeding Our Future seriously deficient in its administration of CACFP between January 15, 2021, and June 4, 2021, and in its administration of SFSP between January 15, 2021, and May 13, 2021. As a result, when MDE received Feeding Our Future's SFSP sponsorship application for the upcoming 2022 program year in the spring of 2021, it denied the application as required by federal regulations.[48] However, after MDE determined on June 4, 2021, that Feeding Our Future had corrected the deficiencies, MDE approved Feeding Our Future's SFSP application.

MDE officials told us that the department approved Feeding Our Future's 2022 SFSP program year application based, in part, on the actions the organization took to correct the serious deficiencies. However, as we discuss in greater detail in Chapter 5, we found MDE's assessment of these corrective actions to be inadequate. As a result, weaknesses in MDE's assessment of Feeding Our Future's corrective actions became weaknesses in MDE's evaluation of Feeding Our Future's 2022 SFSP program year application.

Additionally, the fact that MDE initiated a serious deficiency process in early 2021 with Feeding Our Future indicates that the organization had experienced operational problems prior to the 2022 SFSP program year. As permitted by law, this should have prompted MDE to conduct preapproval visits of Feeding Our Future and/or some of its sites to confirm the accuracy of its 2022 SFSP application and assess the organization's ability to successfully operate SFSP.[49] However, MDE did not conduct any preapproval visits before approving Feeding Our Future's application in June 2021.

Further, as we discuss later in this chapter, MDE initiated, but did not complete, an SFSP administrative review of Feeding Our Future in August 2020. Given the decisions to pause its administrative review and not to conduct preapproval visits, MDE approved Feeding Our Future's application without having a full understanding of the performance and compliance of the organization's summer food service program.

[47] 7 *CFR*, secs. 225.6(b)(9) and 225.11(c) (2021).

[48] *Ibid*.

[49] 7 *CFR*, sec. 225.7(d)(1) (2021). From August 31, 2020, to June 30, 2021, USDA waived requirements related to preapproval visits of SFSP sponsors due to the COVID-19 pandemic. However, this waiver did not prohibit MDE from conducting preapproval visits. (U.S. Department of Agriculture, Food and Nutrition Service, COVID-19: Child Nutrition Response #57, *Nationwide Waiver to Allow Reimbursement for Meals Served Prior to Notification of Approval and Provide Flexibility for Pre-Approval Visits in the Summer Food Service Program*, September 11, 2020; extended by U.S. Department of Agriculture, Food and Nutrition Service, COVID-19: Child Nutrition Response #69, *Nationwide Waiver to Allow Reimbursement for Meals Served Prior to Notification of Approval and Provide Flexibility for Pre-Approval Visits in the Summer Food Service Program-EXTENSION*, October 9, 2020.)

Recommendations

As outlined in Exhibit 3.1, MDE had concerns about nearly all of Feeding Our Future's sponsor applications and budget revisions. While Feeding Our Future was responsive to some of MDE's concerns, it ignored others and continued to operate.

Although our findings focused on MDE's approval of Feeding Our Future's applications, the issues we identified raise broader concerns about the rigor of MDE's application approval process. We think MDE needs to make improvements to this process, aided by legislative changes.

RECOMMENDATION

The Legislature should either establish criteria in statute or give MDE the authority to conduct rulemaking to establish criteria that the department must consider when determining whether to approve organizations for CACFP or SFSP.

To ensure program effectiveness and integrity, MDE's reviews of sponsor applications must include a substantive assessment of organizations' ability to meet program performance standards. Such an assessment must be based on clearly defined program standards and authority. We think MDE—and CACFP and SFSP sponsors and sites—would benefit from application criteria specified in state law.

MDE officials told us that they believe the department's current application review process includes a substantive assessment of sponsors' compliance with performance standards. However, as previously noted above, MDE officials also told us that they believed they lacked legal justification to deny Feeding Our Future's applications. We question the adequacy of an application review process that included a substantive assessment of Feeding Our Future's performance, but also deprived MDE of the legal grounds to act on its assessment and deny the organization's application. As a result, when working with the Legislature to develop criteria in law—or when writing administrative rules—MDE should reevaluate its application review policies and consider what changes may be needed so that its application process *requires*, rather than *encourages*, sponsors' compliance with performance standards.

As MDE and the Legislature work to identify requirements that should be established in law, they should remember that state requirements for CACFP and SFSP (1) must receive USDA approval; and (2) cannot be the *sole basis* upon which MDE takes an adverse action, such as denying an application.[50] Rather than seeking to create new program requirements that are substantively distinct from federal law, the Legislature and MDE should focus their efforts on using state statutes and rules to interpret, clarify, and implement existing federal CACFP and SFSP regulations.

[50] 7 *CFR*, secs. 225.18(f) and 226.25(b) (2023); U.S. Department of Agriculture, Food and Nutrition Service, Memorandum CACFP 09-2013, *Additional State Agency Requirements in the Child and Adult Care Food Program* (Washington, DC, March 2013), 2; and U.S. Department of Agriculture, Food and Nutrition Service, Memorandum SFSP 06-2013 - REVISED, *Additional State Agency Requirements in the Summer Food Service Program* (Washington, DC, January 2013), 2.

RECOMMENDATION

MDE should take additional steps to verify information provided in support of sponsorship applications submitted by high-risk applicants.

In addition to required preapproval visits, MDE should take additional steps—such as conducting desk audits or visits of sites, food preparation facilities, and vendors—to verify statements and documents provided in support of certain sponsor applications. Such activities should be based on an applicant's risk of noncompliance, so that sponsors exhibiting rapid growth or those with a history of operational issues, for example, receive greater scrutiny. And, if the information an organization supplies in its application seems implausible, unusual, or unexpected relative to its past performance in the program, MDE should investigate the irregularity, as required by law.[51] On the other hand, when sponsors are smaller in size and have long histories of program compliance, it may be more appropriate for MDE to rely on unverified application documentation when determining whether to approve or disapprove sponsor applications.

Administrative Reviews

By law, MDE is responsible for helping sponsors comply with CACFP and SFSP regulations.[52] One way in which MDE does this is through administrative reviews. As Exhibit 3.2 shows, federal regulations establish requirements for the frequency and content of administrative reviews of sponsors and sites in both CACFP and SFSP.[53]

Federal regulations also specify how MDE should select sponsors and sites for inclusion in its reviews.[54] Further, USDA provides guidance to state agencies on how they should prioritize their review efforts. For example, USDA encourages, but does not require, state agencies to select CACFP and SFSP sponsors and sites for review based on risk.[55]

[51] Federal regulations require MDE to promptly investigate any "irregularities" it discovers in connection with CACFP and SFSP operations and "take appropriate action to correct any irregularities" (7 *CFR*, secs. 225.11(b) and 226.6(n) (2023)). We discuss MDE's investigations of alleged irregularities in Feeding Our Future's operations in Chapter 4.

[52] 7 *CFR*, secs. 225.6(a)(1); 225.7(a) and (e); and 226.6(a) and (m) (2023).

[53] As described in Exhibit 3.2, MDE must conduct administrative reviews of CACFP independent centers as well as sponsors and a percentage of sponsored sites. Independent centers are not sponsored and can be child-care centers, afterschool or outside-school-hours care centers, emergency shelters, and adult day care centers. Like CACFP sponsors, they enter into an agreement with MDE to assume administrative and financial responsibility for CACFP operations.

[54] 7 *CFR*, secs. 225.7(e)(2) and (e)(5); and 226.6(m)(2) and (m)(6) (2023).

[55] Several risk factors mentioned in USDA guidance are especially relevant to Feeding Our Future: (1) sponsor size; (2) sponsors and sites with high meal claims compared with the other sponsors and sites in the state; (3) sponsors with many sites; and (4) sites claiming more than 90 percent attendance every month. (U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 9-10; and U.S. Department of Agriculture, *Summer Food Service Program State Agency Monitor Guide* (Washington, DC, February 2017), 13).

Exhibit 3.2

Federal regulations provide requirements related to the number, frequency, and content of administrative reviews of CACFP and SFSP sponsors and sites.

Requirement Type	Requirement
Minimum Number of Reviews	MDE must review: • At least 33.3 percent of all CACFP sponsors and independent centers annually. At least 15 percent of the total number of CACFP site reviews must be unannounced. • The number of SFSP sponsors whose program reimbursements, in aggregate, accounted for at least one-half of total SFSP reimbursements in the prior year. Reviews of CACFP sponsors with 100 sites or less must include 10 percent of the sponsor's sites; reviews of CACFP sponsors with more than 100 sites must include 5 percent of the first 1,000 sites and 2.5 percent of sites in excess of 1,000. Reviews of SFSP sponsors with 10 or more sites must include at least 10 percent of the sponsor's sites; reviews of SFSP sponsors with fewer than 10 sites must include at least 1 site.
Review Frequency and Timing	New CACFP sponsors with 5 or more sites must be reviewed within 90 days of the beginning of program operations. Ongoing/renewing CACFP sponsors with 1 to 100 sites must be reviewed at least once every three years, and CACFP sponsors with more than 100 sites must be reviewed at least once every two years. New SFSP sponsors must be reviewed during their first year of operation. Ongoing/renewing SFSP sponsors must be reviewed at least once every three years and the year after any significant operational problems occur.
Review Priorities	When choosing CACFP sponsors for review, MDE must target for more frequent review sponsors whose prior review included a finding of serious deficiency. When choosing SFSP sponsors and sites to review, MDE must, at a minimum, consider the sponsors' and sites' previous participation in the program, current and previous SFSP performance, and the results of previous reviews. MDE must develop criteria for SFSP site selection that allow it to meet the minimum number of site reviews required by SFSP regulations.[a] MDE must select sites that reflect the sponsor's entire population of sites and consider characteristics such as the: • Maximum number of meals the sites are approved to serve. • Methods of food preparation. • Time since MDE's last site review. • Type of site and its physical location.[a] MDE may consider additional criteria when selecting SFSP sites to review, including recommendations from the sponsor or potential errors or large changes in meal counts.[a] Federal guidance for CACFP and SFSP encourages state agencies to develop risk factors to identify high-risk sponsors or sites that should be prioritized for onsite review. Recommended high-risk factors include: • CACFP and SFSP sponsors or sites with high numbers of meal claims compared to other sponsors or sites. • CACFP and SFSP sponsors with many sites, larger sites, or a large number of participating children. • CACFP sponsors or sites claiming more than 90 percent attendance each month. • CACFP sites with an average daily participation greater than enrollment. • CACFP sponsors or sites claiming more than two meals and one snack or one meal and two snacks for each participant each day.

Continued on the next page.

Exhibit 3.2 (continued)

Requirement Type	Requirement
Review Content	MDE must review **CACFP** sponsors': • Financial management, including administrative and operational costs, program and nonprogram income, accounting systems, accuracy of claims processing and reimbursements for claimed meals and snacks, and required audits. • Monitoring of sites, including whether they have adequate numbers of monitoring staff, how frequently they have conducted site reviews, and whether they have a system to verify enrollment and attendance at their sites. • Training records; records retention policies; and procurement and contracts with food vendors, food service management companies, and administrative services providers. MDE must review **SFSP** sponsors': • Expenditures, including whether spending is allowable, consistent with budgeted costs, compliant with USDA guidance, and comparable to the previous year's expenditures. • Administrative spending, including its reasonableness and whether it interferes with quality meal service. • Food service revenues and net cash resources. Related to site operations, MDE must:[b] • Confirm the accuracy of five days of **CACFP** meal and snack counts in comparison to attendance and/or enrollment records. • Validate **SFSP** meal claims and determine rate of meal claim errors by reconciling daily meal and snack counts, requests for reimbursements, and food delivery receipts for a sample of sponsored sites.[a] • Verify eligibility for free and reduced-price **CACFP** meals. • Review **CACFP** site staff training records and meal production and service records, including menus, nutritional labels, and meal and snack service times. • Ensure **CACFP** sites have active child-care licenses, food production permits, and health inspection reports, when relevant.

[a] During Feeding Our Future's participation in SFSP, this requirement was not included in federal regulations; see 7 *CFR*, sec. 225.7(d)(2) (2020).

[b] Federal regulations do not explicitly require MDE to include meal service observations during administrative reviews of sponsors. However, USDA guidance handbooks recommend that MDE staff observe meal service at sponsored sites during their administrative reviews.

Source: Office of the Legislative Auditor, summary of 7 *CFR*, secs. 225.7(e) and 226.6(m) (2023); U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014); and U.S. Department of Agriculture, *Summer Food Service Program State Agency Monitor Guide* (Washington, DC, February 2017).

When MDE discovers noncompliance during an administrative review, federal regulations require sponsors to take corrective action to resolve the noncompliance.[56] SFSP regulations require, and USDA's guidance for CACFP recommends, that MDE conduct follow-up reviews to ensure that sponsors' and sites' planned corrective actions were actually implemented.[57] As we discuss further in Chapter 5, repeat or flagrant instances of noncompliance discovered during administrative reviews may result in a sponsor being designated as seriously deficient and subject to termination from CACFP or SFSP participation.

MDE's only administrative review of Feeding Our Future's CACFP operations—conducted in 2018—resulted in serious findings that required follow-up, but MDE never conducted a follow-up review.

MDE conducted an administrative review of Feeding Our Future in December 2018, roughly four months after the organization made its first meal claims in August 2018.[58] The review included onsite visits of 4 of the organization's 23 sites and resulted in 22 findings across 11 of the 13 areas included in the review. The review's analysis of meal claims, enrollment, attendance, and meal production and service records focused on October 2018.[59] Select MDE findings are presented in Exhibit 3.3. MDE documents indicate that it considered all 11 review areas with findings as candidates for a possible follow-up review.

Many of the findings in Exhibit 3.3 are related to issues that increase the risk of fraud. For example, MDE found that one or more of the four sites included in the review had failed to collect child enrollment information, incorrectly inflated average daily attendance, claimed unallowable food service expenses, improperly observed or counted meals and snacks at the time of meal service, and/or failed to include the amount of food prepared or number of meals delivered in meal preparation reports.

In addition to the findings at Feeding Our Future's sites, several other findings indicated deficiencies in the ability of the organization to manage its CACFP program. For example, Feeding Our Future's site monitoring forms revealed that it had (1) failed to follow up on findings from its site visits to ensure that sites took corrective action and (2) improperly verified (or failed to document its verification of) meal claims from

[56] 7 CFR, secs. 225.7(k); 225.11(f)(1); and 226.6(m)(3)(iv) and (o) (2023); and U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 46, 56.

[57] 7 *CFR*, secs. 225.7(k) and 225.11(f)(1) (2023). Unlike SFSP regulations, CACFP regulations do not explicitly require MDE to conduct follow-up reviews, but CACFP regulations reference "follow-up efforts" in the same section as it discusses administrative reviews and corrective actions (7 CFR, sec. 226.6(m) (2023)). USDA guidance documents provide best practices for MDE's follow-up reviews: U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 57; and U.S. Department of Agriculture, *Summer Food Service Program State Agency Monitor Guide* (Washington, DC, February 2017), 58, 65.

[58] Federal regulations required MDE to review new sponsors of five or more sites within the first 90 days of operations (7 *CFR*, sec. 226(m)(6)(iii) (2018)). Three Feeding Our Future sites received reimbursement for claimed meals and snacks in August 2018, and six Feeding Our Future sites received reimbursement for claimed meals and snacks in September 2018.

[59] MDE's administrative review also included menus from December 2018.

those sites. At a more general level, MDE found that Feeding Our Future had outdated management policies that failed to specify how it conducted routine checks of submitted claims, handled meal disallowances and overclaims, notified sites of noncompliance, or evaluated sites' corrective action plans.

Exhibit 3.3

MDE found deficiencies in many areas of Feeding Our Future's CACFP operations in 2018.

Program Area	Findings and Observations

Food Quantity and Production
MDE ensures that meal production records document what food was prepared and how many meals and snacks were produced.
	• Records failed to fully document food items prepared and portions served.
	  o Meal production reports did not include amount of food prepared and/or number of meals delivered (2 sites).
	  o Meal production records did not match dated menu (1 site).
	  o Portion menu not posted in serving area (1 site).
	  o Child Nutrition labels or Product Formulation Statements were not on file to demonstrate how commercially prepared foods credit toward the meal pattern (at least 1 site).[a]
	• Snack that failed to meet nutritional requirements claimed (1 site).

Meal Service Observation MDE observes meal service to ensure service meets federal regulations, including meal pattern requirements and whether meal and snack counts are accurately taken at the time of meal service.	• Special diet documentation did not meet program requirements (1 site). • Fluid milk meal pattern requirements not met (2 sites).[a] • Minimum portion size of fruit and grain not served (1 site). • Breakfast and snack counts not recorded at time of meal service (1 site). • Site staff did not monitor food items taken and declined by children during meal service (1 site). • Food that did not meet infant meal pattern found in infant room refrigerator (1 site).[a] • Infant meal pattern not posted in food preparation area at infant room (1 site).[a]
Menus MDE ensures menus meet meal pattern requirements.[a]	• Milk fat content not documented (4 sites). • Labels and receipts did not document whole-grain-rich food items (1 site). • Breakfast menu substitutions not recorded (1 site).

Supporting Documents and Training
MDE reviews sponsor and site training records to ensure the sponsor conducted and documented required training.
	• Adequate CACFP site staff training documentation was not maintained (3 sites).
	  o Lack of documentation of required site staff training (1 site).
	  o Training records did not include date of training (2 sites).

Multisite Sponsor Management Plan MDE ensures that sponsor's management plan reflects current operations and promotes compliance with the performance standards found in federal law.	• The management plan did not reflect current program operations. • The plan stated there are no paid employees when sponsor had paid employees at the time of review. • Fiscal accountability training for Board of Directors not documented. • Lack of detail about how administrative funds are separated from reimbursements. • No policy regarding sponsor review and approval of site meal claims. • Lack of written procedures related to sponsor monitoring of sites. Missing or incomplete elements included conducting preapproval visits, issuing written findings to sites, reviewing sites' corrective actions, and making claim reductions or disallowances.

Continued on the next page.

Program Area	Findings and Observations

Multisite Monitoring
MDE ensures that the sponsor is monitoring sites in compliance with requirements of federal law.
	• Sponsor's monitoring visits of its sites did not meet program requirements.
	  o Meal counts from day of visit were improperly compared to counts from the previous five days of meal counts (1 site).
	  o Five-day meal count reconciliation not documented (1 site).
	  o Sponsor did not follow up on previous findings of noncompliance found at site (1 site).
	• Agreements between Feeding Our Future and sites were not complete due to missing signature dates (16 sites).
	• Sponsor did not check the names of board members at nonprofit sites to make sure they were not on a list maintained by the federal government of individuals and entities disqualified from participating in child nutrition programs (all nonprofit sites).

Child Enrollment Forms MDE checks that sponsor annually collected enrollment forms and forms are accurately completed. Forms establish children's normal days and hours of attendance, and types of meals received.	• Enrollment information not collected (1 site).

Attendance and Meal Claim Verification
MDE ensures that sites accurately record attendance and count meals and/or snacks.
	• Average daily attendance overreported (2 sites).
	  o Total attendance overcounted (2 sites).
	  o Number of days in operation undercounted (1 site).
	  o Inconsistent method of counting meals across classrooms (1 site).
	• Meal and snack counts were used to generate attendance instead of counting attendance and meal counts separately (1 site).

Fiscal Integrity
MDE reviews sponsor's financial records and management policies to ensure all funds are properly received, held, and dispersed. Includes ensuring that program funds only pay for allowable costs and that the sponsor's processes for approving meal claims and paying reimbursements are accurate and timely.
	• Unallowable food service expenses were reported as CACFP expenses (2 sites).
	  o Food that did not meet program nutritional requirements misreported as allowable program expense (1 site).
	  o Expenses for food served to adults and children not participating in the program misreported as allowable program expense (1 site).
	• Site prepares food onsite for children at site and is a food vendor for another child-care center without adequate accounting systems to separate the costs of vended meal operations from the site's CACFP program operations (1 site).

Procurement MDE reviews procurement documentation to ensure sponsor and site procurement processes meet federal regulations.	• Site used "micro purchasing" procedures, but only purchased from one vendor (1 site). • Vendor used by site not included in required price comparisons (1 site).
Civil Rights MDE ensures sponsor complies with civil rights laws and regulations, including those related to race, color, national origin, sex, and disability.	• Nondiscrimination statement was not included in CACFP parent handbook (2 sites).

Continued on the next page.

Exhibit 3.3 (Continued)

Program Area	Findings and Observations
Household Income Statements (HIS) MDE checks that the sponsor collected HIS forms and forms are accurately completed. HIS forms are used to determine eligibility of children for participation and rate of reimbursement.	• Improper use of parent signature date resulted in incorrect date of when meals were eligible for reimbursement in the program (1 site). • Parent signature date missing (at least 1 site). • Level of reimbursement incorrectly assigned (3 sites).
For-Profit Program MDE ensures at least 25 percent of children at sites are eligible under federal regulations for free or reduced-price meals.	• Incorrect calculation of percentage of children eligible for free or reduced-price lunch, but site still eligible under corrected percentage (1 site).

[a] A meal pattern includes the individual food items, portion sizes, and nutritional content of meals and snacks.

Source: Office of the Legislative Auditor, summary of Minnesota Department of Education documents.

In response to MDE's findings and technical assistance, Feeding Our Future drafted a detailed corrective action plan that consisted primarily of (1) promising to update Feeding Our Future's policies and procedures; (2) additional documentation supporting site claims and program-related procurements; and (3) retraining sponsor, site, and vendor staff, including, for some trainings, documentation of the staff who attended the training, the location of the training, and the date the training was conducted.

Federal CACFP regulations establish few specific requirements for MDE's administrative review follow-up activities, but USDA guidance states that follow-up reviews may be conducted any time corrective action is required.[60] Guidance further states that the purpose of a follow-up review is to determine whether the sponsor has completely corrected review findings according to its approved corrective action plan. In addition, the guidance explains that for reviews that initially uncovered only minor findings, "if any of the initial findings still remain…the State agency should make a determination on whether additional corrective actions will suffice or whether to declare the sponsor seriously deficient."[61] Guidance also recommends that follow-up reviews should be unannounced and should occur after the state agency accepts the sponsor's corrective action plan. In addition, the guidance indicates that reviews can be conducted offsite with a "desk review," or in some cases onsite, depending upon the need to directly observe that corrective action has been implemented.[62]

[60] 7 *CFR*, sec. 226.6(m) (2023); and U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 57. Federal regulations provide more specific requirements for MDE follow-up efforts when it finds deficiencies in sponsors' decisions concerning children's eligibility for free or reduced-price lunch (7 *CFR*, sec. 226.23(h) (2019)). Similarly, federal regulations require MDE to conduct follow-up if it has reason to believe that a sponsor or its principals were determined ineligible to participate in a non-CACFP publicly funded program due to violations of program requirements (7 *CFR*, secs. 226.6(b)(1)(xiii)(C) and (b)(2)(iii)(C) (2023)).

[61] U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies: A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 57.

[62] *Ibid*.

MDE staff indicated that all of its findings that required corrective action from its 2018 administrative review of Feeding Our Future warranted follow-up. While many of MDE's findings could be reviewed offsite, others (such as findings related to attendance verification, meal service, and food preparation recordkeeping) would be best reviewed onsite as meal service or food preparation was occurring. As a result, we expected to see evidence of both follow-up desk reviews and unannounced onsite observations to ensure that Feeding Our Future staff, and the staff at its sponsored sites, were fully implementing the organization's updated procedures and applying the training they received as part of Feeding Our Future's corrective action plan.

Contrary to federal guidance and the department's statement to Feeding Our Future, MDE did not conduct any follow-up review activity of the organization beyond asking questions and providing technical assistance and training.[63] When we asked why it did not conduct a follow-up review to ensure that Feeding Our Future's corrective action plan was being fully implemented, MDE told us that "The follow-up review was scheduled for 2020 but did not happen due to the COVID-19 pandemic…we could have done a desk review but wanted to do the full review so we paused until the pandemic was over."[64]

MDE started, but did not complete, an administrative review of Feeding Our Future's SFSP operations.

Similar to CACFP, federal regulations require state agencies to conduct a review of SFSP sponsors at least once during their first year of operation.[65] Accordingly, after MDE signed its SFSP program agreement with Feeding Our Future in June 2020, MDE initiated an SFSP administrative review in August 2020.[66] In October 2020, MDE conducted virtual site visits using the live video functionality of Feeding Our Future's executive director's phone. However, MDE paused the administrative review in October 2020 because, according to MDE staff, their virtual site visits "were not working."[67]

We question MDE's decision to pause its SFSP administrative review for several reasons. First, MDE had not conducted the follow-up reviews necessary to ensure that Feeding Our Future had corrected the deficiencies the department identified in its December 2018 CACFP administrative review. Second, MDE's June 2020 SFSP preapproval visit of Feeding Our Future resulted in a considerable number of "action items." Third, in the four months that Feeding Our Future's SFSP program had been in operation, it had already claimed large numbers of SFSP meals and snacks. Specifically, from June 2020

[63] In February 2019, MDE told Feeding Our Future that it would conduct a follow-up review within the next six to nine months (August to November 2019).

[64] Minnesota Department of Education, written response to Office of the Legislative Auditor questions, June 2, 2023. MDE clarified that visits of Feeding Our Future and its CACFP sites were scheduled for October through December 2020. As we discuss in more detail in the next section, MDE chose not to conduct these visits; applicable waivers in effect at the time did not prohibit MDE from conducting site visits.

[65] 7 *CFR*, sec. 225.7(e)(4)(i) (2023).

[66] As stated above, MDE conducted announced virtual site visits of two Feeding Our Future sites in August 2020. Neither of these visits were part of MDE's paused SFSP administrative review.

[67] Minnesota Department of Education, written response to Office of the Legislative Auditor questions, February 24, 2023.

through September 2020, Feeding Our Future claimed roughly 2.4 million SFSP meals and snacks worth nearly $6.6 million in reimbursements.[68]

Even if virtual site visits were proving difficult, we think MDE should have identified other ways to review Feeding Our Future's SFSP operations, including conducting socially distanced observations of Feeding Our Future sites from site parking lots or conducting desk reviews of Feeding Our Future's meal claims and food production records.[69] It did not do so.

RECOMMENDATION

MDE should conduct follow-up reviews, as needed, to ensure sponsors fully implement corrective action plans that result from administrative reviews.

While we question MDE's decisions to delay its follow-up CACFP review and pause its SFSP administrative review in the fall of 2020, we recognize that the COVID-19 pandemic and related waivers affected its decision making. During at least some of the time MDE was delaying its follow-up CACFP review, USDA had waived the requirement that MDE conduct administrative reviews of sponsors with more than 100 sites at least once every two years. From March 2020 through 2021, USDA also permitted MDE to conduct offsite monitoring of CACFP and SFSP sponsors because of the COVID-19 pandemic. Further, regulations allowed MDE one year, or until June 2021, to conduct a first-year administrative review of the organization's SFSP operations. However, MDE no longer had to meet this one-year deadline when USDA waived this requirement for SFSP in February 2021.

As we discuss in the next section, while USDA's monitoring waivers *permitted* MDE to engage in less monitoring overall, they did not *prohibit* MDE from conducting administrative reviews or onsite monitoring visits of Feeding Our Future. In fact, in its request for a Minnesota-specific monitoring waiver, MDE promised to do the opposite: conduct targeted monitoring of sponsors, like Feeding Our Future, who claimed an unusually high or implausible number of meals and snacks or those at high risk of meal claim inaccuracies or discrepancies.[70]

For high-risk sponsors such as Feeding Our Future, MDE should, at a minimum, collect additional documentation, interview staff at sites and the sponsor, and follow federal guidance by conducting virtual or in-person site visits to confirm that the sponsor has implemented the changes it pledged to make in its corrective action plan. If a corrective action plan is complex or includes many elements, we think MDE could take a risk-based approach to verifying the sponsor's implementation of its corrective action plan. In doing

[68] This was in addition to the nearly 795,000 CACFP meals and snacks worth roughly $1.6 million in reimbursements Feeding Our Future claimed to have served during the same period.

[69] During this period, some of Feeding Our Future's sites were distributing bundled meals to students and their parents or guardians for consumption offsite. This means that meal service may have occurred outside where it could have been observed by socially distanced MDE staff.

[70] For more information on USDA's Minnesota-specific monitoring waiver, see Acting Director, Program Monitoring and Operational Support Division, Child Nutrition Programs, U.S. Department of Agriculture, letter to Director of Nutrition, Minnesota Department of Education, *MDE Oversight Waiver Response Final*, February 2, 2021.

so, MDE should consider both the risks posed by the sponsor involved and the risks to program integrity that the elements of a corrective action plan seek to address.

Impact of Federal COVID-19 Waivers on Oversight

The U.S. Department of Health and Human Services declared COVID-19 a public health emergency on January 31, 2020, and on March 11, 2020, the World Health Organization declared COVID-19 a pandemic. On March 13, 2020, Minnesota's Governor issued an executive order declaring a peacetime emergency, and on March 15, 2020, the Governor issued an executive order closing all Minnesota public schools from March 18 to March 27, 2020.[71] Public schools remained closed to in-person learning through the rest of the 2019-2020 school year, opting instead for distance-learning options. The majority of Minnesota public schools operated a virtual or hybrid learning model at the beginning of the 2020-2021 school year.

Also in March 2020, the Governor directed Minnesotans to stay home and ordered the closure of nonessential businesses in an effort to slow the spread of COVID-19 in the state.[72] The resulting economic disruption and recession led Minnesota's unemployment rate to increase from 4 to 11 percent and labor market participation to drop 2 percent from its prepandemic level. As household incomes dropped, food insecurity increased. This food insecurity was exacerbated for children, as school closures denied them access to a variety of school nutrition programs that may have previously provided them with free or reduced-price meals and snacks.

In addition to school closures, public health guidance discouraged nonessential in-person interaction and congregate activity. This made meal preparation and distribution more complex at CACFP and SFSP sites, while also raising the health risks of in-person monitoring of sites for MDE and sponsor staff. In response to these and other challenges, USDA looked for ways to provide states, sponsors, and sites flexibility in how they administered CACFP and SFSP.

In response to the COVID-19 pandemic, the federal government issued waivers that temporarily modified eligibility and oversight requirements for CACFP and SFSP.

From March 2020 to July 2022, USDA issued COVID-19 waivers to suspend federal requirements for CACFP and SFSP.[73] Some waivers were nationwide and automatically applied to state agencies or sponsors that elected to utilize them. Other waivers were state

[71] State of Minnesota Emergency Executive Order 20-01, "Declaring a Peacetime Emergency and Coordinating Minnesota's Strategy to Protect Minnesotans from COVID-19," March 13, 2020; and State of Minnesota Emergency Executive Order 20-02, "Authorizing and Directing the Commissioner of Education to Temporarily Close Schools to Plan for a Safe Educational Environment," March 15, 2020.

[72] State of Minnesota Emergency Executive Order 20-04, "Providing for Temporary Closure of Bars, Restaurants, and Other Places of Public Accommodation," March 16, 2020; and State of Minnesota Emergency Executive Order 20-20, "Directing Minnesotans to Stay at Home," March 25, 2020.

[73] Title II of the Families First Coronavirus Response Act of 2020 (Public Law 116-127), also known as the "COVID–19 Child Nutrition Response Act," gave USDA the authority to issue pandemic-related waivers.

specific and had to be requested by state agencies. Similarly, some waivers required sponsors to request approval from state agencies before they could be implemented.

Generally, these waivers provided flexibility for CACFP and SFSP program operations; modified oversight of the programs; and gave sites greater flexibility in terms of how, when, and to whom they served food. The intent of these waivers was to maintain program integrity and to provide meals and snacks to eligible participants, while also supporting social distancing requirements to reduce the exposure to COVID-19.

There were six general categories of pandemic-related waivers used in Minnesota for CACFP and SFSP:

- **Meal service waivers** altered how sites were allowed to serve meals and snacks. Taken together, these waivers allowed sites to "bundle" meals and snacks and distribute several food items to children or their parents or guardians at a single point in time. (Prior to the pandemic, sites were required to serve meals and snacks to children in a congregate setting at specified times.) Pandemic-related meal service waivers were in effect from March 2020 to September 2022.

- **State agency onsite monitoring waivers** allowed MDE to conduct some monitoring activities offsite to support social distancing health guidance. MDE was not prohibited from conducting onsite visits, but rather was encouraged to conduct as much monitoring as it could offsite to ensure the integrity of the program. These waivers were in effect from March 2020 to June 2023.

- **Administrative review waivers** gave state agencies flexibility in the number and frequency of administrative reviews of sponsors and their sites. For example, in April 2020, USDA issued a waiver that removed the requirement that agencies annually review at least one-third of all CACFP sponsors, with at least 15 percent of those reviews being unannounced. Additionally, it waived the requirement that independent CACFP centers and sponsoring organizations with 1 to 100 sites be reviewed every three years, and those with over 100 sites be reviewed every two years. These types of waivers were in effect from April 2020 to September 2022.

- **Area eligibility waivers** allowed sites to be located in places that, prior to the waivers, did not qualify for CACFP and SFSP based on the income of households in the given area. Additionally, some waivers also allowed some SFSP sites to operate based on their location only and not on the income of the individuals receiving food. One key Minnesota-specific waiver, issued by USDA in April 2020, stated that SFSP sponsors in good standing were able to operate sites not located in "areas in which poor economic conditions exists," meaning a site could be located anywhere in the state as long as MDE approved it. These pandemic-related area eligibility waivers were in effect from April 2020 through April 2023.

- **Application approval waivers** gave state agencies flexibility in SFSP sponsor application deadlines. These waivers allowed MDE 45 days, instead of 30 days, to approve or deny applications. These waivers were in effect from June 2020 through July 2020, and again from February 2021 through July 2021.

- **Sponsor onsite monitoring waivers** temporarily suspended some requirements associated with sponsors' periodic in-person visits and reviews of sites. These waivers were in effect from March 2020 through June 2023.

While the waivers generally modified requirements over one continuous period of time, MDE implemented nearly 100 different waivers during the COVID-19 pandemic. Each individual waiver had an effective date and an expiration date, and many were extended several times due to the length of time in which the COVID-19 pandemic affected the nation. Waivers sometimes changed slightly when they were extended. For example, an initial waiver that removed nutritional requirements of food items that could be served by sites, issued on March 25, 2020, applied to both CACFP and SFSP. However, the fourth and fifth extensions of this waiver, issued on June 25, 2020, and July 30, 2020, respectively, created separate waivers for CACFP and SFSP.

Some waivers that facilitated meal-bundling required state agencies to have a plan to ensure sites maintained program integrity, but MDE had no such plan, and its oversight was inadequate.

Waivers allowing parents or guardians to pick up meals on behalf of children directed state agencies to have a plan for ensuring that program operators were able to maintain accountability and program integrity. Specifically, USDA directed state agencies to ensure that sponsors and sites had processes so that children did not receive duplicate meals and only parents or guardians of eligible children received meals.[74]

Despite the USDA directive, MDE never produced a formal written plan outlining how it would ensure that program operators had taken adequate steps to maintain accountability and program integrity when distributing meals to parents or guardians. MDE officials told us the department outlined these plans in an annual state plan and a plan developed in response to pandemic-related waivers. However, neither plan directly addressed meal bundling. The annual state plan, submitted to and approved by USDA for program year 2021, generally explained MDE's program execution, overall monitoring approach, and related budget plans for the upcoming program year.[75] The pandemic plan addressed MDE's procedures to identify, assess, control, and monitor risks posed to the program as a result of the USDA issued waivers, but it did not address the meal-bundling waivers explicitly.

[74] See, for example, U.S. Department of Agriculture, Food and Nutrition Service, COVID-19: Child Nutrition Response #5, *Nationwide Waiver to Allow Parents and Guardians to Pick Up Meals for Children*, March 25, 2020.

[75] Minnesota Department of Education, *Summer Food Service Program (SFSP) Management and Administrative Plan* (St. Paul, February 2021). This plan was required by 7 *CFR*, sec. 225.4(a) (2021).

MDE officials stated its meal-bundling compliance work was limited to supplying guidance and providing technical assistance to their sponsors. Additionally, MDE stated that it regularly reached out to Feeding Our Future to voice concerns related to its large number of site applications and how program integrity could be maintained as the number of its sites grew. However, an MDE official indicated that despite the department's efforts, it was difficult to determine compliance, and MDE often had to rely on a sponsor's truthfulness.

Further, MDE did not review a written plan from Feeding Our Future about how its sites would avoid duplicate meals and only distribute meals to the parents or guardians of eligible children. An MDE official stated that sponsors were not required to provide this kind of plan to MDE. Additionally, MDE did not request the records necessary to validate even a sample of Feeding Our Future sites' bundled meal claims—such as meal preparation records, invoices, attendance, or menus—for one year after USDA issued the first pandemic-related waiver.[76] During the fall of 2020, Feeding Our Future sites were claiming to serve, on average, roughly 2.9 million meals and snacks a month, but MDE did not initiate a meal validation process for Feeding Our Future until the end of March 2021.[77]

Despite having the authority to do so under federal regulations, MDE did not provide us documentation showing that it visited any of Feeding Our Future's sites in person during the COVID-19 pandemic.[78] MDE could have used these visits to confirm the plausibility of bundled-meal counts or to check that site staff were taking steps to prevent meal duplication or the distribution of meals to the parents or guardians of ineligible children. USDA waivers never prohibited MDE from conducting onsite monitoring, but rather encouraged state agencies to use offsite monitoring to the maximum extent possible to ensure program integrity.

Waivers that modified monitoring requirements for state agencies and sponsors encouraged offsite reviews and alternative forms of oversight, but MDE's offsite monitoring of Feeding Our Future was limited.

As we described above, beginning in March 2020, USDA waived requirements that *state agencies* conduct onsite monitoring visits of CACFP and SFSP sponsors (and a percentage of their sites). Other nationwide and state-specific waivers permitted state agencies to delay or skip reviews and visits of sponsors and their sites. At the same time, USDA waived requirements that CACFP and SFSP *sponsors* conduct site reviews onsite. Other nationwide and state-specific waivers permitted sponsors to skip required visits and reviews of their sites. Further, some monitoring-related waivers allowed reviews of CACFP sites to be announced rather than unannounced and to not include observation of meal service.

[76] Federal regulations required Feeding Our Future to make records available when requested by MDE, USDA, and others (7 *CFR*, secs. 225.15(c)(1) and 226.10(d) (2021)).

[77] We discuss MDE's review of Feeding Our Future's meal validation documents in Chapter 5.

[78] 7 *CFR*, secs. 225.7(d); 225.12(f); and 226.6(b)(4)(iii) (2020).

Even though many monitoring requirements were waived during the COVID-19 pandemic, USDA still encouraged states to have a system in place to continue some kind of oversight and monitoring. Waivers related to state agency onsite monitoring stated that "State agencies should, to the maximum extent practicable, continue monitoring activities of Program operations offsite (e.g., through a desk audit)."[79]

In a January 2021 waiver request to pause some monitoring activities for CACFP and SFSP, MDE stated that it would implement a program integrity and risk management plan that identified "high risk [Child Nutrition Program] sponsors needing additional support via targeted technical assistance, training, and/or reviews."[80] As part of its plan, which USDA approved in February 2021, MDE said it would conduct claims trend analysis to identify sponsors for red-flags; use data to determine if any sponsors were at high risk for claiming inaccuracies; collect claim validation data for desk audits; contact sponsors about questionable claims; and, if needed and possible, conduct onsite visits. The boxes below outline MDE's key monitoring and oversight activities before and after its implementation of pandemic-related waivers.

MDE's Monitoring Activities Before COVID-19 Pandemic-Related Waivers

Monitoring activities were primarily conducted onsite. During onsite reviews, MDE:

- Observed meal and snack service and meal and snack counting, and reviewed associated records.
- Reviewed documentation, such as approved household income statements and sponsors' processes to submit claims.

The offsite portion of reviews was limited, if conducted at all, and included only some prereview of documentation sponsors provided.

MDE's Monitoring Activities After COVID-19 Pandemic-Related Waivers

Monitoring activities were primarily conducted offsite to support social distancing requirements. During these reviews, MDE:

- Observed meal and snack service and meal and snack counting virtually (typically through a video call), but the observation method largely depended on the site's technical capabilities.
- Sponsors were required to complete and submit forms and requested documentation to MDE via electronic means.

USDA permitted MDE to skip formal onsite reviews of sponsors throughout most of the duration of the pandemic.

We asked MDE officials about the extent to which Feeding Our Future was included in the implementation of its program integrity and risk management plan for monitoring. An MDE official confirmed that the department evaluated the risk of Feeding Our Future by (1) analyzing trends in Feeding Our Future's claims and payment data, (2) tracking the growth in its sites, and (3) tracking errors and other issues in its site applications. MDE indicated that the department used this information to identify risks posed by specific sites, and as justification for finding Feeding Our Future "seriously deficient" in 2021.

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[79] See, for example, U.S. Department of Agriculture, Food and Nutrition Service, COVID-19: Child Nutrition Response #11, *Nationwide Waiver of Onsite Monitoring Requirements for State Agencies in the Summer Food Service Program*, March 27, 2020.

[80] Director of Nutrition, Health and Youth Development Division, Minnesota Department of Education, letter to U.S. Department of Agriculture, *Child Nutrition Program State Waiver Request Template*, January 19, 2021.

Despite the significant growth in Feeding Our Future's meal claims (as we presented in Chapter 2), Feeding Our Future's meal claims were not subject to a desk audit until the end of March 2021.[81] MDE had not previously conducted a desk audit of Feeding Our Future, despite numerous findings in Feeding Our Future's first administrative review in December 2018.

RECOMMENDATION

MDE should place a greater emphasis on program integrity and risk-based monitoring if oversight requirements are waived again in the future.

Understandably, MDE placed an emphasis on providing food to hungry children and eligible adults throughout the duration of the COVID-19 pandemic. This prioritization, however commendable, also put the programs' integrity at risk. We think that the flexibility the waivers gave MDE regarding monitoring should have made focusing on high-risk sponsors, like Feeding Our Future, easier, not harder. MDE could have freed up staff resources working with lower-risk sponsors to instead focus on one of its largest sponsors, Feeding Our Future. It was MDE's choices that made monitoring waivers a source of reduced oversight, not the waivers themselves.

In the future, if oversight requirements are waived again, MDE should place priority on making appropriate adaptations to its oversight activities to ensure the integrity of CACFP and SFSP. This could include focusing on sponsors or sites that exhibit warning signs, such as large increases in sites, meals, or reimbursements; and ensuring that any adaptations MDE creates ensure sponsors and sites continue to adhere to program regulations and requirements.

[81] As we discuss further in Chapter 5, we identified a number of issues in the files MDE reviewed for this desk audit. Generally, MDE failed to consistently request missing or incomplete documentation it would have needed to verify Feeding Our Future's meal claims. Additionally, MDE did not question Feeding Our Future regarding documentation that had indications of potentially fraudulent activity.

Chapter 4: Complaint Investigations

Between June 2018 and December 2021, the Minnesota Department of Education (MDE) received at least 30 complaints involving Feeding Our Future or its sites.[1] The complaints included allegations that Feeding Our Future used unethical or inappropriate methods to recruit sites; operated sites at locations without the property owners' permission, and at those locations, ran a messy and haphazard food distribution process; and demanded kickback payments from vendors to serve food at its sites.

By law, state agencies must "promptly investigate complaints received or irregularities noted in connection with" the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) and "take appropriate action to correct any irregularities."[2]

Many of MDE's complaint investigation procedures and practices were inappropriate or of limited usefulness, particularly in the context of the alleged fraud.

Key Events in the Timeline: Complaints

June 2018 – MDE received the first of many complaints alleging poor management practices at Feeding Our Future. MDE received 16 additional such complaints between June 2018 and December 2021.

July 2018 – MDE received the first of many complaints alleging unethical site recruitment practices by Feeding Our Future. MDE received seven additional such complaints between July 2018 and January 2021.

June 2019 – MDE received the first of two complaints that alleged Feeding Our Future required kickbacks from vendors. MDE received one additional complaint regarding kickbacks in August 2021.

June 2019 – MDE received the first of several complaints alleging improper program implementation at Feeding Our Future or its sites. MDE received three additional such complaints between June 2019 and August 2021.

See Appendix A for more information.

Generally, when MDE received a complaint about Feeding Our Future or its sites, MDE's first step was to share the complaint with Feeding Our Future.[3] When determining whether complaints were substantiated, MDE often relied on the statements made by Feeding Our Future's executive director and inconsistently took steps to verify the truthfulness of their statements. As we discuss in this chapter, this approach was flawed for several reasons. Most importantly, MDE had reason to doubt Feeding Our Future's trustworthiness as a sponsor, yet MDE continued to ask Feeding Our Future to resolve complaints about itself.

[1] As we show in Appendix A, Feeding Our Future became a CACFP sponsor in July 2018, an SFSP sponsor in June 2020, and was terminated as a sponsor from both programs in January 2022. Appendix A provides a brief description of each of the complaints MDE received about Feeding Our Future, along with the date MDE received each complaint.

[2] 7 *CFR*, secs. 225.11(b) and 226.6(n) (2023).

[3] According to MDE's complaint investigation procedures, this practice allows sponsors the opportunity to investigate what occurred, provide a response, and/or resolve any disagreements with the complainant.

More broadly, despite repeated warnings by the U.S. Department of Agriculture's (USDA's) Office of Inspector General of the risks of fraud, waste, and abuse in federal nutrition programs, MDE was not prepared to investigate these issues in CACFP or SFSP.[4] MDE assigned investigative duties to child-nutrition program staff, rather than trained investigators. And, MDE relied on limited-scope USDA reviews of MDE's complaint investigation procedures to inform whether and how it investigated complaints about Feeding Our Future.[5]

Finally, MDE officials told us that the department met the federal requirement to inform USDA of "any suspected fraud or criminal abuse…which would result in a loss or misuse of Federal funds" in SFSP when it shared its concerns about Feeding Our Future with USDA's Office of Inspector General in October or November 2020.[6] However, informing USDA of its concerns did not absolve MDE of its legal responsibility to (1) "promptly investigate" program-related complaints and irregularities, and (2) "take appropriate action to correct any irregularities" in CACFP and SFSP.[7] In the end, MDE missed opportunities to investigate allegations about Feeding Our Future's administration of federal nutrition programs and take timely action to hold the organization accountable to program requirements, when warranted.

In this chapter, we first discuss limitations with MDE's written complaint investigation procedures. Then, we highlight shortcomings in MDE's investigation practices. We conclude the chapter with recommendations to MDE.

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[4] USDA's Office of Inspector General considers both CACFP and SFSP to be at "high risk" for improper payments, including duplicate payments, payments to ineligible recipients or for ineligible goods or services, payments not authorized by law, and payments for a good or service not received (U.S. Department of Agriculture, Office of Inspector General, *USDA's Compliance with Improper Payment Requirements for Fiscal Year 2021*, Audit Report 500024-0002-24 (Washington, DC, June 2022), 1-2, 10). See also: U.S. Department of Agriculture, Office of Inspector General, *Review of Management Controls for the Child and Adult Care Food Program*, Audit Report 27601-0012-SF (Washington, DC, November 2011),1-3, 25-29; U.S. Department of Agriculture, Office of Inspector General, *New York's Controls Over Summer Food Service Program,* Audit Report 27004 0001-23 (Washington, DC, September 2018), 3-7, 15-17, 27-30; and U.S. Department of Agriculture, Office of Inspector General, *Summer Food Service Program in Texas—Sponsor Costs*, Audit Report 27004-0003-21 (Washington, DC, March 2019), 4-7, 12-15, 30-36.

[5] USDA evaluated MDE's management of SFSP and CACFP in 2018 and 2019, respectively, and neither evaluation resulted in findings of noncompliance related to MDE's complaint investigation procedures. However, USDA's guidance for CACFP management evaluations directs USDA evaluators to "review a sample of *one or two complaints* to determine if the process is being followed" (emphasis added; U.S. Department of Agriculture, Food and Nutrition Service, *Guidance, Management Evaluation of State Agency Operations, Child and Adult Care Food Program* (Washington, DC, Fiscal Year 2019), 82). While the scope of the SFSP management evaluation is broader with regard to complaints, Feeding Our Future was not participating in SFSP during the period covered by USDA's 2018 evaluation of MDE's management of SFSP.

[6] 7 *CFR*, sec. 225.11(b) (2020). Federal regulations did not include a similar requirement for CACFP, but both CACFP and SFSP regulations stated that USDA "may make investigations at the request of the State agency" (7 *CFR*, secs. 225.11(b) and 226.6(n) (2020)). The exact date MDE shared its concerns with USDA's Office of Inspector General is unclear.

[7] 7 *CFR*, secs. 225.11(b) and 226.6(n) (2020).

Complaint Investigation Procedures

Clear and detailed complaint investigation procedures are important for several reasons. They promote consistency in decision-making processes, establish clear expectations for individuals' work, and create standards to which that work can be held accountable. Further, federal guidance for CACFP directs MDE to have complaint investigation procedures that are written, accommodate verbal or written complaints, ensure prompt investigations, and document evidence and "actions taken" in complaint files.[8]

While MDE had written complaint investigation procedures, their limited scope and failure to address important issues undermined their ability to promote good investigative practices.

MDE's procedures for addressing complaints involving CACFP and SFSP sponsors and sites lacked detail, assumed parties were acting in good faith, and did not account for common types of complaints.

Throughout most of the period Feeding Our Future was a sponsor for CACFP and SFSP, MDE's written complaint investigation procedures did not include detailed information to guide the processes of complaint intake, investigation, and documentation.[9] For example, MDE's complaint investigation procedures did not:

- Establish who was responsible for accepting complaints, the methods by which complaints could be received (such as by phone, e-mail, or U.S. mail), and how complaints should be tracked or recorded.[10]

- Include guidance for determining which complaints should be investigated and which could be deferred. Given limited resources and variation in the seriousness of allegations, organizations with investigatory duties typically develop a system for prioritizing which complaints to investigate.

- Provide sufficient direction on the investigatory steps MDE staff should take to confirm the veracity of allegations or corroborate the responses given by complaint subjects. While MDE's procedures referenced standard investigative

[8] U.S. Department of Agriculture, Food and Nutrition Service, *Monitoring Handbook for State Agencies, A Child and Adult Care Food Program Handbook* (Washington, DC, updated May 2014), 59.

[9] MDE updated its CACFP and SFSP complaint investigation procedures in October 2021. In addition to complaint investigation procedures, MDE submitted plans to the USDA in 2018, 2019, and 2021 that discussed its approach to complaint investigations. According to the plans, MDE said it aimed to (1) begin investigations within two business day to determine the validity of the complaint, (2) maintain a complaint log and document evidence and actions, and (3) have timelines for correcting deficiencies that depended upon the type and severity of deficiencies found. However, throughout most of the period Feeding Our Future was active, MDE's complaint investigation procedures did not incorporate these elements. For example, prior to October 2021, MDE's complaint investigation procedures did not instruct MDE staff to maintain a complaint log. Further, complaint investigation procedures, both before and after October 2021, do not discuss timelines for correcting deficiencies discovered during investigations.

[10] Beginning in October 2021, MDE's CACFP and SFSP complaint procedures provided brief instructions on how to document complaints received.

practices, such as site visits, witness interviews, and document collection, they did not provide a detailed explanation of when or how these practices should be conducted.

- Provide standards or guidance on recordkeeping, including how staff should document their investigations or what evidence should be retained to support their conclusions.[11] By law, MDE must maintain evidence of its investigations and actions taken to correct program irregularities.[12] A lack of recordkeeping standards could make it more difficult for investigators to draw upon previous evidence and findings when investigating sponsors who are the subject of multiple complaints.

In addition to lacking detail, MDE's complaint investigation procedures emphasized the role of complainants and the subjects of the complaints in resolving complaints on their own. For example, prior to October 2021, the first step of MDE's CACFP and SFSP complaint investigation procedures directed MDE or the complainant to share the content of the complaint with the subject of the complaint, so that the subject of the complaint could investigate their own conduct and/or attempt to resolve the complaint without further MDE investigation. Only after the parties to the complaint had failed to resolve the issue did the procedures prompt MDE to accept a formal or written version of the complaint that included "all details, particularly names of witnesses" to "collaborate [*sic*] the facts."[13] Once MDE received a formal complaint, procedures again directed MDE to give the subject of the complaint an opportunity to respond.

While these procedures may have been appropriate when both the subject of the complaint and the complainant were credible and acting in good faith, such an approach would be inappropriate once MDE suspected that one or both parties lacked credibility or were acting in bad faith. MDE's complaint investigation procedures provided no guidance to staff for situations in which they doubted the credibility of complainants, complaint subjects, or witnesses. In these instances, a more effective approach would be for MDE to engage in at least some independent fact-finding before further engaging with complainants and complaint subjects.[14]

Finally, MDE's complaint investigation procedures did not provide guidance about how to investigate different types of complaints. The CACFP procedure pertained only to complaints about site recruitment and did not provide any guidance about whether or how to investigate other types of complaints, such as complaints about meal service,

[11] After October 2021, one of MDE's two public complaint procedures stated "Upon receipt of complaint, complaint is logged on SFSP Complaint Log and document facts are collected and recorded" but provided no further directions (Minnesota Department of Education, Nutrition, Health and Youth Development, *Complaint Procedure for Summer Food Service Program*, revised October 2021).

[12] 7 *CFR*, secs. 225.11(b) and 226.6(n) (2023).

[13] Minnesota Department of Education, *Child and Adult Care Food Program Recruitment Complaint Procedure*, created December 28, 2010, revised February 26, 2019; and Minnesota Department of Education, Food and Nutrition Service, *Complaint Procedure for Summer Food Service Program*, approved May 1, 2015.

[14] In contrast to the SFSP policy in effect prior to October 2021, the first steps in MDE's updated SFSP policy direct MDE staff to document that "facts are collected and recorded" and then to begin "looking into the facts and evidence surrounding the complaint" (Minnesota Department of Education, Nutrition, Health and Youth Development, *Complaint Procedures for Summer Food Service Program*, revised October 2021).

food preparation, or misuse of program funds.[15] In contrast, MDE's SFSP procedures made no mention of improper recruitment. Instead, the procedures provided general directions that were not specific to any type of complaint.

Investigations of Complaints Involving Feeding Our Future

Given its limited resources, it is reasonable for MDE to defer investigations in situations in which complaints are vague, evidence is difficult to obtain, or the complainant or witnesses are uncooperative. However, it is also reasonable to expect MDE to investigate repeated complaints alleging fraud or other serious concerns. As we discuss in this section, MDE did not always conduct independent investigations, and when it did, MDE's investigations were inadequate.

MDE did not investigate some complaints about Feeding Our Future, despite their frequency or seriousness.

Based on our review of MDE documents, MDE contacted Feeding Our Future or its sites in response to many of the complaints it received, but often took no other investigative steps. It was not always clear why MDE determined that some complaints could be addressed with few or no investigative steps, while others deserved a full investigation.

In some cases, MDE placed conditions on what types of complaints regarding Feeding Our Future it would accept or demanded that complainants provide further evidence before it would investigate, even when the complaint involved program irregularities. For example, a June 2018 complaint alleged that Feeding Our Future's executive director had improperly, through acts of theft and forgery, taken control of the organization from the other founding members. MDE responded to the complainant that they should not provide further information to MDE about Feeding Our Future unless "there is a conviction for any business related offense; or the organization is no longer in good standing with the IRS…."[16]

MDE officials told us that the department did not investigate this allegation because it (1) notified law enforcement of the complaint and was told that no criminal investigation was forthcoming, and (2) did not view the allegation as a "program irregularity" that it would be required to investigate under federal law.[17] However, the subject of the complaint represented themselves as the board chair and president of Feeding Our Future, and given this role, they would be responsible for overseeing how the organization spent federal funds. They would also be responsible for addressing

[15] According to USDA guidance and MDE policy, sponsors should not recruit sites that are already participating in CACFP under another sponsor. MDE's policy indicates that inappropriate recruitment practices include encouraging already sponsored sites to switch sponsors, making negative comments about other sponsors, or offering money or other incentives to sites to become sponsored or to switch sponsors. According to MDE's policy, appropriate practices include identifying sites that are not already sponsored and then providing the nonsponsored sites information about the benefits of CACFP.

[16] CACFP and SFSP Supervisor, Minnesota Department of Education, e-mail to complainant, June 26, 2018.

[17] 7 *CFR*, sec. 226.6(n) (2018).

any deficiencies in organization's operations. We find it difficult to understand why MDE did not consider an allegation that an individual improperly assumed key management responsibilities of a sponsoring organization to be a "program irregularity" worthy of investigation.

On other occasions, MDE did not initiate an investigation, even after its initial follow-up with complainants revealed program irregularities. For example, in May 2021, an SFSP site contacted MDE to express concern that it would not be able to continue under Feeding Our Future's sponsorship. On the same day, a second SFSP site contacted MDE and claimed that it had not received a monthly reimbursement check from Feeding Our Future. During conversations with the two complainants, MDE discovered (1) the first complainant claimed that they had never discussed CACFP with Feeding Our Future, but the site had been an approved CACFP site for two program years; (2) the second complainant did not know it had a pending CACFP site application; and (3) the second complainant was operating at a location that differed from the address listed in MDE systems.

As we discussed in Chapter 1, as these sites' sponsor, Feeding Our Future was responsible for submitting program applications on their behalf, training site staff to meet applicable program regulations, and maintaining records that support the sites' meal claims and demonstrate the sites' compliance with law.[18] At a minimum, the irregularities MDE identified should have led it to review documents it had, or could have obtained, for misrepresentations, inaccuracies, and completeness. For example, for the site that was approved for both CACFP and SFSP, MDE could have reviewed previously approved meal claims and documentation of Feeding Our Future's monitoring of the site to ensure that the site claimed meals and snacks for the correct program and followed the correct set of program regulations. Other than speaking with representatives of the sites, MDE took no additional investigative steps to ensure program compliance. The U.S. Department of Justice would later charge the first complainant in the alleged fraud scheme.

As a final example, four months after denying a for-profit restaurant's SFSP site application renewal, MDE received a complaint that food distribution was continuing to occur at the site. Specifically, the owner of the property reported to MDE that they were "not comfortable" with Feeding Our Future's food distribution activity on their property and alleged that they had received complaints about Feeding Our Future's meal service, including that staff were "dumping milk outside."[19] The complainant also stated that they attempted to resolve the dispute with Feeding Our Future, but Feeding Our Future's executive director did not listen to their complaint.

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[18] Federal regulations and program agreements between MDE and Feeding Our Future specify the records that sponsors should maintain, as well as MDE's authority to access those records (7 *CFR*, secs. 225.6(i)(13) and (i)(14); 225.15(c)(1); 226.6(b)(4)(iii); 226.10(d); and 226.15(e) (2023); Minnesota Department of Education and Feeding Our Future, *Child and Adult Care Food Program Agreement*, ED-02409-04E, effective July, 27, 2018; and Minnesota Department of Education and Feeding Our Future, *Summer Food Service Program Agreement for Private Non-Profit or Public Non-School Organization*, ED-02372-04E, effective June 30, 2020).

[19] Complainant, e-mail to Business Operations Support Services and CACFP and SFSP Supervisors, Minnesota Department of Education, "[Address]," October 27, 2021; and CACFP and SFSP Supervisor, Minnesota Department of Education, e-mail to complainant, "Child Nutrition Site Complaint," October 29, 2021.

In response, MDE told the complainant that the restaurant at the address in the complaint was a child nutrition program vendor and formerly a food distribution site. MDE then informed the complainant that MDE does not settle site disputes, and they should discuss issues with "the current lease or liability…with the leaseholder."[20] According to MDE's complaint log, the complaint was classified as a "dispute with property owner" that had "no resolution."[21] The U.S. Department of Justice would later charge both the complainant and several individuals associated with the restaurant named in the complaint in the alleged fraud scheme.

When we asked MDE how it decided whether a complaint would receive a full investigation, MDE stated that it followed the complaint investigation procedures discussed above. As we stated previously, procedures did not establish criteria for determining when MDE staff should pursue a more extensive or formal investigation.

MDE inappropriately asked Feeding Our Future to investigate complaints about itself.

Between July 2018 and January 2020, MDE received several complaints from a different child nutrition program sponsor alleging that Feeding Our Future was improperly recruiting its sites to transfer to Feeding Our Future's sponsorship. Following MDE's CACFP recruitment complaint procedure, MDE staff repeatedly assigned responsibility for initial fact-finding and dispute resolution to Feeding Our Future and the complainant.

For example, in September 2018, MDE requested that the complainant and Feeding Our Future "come to agreement on the actual facts related to the recruitment efforts" before the department would investigate.[22] The complainant informed MDE that they had a poor relationship with Feeding Our Future's executive director and that the executive director would likely not speak with them. Despite this comment, at the end of its investigation, MDE again prompted the "two sponsors to resolve any conflicts directly with each other before preparing additional written complaints to MDE."[23] In December 2019, when MDE received yet another recruitment-related complaint about Feeding Our Future from the same complainant, it echoed its previous guidance and encouraged Feeding Our Future to resolve the complaint with the complainant. According to Feeding Our Future, it received "a hostile response and unwillingness to have a productive conversation."[24] This did not deter MDE from again repeating its

[20] Business Operations Support Services Supervisor, Minnesota Department of Education, e-mail to complainant, "[Address]," October 27, 2021.

[21] "Complaint Log Start Oct 2021" (spreadsheet of child nutrition program complaints, Minnesota Department of Education, Roseville, October, 1 2021).

[22] CACFP and SFSP Supervisor, Minnesota Department of Education, e-mail to complainant, "Programs," September 24, 2018.

[23] CACFP and SFSP Supervisor, Minnesota Department of Education, memorandum to executive directors of two sponsor organizations, *Minnesota Department of Education's (MDE) response to the unethical recruitment complaints*, March 11, 2019.

[24] Executive Director, Feeding Our Future, letter to CACFP and SFSP Supervisor, Minnesota Department of Education, *Feeding Our Future's response to recruitment complaints*, January 9, 2020.

preference that the two sponsors attempt to resolve their disputes before submitting additional complaints to MDE.

In a different case, in August 2021, MDE received conflicting reports of inappropriate or illegal behavior by Feeding Our Future, a site, and a vendor. Specifically:

- One of Feeding Our Future's sites contacted MDE alleging that Feeding Our Future had not paid its food vendor. The vendor told MDE that Feeding Our Future had demanded a kickback, and when the vendor refused to pay, Feeding Our Future canceled the vendor's contract in retaliation.

- According to the site, a new vendor Feeding Our Future assigned to the site delivered an insufficient number of meals, many of which violated food safety and dietary requirements.

- In separate correspondence with MDE, Feeding Our Future stated that it wanted to take administrative action against the site for submitting fraudulent claims, soliciting a kickback from its former vendor, and making a false complaint to MDE about its new vendor, among other serious allegations.

Rather than initiating a full independent investigation into Feeding Our Future or the site and vendors involved, MDE referred the site's, and the site's original vendor's complaints, to Feeding Our Future "for resolution."[25] MDE told Feeding Our Future that it expected the organization to "correct any program non-compliance, or discontinue operations at that site if site staff were uncooperative."[26]

We are troubled by MDE's decision to refer these complaints and alleged program irregularities back to Feeding Our Future for resolution rather than conducting its own independent investigation. In effect, MDE directed Feeding Our Future to investigate itself, including allegations of fraud at an SFSP site that should have been under the organization's full control.[27] MDE made this decision roughly four months after sharing its fraud concerns about Feeding Our Future with the FBI. The U.S. Department of Justice later charged the executive director of the organization operating the site and the owners of both vendors named in the complaint in the alleged fraud scheme. The site operator pled guilty to criminal wire fraud charges on January 10, 2024.[28]

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[25] "Complaint Log Start Oct 2021" (spreadsheet of child nutrition program complaints, Minnesota Department of Education, Roseville, October, 1 2021).

[26] CACFP and SFSP Supervisor, Minnesota Department of Education, e-mail to Executive Director, Feeding Our Future, "Re: FW: Serious Deficiency – [Site]," August 30, 2021.

[27] By law, Feeding Our Future was required to "exercise[] full control and authority" as well as "accept[] final financial and administrative responsibility" for operations at all of its SFSP sites (7 *CFR*, sec. 225.14(c)(1) and (d)(6)(i) (2021)).

[28] In its September 7, 2021, letter to its sponsored site and MDE, Feeding Our Future stated that it conducted a site visit of the complainant's new vendor on August 27, 2021. Feeding Our Future claimed that during the visit, the new vendor showed Feeding Our Future staff its processes and systems. According to a U.S. Department of Justice charging document, an individual suspected of participating in the alleged fraud created the new vendor "in or about August 2021…in part, to give the false impression that [the new vendor] was involved in the food business when, in reality, it was a shell company to further the scheme to defraud." (U.S. District Court, District of Minnesota, Superseding Indictment, 22-CR-226 (NEB/TNL), 13, March 7, 2023.)

When MDE decided to investigate complaints about Feeding Our Future, the investigations were inadequate.

In the cases when MDE did conduct an investigation, MDE did not consistently interview available witnesses or review available documents to verify statements made by complainants, Feeding Our Future, or representatives of sponsored sites. Additionally, MDE did not visit Feeding Our Future sites named in complaints, even when the complaint was related to issues with meal service and food preparation—issues for which the most straightforward method of determining whether these complaints were credible would have been to visit the site.[29] Instead, in many of the complaint files we reviewed, MDE's investigations seemed to rely, almost entirely, on statements made by complainants and Feeding Our Future's executive director and legal counsel. MDE sometimes reviewed statements made by witnesses, but MDE often received witness statements indirectly from the complainant and/or Feeding Our Future, rather than directly from the witnesses themselves.

For example, in September 2018, January 2019, March 2019, and December 2019, MDE received at least three separate complaints from a sponsor alleging that Feeding Our Future was inappropriately recruiting its sites. The complainant repeatedly identified a specific Feeding Our Future staff person who they alleged was improperly recruiting its sites and said the improper recruiting was taking place at meetings of a specific child-care provider association. In its response to the complaints, Feeding Our Future did not deny that the staff person was at the complainant's sites or that the staff person had attended a meeting of the child-care provider association. However, MDE never attempted to contact this individual or anyone representing the named child-care provider association. Instead, MDE relied primarily on Feeding Our Future's statements and documentation completed by sites transferring to Feeding Our Future's sponsorship to determine that the complaints were unsubstantiated.[30]

MDE also decided against following-up with witnesses offered by a complainant to confirm the credibility of Feeding Our Future's statements about its recruitment practices. In one instance, a complainant offered a written statement from a witness to support their allegations, but the offer was made after MDE had already shared the complaint with Feeding Our Future and received a response. As a result, MDE decided that collecting additional statements from the witness would be "out of scope" and did not obtain further information from the witness. In another instance, a complainant offered to introduce several witnesses and video surveillance footage as evidence of improper recruitment, but the offer came after MDE had closed the complainant's most

[29] This was true for complaints MDE received prior to and after the onset of the COVID-19 pandemic.

[30] Site transfer documentation asks transferring sites to provide a reason for their transfer to a new sponsor. On several occasions, MDE could have verified the reason sites provided for transferring to Feeding Our Future, but did not. For example, several sites stated that they transferred to Feeding Our Future due to their current sponsor paying them late or not at all. By law, sponsors must maintain documentation of meal claims, reimbursements, and payments (7 *CFR*, secs. 225.15(c)(1) and 226.15(e) (2023)). MDE did not request payment documentation from the sponsors of sites who referenced payment issues as their reason for transferring to Feeding Our Future. On other occasions, sites named third parties, some of whom were also federal nutrition program participants, who recommended that they transfer to Feeding Our Future. MDE did not contact these third parties.

recent complaint. MDE did not follow up with the sponsor about the witnesses or collect additional written or verbal statements.

As another example, in an October 2021 complaint, the complainant alleged that Feeding Our Future was "delivering food to nobody in particular - just leaving it in common areas or entry ways" and creating messes at three locations where it did not have permission to operate.[31] Only months before, MDE had taken administrative action against Feeding Our Future, in part due to complaints it received alleging that Feeding Our Future was operating at locations without the property owners' permission. MDE had deferred this part of the administrative action because Feeding Our Future had assured MDE that it would secure the permission of property owners before beginning operations at its sites.[32]

MDE requested further information from the complainant, an individual claiming to represent the complainant, and Feeding Our Future. However, when Feeding Our Future denied the allegations, MDE did not take reasonable steps to verify the organization's statements. In its response, Feeding Our Future claimed that it had conducted multiple site visits of one of the sites mentioned in the complaint. For another site, Feeding Our Future asserted that the site only did home deliveries so it would not have been possible for food to be left at the site. In the complaint files we reviewed, we found no evidence that MDE contacted representatives of the sites directly about the nature of their program participation or whether they had received complaints from others at the property where they operated. Further, we found no evidence that MDE requested documentation of Feeding Our Future's monitoring visits of the sites to verify that the sites were adequately monitored and compliant with federal regulations. MDE also did not obtain documents Feeding Our Future was required to maintain regarding how the site prepared and served meals and snacks. We also found no evidence that MDE visited the sites to observe food preparation and distribution or asked others at the properties if they had similar concerns.

Recommendations

In response to the alleged fraud scheme involving Feeding Our Future, the 2023 Legislature established an Office of the Inspector General within MDE.[33] The inspector general is responsible for "protecting the integrity of the department and the state by detecting and preventing fraud, waste, and abuse in department programs," including CACFP and SFSP.[34]

As MDE establishes its Office of the Inspector General, it will decide whether and how to investigate complaints like the ones we discussed in this chapter. Regardless of

[31] Complainant, child nutrition complaint forms submitted to Minnesota Department of Education, received on October 21-23, 2021.

[32] We discuss this administrative action in Chapter 5.

[33] *Laws of Minnesota* 2023, chapter 55, art. 12, sec. 12, codified as *Minnesota Statutes* 2023, 127A.21.

[34] *Minnesota Statutes* 2023, 127A.21, subd. 1.

which unit within MDE conducts these investigations, we believe MDE needs to make significant improvements to both its complaint investigation procedures and investigation practices.

RECOMMENDATIONS

MDE should revise its CACFP and SFSP complaint investigation procedures so that they:

- **Include criteria for prioritizing complaints and initiating proactive investigations.**
- **Address all common types of complaints that MDE staff may encounter.**
- **Provide detailed guidance on evidence collection.**

As we discussed earlier, MDE did not investigate all of the complaints it received. In some circumstances, such as when the complaint is vague and collecting further evidence is impracticable, deferring an investigation may be reasonable. However, MDE should have clear written criteria for when it will defer an investigation and clear guidance for how its staff should document their decisions. MDE should also have criteria it can use to prioritize complaints so that it can efficiently utilize its limited resources in a way that best protects public resources and the vulnerable populations (children and dependent adults) that CACFP and SFSP serve.

MDE should also develop procedures that describe when it will independently initiate investigations in response to irregularities it discovers, separate from any complaints it receives. If MDE were to notice an unusual trend in claim data or become aware of an irregularity due to an audit or administrative review, federal regulations require that MDE promptly investigate the irregularity.[35] MDE is not required to receive a complaint about an irregularity before it may begin an investigation.

As we previously explained, MDE's written complaint investigation procedures for CACFP are specifically designed to address complaints related to sponsors' recruitment of sites. However, MDE should consider developing a CACFP investigation procedure that addresses complaints beyond those related to recruitment. It should also consider whether a recruitment-specific investigation procedure would be appropriate for SFSP. Alternatively, MDE could develop general complaint investigation procedures that include both CACFP and SFSP in their scope. As we discuss in more detail below, MDE should consider including guidance on how implementation of the procedures should vary depending upon the identity of the complainant, the subject of the complaint, and the type of allegation.

[35] 7 *CFR*, secs. 225.11(b) and 226.6(n) (2023).

As discussed above, MDE's current complaint investigation procedures provide only limited guidance on evidence collection. MDE should revise its procedures to provide clear expectations to staff about what evidence should be collected and when and how it should be collected. Relevant guidance could address:

- Witness, complainant, and complaint subject interviews and written questionnaires.
- Compliance-focused onsite visits and reviews.
- Document reviews, including monitoring forms, previous administrative reviews, financial audits, vendor contracts, and attendance and meal claim records.
- Analysis of trends in meal claims and reimbursements.

RECOMMENDATION

MDE should prioritize independent fact-finding in response to complaints.

When evaluating and investigating complaints about *sites* or *vendors*, it is often reasonable for MDE to refer complaints to the relevant sponsor for resolution. By law, sponsors are responsible for ensuring their sites comply with program regulations.[36] Further, sponsors work directly with vendors and site staff, so they have both the relationships and the information necessary to monitor for and remediate noncompliance.

When MDE receives complaints about *sponsors*, however, we think it is imperative for MDE to conduct independent fact-finding. MDE could begin the investigation by independently collecting evidence; reviewing previous administrative reviews conducted by the department; contacting potential witnesses; conducting unannounced site visits of the sponsor, its sites, or vendors; and requesting and reviewing documents (such as attendance sheets, meal and snack counts, sponsor monitoring forms, and invoices) before sharing details of the complaint with the subject and reviewing the subject's response.

If a complaint involves a dispute between two parties, MDE's current procedures direct staff to encourage the complainant and subject of the complaint to settle any dispute or misunderstanding on their own. This facilitative approach may be appropriate when MDE believes that the complainant and the subject of the complaint have a respectful relationship. However, encouraging dispute resolution when MDE knows that the relationship is hostile seems unlikely to produce a fair outcome that ensures compliance with the law. In these circumstances, MDE should take a more active role in settling the dispute, including pursuing independent fact-finding as needed.

[36] 7 *CFR*, secs. 225.14(c)(1), (c)(4), and (d)(3); 225.15(a)(1); 226.15(c); and 226.16(c) and (d) (2023).

RECOMMENDATION

MDE should limit the information it shares with the subject of a complaint in an effort to protect complainants from retaliation.

Protecting complainants from retaliation is an important aspect of being a trusted resource for complainants. Our review of complaint files suggests that such protection could have encouraged greater cooperation with MDE's investigations. As early as February 2019, MDE encountered an individual who was unwilling to share their identity and serve as a witness to support an allegation against Feeding Our Future. On two occasions when MDE staff tried to verify sites' reasons for transferring to Feeding Our Future, the sites refused to answer questions about Feeding Our Future's recruitment. In January 2019, a sponsor alleged that some site representatives feared that they would be retaliated against for providing information to MDE. The same sponsor described an environment of "hostility" in which site representatives did not want to "speak against their peers in their community."[37] In March 2019, when a sponsor offered to introduce witnesses to support one of its complaints about Feeding Our Future, it mentioned that those witnesses preferred that their identities be protected from disclosure to anyone outside of MDE. In another instance, the sponsor stated that a site representative specifically wanted their identity protected from Feeding Our Future's executive director.

In carrying out this recommendation, MDE should consider whether and how to apply existing provisions of the Minnesota Government Data Practices Act. If it finds that these statutes do not adequately address data practices issues related to investigations of CACFP and SFSP program irregularities, MDE should propose legislation to ensure that it can exercise effective oversight of the programs.

RECOMMENDATION

MDE should evaluate the implementation of recent statutory changes related to its investigative authority, and promptly propose needed changes to the Legislature.

The 2024 Legislature amended statutes to give MDE's Office of the Inspector General additional authority, including the ability to administer oaths, subpoena witnesses, and access data of any classification maintained by CACFP and SFSP program participants.[38] Additionally, under certain circumstances, the inspector general may now recommend to the MDE commissioner administrative sanctions, including withholding payments to program participants.[39]

[37] Complainant, e-mail to CACFP and SFSP Supervisor, Minnesota Department of Education, "Program Recruitment," December 26, 2019.

[38] *Minnesota Statutes* 2023, 127A.21, as amended by *Laws of Minnesota* 2024, chapter 115, art. 10, sec. 2.

[39] *Ibid*.

As it implements these recent statutory changes, MDE should evaluate the extent to which they support the department's ability to investigate allegations of fraud, waste, and abuse involving CACFP and SFSP. If MDE identifies gaps in its authority, it should promptly propose needed changes to the Legislature, as directed by state law.[40] For example, if MDE determines that it could benefit from limited rulemaking authority to codify its investigation procedures—or additional specificity concerning the rights and duties of program participants as witnesses, complainants, or complaint subjects during investigations—it should proactively work with the Legislature to address these issues.

[40] *Minnesota Statutes* 2023, 127A.06, requires that MDE recommend to the Legislature and the governor legislation relating to the state system of education that would make its laws "more readily understood and more effective in execution."

Chapter 5: Serious Deficiency Process

If the Minnesota Department of Education (MDE) finds a sponsor noncompliant with federal law in its administration of the Child and Adult Care Food Program (CACFP) or Summer Food Service Program (SFSP), it must declare the sponsor "seriously deficient."[1] The purpose of this designation—and the resulting process to correct the deficiency—is to ensure program integrity and compliance with federal regulations. The serious deficiency process also gives MDE the ability to terminate sponsors who prove unwilling or incapable of correcting serious problems.

A state agency can find a sponsor seriously deficient at any time during its participation in CACFP or SFSP.[2] Serious deficiencies include submitting false information on a sponsor's application, failing to properly monitor sites, claiming reimbursements for meals and snacks not served to participants, or anything else a state agency determines affects a sponsor's ability to administer the program.[3]

Key Events in the Timeline: Serious Deficiencies

January 15, 2021 – MDE issued a first set of serious deficiencies for CACFP and SFSP due to the revocation of Feeding Our Future's nonprofit status and noncompliance with federal audit requirements.

March 29, 2021 – MDE initiated a process to terminate Feeding Our Future's CACFP sponsorship due to a lack of corrective action for the first set of serious deficiencies.

March 31, 2021 – MDE issued a second set of serious deficiencies for CACFP due to issues regarding Feeding Our Future's financial viability and management, administrative capabilities, and program accountability.

May 13, 2021 – MDE vacated the notice of proposed termination and disqualification, therefore deferring the first set of serious deficiencies.

June 4, 2021 – MDE deferred the second set of serious deficiencies. Feeding our Future was no longer under any serious deficiencies at this point and could continue to operate as normal.

See Appendix A for additional information.

[1] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(i), (c)(2)(i), and (c)(3)(i) (2023).

[2] *Ibid*.

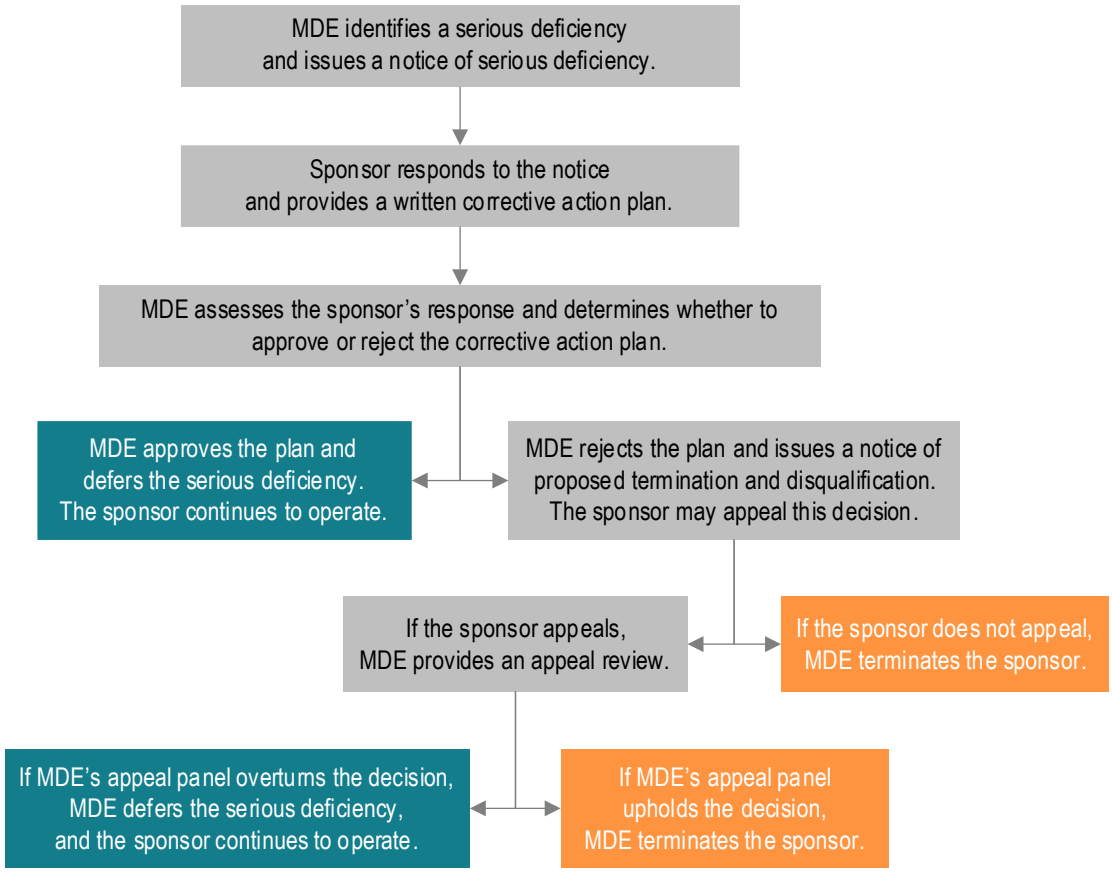
[3] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(ii), (c)(2)(ii), and (c)(3)(ii) (2023). Federal guidance directs state agencies to exercise discretion when deciding whether administrative errors or management problems reach the level of a serious deficiency. U.S. Department of Agriculture (USDA) guidance for CACFP directs state agencies to consider factors including: (1) the severity of the problem, such as whether it was an isolated error or demonstrates a systemic problem; (2) the degree of responsibility attributable to the sponsor; (3) the sponsor's history of participation in the program; and (4) the degree to which the problem impacts program integrity (U.S. Department of Agriculture, Food and Nutrition Service, *Serious Deficiency, Suspension, & Appeals for State Agencies & Sponsoring Organizations, A Child and Adult Care Food Program Handbook* (Washington DC, February 2015), 25-26). For example, minor noncompliance—such as occasional recordkeeping errors—that the sponsor has repeated over time without correction could result in a serious deficiency. However, if MDE finds a violation that threatens the health or safety of program participants, it must immediately take steps to terminate either the sponsor or the site, depending on the program (7 *CFR*, secs. 225.11(f)(3) and 226.6(c)(5)(i) (2023)).

As Exhibit 5.1 shows, after MDE identifies a serious deficiency, MDE notifies the sponsor that it is "seriously deficient" and specifies (1) the actions the organization must take to correct the serious deficiencies, and (2) the time allotted to correct the serious deficiencies. The sponsor then corrects the deficiencies and submits a written plan to MDE describing how it will prevent the deficiencies from reoccurring.[4]

Exhibit 5.1

The serious deficiency process consists of several steps.

The process ends with either **deferral**, which allows a sponsor to continue participating in CACFP or SFSP, or **termination**.



Source: Office of the Legislative Auditor.

[4] According to federal guidance, a sponsor's corrective action plan must include detailed information about what it will change, how and when it will make the changes, and who is responsible for the changes, among other things (U.S. Department of Agriculture, Food and Nutrition Service, *Serious Deficiency, Suspension, & Appeals for State Agencies & Sponsoring Organizations, A Child and Adult Care Food Program Handbook* (Washington, DC, February 2015), 19; and U.S. Department of Agriculture, *Summer Food Service Program, State Agency Monitor Guide* (Washington, DC, February 2015), 60).

If MDE believes that the sponsor's plan will fully correct the serious deficiencies, it defers the deficiencies and allows the sponsor to continue participating in the program. On the other hand, if MDE rejects the sponsor's corrective action plan, MDE must move to terminate the sponsor from program participation.[5] Sponsors can appeal MDE's decision to deny an application or terminate their participation in CACFP or SFSP, but they cannot appeal MDE's serious deficiency determinations.[6]

MDE found Feeding Our Future seriously deficient on two occasions, but ultimately deferred all serious deficiencies without taking reasonable steps to ensure the organization implemented corrective actions.

MDE declared Feeding Our Future seriously deficient in January 2021 and again in March 2021. The first set of serious deficiencies, which MDE issued in January 2021 for both CACFP and SFSP, related to the revocation of Feeding Our Future's nonprofit status by the Internal Revenue Service (IRS) and Feeding Our Future's failure to submit an audit of its financial statements and internal controls. When MDE notified Feeding Our Future of serious deficiencies in CACFP for a second time in March 2021, these same two issues were included as part of MDE's larger concerns with Feeding Our Future's financial management, administrative capabilities, and program accountability.[7]

By June 2021, MDE had deferred all of Feeding Our Future's serious deficiencies, and the organization continued to operate as a sponsor for CACFP and SFSP. As we explain further in this chapter, MDE deferred the serious deficiencies without collecting sufficient evidence that the organization had fully and permanently addressed the serious deficiencies MDE identified. MDE made this decision during a time when it clearly had concerns about the organization's operations. For example, as we discussed in Chapter 3, when MDE reviewed the organization's CACFP sponsor application in the fall of 2020, it questioned Feeding Our Future's compliance with federal regulations. Further, in February 2021, the Federal Bureau of Investigation (FBI) notified MDE of allegations it received involving Feeding Our Future, all of which would later be reflected in the federal

Requirement for Deferring Serious Deficiencies in CACFP

If corrective action has been taken to *fully and permanently* correct the serious deficiency(ies) within the allotted time and to the State agency's satisfaction, the State agency must: (i) Notify the [sponsor's] executive director and chairman of the board of directors, and the responsible principals and responsible individuals, that the State agency has temporarily [deferred] its serious deficiency determination; and (ii) Offer [the sponsor] the opportunity to resubmit its application. (Emphasis added.)

— 7 *CFR*, secs. 226.6(c)(1)(iii)(B)(1), (c)(2)(iii)(B)(1), and (c)(3)(iii)(B)(1) (2023)

[5] 7 *CFR*, secs. 225.11(c); and 226.6(c)(1)(iii)(C), (c)(2)(iii)(C), and (c)(3)(iii)(C) (2023).

[6] 7 *CFR*, secs. 225.13(a); and 226.6(k)(2)(i), (k)(2)(iii) and (k)(3)(ii) (2023). In Minnesota, appeals are made to MDE's appeal panel, which consists of three MDE employees who were not involved in the action being appealed. After reviewing relevant documentation; analyzing relevant legal requirements; and if requested, holding a hearing, the panel issues a decision on whether to uphold MDE's decision. Although the appeal panel's decision is considered MDE's final administrative determination, state statutes permit that decision to be appealed directly to the Minnesota Court of Appeals (*Minnesota Statutes* 2023, 14.69).

[7] See Appendix A for a detailed timeline of Feeding Our Future's serious deficiency process.

criminal charges filed in 2022 through early 2024.[8] The FBI's notification was in addition to the numerous complaints MDE had already received about the organization by this time, which we discussed in Chapter 4.

In this chapter, we first describe the serious deficiencies MDE identified. Then, we discuss shortcomings with MDE's oversight of the serious deficiency process and provide recommendations for improvement.

Feeding Our Future's Serious Deficiencies

Nonprofit Status Deficiency

Feeding Our Future's eligibility to participate as a sponsor in CACFP and SFSP was based, in part, on its status as a private nonprofit organization. For an organization to be considered a private nonprofit organization under federal laws related to CACFP and SFSP, it must be tax-exempt under relevant provisions of the U.S. Internal Revenue Code.[9] The IRS revoked Feeding Our Future's tax-exempt status in February 2020, due to Feeding Our Future's failure to meet IRS reporting requirements for three consecutive years. The IRS posted the revocation on its website in May 2020.

As a result, when Feeding Our Future certified the truthfulness of its SFSP sponsor application and signed its program agreement with MDE in May 2020, it misrepresented itself as a tax-exempt, private nonprofit organization. When Feeding Our Future submitted its annual CACFP sponsor application in August 2020, Feeding Our Future again misrepresented its tax-exempt status on a sponsorship application.[10]

In January 2021, MDE found Feeding Our Future seriously deficient in both CACFP and SFSP, in part, due to the lapse of its nonprofit status.[11] MDE's March 2021 serious deficiency notice for CACFP cited Feeding Our Future's failure to update its policies and procedures to ensure the organization would meet IRS reporting requirements, among other things.

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[8] Specifically, the FBI asked whether MDE had received any complaints related to Feeding Our Future. The FBI stated that it had received allegations that Feeding Our Future's executive director was "accepting kickbacks for providing food contracts through USDA," "submitting for reimbursements for meals without proper or insufficient paperwork," and was not "providing the meals" they said they had provided (Special Agent, Federal Bureau of Investigation, e-mail to Risk Manager, Minnesota Department of Education, "[Executive Director, Feeding Our Future]," February 22, 2021).

[9] 7 *CFR*, secs. 225.2, 225.14(b), and 226.15(a) (2023).

[10] We asked MDE officials why the department did not address the revocation of Feeding Our Future's tax-exempt status prior to approving its SFSP sponsor application in June 2020. An MDE official stated that staff verified Feeding Our Future's nonprofit status in March or April 2020, when the organization notified MDE of its intent to apply to be an SFSP sponsor. Since the IRS did not post Feeding Our Future's February 2020 revocation on its website until May 2020, and MDE did not check Feeding Our Future's nonprofit status again before it approved Feeding Our Future's SFSP application, MDE approved the application assuming that Feeding Our Future still had tax-exempt status.

[11] MDE cited Feeding Our Future's submission of false information on an application as a serious deficiency for SFSP, but not for CACFP.

Federal Single Audit Deficiency

Federal law requires that nonfederal entities that annually spend $750,000 or more in federal funds be audited.[12] An independent auditor must perform the audit, which may be specific to an individual federal program or cover multiple programs (called a "federal single audit").[13] The audit must be submitted to a digital audit repository, known as the Federal Audit Clearinghouse, within 30 calendar days after the auditee receives the audit report or within nine months after the end of the auditees' fiscal year, whichever is earlier.[14]

As part of an audit, auditees must provide to the auditor (1) financial statements, including a schedule showing the amount of federal fund expenditures by federal program; (2) notes on the accounting policies used to prepare the schedule of federal expenditures; (3) a summary of prior audit findings and corrective actions to address those findings; and (4) access to staff, accounting books and records, and any other supporting documentation or information needed for the audit.[15] As we discuss in greater detail below, federal single audits are not purely financial. They evaluate the auditee's compliance with legal requirements that could materially affect the program, in addition to providing an accounting of their program-related expenditures.

MDE first notified Feeding Our Future that its federally required audit was past due in October 2020. Feeding Our Future responded that it was utilizing a waiver that extended the audit deadline to December 31, 2020. In early January 2021, when MDE confirmed that Feeding Our Future had failed to upload its audit to the Federal Audit Clearinghouse by the extended deadline, MDE e-mailed Feeding Our Future about the status of its audit. After receiving no response, MDE declared Feeding Our Future seriously deficient in January 2021, in part, due to its failure to meet single audit requirements. In March 2021, MDE issued another serious deficiency related to Feeding Our Future's federal single audit. The March serious deficiency notice stated that the audit Feeding Our Future submitted in response to the January serious deficiency notice was incomplete and conducted by an unlicensed auditor.

[12] 2 *CFR*, sec. 200.501(a) (2023).

[13] 2 *CFR*, secs. 200.501(a); 200.507(a)-(b); and 200.514 (2023).

[14] 2 *CFR*, sec. 200.512(a)-(d) (2023).

[15] 2 *CFR*, secs. 200.508 and 200.510 (2023).

Performance Standards Deficiency

Federal regulations provide three performance standards for sponsors' administration of CACFP and SFSP, as outlined in the boxes below.[16]

CACFP and SFSP Performance Standard 1: Financial Viability and Management

Sponsors must be financially viable and must:

- Have adequate resources to operate on a daily basis (CACFP only).
- Have appropriate site recruitment practices.
- Have adequate resources to pay debts, employees, and suppliers during temporary interruptions in program payments.
- Document their financial viability, such as through financial statements and audits.
- Have budgets that contain necessary, reasonable, allowable, and documented costs.

CACFP and SFSP Performance Standard 2: Administrative Capability

Sponsors must be capable of administering CACFP or SFSP and must have:

- Appropriate and effective management practices to ensure compliance with federal law.
- Adequate numbers and types of staff, including monitoring staff.
- Written policies and procedures that (1) assign program responsibilities and duties and (2) ensure compliance with civil rights regulations.

CACFP and SFSP Performance Standard 3: Program Accountability

Sponsors must have internal controls and other management systems in place to guarantee fiscal accountability and other program operational requirements. For example, they must have:

- An independent governing board (CACFP only).
- Written management controls to ensure fiscal integrity and accountability.
- A system of safeguards and controls to prevent and detect improper financial activities by employees.
- Recordkeeping systems to account for and retain program records.

In March 2021, MDE declared Feeding Our Future seriously deficient in CACFP for failing to meet each of the three performance standards. It cited, among other things, Feeding Our Future's continued noncompliance with federal single audit requirements; the sponsor's rapid growth; and shortcomings in the organization's financial management, administrative capability, and program accountability.[17] In contrast to the previous serious deficiency determination, MDE used the March 2021 serious deficiency determination as grounds to (1) withhold payment from Feeding Our Future, (2) stop processing Feeding Our Future's site applications, and (3) deny Feeding Our Future's application to be an SFSP sponsor.

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[16] 7 *CFR*, secs. 225.6(d)(1)-(3); and 226.6(b)(1)(xviii)(A)-(C) and (b)(2)(vii)(A)-(C) (2023). In the years Feeding Our Future participated in SFSP, federal regulations did not require the organization to comply with the SFSP-specific performance standards shown above. The regulations were amended in October 2022 to add these requirements, more than eight months after MDE terminated Feeding Our Future's participation in SFSP.

[17] As we described in Chapter 3, Feeding Our Future submitted, on an annual basis, a sponsor application and budget. In these budgets, Feeding Our Future provided estimates of the amount of reimbursement it expected to claim through CACFP. By the end of February 2021—five months into the 2021 CACFP program year—the number of meals and snacks Feeding Our Future claimed for reimbursement, and the number of sites under its sponsorship, approached or exceeded the 12-month estimates found in its 2021 program year application and budget.

Shortcomings in Oversight

For each of the serious deficiencies MDE identified, the department required Feeding Our Future to take certain corrective actions before it would defer them. For the first set of serious deficiencies, MDE required Feeding Our Future to submit a corrective action plan by the end of January 2021. When it did not provide a complete response by the deadline, MDE began a process to terminate Feeding Our Future's participation in CACFP.[18]

However, by June 2021, MDE had deferred all of Feeding Our Future's serious deficiencies based on additional information it received from the organization. But, as we stated at the beginning of the chapter, MDE took only limited steps to confirm the accuracy of this information and Feeding Our Future's claims. Below, we describe three areas in which MDE either could have obtained information—or already had information in its possession—that we think should have led MDE to pursue terminating Feeding Our Future's participation in CACFP and SFSP months earlier than it did.[19] In summary, MDE:

- Accepted an "audit" that did not meet federal audit standards.
- Did not take basic steps to verify the information Feeding Our Future provided in its corrective action plans.
- Failed to investigate indicators of the alleged fraud scheme evident in documentation it obtained to validate Feeding Our Future's meal claims.

MDE accepted an audit of Feeding Our Future's use of federal funds that did not meet basic audit standards.

In late January 2021, Feeding Our Future submitted a copy of a single audit report to MDE. In early March, MDE determined that Feeding Our Future's auditor had not uploaded the audit to the Federal Audit Clearinghouse, as required by law.[20] MDE also noted that the audit was missing required elements and was conducted by an unlicensed auditor. By the end of March 2021, Feeding Our Future's audit still had not been uploaded to the clearinghouse; Feeding Our Future had not responded to MDE's request to provide its auditor's contact information so that MDE could discuss the audit's missing elements with the auditor; and Feeding Our Future had not submitted acceptable federal-single-audit-related written procedures and internal controls.

[18] According to an MDE official, MDE did not begin the process to terminate Feeding Our Future's participation in SFSP because CACFP and SFSP have different serious deficiency and appeal timelines, which would have made it difficult to combine the two processes. As a result, MDE opted to move forward with only the CACFP termination.

[19] MDE terminated Feeding Our Future's participation in CACFP and SFSP on January 20, 2022, the day federal authorities executed search warrants at Feeding Our Future's office and several other locations affiliated with the organization.

[20] 2 *CFR*, sec. 200.512(d) (2021).

In late March 2021, because of these and other issues, MDE moved forward with a proposal to terminate Feeding Our Future's participation in CACFP. In late April 2021, Feeding Our Future responded by providing an engagement letter with a new auditor to complete a new audit covering the same period as the incomplete audit it had provided to MDE in January 2021. Further, Feeding Our Future provided more detailed written procedures and internal controls that described the roles of Feeding Our Future's executive director, senior staff members, the board of directors, and contract auditors in ensuring its future compliance with federal single audit requirements.

However, the engagement letter contained signs that any resulting audit would not meet federal single audit requirements. For example, the engagement letter lacked any mention of a federal single audit, federal rules relevant to federal single audits, generally accepted government auditing standards, or the year for which the audit was needed.

Along with the engagement letter, Feeding Our Future provided MDE with the new auditor's contact information. We asked MDE if it ever contacted the new auditor about Feeding Our Future's federal single audit.[21] MDE stated that it did not, missing an opportunity to clarify with the new auditor and Feeding Our Future what should, at a minimum, be included within the audit's scope.

Further, the federal single audit Feeding Our Future eventually submitted to MDE in May 2021 was completed by yet a *different* auditor than the one that Feeding Our Future told MDE it had hired to complete the audit. MDE did not ask Feeding Our Future about this change in auditors.

We identified a number of issues with the audit report Feeding Our Future submitted to MDE that we think MDE staff should have identified and acted on. For example, there were discrepancies between the amounts of CACFP reimbursements Feeding Our Future reported in the audit when compared to MDE's claims data. The audit report also lacked components required by federal law. For example, the report did not include a section on internal controls over financial reporting or a section on compliance and internal controls related to CACFP requirements.

Based on these omissions from the audit report, it would have been reasonable for MDE to have required the auditor to provide documentation showing how it conducted the audit. Federal law requires that auditors retain such documentation for at least three years after the issuance of the audit report and that "Audit documentation must be made available upon request to the…oversight agency…at the completion of the audit, as part of a quality review, to resolve audit findings, or to carry out oversight responsibilities."[22] We found no evidence that MDE requested or reviewed audit documentation from Feeding Our Future's auditor.

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[21] In a May 6, 2021, letter to Feeding Our Future, MDE stated it would "meet with [the auditor] to receive confirmation the audit is being completed…[the auditor] must respond to MDE's request for information regarding their plan to complete the audit and the status of the single audit…. The single audit must include all required sections as outlined in 2 CFR 200 Subpart F in order for the single audit to be accepted." (Supervisor of Business Operations, Minnesota Department of Education, letter to Executive Director and President of the Board of Directors, Feeding Our Future, *Regarding: Notice of Proposed Termination and Disqualification of CACFP Sponsorship*, May 6, 2021.)

[22] 2 *CFR*, sec. 200.517 (2021).

Had MDE reviewed audit documentation, it would have likely discovered that the auditor did not meet basic requirements for a federal single audit. Most notably, the auditor failed to:

- Plan an adequate risk assessment of Feeding Our Future's operations and internal controls to identify the risk of material misstatements in Feeding Our Future's financial statements, including material misstatements due to fraud.
- Ask Feeding Our Future management and staff how they manage fraud risks and whether they have any knowledge of any actual or suspected fraud related to the nonprofit organization.
- Examine inflows of funds to Feeding Our Future.

Given these and other shortcomings, the documents Feeding Our Future's auditor submitted to the Federal Audit Clearinghouse in May 2021 cannot reasonably be characterized as a federal single audit. Therefore, we think MDE should have determined that the parts of Feeding Our Future's corrective action plan that referenced the audit's submission were unacceptable and incomplete.

Such a determination would have withstood the scrutiny of Minnesota's accounting regulators. In January 2023, the Minnesota Board of Accountancy determined that the audit report did not meet generally accepted auditing standards and that it "played a role in allowing Feeding Our Future to engage in a fraud resulting in the misappropriation of more than $250,000,000 in public funds."[23] As a result of the auditor's "pervasive failures" during its engagement with Feeding Our Future, the Minnesota Board of Accountancy suspended the auditor from practicing as a certified public accountant on the grounds that they were a threat to the public.[24]

MDE did not collect sufficient evidence to determine whether Feeding Our Future resolved deficiencies related to its financial management and monitoring of its sites.

In late April 2021, Feeding Our Future submitted to MDE the corrective action plan it developed in response to the March 2021 serious deficiency. While Feeding Our Future's plan largely appeared to be responsive to MDE's concerns, MDE did not take proactive steps to determine if Feeding Our Future had fully and permanently corrected its serious deficiencies.

For example, Feeding Our Future's corrective action plan and updated financial management policy show that a contracted accounting firm and separate auditing firm

[23] State of Minnesota Board of Accountancy, *In the Matter of the CPA Firm Permit of CPA Global Portfolio Consulting C.A., LLC, and the CPA Certificate of Charles Amevo, Order Continuing Temporary Suspension* (File nos. 2022-029, -56, -57, January 26, 2023), 2.

[24] State of Minnesota Board of Accountancy, *In the Matter of the CPA Firm Permit of CPA Global Portfolio Consulting C.A., LLC, and the CPA Certificate of Charles Amevo, Temporary Suspension Order* (File nos. 2002-029, -56, -57, January 13, 2023), 5. In May 2024, the Minnesota Board of Accountancy issued a consent order imposing several sanctions on the auditor, including revoking the auditor's certified public accountant certificate.

were to play a central role in managing Feeding Our Future's finances moving forward. Specifically, Feeding Our Future claimed that the yet-to-be-hired accounting firm would:

> oversee all Feeding Our Future's accounting needs, including its bookkeeping, balance sheets, journal entries, monthly closeouts, and reconciling its activities and cash flow. The accounting firm will be asked to make recommendations on best practices and policies for all record and bookkeeping. In addition, the accounting firm will be responsible for completing all federal and state required tax documentation and ensuring that Feeding Our Future remains in good standing.[25]

We asked MDE if it ever reviewed documentation, such as a list of firms contacted, to support Feeding Our Future's claim that it was in the process of hiring an outside firm to handle its accounting. MDE replied that it did not review any documentation related to the hiring process because Feeding Our Future's legal counsel had asserted, in court, that the hiring process was ongoing. Further, MDE said that it would not typically review procurement documentation, including contracts, until a sponsor's administrative review; Feeding Our Future's next administrative review was scheduled to begin in January 2022.

Another example of MDE's failure to adequately scrutinize Feeding Our Future's corrective action plan was its acceptance of the organization's procedures to manage its rapid growth. In its corrective action plan, Feeding Our Future claimed its sites were "better staffed and equipped than any other sponsor in the history of the program," and that Feeding Our Future maintained direct control over food service and meal and snack counts for some sites.[26] Feeding Our Future also provided information and policies about how it trained and onboarded new sites, and how it provided ongoing training and technical assistance to staff at existing sites. According to Feeding Our Future, this included increased monitoring visits of sites significantly beyond the federal requirements that existed prior to the COVID-19 pandemic (as we explained in Chapter 3, pandemic-related waivers permitted fewer visits). Feeding Our Future also claimed that it held an "open house" meeting with sites each Friday in March 2021 in order to review program rules and provide an opportunity for sites to ask questions.

To onboard new sites, Feeding Our Future claimed that it met with sites four times before they started making claims (including the preapproval visit required by CACFP rules), with the fourth visit including an observation of meal service as well as training on attendance, meal counts, and the claims-submission process. Feeding Our Future also claimed that it visited all sites within their first six weeks of operation to observe meal service, as required by law, and that designated staff would visit each site monthly until the site could consistently demonstrate compliance with all program regulations.

However, MDE took few steps to confirm that Feeding Our Future was implementing the onboarding and monitoring practices it described in its corrective action plan. For example, MDE did not collect records that could have confirmed whether the March 2021 open houses occurred. Similarly, MDE did not collect documentation of Feeding Our Future's onboarding visits of new sites, despite Feeding Our Future's claim that "routine" visits of new sites for compliance was a process it implemented

[25] Executive Director, Feeding Our Future, *Corrective Action Plan – March 31, 2021,* 9.

[26] *Ibid.,* 5.

several months prior to the submission of its corrective action plan. Further, MDE did not review documentation to confirm Feeding Our Future's claims that its program staff increased monitoring visits of existing sites beyond federal minimum requirements. Finally, MDE never contacted staff at Feeding Our Future sites to determine if the organization was implementing its new policies.

Meal validation documents MDE collected from Feeding Our Future contained indications of the alleged fraud, but MDE approved all meal claims without investigating these irregularities.

As part of MDE's March 2021 notice of serious deficiency to Feeding Our Future, MDE informed Feeding Our Future that it would stop paying the organization's meal claims until it submitted a corrective action plan and documentation sufficient to validate its meal claims. MDE based this action on a section of federal regulations that applies across programs that allows state agencies to take specific steps to encourage compliance with federal laws.[27] In late April 2021, Feeding Our Future began providing claims documentation to MDE for 104 sites, including meal and snack counts, attendance records, menus, and vendor invoices.

According to an MDE official, a team of staff compared the number and types of meals and snacks Feeding Our Future claimed to counts of meals and snacks purportedly provided at sites. They also reviewed documentation of purchased food to determine whether it was sufficient to cover the claimed number of meals and snacks. The MDE official also said staff reviewed menus to ensure they met nutrition requirements. MDE's meal validation process was conducted offsite. MDE did not visit, virtually or otherwise, any of the sites (or vendors that served the sites) as part of its review.

We reviewed Feeding Our Future's meal validation documents for 28 of the 104 sites included in MDE's request. We selected sites that were directly named in the federal indictments or were a site whose vendor was named in the indictments.[28]

We identified a number of concerns in the files we reviewed. In summary, MDE did not consistently request from Feeding Our Future missing or incomplete documentation it would have needed to verify the validity of meal claims. MDE also did not question the organization about documentation that contained indications of the alleged fraud. For example:

- MDE required that Feeding Our Future provide **daily meal and snack count records** for CACFP and SFSP sites. Of the 28 sites we examined, 13 sites claimed the exact same number of meals and snacks served for six or seven days a week for the entire month. Another eight sites claimed a very similar (within ten) number of meals and snacks for each day of the month. Several of

[27] MDE cited 2 *CFR*, sec. 200.339 (2023). In *Partners in Nutrition d/b/a Partners in Quality Care's Consolidated Appeals*, 995 N.W.2d 631 (Minn. Ct. App. 2023), the Minnesota Court of Appeals concluded, in relation to a different CACFP sponsor, that MDE could not withhold reimbursement payments on the basis of this regulation. Rather, the court held that MDE could require the prepayment submission of required documentation that could, in turn, form the basis to deny reimbursement under CACFP.

[28] We selected these sites based on charging documents made public between September 2022 and March 2023.

the federal indictments related to the alleged fraud scheme cited identical or nearly identical meal count sheets as evidence of the alleged crimes.

MDE did not provide us with any evidence that showed it questioned Feeding Our Future about these patterns of claims. MDE requested that Feeding Our Future provide meal and snack count records for the four sites that initially did not have meal and snack count records, but MDE did not receive these records.

- CACFP sites were required to have **attendance records**. Four of the 12 CACFP sites in our review did not have attendance records; MDE followed up with Feeding Our Future about each missing record. However, there were other discrepancies—like attendance records that showed more or fewer kids in attendance than meals and snacks served, disorganized records that were impossible to discern, and inappropriate ages of children based on the classroom they were assigned—which MDE did not question. According to the federal indictments, some defendants created fake attendance records to cover up the alleged fraud, with some records containing computer-generated names or ages.

- Feeding Our Future was required to provide **menus** that reflected the actual meals and snacks served in March 2021 for each CACFP and SFSP site. Nearly all of the sites we reviewed (25 of the 28 sites) did not provide menus that showed meals and snacks served. Some of the menus were not dated and contained the exact same food items for each meal. Further, 7 of the 25 sites did not provide a menu at all. While all 25 should have received further scrutiny—as they did not meet MDE's standards—MDE only followed-up about the menus at 13 of the 25 sites.

- MDE required Feeding Our Future to provide **vendor invoices** for SFSP sites. Of the 17 SFSP sites in our review, 8 did not have vendor invoices as required. MDE did not contact Feeding Our Future to request invoices for any of the eight sites. Among the sites that did provide invoices, MDE also did not follow up on concerning issues, such as invoices that contained very little information on the food purchased; invoices that specified meal types provided that were not claimed (such as an invoice for "breakfast" when the site did not claim any breakfasts); and receipts for things like car washes and a pressure washer, which are not allowable expenses under SFSP.

When MDE followed up with Feeding Our Future to request additional documentation for certain sites, it told Feeding Our Future that it would "disallow claims missing documentation if not received by June 18, 2021."[29] According to MDE officials, Feeding Our Future did not respond to the department's request. However, MDE did not deny or adjust downward Feeding Our Future's claims for any of the sites for which we had concerns, nor did it further investigate irregularities evident in the

[29] CACFP Review Team Lead, Minnesota Department of Education, e-mail to Executive Director, Feeding Our Future, "Claim Validation," June 11, 2021.

documentation it already had.[30] MDE paid a total of $10.1 million for 3.8 million meals and snacks purportedly served in March 2021 at these 28 sites.

MDE cited a lack of U.S. Department of Agriculture (USDA) guidance, COVID-19-related waivers, and ongoing litigation as reasons for why it made no downward claim adjustments or did not deny any claims. An MDE official told us that USDA provided MDE unclear responses on how to validate meal claims and recognize red flags in the context of the COVID-19 waivers. Further, an MDE official said that when MDE reached out to USDA to notify it of unusual attendance patterns, USDA responded that perfect attendance would be possible due to the waivers.

As we discuss further in Appendix B, from late 2020 through early 2022, MDE and Feeding Our Future were engaged in litigation. On April 13, 2021, Feeding Our Future filed a motion for a temporary restraining order precluding MDE from withholding reimbursements for Feeding Our Future's meal claims. In the motion, Feeding Our Future asserted that MDE's refusal to pay the organization's meal claims violated federal policy. During an April 21, 2021, hearing, a Ramsey County District Court judge indicated that MDE's actions were "a real problem," but did not rule on the matter because it had not been presented in a way that gave the court jurisdiction.[31] In response to the judge's statement, MDE resumed paying Feeding Our Future.[32]

RECOMMENDATION

MDE should conduct more active follow-up to ensure sponsors and sites fully implement corrective action plans that result from serious deficiency processes.

While federal regulations do not *require* MDE to conduct onsite visits or collect additional evidence before deferring serious deficiencies, it also does not prevent MDE from conducting these activities.[33] Given the information it had at the time, we think it is reasonable to expect MDE to have, at a minimum, collected additional documentation and conducted onsite visits of Feeding Our Future and its sites to verify statements Feeding Our Future made in its corrective action plans. By June 2021, MDE should have viewed Feeding Our Future as an entity at high risk for noncompliance and fraud. Feeding Our Future's size alone meant that any fraud or noncompliance—even if it affected only a small percentage of meal claims—posed significant risks to both taxpayers and the individuals who depended on Feeding Our Future for food. As a result, MDE should have taken additional steps beyond the minimum required by law

[30] As we discussed in Chapter 4, federal regulations require MDE to "promptly investigate complaints received or irregularities noted in connection with" CACFP and SFSP and "take appropriate action to correct any irregularities" (7 *CFR*, secs. 225.11(b) and 226.6(n) (2023)).

[31] Motion Hearing, April 21, 2021, 64:10, *Feeding Our Future v. Minnesota Department of Education*, 62-CV-20-5492.

[32] Despite MDE's resumption of payment in April 2021, Feeding Our Future continued to seek a temporary restraining order against MDE over the "stop pay" issue until the judge denied the request as moot at the end of June 2021.

[33] As we noted in Chapter 3, federal pandemic-era waivers in effect at the time also did not prevent MDE from conducting these activities.

when assessing whether Feeding Our Future was fully and faithfully implementing its corrective action plan.

As we recommended in Chapter 3, MDE should contact staff at sites and the sponsor directly to confirm whether the sites or sponsors have implemented the changes they pledge to make in their corrective action plans. Further, MDE should request additional evidence and conduct site visits to inform its decision before deferring serious deficiencies.

If a corrective action plan is complex or includes many elements, it may be unreasonable to expect MDE to verify that every element of a plan is fully implemented. In these cases, MDE should take a risk-based approach to verifying sponsors' implementation of their corrective action plans that considers both the riskiness of the sponsors involved and the risks to program integrity that the elements of a corrective action plan seek to address. For example, the corrective action plan from a small sponsor whose serious deficiencies centered on poor recordkeeping may require only minimal follow-up from MDE. In contrast, the corrective action plan of a large sponsor with a history of serious deficiencies in financial management and program accountability likely requires more intensive follow-up.

List of Recommendations

- The Legislature should either establish criteria in statute or give the Minnesota Department of Education (MDE) the authority to conduct rulemaking to establish criteria that the department must consider when determining whether to approve organizations for the Child and Adult Care Food Program (CACFP) or Summer Food Service Program (SFSP). (p. 33)

- MDE should take additional steps to verify information provided in support of sponsorship applications submitted by high-risk applicants. (p. 34)

- MDE should conduct follow-up reviews, as needed, to ensure sponsors fully implement corrective action plans that result from administrative reviews. (p. 42)

- MDE should place a greater emphasis on program integrity and risk-based monitoring if oversight requirements are waived again in the future. (p. 48)

- MDE should revise its CACFP and SFSP complaint investigation procedures so that they:

  - Include criteria for prioritizing complaints and initiating proactive investigations.

  - Address all common types of complaints that MDE staff may encounter.

  - Provide detailed guidance on evidence collection. (p. 59)

- MDE should prioritize independent fact-finding in response to complaints. (p. 60)

- MDE should limit the information it shares with the subject of a complaint in an effort to protect complainants from retaliation. (p. 61)

- MDE should evaluate the implementation of recent statutory changes related to its investigative authority, and promptly propose needed changes to the Legislature. (p. 61)

- MDE should conduct more active follow-up to ensure sponsors and sites fully implement corrective action plans that result from serious deficiency processes. (p. 75)

OLA

Appendix A: Timeline of Key Events

Key for Timeline

Depicts events concerning MDE's review of Feeding Our Future's applications or operations, as we discussed in Chapter 3.

Depicts events concerning complaints MDE received about Feeding Our Future, as we discussed in Chapter 4.

Depicts events corresponding to Feeding Our Future's serious deficiencies in two federal nutrition programs, as we discussed in Chapter 5.

Depicts events corresponding to the *Feeding Our Future v. Minnesota Department of Education* court case, as we discuss in Appendix B.

On the following pages, we present a detailed timeline of the Minnesota Department of Education's (MDE's) oversight of Feeding Our Future. This timeline begins with the inception of Feeding Our Future as an organization in November 2016, and goes through February 2024.

Some events in the timeline below are identified by an icon, as defined by the box to the left. The "Comments" column in the timeline indicates additional information relevant to the particular event, such as what caused the particular event to occur, or a resulting effect of the event.

Exhibit A.1

Timeline of Key Events Related to Feeding Our Future's Participation in Federal Nutrition Programs

	Date	Event	Comments
	November 7, 2016	**Feeding Our Future was established.**	
	February-March 2017	**Feeding Our Future applied to MDE to become a Child and Adult Care Food Program (CACFP) sponsor for the 2017 program year.**[1]	
	March 13, 2017	**MDE notified Feeding Our Future that its CACFP sponsor application was incomplete.** MDE requested additional information pertaining to Feeding Our Future's site recruitment practices, financial viability, and governing board members' responsibilities, among other things.	
	April 7, 2017	**MDE denied Feeding Our Future's CACFP sponsor application because it did not demonstrate financial viability, administrative capability, and program accountability.** MDE stated this action was appealable.	
	April 12, 2017	**Feeding Our Future appealed MDE's decision to deny its CACFP sponsor application.**	

Continued on the next page.

[1] CACFP program years begin on October 1 and end on September 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2017 began on October 1, 2016, and ended on September 30, 2017.

	Date	Event	Comments
	June 12, 2017	**MDE's appeal panel accepted the appeal from Feeding Our Future and approved its CACFP application.**	
	July 3, 2017	**The Minnesota Court of Appeals issued an opinion in favor of another sponsor, Partners in Nutrition.** MDE initially rejected Partners in Nutrition's CACFP application based on a lack of proof of financial viability. The court determined MDE did not appropriately consider all evidence and based its decision on an incorrect interpretation of federal law.	MDE had denied Feeding Our Future's initial application earlier in 2017, partially based on a lack of demonstrated financial viability.
	February 26, 2018	**MDE conducted a preapproval visit of Feeding Our Future for CACFP.** Feeding Our Future began operation as a CACFP sponsor soon after the visit.	
	June 2018	**MDE received a complaint regarding Feeding Our Future's management practices.** The complainant stated that Feeding Our Future's executive director had improperly taken control of the organization from the other founding members. An MDE official responded, asking the complainant to work the issues out with Feeding Our Future's executive director. The MDE official stated that they did not wish to be kept informed of future developments unless there was a conviction for any business-related offense, or the organization was no longer in good standing with the Internal Revenue Service (IRS).	This was the first complaint MDE received involving Feeding Our Future.
	July 25, 2018	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complaint stated that Feeding Our Future's executive director had been meeting with sites currently sponsored by their organization to discuss moving or transferring their food program to Feeding Our Future. MDE responded by discussing the complaint with Feeding Our Future's executive director and adding an addendum to MDE's agreement with Feeding Our Future that placed limitations on site transfers.	This was the second complaint MDE received involving Feeding Our Future.
	July 27, 2018	**Feeding Our Future and MDE entered into an agreement allowing it to receive reimbursements for claimed CACFP meals and snacks.**	
	August 2018	**Feeding Our Future began claiming meals and snacks served through CACFP.** Feeding Our Future claimed a total of nearly 13,000 meals and snacks in August 2018.	

Continued on the next page.

Date	Event	Comments
September 24, 2018	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complainant stated that about ten of their organization's sites had left to work with Feeding Our Future. Feeding Our Future allegedly offered to sponsor the sites for a lower administrative fee percentage than what the complainant's organization charged. MDE encouraged the complainant to discuss their concerns directly with Feeding Our Future's executive director, and stated MDE would only step in to investigate if the two parties could not come to an agreement.	This was the third complaint MDE received involving Feeding Our Future.
December 2018	**MDE began its only administrative review of Feeding Our Future.**	
January 22, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** MDE sent the complaint to Feeding Our Future's executive director and asked that they provide a written response. Based on that response, and previous correspondence between MDE and the sites that transferred to Feeding Our Future, MDE determined that there was not sufficient evidence to conclude that Feeding Our Future used unethical recruiting practices. MDE suggested that in the future, the two sponsors attempt to resolve conflicts with each other before making complaints to MDE.	This was the fourth complaint MDE received involving Feeding Our Future.
February 15, 2019	**MDE completed its only administrative review of Feeding Our Future and issued findings.** There were 22 findings in this review, and MDE required Feeding Our Future to prepare a corrective action plan for each finding.	Due to the number of concerns found during the review, MDE told Feeding Our Future it would conduct a follow-up review within six to nine months. As we discussed in Chapter 3, this follow-up review never occurred.
February 20, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's management practices.** The complainant stated in a letter to the U.S. Department of Agriculture (USDA) Midwest Regional Office that the executive director of Feeding Our Future took control of the entity through theft and forgery. In the letter, the complainant expressed other concerns, including that MDE's actions in response to their previous complaints were inadequate.	This was the fifth complaint MDE received involving Feeding Our Future.
February 25, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complainant passed along an anonymous letter that alleged Feeding Our Future was recruiting sites at a local child-care organization meeting.	This was the sixth complaint MDE received involving Feeding Our Future.

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	Date	Event	Comments
	April – August 2019	**MDE completed a review of Feeding Our Future's revised budget for the 2019 CACFP program year.** MDE had several concerns, including that Feeding Our Future's staff salaries were above average and its cash flow was insufficient to cover staff salaries and office space rental costs. MDE approved the revised budget.	See Exhibit 3.1 for a complete list of MDE's concerns.
	June 20, 2019	**MDE accepted Feeding Our Future's corrective action plan.** However, MDE determined that additional follow-up would be required.	The corrective action plan was a result of the administrative review conducted by MDE that concluded in February 2019.
	June 27, 2019	**MDE received a complaint from a sponsor regarding kickbacks solicited by Feeding Our Future.** MDE contacted the complainant, but they stated the original source of the complaint was not willing to speak with MDE and they did not want their name and the name of their organization to be disclosed.	This was the seventh complaint MDE received involving Feeding Our Future.
	June 28, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's program implementation.** The complainant stated a site sponsored by Feeding Our Future indicated that it did not require the site to retain receipts or have a menu with nutritional requirements.	This was the eighth complaint MDE received involving Feeding Our Future.
	September 24, 2019	**Feeding Our Future submitted an application and budget for the 2020 CACFP program year.** MDE identified a number of issues, including that Feeding Our Future: • Did not have any dedicated accounting or financial staff despite its projected growth and the amount of federal dollars it managed. • Planned to spend at least $30,000 to contract with a lawyer located out-of-state to serve as a compliance manager. • Planned to pay significantly higher salaries to its executives and senior management than the average of comparable organizations in the region. MDE approved the application and budget, except for a budget item related to the compliance manager contract.	The individual named as Feeding Our Future's compliance manager was Feeding Our Future's counsel for the *Feeding Our Future v. Minnesota Department of Education* lawsuit, which began in late 2020. See Exhibit 3.1 for a complete list of MDE's concerns.
	November 27, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complainant stated that MDE's delay in approving their organization's sites allowed Feeding Our Future to contact these sites promising larger claims on a faster timeline. The complainant stated that this was false advertising.	This was the ninth complaint MDE received involving Feeding Our Future.

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	Date	Event	Comments
	December 26, 2019	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complainant alleged that Feeding Our Future's executive director and another staff person had repeatedly visited their organization's sites with the intention of recruiting them to Feeding Our Future. MDE shared this complaint directly with Feeding Our Future, and the executive director responded in writing to the accusations made by the complainant. In June 2020, MDE provided a written response to both sponsors indicating MDE had determined there was not sufficient evidence to demonstrate that Feeding Our Future engaged in unethical recruitment practices. MDE again encouraged the two sponsors to attempt to resolve any conflicts before involving MDE.	This was the tenth complaint MDE received involving Feeding Our Future.
	January 3, 2020	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment.** The complainant stated that Feeding Our Future was aggressively recruiting their organization's sites. In response, MDE requested more information from the complainant, but it is unknown if additional action was taken.	This was the eleventh complaint MDE received involving Feeding Our Future.
	January 31, 2020	**U.S. Department of Health and Human Services declared a public health emergency due to COVID-19.**	
	February 15, 2020	**IRS revoked Feeding Our Future's nonprofit status.** The revocation was a result of Feeding Our Future's failure to file documentation needed to maintain its status.	MDE later issued a serious deficiency for this, but not until January 2021.
	March 11, 2020	**World Health Organization declared COVID-19 a pandemic.** Soon after, USDA began issuing waivers that suspended some requirements for federal nutrition programs.	See Chapter 3 for our assessment of MDE's implementation of federal pandemic-era waivers.
	March 13, 2020	**Minnesota's Governor issued an executive order declaring a peacetime emergency in regard to the COVID-19 pandemic.** This order allowed the Minnesota Department of Health to continue to provide guidance for and lead the coordination of any statewide responses to the COVID-19 pandemic. This order also allowed the Minnesota National Guard to ensure its readiness to assist as needed during the peacetime emergency.	
	March 15, 2020	**Minnesota's Governor issued an executive order closing all Minnesota public schools beginning on March 18.** Public schools remained closed to in-person learning through the end of the 2019-2020 school year. At the beginning of the 2020-2021 school year, the majority of Minnesota public schools operated a virtual or hybrid learning model.	

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	Date	Event	Comments
	April 2020	**During a virtual visit of one of Feeding Our Future's sites, MDE staff witnessed about 30 kids receiving meals in 15 minutes.** Then, Feeding Our Future's executive director's phone died and they stated that within the next hour, 1,800 additional kids came when their phone was dead. We have no evidence indicating MDE investigated this irregularity.	
	April 13-23, 2020	**Feeding Our Future submitted applications for eight sites for participation in CACFP.**	
	April 28, 2020	**Feeding Our Future sent MDE a draft complaint and litigation hold.** Feeding Our Future stated that if the eight site applications it submitted between April 13-23 were not approved by April 30, 2020, it would file its complaint in district court.	
	April 29, 2020	**MDE approved the eight Feeding Our Future site applications.** MDE approved the 8 site applications in question, along with an additional 4, for a total of 12 site applications.	
	May 21, 2020	**Feeding Our Future applied to MDE to participate in the Summer Food Service Program (SFSP) for the 2021 program year.[2]** On this application, Feeding Our Future attested that it was a tax-exempt entity when, in fact, its tax-exempt status was revoked by the IRS on February 15, 2020. The IRS posted the revocation on its website on May 11, 2020. MDE approved the application on June 30, 2020.	
	June 18, 2020	**MDE remotely conducted a preapproval visit of Feeding Our Future for SFSP.** This visit resulted in findings related to all nine of Feeding Our Future's proposed SFSP sites, including that Feeding Our Future's application failed to accurately describe meal service at nearly all of its proposed sites.	
	June 30, 2020	**Feeding Our Future and MDE entered into an agreement allowing it to receive reimbursements for claimed SFSP meals and snacks.**	
	August 2020	**MDE began, but did not complete, an administrative review of Feeding Our Future's SFSP operations.** In October 2020, MDE conducted virtual visits at some of Feeding Our Future's sites, but MDE paused this review because, according to an MDE official, the virtual site visits "were not working."	

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[2] SFSP program years begin on May 1 and end on April 30 of the following year. The program year is designated by the calendar year in which it ends; thus, program year 2021 began on May 1, 2020, and ended on April 30, 2021.

	Date	Event	Comments
	August 31, 2020	**Feeding Our Future submitted an application and budget for the 2021 CACFP program year.** MDE identified a number of issues, including that Feeding Our Future: • Hired 14 new staff without appropriate approval. • Lacked dedicated accounting or financial staff, despite MDE's recommendation to do so the prior year. • Did not provide adequate documentation and justification for hiring a compliance manager even after MDE had disapproved the expense in the prior year. MDE approved the application and budget, except for a budget item related to the compliance manager contract.	See Exhibit 3.1 for a complete list of MDE's concerns.
	October or November 2020[3]	**MDE escalated concerns about Feeding Our Future to the USDA's Office of Inspector General.** Primarily, MDE was concerned about Feeding Our Future's growth.	
	October 12, 2020	**MDE received a complaint from a sponsor alleging fraud in CACFP and SFSP.** The complainant alleged that a "fraud ring" was fixated on the CACFP and SFSP. The complainant stated that it involved child-care centers, SFSP sites, at least one restaurant, and an unnamed sponsoring organization.	
	November 20, 2020	**Feeding Our Future filed a lawsuit against MDE.** The lawsuit, filed in Ramsey County District Court, stated that despite federal regulations requiring MDE to process applications within 30 days, it had not acted on many of Feeding Our Future's applications for more than 60 days.	
	December 2020	**MDE received a complaint from a sponsor regarding Feeding Our Future's management practices.** The complainant alleged that Feeding Our Future was not responding to site requests to transfer to another sponsor. In response, MDE requested more information, but it is unknown what the results of the inquiry were.	This was the twelfth complaint MDE received involving Feeding Our Future.
	December 11, 2020	**MDE received a complaint from a sponsor regarding Feeding Our Future's management practices.** The complainant reported that a group of individuals came to them and stated that Feeding Our Future "bought" their sites.	This was the thirteenth complaint MDE received involving Feeding Our Future.
	December 15, 2020	**MDE received a complaint from a sponsor regarding Feeding Our Future's program implementation.** The complainant stated that some sites sponsored by Feeding Our Future have complained that they felt like they "were being used" by their sponsor.	This was the fourteenth complaint MDE received involving Feeding Our Future.

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[3] The exact date of this event is unclear.

	Date	Event	Comments
	December 22, 2020	**Based on the agreement of MDE and Feeding Our Future, a Ramsey County District Court judge ordered MDE to issue decisions on Feeding Our Future's CACFP and SFSP applications in a "reasonably prompt manner."** The court's order mandated that if MDE received an incorrect or incomplete application, it must notify Feeding Our Future why it believed the application to be incorrect or incomplete and provide appropriate technical assistance to correct or complete the application.	
	December 22, 2020	**MDE denied all 68 of Feeding Our Future's pending SFSP site applications.** The denial was due to: (1) the fact that Feeding Our Future was already serving 75,000 children per day at existing SFSP sites, which exceeded the 50,000 per day limit established in federal law; and (2) MDE's determination that Feeding Our Future's site applications failed to demonstrate how it could manage a program roughly twice the size of the federal limit. Feeding Our Future submitted an appeal to MDE's appeal panel on January 4, 2021. On February 4, 2021, the appeal panel upheld MDE's denial of the site applications.	
	December 27, 2020	**MDE received a complaint from a sponsor regarding Feeding Our Future's management practices.** The complainant stated that a site sponsored by Feeding Our Future reached out to them to inquire about changing their sponsorship. The site operator said they had tried reaching out to Feeding Our Future to sign the transfer request, but they had not heard back for weeks.	This was the fifteenth complaint MDE received involving Feeding Our Future.
	January 19, 2021	**MDE received a complaint regarding Feeding Our Future's program implementation.** A complainant stated that there were two U-Haul trucks in their parking lot giving out food items to individuals. In response, MDE requested that Feeding Our Future conduct a site visit to investigate the complaint. After conducting the site visit, Feeding Our Future's executive director reported back to MDE that the individual distributing food stated they were sponsored by another sponsor.	This was the sixteenth complaint MDE received involving Feeding Our Future.
	January 15, 2021	**MDE declared Feeding Our Future seriously deficient for CACFP and SFSP.** This was due to the IRS's revocation of Feeding Our Future's nonprofit status and Feeding Our Future's noncompliance with federal audit requirements. Feeding Our Future was required to respond within ten business days with a written corrective action plan. Feeding Our Future responded to the serious deficiency determination on January 26. It provided a copy of an audit report for the year ending September 30, 2019, and a copy of a letter from the IRS dated December 1, 2020, stating that Feeding Our Future was exempt from federal income tax, retroactive to February 2020.	Feeding Our Future responded to the serious deficiency determination within ten business days; however, MDE indicated Feeding Our Future did not provide a corrective action plan. And, after Feeding Our Future provided the audit report, MDE found issues with it, as we discussed in Chapter 5.

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	Date	Event	Comments
	January 29, 2021	**MDE received a complaint from a sponsor regarding Feeding Our Future's site recruitment practices.** The complainant stated that Feeding Our Future and another sponsor had been continously and constantly recruiting their sites to switch sponsors. The sponsor also stated that the two sponsors were spreading misinformation about the nutrition programs and their intentions. MDE indicated it would send the complaint information to Feeding Our Future and require follow-up.	This was the seventeenth complaint MDE received involving Feeding Our Future.
	February 2, 2021	**Feeding Our Future provided a corrective action plan to MDE as required by the January 15, 2021, serious deficiency determination.** The plan stated the IRS had mistakenly revoked Feeding Our Future's federal income tax exemption status, and that a single audit was completed before it was due at the end of 2020. Feeding Our Future planned to check why the audit did not appear on the Federal Audit Clearinghouse website.	MDE later determined the corrective action plan to be insufficient. Due to this and other issues, MDE initiated the process to terminate Feeding Our Future's participation in CACFP on March 29, 2021.
	February 22, 2021	**The Federal Bureau of Investigation (FBI) notified MDE of allegations it received involving Feeding Our Future.** The allegations were that Feeding Our Future's executive director was (1) accepting kickbacks for participation in federal nutrition programs, (2) submitting reimbursements for meals without proper or insufficient paperwork, and (3) not providing meals they said they provided.	
	March 2021	**MDE received a complaint from a Minnesota school district regarding Feeding Our Future's management practices.** The school district stated that sites sponsored by Feeding Our Future were operating on Minneapolis Parks and Recreation Board land without approval. MDE sent information about the complaint to Feeding Our Future.	This was the eighteenth complaint MDE received involving Feeding Our Future.
	March 5, 2021	**MDE sent a letter to Feeding Our Future indicating the key pieces of the single audit that were missing and requested the contact information of the audit firm.** Feeding Our Future did not provide the information by the March 15, 2021, deadline.	Feeding Our Future's lack of response regarding the missing single audit and other issues caused MDE to issue a notice of proposed termination and disqualification on March 29, 2021.
	March 24, 2021	**MDE received a complaint from an individual regarding Feeding Our Future's management practices.** The individual alleged that a site sponsored by Feeding Our Future had never distributed food to children or parents. In response, MDE requested more information from the complainant, but there was no documented resolution.	This was the nineteenth complaint MDE received involving Feeding Our Future.

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	Date	Event	Comments
✕	March 29, 2021	**MDE initiated a process to terminate Feeding Our Future's CACFP sponsorship. MDE stated that the serious deficiencies issued on January 15, 2021, had not been fully corrected.** Specifically, MDE found that (1) Feeding Our Future's written corrective action plan provided on February 2, 2021, was not sufficient; and (2) Feeding Our Future had not responded with the contact information for the auditor as requested on March 5, 2021. The date of proposed termination was set for April 30, 2021. Feeding Our Future was able to appeal within 15 days.	A second set of serious deficiencies was issued two days later on March 31, 2021.
✕	March 31, 2021	**MDE issued a second set of serious deficiencies for CACFP.** MDE determined Feeding Our Future was seriously deficient due to concerns about Feeding Our Future's financial viability and financial management, administrative capabilities, and program accountability. MDE indicated if Feeding Our Future did not correct the serious deficiencies by April 30, 2021, MDE would move to terminate Feeding Our Future's participation in CACFP and disqualify it from future CACFP participation.	MDE used this second set of serious deficiencies as grounds to deny Feeding Our Future's 2022 SFSP application. Additionally, MDE stopped paying Feeding Our Future's claims for reimbursement and issuing site IDs for Feeding Our Future in order to create new sites. Feeding Our Future challenged these actions in April 2021 court filings.
	April 2021	**MDE provided information to the FBI regarding fraud suspicions with Feeding Our Future and sites under its sponsorship.** MDE believed some of Feeding Our Future's sites were submitting fradulent documents and artificially inflating the number of individuals receiving meals and snacks in order to obtain federal funds, which were then diverted away from the nutrition program.	The FBI began an investigation in May 2021.
✕	April 1, 2021	**MDE and the USDA Midwest Regional Office met about the serious deficiency process and notice of proposed termination.** According to MDE, the USDA Midwest Regional Office supported its decision to stop paying Feeding Our Future's claims for reimbursement and indicated that MDE had the authority for this decision.	
✕	April 7, 2021	**MDE sent Feeding Our Future instructions for documentation it needed to submit in response to the March 31, 2021, serious deficiencies.** MDE requested meal validation documents, documents related to Feeding Our Future's operations, and a corrective action response letter.	
✕	April 12, 2021	**Feeding Our Future appealed MDE's March 29, 2021, notice of proposed termination and disqualification of CACFP sponsorship.** The notice was based on the January 15, 2021, serious deficiencies.	

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	Date	Event	Comments
	April 13, 2021	**Feeding Our Future filed a motion in Ramsey County District Court for a temporary restraining order and to hold MDE in contempt of court.** In its request for a temporary restraining order, Feeding Our Future asserted that MDE could not lawfully withhold reimbursements. In its request to hold MDE in contempt of court, Feeding Our Future alleged that MDE's refusal to accept or process Feeding Our Future applications violated the court's December 22, 2020, order.	The December 22, 2020, court order stated MDE must issue a decision on Feeding Our Future's site applications in a "reasonably prompt manner." The court also directed that if an application is incorrect or incomplete, MDE must notify Feeding Our Future why it is incomplete or incorrect and provide technical assistance if appropriate.
	April 15, 2021	**MDE sent Feeding Our Future instructions on how to submit documentation to support its meal claims.** The documentation required for meal validation included meal and snack count records, attendance records, menus for all meals and snacks served, vendor invoices, and education and enrichment activities offered to children.	This meal validation requirement was a result of the second set of serious deficiencies issued on March 31. We discussed MDE's review of Feeding Our Future's meal validation documents in Chapter 5.
	April 20, 2021	**Feeding Our Future notified MDE that it started uploading documentation related to MDE's decision to stop paying the organization's meal claims.**	Several of the sites for which Feeding Our Future provided documentation were eventually named in federal criminal indictments.
	April 21, 2021	**Ramsey County District Court heard Feeding Our Future's motion for a temporary restraining order and to hold MDE in contempt of court.** The court determined that MDE's "stop pay" order was not within the scope of the existing lawsuit, and that the court therefore did not have jurisdiction over that issue. However, the court indicated that MDE's decision to stop paying Feeding Our Future's claims was "a real problem."	Nine days later, MDE removed its "stop pay" order.
	April 28, 2021	**Feeding Our Future submitted a corrective action plan in response to the March 31, 2021, serious deficiency letter.**	
	April 29, 2021	**MDE denied all 184 pending CACFP and SFSP site applications as a result of the March 31, 2021, deficiency.** MDE stated that this denial was appealable.	
	April 30, 2021	**Feeding Our Future provided documentation required by the March 31, 2021, notice of serious deficiency.**	
	April 30, 2021	**MDE removed its "stop pay" order on Feeding Our Future's account within its claims processing system.** MDE removed the "stop pay" order due to the court's statements on April 21, 2021.	
	May 2021	**FBI began an investigation into Feeding Our Future.**	

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	Date	Event	Comments
	May 3-6, 2021	**Feeding Our Future sought timely administrative review of MDE's April 29, 2021, decision to deny 184 site applications.** MDE's appeal panel conducted the review.	
	May 5, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** The site, sponsored by Feeding Our Future, reached out to MDE to state they had not received their March reimbursement check. During this conversation, MDE noticed several irregularites between what the site stated versus what Feeding Our Future had reported, including which food program the site utilized and the site address.	This was the twentieth complaint MDE received involving Feeding Our Future.
	May 5, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** The site, sponsored by Feeding Our Future, raised concerns about not being able to continue to operate with their current sponsor. During this conversation, MDE noted that the site's application stated they were operating under CACFP, whereas the site stated they were operating under SFSP.	This was the twenty-first complaint MDE received involving Feeding Our Future.
	May 11, 2021	**Feeding Our Future provided a single audit report to MDE, as well as documentation that the audit had been submitted to the Federal Audit Clearinghouse.**	We discussed issues with the audit in Chapter 5.
	May 13, 2021	**MDE sent a letter to Feeding Our Future vacating the March 29, 2021, notice of proposed termination and disqualification.** MDE vacated the notice of proposed termination and disqualification due to Feeding Our Future's submission of a single audit report on May 11, 2021. However, the serious deficiencies from March 31, 2021, remained in effect.	Additionally, this action deferred the January 15, 2021, serious deficiency, as the proposed termination and disqualification stemmed from this serious deficiency.
	May 21, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** A site contacted MDE and raised concerns about Feeding Our Future's reimbursement practices. The site stated that Feeding Our Future contacted them trying to recruit them for CACFP and SFSP participation. Feeding Our Future stated that if the site chose to be sponsored by them, they could provide reimbursement back to October 2020. In response, MDE contacted the complainant and provided resources on other ways to participate in SFSP.	This was the twenty-second complaint MDE received involving Feeding Our Future.
	June 1, 2021	**MDE sent its reply to the documentation Feeding Our Future provided in response to the March 31, 2021, serious deficiency letter.** The letter indicated that MDE accepted all but one of Feeding Our Future's corrective actions. MDE indicated it was still waiting for Feeding Our Future's revised budget, which the organization provided on June 2.	

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	Date	Event	Comments
	June 4, 2021	**MDE determined that Feeding Our Future fully and permanently corrected the serious deficiencies issued on March 31, 2021, and therefore deferred the serious deficiency.** After this action, Feeding Our Future was no longer seriously deficient and could continue operating as normal.	
	June 10, 2021	**MDE approved Feeding Our Future's application for the 2022 SFSP program year.**	
	June 11, 2021	**MDE notified Feeding Our Future that it had reviewed site claim documents to validate March claims for reimbursement and that more information was required.** MDE stated that documentation was required by June 18, 2021, or claims would be denied.	According to an MDE official, Feeding Our Future did not respond to this request. However, as we discussed in Chapter 5, MDE did not deny or adjust downward claims that required additional supporting documentation.
	June 15, 2021	**MDE's appeal panel and Feeding Our Future participated in a hearing pertaining to Feeding Our Future's appeal of MDE's April 29, 2021, decision to deny 184 site applications.**	
	June 18 and 23, 2021	**Feeding Our Future and MDE participated in hearings in Ramsey County District Court regarding various motions filed by Feeding Our Future.** The June 18 hearing related to Feeding Our Future's motions for a temporary restraining order, to amend the complaint to add additional claims, to hold MDE in contempt of court, and to compel discovery responses. The June 23 hearing was called by the court to modify the ruling the court made during the June 18 hearing.	
	June 24, 2021	**MDE was held in contempt of court.** The court determined that MDE was in violation of the December 22, 2020, court order because it had not allowed Feeding Our Future to obtain site IDs in a timely manner. The court ordered MDE to pay Feeding Our Future $47,500 in sanctions and legal fees.	
	June 25, 2021	**MDE denied all of Feeding Our Future's pending SFSP applications (15) for for-profit sites with self-vended food contracts, concluding that such an arrangement violated the federal prohibition on providing SFSP funds to a for-profit site.** MDE asserted that for-profit sites cannot both be a vendor and a distribution site for the federal food program. MDE denied an additional site application because the property owner stated that they had not given Feeding Our Future permission to operate there.	Feeding Our Future appealed this denial on the same day.

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	Date	Event	Comments
	June 28, 2021	**MDE's appeal panel issued its final decision regarding MDE's denial of 184 CACFP and SFSP site applications.** MDE's appeal panel affirmed the department's April 29, 2021, decision to deny Feeding Our Future's site applications. The appeal panel's decision was based on its determination that MDE was not required to permit program expansion during the period when Feeding Our Future failed to comply with regulatory requirements.	In part based on this decision, Feeding Our Future filed a second motion to hold MDE in contempt of court on July 6, 2021. And, on July 27, 2021, Feeding Our Future appealed the MDE panel's decision to the Minnesota Court of Appeals.
	July 6, 2021	**Feeding Our Future filed a second motion to hold MDE in contempt of court.** In part, Feeding Our Future claimed MDE took an inconsistent position during the appeal process related to the department's denials of Feeding Our Future's site ID requests.	
	July 14, 2021	**MDE's appeal panel issued its final decision regarding MDE's denial of 16 SFSP site applications.** MDE's appeal panel upheld the June 25, 2021, decision to deny 16 SFSP site applications. Fifteen sites were denied on the basis that for-profit sites were prohibited from serving simultaneously as the contracted food vendor and distribution site, and one on the basis that the property owner of the proposed site had not given Feeding Our Future permission to operate there.	On August 5, 2021, Feeding Our Future appealed the MDE panel's decision to the Minnesota Court of Appeals
	July 15, 2021	**Ramsey County District Court heard and denied Feeding Our Future's second motion to hold MDE in contempt of court.** The motion was denied on the basis of being premature.	
	July 15, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** An individual contacted MDE to report that they went to a site sponsored by Feeding Our Future and found that no food was being served there. The complainant asked the staff at the site, and they knew nothing about food service at the location. In response, MDE contacted Feeding Our Future. Its executive director stated that the site MDE inquired about had changed locations effective July 1, 2021. However, after research, MDE could find no record that Feeding Our Future ever informed MDE of the change in location.	This was the twenty-third complaint MDE received involving Feeding Our Future.
	July 27, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** A site, sponsored by Feeding Our Future, contacted MDE to request to be transferred to another sponsor due to Feeding Our Future's poor communication. The site stated that Feeding Our Future came to the site once to get it enrolled in CACFP, but never came again. The complainant also said Feeding Our Future was very difficult to contact when they had questions about how to operate their food program. MDE planned to contact Feeding Our Future about the complaint, but the transfer was successfully completed on July 30, 2021, resolving the issue.	This was the twenty-fourth complaint MDE received involving Feeding Our Future.

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Date	Event	Comments
August 2021	**MDE received a complaint from a vendor regarding Feeding Our Future's management practices and kickbacks.** A vendor, who previously provided food services for a site, contacted MDE to report that Feeding Our Future had terminated the vendor's contract. The vendor stated they believed Feeding Our Future did this in retaliation when the vendor refused to provide a kickback. In response, MDE referred at least part of the complaint to Feeding Our Future.	This was the twenty-fifth complaint MDE received involving Feeding Our Future. MDE also received a complaint from a site serviced by this vendor (see below).
August 2021	**MDE received a complaint from a site regarding Feeding Our Future's program implementation.** A site, sponsored by Feeding Our Future, contacted MDE to report an issue with a vendor caused by Feeding Our Future. The site stated that Feeding Our Future informed them their current vendor would no longer be able to service them, and promised to provide a replacement vendor. However, the complainant claimed this replacement vendor was ill-prepared and delivered spoiled food items in an unrefrigerated truck. The site reported this to Feeding Our Future, but Feeding Our Future never replaced the vendor, which left the site to find a new vendor on their own. In response, MDE referred the complaint to Feeding Our Future.	This was the twenty-sixth complaint MDE received involving Feeding Our Future. MDE also received a complaint from the site's vendor (see above).
August 31, 2021	**Feeding Our Future submitted an application and budget for the 2022 CACFP program year.** MDE raised several concerns, including: • "Unreasonable" and noncompliant enrollment numbers for some CACFP sites. • Uncertainties about site compliance with attendance, occupancy limit, Minnesota Department of Health food service licensing, and meal service requirements. MDE approved the application and budget.	See Exhibit 3.1 for a complete list of MDE's concerns.
September 22, 2021	**MDE received a complaint from an individual regarding Feeding Our Future's management practices.** A complaint was referred to MDE alleging that Feeding Our Future's nonprofit status had been revoked by the IRS, but that it was still receiving CACFP payments. MDE did not investigate this complaint, as this issue was part of the January 15, 2021, serious deficiency notice.	This was the twenty-seventh complaint MDE received involving Feeding Our Future.
October 20, 2021	**Feeding Our Future brought a motion for a temporary restraining order and injunction.** Feeding Our Future alleged that an MDE staff person stole food from a Feeding Our Future site and intentionally destroyed relevant evidence. Through this motion, Feeding Our Future was seeking an order to prevent MDE staff from doing these alleged actions again. The motion was denied by the court on November 24, 2021.	

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	Date	Event	Comments
	October 21-23, 2021	**MDE received three complaints from an individual regarding Feeding Our Future's management practices.** The complainant reported that three sites sponsored by Feeding Our Future did not have permission to be operating in their present locations. The complainant alleged that the sites were not delivering food directly to individuals, but rather were leaving the food items in common areas creating a mess. MDE indicated that the complaint claims could not be substantiated and stated Feeding Our Future provided clarification regarding the sites.	This was the twenty-eighth complaint MDE received involving Feeding Our Future.
	October 27, 2021	**MDE received a complaint from an indivdual regarding Feeding Our Future's management practices.** An individual contacted MDE to report that food was being distributed at a property they owned without their consent. The individual stated they had received numerous complaints from neighbors, including accusations of the site operators dumping milk outside of the premises. MDE stated the restaurant located at the address the individual provided was not authorized to operate as a site, and advised the complainant to take the issue up with the lease holder.	This was the twenty-ninth complaint MDE had received involving Feeding Our Future.
	December 16, 2021	**MDE received a complaint from a site regarding Feeding Our Future's management practices.** The complainant stated they were not receiving their payments in a timely manner from Feeding Our Future, among other things. MDE referred the site to their sponsor and asked the site to stop contacting MDE until MDE had completed the investigation with the information the site had already provided.	This was the thirtieth complaint MDE received involving Feeding Our Future.
	January 20, 2022	**FBI executed search warrants at Feeding Our Future's office and several other locations affiliated with the nonprofit organization. MDE terminated Feeding Our Future's participation in CACFP and SFSP.** MDE indicated the termination was based on the supporting documentation filed through the U.S. District Court, which alleged Feeding Our Future and its executive director submitted false and fraudulent claims. MDE also immediately stopped payments to Feeding Our Future. MDE stated that these actions were appealable. Feeding Our Future did not appeal any of these actions.	
	January 27, 2022	**Ramsey County District Court issued an order dismissing the *Feeding Our Future v. Minnesota Department of Education* case.** The parties agreed to dismiss the case without prejudice, thereby rendering ineffective the December 22, 2020, order requiring MDE to approve or disapprove Feeding Our Future's CACFP and SFSP site applications in a "reasonably prompt manner."	

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Date	Event	Comments
February 25, 2022	**Feeding Our Future began the process of dissolving as an organization.**	
September 20, 2022	**U.S. Department of Justice announced federal criminal charges against Feeding Our Future's executive director and 46 other individuals.** These individuals were charged with various financial crimes related to their alleged roles in a $250 million fraud scheme to exploit both CACFP and SFSP.	
October 19, 2022	**U.S. Department of Justice announced charges against two additional defendants.**	
October 28, 2022	**U.S. Department of Justice announced charges against an additional defendant.**	
March 13, 2023	**U.S. Department of Justice announced charges against ten additional defendants.**	
February 5, 2024	**U.S. Department of Justice announced charges against ten additional defendants.** As of May 2024, a total of 70 individuals had been charged in relation to the alleged fraud. Of these 70, 18 had pleaded guilty to their charges.	

Source: Office of the Legislative Auditor.

OLA

Appendix B: Site Applications and Litigation

In 2020 and 2021, the Minnesota Department of Education's (MDE's) application process for the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) sites was scrutinized in district court as part of a lawsuit Feeding Our Future filed against MDE in November 2020.[1] Given that MDE's approval of Feeding Our Future's site applications facilitated the organization's rapid expansion, this litigation gained added significance after the U.S. Department of Justice announced criminal charges against 47 defendants in September 2022 for their roles in allegedly defrauding the federal government and other crimes.[2] As such, we describe the litigation below with an emphasis on how it affected MDE's review of Feeding Our Future's site applications.

Key Events in the Timeline: Feeding Our Future's Lawsuit Against MDE

November 20, 2020 – Feeding Our Future filed a lawsuit against MDE.

December 22, 2020 – Based on the agreement of MDE and Feeding Our Future, Ramsey County District Court ordered MDE to issue decisions on Feeding Our Future's CACFP and SFSP site applications in a "reasonably prompt manner."

June 24, 2021 – MDE was held in contempt of court and ordered to pay Feeding Our Future $47,500 in sanctions and legal fees.

January 27, 2022 – Ramsey County District Court issued an order dismissing the *Feeding Our Future v. Minnesota Department of Education* case.

See Appendix A for more information.

Site Application Process

For a site to participate in CACFP or SFSP, a sponsor must submit an application on its behalf to MDE for approval.[3] MDE's site application process has two parts: an initial review of a potential site's eligibility and a more detailed review of information provided on a site application.

The process begins when a sponsor requests a site ID.[4] When MDE receives a site ID request, it confirms the site's eligibility to participate under federal regulations by identifying its exact geographic location and determining whether the entity (1) is located in a low-income area or serves a sufficient number of individuals from

[1] See Chapter 1 for a description of CACFP and SFSP.

[2] U.S. Department of Justice, Office of Public Affairs, *PRESS RELEASE: U.S. Attorney Announces Federal Charges Against 47 Defendants in $250 Million Feeding Our Future Fraud Scheme* (Washington, DC, September 20, 2022), https://www.justice.gov/opa/pr/us-attorney-announces-federal-charges-against-47-defendants-250-million-feeding-our-future, accessed January 17, 2024.

[3] 7 *CFR*, secs. 225.6(c)(2)(iii), (c)(3)(ii), and (g); and 226.16(b)(2) (2023).

[4] A site ID defines the latitude and longitude of the site so that MDE can ensure that it is not already sponsored and, for some sites, determine if the site is eligible due to its location in a low-income area. The ID also serves as an organization ID for payments, indicates whether the site is a school, and is linked to the site's street address.

low-income households; (2) is a nonprofit organization or certain type of for-profit entity; (3) is properly licensed, when appropriate; and (4) is not already sponsored by another organization. Once MDE determines that the site is eligible, the department issues a site ID.

The second step of the process begins when the sponsor completes an application for the site and provides information about the meals and snacks the site will serve, methods of meal and snack preparation, and catering contracts, among other things. For a site to receive final approval, MDE must confirm that the sponsor requesting the site has corrected any findings discovered during administrative reviews, is not currently subject to administrative action due to deficiencies in its program administration, and has a CACFP or SFSP program agreement with MDE that matches the program to be operated at the site.

Litigation with Feeding Our Future

Beginning in November 2020 and until the organization's termination from the program in January 2022, Feeding Our Future challenged MDE's handling of its site applications in court, and questioned the legality of MDE's site application review process more generally.

MDE rejected Feeding Our Future site applications for several reasons, including:

- The proposed site or Feeding Our Future did not meet the eligibility criteria found in federal law.
- The site application contained errors or was incomplete.
- Feeding Our Future failed to provide complete and accurate information requested during the application process.
- The approval of a proposed site would exceed the size limits.[5]

In April 2020, Feeding Our Future initiated the site application process for eight proposed CACFP after-school sites. In later district court filings, Feeding Our Future claimed that MDE had refused to process applications for these sites, which led Feeding Our Future to threaten legal action. MDE ultimately approved these applications later in April, and Feeding Our Future did not file a legal complaint at that time. However, Feeding Our Future would sue MDE later in the year.

[5] By law, MDE "must not approve any sponsor to operate more than 200 sites or to serve more than an average of 50,000 children per day" (7 *CFR*, sec. 225.6(b)(6) (2021)). Although federal regulations permit MDE to grant exceptions to this requirement, MDE confirmed that it has never done so. MDE's CACFP program agreement with Feeding Our Future states that "MDE reserves the right to impose program size limitations for a Sponsoring Organization based on program size, staffing patterns, program experience and organization" (Minnesota Department of Education, *Child and Adult Care Food Program Agreement*, signed July 27, 2018). MDE's SFSP program agreement with Feeding Our Future did not contain similar language.

Feeding Our Future sued MDE in November 2020 alleging that the department was delaying its approval of the organization's site applications beyond time limits found in federal law.

According to Feeding Our Future, beginning in September 2020 and throughout 2021, MDE took several months to review some of Feeding Our Future's site applications. In November 2020, Feeding Our Future filed a lawsuit in Ramsey County District Court, alleging that MDE had "consistently refused to allow Feeding Our Future to submit applications to open new meal sites."[6]

Specifically, Feeding Our Future claimed that between September 8, 2020, and November 20, 2020, MDE refused to issue site IDs to 41 proposed CACFP and SFSP locations and failed to act on another 10 proposed sites for 30 days or more. MDE denied the allegations and stated that many pending applications remained pending because Feeding Our Future had failed to provide MDE with complete and accurate information about the sites. According to Feeding Our Future, after the organization and MDE agreed to work together to resolve their issues in a November 24, 2020, conference call with a district court judge, MDE approved 39 of the 51 SFSP site applications by December 9, 2020. Two weeks later, as shown in Exhibit B.1, MDE acted on another batch of site applications by denying nearly 70 SFSP sites due to limitations in federal law on the number of children SFSP sponsors can serve in a single day.

The resolution of some of the pending site applications did not prompt Feeding Our Future to drop its suit. On December 22, 2020, using language agreed upon by Feeding Our Future and MDE, a Ramsey County district court judge issued an order specifying how MDE must process Feeding Our Future's complete and correct site applications moving forward. Key requirements of the order are in the box at right.

Court Ordered Site Application Process Requirements

MDE must:

- Approve or disapprove complete and correct site applications in a **reasonably prompt** manner.
- **Provide notification** of why it believes a site application is incomplete or incorrect.
- **Provide technical assistance** needed to make site applications complete and correct.

— Order, Ramsey County District Court, December 22, 2020

Over the following year, Feeding Our Future repeatedly referenced this order in filings asking the court to address MDE's unwillingness to issue site IDs and the department's delays in making decisions on submitted applications. For example, in March 2021, MDE stopped issuing Feeding Our Future site IDs due to an ongoing administrative action against the organization for its failure to meet CACFP performance standards. After receiving notice of MDE's decision, Feeding Our Future filed a motion seeking to hold MDE in contempt of court, arguing that MDE's decision to stop processing site applications was a violation of the district

[6] Complaint, November 20, 2020, *Feeding Our Future v. Minnesota Department of Education*, 62-CV-20-5492 (Minn. Dist. Ct.), 6. In addition to claims based on federal program regulations, Feeding Our Future asserted that MDE's delayed processing of site applications and the requirements of its site application process violated state human rights laws, constituted a breach of contract between the department and the organization, interfered with the organization's contracts with its sites and food vendors, and violated the organization's constitutional rights.

court's December 2020 order that MDE must approve or disapprove Feeding Our Future's site applications in a "reasonably prompt manner."[7] During an April 21, 2021, hearing about Feeding Our Future's motion, the judge stated that Feeding Our Future must be allowed to submit site applications, MDE must issue site IDs even if it believed the full site application would be denied, and MDE must promptly approve or disapprove any submitted applications in compliance with the court's December order.

A week later, as shown in Exhibit B.1, MDE denied 184 CACFP and SFSP site applications. MDE denied 149 of the 184 proposed sites without issuing the proposed location a site ID.

Exhibit B.1

Between December 2020 and December 2021, MDE denied around 280 of Feeding Our Future's site applications.

Date of Site Application Denial	Number of Sites Denied	Reason for Denial and Subsequent Events
December 22, 2020	68 SFSP sites	MDE denied the site applications because: • Existing Feeding Our Future SFSP sites were serving 75,000 children per day at the time of application, a number that exceeded the 50,000 per day limit established in federal law. • Feeding Our Future's site applications failed to demonstrate the organization's capability to manage a summer food service program roughly twice the size of the federal limit. Feeding Our Future submitted an appeal to MDE's appeal panel. The appeal panel upheld MDE's denial of the site applications.
April 29, 2021	184 CACFP and SFSP sites (149 of 184 proposed sites were denied site IDs)	MDE denied the site applications: • In an effort to comply with a judicial order. • Because Feeding Our Future was ineligible to sponsor additional sites due to its failure to correct serious deficiencies in its administration of CACFP and SFSP. Feeding Our Future submitted an appeal to MDE's appeal panel. The appeal panel upheld MDE's denial of the site applications. In July 2021, Feeding Our Future appealed the MDE panel's decision to the Minnesota Court of Appeals. Feeding Our Future argued that MDE violated federal regulations and acted arbitrarily and capriciously by (1) using a two-step application process to prevent 144 sites from submitting complete applications by not issuing them site IDs; and (2) denying site IDs on the basis of Feeding Our Future's serious deficiencies. After a federal investigation into Feeding Our Future's alleged role in the fraud scheme became public and MDE terminated the organization's participation in CACFP and SFSP, the court of appeals dismissed Feeding Our Future's appeal as moot. Feeding Our Future also referenced MDE's April 2021 site application denials in briefs it filed to support its previous motions to (1) hold MDE in contempt for failing to process site applications in a reasonably prompt manner, and (2) compel MDE to issue requested site IDs. In June 2021, the court held MDE in contempt of court.

Continued on the next page.

[7] Notice of Motion and Motion for an Emergency Temporary Restraining Order and Order for Contempt of Court, April 13, 2021, *Feeding Our Future v. Minnesota Department of Education*, 62-CV-20-5492 (Minn. Dist. Ct.).

Date of Site Application Denial	Number of Sites Denied	Reason for Denial and Subsequent Events
June 25, 2021	16 SFSP sites	MDE denied 15 of the site applications because the proposed for-profit sites would serve as both food distribution sites and food vendors for Feeding Our Future, contrary to updated U.S. Department of Agriculture (USDA) guidance. Feeding Our Future submitted an appeal to MDE's appeal panel. The appeal panel upheld MDE's denial of the site applications. In August 2021, Feeding Our Future appealed the MDE panel's decision to the Minnesota Court of Appeals. In its brief in support of its appeal, Feeding Our Future asserted that the MDE appeal panel's decision relied on misrepresentations by the department to reach its decision, and suffered from procedural defects. After a federal investigation into Feeding Our Future's alleged role in the fraud scheme became public and MDE terminated the organization's participation in CACFP and SFSP, the court of appeals dismissed Feeding Our Future's appeal as moot.
December 3, 2021	13 CACFP sites	MDE denied the site applications because planned meal types and snacks would prevent the proposed for-profit sites from meeting eligibility requirements.

Source: Office of the Legislature Auditor, analysis of Minnesota Department of Education documents and relevant Ramsey County District Court filings.

In June 2021, MDE was held in contempt of court for failing to comply with a December 2020 order.

During an April 30, 2021, hearing, the district court judge presiding over Feeding Our Future's lawsuit expressed concern that MDE's recent denials of Feeding Our Future's site applications may not have complied with the December 2020 order. Specifically, the judge warned that:

- MDE's denial of 149 site IDs was equivalent to preventing Feeding Our Future from submitting a site application rather than, as argued by MDE, a site application denial as the first step of the site application process.
- MDE had not provided a specific reason for denying each individual site.
- The corrective actions MDE proposed to Feeding Our Future to resolve serious deficiencies in the organization's program were not equivalent to providing the technical assistance needed to make the organization's applications complete, as required by the court's order.

Given these concerns, the judge ordered MDE to provide evidence and argument to show that it had complied with the December 2020 order, such that it should not be held in contempt of court.

On June 24, 2021, after two hearings on the matter, the district court issued an order finding MDE in contempt. The district court found that MDE failed to provide an adequate justification for the amount of time it took to consider site ID requests. The court also concluded that, in the absence of adequate justification, MDE's delay in

issuing site ID's was unreasonable and violated the court's December 2020 order to act on Feeding Our Future's site applications in a "reasonably prompt manner." On that basis, the judge found MDE in contempt and imposed monetary sanctions of $35,750 to ensure the department would comply with the December 2020 order and any future court orders. The court also ordered MDE to pay an additional $11,750—an amount that MDE and Feeding Our Future agreed was reasonable—towards attorneys' fees incurred by Feeding Our Future in bringing motions for contempt.

In compliance with the court's December 2020 order, by July 2, 2021, MDE informed Feeding Our Future that it would process 143 of the 149 site ID requests that it had denied on April 29, 2021, and issue site IDs to eligible sites. Feeding Our Future would then be able to complete the site applications, and MDE would decide to deny or approve the sites on the merits of their applications. By July 13, 2021, MDE had issued site IDs to 128 of the 143 sites that had previously been denied site IDs and was collecting additional information about the remaining 15 sites without IDs. By the same date, of the 79 site applications with site IDs that also included required documentation (such as a meal plan), MDE had approved 5, denied 0, and was requesting clarification for 1. MDE promised to process the remaining applications "as quick as possible."[8]

In addition to challenging MDE's delays in issuing site IDs and the pace at which the department reviewed site applications, Feeding Our Future challenged several other department actions in court. For example, Feeding Our Future alleged that MDE violated federal law when it changed the end dates on several approved site applications without explanation in order to shorten their program participation. Feeding Our Future claimed MDE altered the site applications instead of using the termination process as a way to deprive the organization of the right to appeal. As we discussed in Chapter 5, Feeding Our Future challenged MDE's decision to withhold payments from the organization until it had provided additional documentation to support its meal claims. After a district court judge commented that MDE's decision to withhold payments seemed inconsistent with federal regulations, MDE resumed paying Feeding Our Future despite receiving only some of the requested meal claims documentation (and without a formal order from the court to resume payments).

As we discussed above, Feeding Our Future's central complaints against MDE focused on the department's alleged noncompliance with specific federal nutrition program regulations. However, the organization also asserted other claims against MDE, including (1) breach of contract between MDE and Feeding Our Future; (2) interference in the contracts between Feeding Our Future and its sites; (3) discrimination against Feeding Our Future on the grounds of race, national origin, color, and religion; (4) denial of federal and state due process; and (5) defamation of Feeding Our Future.[9]

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[8] Third Declaration of [MDE staff person], July 13, 2021, *Feeding Our Future v. Minnesota Department of Education and [Assistant Commissioner of Education], in his official capacity*, 62-CV-20-5492 (Minn. Dist. Ct.), 4.

[9] During the course of this litigation, Feeding Our Future sought to add a number of claims against MDE to those it first asserted against MDE. These claims included fraud, civil theft, conversion, and abuse of the legal process; the court denied Feeding Our Future's motion to add these claims to their suit. Feeding Our Future also asserted a defamation claim against an MDE staff person in their personal capacity, though Feeding Our Future agreed to drop that claim soon thereafter. From the claims Feeding Our Future sought to add to their suit, the court only permitted the claim of defamation against MDE and an MDE staff person, acting in their official capacity, to move forward.

These claims were never adjudicated by the court. As we discussed in Chapter 2, on January 20, 2022, the Federal Bureau of Investigation executed search warrants on Feeding Our Future's office and other properties associated with the organization and its staff. A week later, the court adopted the stipulation of MDE and Feeding Our Future for the dismissal of the district court proceeding without prejudice.[10]

[10] In December 2022, MDE sued Feeding Our Future and its executive director in Ramsey County District Court alleging that the organization's litigation against MDE, which we describe above, was an abuse of the legal process and malicious prosecution (Complaint, February 16, 2023, *Minnesota Department of Education v. Feeding Our Future and Executive Director*, 62-CV-23-863 (Minn. Dist. Ct.)). MDE was seeking to recover nearly $584,000 in attorneys' fees and other costs related to defending itself against Feeding Our Future's lawsuit and a court order to prohibit Feeding Our Future from suing MDE in the future. In January 2024, the court dismissed the malicious prosecution claim but permitted the abuse of process claim to proceed.

OLA

DEPARTMENT OF EDUCATION

June 7, 2024

Ms. Judy Randall
Legislative Auditor
Office of the Legislative Auditor
658 Cedar St., Room 140
St. Paul, MN 55155

Auditor Randall,

Thank you for the opportunity to comment on the Office of the Legislative Auditor's ("OLA") special review of the Minnesota Department of Education's oversight of the nonprofit organization Feeding Our Future ("FOF"). The Minnesota Department of Education (the "Department" or "MDE") is committed to program integrity and strong fiscal oversight of our programs and the important work we do on behalf of children and adults across the state. What happened with Feeding Our Future was a travesty – a coordinated, brazen abuse of nutrition programs that exist to ensure access to healthy meals for low-income children. The responsibility for this flagrant fraud lies with the indicted and convicted fraudsters.

MDE appreciates the time and effort that the OLA has put into the review of MDE's oversight of federal nutrition programs, as well as the collegial and collaborative process through which OLA has engaged MDE. OLA has provided helpful suggestions in this report and MDE appreciates the detailed attention to MDE's practices. But MDE disputes the OLA's characterization regarding the adequacy of MDE's oversight – MDE's oversight of these programs met applicable standards and MDE made effective referrals to law enforcement. The fraud here was perpetuated by a criminal enterprise that capitalized on risk created by a global pandemic.

MDE's oversight of this program is frequently reviewed, and we view these reviews as useful continuous improvement tools. This special review validates many of MDE's own observations made over the past two years as the Department sought to learn from this experience and build safeguards to prevent future issues. MDE did not wait for this report to take action; MDE has proactively made changes for multiple years to enhance program oversight and integrity.

This response will proceed in two parts: first, I want to highlight the efforts MDE staff undertook to enforce program requirements and bring an end to the fraud in these programs. Second, Part II will highlight a series of steps MDE, as a continuous improvement agency, has taken to strengthen our ability to ensure program integrity in these and other programs.

Part I: MDE's Oversight and Accountability Efforts

During the trial in which five defendants have been found guilty on the majority of charges of fraud and other crimes, FBI Agent Jared Kary said that the FBI "dug into the case after [MDE] reported suspected fraud in spring

2021."[1] Both prior to my appointment as commissioner, and no doubt after I leave, MDE stood and will stand ready to protect state and federal funds and to ensure those programs are administered with integrity. The arc of MDE's efforts to oversee and hold sponsors such as Feeding Our Future accountable reflects the dedication of MDE's staff to ensuring that these program funds are used as intended to benefit children.

Agent Kary's court room testimony highlights that MDE's oversight of FOF and efforts to work in partnership with federal investigators were central to the discovery of and termination of the ongoing fraud. The Department's approach, as evidenced by this report and other reviews, met applicable federal standards, and in many cases exceeded those standards.

The story of MDE's oversight of Feeding Our Future began before FOF existed, when MDE denied the nonprofit organization Partners in Nutrition ("PIN")'s application to expand to be an unaffiliated sponsor for multiple sites, on the basis of financial viability. PIN appealed to the Minnesota Court of Appeals, which ruled that MDE did not have the authority to apply financial viability standards more stringent than the "relatively minimal standard" in federal regulations.[2]

Feeding Our Future began operating the Summer Food Service Program in June 2020. Upon receiving claims for that summer, MDE observed rapid growth in the number of community sites and new sites sponsored by Feeding Our Future as well as an exponential increase in the rate of meal reimbursement claims and dollars flowing to this sponsor. As required by federal regulations, MDE staff repeatedly worked with Feeding Our Future representatives to understand the increased demand. As the OLA report observes, MDE made extensive findings about FOF's shortcomings. In response to these findings, and in consideration of the PIN decision, MDE staff also reached out to the USDA Midwest Regional Office multiple times seeking advice and support regarding this notably rapid growth, and how to best exercise oversight in light of it. In October 2020, MDE escalated the issue to the USDA Office of the Inspector General, but that did not resolve the issue either.

After MDE raised concerns about the number of new sites sponsored by Feeding our Future and the unexplained increase in meal reimbursement claims, Feeding Our Future filed a lawsuit against MDE in November of 2020, challenging MDE's authority to regulate the program.

MDE stopped approving Feeding Our Future's new Summer Food Service Program ("SFSP") applications in December 2020, denying dozens of Feeding Our Future site applications that month. In January 2021, MDE

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[1] Kelly Smith, FBI agent reveals how the agency's massive fraud investigation began in Feeding Our Future trial (May 1, 2024), https://www.startribune.com/fbi-agent-reveals-how-the-agencys-massive-fraud-investigation-began-in-feeding-our-future-trial/600363160/.

[2] *Partners in Nutrition's Appeal of Disapproval of Site Expansion in CACFP Program*, 904 N.W.2d 223, 232–33 (Minn. Ct. App. 2017) ("Federal regulations establish a relatively minimal standard for financial viability. MDE does not have the discretion to create its own unduly restrictive test. For each of the foregoing reasons, we conclude that MDE erred by applying a legal standard separate from, and more stringent than, the applicable federal regulations").

declared Feeding Our Future seriously deficient due to incomplete financial audits and a lapsed non-profit status with the IRS.

In spring of 2021, MDE again declared Feeding Our Future seriously deficient for non-conformance with USDA Child and Adult Food Care Program ("CACFP") Performance Standards and denied numerous site applications. MDE also issued a 'stop pay' order that halted all payments to Feeding our Future to give MDE time to verify that all meal claim reimbursements submitted were valid and allowable.

MDE also reported concerns to the FBI. MDE remained in regular contact with the FBI and later, the U.S. Attorney's Office, for the duration of Feeding Our Future's operations, through the FBI's raids on Feeding our Future locations, and through the U.S. Attorney's announcements of criminal indictments.

Feeding Our Future continued to fight MDE's authority to deny new site applications in court. On April 21, 2021, a judge warned MDE that it did not have the authority to stop payment to Feeding Our Future and would need to continue to pay Feeding Our Future's claims or face possible contempt charges. MDE was then found in contempt of court and assessed fines of over $40,000 for having attempted to impose oversight that the court found MDE did not have. That summer and fall, Feeding Our Future continued to abuse the court to perpetuate its massive fraud scheme through additional motions for injunction and contempt.

MDE continued efforts to safeguard program integrity through available mechanisms, including regular reporting to appropriate law enforcement entities and cooperation with those investigations. MDE's reporting and adherence to requests from the FBI led to 70 criminal indictments, 18 of which have since pled guilty to, and five of which have been found guilty of, charges such as wire fraud and other financial crimes. MDE utilized a wide array of tools, including federal law enforcement, to protect this program.

MDE took steps to assert program controls it deemed necessary to ensure program integrity, and yet MDE was met with aggressive lawsuits challenging its authority to do so. As the OLA report recognizes, criminals took advantage of the program even though MDE met or exceeded relevant federal regulations. At all times MDE made its best judgments about its authority for oversight in the context of relevant legal requirements and pushback.

MDE is committed to strong oversight and program participation, and, to that end, the Department looks forward to incorporating many of the recommendations by the OLA. But to be clear – the blame for this once in a lifetime, brazen, flagrant fraud lies with the indicted and convicted fraudsters, not individual food program personnel who have dedicated their careers to feeding children and who tried to stop this fraud.

Part II: Forward-looking Solutions

The program that operated during OLA's review was operating during an unprecedented global pandemic to the best of its ability. The lessons learned from that time period have been embraced by MDE. We have independently implemented changes to strengthen the Department's oversight:

Office of Inspector General

In the 2023 legislative session, MDE proposed and established an Office of Inspector General ("OIG") in statute to assist the Department with protecting the integrity of the Department and the state by detecting and preventing fraud, waste, and abuse in department programs. MDE led this initiative and ultimately received $2 million to establish and fund the operations of the office. As the OLA notes, in 2024 we proposed additional changes to clarify and expand the powers of the OIG to ensure it has the investigatory and enforcement tools needed to fulfill its important functions, which the legislature passed in May 2024.

General Counsel's Office

In late 2021, MDE recognized a need for full time, dedicated legal counsel. This position was designed to provide the agency in-house counsel and legal guidance as the agency implemented both new and existing programs. After my appointment as Commissioner, I made the determination that the office needed additional resources, including the creation of a Deputy General Counsel position. In light of the work that MDE does and the need to undertake that work with fidelity to the law, I determined that it was imperative that the agency's legal counsel and advice flow directly to leadership. For that reason, I made the decision to reorganize my leadership team and have the General Counsel report directly to me.

Updated Fraud Reporting Policy and Training

In the fall of 2022, MDE updated its fraud reporting policy, and on December 1, 2022, MDE's General Counsel provide training to the entire MDE staff on the updated policy and MDE staff's general reporting requirements under Minnesota state statutes.

Risk Management and Audit Personnel

MDE sought and received funds from the legislature to support risk management and an additional auditor in the school finance division. This will ensure that MDE is not just reacting to potential situations, but proactively detecting problems in order to prevent fraud, waste, and abuse.

Outside Financial Review of Sponsors

In 2022, MDE also contracted with a national firm, MH Miles, to conduct in-depth finance reviews of certain community nutrition sponsors. In addition to conducting the reviews of certain sponsors, MDE has engaged in conversations with MH Miles about best practices for these reviews. One change MDE implemented in light of these learnings is stricter timeframes regarding corrective action, review, response and documentation collection.

Updated Technology and Tracking Tools

The Cyber-Linked Interactive Child Nutrition System (CLiCS) is the main technology system of the MDE Nutrition Program Services division and the USDA Child Nutrition programs administered by MDE. MDE is currently investing millions into a multi-year project to provide updates and improvements to CLiCS, which will significantly enhance oversight by allowing for improved and more readily available sponsor submitted data reporting, including vended meal contracts, estimated reimbursements, and changes to applications. This will

allow staff to more easily identify risk as opposed to manually checking items. The project is being conducted in two phases with an estimated completion date of December 31, 2025.

Nutrition Program Statutory Changes

In 2023, MDE proposed significant statutory changes to further increase our oversight tools and frameworks for the CACFP and SFSP programs, which passed in the 2023 legislative session. These included four categories of changes:

(1) Training requirements for organizations and staff applying to MDE-operated nutrition programs;
(2) Financial viability requirements for sponsor applicants, including proof of existence for at least one year, the most recent tax return, profit and loss statement and balance sheet or similar, and evidence that at least ten percent of the organization's operating revenue comes from sources other than nutrition programs;
(3) Limits on the number of times a site may transfer between sponsor organizations in a year; and
(4) Location and proximity restrictions to ensure multiple sites are not, with limited exceptions, within a certain distance of each other.

Conclusion

Within days of my appointment as Commissioner in January 2023 I convened members of MDE leadership to help me understand what happened with Feeding our Future, what MDE learned, and what MDE needed to do to ensure it has appropriate safeguards in place. Shortly thereafter, in one of my first actions as Commissioner, I came before members of the House and Senate related to another OLA review and shared that my approach as Commissioner of MDE would be oriented towards accountability and continuous improvement. As discussed in this response, MDE has been intentional and focused on accountability and working to find agency-wide solutions to enhance program integrity and strong fiscal oversight.

I would like to thank Auditor Randall, and Katherine Theisen, Director of Special Reviews, for the work their team has put into this special review. The Department looks forward to making changes outlined in the report to help ensure that Minnesota continues to be the best state in the country for children to grow up in regardless of race, ethnicity, religion, economic status, gender identity, sexual orientation, disability, or zip code.

Sincerely,

Willie L. Jett II
Commissioner
Minnesota Department of Education

OLA

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Department of Human Services: Outstanding Provider Debt in Minnesota's Medicaid Program

Performance Audit

December 2024

Financial Audit Division

Office of the Legislative Auditor

State of Minnesota

Financial Audit Division

The division has authority to audit organizations and programs in the state's executive and judicial branches, metropolitan agencies, several "semi-state" organizations, state-funded higher education institutions, and state-funded programs operated by private organizations.

Each year, the division selects several of these organizations and programs to audit. The audits examine the policies and procedures—called internal controls—of the organizations to ensure they are safeguarding public resources and complying with laws that govern their financial and program operations. In addition, the division annually audits the State of Minnesota's financial statements and the financial statements of three state public pension systems. The primary objective of these financial audits is to assess whether the statements fairly present the organization's financial position according to Generally Accepted Accounting Principles.

The Office of the Legislative Auditor (OLA) also has a Program Evaluation Division. The Program Evaluation Division's mission is to determine the degree to which state agencies and programs are accomplishing their goals and objectives and utilizing resources efficiently.

OLA also conducts special reviews in response to allegations and other concerns brought to the attention of the Legislative Auditor. The Legislative Auditor conducts a preliminary assessment in response to each request for a special review and decides what additional action will be taken by OLA.

For more information about OLA and to access its reports, go to: www.auditor.leg.state.mn.us.

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

Judy Randall, Legislative Auditor
State of Minnesota

December 10, 2024

Members
Legislative Audit Commission

Jodi Harpstead, Commissioner
Department of Human Services

This report presents the results of our performance audit of the Department of Human Services' (DHS's) outstanding provider debt in Minnesota's Medicaid program for the period of October 2006 through June 2023. The objectives of this audit were to determine if DHS had adequate internal controls over selected financial activities and complied with significant finance-related legal requirements.

DHS only partially agrees with Finding 1, detailed on page 18, which states that the department "has not attempted to recover over $40 million in outstanding overpayments…." While the department states that it has made collection efforts on some of the overpayments, DHS did not begin recovery of the majority of these overpayments—an amount we conservatively estimate as $40 million—until after the Office of the Legislative Auditor initiated this audit.

Further, DHS does not agree with Finding 2, detailed on page 19, which states that the department is "planning to forgo recovery of outstanding provider debt that may still be recoverable." While many factors support this finding, the clearest one is DHS's decision to write off outstanding provider balances less than $1,000, despite its policy requiring it to recover overpayments greater than $25.

In summary, we have considered all information presented by DHS and believe the evidence we obtained and the testing we performed during the course of the audit support our conclusions.

This audit was conducted by Lisa Makinen, CPA (Auditor in Charge), and auditor Erick Olsen.

We received the full cooperation of DHS staff while performing this audit.

Sincerely,

Judy Randall
Legislative Auditor

Lori Leysen, CPA
Deputy Legislative Auditor

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Report Summary

Conclusion

The Department of Human Services did not comply with the significant finance-related legal requirements we tested and generally had inadequate internal controls. The more significant instances of noncompliance and internal control weakness were in the areas of recovering outstanding provider debt and accurately reporting the accounts receivable amount on the state's financial statements.

The list of findings below and the full report provide more information about these concerns.

Findings and Recommendations

Finding 1. The Department of Human Services has not attempted to recover over $40 million in outstanding overpayments to Medical Assistance providers' accounts. (p. 7)

Recommendations

- The Department of Human Services should recover outstanding overpayments from Medical Assistance providers.
- The Department of Human Services should improve internal controls to ensure that it regularly pursues collection of provider overpayments.

Finding 2. The Department of Human Services is planning to forgo recovery of outstanding provider debt that may still be recoverable. (p. 9)

Recommendations

- The Department of Human Services should recover outstanding provider debt in accordance with state law and its own policy.
- The Department of Human Services should work with the Legislature to clarify its authority to recover outstanding provider debt.

Finding 3. The Department of Human Services has not accurately reported its accounts receivable balance to Minnesota Management and Budget for inclusion in the state's financial statements since 2019. (p. 11)

Recommendations

- The Department of Human Services should accurately report its accounts receivable balance in the state's financial statements.
- The Department of Human Services should improve internal controls to ensure it accurately reports accounts receivable in the state's financial statements.

Finding 4. The Department of Human Services was unable to provide adequate data to enable us to confirm the outstanding provider balances. (p. 12)

Recommendations

- The Department of Human Services should ensure that it maintains adequate documentation to support the outstanding provider balances.

- The Department of Human Services should ensure that the outstanding provider debt recorded in the Medicaid Management Information System is accurate.

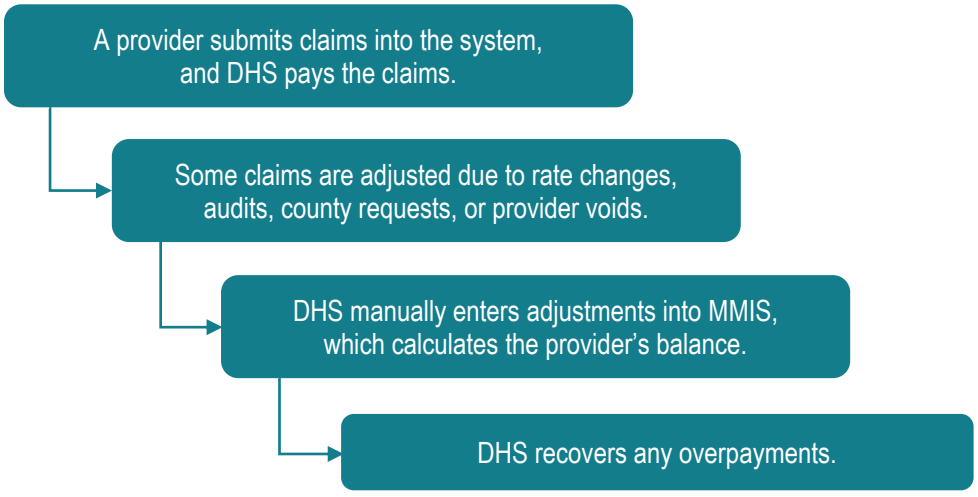
Background

The Department of Human Services (DHS) oversees the Minnesota Health Care Programs (MHCP), which include Medical Assistance, MinnesotaCare, and the Minnesota Family Planning Program. These programs work with medical providers in health care clinics, hospitals, nursing homes, and other settings to provide health care coverage to eligible adults, families with children, people with disabilities, and seniors. DHS receives federal, state, and county funds to administer and manage these programs.

For services provided through Medical Assistance, providers are compensated through managed care organizations or on a fee-for-service basis.[1] Providers that are reimbursed on a fee-for-service basis submit claims through the Medicaid Management Information System (MMIS), and DHS reimburses the providers directly for those claims.[2] Adjustments to these fee-for-service claims, such as retroactive rate changes or discovery of errors, can result in overpayments. These overpayments are referred to by DHS as "provider credits." Because these provider credits are actually debts owed by the providers to DHS, we refer to these overpayments as "provider debt" and "outstanding provider balance(s)" throughout the report.

Exhibit 1 outlines the process from when a provider initially submits claims into MMIS to when DHS recovers any overpayments.

Exhibit 1
Provider Claims Process



Source: Office of the Legislative Auditor, based on interviews with Department of Human Services staff.

[1] Fee-for-service requires DHS to directly reimburse the provider based on the services provided to a patient.

[2] MMIS is a system that does not interface with the state's accounting system.

Audit Scope, Objectives, Methodology, and Criteria

We conducted this audit to determine whether DHS had adequate internal controls and complied with significant finance-related legal requirements. The audit scope included overpayments due from providers as a result of claims adjustments. The period under examination included all outstanding Medical Assistance, fee-for-service provider debt, from October 2006 through June 2023. For Fiscal Year 2023, DHS certified to Minnesota Management and Budget (MMB) a provider debt balance of $51.7 million, across a total of 2,557 providers.[3]

As reflected in MMIS, providers of all types have debt balances. Our audit primarily focused on long-term care facilities with outstanding balances, which collectively accounted for $32.3 million from 214 providers. We also reviewed the nine largest outstanding provider balances, which consisted of six long-term care facilities, a hospital facility, an intermediate care facility for persons with developmental disabilities (ICF/DD), and a consolidated provider.[4]

Of the 214 long-term care facility providers, we tested a random sample of 50 providers, which accounted for a total of $2.2 million in DHS overpayments. We also tested six judgmentally selected long-term care facility providers, each with balances ranging from $2.2 million to $5.4 million, and three additional providers, each with balances over $1.4 million.

Exhibit 2 outlines information about the provider types that we tested.

Exhibit 2

Provider Types with Outstanding Balances (in Millions)

Provider Type	Providers Tested	Outstanding Provider Debt Tested	Total Providers	Total Outstanding Provider Debt
Long-Term Care Facility	56[a]	$23.6	214	$32.3
Hospital Facility	1	1.8	146	3.2
Intermediate Care Facility/ Developmental Disabilities	1	1.7	19	2.0
Consolidated Provider	1	1.4	118	2.9
Total	59	$28.5	497	$40.4

[a] The long-term care facility provider type includes 50 randomly selected providers and 6 judgmentally selected providers. The outstanding balance of the 6 judgmentally selected providers totaled $21.4 million.

Source: Office of the Legislative Auditor, based on data from the Department of Human Services.

[3] *Minnesota Statutes* 2024, 16D.03, subd. 2, requires agencies to report/certify these balances quarterly. The quarterly certification template from MMB requires the financial manager, in this case the Financial Operations Division director, to attest that they have reviewed the balances and related information—including collectability and fair presentation, no material omissions, inclusion of all applicable receivables, and retention of supporting documentation for write-offs.

[4] A consolidated provider is a provider type that is created by DHS staff to tie multiple records together when the owners and tax IDs are the same and they share the same National Provider Identifier (NPI). For example, a consolidated provider could include a long-term care facility, occupational therapists, and a residential treatment center.

We designed our work to address the following questions:

- Did the Department of Human Services comply with legal requirements for recovering outstanding debt from providers, and did it have adequate internal controls to ensure compliance with these legal requirements?

- Did the Department of Human Services comply with legal requirements related to financial reporting, and did it have adequate internal controls to ensure compliance with these legal requirements?

To gain an understanding of DHS's internal controls and compliance, we interviewed staff from DHS, and we reviewed related policies and procedures. To answer the questions listed above, we tested a sample of 59 providers to determine the accuracy of their reported balances. We also reviewed the past eight years of certifications to MMB, and we surveyed the nine other DHS programs that also do not use the state's accounting system to track their receivables.

We conducted this performance audit in accordance with generally accepted government auditing standards.[5] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. When sampling was used, we used a sampling method that complies with generally accepted government auditing standards and that supports our findings and conclusions. That method does not, however, allow us to project the results we obtained to the populations from which the samples were selected.

We assessed internal controls against the most recent edition of the internal control standards, published by the U.S. Government Accountability Office.[6] To identify legal compliance criteria for the activity we reviewed, we examined state and federal laws, and policies and procedures established by DHS and MMB.

[5] Comptroller General of the United States, Government Accountability Office, *Government Auditing Standards, 2018 Revision* (Washington, DC, Technical Update April 2021).

[6] Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (Washington, DC, September 2014). In September 2014, the State of Minnesota adopted these standards as its internal control framework for the executive branch.

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Outstanding Provider Debt

When the Department of Human Services (DHS) pays a Medical Assistance (MA) provider for services, it can sometimes result in an overpayment due to subsequent adjustments to the claim. When an MA provider has a balance from such an overpayment, the Medicaid Management Information System (MMIS)—the system DHS uses to manage these payments—prioritizes reducing that outstanding balance before paying any additional claims submitted by the provider. If there are no subsequent claims submitted by the provider, DHS has a procedure to mail a notice to the provider regarding the outstanding balance.[7]

DHS has two divisions responsible for identifying and collecting outstanding provider debt from MA providers: Health Care Administration (HCA) and the Financial Operations Division (FOD). HCA staff run a report every two weeks to identify any outstanding provider balances. HCA has a procedure with instructions on how to send letters to providers to notify them of their outstanding balances.[8] Additionally, DHS policy states that FOD is to manage the accounts receivable billing function for DHS once the program area, in this case HCA, identifies the debt and notifies the providers. This policy also assigns responsibility to FOD to manage debt-collection activities.[9]

Minnesota Management and Budget policy states that state agencies are responsible for maintaining internal policies to ensure debt collection. That same policy also requires agencies to refer debt that is over 120 days past due to the Minnesota Department of Revenue (DOR).[10]

FINDING 1

The Department of Human Services has not attempted to recover over $40 million in outstanding overpayments to Medical Assistance providers' accounts.

DHS has not made any attempt to recoup outstanding MA-provider debt since 2019, when it sent a collection notice to one provider, nor has it referred the outstanding debt to DOR.[11] The last date for which DHS has documentation that it mailed collection notices to numerous MA providers is February 11, 2015.

[7] In addition to collecting outstanding debt from providers with current claim activity through its normal procedures, DHS recovers some outstanding debt from identified providers that are reviewed by a Medicaid Recovery Audit Contractor.

[8] Department of Human Services, Health Care Administration Procedure, *CB Report - Quarterly and Overdue Report.*

[9] Minnesota Department of Human Services, Accounts Receivable Policy Manual, revised January 2024, secs. 3.0 and 6.0.

[10] Minnesota Management and Budget, Statewide Operating Policy 0504-01, *Debt Collection Process and Actions*, revised March 9, 2021.

[11] The most recent documented instance of DHS sending a collection notice to a provider occurred on March 5, 2019, when it sent a collection notice to one provider.

Although the department's policies and procedures indicate that both HCA and FOD have a role in MA-provider debt collection, staff in both divisions told us that they do not take actions to recover outstanding provider debt. Despite HCA's procedure requiring staff to send notification letters to providers with outstanding balances, HCA staff told us that they were not aware that this was their responsibility. Similarly, despite DHS's policy directing FOD to manage debt collections, FOD staff told us that because the MA-provider debt information is in a system with which they are not familiar, they do not assist with the collection of outstanding MA-provider debt.[12] DHS did not have any controls in place to ensure that the department notified MA providers of their outstanding balances.

By not attempting to recoup the outstanding MA-provider debt, DHS has not collected—and potentially lost—money that the State of Minnesota is owed.

RECOMMENDATIONS

- **The Department of Human Services should recover outstanding overpayments from Medical Assistance providers.**

- **The Department of Human Services should improve internal controls to ensure that it regularly pursues collection of provider overpayments.**

In response to our questions and to resolve the outstanding MA-provider debt, DHS plans to review provider accounts with large balances and changes in ownership. According to DHS, there are more than 340 providers with changes in ownership it plans to review to ensure it correctly transferred the outstanding balances, totaling almost $20 million, to the new owners. DHS also plans to pursue collections on approximately $6 million in provider debt for around 120 providers with balances that are between three and six years old.[13]

On the other hand, DHS has identified three groups of providers from whom it does not plan to pursue collections, as outlined below. DHS plans to remove the outstanding balances associated with these providers from the Medicaid system, essentially "writing off" these balances.[14]

- Providers with outstanding balances, totaling approximately $11.3 million, that are more than six years old.

[12] FOD staff stated that they only process billing and collections from the state's accounting system. For any other system DHS uses to manage these activities, FOD staff told us that the applicable program handles all billings and collections. DHS has nine systems that manage their accounts receivable activity outside of the state's accounting system. We reached out to these program areas, four of which told us that they receive billing and collection assistance from FOD.

[13] DHS told us it started reviewing long-term care facilities with the largest outstanding balances and a change in ownership. According to DHS, it was able to resolve $14 million of the provider debt in this review. We have not audited this work.

[14] We have not audited these amounts.

- Providers with outstanding balances, totaling approximately $22,000, who have filed for bankruptcy or are deceased.

- Providers with outstanding balances, totaling approximately $160,000, that are under $1,000.

According to DHS policy, outstanding balances below $25 can be written off after 120 days from when DHS issues a notification letter to the provider.[15]

FINDING 2

The Department of Human Services is planning to forgo recovery of outstanding provider debt that may still be recoverable.

DHS's plan not to pursue collections on outstanding provider balances that are under $1,000 (but more than $25) is not in accordance with its own accounts receivable policy. Nonetheless, DHS leadership gave approval to not collect outstanding provider balances up to $1,000 for this specific situation because of the administrative burden they believe it would pose.

Further, DHS indicated to us that it did not plan to pursue recovery of outstanding provider balances that are more than six years old because of the six-year statute of limitations set out in *Minnesota Statutes* 541.05, subd. 1. However, case law indicates this statute does not apply to administrative actions to recoup overpayments.[16]

In response to our draft report, DHS told us that it could only administratively recover overpaid funds through recoupment from future payments; as a result, it could not recover overpayments from former providers who no longer provided services. We disagree and do not believe that this interpretation reflects state law.[17] As the Minnesota Supreme Court recognized nearly 40 years ago, such an "interpretation of the statute and regulations would enable any provider who commits fraud or abuse in

[15] Minnesota Department of Human Services, Accounts Receivable Policy Manual, revised January 2024, sec. 6.4.

[16] *In re Wage & Hour Violations of Holly Inn, Inc.*, 386 N.W.2d 305, 308 (Minn. Ct. App. 1986); and *In re PERA Salary Determinations Affecting Retired & Active Emps. of City of Duluth*, 820 N.W.2d 563, 575 (Minn. Ct. App. 2012). The Minnesota Court of Appeals has also held that equitable defenses related to a delay in pursuing recovery of an overpayment are not applicable in the MA context. See *Leisure Hills of Grand Rapids, Inc. v. Minnesota Dep't of Hum. Servs.*, 480 N.W.2d 149, 151 (Minn. Ct. App. 1992). In one recent case, the Office of Administrative Hearings held that neither the statute of limitations nor equitable defenses precluded DHS administrative action to recover MA overpayments. See *In re SIRS Appeal by Caring Nurses, LLC*, No. 60-1800-38446, 2023 WL 4548253, at *6 (Minn. Office Admin. Hearings, July 11, 2023), available at https://mn.gov/oah/assets/1800-38446-caring-nurses-dhs-sirs-order-denying-motion-amend_tcm19-584359.pdf.

[17] *Minnesota Statutes* 2024, 256B.064, subd. 1c(b), authorizes DHS to "obtain monetary recovery using methods including *but not limited to* the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid" [emphasis added]. *Minnesota Rules* 9505.0465, subp. 2, authorizes DHS to "[demand] that the provider refund amounts" that were erroneously paid, https://www.revisor.mn.gov/rules/9505.0465/, accessed December 2, 2024. *Minnesota Rules* 9505.2215, subp. 2, identifies deductions from future payments as one of four potential means of recovery, https://www.revisor.mn.gov/rules/9505.2215/, accessed December 2, 2024.

submitting claims to insulate himself from recovery by terminating his provider status."[18] The Minnesota Supreme Court therefore concluded that the department could "recover funds already paid," rather than being "limited to debiting future payments" to recover an overpayment.[19]

Finally, DHS and OLA disagree as to whether the six-year statute of limitations set out in *Minnesota Statutes* 541.05, subd. 1, prevents the department from pursuing recovery of overpayments through judicial action in addition to administrative actions. While there do not appear to be any definitive answers to this question in an MA context, case law related to other state agencies indicates that the department may be able to begin judicial action to enforce an administrative order within six years after completing the administrative process.[20]

By choosing not to recover these balances, DHS may be forgoing money that is owed to the state.

RECOMMENDATIONS

- **The Department of Human Services should recover outstanding provider debt in accordance with state law and its own policy.**
- **The Department of Human Services should work with the Legislature to clarify its authority to recover outstanding provider debt.**

[18] *Brown v. Minnesota Dep't of Pub. Welfare*, 368 N.W.2d 906, 910 (Minn. 1985).

[19] *Brown* cited *Minnesota Statutes* 1984, 256B.064, subd. 1c, for this authority. The language regarding recovery options in that provision at the time is nearly identical now, in that it authorized the department to "obtain monetary recovery" using methods that included "assessing and recovering moneys erroneously paid and debiting from future payments any moneys erroneously paid." *Brown* also cited administrative regulations that are substantially similar to the language of current regulations.

[20] *In re Wage & Hour Violations of Holly Inn, Inc.*, 386 N.W.2d 305, 308 (Minn. Ct. App. 1986).

Financial Reporting of Outstanding Provider Debt

For purposes of reporting an accurate accounts receivable balance in the state's financial statements, Minnesota Management and Budget (MMB) policy requires state agencies to analyze their accounts receivable activity annually and estimate the portion of debt they do not expect to recoup.[21] DHS policy outlines the conditions in which a debt is considered uncollectible.[22]

To generate the financial reporting information for accounts receivable related to provider debt, Health Care Administrative (HCA) staff first pull the outstanding provider balances from the Medicaid Management Information System (MMIS). HCA staff run a preprogrammed report and verify the accuracy of the accounts receivable amounts. This report includes the percentage of the outstanding provider balance that DHS does not expect to recoup, which is calculated using a preset formula.

HCA staff then send the report to Financial Operations Division (FOD) staff, who review this information and certify the accounts receivable balance to MMB on a quarterly basis.[23] FOD's review includes identifying whether the accounts receivable amount for provider debt deviates more than 10 percent from the previous quarter and determining whether there is a reasonable explanation for the deviation.

FINDING 3

The Department of Human Services has not accurately reported its accounts receivable balance to Minnesota Management and Budget for inclusion in the state's financial statements since 2019.

DHS has not updated or reassessed its calculation to determine the portion of debt it does not expect to recoup from providers since Fiscal Year 2019. At that time, DHS reduced its percentage of the portion of debt it did not expect to recoup from 6 percent to 5 percent.[24] The percentage has remained the same since then. However, because DHS has neither tried to collect outstanding provider balances nor written off any uncollectible balances, the total accounts receivable balance has been increasing since Fiscal Year 2016. The longer a debt is outstanding, the less likely it is for DHS to

[21] Minnesota Management and Budget, Statewide Operating Procedure 0501-01.1, *Managing & Reporting of Accounts Receivable*, revised March 9, 2021.

[22] Minnesota Department of Human Services, Accounts Receivable Policy Manual, revised January 2024, sec. 5.2. Examples of conditions under which a debt is considered uncollectible include inability to locate the debtor, cost of collection exceeding the amount recovered, or debt having been discharged in bankruptcy.

[23] MMB is responsible for creating the state's financial statements. In order to ensure the accuracy of balances reported in the statements, state law requires agencies to report their debts owed to MMB on a quarterly basis. *Minnesota Statutes* 2024, 16D.03, subd. 2.

[24] In 2016, DHS estimated it would not be able to recover 58 percent of the outstanding provider debt. DHS decreased this percentage to 6 percent in 2017 and 2018 before dropping it to 5 percent in 2019.

recoup the money. This, in turn, increases the likelihood that these debts will become uncollectible and will need to be written off.

FOD staff told us it is the responsibility of HCA to determine the percentage of the outstanding provider debt that DHS does not expect to recoup. HCA staff told us they were unaware that this was their responsibility.

As a result of DHS not pursuing outstanding provider debts, as discussed in Finding 1, DHS has not identified the uncollectible amounts that it should have written off. In addition, when FOD staff reviewed the quarterly reports from HCA, they did not examine why the outstanding balance continued to grow, why the percentage of the portion of debt it did not expect to recoup had not changed, or why older balances had not been written off.

By not writing off uncollectible balances and not updating the percentage of outstanding provider balances that DHS does not expect to recoup, the accounts receivable balance is overstated in the state's financial statements.

RECOMMENDATIONS

- **The Department of Human Services should accurately report its accounts receivable balance in the state's financial statements.**
- **The Department of Human Services should improve internal controls to ensure it accurately reports accounts receivable in the state's financial statements.**

DHS pays medical providers based on the claims these medical providers submit. As discussed earlier, sometimes an adjustment may be needed if there is a retroactive rate change or if the provider discovers an error. When DHS staff enter an adjustment into MMIS, they add a note to explain why the adjustment was made.

MMB policy requires agencies to have adequate controls "in both policy and practice" over their accounts receivable; the policy also requires that the accounts receivable must be reconciled at least quarterly.[25] Furthermore, state statutes require DHS to retain the documentation of these reconciliations.[26]

FINDING 4

The Department of Human Services was unable to provide adequate data to enable us to confirm the outstanding provider balances.

Based on the documentation DHS provided, we could not confirm the provider balances for 20 of the 59 providers we tested, resulting in variances ranging from $43 to

[25] Minnesota Management and Budget, Statewide Operating Policy 0501-01, *Managing & Reporting of Accounts Receivable*, revised March 9, 2021.

[26] *Minnesota Statutes* 2024, 15.17, subd. 1.

$151,985.[27] In other words, when we reviewed the data provided by DHS, we were not able to recalculate the reported balances for over 33 percent of our sample. A DHS staff member adjusted the outstanding provider balances for 16 of these 20 samples on the same date in 2018. However, DHS was not able to explain why the staff member made those adjustments. In addition, over 65 percent of the providers we tested had incorrect dates associated with their outstanding balances. These dates are used to determine the age of the outstanding balances for collection purposes. These dates also help determine the percentage of the outstanding provider debt that DHS does not expect to recoup, as discussed in Finding 3.

The provider claims data is kept in MMIS for approximately three years. After three years, DHS only retains summary level claims data in MMIS; notes, such as those describing reasons for adjustments, are no longer available. Because DHS did not retain supporting information to explain the variances for the 20 outstanding provider balances, it was not possible for us to verify these balances with confidence.

The balances we used for testing came from the same preprogrammed report that DHS uses to identify outstanding provider balances. However, DHS does not verify or review this report for accuracy, and the staff person that developed the criteria for the report is no longer with DHS. Further complicating the accuracy of the report, DHS staff told us that in 2017 they stopped transferring the provider balance when there was a change in ownership for a provider's business. Instead, DHS kept the balance with the original provider and also added it to the new provider's account. As such, DHS told us that it duplicated some of the outstanding balances. We could not confirm these claims.[28]

Because DHS could not provide reliable records or sufficient support for the provider balances, we have no confidence in the accuracy of the outstanding provider debt DHS is reporting.

RECOMMENDATIONS

- **The Department of Human Services should ensure that it maintains adequate documentation to support the outstanding provider balances.**

- **The Department of Human Services should ensure that the outstanding provider debt recorded in the Medicaid Management Information System is accurate.**

[27] The values reported here are absolute values.

[28] Just over one-half of the providers we tested have had at least one change in ownership, some with as many as four changes.

OLA

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December 6, 2024

Judy Randall, Legislative Auditor
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Dear Ms. Randall:

Thank you for the opportunity to review and comment on the report issued by your office, titled *Department of Human Services: Outstanding Provider Debt in Minnesota's Medicaid Program*. The Department of Human Services (Department) recognizes the importance of internal controls to manage taxpayer dollars from the beginning of the payment process to the end.

The complexities in collecting the provider credit balances are substantial. The majority of these balances represent organizations no longer doing business and we have had a very low return on any recovery work.

From 2018 to the present, the Department has worked with its contracted Medicaid Recovery Audit Contractor (RAC)[1] to recover provider credits from hospitals and nursing homes, which are the provider groups with the largest amounts of outstanding balances. The RAC has been successful in recovering some outstanding provider credit balances.

However, the RAC, which is paid on a contingency basis based on a percentage of what it recovers, was only able to recover $125,000, from 2018 to 2022, so RAC elected to stop those efforts. More recently, the RAC started a project in late 2023 to recover provider credits from nursing homes and has thus far recovered approximately $74,000. This demonstrates the challenges of attempting to recover from providers who are no longer billing Medicaid and are often no longer in business.

[1] Section 6411 of the Affordable Care Act, which amended Section 1902(a)(42)(B)(i) of the Social Security Act, and is subject to the requirements of 42 CFR, Part 455, Subpart F, requires States and territories to establish Medicaid Recovery Audit Contractor (RAC) programs to identify and correct improper Medicaid payments, on a post-payment basis, for health care services provided to Medicaid beneficiaries. RAC contractors are paid on a contingency basis from the amounts actually recovered and directly related to the RAC's review of Medicaid claims. In Minnesota, current contract language states, the RAC contractor is paid 12.5% for all Medicaid overpayments recovered from provider types other than Durable Medical Equipment (DME).

The Department agrees with most of your findings and all of your recommendations and is already implementing improvements to our processes.

However, the Department respectfully disagrees with the conclusions of the OLA report that it is not handling outstanding provider debt in accordance with state law. As discussed below, the report elides key legal issues, misconstrues the few authorities on which it relies, and faults the Department for not taking actions not authorized by the Legislature.

First, the report does not clearly explain what administrative action OLA finds the Department could have or should have taken. While the Department agrees that state law and regulations authorize the Department to "assess" funds improperly paid and "demand" that providers refund such amounts, these authorities are silent as to any means of enforcing such demands or assessments apart from debiting improperly paid funds from future payments.[2] Absent clear statutory authority rendering the Commissioner's orders directly enforceable in district court, the remedies offer little hope of recovery for debts incurred outside the statute of limitations.

The cases relied upon in OLA's report do not lead to a different conclusion. In *In re Wage & Hour Violations of Holly Inn, Inc.*, for example, the Minnesota Court of Appeals held that the statute of limitations does not bar a state agency from seeking administrative remedies.[3] But Holly Inn is readily distinguishable, as it involved a statute that expressly gave the labor commissioner authority to enforce its orders by bringing an action in district court:

> The commissioner may bring an action in the district court where an employer resides or where the commissioner maintains an office to enforce or require compliance with orders issued under subdivision 4.[4]

And indeed, the Court of Appeals expressly relied on this fact, stating that "[r]egardless of when a claim is made, however, the general two-year statute would not begin to run until there has been an order issued by the commissioner, *since the court action would be solely to enforce that order*."[5]

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[2] Minn. Stat. § 256B.064, subd. 1c(b) (providing that "[t]he commissioner may obtain monetary recovery using methods including but not limited to the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid"); Minn. R. 9505.0465, subp. 2 ("The monetary recovery may be made by withholding current payments due the provider, by demanding that the provider refund amounts so received as provided in part 9505.1950, or by any other legally authorized means.").

[3] *See* 386 N.W.2d 305, 308 (Minn. Ct. App. 1986).

[4] *Id*. at 311 (citing Minn. Stat. § 177.27, subds. 5–6 (Supp. 1985)).

[5] *Id*. at 308 (emphasis added). *In re PERA Salary Determinations Affecting Retired & Active Emps. of City of Duluth*, 820 N.W.2d 563 (Minn. Ct. App. 2012), *Leisure Hills of Grand Rapids, Inc. v. Minnesota Dep't of Hum. Servs.*, 480 N.W.2d 149 (Minn. Ct. App. 1992), and *In re SIRS Appeal by Caring Nurses, LLC*, No. 60-1800-38446, 2023 WL 4548253, at *6 (Minn. Office Admin. Hearings, July 11, 2023), did not address the applicable statute of limitations when an agency seeks to enforce an administrative order in state court.

No similar provision applies to orders of the Commissioner assessing overpayments against Medical Assistance providers. And although the Legislature has provided that the Commissioner's orders become judgments by operation of law when pursuing overpayments to individual Medical Assistance *recipients*,[6] it made no such provision for orders assessing provider overpayments—strongly suggesting that it did not intend for such orders to be enforceable as judgments in district court.[7] Yet the OLA report seemingly faults the Department for not pursuing a remedy that the Legislature did not grant.

Brown v. Minnesota Dep't of Pub. Welfare is similarly inapposite. In that case, the Minnesota Supreme Court held that the Department was authorized to "assess" and seek recovery of funds erroneously paid to a vendor, but the case did not address the options available to enforce such assessments, did not hold that orders of the Commissioner are enforceable in state court, and did not hold that the statute of limitations would run from the date of such assessment rather than the date the debt was incurred.[8] Indeed, no statute of limitations was at issue in the case. OLA's suggestion that a contrary position would "enable any provider who commits fraud or abuse … to insulate himself from recovery by terminating his provider status"[9] ignores the fact that recovery in state court is always an option for any balances incurred within the applicable statute of limitations, which the Department has never disputed.

In sum, while OLA disagrees with the Department's interpretation and does not "believe" that it reflects state law, OLA does not identify sufficient authority to substantiate a finding or suggestion that the Department has legally enforceable options to collect provider balances beyond the limitations period. The Department, however, intends to send notices requesting repayment from providers whose debts are more than 6 years old, above $1,000, and for whom the Department has contact information.

Regarding the report's other findings, the Department has already taken significant steps to resolve the issues identified in this report. The agency has undertaken two tracks to approach the issues identified by the auditors, both during the audit and in the audit report.

---

[6] *See* Minn. Stat. § 256.0471, subd. 1. Vendors of medical care are not "recipients" for purposes of this statute, as provider overpayments are adjudicated under Chapter 14 rather than the contested case process referenced in section 256.0471. *See id.* at subd. 3; Minn. Stat. § 256B.064, subd. 2(f); *see also* Minn. Stat. § 256.045, subd. 3(f). And even under section 256.0471, the Legislature directed that the Commissioner's orders become judgments *only where notification was issued within the applicable statute of limitations*. *See* Minn. Stat. §§ 256.0471, subd. 2; 541.05.

[7] *See Halvorson v. B&F Fastener Supply*, 901 N.W.2d 425, 430 (Minn. 2017) (rejecting interpretation of workers' compensation law that would not give effect to every word and would render portions of statute unnecessary); *Hersh Properties, LLC .v McDonald's Corp.*, 588 N.W.2d 728, 735 (Minn. 1999) (rejecting construction of Marketable Title Act that would render portions unnecessary); *see also State v. Friese*, 959 N.W.2d 205, 210 (Minn. 2021) (courts must read statutes as a whole and "favor an interpretation that gives 'each word or phrase in a statute a distinct, not an identical, meaning' "); Minn. Stat. § 645.16(1)–(8) (Legislature's intent may be ascertained by considering, among other things, the occasion and necessity for the law, former law on the same or similar subjects, contemporaneous legislative history, and the circumstances under which law was enacted).

[8] *See* 368 N.W.2d 906, 910–12 (Minn. 1985).

[9] OLA Report at 10 (quoting *Brown*, 368 N.W.2d at 910).

First, the agency has reviewed the outstanding, aged provider credit balances to clear these existing balances through collection and write-off, prioritizing those balances that may have the highest likelihood to collect.

Second, we have engaged our Office of Continuous Improvement to assist in mapping and standing up a process for oversight and collection action on these balances into the future. This process creates an accountability chain that ensures steps are completed and amounts reported to MMB and CMS are accurate and can be easily tracked.

This new process will create clear decision points for action and will ensure that our systems of record – claims data in MMIS and accounts receivables in SWIFT – reflect the accurate status of each credit balance. This new process will also create quality assurance opportunities for more proactive claims and provider review, which have not been previously formalized.

Below are the Department's responses to the specific recommendations.

Audit Finding 1

The Department of Human Services has not attempted to recover over $40 million in outstanding overpayments to Medical Assistance providers' accounts.

Audit Recommendation 1-1 and 1-2

- The Department of Human Services should recover outstanding overpayments from Medical Assistance providers.
- The Department of Human Services should improve internal controls to ensure that it regularly pursues collection of provider overpayments.

Agency Response to Recommendations 1-1 and 1-2:

The Department partially agrees with this finding and agrees with the recommendations. The Department routinely recovers provider overpayments for currently enrolled providers as part of Department's ongoing claims processing process. The Department also engages RAC contractors to collect provider overpayments that cannot be resolved through ongoing claims processing. The credits reviewed in this report are an important subset of all provider credit balances incurred by the Department and we agree that we need to better manage this subset of provider credit balances.

The Department has analyzed and started the recovery process for the outstanding provider credit balances referenced in the report. We confirmed previous collection efforts for certain balances through surety bonds or other mechanisms and have sent collection letters to providers with outstanding provider credit balances. We will continue this work until all provider credit balances referenced in this report have been evaluated and addressed.

We are also developing a new process for managing this subset of provider credits. Credit balances that can't be collected through our claims processing procedures and that are under 1 year (2024 – present) will be incorporated into our new process for reviewing and pursuing collections on these balances. We anticipate that our new process will be operational by January 17, 2025.

Person Responsible: Britt Kringle
Estimated Completion date**: April 2025**

Audit Finding 2

The Department of Human Services is planning to forgo recovery of outstanding provider debt that may still be recoverable.

Audit Recommendation 2-1

- The Department of Human Services should recover outstanding debt in accordance with state law and its own policy.

Agency Response to Recommendations 2-1:

As stated previously, the Department respectfully disagrees with this finding for reasons discussed above, but agrees with the recommendation. Identifying, addressing, and pursuing these balances, particularly the older balances is a time-consuming and administratively burdensome process. The Department has elected to write-off balances of less than $1,000 (the average value of provider credits below $1,000 is $162) and directed staff to other activities with a greater return on investment for Minnesota taxpayers. The Department will review the current $25 threshold for writing off accounts receivable and will update the policy accordingly.

Person Responsible: Britt Kringle
Estimated Completion date**: April 2025**

Audit Recommendation 2-2

- The Department of Human Services should work with the Legislature to clarify its authority to recover outstanding debt.

Agency Response to Recommendations 2-2:

Given the lack of clarity surrounding the issues above, the Department is happy to work with the Legislature if it wants to explore expanding or clarifying the means by which the Department can collect long overdue outstanding debts.

Person Responsible: Britt Kringle
Estimated Completion date**: May 2025**

Audit Finding 3

The Department of Human Services has not accurately reported its accounts receivable balance to Minnesota Management and Budget for inclusion in the state's financial statements since 2019.

Audit Recommendations 3-1 and 3-2

- The Department of Human Services should accurately report its accounts receivable balance in the state's financial statements.
- The Department of Human Services should improve internal controls to ensure it accurately reports accounts receivable in the state's financial statements.

Agency Response to Recommendations 3-1 and 3-2:

The Department agrees with this finding and related recommendations. As part of the new process to manage these provider credit balances, the Department will analyze and correct the allowance for doubtful accounts.

Person Responsible: Dave Greeman
Estimated Completion date**: April 2025**

Audit Finding 4

The Department of Human Services was unable to provide adequate data to enable us to confirm the outstanding provider balances.

Audit Recommendations 4- 1 and 4-2

- The Department of Human Services should ensure that it maintains adequate documentation to support the outstanding provider balances.
- The Department of Human Services should ensure that the outstanding provider debt recorded in the Medicaid Management Information System is accurate.

Agency Response to Recommendations 4-1 and 4-2:

The Department agrees with this finding and recommendation. The new process for managing these provider credit balances will assure that they are reviewed and referred for collection after one year of no warrant adjustments if the provider is still currently enrolled. The documentation related to balances referred to collection will be retained in accordance with our data retention policies and be available beyond the current 3 years that MMIS retains this data.

Person Responsible: Matt Woods
Estimated Completion date**: April 2025,**

We appreciated the professionalism and dedicated efforts of your staff during this audit. Our policy and practice is to follow up on all audit findings to evaluate our progress toward resolution.

If you have further questions, please contact Gary L. Johnson, Director of Internal Controls and Accountability, Minnesota Department of Human Services at (651) 431-3623.

Sincerely,

Jodi Harpstead
Commissioner

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Department of Human Services Licensing Division: Support to Counties

2024 Evaluation Report

Program Evaluation Division

Office of the Legislative Auditor

State of Minnesota

Program Evaluation Division

The Program Evaluation Division was created within the Office of the Legislative Auditor (OLA) in 1975. The division's mission, as set forth in law, is to determine the degree to which state agencies and programs are accomplishing their goals and objectives and utilizing resources efficiently.

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Judy Randall, Legislative Auditor
State of Minnesota

February 2024

Members of the Legislative Audit Commission:

The Department of Human Service (DHS) supports and oversees county agencies that process licenses for certain programs that serve children and vulnerable adults. DHS has supported county licensors in many ways, and the county licensors who responded to our survey were generally satisfied with the resources and guidance that DHS has provided.

Nevertheless, we suggest a number of improvements, including that DHS provide better support for county licensors who process licenses for certain residential facilities that serve older or vulnerable adults (Community Residential Settings). Further, we recommend that the new Department of Children, Youth, and Families consider the recommendations in this report when it assumes DHS's licensing responsibilities related to children's services.

Our evaluation was conducted by Sarah Delacueva (project manager), Gretchen Becker, Hannah Geressu, and Kaitlyn Schmaltz. DHS cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

Judy Randall
Legislative Auditor

Jodi Munson Rodríguez
Deputy Legislative Auditor

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Summary **February 2024**

Department of Human Services Licensing Division: Support to Counties

The Department of Human Services (DHS) has generally done a good job supporting county licensors. Nevertheless, there is room for improvement, especially given upcoming structural changes at the state level.

Report Summary

DHS Support to County Licensing Agencies

The staff of county licensing agencies—"county licensors"—rely on support from DHS for numerous reasons, such as training, guidance on new licensing policies, or assistance in emergent situations. DHS supports county licensors through trainings, optional meetings, newsletters, and by responding to county licensor questions submitted via telephone or e-mail (known as "triage").

- Both the county licensors and DHS staff who responded to our surveys generally agreed that DHS has, overall, provided effective support to county licensors. (p. 16)
- Most county licensors and DHS staff who responded to our surveys reported favorable opinions of DHS's communication of licensing requirements. (pp. 17-18)
- DHS has provided a range of supports to county licensors across programs, but has provided less support targeted to those who license Community Residential Settings (CRS). (pp. 14-15)

  Recommendation ► DHS should improve the support it provides for CRS licensors. (p. 22)

- While most county licensors who responded to our survey noted that DHS's triage responses were timely, some CRS licensors reported that it took significant time to receive responses from DHS. (pp. 18-19)

  Recommendations ► DHS should (1) develop a formal policy and establish a timeframe in which staff must respond to triage inquiries, and (2) track how long it takes staff to respond to inquiries. (p. 22)

- DHS has not put certain guidance in writing, making it difficult for county licensors to obtain consistent and timely information. (pp. 20-21)

  Recommendation ► DHS should provide written guidance that is easily accessible to all county licensors. (pp. 22-23)

Background

DHS licenses individuals and businesses that provide care for children and vulnerable adults. DHS is exclusively responsible for the licensing activities related to many types of human services programs.

For other programs, DHS delegates certain licensing responsibilities to county governments, as allowed by Minnesota statutes. These programs include: (1) Family Child Care; (2) Child Foster Care; (3) Adult Foster Care; and (4) Community Residential Settings, which are residential facilities that serve adults with disabilities.

For programs with county-delegated licensing, county licensing agencies determine whether applicants meet licensing requirements. DHS's Licensing Division then issues licenses or sends denial letters based on county recommendations. Similarly, county licensing agencies monitor providers on an ongoing basis, and DHS sanctions providers (as needed) based on county recommendations.

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DHS-County Partnership

The county-delegated licensing system requires DHS and county licensors to work together to license service providers and perform other licensing functions. Significant changes, however, are on the horizon. In 2023, the Legislature created a new Department of Children, Youth, and Families (DCYF), and DHS's licensing of child care and child foster care services will be transferred to DCYF once the new department is operating.

- Two-thirds of county licensors reported that the partnership between DHS and county licensors is strong. (pp. 25-26)

- Most county licensors and DHS staff that we surveyed had favorable opinions of DHS's process for regularly reviewing the work of county licensing agencies (the "Rule 13" review process). (p. 32)

- DHS has made consistent efforts to inform and engage county licensors as it implemented changes to programs with county-delegated licensing. (pp. 33-37)

- DHS has sometimes been slow to issue licensing actions when providers do not comply with program requirements, which can negatively impact the department's relationship with county licensors. (pp. 29-31)

  Recommendations ► DHS should (1) establish timeframes for processing licensing actions that are uniform across programs with county-delegated licensing, and (2) ensure that it addresses all recommendations for licensing actions within those timeframes. (p. 31)

- While most county licensors indicated that DHS had provided clear guidance on the division of licensing roles, some licensors expressed frustration about the delineation between those roles. (pp. 27-28)

  Recommendation ► DHS and DCYF should take extra care to provide clear and consistent guidance on the respective roles of state agencies and county licensors, especially in light of the upcoming division of licensing oversight between the two departments. (p. 38)

  Recommendation ► DCYF should adopt the recommendations from this report that are relevant to its activities. (p. 38)

Summary of Agency Response

In a letter dated February 15, 2024, Commissioner Jodi Harpstead said that DHS appreciated OLA's review and is "pleased that the recommendations align with our plans for improvement, which we are working to implement thanks to the investment of resources by the governor and 2023 Legislature." She stated that DHS is already using the additional resources to hire staff, and that filling those positions is "likely to help address many of the concerns about support" for CRS licensors. She said that as DHS prepares to transition programs to DCYF, the two departments are working closely to "ensure that licensing functions will continue without interruption, and that all partners, including county licensors, will have clear guidance on the respective roles of DHS and DCYF."

The full evaluation report, *Department of Human Services Licensing Division: Support to Counties*, is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/ped/2024/DHS-licensing.htm**

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Introduction

The State of Minnesota requires licensing for many professions to ensure that the members of those professions—and the services that they provide—meet minimum standards. When people or businesses provide certain services related to caring for children or vulnerable adults, the Department of Human Services (DHS) Licensing Division oversees their licensure.

While DHS staff oversee the licensure and compliance of many programs, the department delegates some licensing responsibilities to county governments for certain programs, including in-home child care (known as Family Child Care), Adult Foster Care, Child Foster Care, and certain residential facilities (known as Community Residential Settings) that serve individuals with disabilities. For each of these programs, county licensing agencies are responsible for processing applications and monitoring providers; DHS is responsible for issuing licenses and sanctioning providers (as needed) based on recommendations from counties.

In May 2023, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate the DHS Licensing Division's support to counties. Our evaluation addressed the following questions:

- **To what extent has the DHS Licensing Division communicated effectively with county partners about licensing requirements?**
- **How well has the DHS Licensing Division supported county staff as they carry out licensing requirements?**
- **How can the DHS Licensing Division ensure a strong state-county partnership?**

We used a number of methods to evaluate DHS's communication with and support to county licensors. We surveyed county licensors and the DHS staff who support them. We also conducted focus groups of county licensors from across the state. We interviewed DHS licensing managers and staff; reviewed past DHS communications, training materials, and technical assistance logs related to licensing questions; and observed trainings and monthly meetings that DHS conducted for county licensors.

Additionally, we reviewed state statutes, rules, and session laws; DHS inspection and county review checklists; DHS's website; and other relevant documents and resources. We also analyzed DHS licensing data.

We focused our evaluation on the relationship between the DHS Licensing Division and county licensors. Thus, we did not evaluate DHS's relationship with the license holders that actually provided services to Minnesotans. We also did not evaluate whether county licensors made appropriate licensing decisions, nor whether license holders provided appropriate services. Further, we did not exhaustively evaluate DHS's compliance with licensing laws; we focused on those related to supporting counties. Finally, while criminal history checks on service providers (known as "background studies") are a part of the licensing process, they are conducted by a separate division within DHS, and were therefore outside the scope of this evaluation.

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Chapter 1: Background

Hundreds of thousands of Minnesotans entrust the care of their loved ones—whether young children or vulnerable adults—to licensed care providers. Human services licensing protects the health, safety, and rights of those service recipients by ensuring that service providers meet minimum standards. At the time this report was published, the Department of Human Services (DHS) was the state agency that oversaw the licensure of individuals and businesses that care for children and vulnerable adults.[1]

In this chapter, we give an overview of human services licensing, including its structure, types of programs, and numbers of license holders (whom we refer to as "providers"). We then describe the processes that DHS and others follow when licensing human services providers.

Licensing Overview

DHS's Licensing Division is part of the department's Office of the Inspector General. The Licensing Division consists of several units that either directly license or oversee the licensing of more than 20 types of providers serving children and vulnerable adults. As of the end of Fiscal Year 2023, there were more than 21,000 providers operating with licenses issued by the DHS Licensing Division.

DHS directly licenses providers in some programs; for other programs, the department delegates certain licensing responsibilities to county governments.

Minnesota statutes allow DHS to delegate certain licensing responsibilities to county governments.[2] Historically, DHS has delegated some responsibilities—such as application processing—for child care and foster care services that take place in a license holder's own home.[3] DHS, on the other hand, directly licenses most larger, commercial settings. For example, county licensing agencies process applications for *Family Child Care* settings, in which the child care typically takes place in the

[1] The 2023 Legislature established a new state agency: the Department of Children, Youth, and Families. *Laws of Minnesota* 2023, chapter 70, art. 12, sec. 14, codified as *Minnesota Statutes* 2023, 142A.02, subd. 1. Relevant programs will move to the new department during Fiscal Year 2025. After the transition, the Licensing Division units that perform or oversee licensing related to children's services will move to the new department (either in whole or in part). DHS will continue to perform or oversee licensing for adult services. We discuss the implications of this new department further in Chapter 3.

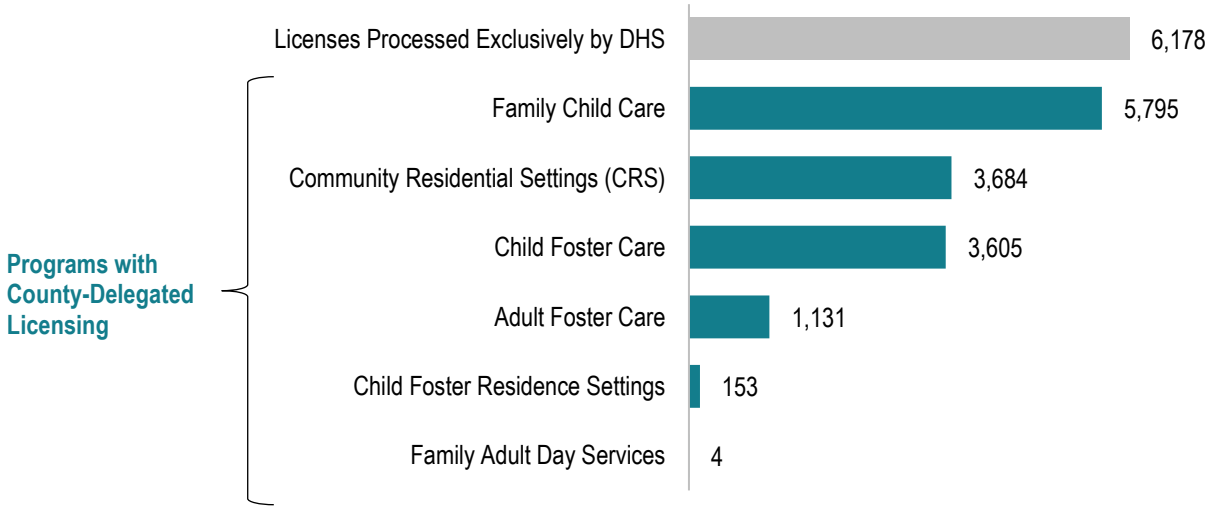
[2] *Minnesota Statutes* 2023, 245A.16, subd. 1(a). Throughout this report, we refer to the county departments—often human services or social services departments—that perform a county's licensing work as "county licensing agencies." We also use the term to refer to multicounty cooperative organizations that undertake licensing activities on behalf of their members.

[3] County licensing agencies also handle licensing activities for some similar care settings that serve small numbers of individuals but for which the license holder does not reside in the facility, such as Child Foster Residence Settings, Community Residential Settings, and Special Family Child Care (which includes certain instances of nonresidential child care taking place in locations such as schools, churches, or commercial buildings).

provider's home. DHS, however, undertakes all licensing responsibilities related to larger *Child Care Centers*, which generally care for children in commercial settings.

County licensing agencies processed 70 percent of all active licenses overseen by the DHS Licensing Division as of the end of Fiscal Year 2023. The following chart compares the number of active licenses in each program for which counties processed the licenses, compared with the number from the remaining programs that DHS processed directly.

Active Human Services Licenses, June 2023



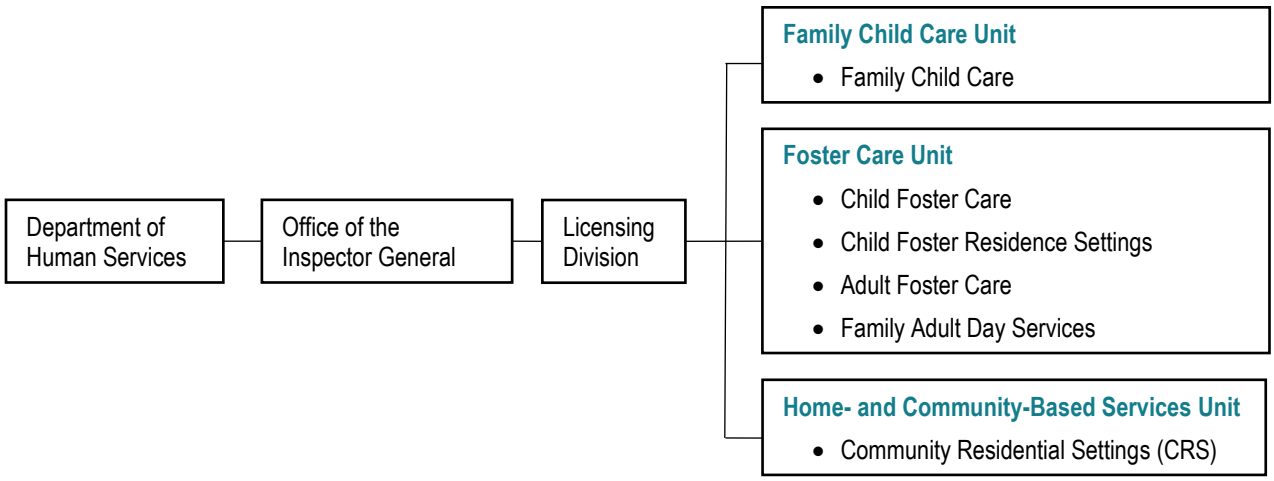
Notes: The chart excludes licenses for providers that had permanently closed or were otherwise suspended from operating. The gray bar represents the sum of all licenses processed exclusively by DHS across nearly 20 programs, including Child Care Centers, Mental Health Clinics, and Substance Use Disorder Treatment Facilities, among others.

Source: Office of the Legislative Auditor, analysis of DHS licensing data, June 30, 2023.

The programs with county-delegated licensing fall under the oversight of one of three units within the DHS Licensing Division, as shown in the organizational chart that follows. As of mid-2023, the DHS Licensing Division had 11 staff in its Foster Care Unit and 10 staff in its Family Child Care Unit. While there were 21 staff in the Home- and Community-Based Services Unit, this unit has historically dedicated only 1 staff member to Community Residential Settings licensing.[4]

[4] Home- and Community-Based Services include a wide array of services for adults with disabilities or any individual who is age 65 or older, most of which are licensed exclusively by DHS staff. As of the publication of this report, DHS was in the process of hiring additional staff to support Community Residential Settings licensors.

DHS Oversight of County-Delegated Licensing



Note: This is a simplified organizational chart showing only those units relevant to this report and the programs with county-delegated licensing that they oversee.

Source: Office of the Legislative Auditor.

Programs with County-Delegated Licensing

For our evaluation, we focused on the relationship between DHS and the county staff that perform certain licensing activities on the department's behalf. The table on the next page describes the key programs for which DHS has delegated licensing responsibilities to county licensors. It also shows the number of active licenses and the maximum number of individuals those providers are licensed to serve (as of the end of Fiscal Year 2023).

Foster Care

The table that follows shows two separate Foster Care programs: Child Foster Care and Adult Foster Care. DHS's Foster Care Unit oversees both programs, and many county licensors work with both. Throughout this report, we refer to the two programs collectively as "Foster Care" when discussing a type of DHS support or a requirement that applies to both. However, we discuss the programs separately when it makes sense to draw a distinction between them.

The Foster Care Unit also oversees the licensing of "Child Foster Residence Settings" and "Family Adult Day Services" providers. Due to the small numbers of licenses in these programs, we do not discuss them further in this report.

Programs with County-Delegated Licensing, June 2023

Program	Description	Number of Licenses	Maximum Number Served
Family Child Care	Supervision and care for children outside of their own home for fewer than 24 hours per day, typically taking place in the license holders' homes	5,795	68,511
Child Foster Care	Temporary residential care in the license holders' homes for children who cannot safely remain in their own homes due to alleged or substantiated neglect, drug abuse on the part of their caretaker, or other reasons	3,758[a]	8,513[a]
Adult Foster Care	Ongoing residential care in the license holders' homes for seniors and adults with disabilities who require some daily care, but not skilled nursing	1,135[b]	2,882[b]
Community Residential Settings (CRS)	Ongoing residential care settings for adults in which at least one resident receives certain types of disability services; the settings are not in the license holders' homes and residents are supported by paid staff who work in shifts to provide 24-hour care	3,684	13,138

[a] These figures include a small number of settings known as "Child Foster Residence Settings," which provide care for small numbers of foster children in licensed homes where the license holders do not reside.

[b] These figures include a small number of settings known as "Family Adult Day Services," which provide nonresidential care for adults in the license holders' homes.

Source: Office of the Legislative Auditor, analysis of DHS licensing data, June 30, 2023.

County Licensing Agencies

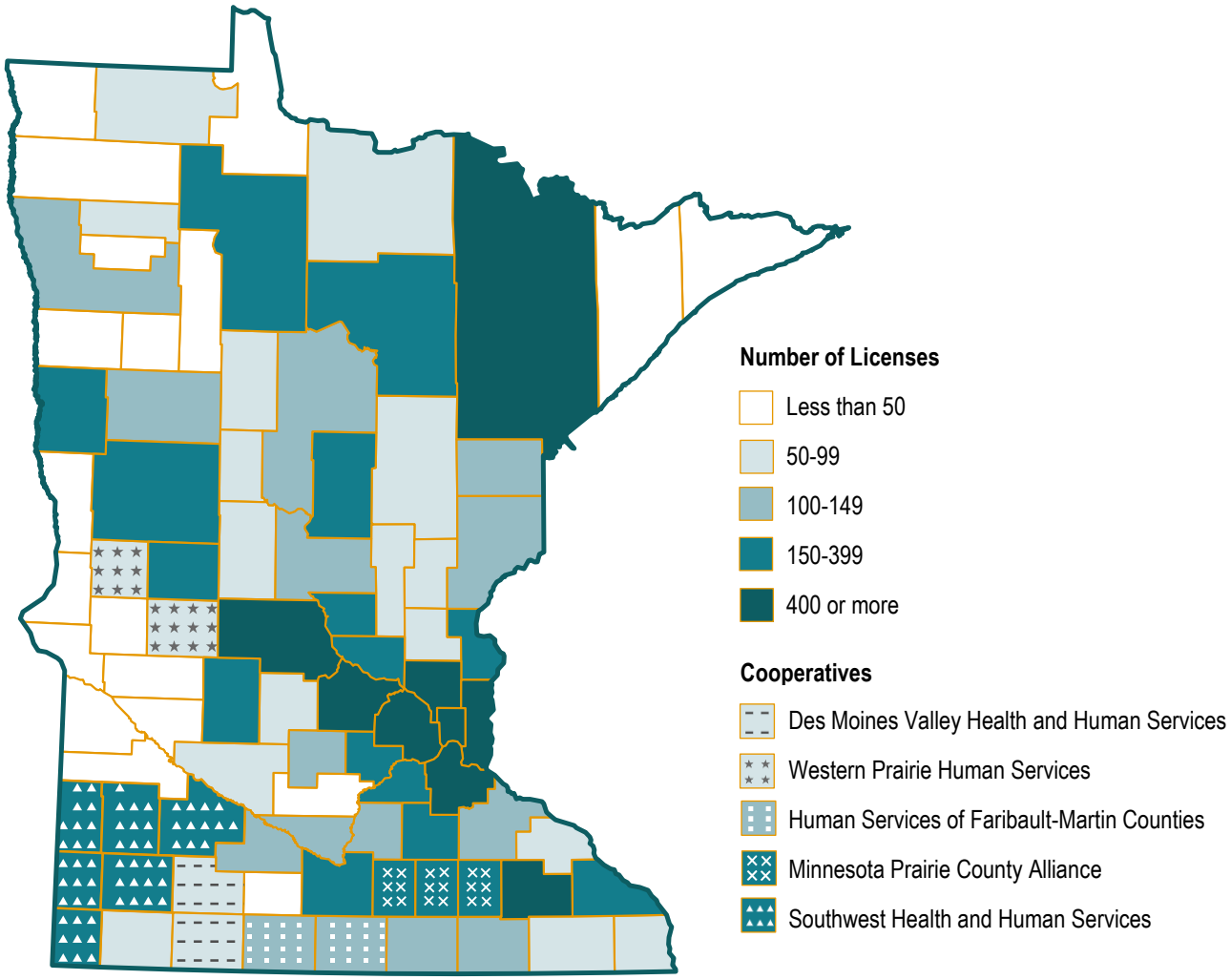
Across Minnesota, county licensing agencies vary both in the number of licensing staff they have and in the number of licenses they process. Large county licensing agencies tend to have multiple staff licensors who may specialize in processing a particular type of license. Hennepin County has the largest licensing staff, with nearly 50 specialized staff licensors according to a mid-2023 licensor list. In contrast, less populous counties may have just one or two licensors who each conduct licensing activities related to multiple programs. Some other counties rely on multicounty cooperative organizations serving their region to conduct some or all of the county's licensing activities.

In Fiscal Year 2023, the vast majority of county licensing agencies oversaw fewer than 80 licenses per staff licensor (with the average being around 50).[5] However, county licensing staff workloads varied widely—from 5 to more than 120 licenses per licensor in Fiscal Year 2023. These different staffing arrangements and workloads can impact the amount and type of support the county licensors require from DHS.

[5] This encompasses any license the county licensing agency might have spent time on, including licenses issued, renewed, or otherwise monitored, as well as licenses that were revoked during Fiscal Year 2023. The staff numbers do not include licensing supervisors, who may or may not participate in day-to-day licensing activities alongside their staff.

More populous counties are likely to have a greater demand for child care or other licensed human services than less populous counties, and thus are likely to have more licensed providers. The following map shows the number of current licenses, as of the end of Fiscal Year 2023, for which each county licensing agency was responsible. It also shows the groups of counties that license cooperatively.

County Licensing Agencies by Number of Licenses, Fiscal Year 2023



Notes: The color of the county reflects the number of licenses across all programs with county-delegated licensing for which the associated county licensing agency or cooperative was responsible in Fiscal Year 2023, including licenses that were suspended or revoked during that time. For the county cooperatives, the color reflects the total number of licenses processed and monitored by the cooperative. As such, each individual county within the cooperative may be the home to fewer licensed providers than the color-coding suggests.

Source: Office of the Legislative Auditor, analysis of DHS licensing data, June 30, 2023.

County-Delegated Authority

Since at least 1987, the Minnesota Legislature has empowered DHS to delegate some human services licensing activities to local units of government.[6]

For certain programs, DHS has delegated application processing and license monitoring to county licensing agencies.

Statutes largely allow DHS to determine which licensing functions, such as application processing and inspections, to delegate to county and private agencies.[7] While DHS must make the final decision about whether to issue a license, it can give county and private agencies the authority to make licensure recommendations to DHS, including recommendations to deny an application or to suspend or revoke a license.[8]

County-Delegated Licensing Functions

The licensing functions that DHS has formally delegated to county licensing agencies include, but are not limited to:

- Accepting and processing license applications
- Conducting inspections of providers
- Recommending approval or denial of applications for licensure
- Monitoring compliance with applicable licensing rules
- Investigating allegations of license violations
- Issuing correction orders
- Recommending sanctions, up to license revocation

— *Minnesota Rules*, 9543.0030, subp. 1

DHS has chosen to delegate to county licensing agencies all of the licensing functions that the law allows it to delegate. The department formally outlines the functions it delegates for Family Child Care and Foster Care licensing in its rules; the box to the right lists some of these delegated functions.[9] DHS delegates many of the same functions to county licensing agencies for Community Residential Settings (CRS) licensing, but it has not issued a corresponding set of rules governing CRS licensure.

[6] *Laws of Minnesota* 1987, chapter 333, sec. 17, newly specified that DHS's commissioner could designate certain licensing functions and activities to county licensing agencies. The licensing statutes from 1986 (specifically *Minnesota Statutes* 1986, 245.783, subd. 2) and earlier allowed the State Fire Marshal, rather than the DHS commissioner, to delegate license inspection duties to local units of government.

[7] *Minnesota Statutes* 2023, 245A.16, subd. 1(a). "Private agencies" include nonprofit organizations to which DHS delegates Child Foster Care licensing functions under *Minnesota Rules*, 9543.0030, subp. 2, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023. We did not evaluate DHS's relationship with private agencies.

[8] *Minnesota Statutes* 2023, 245A.04, subd. 7(a); and 245A.16, subd. 1(a).

[9] *Minnesota Rules*, 9543.0030, subp. 1, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023.

Overview of Licensing Processes

The following table summarizes the steps involved in issuing and monitoring Foster Care, Family Child Care, and CRS licenses.[10] It also illustrates which functions are DHS's responsibility and which functions the department delegates to county licensing agencies.

Division of Licensing Responsibilities for Programs with County-Delegated Licensing

Licensing Functions	County Agency	DHS
Accept applications	✓	
Conduct inspections	✓	
Perform background studies		✓
Review applications	✓	
Recommend licensure or application denial	✓	
Issue licenses or deny applications		✓
Monitor providers	✓	
Conduct investigations	✓	✓
Issue correction orders	✓	
Recommend license suspension or revocation	✓	
Revoke or suspend licenses		✓

Source: Office of the Legislative Auditor.

Statutes prescribe a single general process for DHS to issue all of its license types.[11] Individuals or organizations submit applications to provide services, and DHS or county licensing agencies collect information and determine whether applicants comply with the licensing requirements for the types of services they intend to provide. For the Family Child Care, Foster Care, and CRS programs, DHS largely relies on county licensing agencies to interact with prospective providers and to assess whether they qualify for licensure.

License Issuance

To apply for a human services license, a prospective provider first submits a license application, on a DHS form, to the county licensing agency. Then, a county licensor who works in the program area inspects the applicant's home or other care setting using a DHS checklist of applicable licensing requirements.[12] The checklists require county licensing agencies to confirm, for example, that the applicant's home is free of certain

[10] An important distinction for CRS licenses is that applicants must first apply for a Home- and Community-Based Services license, which DHS processes directly. Once DHS issues the Home- and Community-Based Services license, the department then refers the applicant to their local county licensing agency to apply for a supplemental CRS license. County licensing agencies process the CRS portion of the applications in generally the same manner that they do with other delegated license types.

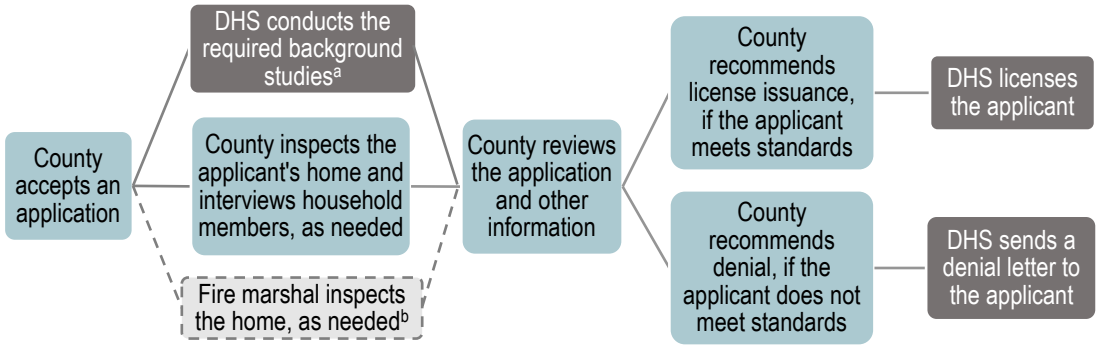
[11] *Minnesota Statutes* 2023, 245A.04.

[12] *Minnesota Statutes* 2023, 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0040, subp. 2B, https://www.revisor.mn.gov/rules/9543.0040/, accessed December 14, 2023. The checklists include requirements from *Minnesota Statutes* 2023, 245A, as well as *Minnesota Rules*, 9502, for Family Child Care; *Minnesota Rules*, 9555, for Adult Foster Care; and *Minnesota Rules*, 2960, for Child Foster Care.

hazards and includes spaces appropriate to the care being provided. In addition, DHS must conduct background studies of the applicant, other potential caregivers, and certain other individuals who reside in the home.[13] For Foster Care, the county licensing agency also conducts in-person interviews with all family members and other adults in the household.[14]

To process an initial license application for a program with county-delegated licensing, DHS and county licensing agencies generally follow the steps outlined in the following exhibit.

Simplified Overview of the Initial Licensing Process



[a] For CRS applicants, DHS conducts required background studies before referring the applicant to the county licensing agency to complete an application to license the CRS facility.

[b] Whether the applicant needs a fire marshal inspection depends on the type of license sought and other circumstances.

Source: Office of the Legislative Auditor.

County licensing agencies must determine that applicants comply with licensing requirements before recommending that DHS issue an initial license.

Once the county licensing agency has completed its inspections and interviews, the county licensor reviews all available information, such as application materials and inspection documentation. Based on the county licensor's review, the county licensing agency determines whether DHS should license the applicant. If the county licensing agency finds that the applicant meets legal requirements (the applicant is qualified and the home meets health and safety standards), it forwards a form to DHS that contains

[13] *Minnesota Statutes* 2023, 245C.03, subd. 1; and 245C.04, subd. 1(a). A background study is a check for historical criminal and abusive behavior that would disqualify an individual from working with the population they are applying to serve.

[14] *Minnesota Statutes* 2023, 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0060, subp. 4A, https://www.revisor.mn.gov/rules/9543.0060/, accessed December 14, 2023.

the county's recommendation for licensure.[15] If the county licensing agency finds that the applicant does not meet licensing requirements, it documents relevant evidence for DHS and submits a recommendation to DHS to deny the license.[16]

DHS issues licenses based on the recommendations of county licensing agencies.

To complete the process, DHS either issues the license or notifies the applicant of a denial based on the county licensing agency's recommendation. DHS does not have a separate process to assess the county licensing agency's licensing recommendation. DHS managers told us that instead, DHS staff check to make sure the recommendation form is complete and then issue the license. If the county licensing agency recommended a denial, DHS staff also ensure that the county's documentation shows that there is a sufficient statutory basis for the denial before mailing a denial letter to the applicant.

A license holder may provide services for one year with an initial license; thereafter, Minnesota statutes allow each license renewal to last for up to two years.[17] To renew a license, statutes require the provider to submit another application to the county licensing agency and pass an inspection.[18]

Issue: Continuous Licensing vs. License Renewal

DHS told us that the department does not require all providers to renew their licenses using the process described in this chapter. Instead, DHS uses "continuous licensing" for many of its license types, including Home- and Community-Based Services licenses. The department also has plans to convert Family Child Care and Foster Care licenses to continuous licenses in the future, starting with Family Child Care in 2025. To maintain a continuous license, a provider simply pays a renewal fee and undergoes an inspection; the provider is not required to apply for a new license every two years.

Based on our analysis, statutes are currently incompatible with continuous licensing, given that they require (1) licenses to expire at least every two years and (2) the license holder to apply again in order to continue operating. Specifically:

- *Minnesota Statutes* 2023, 245A.16, subd. 1(e), states that "a license…may be issued for up to two years."
- *Minnesota Statutes* 2023, 245A.04, subd. 7(l), states that "unless otherwise specified by statute, all licenses issued…expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date."

RECOMMENDATION: If DHS wishes to implement continuous licensing, it should work with the Legislature to amend statutes in a manner that allows the process.

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[15] *Minnesota Statutes* 2023, 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0040, subp. 5A, https://www.revisor.mn.gov/rules/9543.0040/, accessed December 14, 2023.

[16] *Minnesota Statutes* 2023, 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0040, subp. 5C, https://www.revisor.mn.gov/rules/9543.0040/, accessed December 14, 2023.

[17] *Minnesota Statutes* 2023, 245A.16, subd. 1(e). Foster Care providers who are related to the person that they are caring for can be licensed for two years with an initial license.

[18] *Minnesota Statutes* 2023, 245A.04, subds. 4(a) and 7(l); and 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0040, subp. 6, https://www.revisor.mn.gov/rules/9543.0040/, accessed December 14, 2023. County licensing agencies must inspect Family Child Care providers at least annually and must conduct other provider inspections at least once every two years, as a part of the license renewal process.

Ongoing Monitoring

County licensing agencies monitor providers and help DHS to enforce licensing requirements.

The county licensing agency is responsible for monitoring whether providers comply with applicable licensing requirements.[19] If a county licensor finds that a provider no longer meets licensing requirements after conducting a licensing inspection, the county licensing agency can take one of two types of enforcement actions depending on the severity or nature of the violation. County licensing agencies have the authority to issue "correction orders," which require the provider to address certain violations that do not imminently endanger the health, safety, or rights of people served by the provider.[20] For more serious issues, county licensing agencies may recommend that DHS change the status of a license by suspending, making conditional, or revoking the license.[21] DHS determines whether to take action on these recommendations after reviewing documentation submitted by the county licensing agency. We discuss these "licensing actions" further in Chapter 3.

According to a DHS manager, the department and county governments also share responsibility for investigating certain complaints about licensed providers. Generally, if a complaint alleges imminent danger to an *adult* served by the program (a maltreatment complaint), DHS investigates the complaint. If a complaint alleges *child* maltreatment, the county's child protection unit conducts an investigation. If the complaint alleges another type of licensing violation, the county licensing agency investigates the complaint. If a county licensor finds that a provider no longer meets licensing requirements after conducting an investigation, the county licensing agency can either issue a correction order or recommend a licensing action to DHS.[22]

[19] *Minnesota Statutes* 2023, 245A.04, subd. 6(a); and 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0030, subp. 1E, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023. County licensing agencies are responsible for determining whether the provider complies with rules governing Family Child Care and Foster Care programs, as well as requirements in *Minnesota Statutes* 2023, Chapters 245A and 245C. County licensing agencies are also responsible for determining whether CRS providers comply with requirements in *Minnesota Statutes* 2023, Chapter 245A, and a subset of requirements in Chapter 245D.

[20] *Minnesota Statutes* 2023, 245A.06, subd. 1(a); and 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0030, subp. 1H, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023.

[21] *Minnesota Statutes* 2023, 245A.07; and 245A.16, subd. 1(a); and *Minnesota Rules*, 9543.0030, subp. 1I, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023.

[22] *Minnesota Statutes* 2023, 245A.16, subd. 2(b); and *Minnesota Rules*, 9543.0070, subps. 2 and 3, https://www.revisor.mn.gov/rules/9543.0070/, accessed December 14, 2023.

Chapter 2: DHS Support to County Licensors

While the Department of Human Services (DHS) has delegated some licensing functions to county licensing agencies, DHS is legally required to "provide instruction and technical assistance" to county agencies "that have been designated or licensed by the commissioner to perform licensing functions and activities."[1] DHS accordingly provides assistance to county licensors on how to interpret licensing standards, process license applications, resolve issues that arise in licensed care settings, and address other matters related to licensing.

Key Findings in This Chapter

- DHS has provided less support for Community Residential Settings (CRS) licensors compared to licensors in other programs with county-delegated licensing.
- Most county licensors reported generally favorable opinions of DHS's support.
- DHS has not put certain guidance in writing for county licensors.

In this chapter, we start with a discussion of DHS staffing. We then discuss the methods that DHS uses to support county licensors before delving more deeply into two areas of concern reported by some county licensors: technical assistance (or "triage") and the lack of certain written communication from DHS. Finally, we make recommendations for improvement at the end of the chapter.

DHS Resources

DHS's staffing affects the quantity and quality of support that the department can provide to county licensors.

County licensors and DHS staff alike shared concerns about insufficient staffing within DHS's Licensing Division.

To learn about the effectiveness of DHS's support to county licensors, we conducted surveys of all county licensors in Minnesota and of select DHS Licensing Division staff who work with county licensors.[2] Though we did not ask about it explicitly, dozens of county licensors shared concerns about DHS's staffing levels. Staffing also arose as a prevalent issue in the responses to the DHS staff survey. Several DHS staff commented

[1] *Minnesota Statutes* 2023, 245A.16, subds. 1(a) and 5(a); and *Minnesota Rules*, 9543.0030, subp. 1, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023.

[2] In August 2023, we surveyed staff licensors and licensing supervisors from all counties and county cooperatives and received responses from 78 percent of them (302 of 385 county licensors). We also surveyed all DHS staff in the three Licensing Division units that oversee county-delegated programs: Family Child Care, Foster Care, and Home- and Community-Based Services. We received responses from 88 percent (37 of 42) of the DHS staff that we surveyed.

> It constantly feels like we are flying by the seat of our pants. I believe the root cause of this is that we have way more work to do than we do people to do the work--or at least do the work well, consistently, and timely.
>
> **— DHS Staff Member**

that the agency would provide county licensors with more support if it had more staff to do so.

DHS managers told us that over the past several years, the Licensing Division has been consistently under-resourced, particularly with respect to Community Residential Settings (CRS) and Adult Foster Care. For example, DHS has historically dedicated just one staff person to supporting more than 100 CRS licensors, who together process on average 173 new CRS licenses each year (and monitor a total of nearly 3,700 licenses). During the 2023 legislative session, DHS requested and received $10 million for the 2024-2025 biennium to add staff to its Home- and Community-Based Services and Foster Care units.[3]

A DHS manager explained that the funding would be used to begin adding more than two dozen licensor positions to the Home- and Community-Based Services Unit (which performs direct licensing for many programs).[4] One of those positions will be an additional CRS liaison (bringing the total to two). The DHS manager also told us that they plan to add 11 positions to the Foster Care Unit (doubling its size). The manager said that the additional Foster Care staff will allow the unit to dedicate more resources to Adult Foster Care licensing and will allow it to work closely with the CRS liaisons "to build up more training, technical assistance, and support" for county licensors.[5]

Overview of DHS Support to County Licensors

County licensors rely on support from DHS for numerous reasons, such as training, guidance on new licensing policies, or assistance in emergent situations.

DHS has provided a range of supports to county licensors across programs, but has provided less support targeted to those who license CRS.

Community Residential Settings (CRS)

Throughout this chapter, we discuss a number of instances in which we find that DHS has generally provided adequate support to county licensors, but for which we have concerns related to CRS licensing. We highlight these CRS concerns using **bold teal font**.

DHS has supported county licensors through trainings, ongoing and ad hoc meetings, newsletters, and written or verbal responses to licensor inquiries, among other methods.

Trainings. DHS has provided numerous required and optional trainings for county licensors. The department requires new licensors to complete certain DHS trainings upon starting their roles.[6] After licensors complete their initial

[3] *Laws of Minnesota* 2023, chapter 70, art. 20, sec. 2.

[4] Home- and Community-Based Services include a wide array of services for adults with disabilities or any individual who is age 65 or older, most of which are licensed exclusively by DHS staff.

[5] Most CRS licensors also license Adult Foster Care providers, and certain training and licensing processes overlap for CRS and Adult Foster Care. A manager said that DHS is in the process of hiring a new CRS and Adult Foster Care supervisor, which may also improve its support to these licensors.

[6] *Minnesota Statutes* 2023, 245A.16, subds. 5(a) and 7.

required trainings, DHS requires them to complete six hours of continuing professional education every year, and Fire Marshal training every four years. In addition, DHS has provided optional trainings on a variety of topics, such as how to electronically record the results of Family Child Care provider inspections or how to issue "correction orders" to providers, which require the provider to address certain violations that do not imminently endanger the health, safety, or rights of people served by the provider.

DHS has not made clear to county licensors the extent to which its trainings apply to CRS licensors. While DHS managers told us that most of the Adult Foster Care-specific trainings are applicable to CRS, they acknowledged the lack of dedicated CRS-specific training content. A DHS manager told us that the department does not currently have the capacity to develop additional training for licensors. Some county licensors told us they were not aware that DHS offered CRS-applicable training.

Optional Meetings. DHS has hosted various types of virtual meetings to address county licensors' questions, concerns, and issues related to licensing; these include, for example, separate monthly meetings for Family Child Care licensors and Foster Care licensors (both child and adult). These meetings have covered a range of topics, such as requesting a Fire Marshal inspection, submitting licensing forms, and identifying child care background studies that have expired. **DHS has not historically offered regular monthly meetings with content explicitly tailored to CRS licensors. According to DHS managers, they began hosting combined meetings with CRS and Adult Foster Care licensors in January 2024.**

Licensor Link Newsletters. DHS has sent program-specific "Licensor Link" newsletters via e-mail to Family Child Care licensors on a monthly basis and to Foster Care licensors on a quarterly basis. The Licensor Link newsletters have typically contained announcements about upcoming meetings or trainings and tips on various licensing-related topics. **DHS does not currently produce Licensor Link newsletters specific to CRS licensing.**

Triage. DHS staff and county licensors have often interacted via DHS's "triage" technical assistance system, which enables licensors to contact DHS staff via phone or e-mail to discuss questions, concerns, or issues related to their licensing work. We discuss DHS's triage system in more detail in another section of this chapter.

Perceptions of DHS Support

Our surveys of county licensors and DHS staff contained several parallel questions about DHS's support to county licensors, which allowed us to compare the responses of county licensors and DHS staff across the same licensing-related topics. We also held four focus groups with county licensors who represented 24 county licensing agencies across the state.[7]

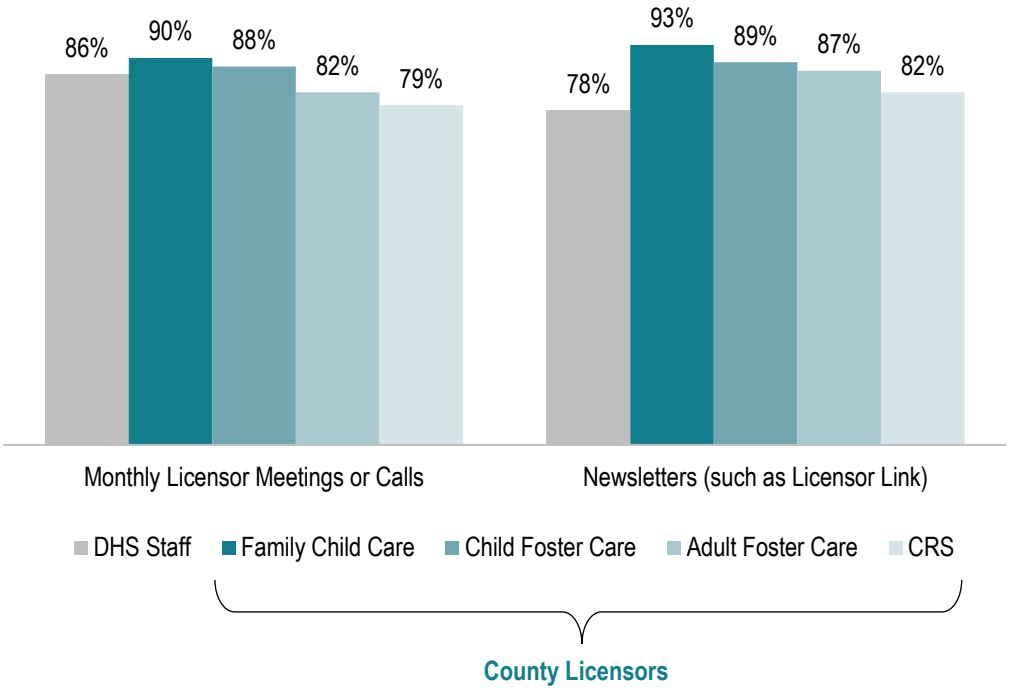
[7] In August 2023, we held two in-person focus groups with licensors from the Twin Cities metropolitan area and two virtual focus groups with licensors from Greater Minnesota.

Both the county licensors and DHS staff who responded to our surveys generally agreed that DHS has, overall, provided effective support to county licensors.

In the survey responses, county licensors and DHS staff generally reported favorable opinions of the support and resources that DHS provides to licensors that we asked them about. We asked both county licensors and DHS staff to assess the usefulness of various types of support that DHS provides to licensors. Most county licensors and DHS staff who responded to our surveys (generally more than 70 percent) agreed or strongly agreed that DHS provides useful support across a range of methods. The following charts summarize the responses of DHS staff and county licensors to two questions about DHS's methods of support to licensors.

> …I find it helpful to have a strong partnership with DHS. I don't hesitate to reach out if there is a need to consult on a certain situation. I look to DHS for consultation and advice in unique and difficult situations.
>
> **— County Licensor**

Percentage of Survey Respondents Who Agreed or Strongly Agreed that DHS's Methods of Support to County Licensors Are Useful



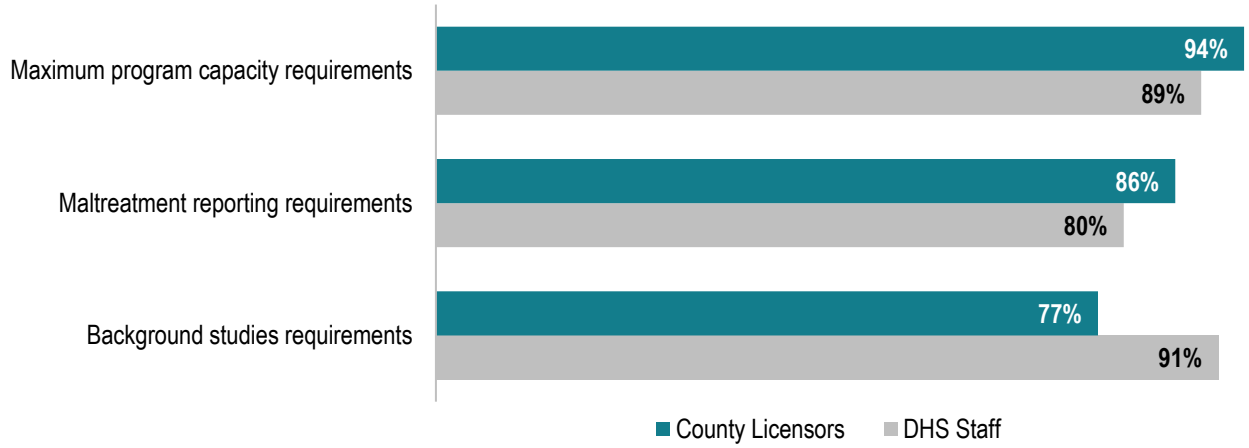
Notes: We omitted from our analysis respondents who either skipped these questions or selected "Not applicable." County licensors responded to these questions for each program they licensed. Depending on the question, respondents included 169 or 170 Family Child Care licensors, 178 or 179 Child Foster Care licensors, 124 Adult Foster Care licensors, 111 or 114 CRS licensors, and 36 DHS staff. The exhibit includes two selected examples of supports listed on the survey; results were mostly positive for all options.

Source: Office of the Legislative Auditor, analysis of county licensor and DHS staff surveys, 2023.

Most county licensors and DHS staff who responded to our surveys reported favorable opinions of DHS's communication of licensing requirements, but some county licensors shared concerns about unclear or inconsistent information.

We asked county licensors and DHS staff a series of questions about the guidance that DHS provides to county licensors on licensing requirements. As the following charts show, most respondents to both surveys agreed or strongly agreed that DHS provides *clear* guidance on the licensing requirements that we asked them about. In addition, generally more than 70 percent of licensors and DHS staff agreed or strongly agreed that DHS provides *enough* guidance for the licensing requirements that we asked them about.

Percentage of Survey Respondents Who Agreed or Strongly Agreed that DHS Provides Clear Guidance to County Licensors on Licensing Requirements



Notes: We omitted from our analysis respondents who either skipped these questions or selected "Not applicable." Depending on the question, respondents included from 296 to 298 county licensors and 35 DHS staff. The charts include selected examples of licensing requirements; results were mostly positive for all requirements that appeared on the survey.

Source: Office of the Legislative Auditor, analysis of county licensor and DHS staff surveys, 2023.

Most county licensors (55 percent) agreed or strongly agreed that DHS provides them with useful examples of how *providers* can comply with program standards. An even larger majority of county licensors (65 percent) agreed or strongly agreed that DHS provides them with useful examples of how *licensors themselves* can comply with licensing statutes and rules.

> As licensors, we represent the Commissioner of DHS. However, there are times we seek clarification from DHS and are not given clear answers.
>
> I feel the team at DHS wants to be supportive and have a good relationship with licensors, however, sometime[s] guidance is unclear.
>
> **— County Licensors**

Despite generally favorable responses to our surveys, DHS has room to improve. We heard concerns about DHS's guidance from some county licensors. At least a dozen licensors who responded to our open-ended focus group and survey questions suggested that DHS's guidance is unclear. In addition, several licensors commented on a lack of DHS guidance on licensing requirements. For example, one licensor wrote, "DHS will not provide guidance when certain questions are asked. When we ask DHS what a provider needs to do to be in compliance, answers are needed, not a reference to Rule and Statute and told to 'follow this.'" Several licensors also described DHS's guidance as being inconsistent when different DHS staff respond to licensors' questions. Lastly, of the licensors whose comments we discuss in this paragraph, **nearly a dozen county licensors were critical of the guidance that DHS provides for CRS licensing**.

Triage

As stated previously, DHS uses its "triage," or technical assistance, system to respond to county licensor questions and concerns. Triage is one of the key ways that DHS provides county licensors both with technical support on licensing tools and with guidance on statutes and rules.

DHS fields a significant number of phone and e-mail inquiries from county licensors through the triage system.[8] During Fiscal Year 2023, DHS received more than 1,500 inquiries related to Foster Care and more than 3,000 inquiries related to Family Child Care. The topics of these inquiries included clarification on statutes and rules, technical assistance for licensing forms or tools, and maltreatment reports about providers, among others. **DHS did not systematically track the number of inquiries it received related to CRS**.

Timeliness

While most county licensors who responded to our survey noted that DHS's triage responses were timely, some CRS licensors reported that it took significant time to receive responses from DHS.

While DHS does not have a formal policy defining the timeframe in which staff must reply to inquiries from county licensors, each unit has established general expectations. A Family Child Care Unit manager said that they expect Family Child Care staff to respond to most inquiries on the same day they are received. If the inquiry requires additional consultation or research, DHS expects Family Child Care staff to let licensors know they are looking into the issue and will get back to them. A Foster Care Unit manager told us that DHS expects Foster Care staff to respond to licensor inquiries

[8] Some of the triage inquiries DHS received came from license holders or other members of the public, rather than from licensors.

> Triage has been a great tool with a very quick response time. I appreciate how quick they are with getting back to you.
>
> **— County Licensor**

within three business days. DHS told us that the CRS Unit tries to respond within one business day, but the response times may vary.

More than 70 percent of county licensors who responded to our survey agreed or strongly agreed that DHS provides timely triage for questions related to statewide licensing requirements. Several licensors told us that they appreciate the quick triage responses from DHS. However, some county licensors expressed concerns about the timeliness of DHS's responses to triage inquiries.

One-quarter of all county licensors who responded to our survey, **and 40 percent of those who license CRS**, disagreed or strongly disagreed that they received timely triage for questions related to statewide licensing requirements. More than 20 county licensors **volunteered concerns about the timeliness of DHS's triage responses, particularly in response to CRS-related questions**. Several county CRS licensors told us that they had waited long periods of time for a response when they reached out to DHS for assistance with CRS matters. Multiple licensors reported that they had waited months to receive a response, or were still waiting to receive a response, to CRS-related questions they sent to DHS months prior.

> I don't feel like DHS is supportive at all for CRS. There is never anyone available to answer the phone and it takes weeks to answer e-mails.
>
> **— County Licensor**

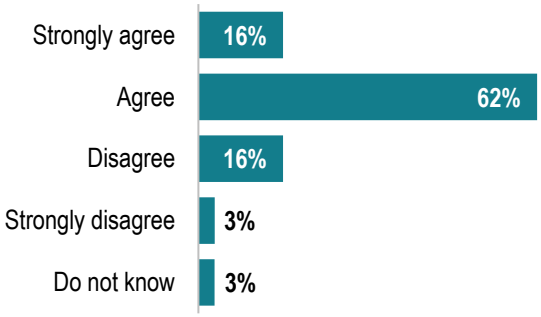
DHS does not track how long it takes its staff to respond to triage inquiries for any license type. Because DHS does not track this information, the department is not able to easily identify individual inquiries that did not receive a response for an extended period of time.

Usefulness

Most county licensors who responded to our survey agreed that DHS provides useful information in response to triage inquiries, but dozens shared concerns about inconsistent responses.

Almost 80 percent of county licensors who responded to our survey agreed or strongly agreed that DHS provides useful triage, as shown in the following chart. Several licensors described having a positive experience reaching out to triage. For example, during a focus group, one licensor said, "Generally speaking, I think the licensing staff are very…polite, very respectful, and try very hard to be a positive resource when the county is seeking out information, guidance, whatever it may be. They do a pretty good job of responding when you have a concern."

Survey Question: To what extent do you agree that DHS generally provides useful technical assistance "triage" to county licensors on statewide licensing requirements?



Note: A total of 301 county licensors responded to this question; the chart does not include individuals who answered "Not applicable."

Source: Office of the Legislative Auditor, analysis of county licensor survey, 2023.

However, more than two dozen county licensors shared concerns about receiving inconsistent responses to triage questions. Some licensors said that, when presented with similar situations, DHS's responses might change depending on timing or who is responding to the inquiry. One county licensor stated, "Licensors are given different direction/ guidance depending on the day and who the triage person is. Interpretations continuously change and things are confusing."

Both DHS's Family Child Care and Foster Care units maintain working lists of how staff responded to common questions they received from county licensors through triage. A DHS manager told us that staff use this list to ensure they respond to questions consistently. The manager also told us that Family Child Care Unit staff meet regularly to discuss triage-related issues as a team. Another DHS manager explained that two triage questions may seem similar to the licensor asking the question, but require a different response based on the details of each case. They said that each licensing situation is unique, and making an accurate determination often requires a large amount of information. **In contrast to other units, the unit that supports CRS does not have any guidelines or lists of examples to guide how staff should respond to triage inquiries**. However, until recently, only one staff person responded to all CRS inquiries.

As mentioned previously, DHS maintains a log for both Family Child Care and Foster Care inquiries, but these logs do not always contain detailed information about specific inquiries or resolutions. Without this context, it was not possible for OLA to evaluate whether DHS's triage responses were generally consistent.

Written Communication

As discussed in this chapter, county licensors are generally satisfied with the methods that DHS uses to communicate licensing requirements and other information. However, there is room for DHS to improve upon the ways it shares information with county licensors.

DHS has not put certain guidance in writing, making it difficult for county licensors to obtain consistent and timely information.

While DHS holds many optional meetings for county licensors, it has not consistently shared certain information in a written format. One unit's manager explained that the unit does not have the resources to make all presentation slides, for example, accessible

for people with disabilities.[9] However, state standards require executive branch agencies to make slides and other materials accessible prior to displaying them in meetings.[10]

> If changes are implemented and discussed at these meetings, minimally, something should go out in writing from DHS. This is not currently done which leads to inconsistency in licensing across the state.
>
> **— County Licensor**

DHS has also not typically recorded meetings or distributed summaries to all county licensors. In our focus groups, two licensors reported taking screen shots of presentations and sharing them with fellow licensors, a practice that DHS encourages. However, informal sharing among county licensors should not be relied upon as a substitute for uniformly distributed guidance from DHS. When monthly meetings or other optional meetings include new procedures or guidance, licensors who do not attend the meetings may not receive the information in a timely fashion.

Another concern related to written communication is that guidance that DHS has provided in writing can be difficult to find. DHS does not have a searchable archive of past Licensor Link newsletters. Some county licensors raised this as an issue, saying that it is difficult to navigate back to information shared in past newsletters. Some county licensors mentioned that DHS triage staff had referred them to particular newsletters in response to questions they had asked. DHS managers acknowledged, however, that past newsletters are not currently available on DHS's website.

> It's difficult to navigate back to information shared in previous Licensor Link e-mails. It would be helpful to have all of the information stored in one accessible location for workers to look back on as things come up or for new staff.
>
> **— County Licensor**

Recommendations

As we have discussed in this chapter, DHS provides many resources for county licensors, and county licensors generally agree that the support DHS provides is useful. Nonetheless, there is room for improvement, particularly with respect to supporting CRS licensors, responding to triage inquiries, and providing written communication to licensors.

[9] A Foster Care Unit manager reported, however, that the Foster Care Unit makes webinar materials accessible and delivers them via e-mail after meetings occur.

[10] *Minnesota Statutes* 2023, 16E.03, subd. 9, requires Minnesota Information Technology Services to develop accessibility standards and to require state agencies to follow them. The resultant policy states that "agencies and their staff who are responsible for creating, modifying, procuring, or otherwise making available any information and communication technology (ICT) for internal or external use must apply the accessibility standard to their work." Minnesota Information Technology Services, Office of the Chief Information Officer, *Accessibility and Usability of Information Technology Standard*, effective June 14, 2018, https://mn.gov/mnit/assets/Stnd_State_Accessibility_tcm38-61585.pdf, accessed December 14, 2023.

RECOMMENDATION

DHS should improve the support it provides for CRS licensors.

DHS managers explained that they have not always differentiated support for CRS licensors because (1) the vast majority of CRS licensors also license Adult Foster Care and (2) the standards for these two licensed programs are very similar. While it is true that there are fewer than 30 county licensors who license CRS exclusively, DHS should strive to provide clear information about the licensing requirements for all license types.

> The monthly calls do not pertain to CRS. When asked if CRS will have information during the calls, DHS said no. I quit attending these meetings…. Anything in this area would be a welcome change.
>
> **— County Licensor**

DHS should either (1) create trainings, meetings, and Licensor Link newsletters specific to CRS licensing or (2) rebrand its Foster Care supports as "Foster Care and CRS" resources. If DHS determines that the content of CRS-specific resources would be too duplicative of support the department already offers for Foster Care licensors, it should go with the second option and make explicit in advance which agenda or news items are relevant for each licensor group. DHS managers reported that, starting in January 2024, the department has offered a combined monthly meeting for CRS and Adult Foster Care licensors.

RECOMMENDATIONS

DHS should (1) develop a formal policy and establish a timeframe in which staff must respond to triage inquiries from county licensors, and (2) track how long it takes staff to respond to each inquiry.

As mentioned above, DHS does not have a formal policy for how quickly staff should respond to triage inquiries and some licensors expressed concerns about the timeliness of DHS's responses. In the absence of requirements in law, DHS should create a formal written policy for each unit that outlines how quickly staff should respond to triage inquiries from county licensors. DHS should then ensure staff meet the required timeframes by tracking how long it takes staff to respond to and resolve triage inquiries. This will allow DHS to identify if certain types of inquiries, such as those related to CRS, have longer response times, and allocate staff resources appropriately to ensure all inquiries are resolved in a timely manner.

RECOMMENDATION

DHS should provide written guidance that is easily accessible to all county licensors.

In September and November 2023, DHS added a new section to its Licensor Link newsletter for Family Child Care licensors summarizing the important content from the previous monthly meeting. DHS should continue this practice and implement it for Foster Care and CRS newsletters and meetings as well.

To the extent that DHS presents slides or other materials at optional meetings, they should make the materials available to all county licensors in an accessible and timely fashion. Particularly when these meetings present new information about licensing standards or processes, it is important to ensure that all county licensors have equal and timely access to the information. We also recommend that DHS prioritize making meeting materials accessible to people with disabilities prior to presenting them to licensors, in accordance with state accessibility standards.

Finally, we recommend that DHS maintain searchable archives of Licensor Link newsletters, monthly meeting slides, and other relevant materials that constitute guidance on licensing standards. The materials should be tagged by topic and by relevant licensing area(s) to make them easily searchable for county licensors. One DHS manager suggested that keeping an archive of past information could result in county licensors inadvertently referencing information that is out of date. As long as articles and other materials are clearly dated and tagged by topic, county licensors should be able to find and use the most recent relevant information.[11] As we discuss further in Chapter 3, DHS is currently updating its technology systems. DHS plans to roll out its "Provider Licensing and Reporting Hub," which will include a portal specifically for county licensors, starting with Family Child Care licensors in summer 2024. DHS hopes to use this hub to store and better organize Licensor Link e-mails and other county licensor-specific resources.

[11] The department could also make a practice of removing or adding explanatory notes to items that have been superseded by new materials.

OLA

Chapter 3: DHS-County Partnership

The county-delegated licensing system requires the Department of Human Services (DHS) and county licensors to work together to license service providers and perform other licensing functions. The extent to which DHS and county licensors work together can vary depending on the county, type of licensed program, or complexity of a licensing case. For example, the sole Child Foster Care licensor in a county with a relatively small population may rely heavily on DHS's triage system to determine the best course of action in an unfamiliar licensing case. By contrast, a Child Foster Care licensor who works with several other Foster Care licensors in a large, metropolitan county may choose to seek guidance from colleagues rather than contact DHS.

Key Findings in This Chapter

- Most DHS staff and county licensors indicated that they have a strong partnership.
- DHS has sometimes been slow to issue licensing actions when providers do not comply with program requirements.
- DHS has thoroughly engaged licensors about ongoing changes to licensed programs and the Licensing Division itself.

In this chapter, we discuss the perceptions of DHS staff and county licensors regarding different aspects of the DHS-county partnership. We explain how DHS's processing of licensing actions and reviews of county licensors' work affect the partnership. Finally, we end with a discussion of how DHS has worked with county licensing staff as it implemented multiple, substantive changes to county-delegated licensing.

Partnership Strength

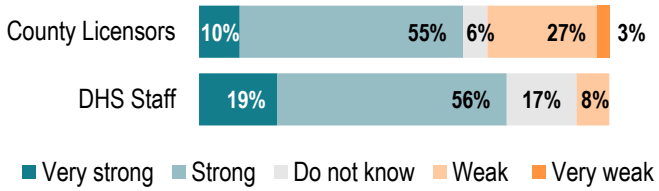
To inform our evaluation of the DHS-county partnership, we reviewed literature on best practices in organizational partnership. Numerous authors identified communication and trust as key characteristics of successful organizational partnerships.[1] As described in the literature, communication and trust strengthen the relationship between organizations and improve their ability to solve problems together.

Two-thirds of county licensors who responded to our survey reported that the partnership between DHS and county licensors is strong.

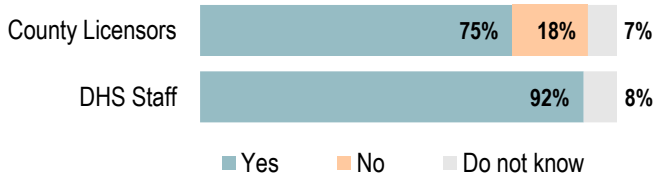
[1] See Zarnaaz Bashir, Vincent Lafronza, Michael R. Fraser, Carol K. Brown, and James R. Cope, "Local and State Collaboration for Effective Preparedness Planning," *Journal of Public Health Management and Practice* 9, no. 5 (2003): 344-351; Phil Bertolini and Ken Theis, "State and County GIS Project Fosters Collaboration," *IT Professional* 12, no. 5 (2010): 10-13; and Ruthnande Kessa, Abdul-Akeem Sadiq, and Jungwon Yeo, "The Importance of Vertical and Horizontal Collaboration: United States' Response to COVID-19 Pandemic," *Chinese Public Administration Review* 12, no. 1 (2021): 61-71.

On our respective surveys of DHS staff and county licensors, we asked respondents to evaluate the strength of the DHS-county partnership.[2] Three-quarters of DHS staff and two-thirds of county licensors who responded to our surveys indicated that the DHS-county partnership is "strong" or "very strong." We also asked survey respondents to indicate whether DHS is generally responsive to licensors' concerns. We observed even more favorable responses across both groups for this question, as shown in the chart at left. In response to the open-ended questions of our county licensor survey, several licensors shared positive experiences working with DHS. For example, one licensor said, "The licensing staff at DHS is for the most part very helpful and friendly."

Survey Question: Generally, how would you characterize the DHS Licensing Division's partnership with county licensors?



Survey Question: Is DHS generally responsive to the concerns of county licensors?



Notes: We omitted from our analysis respondents who skipped these questions. Depending on the question, respondents included 300 or 302 county licensors and 36 DHS staff. The percentages for county licensors in the top chart do not sum to 100 percent due to rounding.

Source: Office of the Legislative Auditor, analysis of county licensor and DHS staff surveys, 2023.

Despite the favorable responses to the survey questions noted above, 30 percent of county licensors indicated that the DHS-county partnership is either "weak" or "very weak." County licensors who responded to our survey described several factors they said weakened the partnership. For example, nearly 30 licensors mentioned a lack of consistent information from DHS. Dozens of licensors also mentioned long wait times for receiving DHS responses, DHS staffing shortages and turnover, or DHS's rollout of licensing changes as factors that have weakened the DHS-county partnership.

At least 20 county licensors who responded to our survey described DHS's interactions with county licensors as being antagonistic, condescending, or unprofessional. Licensors noted that these types of interactions occurred in a variety of licensing-related settings, such as during DHS's reviews of county licensors ("Rule 13" reviews, discussed later in this chapter), triage phone conversations, and monthly licensor meetings.

> There are times when questions are asked by licensors and DHS answers in a way that makes the licensor feel stupid. Or times DHS appears offended by licensors when they are asking clarifying questions.
>
> **— County Licensor**

[2] We surveyed staff licensors and licensing supervisors from all counties and county cooperatives and received responses from 78 percent of them (302 of 385 county licensors). We also surveyed all DHS staff in the three Licensing Division units that oversee county-delegated programs: Family Child Care, Foster Care, and Home- and Community-Based Services. We received responses from 88 percent (37 of 42) of the DHS staff that we surveyed.

Licensing Coordination

Some DHS staff members and county licensors who participated in our surveys and focus groups shared concerns about how well DHS coordinates with county licensors to perform licensing functions, both in general and when issuing licensing actions to providers who failed to meet licensing requirements.

Licensing Roles

As discussed in Chapter 1, Minnesota statutes give DHS the authority to delegate licensing functions to counties, and DHS has done so through its administrative rules.[3] For example, DHS has delegated to county licensing agencies the responsibility to process license applications, conduct inspections of licensed programs, and investigate allegations of license violations.[4] DHS, in turn, must act on county licensor recommendations by issuing licenses and sanctioning providers that have violated licensing standards.[5] Through its delegation of certain licensing responsibilities, DHS has entrusted county agencies with interpreting state licensing requirements at the local level. In turn, county agencies depend on DHS to coordinate effectively with them throughout the licensing process, particularly when determining whether and how to sanction providers.

While most county licensors indicated that DHS had provided clear guidance on the division of licensing roles, some licensors expressed frustration about the delineation between those roles.

On our survey of county licensors, we asked respondents about DHS's guidance related to the division of licensing responsibilities between county licensors and DHS. Licensors' responses to this question were mostly positive: 73 percent agreed or strongly agreed that DHS provides clear guidance on the division of licensing responsibilities.

> Overall, it is clear what DHS's responsibilities are and what the counties' responsibilities are.
>
> I think the division of responsibilities is not a problem area in general.
>
> **— County Licensors**

However, 22 percent of county licensors who responded to our survey disagreed or strongly disagreed that the roles are clearly defined. At least a dozen licensors expressed comments in the county licensor survey describing confusion or concerns about the delegation of licensing responsibilities between DHS and the counties. For example, one licensor wrote, "I guess I am aware of my responsibilities as a licensor but not very sure what all the responsibilities are for DHS when it comes to licensing."

[3] *Minnesota Statutes* 2023, 254A.16; and *Minnesota Rules*, 9543.0030, subp. 1, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 15, 2023.

[4] *Minnesota Rules*, 9543.0030, subp. 1, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 15, 2023.

[5] *Minnesota Statutes* 2023, 245A.04, subds. 6(a) and 7(a); and 245A.07, subd. 1(a).

Several county licensors also cited specific role-related issues, such as DHS "overreach" of its supervisory role, the "middle man" role that county licensing agencies have to play between DHS and providers, or mixed messages from DHS about licensing responsibilities. For example, one licensor wrote, "On occasion DHS has overstepped their 'supervisory' role and have contacted my team, county employed licensors, directly relating to performance…matters. This boundary is regularly tested."

> We struggle with the county delegated system and the fact that in some cases, the supervisors or other leadership will direct their licensors in ways that we would not have if they were our employees.
>
> **— DHS Staff Member**

DHS staff members also raised issues related to the respective roles of DHS and counties under the county-delegated system, particularly the fact that county licensors can get caught between DHS and their own county leadership. In the DHS staff survey, some respondents described instances in which county leadership had contradicted the Licensing Division's guidance on how to implement licensing requirements. One respondent wrote, "Counties have at times told us right out that they will not comply with rules or statutes and we really have no way to make them accountable." We also heard from county attorneys that the separation of authority and responsibilities between county licensors and DHS can be challenging, particularly when the two parties disagree on licensing actions.

Licensing Actions

Under Minnesota's delegated licensing system, DHS must coordinate with county licensors to issue and enforce sanctions against providers who do not meet licensing requirements. As we described in Chapter 1, county licensors may issue correction orders for certain violations that do not imminently endanger the health, safety, or rights of people served by the program.[6] When county licensors observe or learn about more serious issues, they recommend "licensing actions" (which are listed in the box at right) to DHS, and it is the department that ultimately takes action against providers.[7] County licensing agencies may also recommend that DHS deny licensure to applicants.[8]

DHS Licensing Actions

Denial: Decision not to issue a license if an applicant does not meet licensing requirements

Fine: Monetary penalty, issued at DHS's discretion under certain circumstances, for a provider who does not meet licensing requirements

Conditional License: Order that a provider take specific actions to continue operating due to serious or repeated licensing violations

Suspension: Order that a provider indefinitely cease operations due to serious or repeated licensing violations

Temporary Immediate Suspension: Order for a provider to immediately cease operations due to alleged licensing violations that pose an imminent risk to the health, safety, or rights of service recipients

Revocation: Removal of a license due to serious or repeated licensing violations

[6] *Minnesota Statutes* 2023, 245A.06, subd. 1(a); and *Minnesota Rules*, 9543.0030, subp. 1H, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023.

[7] *Minnesota Statutes* 2023, 245A.06, subd. 1(a); and 245A.07, subd. 1(a); and *Minnesota Rules*, 9543.0030, subp. 1I, https://www.revisor.mn.gov/rules/9543.0030/, accessed December 14, 2023. *Minnesota Statutes* 2023, 245A.06, subd. 3, also allows a county licensor to recommend a licensing action against the provider, if the county licensing agency finds that the provider has failed to correct the violation(s) specified in a correction order.

[8] *Minnesota Statutes* 2023, 245A.05(a).

We analyzed DHS data on licensing actions that the agency issued in response to county recommendations. From Fiscal Year 2019 to Fiscal Year 2023, nearly every county licensing agency made recommendations for licensing actions, with counties recommending an average of 364 licensing actions statewide annually. In response to county licensing recommendations submitted to DHS between Fiscal Year 2019 and Fiscal Year 2023, DHS issued a licensing action about 96 percent of the time.[9] However, DHS has issued licensing actions against only a small proportion of providers. Among all providers licensed by county licensing agencies as of the end of Fiscal Year 2023, just 5 percent were subject to a DHS-issued licensing action over the previous five years.

For most types of licensing actions, statutes do not specify how quickly DHS must act on a county licensing agency's recommendation to deny an application or to sanction a provider. However, statutes require DHS to "immediately" issue a temporary immediate suspension if (1) a person's actions, (2) the license holder's failure to comply with licensing requirements, or (3) conditions in the licensed home or setting pose an imminent risk of harm to the health, safety, or rights of persons served by the provider.[10]

Without specific statutory requirements, DHS has set its own licensing action processing standards. DHS's current standards are to address recommendations for licensing actions against Family Child Care providers within, at most, about 60 calendar days (45 business days) and to address recommendations for Foster Care licensing actions within 120 calendar days.[11] DHS does not currently have a standard timeframe for addressing recommendations for Community Residential Settings (CRS) licensing actions. A DHS manager told us that the agency also has a standard to process recommendations for temporary immediate suspensions within 24 hours, regardless of the license type.

DHS has sometimes been slow to issue licensing actions when providers do not comply with program requirements.

According to our analysis of DHS's licensing actions data, the department's licensing action processing time varied across the DHS Licensing Division. DHS's Foster Care Unit processed 58 percent of the county licensing action recommendations it received from Fiscal Year 2019 to Fiscal Year 2023 within its 120-day standard.[12] By contrast, the Family Child Care Unit processed 76 percent of the county licensing action recommendations it received during that timeframe within 60 days, and 93 percent within 120 days.

[9] DHS determined that no action was necessary for almost 4 percent of recommendations submitted between Fiscal Year 2019 and Fiscal Year 2023, and had not yet processed the remaining recommendations as of mid-December 2023.

[10] *Minnesota Statutes* 2023, 245A.07, subd. 2(a).

[11] In our analysis, we used 60 calendar days as opposed to 45 business days for the sake of consistency. A DHS manager explained that the Foster Care standard was originally 45 business days from the receipt of a complete licensing action recommendation, but was adjusted to 120 calendar days due to lack of available resources. Now that it has received funding to add additional Foster Care staff, DHS plans to revise its processing time standard for Foster Care licensing actions to 60 calendar days from the initial receipt of a recommendation.

[12] This analysis excludes county recommendations for licensing actions for which DHS had not yet made a determination as of January 5, 2024.

DHS Licensing Action Processing Time, Fiscal Years 2019-2023

Action Type	Average Number of Calendar Days	Number of Actions
Temporary Immediate Suspension	1	233
Suspension	15	34
Fine	62	320
Conditional License	63	81
Conditional License and Fine	84	80
Revocation	105	386
Denial	111	606

Note: The above table excludes county recommendations for licensing actions for which DHS had not yet made a determination as of January 5, 2024.

Source: Office of the Legislative Auditor, analysis of DHS licensing actions data.

As shown in the table to the left, the number of calendar days it took DHS to issue licensing actions has also varied by the type of licensing action. For recommendations submitted over the past five fiscal years, we found that DHS took an average of more than three months to issue denials and to revoke licenses. DHS was more timely with issuing license suspensions, which require the provider to operations; we found that DHS took an average of about two weeks to process suspensions and one day to issue temporary immediate suspensions.

Long delays on the part of DHS without sufficient communication to county licensors could cause tension between the two parties. Some county licensors expressed frustration with having waited months or years for DHS to take action on their recommendations. The data we analyzed validated those concerns that DHS sometimes takes months or years to issue licensing actions. For example, among the 323 recommendations for licensing actions submitted by counties in Fiscal Year 2023, 34 of them took DHS longer than six months to address.

A few county licensors told us that DHS's delays negatively affected their work with providers. One licensor told us that the delays diminish both the importance of the licensing action and the county licensor's authority. Another licensor said that DHS's delays cause county licensors "enormous stress," since they are on the receiving end of daily calls or e-mails from frustrated providers.

> Our work is often delayed due to how long it takes for DHS to act on recommendations for licensing actions.
>
> **— County Licensor**

County licensors were not the only group to express concerns about delayed decisions from DHS on licensing actions. Three county attorneys whom we interviewed expressed similar concerns about DHS's timeliness on most types of licensing actions.[13] One DHS staff member commented in our survey that while DHS expects county licensors to submit licensing action recommendations in a timely manner, it was rare for DHS to be timely. Another DHS staff member said that DHS's lack of timeliness has "weakened the partnership" with county licensors.

DHS has plans to increase the transparency of its licensing action processes. A DHS manager explained that starting in summer 2024, Family Child Care licensors will enter their recommendations for licensing actions directly into DHS's "Provider Licensing and Reporting Hub," which we discuss in greater detail later in this chapter. This system, which will later roll out to all licensors, will track recommendation submission and DHS processing dates, which may make it easier for the department to communicate with county licensors about the status of pending licensing actions. DHS could also use this system to regularly track and produce internal reports on licensing action timeliness, which it could use to help staff prioritize their work.

[13] The county attorneys we interviewed were satisfied with DHS's expediency in handling temporary immediate suspensions.

RECOMMENDATIONS

DHS should (1) establish timeframes for processing licensing actions that are uniform across programs with county-delegated licensing, and (2) ensure that it addresses all recommendations for licensing actions within those timeframes.

DHS's current maximum of about 60 calendar days (45 business days) for Family Child Care actions is similar to the Foster Care Unit's goal before the timeframe was extended to 120 calendar days. From Fiscal Year 2019 to Fiscal Year 2023, the Family Child Care Unit met its established timeframe about three-quarters of the time. Given that many licensing requirements are similar across programs, we do not think it reasonable that it should take twice as long to process Foster Care licensing actions. As we discussed above, this extended timeframe has the potential to contribute to issues for county licensing staff. We recommend that DHS bring the Foster Care and Family Child Care goals into alignment (at either 45 business days or 60 calendar days) and that the department establish the same timeframe for addressing recommendations for CRS licensing actions.

DHS should then strive to address all recommendations for licensing actions within its established timeframes, as a way to improve its relationship with county licensors and to ensure that providers are being held properly accountable for meeting licensing standards.

Review Process

DHS's primary mechanism for overseeing county licensors' work is through "Rule 13 reviews."[14] In addition to ensuring that counties are meeting licensing expectations, these reviews can have an impact on the relationship between DHS and county licensing staff.

DHS's policy is to review each county's Family Child Care licensing activities every two years and its Foster Care licensing activities every four years. A summary of the scope of these reviews is in the box below.

As a part of the Rule 13 review process, DHS reviews a sample of provider licensing records against a checklist of requirements from state law. DHS also reviews information about the county's licensing process and other records related to the program. At the end of the Rule 13 review, DHS staff discuss any compliance issues they found with county licensors, and respond to their questions.[15]

[14] DHS has an informal numbering system for its administrative rules. "Rule 13" is the shorthand used to refer to *Minnesota Rules*, 9543.0010 through 9543.0150, which establish requirements for counties performing licensing functions delegated by DHS.

[15] DHS supervisors said that the most common compliance issue they find from Family Child Care Rule 13 reviews is missing or incomplete paperwork. From Foster Care Rule 13 reviews, DHS supervisors said that a common issue is how counties document home-safety violations.

"Rule 13" County Certification Reviews

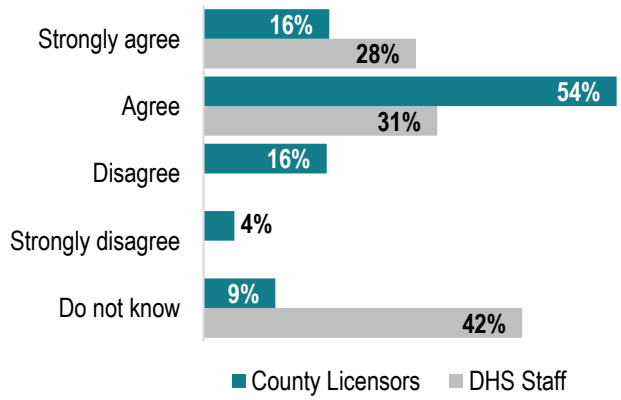
DHS staff review the following information about a county's licensing work, among other items, at least every four years:

- A sample of files related to licensed providers
- Information about county application processing procedures
- Information about county licensing decision making, such as the circumstances under which the county would schedule inspections with a Family Child Care provider
- County staff training records
- Application tracking logs
- Complaint investigation logs

Source: Office of the Legislative Auditor, analysis of DHS's Rule 13 checklists and protocols.

Once DHS completes its review, the department certifies that the county licensing agency complied with state laws.[16] Alternatively, if the county licensing agency was not in compliance, DHS may order the county to correct violations or approve a funding cut to the county.[17] DHS supervisors told us that, in addition to the support methods we discussed in Chapter 2, the department offers one-on-one consultations with county licensors so that they can address specific issues found during Rule 13 reviews.

Survey Question: DHS generally provides useful feedback to county licensors during its county certification ("Rule 13") reviews.



Notes: Chart includes responses from 298 county licensors and 36 DHS staff; the chart does not include individuals who answered "Not applicable" or did not answer the question. The percentages listed do not sum to 100 percent due to rounding.

Source: Office of the Legislative Auditor, analysis of county licensor and DHS staff surveys, 2023.

Most county licensors and DHS staff who responded to our surveys had favorable opinions of the Rule 13 review process.

In our county licensor survey, 70 percent of county licensors agreed or strongly agreed that DHS provides useful feedback during its Rule 13 reviews, as show in the chart at left. One county licensor commented, "I think the Rule 13 checklist is very helpful. It is not overly long and yet addresses the required information that must be reviewed." Among DHS staff surveyed, about 60 percent of respondents agreed or strongly agreed both that DHS provides useful feedback and that DHS's Rule 13 checklists were useful resources.

[16] *Minnesota Statutes* 2023, 245A.16, subd. 6.

[17] DHS staff said that they have never decertified a county licensing agency or cut its funding, but they have required counties to review their processes and submit a corrective action plan.

Transitions

Since 2018, county-delegated licensing, in particular Family Child Care licensing, has gone through substantial changes. The changes to licensing were either (1) required by the Legislature or federal government or (2) initiated by DHS to simplify or improve experiences for county licensors. The DHS Licensing Division is also in the process of undergoing significant changes to its structure, including hiring new staff, as we discussed in Chapter 2, and splitting into two agencies, which we discuss below.

DHS has made consistent efforts to inform and engage county licensors as it implemented changes to programs with county-delegated licensing.

We reviewed DHS's actions around several large, systemic changes to county-delegated licensing and found that DHS has performed considerable outreach to county licensors. DHS provided relevant information to licensors via e-mails, as well as virtual and in-person meetings and trainings. DHS has also solicited licensors' input on major projects through surveys and focus groups.

Licensing Checklist for Family Child Care

In 2018, DHS's Family Child Care Unit introduced the Electronic Licensing Inspection Checklist Information (ELICI) system, which Family Child Care licensors use during inspections of providers.[18] County licensors transitioned to using the ELICI checklist during inspections of Family Child Care providers over several years, and, in 2023, the Legislature formally required Family Child Care licensors to use ELICI.[19] One of DHS's goals during the development of ELICI was to standardize the inspection process for all Family Child Care providers to ensure consistent enforcement of licensing standards across the state. During inspections, county licensors enter information into the standardized ELICI tool. After licensors submit their findings, the system automatically posts certain identified violations to DHS's public website.

DHS Outreach for ELICI

- DHS conducted a pilot project in which Family Child Care licensors from across the state served as beta testers. DHS met with these beta testers several times to gather feedback on the ELICI tool and used this feedback during the tool's development.
- Throughout 2017 and the first part of 2018, DHS provided in-person demonstrations and training on ELICI to county licensors across the state.
- DHS continues to offer training on ELICI to all new county licensors, and refresher trainings for all licensors who request it. DHS also provides optional monthly ELICI trainings for all licensors.

Source: Office of the Legislative Auditor, analysis of DHS ELICI materials.

[18] DHS developed ELICI to replace a previous checklist to comply with the requirements of the federal Child Care and Development Block Grant.

[19] *Laws of Minnesota* 2023, chapter 70, art. 8, sec. 24, codified as *Minnesota Statutes* 2023, 245A.16, subd. 11.

As the previous box shows, DHS performed outreach to both solicit feedback from county licensors on ELICI and train them on how to use the tool during inspections. Since its introduction, DHS has continued to make changes to ELICI based on county licensor feedback. DHS regularly provides updates and tips on ELICI usage in its monthly trainings and newsletters to Family Child Care licensors, and licensors may reach out to DHS's "triage" line with questions or technical issues.

Child Care Regulation Modernization Project

In 2021, the Legislature directed DHS to contract with "an experienced and independent organization or individual" to complete a "Child Care Regulation Modernization" project for Family Child Care and Child Care Centers.[20] The goals of this project, as established by the Legislature, are to:

1. Identify licensing standards to use during abbreviated child care inspections, if providers meet certain criteria.

2. Develop a "risk-based" tiered violation system that ranks licensing violations by severity in order to inform the enforcement of child care standards.

3. Make recommendations to the Legislature for revised child care licensing standards.[21]

DHS contracted with the National Association for Regulatory Administration (NARA) for the project, which was still ongoing when this report was published. As part of the 2021 law, the Legislature required DHS to submit a report with recommendations on how to modernize child care licensing, including any proposed legislative changes.

DHS Outreach for Child Care Regulation Modernization Project

- On behalf of DHS, NARA conducted two surveys asking Family Child Care licensors and other stakeholders for their input on project initiatives and what they would like to see improve.
- NARA held 13 stakeholder meetings, including 2 specifically for Family Child Care licensors. At these meetings, NARA broke stakeholders into small groups for a facilitated discussion about licensing standards and then analyzed themes from these discussions.
- DHS reported the results of outreach activities and progress updates to county licensors and other stakeholders during a virtual meeting. At this meeting, stakeholders had additional opportunities to ask questions about the project.

Source: Office of the Legislative Auditor, analysis of DHS Child Care Regulation Modernization project materials.

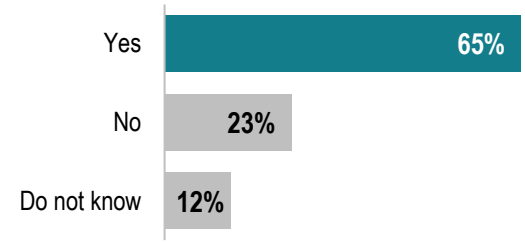
[20] *Laws of Minnesota* 2021, First Special Session, chapter 7, art. 2, secs. 75, 81, and 84.

[21] *Ibid*., secs. 75 and 81.

As shown in the previous box, NARA, on behalf of DHS, provided Family Child Care licensors with opportunities to provide feedback on the Child Care Regulation Modernization project. We found the materials that DHS shared with county licensors over the course of the project and the update session we attended to be clear and useful. DHS and NARA will use the information they gathered during stakeholder engagement activities to inform their recommendations to the Legislature.

Most county licensors who responded to our survey and who participated in the Child Care Regulation Modernization project reported generally positive experiences with DHS's outreach related to the project. Most of these licensors agreed or strongly agreed that DHS provided clear communications about the purpose of the project.[22] Further, nearly two-thirds of these licensors said that they had sufficient opportunity to provide feedback on the project, as shown in the chart at right.

Survey Question: Do you feel you have had sufficient opportunity to provide feedback on the Child Care Regulation Modernization project?



Note: This chart includes responses from 91 county licensors who responded that they had participated in the Child Care Regulation Modernization project and who answered the question.

Source: Office of the Legislative Auditor, analysis of county licensor survey, 2023.

Child Care Systems Transformation Project

In 2022, DHS initiated and began work on a "Child Care Systems Transformation" project to "improve and integrate the information technology systems used for the licensing…of child care providers in Minnesota."[23] The Legislature directed DHS to allocate federal American Rescue Plan (ARP) funds for the project in 2021 and 2023.[24] As part of the Child Care Systems Transformation project, DHS plans to introduce an electronic "Provider Licensing and Reporting Hub." This hub will have separate login portals for both county licensors and providers. It will provide licensors with easier access to information and streamline some reporting features. The Child Care Systems Transformation project will also involve the development of a public website and provider search feature. DHS stated that the Provider Licensing and Reporting Hub for Family Child Care providers and licensors will roll out in Summer 2024, after which the department will begin work on rolling it out for Foster Care and CRS providers and licensors.

[22] About one-half of Family Child Care licensors who responded to our survey reported they had participated in the Child Care Regulation Modernization project.

[23] Department of Human Services, "Child Care Systems Transformation," (September 11, 2023), https://mn.gov/dhs/partners-and-providers/licensing/child-care-and-early-education/child-care-systems-transformation.jsp, accessed September 25, 2023.

[24] *Laws of Minnesota* 2021, First Special Session, chapter 7, art. 2, sec. 84(h); and *Laws of Minnesota* 2023, chapter 70, art. 15, sec. 3.

DHS Outreach for Child Care Systems Transformation Project

DHS has had dozens of engagements with county licensors and other stakeholders related to the project. These engagements include:

- A survey soliciting feedback from county licensors and other stakeholders and a series of focus groups with county licensors.
- Many in-person and virtual presentations and workshops introducing the project or providing updates. At these meetings, county licensors had the opportunity to ask questions and provide feedback on the project.
- Regular e-mails to county licensors with updates on the progress of the project.
- Regular demonstrations on the latest versions of the project to a group of county licensors.

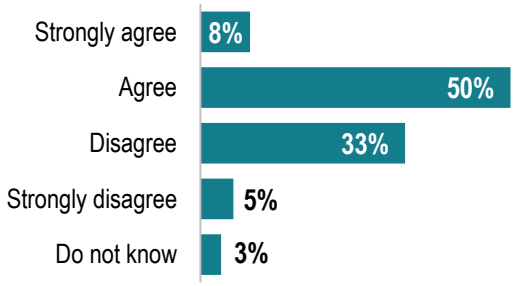
Source: Office of the Legislative Auditor, analysis of DHS Child Care Systems Transformation project materials.

As shown in the box above, DHS has done significant work to solicit input from county licensors and inform them of progress on the Child Care Systems Transformation project. As of the publication of this report, DHS continues to hold optional monthly progress update meetings and demonstrations for county licensors and other stakeholders.

Other Legislative Changes

Since at least 2019, the Legislature has enacted changes to licensing standards for county-delegated programs every year. There have been dozens of changes to Family Child Care licensing alone. For example, in 2023, the Legislature passed a law amending infant safe sleep requirements to prohibit licensed providers from placing an infant down to sleep wearing weighted materials, a hood, or a bib.[25] County licensors must be aware of these changes and monitor them during inspections of license holders.

Survey Question: DHS generally provides timely guidance to county licensors on interpreting new statewide licensing requirements.



Notes: Chart includes responses from 299 county licensors; the chart does not include individuals who answered "Not applicable" or did not answer the question. The percentages listed do not sum to 100 percent due to rounding.

Source: Office of the Legislative Auditor, analysis of county licensor survey, 2023.

DHS has worked to communicate changes to county licensors, both before and after they actually occur. DHS has held meetings to preview potential changes to licensing requirements and has allowed licensors to ask questions. When the Legislature has enacted changes to licensing standards, DHS has sent e-mails to county licensors announcing the changes and has listed the changes on its website. DHS managers told us that DHS would then create an "implementation plan" for each licensed program that outlined how DHS planned to implement each change and would share these plans with licensors and other stakeholders. DHS management told us that when there is a more significant change to licensing requirements, they would also hold a meeting for stakeholders in which DHS presented the legislative changes, described the new requirements and expectations, and allowed stakeholders to ask questions.

[25] *Laws of Minnesota* 2023, chapter 70, art. 8, sec. 19, codified as *Minnesota Statutes* 2023, 245A.1435(d).

The county licensors we surveyed generally felt that DHS's implementation plans and communications related to new licensing requirements were useful and timely. As shown in the prior chart, nearly 60 percent of county licensors agreed or strongly agreed that DHS provides timely guidance on interpreting new licensing requirements. In an open-ended survey response, one licensor stated, "DHS does a nice job of sending out guidance when there are changes or something new is being implemented."

Establishment of New Department

While DHS has been thoughtful in its attempts to consider the feedback of, and to provide useful information for, county licensors as it implemented new initiatives, the biggest change is yet to come.

DHS Licensing Division functions will soon be split among two state agencies.

In 2023, the Legislature created a new Department of Children, Youth, and Families (DCYF) to "provide a sustainable, public face for children's issues in state government."[26] Programs from multiple state agencies—including the departments of Education, Health, and Public Safety—will be transferred to the new department over the course of Fiscal Year 2025. The transfers also include the licensing of services for children, whether licensed by DHS directly or county-delegated.

DHS's licensing and county support functions will be split between DHS and DCYF. The table to the right shows the expected distribution of programs with county-delegated licensing among the two departments.

Future Departmental Division of County-Delegated Licensing

Department of Human Services	Department of Children, Youth, and Families
Adult Foster Care	Child Foster Care
Family Adult Day Services	Family Child Care
Community Residential Settings (CRS)	

The transfer of functions to a new department is bound to come with challenges. However, the division of oversight responsibilities for county-delegated licensing presents a unique complication. Many county licensors work in small agencies and are responsible for licensing multiple types of services. A county licensor who is currently responsible for all types of Foster Care licensing, for example, will soon find that their Adult Foster Care work is supported by DHS while their Child Foster Care work is supported by DCYF. These licensors will need to work with two different state agencies for what was previously the same state function. As such, DHS and the new DCYF will need to collaborate closely to ensure that their expectations for the licensors whom they jointly oversee are clear and consistent.

[26] *Laws of Minnesota* 2023, chapter 70, art. 12, sec. 14, codified as *Minnesota Statutes* 2023, 142A.02, subd. 1; and Minnesota Management and Budget, Implementation Office for the Department of Children, Youth, and Families, "Frequently Asked Questions," https://mn.gov/mmb/dcyf-implementation/faqs/, accessed October 24, 2023.

RECOMMENDATION

DHS and DCYF should take extra care to provide clear and consistent guidance on the respective roles of state agencies and county licensors, especially in light of the transition to two departments.

While the county licensor concerns about licensing roles that we discussed earlier in this chapter were not particularly widespread, they are elevated somewhat by the impending division of licensing oversight between DHS and DCYF. The transition to a new department, if not handled carefully, could easily result in increased confusion about the respective roles of county licensors and the two departments with which they must coordinate. At least 65 county licensors (about 20 percent) currently license services for both children and adults, and they will ultimately receive oversight and support from both DHS and DCYF. This has the potential to be confusing, particularly if DHS and DCYF do not clearly communicate to licensors how roles will be changing or differing between the two departments.

RECOMMENDATION

DCYF should adopt the recommendations from this report that are relevant to its activities.

Throughout this report, we have made recommendations to DHS to improve its support to county licensors. Once DCYF assumes its share of DHS's licensing functions, the new department should also consider the recommendations in this report. Additionally, DCYF should take note of the aspects of the DHS-county licensor relationship that we found work well, and adopt those practices that support a strong state-county partnership. For example, DCYF should continue monthly meetings for Family Child Care and Child Foster Care licensors, and ensure that the materials from these monthly meetings are available and accessible to all licensors.

List of Recommendations

- If the Department of Human Services (DHS) wishes to implement continuous licensing, it should work with the Legislature to amend statutes in a manner that allows the process. (p. 11)

- DHS should improve the support it provides for Community Residential Settings (CRS) licensors. (p. 22)

- DHS should (1) develop a formal policy and establish a timeframe in which staff must respond to triage inquiries from county licensors. and (2) track how long it takes staff to respond to each inquiry. (p. 22)

- DHS should provide written guidance that is easily accessible to all county licensors. (pp. 22-23)

- DHS should (1) establish timeframes for processing licensing actions that are uniform across programs with county-delegated licensing, and (2) ensure that it addresses all recommendations for licensing actions within those timeframes. (p. 31)

- DHS and the Department of Children, Youth, and Families (DCYF) should take extra care to provide clear and consistent guidance on the respective roles of state agencies and county licensors, especially in light of the transition to two departments. (p. 38)

- DCYF should adopt the recommendations from this report that are relevant to its activities. (p. 38)

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Minnesota Department of Human Services
Elmer L. Andersen Building
Commissioner Jodi Harpstead
Post Office Box 64998
St. Paul, Minnesota 55164-0998

February 15, 2024

Judy Randall, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Ms. Randall:

Thank you for the opportunity to review and comment on the draft report issued by your office, titled *Department of Human Services Licensing Division: Support to Counties*. The findings and recommendations will help guide us as we continue improving how we work, communicate and collaborate with counties.

County licensors are our key, trusted partners in the oversight and administration of licensing functions for programs that serve Minnesotans in need. We appreciate the timely review of this important issue and are pleased that the recommendations align with our plans for improvement, which we are working to implement thanks to the investment of resources by the governor and 2023 Legislature.

The DHS Office of Inspector General's (OIG) Licensing Division has worked hard over the last few years to improve communication with county licensors and increase consistency in our work across Minnesota counties. We welcome this report's acknowledgment of the improvements we achieved and our dedication to creating and maintaining positive relationships. The report's recommendations line up with more improvements we would like to make to continue fostering positive relationships and ensuring that county licensors have the resources, guidance and materials they need to perform their work.

During the 2023 legislative session, the OIG Licensing Division was allocated funding for additional positions that will resolve critical resource shortages that have escalated for years. Simply filling these positions is likely to help address many of the concerns about support for community residential setting licensors. We have started hiring, onboarding and training new licensing staff, a process that will continue throughout this year. We have already begun offering more training opportunities for community residential setting licensors and are working to evaluate and comply with accessibility standards to make materials more readily available to county licensors. The additional staffing will help us provide more technical assistance, guidance and training to county licensors.

Additionally, as DHS prepares to transition programs to the new Department of Children Youth and Families (DCYF), we are working closely with the DCYF implementation office at Minnesota Management and Budget to

ensure that licensing functions will continue without interruption, and that all partners, including county licensors, will have clear guidance on the respective roles of DHS and DCYF.

We appreciated your staff's professionalism and dedicated efforts during this audit. Our policy and practice are to follow up on all audit findings to evaluate our progress toward resolution. If you have further questions, please contact Gary L. Johnson, Internal Control and Accountability Office director, Minnesota Department of Human Services at (651) 431-3623.

Sincerely,

Jodi Harpstead
Commissioner

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Board of Animal Health's Oversight of Deer and Elk Farms, April 2018
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Minnesota Film and TV Board, April 2015

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MnDOT Highway Project Selection, March 2016

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

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Office of the Governor and Lieutenant Governor

Performance Audit

November 2025

Financial Audit Division

Office of the Legislative Auditor

State of Minnesota

Financial Audit Division

The division has authority to audit organizations and programs in the state's executive and judicial branches, metropolitan agencies, several "semi-state" organizations, state-funded higher education institutions, and state-funded programs operated by private organizations.

Each year, the division selects several of these organizations and programs to audit. The audits examine the policies and procedures—called internal controls—of the organizations to ensure they are safeguarding public resources and complying with laws that govern their financial and program operations. In addition, the division annually audits the State of Minnesota's financial statements and the financial statements of three state public pension systems. The primary objective of these financial audits is to assess whether the statements fairly present the organization's financial position according to Generally Accepted Accounting Principles.

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

Judy Randall, Legislative Auditor
State of Minnesota

November 4, 2025

Members
Legislative Audit Commission

The Honorable Tim Walz, Governor
The Honorable Peggy Flannagan, Lieutenant Governor
The Office of the Governor and Lieutenant Governor

This report presents the results of our performance audit of the Office of the Governor and Lieutenant Governor for the period July 1, 2022, through December 31, 2024. The objectives of this audit were to determine if the office complied with significant finance-related legal requirements and resolved prior audit findings.

The office only partially agrees with Finding 10 as stated in their response on page 41. We have considered all additional information presented by the office and believe the evidence we obtained and the testing we performed during the course of the audit support our conclusions.

This audit was conducted by Heather Rodriguez (Audit Director) and auditors Sheena Kurth; Lisa Makinen, CPA; and Alec Mickelson.

We received the full cooperation of the office's staff while performing this audit.

Sincerely,

Judy Randall
Legislative Auditor

Lori Leysen, CPA
Deputy Legislative Auditor

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Introduction

The Office of the Governor and Lieutenant Governor is responsible for the general direction, administration, and supervision of the affairs of the executive branch of Minnesota state government, as well as state budget proposals. The office is also in charge of appointing state department heads; members of state boards and commissions; and judges to the state's ten judicial districts, the court of appeals, and the supreme court when vacancies occur.

Auditors focus on internal controls as a key indicator of whether an organization is well managed. Internal controls are the policies and procedures management establishes to govern how an organization conducts its work and fulfills its responsibilities. A well-managed organization has strong controls across all of its internal operations. If effectively designed and implemented, controls help ensure, for example, that inventory is secured, computer systems are protected, laws and rules are complied with, and authorized personnel properly document and process financial transactions.

Minnesota Law Mandates the Implementation of Internal Controls

The Office of the Governor and Lieutenant Governor must have internal controls that:

- Safeguard public funds and assets and minimize incidences of fraud, waste, and abuse.
- Ensure that the Office administers programs in compliance with applicable laws and rules.

The law also requires the Commissioner of Minnesota Management and Budget to review OLA audit reports and help agencies correct internal control problems noted in those reports.

— *Minnesota Statutes* 2025, 16A.057

In this audit, we focused on whether the office had controls to ensure that it appropriately collected receipts and reimbursements from events held at the governor's residence, appropriately spent state funds, accurately paid its vendors and employees, and safeguarded state resources.

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Report Summary

Conclusion

The Office of the Governor and Lieutenant Governor generally did not comply with the criteria we tested. We identified a significant number of instances of noncompliance and internal control deficiencies related to receipts, inventory, and payroll and nonpayroll expenditures.

Findings and Recommendations

Finding 1. The Office of the Governor and Lieutenant Governor did not manage its receipts as required by state law and office policies. (p. 18)

Recommendations

- The Office of the Governor and Lieutenant Governor should ensure that it manages its receipts as required by state law and office policies.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over its receipt processes.

Finding 2. The Office of the Governor and Lieutenant Governor did not provide adequate oversight of timesheet completion and approval. (p. 20)

Recommendations

- The Office of the Governor and Lieutenant Governor should provide adequate oversight of timesheet completion and approval.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over its timesheet completion and approval processes.

Finding 3. Prior Audit Findings Partially Resolved. The Office of the Governor and Lieutenant Governor did not attempt to resolve incorrect floating holiday and vacation leave payouts. (p. 22)

Recommendations

- The Office of the Governor and Lieutenant Governor should reduce the vacation balance for the state employee identified.
- The Office of the Governor and Lieutenant Governor should recover the overpayments it made for each former employee identified.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over employee vacation leave balances or formally document its prohibition on vacation cap extensions.

Finding 4. Prior Audit Finding Unresolved. The Office of the Governor and Lieutenant Governor did not document one employee's eligibility for paid parental leave. (p. 23)

Recommendation

The Office of the Governor and Lieutenant Governor should ensure it sufficiently documents employee eligibility for paid parental leave.

Finding 5. The Office of the Governor and Lieutenant Governor did not issue correct retroactive pay rate adjustments for seven employees. (p. 24)

Recommendations

- The Office of the Governor and Lieutenant Governor should recover the retroactive pay rate adjustment overpayments it made for each employee identified.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure the accuracy of retroactive pay rate adjustments.

Finding 6. The Office of the Governor and Lieutenant Governor did not have required documentation to support some payroll and leave adjustments. (p. 26)

Recommendations

- The Office of the Governor and Lieutenant Governor should document all payroll and leave balance adjustments, as required by state policy.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it documents payroll and leave balance adjustments in accordance with state policy.

Finding 7. The Office of the Governor and Lieutenant Governor did not manage its inventory in accordance with its property management policy. (p. 27)

Recommendations

- The Office of the Governor and Lieutenant Governor should maintain an updated inventory of the assets and sensitive items it owns or is responsible for tracking.
- The Office of the Governor and Lieutenant Governor should segregate incompatible duties in its purchasing, accounting, and property management processes or develop internal controls to effectively mitigate the risk.

Finding 8. The Office of the Governor and Lieutenant Governor made numerous late payments to its vendors. (p. 30)

Recommendations

- The Office of the Governor and Lieutenant Governor should promptly pay its vendors.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it pays vendor invoices promptly.

Finding 9. The Office of the Governor and Lieutenant Governor made numerous inaccurate reimbursements to employees and payments to vendors. (p. 31)

Recommendations

- The Office of the Governor and Lieutenant Governor should resolve inaccurate payments.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it accurately reimburses employees and pays vendors.

Finding 10. The Office of the Governor and Lieutenant Governor did not have documentation to support numerous employee expenditure reimbursements, vendor payments, and purchasing card transactions. (p. 33)

Recommendations

- The Office of the Governor and Lieutenant Governor should ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.

Finding 11. Prior Audit Finding Unresolved. The Office of the Governor and Lieutenant Governor did not ensure its purchasing card policy contained consistent requirements regarding when cardholders must sign new use agreements.

The Office of the Governor and Lieutenant Governor did not require state purchasing cardholders to sign new use agreements in compliance with its policy. (p. 34)

Recommendations

- The Office of the Governor and Lieutenant Governor should revise its policy to clearly indicate the frequency that cardholders must sign new use agreements.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over state purchasing cards to ensure each cardholder signs new use agreements as required by its policy.

Finding 12. The Office of the Governor and Lieutenant Governor split some purchasing card purchases, which circumvented established internal controls on spending limits. (p. 35)

Recommendation

The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that state purchasing cardholders do not split payments without prior approval.

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Background

Article V of the *Minnesota Constitution* establishes the Office of the Governor and Lieutenant Governor as part of the executive branch of state government; the office operates under the authority provided in the Minnesota Constitution; *Minnesota Statutes*, Chapter 4; and various other state statutes. The Governor and Lieutenant Governor are elected jointly for a four-year term that begins the first Monday in January following the state's general election. The Governor and Lieutenant Governor share offices and support staff.

Governor Tim Walz and Lieutenant Governor Peggy Flanagan were first elected in November 2018 and were re-elected in November 2022.

Major duties of the governor include:

- Appointing state department heads; members of state boards, councils, and commissions; and judges to the state's ten judicial districts, the court of appeals, and the supreme court when vacancies occur.
- Chairing the State Executive Council, the State Board of Investment, and the Land Exchange Board and serving as a member of the Board of Pardons.
- Serving as Commander-in-Chief of the Minnesota National Guard and overseeing emergency responses.
- Issuing extradition papers, proclamations, and writs of special elections.
- Informing the Legislature of the state's general condition; reviewing, vetoing, or signing into law legislation; consulting with state legislators during annual legislative sessions; and calling special sessions of the Legislature when needed.
- Directing, administering, and supervising the affairs of the executive branch of Minnesota state government, as well as proposing the state budget.
- Performing all other duties as specified by the laws of the state.

The lieutenant governor's chief duty is to assist the governor in carrying out the functions of the executive branch and be prepared to act in the governor's place in the event the governor vacates office or is unable to perform the duties of the office. The lieutenant governor's official duties also include:

- Calling to order the senate on convening day.
- Executing any powers, duties, responsibilities, and functions of the governor delegated to the lieutenant governor by the governor (except Constitutional duties).
- Chairing the Capitol Area Architectural and Planning Board and the Advisory Committee on Capitol Area Security.
- Serving as a member of the State Capitol Preservation Commission and the State Executive Council.

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Audit Scope, Objectives, and Methodology

We conducted this audit to determine whether the Office of the Governor and Lieutenant Governor complied with the criteria we tested and resolved prior audit findings.[1] The audit scope included receipts, payroll expenditures, inventory of assets, and nonpayroll expenditures. The period under examination went from July 1, 2022, through December 31, 2024. Exhibit 1 shows the appropriations, receipts, and expenditures during the audit scope.

Exhibit 1

Appropriations, Receipts, and Expenditures, July 1, 2022, Through December 31, 2024

Beginning Balance	$ 1,007,692
General Fund Appropriations	22,321,000
Receipts	5,335,658
Expenditures	(23,537,602)
Cancelled Appropriations[a]	(78,978)
Ending Balance	$ 5,047,770

[a] The office did not spend $14,930 from the Fiscal Year 2022 appropriation, which cancelled back to the Federal Fund. The office did not spend $64,048 from the Fiscal Year 2023 appropriation, which cancelled back to the General Fund.

Source: Office of the Legislative Auditor, based on data in the state's accounting system.

We conducted this performance audit in accordance with generally accepted government auditing standards.[2] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. When sampling was used, we used a sampling method that complies with generally accepted government auditing standards and that supports our findings and conclusions. That method does not, however, allow us to project the results we obtained to the populations from which the samples were selected.

[1] Office of the Legislative Auditor, Financial Audit Division, *Office of the Governor and Lieutenant Governor: Performance Audit* (2022). In addition to the findings from the 2022 report, the Governor's Office had two findings in a multiagency report we issued in May 2023, *COVID-19-Related Emergency Purchases*. We did not follow up on those two findings in this audit. Instead, we included them in our annual follow-up report, which was released September 22, 2025.

[2] Comptroller General of the United States, Government Accountability Office, *Government Auditing Standards, 2018 Revision* (Technical Update April 2021).

We assessed internal controls against the internal control standards published by the U.S. Government Accountability Office.[3] We assessed compliance against the criteria identified in the Appendix.

Receipts

The 24 state cabinet-level agencies made payments to the office for services provided to support the agency at the state and federal levels. The office also collected reimbursements for events held at the governor's residence and additional miscellaneous receipts.

During the scope of the audit, the office collected $5,335,658 in interagency receipts, event reimbursements, and other receipts. Exhibit 2 shows the receipts by type.

Exhibit 2

Interagency Receipts, Event Reimbursements, and Other Receipts, July 1, 2022, Through December 31, 2024

Type of Receipt	Amount
Interagency Receipts for Services Provided[a]	$5,313,455
Governor's Residence Event Reimbursements	16,925
Other[b]	5,278
Total	$5,335,658

[a] The office collected interagency receipts of $5,040,800 through the reoccurring interagency receipts it collects. During the scope of the audit, the office also collected $272,655 in additional interagency agreements with cabinet agencies for one-time services it provided.

[b] "Other" includes items such as reimbursements for miscellaneous expenditures and insurance dividends. We did not test six deposits in this category totaling $157 and one transaction reversing a deposit totaling ($261). As a result, the deposits we tested in this category totaled $5,382.

Source: Office of the Legislative Auditor, based on data in the state's accounting system.

We designed our work to determine whether the office billed, collected, and deposited receipts in compliance with the criteria we tested (as listed in the Appendix). We also examined the office's related internal controls. Exhibit 3 lists the areas we tested related to receipts, our methodology for testing those areas, and the results of our tests.

[3] Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014). In September 2014, the State of Minnesota adopted these standards as its internal control framework for the executive branch.

Exhibit 3

Receipts: Areas Tested, Testing Methodology, and Results

Area Tested	Testing Methodology	Result
Interagency Receipts for Shared Services Provided	• We tested the appropriateness of the amounts billed for all 48 reoccurring interagency agreements, totaling $5,040,800. • We tested the accuracy of the amounts collected and recorded for all 48 reoccurring interagency agreements for shared services and two additional one-time receipts for shared services, totaling $5,313,455.	No significant issues; prior audit finding resolved
Governor's Residence Event Reimbursements	• We tested the accuracy and completeness of the billings and receipts for all nine events, primarily related to nonstate entities, at the governor's residence. The event contracts totaled $15,271 and the related deposit totaled $1,049. • We tested the accuracy of the billings and receipts for two events state entities held at the governor's residence. The office did not have contracts for these events, but the two related deposits totaled $15,876. • We reconciled the office's deposit logs to bank documentation and deposits in the state's accounting system to determine if the office deposited and accurately recorded cash and check receipts totaling $210.[a]	See Finding 1 on page 18
Other Deposits	• We tested the accuracy of five miscellaneous deposits, totaling $5,382.	See Finding 1 on page 18
Unrecorded Deposits	• We tested the validity of four deposits, totaling $3,458, that the office entered into the state's accounting system but did not fully process.[b]	See Finding 1 on page 18

[a] The $210 does not appear in Exhibit 2 since the office did not record the receipts in the state's accounting system.

[b] The $3,458 does not appear in Exhibit 2 since the office did not fully process the deposits in the state's accounting system.

Source: Office of the Legislative Auditor.

Payroll Expenditures

As of December 2024, the office employed 75 staff. During the scope of the audit, the office had $19,804,615 in payroll expenditures. Exhibit 4 shows the payroll expenditures by type.

Exhibit 4

Payroll Expenditures, July 1, 2022, Through December 31, 2024

Type of Expenditure	Gross Pay	Employer Expenditures[a]	Total
Hours Worked and Leave Taken	$14,918,832	$4,062,494	$18,981,326
Retroactive Pay Rate Adjustments	369,700	77,043	446,743
Separation Pay	205,891	14,252	220,143
Leave Conversions	98,205	19,026	117,231
Other[b]	205	38,967	39,172
Total	$15,592,833	$4,211,782	$19,804,615

[a] "Employer Expenditures" includes the employer's share of FICA, insurance, and retirement contributions.

[b] "Other" includes $13,329 paid to the Minnesota Department of Administration for worker's compensation, $25,062 paid to the Department of Employment and Economic Development for unemployment compensation, and $781 for miscellaneous payroll costs. We did not test these expenditures.

Source: Office of the Legislative Auditor, based on data in the state's accounting system.

We designed our work to determine whether the office accurately compensated employees in compliance with the criteria we tested (as listed in the Appendix). We also examined the office's related internal controls. Exhibit 5 lists the areas we tested related to payroll, our methodology for testing those areas, and the results of our tests.

Exhibit 5

Payroll Expenditures: Areas Tested, Testing Methodology, and Results

Area Tested	Testing Methodology	Result
Hours Worked	• We tested the integrity of payroll by verifying the effectiveness of the office's safeguards over timesheet completion and approval, and reviewing payroll reports for 16 of 61 pay periods.	See Finding 2 on page 20
Governor's and Lieutenant Governor's Salaries	• We tested the accuracy of the Governor's and Lieutenant Governor's salaries.	No issues
Salaries of Employees Working on the Presidential Campaign	• We tested the reasonableness of time worked and leave taken for five individuals who worked on the 2024 presidential campaign in some capacity.	No issues

Area Tested	Testing Methodology	Result
Retroactive Pay Rate Adjustments	• We tested the accuracy of 30 of 151 retroactive pay rate adjustments, which included $86,752 of the $356,706 paid. We initially tested a random sample of 25 retroactive pay adjustments and subsequently expanded testing to five additional retroactive pay adjustments based on our initial testing. We excluded $12,994 in retroactive pay adjustments for two employees who received payments from the office's budget but were never full-time employees of the office.	See Finding 5 on page 24
Separation Payments	• We tested the eligibility for and accuracy of all 39 separation payments, totaling $205,891.	No issues
Holiday Pay	• We tested the accuracy of all holiday and floating holiday pay, which totaled $568,815 and $57,093, respectively.	No issues
	• We verified that the office resolved the previous overpayment of two floating holidays.	See Finding 3 on page 22; prior audit finding partially resolved
Leave Balance Adjustments	• We tested the accuracy of all 15 adjustments to employee's sick or vacation leave balances that exceeded 10 hours.	See Finding 6 on page 26
Vacation Leave Conversions	• We tested the eligibility for and accuracy of 31 conversions of vacation leave to deferred compensation, totaling 1,520 hours and $98,205.	No issues
Payroll Adjustments	• We tested the accuracy of all 24 payroll adjustments, totaling $22,330. We initially tested a random sample of eight payroll adjustments and subsequently expanded testing to the remaining adjustments based on the results of our initial testing.	See Finding 6 on page 26
Paid Parental Leave	• We tested the eligibility for and accuracy of the paid parental leave for one employee who received it, which totaled $957.	See Finding 4 on page 23; prior audit finding not resolved
Maximum Vacation Leave Balances	• We tested that all employees reduced their vacation leave balances to the maximum number of hours allowed by the office's compensation plan.	No issues
	• We verified that the office resolved the overpayment of vacation leave to four employees.	See Finding 3 on page 22; prior finding partially resolved

Source: Office of the Legislative Auditor.

Inventory of Assets

We designed our work to determine whether the office tracked its assets in compliance with the criteria we tested (as listed in the Appendix). We also examined the office's related internal controls. Exhibit 6 lists our methodology for testing inventory and the results of our testing.

Exhibit 6

Inventory: Testing Methodology and Result

Area Tested	Testing Methodology	Result
Inventory	• We conducted a partial inventory to determine if the office was in compliance with its own policies and procedures.	See Finding 7 on page 27

Source: Office of the Legislative Auditor.

Nonpayroll Expenditures

During the scope of the audit, the office had $3,794,373 in nonpayroll expenditures. Exhibit 7 shows the nonpayroll expenditures by type.

Exhibit 7

Nonpayroll Expenditures, July 1, 2022, Through December 31, 2024

Type of Expenditure	Amount
Recurring Expenditures[a]	$2,560,534
Purchases with State Purchasing Cards[b]	354,551
Other Goods and Services	323,774
Professional/Technical Services	251,036
Interagency Purchases	119,560
Employee Expenditure Reimbursements	105,889
State Airplane Use	78,570
Other Expenditures	459
Total	$3,794,373

Note: We did not test "Professional/Technical Services," "Interagency Purchases," or "Other Expenditures."

[a] "Recurring Expenditures" are expenditures that occur regularly, such as monthly rent, cable, and phone expenditures.

[b] This category includes $61,386 that the Minnesota Department of Administration (Admin) purchased on state purchasing cards assigned to the Office of the Governor and Lieutenant Governor but paid for from Admin's budget. On the state purchasing card statements, expenditures were comingled with purchases paid by both offices; we included all expenditures in our testing.

Source: Office of the Legislative Auditor, based on data in the state's accounting system.

We designed our work to determine whether the office obtained and accurately paid for goods and services in compliance with the criteria we tested (as listed in the Appendix). We also examined the office's related internal controls. Exhibit 8 lists the areas we tested related to nonpayroll expenditures, our methodology for testing those areas, and the results of our tests.

Exhibit 8

Nonpayroll Expenditures: Areas Tested, Testing Methodology, and Results

Area Tested	Testing Methodology	Result
Recurring Expenditures	• We tested the accuracy and timeliness of payments for five types of recurring expenditures, including rent, fleet services, information technology, cable, and phone services, totaling $2,068,718. Based on the results of our initial testing, we examined four additional types of recurring expenditures, including parking, rug cleaning, memberships, and subscriptions, totaling $491,659. Overall, we tested $2,560,377 of the $2,560,534 paid.	See Finding 8 on page 30
State Purchasing Cards	• We verified the existence of eight items at the governor's residence that the office purchased with state purchasing cards that were either larger than most purchases or more prone to misappropriation. The purchases totaled $10,839.	No issues
	• We tested the timeliness and accuracy of payments for all 30 billing statements for the consolidated master account.[a] These billing statements closed between June 2022 and November 2024.	See Finding 8 on page 30
	• We tested compliance with state law and purchasing card policies for 49 of 186 monthly purchasing card statements, including 4 judgmentally selected samples and 45 randomly selected samples. These samples included $99,957 of the $361,535 in expenditures on those statements.	See Finding 9 on page 31, Finding 10 on page 33, and Finding 12 on page 35
	• We reviewed the purchasing card agreements for 15 of 16 employees with state purchasing cards to determine if cardholders periodically signed new use agreements, in accordance with office policy.	See Finding 11 on page 34; prior audit finding not resolved
Other Goods and Services	• We tested the accuracy and timeliness of payments for a sample of 41 of 290 vouchers, including 1 judgmental sample and 40 random samples. These samples included $90,973 of the $323,774 paid.	See Finding 8 on page 30, Finding 9 on page 31, and Finding 10 on page 33
Employee Expenditure Reimbursements	• We tested the allowability and accuracy of reimbursements for a random sample of 40 of 618 employee expenditure reimbursements, which included $10,013 of the $127,889 paid.	See Finding 9 on page 31 and Finding 10 on page 33
State Airplane Flights	• We tested the accuracy of all expenditures for the use of state airplanes, totaling $78,570.	See Finding 9 on page 31

[a] Each month, the office receives purchasing card statements for each cardholder's activity. The office also receives a master account statement that summarizes all of the purchases and payments made on each cardholder's account.

Source: Office of the Legislative Auditor.

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Findings and Recommendations

Receipts

The Office of the Governor and Lieutenant Governor collects four different types of receipts: (1) payments from cabinet-level agencies for support at the state and federal levels, (2) reimbursements to cover the cost of events held at the governor's residence, (3) donations to cover costs associated with press events held at the governor's residence, and (4) other ancillary receipts.[4] State law requires that nonstate entities reimburse the state for the cost of events held at the governor's residence.[5] Additionally, office policy establishes the process for collecting, depositing, recording, and reconciling these receipts.[6] The office's records retention schedule requires financial records be maintained for five years unless the records have been audited.[7]

During the scope of the audit, the office entered into nine agreements, primarily with nonstate entities, to hold nine events at the governor's residence, totaling $15,271. Also during the audit scope, the office received donations to cover costs associated with press events at the governor's residence. The office documented 10 collections from these events on two logs, totaling $210. We tested whether the office billed and collected amounts owed for governor's residence events as required by state law and followed its receipts and records retention policies.

During the scope of the audit, the office recorded in the state's accounting system collections totaling $15,876 from two state entities for events held at the governor's residence and five ancillary receipts totaling $5,382.[8] Additionally, the office entered four deposits totaling $3,458 into the state's accounting system but did not fully process them. We tested each of these receipts.

[4] During the scope of the audit, the office collected $5,313,455 from cabinet-level agencies for support. We examined all 48 of the related interagency agreements and the money collected under each agreement. We found no significant issues.

[5] *Minnesota Statutes* 2025, 16B.27, subd. 6. The costs for events at the governor's residence typically include food and beverages, flowers, personnel costs, and indirect costs.

[6] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, Recording and Depositing Receipts*, issued December 5, 2018.

[7] Office of the Governor and Lieutenant Governor, *Records Retention Schedule for the Official Records of the Office of Governor Jesse Ventura* [as adopted by the current administration], issued June 2002.

[8] We excluded six deposits and one deposit reversal from our testing of the "other collections," as described in Exhibit 2.

FINDING 1

The Office of the Governor and Lieutenant Governor did not manage its receipts as required by state law and office policies.

We identified weaknesses in almost every aspect of how the office managed its receipts, as detailed below.

- **The office did not recover the costs of some events held at the governor's residence.** Specifically, the office did not collect $12,448 for seven events held at the governor's residence between August 2022 and January 2023. The office was unaware that it had not collected the amounts it was owed. After we presented the audit results to the office in August 2025, it issued invoices to each organization. We confirmed that the office deposited the full $12,448 due shortly thereafter.

- **The office did not always record deposits accurately in the state's accounting system.** Specifically, the office did not fully process four deposits it entered into the state's accounting system between September 2024 and January 2025, totaling $3,458. This resulted in a difference between the office's cash balance at the bank and in the state's accounting system. After we presented the audit results to the office in August 2025, the office finished processing these deposits.

- **The office did not maintain documentation supporting the amounts it billed or deposited.** Specifically, the office:

    - Did not have documentation to confirm that it deposited $170 in donations it collected from press events held at the governor's residence during December 2023. Without documentation, we could not confirm that the office deposited these donations or that the office appropriately safeguarded the cash and checks from theft.

    - Did not have documentation to support the $10,560 it charged two state entities in November 2022 and March 2024 for events held at the governor's residence. Without documentation, we could not determine if the amount the office charged was accurate.

    - Did not have documentation to support four ancillary receipts it deposited between October 2022 and September 2023, totaling $5,190. Without documentation, we could not confirm what these deposits were for or determine if the deposits were accurate.

These errors happened because the office did not have effective internal controls over its receipt processes, such as periodically reconciling source documents to bank deposits and to records in the state's accounting system. Without adequate internal controls, the office is at risk of theft or not collecting funds it is due. Without accurate records, the office does not have accurate information regarding its budget or financial obligations.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should ensure that it manages its receipts as required by state law and office policies.**
- **The Office of the Governor and Lieutenant Governor should strengthen internal controls over its receipt processes.**

Payroll Expenditures

Timesheets

State employees are paid biweekly. The office follows state policy, which requires that employees complete their own timesheets. The policy also requires that supervisors with direct knowledge of employees' work and leave approve each timesheet.[9]

In August 2022, the office began transitioning from entering time worked and leave taken in its own electronic timesheets to entering the information in the state's payroll system. As a result, the office became subject to a state policy requiring that payroll staff review an "exception report" each pay period, which shows each time an employee did not complete their own timesheet or someone other than the employee's primary supervisor approved the timesheet.[10] Employees and supervisors are required to document why these exceptions occur by adding a comment to the timesheets. When that does not happen, payroll staff are required to obtain and document the reasons for the exceptions. Obtaining this information allows payroll staff to identify when there are ongoing trends of employees not completing their own timesheets or primary approvers not approving employee timesheets that office leadership needs to address.

During the scope of the audit, there were 61 pay periods in which office staff entered time worked and leave taken into the state's payroll system. We tested a random sample of the exception reports for 16 of these pay periods.

The office also enters into interagency agreements to utilize other agencies' staff to support the work of the office. These agreements resulted in the office paying all or a portion of the payroll expenditures for 11 state employees who were not employees of the Governor's Office. One of the 11 state employees worked full-time at the Governor's Office providing all human resources and payroll services, beginning in July 2022. We tested the extent to which the office approved this employee's timesheets for the 64 pay periods they performed work for the office.

[9] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0017, *Self Service Time Entry*, issued February 2011.

[10] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0017, *Self Service Time Entry*, issued February 2011.

FINDING 2

The Office of the Governor and Lieutenant Governor did not provide adequate oversight of timesheet completion and approval.

The office did not ensure that its employees completed their own timesheets and primary supervisors approved employee timesheets, as detailed below.

- We found that employees in two departments within the office frequently did not complete their own timesheets.[11] Employees in one department did not complete their own timesheets during 14 of the 16 pay periods we tested. Employees in the second department did not complete their own timesheets during 7 of the 16 pay periods tested. In each instance, staff that completed the timesheets on behalf of the employees did not add a comment indicating why the exceptions occurred.

- Additionally, the primary supervisors of two departments within the office frequently did not approve their employees' timesheets. Primary supervisors for each of the two departments did not approve timesheets for their departments during 8 and 9 of the 16 pay periods we tested. In each instance, the backup approver did not add a comment indicating why the exception occurred.

  Payroll staff stated that they reviewed the exception report each pay period but did not document their review. Without documentation showing payroll staff's review of the exception report and the follow up they conducted, we could not determine whether they did not review the exception report, they reviewed the report but did not identify the ongoing trends of noncompliance, or they identified the trends but did not take action to remedy them.

The office also did not ensure that it approved the timesheets of the one employee of another state agency that worked for the office full-time, as detailed below.

- We found that the Governor's Office did not approve the employee's timesheets for any of the 64 pay periods we reviewed, even though the employee reported directly to Governor's Office staff. The office extended the interagency agreement for this employee's services in November 2022 and July 2024 but continued to rely on the other agency to approve this employee's timesheets. The office did not consider the effect the long-term agreement had on its ability to adequately oversee the employee's payroll activities.[12]

When employees do not complete their own timesheets or primary supervisors do not approve their employees' timesheets, it increases the risk that employee compensation will be inaccurate. For example, employees could be paid for hours they did not work.

[11] The office assigns all employees to a payroll department and assigns each department to a primary supervisor and one or more backup approvers. A primary supervisor is the individual that is most familiar with the work of the employees in their assigned department. A backup approver is someone that can approve the department's timesheets when the primary supervisor is unavailable.

[12] The last interagency agreement in place during our audit extended through June 2025.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should provide adequate oversight of timesheet completion and approval.**

- **The Office of the Governor and Lieutenant Governor should strengthen internal controls over its timesheet completion and approval processes.**

Holiday and Vacation Leave

Our 2022 audit reported that the office (1) incorrectly paid floating holidays and vacation leave payoffs and (2) did not identify overstated vacation leave balances, as detailed below.[13]

The office incorrectly paid two employees for floating holidays.

- The office paid one employee a second floating holiday in Fiscal Year 2021 instead of requiring the employee to use vacation leave.

- The office also paid one employee $144 for an unused floating holiday upon separation from state service, which the office's compensation plan does not allow.[14]

Additionally, the office did not reduce the vacation leave balances by the required deadline for four employees that received vacation cap extensions.

- Two employees had overstated vacation leave balances of 250 hours and 181.25 hours.

- The overstated leave balances for the other two employees resulted in overpaid vacation leave payoffs of $9,276 and $816 at the time of separation.

In the previous audit, we recommended that the office strengthen internal controls, correct the floating holiday pay errors, and address the vacation leave balance issues we identified.[15] State policy also requires that the office attempt to collect the overpayments, which we also recommended.[16] During this audit, we examined whether the office resolved the overpayments and overstated vacation leave balances.

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[13] Office of the Legislative Auditor, Financial Audit Division, *Office of the Governor and Lieutenant Governor: Performance Audit* (2022), 16–19.

[14] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz and Lt. Governor Peggy Flanagan Compensation Plan*, July 1, 2019–June 30, 2021.

[15] One of the recommendations from our 2022 audit suggested that the office "strengthen internal controls over floating holiday pay." We determined that the office resolved our recommendation by transitioning to the state's payroll system, which has safeguards to prevent the office from paying an employee more than one floating holiday in a fiscal year.

[16] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0033, *Correction of Overpayments*, issued March 2017; and Office of the Legislative Auditor, Financial Audit Division, *Office of the Governor and Lieutenant Governor: Performance Audit* (2022), 16–19.

FINDING 3 *Prior Audit Findings Partially Resolved*

The Office of the Governor and Lieutenant Governor did not attempt to resolve incorrect floating holiday and vacation leave payouts.

The office did not resolve incorrect floating holiday pay for either employee we identified in the prior audit. Specifically, the office did not reduce one employee's vacation leave by eight hours to offset the extra floating holiday it paid out in Fiscal Year 2021 or attempt to collect $144 for the floating holiday it incorrectly paid to a separated employee.

In May 2025, office leadership told us that they had reached out to the affected employee, and they believed the office had reduced their vacation balance by eight hours. However, we reviewed the employee's leave balance record in the state's payroll system, and we could not confirm the reduction of hours. Office leadership also told us that they were not seeking repayment from the separated employee because the overpayment was a result of an error the office made. However, state policy requiring the collection of overpayments does not exempt employees from repayment if the overpayment was outside their control.[17]

The office also did not resolve incorrect vacation leave payouts for two of the four employees we identified in the prior audit. Specifically, the office did not attempt to collect the $9,276 and $816 in overpaid vacation leave it issued to two separated employees. In April 2025, office leadership told us that they did not attempt to collect the overpayments because it was not in the public interest to do so. State law allows debt to be written off for this reason, but we disagree that it would not be in the public interest to pursue the recovery of this debt.[18]

After we presented the audit results to the office in August 2025, the office notified us that it was sending out collection notices to the two employees identified in the prior audit. The office provided copies of the letters it sent, which were dated August 12, 2025. We did not conduct further tests to confirm that the office collected the overpayments.

The prior audit also recommended that the office strengthen internal controls over employee vacation leave balances, to safeguard against these types of overpayments in the future. The office told us that it no longer allows employees to receive vacation cap extensions. While this would eliminate the need for internal controls in this area, the office did not have any formal documentation, such as an internal memo or policy, implementing the change. Without documentation, we could not verify the office's claim.

[17] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0033, *Correction of Overpayments,* issued March 2017.

[18] *Minnesota Statutes* 2025, 16D.09, subd. 1.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should reduce the vacation balance for the state employee identified.**
- **The Office of the Governor and Lieutenant Governor should recover the overpayments it made for each former employee identified.**
- **The Office of the Governor and Lieutenant Governor should strengthen internal controls over employee vacation leave balances or formally document its prohibition on vacation cap extensions.**

Paid Parental Leave

The office's compensation plan provides for up to 240 hours of paid parental leave following the birth or adoption of a child. The plan states:

> Employees are eligible if they meet eligibility criteria for Family and Medical Leave Act ("FMLA") leave, which generally means the employee has been employed by the Governor's office for twelve (12) months and has worked at least 1,250 hours during the year immediately preceding the leave.

Our 2022 audit reported that the office did not appropriately document two employees' eligibility for paid parental leave. We recommended the office strengthen internal controls to ensure that it has sufficient documentation of its employees' eligibility for paid parental leave. During the scope of this audit, we tested whether the office documented the eligibility of one employee that received paid parental leave totaling $957.

FINDING 4 *Prior Audit Finding Unresolved*

The Office of the Governor and Lieutenant Governor did not document one employee's eligibility for paid parental leave.

The office did not have documentation showing that one employee experienced an event that qualified them for paid parental leave. Additionally, while we were able to independently verify that the employee met the eligibility requirements, the office did not have evidence that it verified the employee had been employed by the office for 12 months and worked at least 1,250 hours in the year prior to the leave.

The employee's paid parental leave began in May 2022, before the release of the prior audit report in August 2022. The office did not subsequently obtain documentation demonstrating that the employee met the eligibility requirements, although the employee continued to take paid parental leave through November 2022.

RECOMMENDATION

The Office of the Governor and Lieutenant Governor should ensure it sufficiently documents employee eligibility for paid parental leave.

Pay Rate Adjustments

The office records pay rate increases in the state's payroll system with an effective date. If that effective date is within the current or a future pay period, the payroll system will calculate pay at the new rate starting on the effective date. If that effective date is in a prior pay period, the state pays the employee a retroactive pay rate adjustment.

When calculating the retroactive pay rate adjustment, the state's payroll system does not factor in previous retroactive pay rate adjustments that employees already received for the same timeframe.[19] For this reason, state policy requires that payroll staff verify the accuracy of the system-calculated retroactive pay rate adjustment.[20]

During the scope of the audit, the office issued 151 retroactive pay rate adjustments totaling $356,706. We tested a random sample of 25 retroactive pay adjustments and subsequently expanded testing to include an additional 5 retroactive pay rate adjustments based on errors we found in our initial sample. The retroactive pay rate adjustments we tested totaled $86,752.

FINDING 5

The Office of the Governor and Lieutenant Governor did not issue correct retroactive pay rate adjustments for seven employees.

The office overpaid retroactive pay rate adjustments for seven employees by a total of $6,711. All seven overpaid employees received a prior retroactive pay rate adjustment for the same timeframe covered by the retroactive pay rate adjustment we tested. The office used the system-calculated amount for the retroactive pay rate adjustment. However, the system used the original amount paid to the employee instead of the adjustment amount paid. One sample was also missing one pay period of activity.

Payroll staff told us that they spot-checked the calculations for accuracy. However, the office did not have evidence of its review of the retroactive pay adjustment calculations. Without documentation we could not determine if payroll staff did not review the calculations or whether their review was not sufficient to identify and correct the resulting errors.

After we presented our audit results in August 2025, the office notified us that it was sending out collection notices to the seven employees it overpaid. The office provided copies of the letters it sent, which were dated August 12, 2025. We did not conduct further tests to confirm that the office collected the overpayments.

[19] For example, an employee received an original compensation rate of $23.95 for the period of July 25, 2022, through August 2, 2022. The state paid the employee a lump-sum payment to retroactively increase their compensation rate during that period to $28.74, on August 26, 2022 (due to a promotion). When the office settled the 2021–2023 labor agreement, the employee was eligible for a lump-sum payment to retroactively increase their compensation rate (during that same period) to $29.60. When the payroll system calculated the associated retroactive pay rate adjustment, it used $23.95 as the baseline salary instead of $28.74.

[20] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0025, *Pay Rate Adjustments*, issued April 2001.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should recover the retroactive pay rate adjustment overpayments it made for each employee identified.**
- **The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure the accuracy of retroactive pay rate adjustments.**

Payroll and Leave Adjustments

The office processes manual adjustments to employees' payroll records to modify the amount or type of payment that it originally processed for an employee. For example, the office may reclassify vacation leave as sick leave or add hours when employees work during a pay period but do not submit timesheets in time for automatic processing in the state's payroll system.

Employees' leave balance adjustments are mostly automated in the state's payroll system, but some users have the ability to manually adjust those balances.[21] There are two primary reasons for adjustments to employees' sick and vacation leave balances. First, the office's compensation plan allows employees to accrue up to eight hours of vacation leave for time they work on a holiday.[22] The state's payroll system automatically adds the vacation leave to employees' balances based on information entered on employees' timesheets. Second, the office manually adjusts leave balances when employees transfer from a state entity that does not use the state's payroll system or when employees separate from state service and forfeit leave balances.

Regardless of the type of adjustment, state policies require that payroll staff document the adjustment made and the reason for the adjustment. In some instances, staff also need to document a supervisor's approval for the adjustment.[23]

During the scope of the audit, the office processed 24 manual payroll adjustments totaling $22,330.[24] We tested a random sample of eight payroll adjustments and subsequently expanded testing to the remaining 16 payroll adjustments based on the results of our initial testing. The office also processed 15 leave balance adjustments that exceeded 10 hours during the scope of the audit. We tested all 15 of these leave balance adjustments.

[21] Minnesota Management and Budget, Statewide Operating Policy and Procedure PAY0026, *Leave Balance Adjustments*, issued December 2007. In certain situations, an agency may need to manually adjust or establish an employee's paid leave balance. Payroll or human resources employees typically perform this function.

[22] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz and Lt. Governor Peggy Flanagan Compensation Plan*, July 1, 2019–June 30, 2021, July 1, 2021–January 31, 2023, and February 1, 2023–June 30, 2025.

[23] Minnesota Management and Budget, Statewide Operating Policy and Procedures PAY0023, *Prior Period Adjustments*, issued October 2005; Statewide Operating Policy and Procedures PAY0024, *Current Period Adjustments*, issued September 2006; and Statewide Operating Policy and Procedures PAY0026, *Leave Balance Adjustments*, issued December 2007.

[24] Approximately 75 percent of all payroll adjustments occurred during Fiscal Year 2023, which was the year the office transitioned to the state's payroll system. This transition likely contributed to the number of payroll adjustments the office processed.

FINDING 6

The Office of the Governor and Lieutenant Governor did not have required documentation to support some payroll and leave adjustments.

For 21 of 24 payroll adjustments and 2 of 15 leave balance adjustments, the office did not document the adjustments it made, the reason it made the adjustments, and supervisory approval for the adjustments, as required by state policy. These adjustments included:

- Ten adjustments to add all payroll activity during one pay period for employees that did not submit timesheets. These adjustments increased payroll expenditures by $7,567.

- Eight adjustments that modified the type of payment made. For example, four adjustments reclassified regular hours worked as leave or overtime. Due to the nature of the adjustments, only one of the eight adjustments affected the amount paid to the employee. It increased payroll expenditures by $59.

- Three adjustments that added or reduced the number of hours paid to the employee or increased the compensation rate originally paid to the employee. These adjustments decreased payroll expenditures by $184.

- Two adjustments to add eight hours of vacation leave to two employees' vacation leave balances; neither employee included the hours on their approved timesheets.

The office did not have sufficient internal controls to ensure that that the office adequately documented and approved adjustments to payroll and leave balances. Payroll staff told us that they relied on verbal communication and approvals; however, without documentation, we could not determine if the office made adjustments that were accurate and properly authorized.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should document all payroll and leave balance adjustments, as required by state policy.**

- **The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it documents payroll and leave balance adjustments in accordance with state policy.**

Inventory of Assets

The office has its own property management policy that defines three categories of assets that it tracks.[25] Capital assets have an acquisition price of $30,000 or more, are expected to be used for more than two years, and do not lose their identity when being used. Non-capital assets have an acquisition price between $5,000 and $29,999. Sensitive items include items such as computers, printers, audio and visual equipment, signature machines, and cell phones.[26]

The office's property management policy requires a periodic inventory of assets and sensitive items, although the office policy includes inconsistent requirements for the frequency of the inventory. One section of the policy states that the office will perform inventory each December, but another section states that the office will inventory capital assets annually, and non-capital assets and sensitive items biennially.

The governor's office in the state capitol and the governor's residence contain assets that other state entities own and manage. For example, Minnesota IT Services (MNIT) owns the laptops issued to office staff, and the Minnesota Department of Administration (Admin) owns the furniture at the governor's residence.[27] The office does not need to include these items in its asset list because the state entities that own the assets track and inventory them.

During the audit, we requested that the office provide its current asset list and the specific dates of inventories the office had completed during the scope of the audit.

FINDING 7

The Office of the Governor and Lieutenant Governor did not manage its inventory in accordance with its property management policy.

The office provided us with a list of current cell phones and hot spots, and a separate document that it claimed was an asset list. The list contained approximately 10 digital equipment items; however, it did not contain the identifying information necessary to track the items (such as asset numbers and serial numbers). The office had not updated the list since November 2023.

We reviewed the state's accounting system and found a separate asset tracking list for the office; staff were not aware of this list. This asset tracking list contained approximately 80 items that were in service, but the office had not added to the list since 2019. We selected a sample of 18 items from the asset list in the state's accounting system and requested to view them. The office confirmed that it did not have any of the 18 items requested.

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[25] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, Property Management*, issued December 5, 2018.

[26] The property management policy requires that the office tracks some sensitive items, such as computers, signature machines, and cell phones, regardless of their cost. The policy only requires that the office tracks other sensitive items, such as printers and audio and visual equipment, if the cost exceeds $500.

[27] *Minnesota Statutes* 2025, 16B.27, subd. 2.

Since the office did not have a complete and current inventory list, we performed additional procedures to better understand the office's management of its assets and sensitive items. We conducted walkthroughs of the governor's office at the state capitol and of the governor's residence; we documented 32 items that had an asset tag and that we believed could meet the office's thresholds for tracking.[28] Other state entities (such as MNIT and Admin) owned and were tracking 21 of the 32 items with asset tags. Of the remaining 11 items with asset tags:

- Four items were on the office's asset list in the state's accounting system but were listed as disposed. This included two shredders and one printer at the capitol and a shredder at the governor's residence.

- Seven items were not on any asset lists. These items included a television, a printer, a mini fridge, an autopen, a scanner, and two podiums. All items were at the governor's office in the state capitol.

During the walkthroughs, we also learned that the office had temporary access badges, which are considered sensitive items. Another state agency issues and owns the badges but does not conduct a periodic inventory to verify that the badges have not been lost or stolen. For this reason, we believe it is the office's responsibility to track the badges. The office told us that it was not tracking the access badges on an asset list because they believed another state agency managed the badges.

While the procedures and testing we performed indicate that the office has not kept an updated inventory list for many years, we attribute this issue to staff turnover in key positions. The employee responsible for all aspects of inventory management started in January 2024. The employee did not receive inventory training when they started the position and was not aware of the asset management tools in the state's accounting system until we began our audit in January 2025. While the office is not required to maintain non-capital assets and sensitive items in the asset management tool, that is where it has tracked them in the past.

In addition to not tracking inventory, the office has not maintained adequate segregation of duties. During our testing, one employee was responsible for purchasing and receiving goods and services; processing vendor payments; tracking and disposing of inventory; conducting physical inventories; monitoring compliance with the office's property management policy; and ensuring adequate internal controls over property management.

By not tracking assets and sensitive items and not maintaining adequate segregation of duties, the office significantly increases the risk that assets will be misappropriated without detection.

[28] Asset tags are uniquely numbered stickers that are attached to the asset and used to track it while it is in use.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should maintain an updated inventory of the assets and sensitive items it owns or is responsible for tracking.**

- **The Office of the Governor and Lieutenant Governor should segregate incompatible duties in its purchasing, accounting, and property management processes or develop internal controls to effectively mitigate the risk.**

Nonpayroll Expenditures

Payment Timing

State law requires that state agencies pay vendors within 30 days of receiving an invoice for goods or services.[29] We tested the following types of expenditures to determine if the office paid vendors promptly.

- **Payments for recurring expenditures**, totaling $2,560,377. The office processed these payments to nine vendors for services it utilized repeatedly. Examples included rent, information technology, cable, and phones. We performed detailed testing on four vendors the office paid $2,068,718 during the audit scope. These payments related to 208 invoices.

- **Payments for state purchasing card expenditures**, totaling $354,961. The office processed 80 payments against 30 master billing statements that closed between June 2022 and November 2024.[30] We tested all of these payments.

- **Payments for various goods and services expenditures**, totaling $323,774. The office processed 290 payment vouchers for goods and services, such as supplies, delivery, printing, and training. We tested a random sample of 40 vouchers as well as 1 additional voucher we identified in our analysis.

Because the office is not required to track the date it receives invoices, we determined if it paid an invoice balance by the end of the next billing cycle (state purchasing card expenditures) or within 30 days of the invoice date or by the invoice due date (recurring and various other expenditures). If the office did not pay the invoice balance by those dates, we considered it a late payment.

[29] *Minnesota Statutes* 2025, 16A.124, subd. 3.

[30] Each month, the office receives purchasing card statements for each cardholder's activity. The office also receives a master account statement that summarizes all of the purchases and payments made on each cardholder's account.

FINDING 8

The Office of the Governor and Lieutenant Governor made numerous late payments to its vendors.

The office consistently made late payments to its vendors during the scope of the audit.

- Of the 208 invoices for recurring expenditures we tested, the office paid 92 invoices between 1 day and 359 days late. The 92 invoices were paid an average of 31 days late.

- Of the 30 billing statements for state purchasing card expenditures we tested, the office paid 29 billing statements late. The unpaid balances continued to roll forward from month-to-month.

- Of the 41 invoices for various goods and services expenditures we tested, the office paid 23 invoices between 3 and 128 days late. The 23 invoices were paid an average of 34 days late.

Two additional issues with state purchasing cards resulted in late vendor payments.

- The office did not fully process six vouchers to pay 14 state purchasing card transactions. Office staff initiated the payment process in the system; however, they did not enter the final approval needed to complete the payment process. As a result, the office did not remit $1,013 to the vendor for payment.

- One of 80 purchasing card payments was returned to the office but the office did not reissue the payment, even though it was for a legitimate expenditure. Office staff did not identify the issue because they did not verify that the payments the office made appeared on subsequent billing statements.

The office did not have internal controls to ensure the timeliness of payments to vendors. As a result, the office was charged $1,062 in reactivation and late fees during the scope of the audit. It also did not maximize the prompt payment rebates offered by the state purchasing card vendor.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should promptly pay its vendors.**

- **The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it pays vendor invoices promptly.**

Payment Accuracy

Internal control standards direct management to design control activities to address risks that exist within a process.[31] For example, internal controls should ensure that employees process payments accurately and appropriately document transactions.

We tested the following types of expenditures to determine if the office accurately reimbursed employees and paid vendors.

- The office reimbursed 618 employee expenditure requests during the scope of the audit, totaling $127,889. We tested a random sample of 40 reimbursements.
- The office paid 25 invoices for the use of state airplanes during the scope of the audit, totaling $78,570. We tested all of these payments.
- The office issued 290 vouchers to pay for various goods and services during the scope of the audit, totaling $323,774. We tested a random sample of 40 vouchers as well as 1 additional voucher we identified in our analysis.
- The office received 186 individual purchasing card statements with $361,535 in expenditures. We tested a random sample of 45 purchasing card statements as well as 4 additional statements we identified in our analysis.

FINDING 9

The Office of the Governor and Lieutenant Governor made numerous inaccurate reimbursements to employees and payments to vendors.

The office made the following inaccurate payments during the scope of the audit.

- Of the 40 employee expenditure reimbursements we tested, 14 contained various errors that resulted in inaccurate payments to employees, including (1) miscalculated mileage, (2) incorrectly claimed meals, and (3) math errors. In addition, we identified instances where the request for reimbursements did not match the payments to the employees and where the office miscoded the reimbursements as taxable or not taxable in the state's payroll system. As a result, the office overpaid seven reimbursements by a total of $135 and underpaid four reimbursements by a total of $120. The office also incorrectly charged or did not charge taxes on five reimbursements.[32]
- Of the 25 state airplane payments we tested, the office duplicated payments for two flights. The Minnesota Department of Transportation (MnDOT) originally billed the office with two invoices that had incorrect flight dates. When MnDOT realized the error, it issued corrected invoices. The office incorrectly paid all four invoices, resulting in an overpayment of $7,406.

[31] Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014), 45–48.

[32] Two of the employee expense reimbursements contained more than one error.

- Of the 41 goods and services payments we tested, 3 contained sales tax errors. In each case, the office directed the state's accounting system to automatically remit sales taxes directly to the Department of Revenue. However, the office also paid the sales taxes included on the vendor invoices directly to the vendor. As a result, the office overpaid $235 in sales taxes.

- Of the 49 individual purchasing card statements we tested, a purchase on 1 statement contained sales tax errors. The vendor did not include sales tax on the invoice but the cardholder indicated that they paid sales tax on their purchasing log. As a result, the office underpaid $92 in sales taxes.

For some errors, the office had internal controls but they were not effective in identifying the errors. For example, employees' supervisors reviewed six of the expenditure reimbursement requests but did not catch the errors we identified. For other errors, the office did not have internal controls to ensure the accuracy of payments. For example, the office did not verify that state airplane invoices matched the supporting documentation and did not confirm if it had previously paid for the flights.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should resolve inaccurate payments.**

- **The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it accurately reimburses employees and pays vendors.**

Expenditure Support

The office is subject to many different purchasing policies and procedures. For example, the office has its own policies on state business travel and purchasing card use, both of which require documentation such as itemized receipts and preapproval for travel exceeding 35 miles.[33] Additionally, the office follows state procurement and purchasing card policies, which require the office to retain documentation such as evidence of solicitation and approved exceptions to the policies.[34] We detail all of the criteria we tested against in the Appendix.

We tested employee expenditure reimbursements, vendor payments, and purchasing card transactions to determine if the office had complied with the applicable policies. We list the populations we tested prior to Finding 9 on the previous page.

[33] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, Employee Business Travel*, issued February 12, 2020, and *Policy on Purchasing Card Use*, issued December 5, 2018, revised September 2024.

[34] Minnesota Department of Administration, Office of State Procurement, *Authority for Local Purchase Manual, sec. 2.15 Documentation for Solicitation File*, revised October 1, 2022, and July 7, 2023, and *Purchasing Card Use Policy 1b, sec. 2.6 Purchasing Card Use Exceptions*, issued November 2013, revised April 2018.

FINDING 10

The Office of the Governor and Lieutenant Governor did not have documentation to support numerous employee expenditure reimbursements, vendor payments, and purchasing card transactions.

The office did not have documentation to support the following expenditures that occurred during the scope of the audit.

- 16 of 40 employee expenditure reimbursements we tested did not include all required documentation or required information:
    - 11 were missing written preapprovals for travel exceeding 35 miles
    - 4 were missing out-of-state travel authorizations forms
    - 2 were missing justification and approval forms for expenditures submitted more than 60 days after travel
    - 2 were missing departure and arrival times for reimbursement requests, which is necessary to validate that the employee was eligible for meal reimbursements[35]
- 40 of the 41 vendor payments we tested did not include all required documentation:
    - 1 was missing all procurement and payment documentation
    - 2 were missing price quotes or other documentation proving that the office competitively solicitated the purchases
    - 40 were missing packing slips, email confirmations, or other evidence proving that the office received the goods and services it purchased[36]
- Of the 49 individual purchasing card statements we tested, 18 did not have all required documentation. The office did not provide any receipts for transactions on seven statements, did not provide some receipts for transactions on eight statements, and did not provide itemized receipts for transactions on four statements.[37]

The office did not have sufficient internal controls to ensure that expenditures were adequately supported by documentation and approved. The office told us that for some items—such as travel exceeding 35 miles—they gave verbal approvals. However, without documentation, we could not determine that the expenditures were properly authorized, appropriate, and accurate.

[35] Three of the employee expenditure reimbursements were missing multiple types of documentation.

[36] Three of the vouchers were missing multiple types of documentation.

[37] One sample was missing receipts for some purchases and had non-itemized receipts.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.**
- **The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.**

Purchasing Card Use Agreements

Our 2022 audit reported that the office's policy included inconsistent requirements for how often purchasing cardholders were required to sign a new use agreement.[38] One section of the policy stated that new use agreements must be signed every three years, but another section stated that new agreements must be signed every four years.[39] In the previous audit, we recommended the office revise its policy to clearly indicate how often cardholders must sign new use agreements. During this audit, we reviewed whether the office resolved the inconsistency.

During the scope of the audit, 16 office employees had state purchasing cards. We tested whether the office required 15 of the cardholders to sign new use agreements in compliance with its policy.[40]

FINDING 11 *Prior Audit Finding Unresolved*

The Office of the Governor and Lieutenant Governor did not ensure its purchasing card policy contained consistent requirements regarding when cardholders must sign new use agreements.

The Office of the Governor and Lieutenant Governor did not require state purchasing cardholders to sign new use agreements in compliance with its policy.

In September 2024, the office updated its policy on purchasing cards; however, the policy still contained inconsistencies regarding the frequency of signing new use agreements. One section of the policy stated that new use agreements must be signed every two years, but another section stated that new agreements must be signed every three years.

[38] Office of the Legislative Auditor, Financial Audit Division, *Office of the Governor and Lieutenant Governor: Performance Audit* (2022), 22–23.

[39] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, Policy on Purchasing Card Use*, issued December 5, 2018.

[40] We did not test one cardholder's compliance with the office's requirement on new use agreements. This employee made their last state purchasing card purchase during the billing cycle that ended in July 2022. We released the prior audit report in August 2022 and, therefore, the office did not have sufficient time to obtain an updated use agreement.

We performed our testing to determine if the office required cardholders to sign new use agreements in the three-year period between fiscal years 2023 and 2025. We determined that one state purchasing cardholder had not signed a new use agreement since 2018, and two had not signed new use agreements since 2019.

These same three cardholders were identified in a finding in the prior audit report. We released the prior audit report in August 2022, and the three cardholders with expired agreements made their last state purchasing card purchases during the billing cycles ending in December 2022 and January 2023. The office told us that it believes the four or five months between the release of the prior audit report and the cardholders' last purchases was not sufficient time for it to execute new use agreements. We disagree.

The office did not have sufficient internal controls to ensure that purchasing cardholders sign new use agreements in compliance with its policy during the entire scope of the audit. Nevertheless, the office did obtain signed use agreements for all six current cardholders as of January 2025. Requiring cardholders to sign new use agreements is important because it reminds them of the responsibilities and limitations associated with having a state purchasing card.

RECOMMENDATIONS

- **The Office of the Governor and Lieutenant Governor should revise its policy to clearly indicate the frequency that cardholders must sign new use agreements.**
- **The Office of the Governor and Lieutenant Governor should strengthen internal controls over state purchasing cards to ensure each cardholder signs new use agreements as required by its policy.**

Purchasing Card Limits

Office policy establishes guidelines for the use of state purchasing cards, including maximum amounts for individual transactions ($5,000) and total transactions in a billing cycle ($20,000).[41] The policy also prohibits splitting a purchase into smaller transactions to circumvent purchasing limits, unless the cardholder receives an approved exception.

FINDING 12

The Office of the Governor and Lieutenant Governor split some purchasing card purchases, which circumvented established internal controls on spending limits.

Of the 49 individual purchasing card statements we tested, 2 contained purchases that the cardholder split into two transactions to avoid the $5,000 spending limit without obtaining preapproval. The first purchase was for flowers totaling $7,893. The second

[41] Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, Policy on Purchasing Card Use*, issued December 5, 2018, revised September 2024.

purchase was for furniture totaling $7,343. Both purchases were related to the governor's residence.

In each instance, the office did not have sufficient internal controls to prevent the noncompliance. The split transactions occurred in June 2022 and June 2023. At that time, the two cardholders had not signed a new use agreement since October 2015. The use agreements require employees to acknowledge their understanding of the related office policy.

Transaction limits on state purchasing cards are set to deter cardholders from making purchases that are over $5,000 and subject to competitive solicitation.[42]

RECOMMENDATION

The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that state purchasing cardholders do not split payments without prior approval.

[42] Minnesota Department of Administration, Office of State Procurement, *Authority for Local Purchase Manual, sec. 2.5 Competitive Requirements*, revised October 1, 2022, and July 7, 2023.

Appendix: Compliance Requirements Tested

Area Tested	Compliance Requirement
Receipts: • Interagency Receipts for Shared Services Provided • Governor's Residence Event Reimbursements • Other Deposits • Unrecorded Deposits	• Interagency agreements with members of the Governor's Cabinet • *Minnesota Statutes* 2025, 16B.27, subd. 6 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*, *Recording and Depositing Receipts*, issued December 5, 2018 • Office of the Governor and Lieutenant Governor, *Records Retention Schedule for the Official Records of the Office of Governor Jesse Ventura* [as adopted by the current administration], issued June 2002

Payroll Expenditures:
• Hours Worked
• Governor's and Lieutenant Governor's Salaries
• Salaries of Employees Working on the Presidential Campaign
• Retroactive Pay Rate Adjustments
• Separation Payments
• Holiday Pay
• Leave Balance Adjustments
• Vacation Leave Conversions
• Payroll Adjustments
• Paid Parental Leave
• Maximum Vacation Leave Balances
	• Compensation Council, memorandum to Speaker of the House and President of the Senate, *Compensation Council Recommendations*, March 31, 2023
	• *Laws of Minnesota* 2001, First Special Session, chapter 10, art. 1, sec. 2, subd. 4
	• Minnesota Association of Professional Employees (MAPE), *Unit 14: General Professional Labor Agreement Between the State of Minnesota and the Minnesota Association of Professional Employees, July 1, 2023–June 30, 2025*
	• Minnesota Management and Budget, Human Resources and Labor Relations Policy 1435, *Paid Parental Leave*, revised January 2020
	• Minnesota Management and Budget, *Mass Retroactive Pay Adjustments – Reference*
	• Minnesota Management and Budget, Statewide Operating Policies and Procedures:
	  ○ PAY0016, *Biweekly Time Reporting by Employees*, issued February 2011
	  ○ PAY0017, *Self Service Time Entry*, issued February 2011
	  ○ PAY0023, *Prior Period Adjustments*, issued October 2005
	  ○ PAY0024, *Current Period Adjustments*, issued September 2006
	  ○ PAY0025, *Pay Rate Adjustments*, issued April 2001
	  ○ PAY0026, *Leave Balance Adjustments*, issued December 2007
	  ○ PAY0028, *Agency Verification of Payroll and Human Resources Transactions*, issued August 2011
	  ○ PAY0033, *Correction of Overpayments*, issued March 2017
	  ○ PAY0038, *Severance, Leave and Other Payoffs*, issued December 2007
	  ○ 0504-01, *Debt Collection Process and Actions*, revised March 9, 2021
	• *Minnesota Statutes* 2025, 16D.09, subd. 1
	• Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz and Lt. Governor Peggy Flanagan, Compensation Plan*, July 1, 2019–June 30, 2021, July 1, 2021–January 31, 2023, and February 1, 2023–June 30, 2025

Area Tested	Compliance Requirement
Inventory	• Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014) • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*, *Property Management*, issued December 5, 2018
Nonpayroll Expenditures: • Recurring Expenditures	• *Minnesota Statutes* 2025, 16A.124, subd. 3 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*, *Political Activities*, issued 2019
Nonpayroll Expenditures: • State Purchasing Cards	• Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014) • Minnesota Department of Administration, Office of State Procurement: o *Authority for Local Purchase Manual*, revised October 1, 2022, and July 7, 2023 o *Purchasing Card Use Policy 1b,* issued November 2013, revised April 2018 • Minnesota Management and Budget, Statewide Operating Policy 0802-01, *Payment Request, Preparation, and Approval*, revised July 20, 2022 • *Minnesota Statutes* 2025, 16A.124, subd. 3; and 16B.27, subd. 2 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*: o *Policy on Purchasing Card Use*, issued December 5, 2018, revised September 2024 o *Political Activities*, issued 2019 • Office of the Governor and Lieutenant Governor, *Records Retention Schedule for the Official Records of the Office of Governor Jesse Ventura* [as adopted by the current administration], issued June 2002
Nonpayroll Expenditures: • Other Goods and Services	• Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014) • Minnesota Department of Administration, Office of State Procurement: o *Authority for Local Purchase Manual*, revised October 1, 2022, and July 7, 2023 o *Purchasing Policy 23: Acquisitions ALP Policy, Procedures, and Training Overview*, revised July 2023 • *Minnesota Statutes* 2025, 16A.124, subd. 3; 16A.41, subd. 1; and 43A.38, subd. 2 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*, *Political Activities*, issued 2019 • Office of the Governor and Lieutenant Governor, *Records Retention Schedule for the Official Records of the Office of Governor Jesse Ventura* [as adopted by the current administration], issued June 2002

Area Tested	Compliance Requirement
Nonpayroll Expenditures: • Employee Expenditure Reimbursements	• Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014) • Internal Revenue Service: o *Publication 15, (Circular E), Employer's Tax Guide*, revised December 16, 2021, December 13, 2022, and December 19, 2023 o *Standard Mileage Rates* • Minnesota Management and Budget, *Employee Business Expenses BTX – Reference* • Minnesota Management and Budget, Administrative Procedure 4.4, *Special Expenses*, issued May 9, 1983, revised December 3, 2013 • *Minnesota Statutes* 2025, 15.435; and 43A.38, subd. 2 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz and Lt. Governor Peggy Flanagan Compensation Plan*, July 1, 2019–June 30, 2021, July 1, 2021–January 31, 2023, and February 1, 2023–June 30, 2025 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*: o *Political Activities*, issued 2019 o *Employee Business Travel*, issued February 12, 2020
Nonpayroll Expenditures: • State Airplane Flights	• Comptroller General of the United States, Government Accountability Office, *Standards for Internal Control in the Federal Government* (September 2014) • *Minnesota Statutes* 2025, 16A.124, subd. 4; and 43A.38, subd. 4 • Office of the Governor and Lieutenant Governor, *Office of Governor Tim Walz & Lt. Governor Peggy Flanagan*, *Political Activities*, issued 2019 • Office of the Governor and Lieutenant Governor, *Records Retention Schedule for the Official Records of the Office of Governor Jesse Ventura* [as adopted by the current administration], issued June 2002

OLA

Office of Governor Tim Walz &
Lt. Governor Peggy Flanagan

October 31, 2025

Judy Randall, Legislative Auditor
Office of the Legislative Auditor
140 Centennial Office Building
658 Cedar Street
Saint Paul, MN 55155

Dear Auditor Randall:

Thank you for the opportunity to review and comment on the Office of the Legislative Auditor's performance review of the *Office of the Governor and Lieutenant Governor*. The Governor's Office appreciates your office's review and recommendations. This review was wide-ranging. It examined areas not raised in the OLA's 2022 financial audit of the Governor's Office and even identified practices that predated the current administration.

In the course of that thorough review, the OLA identified narrow and discrete areas for improvement. Even before the OLA initiated this review, the Governor's Office had resolved almost half of the issues identified, many of which were isolated to 2022. We have taken significant steps to improve internal controls to mitigate future issues by implementing strengthened standard operating procedures about documentation, billing, receipt management and reconciliation, and asset management. Moreover, we made strategic employment decisions to increase capacity and professionalize the office's operations function. Importantly, this review did not find any financial misuse or malfeasance.

The Governor's Office has resolved 11 of 12 of the report's findings and implemented its recommendations.

Finding	Status	Date
Finding 1	Resolved	2024
Finding 2	Resolved	Spring 2025
Finding 3	Resolved	Summer 2025
Finding 4	Resolved	2022
Finding 5	Resolved	Summer 2025
Finding 6	Resolved	Spring 2025
Finding 7	Partially Resolved	Winter 2025
Finding 8	Resolved	Spring 2025
Finding 9	Resolved	Summer 2025
Finding 10	Resolved	2025
Finding 11	Resolved	2024
Finding 12	Resolved	2024

We value the thorough and professional review conducted by the OLA's staff. Throughout the audit process, we have appreciated the OLA's collaborative work with our office to identify opportunities to improve internal controls. Below are our office's responses to the audit findings cited in the report:

Response to the OLA's Findings and Recommendations

OLA Finding 1

- The Office of the Governor and Lieutenant Governor did not manage its receipts as required by state law or office policies.

OLA Recommendations pertaining to Finding 1

- The Office of the Governor and Lieutenant Governor should ensure that it manages its receipts as required by state law and office policies.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over its receipt processes.

Agency Response to Finding 1

- **Narrative Response:** The Governor's Office agrees with the OLA's finding and supports the OLA's recommendations.
- **Current Status:** Resolved.
- **Corrective Action:** The Governor's Office has strengthened its internal controls to better manage receipts. Specifically, we have added more employee training, updated standard operating procedures, introduced new software, and hired new staff focused on these tasks.
- **Completion Date:** 2024.

OLA Finding 2

- The Office of the Governor and Lieutenant Governor did not provide adequate oversight of timesheet completion and approval.

OLA Recommendations pertaining to Finding 2

- The Office of the Governor and Lieutenant Governor should provide adequate oversight of timesheet completion and approval.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over its timesheet completion and approval processes.

Agency Response to Finding 2

- **Narrative Response:** While the Governor's Office practice of timesheet oversight was consistent with the practice of other state agencies, the Governor's Office agrees with the OLA's finding and supports the OLA's recommendations.
- **Current Status:** Resolved.
- **Corrective Action:** In 2022, after the OLA's prior audit, the Governor's Office strengthened its internal controls over its timesheet completion and approval processes by providing additional manager and employee training, updating standard operating procedures, and implementing new software to ensure proper timesheet management. We again updated our standard operating procedures in the spring of 2025.
- **Completion Date:** Spring 2025.

OLA Finding 3

- The Office of the Governor and Lieutenant Governor did not attempt to resolve incorrect floating holiday and vacation leave payouts.

OLA Recommendations pertaining to Finding 3

- The Office of the Governor and Lieutenant Governor should reduce the vacation balance for the state employee identified.
- The Office of the Governor and Lieutenant Governor should recover the overpayments it made for each former employee identified.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over employee vacation leave balances or formally document its prohibition on vacation cap extensions.

Agency Response to Finding 3

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations. The Governor's Office sent letters to the former employees seeking to recover the overpayments.
- **Current Status:** Resolved.
- **Corrective Action:** The Governor's Office strengthened its internal controls related to payroll management in fall 2022 when we started using the State's payroll management system. Since then, there have been no payroll or benefit incidents. Additionally, we have taken other actions including strengthened internal controls over its floating holiday usage and vacation payouts such as: more manager and employee training and updated standard operating procedures. As noted above, in 2025, the Governor's Office sent letters attempting to recover overpayments.
- **Completion Date:** Summer 2025.

OLA Finding 4

- The Office of the Governor and Lieutenant Governor did not document one employee's eligibility for paid parental leave.

OLA Recommendations pertaining to Finding 4

- The Office of the Governor and Lieutenant Governor should ensure it sufficiently documents employee eligibility for paid parental leave.

Agency Response to Finding 4

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations. The underlying issue raised by the OLA was an isolated incident, which happened in 2022 and was resolved by the Governor's Office shortly thereafter.
- **Current Status:** Resolved in 2022.
- **Corrective Action:** The Governor's Office has strengthened its internal controls to ensure it sufficiently documents employee eligibility for paid parental leave. These controls include more employee training, updated standard operating procedures, and new software.
- **Completion Date:** 2022.

OLA Finding 5

- The Office of the Governor and Lieutenant Governor did not issue correct retroactive pay rate adjustments for seven employees.

OLA Recommendations pertaining to Finding 5

- The Office of the Governor and Lieutenant Governor should recover the retroactive pay rate adjustment overpayments it made for each employee identified.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure the accuracy of retroactive pay rate adjustments

Agency Response to Finding 5

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations. In August 2025, the Governor's Office sent letters to the current and former employees seeking to recover the overpayments.
- **Current Status:** Resolved.
- **Corrective Action:** Going forward, the Governor's Office has taken actions to mitigate the potential for future issues related to retroactive pay rate adjustments, which all occurred during the same timeframe in 2022. The Governor's Office has strengthened its internal controls to ensure the accuracy of retroactive pay rate adjustments through employee training and the automated state payroll system. As noted above, in 2025, the Governor's Office sent letters attempting to recover overpayments.
- **Completion Date:** Summer 2025.

OLA Finding 6

- The Office of the Governor and Lieutenant Governor did not have required documentation to support all payroll and leave adjustments.

OLA Recommendations pertaining to Finding 6

- The Office of the Governor and Lieutenant Governor should document all payroll and leave balance adjustments, as required by state policy.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it documents payroll and leave balance adjustments in accordance with state policy.

Agency Response to Finding 6

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations.
- **Current Status:** Resolved.
- **Corrective Action:** The Governor's Office has strengthened its internal controls to ensure that it documents payroll and leave balance adjustments in accordance with state policy. These controls include more employee training, updated standard operating procedures, and new software.
- **Completion Date:** Spring 2025.

OLA Finding 7

- The Office of the Governor and Lieutenant Governor did not manage its inventory in accordance with its property management policy.

OLA Recommendations pertaining to Finding 7

- The Office of the Governor and Lieutenant Governor should maintain an updated inventory of the assets and sensitive items it owns or is responsible for tracking.
- The Office of the Governor and Lieutenant Governor should segregate incompatible duties in its purchasing, accounting, and property management processes or develop internal controls to effectively mitigate the risk.

Agency Response to Finding 7

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations.
- **Current Status:** Partially Resolved.
- **Corrective Action:** The Governor's Office has segregated incompatible duties in its purchasing, accounting, and property management processes or developed internal controls to effectively mitigate the risk.

- **Planned course of action:** The Governor's Office will work on maintaining an updated inventory of the assets and sensitive items it owns or is responsible for tracking.
- **Completion Date:** Winter 2025.
- **Person Responsible:** Deputy Chief of Staff for Operations and Residence.

OLA Finding 8

- The Office of the Governor and Lieutenant Governor made numerous late payments to its vendors.

OLA Recommendations pertaining to Finding 8

- The Office of the Governor and Lieutenant Governor should promptly pay its vendors.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it pays vendor invoices promptly.

Agency Response to Finding 8

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations.
- **Current Status:** Resolved.
- **Corrective Action:** The Governor's Office has implemented strengthened internal controls to prevent late payments. These additional internal controls include increased training for employees, revised standard operating procedures, and new staff tasked with administrative operations.
- **Completion Date:** Spring 2025.

OLA Finding 9

- The Office of the Governor and Lieutenant Governor made numerous inaccurate reimbursements to employees and payments to vendors.

OLA Recommendations pertaining to Finding 9

- The Office of the Governor and Lieutenant Governor should resolve inaccurate payments.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure it accurately reimburses employees and pays vendors.

Agency Response to Finding 9

- **Narrative Response:** The Governor's Office agrees with the OLA's findings and supports the OLA's recommendations.
- **Current Status:** Resolved.
- **Corrective Action:** The Governor's Office has implemented strengthened internal controls to prevent inaccurate reimbursements. Additionally, the Governor's Office has made adjustments to resolve inaccurate payments. These additional internal controls include increased employee training, revised standard operating procedures, and new staff assigned to administrative operations.
- **Completion Date:** Summer 2025.

OLA Finding 10

- The Office of the Governor and Lieutenant Governor did not have documentation to support numerous employee expenditure reimbursements, vendor payments, and purchasing card transactions.

OLA Recommendations pertaining to Finding 10

- The Office of the Governor and Lieutenant Governor should ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.

- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services.

Agency Response to Finding 10

- **Narrative Response:** The Governor's Office partially agrees with the OLA's findings and supports the OLA's recommendations to the extent that they are consistent with state policy regarding preapproval for in-state travel. The Governor's Office and MMB each have travel policies that only require preapproval in advance of in-state travel, and do not require specific methods of preapproval. The Governor's Office followed these policies and obtained verbal approval before in-state travel.
- **Current Status:** Resolved in 2025.
- **Corrective Action:** The Governor's Office has strengthened internal controls to ensure that it obtains and retains the documentation necessary to support the proper procurement, receipt, and payment of goods and services. These additional internal controls include increased employee training, revised standard operating procedures, and new staff assigned to administrative operations. The Governor's Office will continue to follow the Governor's Office Travel Policy and MMB's Travel Policy.
- **Completion Date:** 2025.

OLA Finding 11

- The Office of the Governor and Lieutenant Governor did not ensure its purchasing card policy contained consistent requirements regarding when cardholders must sign new use agreements.

OLA Recommendations pertaining to Finding 11

- The Office of the Governor and Lieutenant Governor should revise its policy to clearly indicate the frequency that new use agreements must be signed by cardholders.
- The Office of the Governor and Lieutenant Governor should strengthen internal controls over state purchasing cards to ensure each cardholder signs new use agreements as required by its policy.

Agency Response to Finding 11

- **Narrative Response:** The Governor's Office agrees with the OLA's findings, supports the OLA's recommendations, and notes that it resolved the issue in 2024 when it implemented a revised policy.
- **Current Status:** Resolved in 2024.
- **Corrective Action:** The Governor's Office has been using a revised policy since 2024 and all current cardholders have signed agreements.
- **Completion Date:** 2024.

OLA Finding 12

- The Office of the Governor and Lieutenant Governor split some purchasing card purchases, which circumvented established internal controls on spending limits.

OLA Recommendations pertaining to Finding 12

- The Office of the Governor and Lieutenant Governor should strengthen internal controls to ensure that state purchasing cardholders do not split payments without prior approval.

Agency Response to Finding 12

- **Narrative Response:** The Governor's Office agrees with the OLA's findings, supports the OLA's recommendations, and notes that it resolved the issue in 2024 when it implemented a revised policy.
- **Current Status:** Resolved in 2024.
- **Corrective Action:** The Governor's Office has been using a revised policy since 2024 which has strengthened internal controls to ensure that state purchasing cardholders do not split payments

without prior approval. Additional internal controls include increased employee training, revised standard operating procedures, and new staff assigned to administrative operations.

- **Completion Date:** 2024.

Once again, thank you for the opportunity to respond to the OLA's report.

Sincerely,

Chris Schmitter

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Minnesota Department of Health: Human Resources Complaint Management

2025 Evaluation Report

Program Evaluation Division

Office of the Legislative Auditor

State of Minnesota

Program Evaluation Division

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

Judy Randall, Legislative Auditor
State of Minnesota

January 2025

Members of the Legislative Audit Commission:

The Minnesota Department of Health's (MDH's) Human Resources Management Division (HR division) receives complaints involving MDH employees and investigates complaint allegations when warranted. While MDH employees, unions, and HR investigators generally shared positive perceptions of the HR division's complaint management, inconsistent documentation and a lack of written procedures made it unclear whether the HR division consistently managed many aspects of employee complaints.

Further, some current and former employees we surveyed indicated that they believed they had experienced retaliation after submitting a human resources complaint. We recommend that MDH develop written procedures to address retaliation and several other aspects of complaint management.

Our evaluation was conducted by Sarah Delacueva (project manager), Stephanie Besst, Ellie Capra, and Jenna Hoge. MDH cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

Judy Randall
Legislative Auditor

Jodi Munson Rodríguez
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Summary

January 2025

Minnesota Department of Health: Human Resources Complaint Management

It was unclear whether the Minnesota Department of Health's (MDH's) Human Resources Management Division (HR) consistently managed many aspects of employee complaints, due in part to its lack of written procedures.

Report Summary

Complaint Submission

- The large majority of MDH employees who responded to our survey indicated that they knew how to submit a complaint, but some expressed reluctance to do so. (p. 17)

- Based on survey responses, training seems to be an important factor in supervisors' understanding of when to refer complaints to HR. (p. 18)

  Recommendation ► MDH should require all MDH supervisors to attend periodic training about when to refer employee complaints. (pp. 18-19)

Complaint Management

- Although MDH employees, union representatives, and HR investigators generally shared positive perceptions of the HR division's complaint management, some expressed less confidence in how the division manages certain steps. (pp. 14-16)

- The HR division does not have written procedures to help ensure consistency in complaint management. (pp. 19-20)

- A lack of documentation often made it unclear whether the HR division took consistent approaches when deciding how to manage complaints. (p. 24)

- While investigators routinely documented delivery of required data practices and antiretaliation notices during *investigation* interviews, they did not document delivery of these notices during *complaint intake*. (pp. 21-22)

- Based on our file review, investigators did not consistently document having acknowledged complaint receipt. (pp. 25-26)

Background

State employees are entitled to certain workplace protections, and state agencies have a duty to enforce these protections. If an employee feels their protections have been violated, they may report their concern to their agency's HR division. An agency generally cannot discipline an employee for a policy violation without an investigation that substantiates an allegation of wrongdoing. It is illegal to retaliate against an employee who submits a complaint or participates in a complaint investigation.

Minnesota Management and Budget provides best practices for investigations of complaint allegations. Over the last two years, MDH's HR division developed its current processes for managing complaints. These processes involve (1) receiving complaints; (2) determining if a complaint warrants an investigation; (3) if necessary, investigating a complaint's allegation(s), and if substantiated; (4) advising on appropriate discipline.

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- The HR division notified *subjects* when it closed investigations, but it inconsistently notified *complainants* of both intake closure and investigation closure. (pp. 26-27)

  Recommendation ► The HR division should establish complaint management procedures that address the following issues:

  Rights and Protections: Investigators should issue, and document the issuance of, verbal and written data practices and antiretaliation notices during both intake conversations and investigation interviews.

  Decision Making: Investigators should consider certain factors when deciding whether to (1) investigate complaint allegation(s) and (2) interview people identified as having relevant information, and document these decisions.

  Status Notifications: Investigators should communicate with each complainant to acknowledge their complaint and at other predetermined points during complaint management; they should document these communications. (pp. 28-29)

Retaliation

- There is little evidence that the HR division consistently followed up on reports of retaliation that arose during complaint intake or investigation. (p. 32)

- In their survey responses, some current and former MDH employees indicated that they believed they experienced retaliation as a result of submitting a complaint to HR. However, some chose not to report the perceived retaliation. (pp. 33-35)

  Recommendation ► The HR division should develop procedures to address retaliation fears or experiences that emerge through complaint intake or investigation. (p. 33)

- Since state law and labor contracts generally include stronger protections for certified employees, probationary employees are particularly vulnerable to retaliation. (pp. 35-36)

  Recommendation ► The HR division should develop a procedure for examining instances of noncertification of probationary employees who previously submitted complaints. (p. 36)

Summary of Agency Response

In a letter dated January 29, 2025, Commissioner Cunningham said that "MDH is committed to a fair and equitable human resources complaint management process" and that the department values OLA's feedback as it "serves as an important tool for growth and development." The commissioner said that MDH had either begun to implement or would soon implement most of OLA's recommendations. For example, she reported that MDH has developed a departmentwide complaint and investigation procedure, as well as an internal guidance on which documents must be saved in the HR division's case management files. Further, Commissioner Cunningham said that MDH has begun developing resources for all department staff to raise awareness of retaliation and instill confidence in staff to come forward to report retaliation. These include "internal news articles outlining the process for filing a retaliation complaint, …and [MDH's] process for addressing concerns."

The full evaluation report, *Minnesota Department of Health: Human Resources Complaint Management*, is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/ped/2025/HR-complaints.htm**

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OLA

Introduction

The Minnesota Department of Health (MDH) is among Minnesota state government's largest employers; it employs roughly 2,000 people, all of whom are entitled to certain workplace protections, such as freedom from harassment and discrimination. When an employee believes that their workplace rights have been violated, or that a coworker is otherwise breaking department policy or law, the employee may submit a complaint. At MDH, the Human Resources Management Division (HR division or HR) receives complaints, investigates complaint allegations, and presents investigation findings to the relevant decision makers.

Properly managing employee complaints is an important part of maintaining a good relationship between an employer and its workforce. If an employer mismanages or ignores employee complaints, the employer may put itself at legal risk and employee morale may suffer.

In April 2024, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate MDH's management of human resources complaints. Our evaluation addressed the following questions:

- **To what extent are the Minnesota Department of Health's HR division's processes for addressing complaints fair and thorough?**

- **How well does the Minnesota Department of Health's HR division protect employees from retaliation for submitting complaints?**

To determine standards by which to evaluate the efforts of MDH's HR division, we reviewed relevant policies created by Minnesota Management and Budget (MMB) and the training series that MMB offers for human resources employees. We also interviewed relevant employees at MMB and MDH, including all MDH employees who conduct investigations into complaint allegations.

We surveyed all current MDH employees and a sample of recent former MDH employees to learn about their experiences submitting complaints and their confidence in the HR division to properly manage complaints. We also reviewed HR division files related to all complaints the division received in fiscal years 2023 and 2024, as well as their related investigations.

For this evaluation, we focused specifically on the HR division's processes related to employee complaints; we did not evaluate other HR division functions, such as posting employment opportunities or coordinating employee benefits. Further, we did not systematically evaluate the HR division's decisions to investigate complaint allegations or to substantiate or not substantiate the allegations it investigated. Nor did we evaluate the credibility of the complaints themselves. Finally, we evaluated only MDH. We did not evaluate MMB's guidance to agencies or the complaint processes that other state agencies (such as OLA) use when receiving complaints from MDH or other state employees.

OLA

Chapter 1: Background

State employees are entitled to certain workplace protections under state and federal laws and state policies. When employees feel that a coworker has violated their protections, or has violated other laws or policies, they may submit a complaint. It is illegal to retaliate against an employee for submitting a complaint.[1] Failure to address complaints in an appropriate manner puts an agency at legal risk. Further, how an agency manages complaints can have significant and far-reaching consequences within the agency, such as a lack of trust in the agency and its processes and decreased morale among employees.

In this chapter, we define key terms related to complaints and explain to whom a state employee—including an employee of the Minnesota Department of Health (MDH)—may submit a complaint. We briefly discuss *policies* related to complaints for state employees, including Minnesota Management and Budget's (MMB's) role in developing these policies and supporting state agencies as they address the complaints they receive. Finally, we provide an overview of the *processes* that MDH uses to manage complaints.

Overview of Complaints

Definitions of Key Terms

A **complaint** is an allegation or claim of wrongdoing and may be about personnel issues or instances of retaliation, among other things.

A **complainant** is a person who submits a complaint.

A **subject** is a person accused of wrongdoing in a complaint.

Personnel issues include conflicts of interest and ethics violations, discrimination, harassment, performance issues, respectful workplace issues, and violations of policy or law, among other issues.

Retaliation includes adverse actions against an individual because they submitted a complaint, participated in an investigation into a complaint allegation, or opposed behavior that violated law or policy. Adverse actions include discipline, demotion, discharge, exclusion, threats, reprimands, reduced hours, and transfers to less desirable work, among other things. We discuss retaliation in detail in Chapter 3.

Employee complaints may reflect a wide array of concerns about personnel issues or retaliation, which are defined in the box to the left. Complaints can include allegations of disrespectful or inappropriate treatment, discrimination, or harassment. Employees can also complain about another employee's job performance or allege that someone has committed fraud, retaliated, or otherwise broken the law.

State employees may submit complaints to various individuals or entities; some individuals or entities address only certain types of complaints. For example, certain employees may submit allegations of labor contract violations (known as grievances) to their unions. Or, if an employee has a complaint about the commissioner of an agency, they may submit the complaint to MMB.[2] State employees may submit complaints to their supervisor, human resources division, or other agency office.

[1] *Minnesota Statutes* 2024, 181.932, subd. 1.

[2] In addition, Minnesota statutes outline specific types of complaints that should be submitted to particular agencies. For example, state employees and others should report to the Office of the Legislative Auditor any alleged misuse of state money, resources, and data, as well as alleged violations of the state code of conduct for employees in the executive branch of state government. *Minnesota Statutes* 2024, 3.971, subds. 8a and 9; 43A.38; and 43A.39.

Generally, once a state agency receives a complaint, it is best practice to conduct complaint intake, which involves collecting enough information to determine whether the complaint allegation(s) warrant investigation.[3] If an agency conducts an investigation, it should assess evidence to determine whether to substantiate the complaint allegation(s). Once an investigation is complete, agencies generally document the evidence, findings, and determinations in an investigation report. If the agency substantiated any of the allegations, the investigation report becomes the basis for a disciplinary decision, which could range from oral reprimand to discharge.

State law requires an agency to establish "just cause" before it may suspend, demote, or discharge certain permanent state employees.[4] According to MMB, before an agency disciplines a permanent employee, it is best practice to ensure that it can answer "yes" to the seven questions in the box at the right.

Elements of Just Cause

Notice: Did the employee know and understand the rule?

Reasonable rule: Was the rule reasonable?

Investigation before discipline: Was there an investigation before discipline was administered?

Investigation fair and objective: Was the investigation fair and objective?

Substantial proof: Did the investigation produce evidence of wrongdoing?

Equal treatment: Is the rule enforcement internally consistent?

Reasonable penalty: Is the discipline reasonable in relation to the seriousness of the offense?

— MMB, Investigator Training Series

Role of MMB in Complaint Management

The commissioner of MMB is the "chief personnel and labor relations manager" of employees in the state's executive branch.[5] MMB has issued a number of human resources and labor relations policies that explicitly protect and/or govern the behavior of all state employees.

MMB requires executive branch (including MDH) employees to complete annual training sessions on four particular policies, which address the topics of respectful workplace, sexual harassment, harassment and discrimination, and workplace violence.[6] These trainings explain how employees can submit complaints related to each policy and, in some cases, how supervisors should handle the complaints they receive. Each of the written policies also includes instructions on how to submit complaints about violations of the policy and states that retaliation for reporting policy violations is prohibited.

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[3] At times in this report, we refer to the activities of complaint intake and investigation collectively as "complaint management."

[4] *Minnesota Statutes* 2024, 43A.33, subd. 1.

[5] *Minnesota Statutes* 2024, 43A.04, subd. 1(a).

[6] Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023; HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024; and HR/LR Policy 1444, *Workplace Violence Prohibited*, issued March 4, 2021.

Statutes require that MMB establish best practices for conducting human resources investigations "designed to facilitate effective investigations, without compromising the ability to prosecute criminal cases when appropriate."[7] Accordingly, MMB has developed a multipart training series for employees who receive complaints and conduct investigations. MMB initially offered this investigator training as a webinar series in late 2020 and early 2021, and the training has been available as an on-demand video series since that time.[8] The 14 sessions of the investigator training series cover topics such as planning an investigation, writing an investigation report, and protecting the data created during an investigation.

MMB's training series establishes the characteristics of a good investigation and other best practices for investigators to use in their work. We used these trainings to develop standards against which to evaluate MDH's processes, as the box below shows.

Selected Best Practices in Conducting Investigations

- The investigator conducts thorough intake to fully understand allegation(s).
- The investigation subject has the opportunity to tell their side of the story.
- The investigation subject is entitled to union representation (if allowed by their labor contract).
- The investigator talks to all witnesses with relevant information.
- The investigator prepares an investigation report providing evidence of a timely and impartial response to potential misconduct.
- The investigator establishes the elements of just cause before substantiating an allegation.

— MMB, Investigator Training Series

Beyond its training series, MMB has created templates that agencies may use for complaint management. These include a complaint submission form, an investigation plan template, and investigation report templates, among others. MMB has also informed agencies that some of its staff can provide a critical, neutral review of an agency's investigation report draft, upon request.

[7] *Minnesota Statutes* 2024, 43A.325.

[8] MMB again offered the investigator training series as live webinars starting in the summer of 2024.

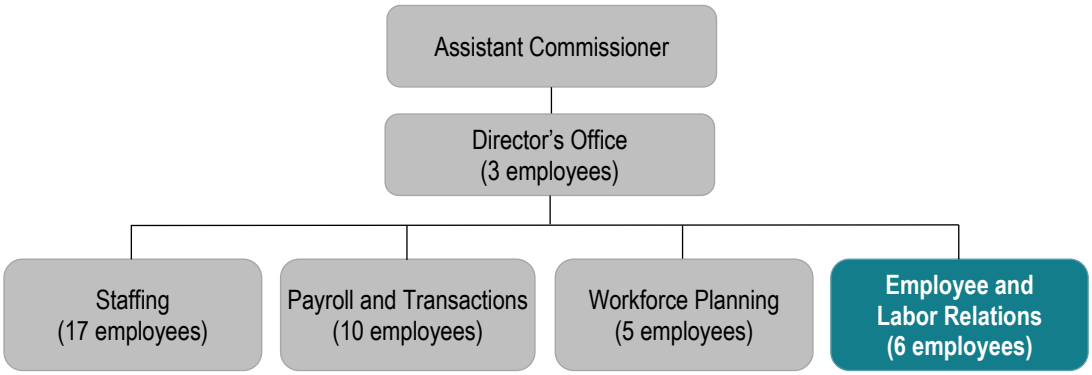
Complaint Management at MDH

As allowed by statutes, MMB has delegated certain administrative functions to MDH's Human Resources Management Division (HR division or HR).[9] The HR division is responsible for managing complaints involving MDH employees. In general, MDH's HR division manages complaints from MDH employees alleging wrongdoing by other MDH employees. Complaints from the public that are unrelated to personnel issues or retaliation are typically addressed through other processes.

Current HR leadership—including the manager who oversees investigations, division director, and assistant commissioner—joined MDH's HR division in the spring of 2022. One of these individuals told us that, prior to their arrival, there were concerns about the division's ability to carry out its work because the division had only a handful of employees and historic retention issues. As Exhibit 1.1 shows, by May 2024, the division had grown to more than 40 employees.

The HR division's Employee and Labor Relations Section manages complaints from MDH employees, among other duties.[10] Since 2022, the investigations manager has established the section's current complaint management processes, and the department has hired four investigators.[11]

Exhibit 1.1
MDH HR Division Sections, 2024



Source: Office of the Legislative Auditor.

[9] *Minnesota Statutes* 2024, 43A.36, subd. 1(a). This delegation is a standard practice for cabinet-level agencies in Minnesota.

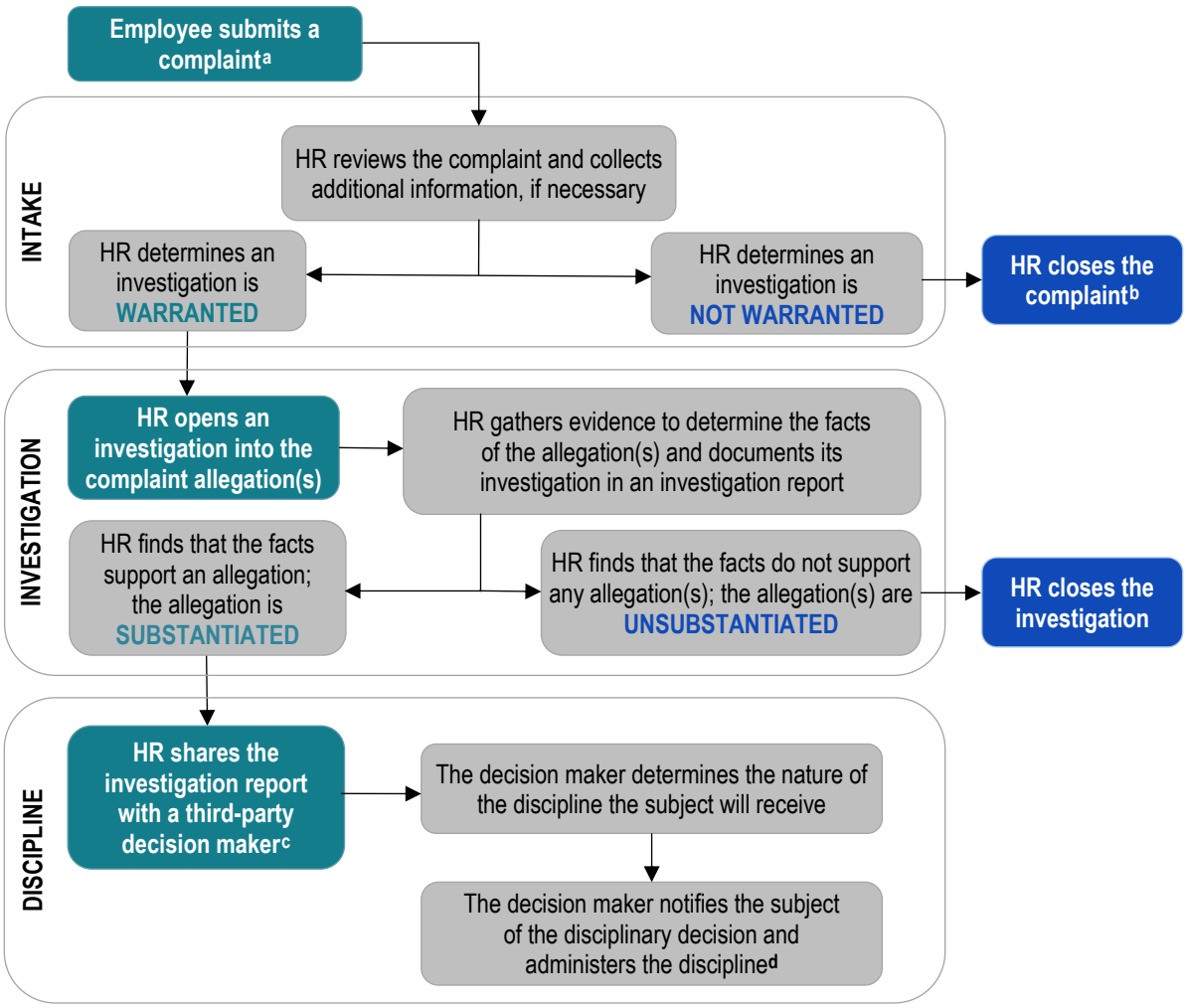
[10] While the Employee and Labor Relations Section manages complaints, we attribute these activities to the "HR division" or "HR" for the sake of simplicity.

[11] Employees in the Employee and Labor Relations Section conduct a variety of labor relations activities. We reviewed only their complaint management, and we refer to employees involved in complaint management as "investigators." One employee in the section primarily addresses issues related to the Americans with Disabilities Act. While MDH has the ability to contract for investigation work, the investigators in its Employee and Labor Relations Section conducted all MDH investigations during the period we reviewed for this evaluation.

Complaint Management Processes

HR investigators manage complaints, beginning when an employee submits a complaint, through—when warranted—investigation of the complaint allegation(s) and consultation on discipline decisions. Based on our review, typical complaint management involves the steps and elements we show in Exhibit 1.2 and describe below: complaint submission, intake, investigation, and discipline.

Exhibit 1.2
Overview of MDH HR Complaint Management



[a] An employee may submit a complaint directly to HR or to another MDH employee, such as their supervisor. If an employee outside of the HR division receives a complaint, MDH expects that employee to forward the complaint to HR.

[b] HR may close the complaint without taking action or by taking action other than investigation. Other actions may include assigning professional development or coaching, among other things.

[c] The decision maker is typically the subject's supervisor.

[d] If a subject does not agree with a disciplinary decision, the subject's union (if relevant) may file a grievance. We did not review the grievance process as part of this evaluation.

Source: Office of the Legislative Auditor.

Submission

An MDH employee may submit a complaint to the HR division through a variety of methods, such as in an e-mail or during a one-on-one meeting. The HR division also maintains an online form through which any MDH employee may report concerns and can choose to remain anonymous. An employee may also submit a complaint to their supervisor or another MDH employee. HR division leadership told us that when an MDH employee outside of HR—such as a supervisor—receives a complaint, HR expects the complaint recipient to submit the complaint to the HR division.[12]

During fiscal years 2023 and 2024, the division received 82 complaints that involved MDH employees.[13] We describe examples of various complaint topics and the frequency with which the division received complaints about each topic in the box below.[14]

Complaint Examples

Topic and Complaint Frequency	Example
Respectful Workplace (38)	An employee complains that their colleague is generally uncooperative and rolls their eyes and huffs when others share ideas in meetings.
Discrimination (12)	An employee complains that her colleagues do not include her in key meetings because she is a woman.
Performance (10)	An employee complains that another employee does not meet minimum job standards.
Harassment (7)	Employees complain that their colleague repeatedly makes sexual comments to them.
Work Hours and Attendance (6)	An employee complains that another employee consistently arrives to their worksite late and departs early.
Retaliation (4)	Employees complain that after they raised concerns about their supervisor, their supervisor excluded them from meetings relevant to their work and removed their access to a key database.

[12] Relatedly, some MMB policies require supervisors to submit certain complaints to HR. Minnesota Management and Budget, HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 4; and HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 5.

[13] In a few cases, the division uncovered an issue through other HR duties or it was not clear how the concern came to the division's attention. We use "receive" to describe all complaints, regardless of their source.

[14] We categorized complaints based on the contents of the division's complaint and investigation files. Some complaints involved more than one type of issue. This list is not comprehensive and includes common complaint categories.

Intake

Intake

The steps an investigator takes to gather information about complaint allegation(s) to determine whether an investigation is warranted.

After receiving a complaint, HR assigns the complaint to an investigator who conducts intake, or collects information from the complainant to understand the allegation(s). This usually includes meeting with the complainant, and it may also include reviewing documents or other evidence.

The HR division concludes intake by determining whether an investigation into the complaint allegation(s) is warranted. According to HR division leadership, in some situations, an investigation may not be the most appropriate response to a complaint. When an investigation is not appropriate, the division may close the complaint and provide mediation, assign training, or take no further action; alternatively, the subject's supervisor may provide coaching or other performance management steps. MMB's investigator training series provides guidance on the conditions that warrant or might not warrant an investigation, which Exhibit 1.3 shows.

Exhibit 1.3

MMB Guidance on When to Investigate

Investigation Warranted	Investigation Might Not Be Warranted[a]
When complaint allegation(s) involve one of the following: 1. Discrimination or sexual harassment 2. A significant performance concern that could lead to discipline 3. Misconduct that could lead to discipline 4. A repeated issue or offense 5. Multiple complainants, even if the allegation(s) are not extreme	For complaints in which, for instance: 1. Complaint allegation(s) do not involve a policy violation 2. No discipline would be warranted, even if the allegation(s) were true 3. The subject is no longer employed at the agency

[a] This list includes only some of the instances when an investigation might not be warranted.

Source: Office of the Legislative Auditor, based on MMB Investigator Training Series.

Investigation

Investigation

The process through which HR determines (1) the facts of a complaint allegation and (2) whether the allegation of wrongdoing is substantiated.

If the information gathered during intake indicates that an investigation is warranted, HR opens an investigation. During a typical investigation, the investigator gathers and reviews evidence to determine the facts of the allegation(s). The investigator also conducts interviews with those who may be involved as either the complainant, the complaint subject, or a witness to the alleged wrongdoing. The investigator summarizes their fact-finding activities and conclusions in an investigation report, including whether the evidence substantiated the allegation(s).

In fiscal years 2023 and 2024, the HR division investigated 38 complaints through 26 investigations; as of the end of Fiscal Year 2024, 6 of these investigations were still in progress.[15] The HR division substantiated complaint allegations in most of the investigations it concluded in fiscal years 2023 and 2024, as Exhibit 1.4 shows.

Exhibit 1.4

Outcomes of MDH HR Investigations, Fiscal Years 2023 and 2024

Outcome	Number
Substantiated	15
Partially substantiated	3
Not substantiated	2

Source: Office of the Legislative Auditor, based on MDH HR division complaint files, fiscal years 2023-2024.

Discipline

The investigator does not determine disciplinary actions; instead, a third-party decision maker (usually the subject's supervisor or another upper-level manager in the subject's division) decides what discipline is appropriate.[16] The primary investigator and a backup investigator meet with the decision maker to review the HR division's investigation report and, if HR substantiated at least one allegation through its investigation, discuss discipline options. During this meeting, the decision maker may ask the primary investigator questions about the investigation. The primary investigator then leaves the meeting. To maintain neutrality, the primary investigator is not involved in determining discipline. Instead, to encourage consistency across disciplinary decisions, a backup investigator provides the decision maker with information about disciplinary actions taken in similar situations. Using this information, the decision maker determines the nature of the discipline.

[15] Most complaints involved the concern of one complainant about one subject. However, one complainant could raise concerns about multiple subjects, or multiple complainants could raise concerns about the same subject. Therefore, the HR division may conduct one investigation into multiple related complaints, resulting in different numbers of investigations and complaints investigated. In addition to the complaints HR investigated, it did not investigate 31 complaints. For the remaining 13 complaints, either HR's documentation was unclear about the complaint outcome (10) or the complainant submitted their concern in the final week of our review period (3), leaving little time for HR to have either opened an investigation or closed intake.

[16] The agency may administer discipline only within the parameters of the subject's labor contract. Individual labor contracts specify allowable disciplinary actions.

Exhibit 1.5
MDH HR Disciplinary Decisions, from Least to Most Severe, Fiscal Years 2023 and 2024

Discipline	Number
Oral reprimand	3
Written reprimand	8
Suspension	2
Discharge	4

Note: In one investigation, the subject received coaching rather than discipline.

Source: Office of the Legislative Auditor, based on MDH HR division complaint files, fiscal years 2023-2024.

Among the 18 investigations the HR division concluded in fiscal years 2023 and 2024 and substantiated, in whole or in part, the most common disciplinary result was a written reprimand. Exhibit 1.5 lists the discipline that subjects of complaints with substantiated allegations received.

If the investigation subject and their union believe that a disciplinary action violates provisions of the employee's labor contract, the union sends a formal letter "grieving" the disciplinary decision.[17] When the HR division receives a grievance notice, it meets with relevant MDH management and the union to review the issue. Generally, MDH determines whether to modify the disciplinary decision or deny the grievance. If MDH denies the grievance, the union may take additional steps, including subsequent grievances or arbitration.

[17] A small percentage of MDH employees are not covered by a union and may have different appeal processes. The HR division received three grievances questioning some element of the discipline an employee received after an investigation that began and concluded in fiscal years 2023 or 2024. Grievances were outside the scope of our evaluation.

OLA

Chapter 2: Complaint Submission and Management

Providing employees avenues to submit complaints—and developing procedures to manage these complaints appropriately and effectively—is an important employer duty. If not appropriately addressed, complaints may lead to legal consequences. Unresolved complaints may also have a negative impact on employee satisfaction and organizational performance.

In this chapter, we discuss how Minnesota Department of Health (MDH) employees view Human Resources Management Division (HR division or HR) complaint management practices and the complaint submission process. We also discuss our evaluation of the fairness and thoroughness of the division's complaint management practices.

Key Findings in This Chapter

- A majority of MDH employees indicated they knew how to submit a complaint, but some expressed reluctance to do so.
- MDH's HR division does not have written procedures for complaint management.
- We could not determine whether HR consistently managed complaints.
- HR notified complaint *subjects* when it closed investigations, but it inconsistently notified *complainants* of both intake closure and investigation closure.

To learn about MDH employees' perceptions, we surveyed all MDH employees as of June 2024.[1] We also surveyed a selection of former employees who left MDH in recent years.[2] We reviewed the division's files to determine how consistently investigators followed certain best practices in their management of the complaints that the division received during fiscal years 2023 and 2024.[3]

[1] Of the 2,007 employees who received our survey, 79 percent (1,578) responded. Survey respondents included 300 employees who identified themselves as managers or supervisors, and 1,278 nonsupervisory employees.

[2] Of the 58 former employees who received our survey, 76 percent (44) responded and reported leaving the department in 2022 or later. We used a nonrepresentative sample consisting of former MDH employees who still worked for the state, as well as a small number of former employees who contacted our office about this evaluation.

[3] We reviewed files for all 82 complaints HR received, as well as their associated investigation files. MDH has limited documentation of complaints that occurred before HR division management changed in the spring of 2022.

Perceptions of HR Division Complaint Management

Perceptions of HR's complaint management can impact employee trust in the division and willingness to submit complaints or participate in investigations. Although Minnesota Management and Budget's (MMB's) investigator training series outlines general guidance for HR investigators about how to manage complaints in a timely, fair, and thorough manner, as shown to the right, MDH employees may reach their own conclusions about the division's complaint management.

Although MDH employees, union representatives, and HR investigators generally shared positive perceptions of the HR division's complaint management, some expressed less confidence in how the division manages certain steps.

Timeliness: MMB does not establish requirements, but its guidance states that investigators should not delay the start of an investigation.

Fairness: MMB instructs investigators to, among other things, remain neutral about complaint allegations, inform investigation participants of their rights and protections, allow all participants to share their perspectives, and excuse themselves from disciplinary decisions.

Thoroughness: MMB guidance directs investigators to consider all evidence, including the testimony of all relevant witnesses, before reaching conclusions.

— MMB, Investigator Training Series

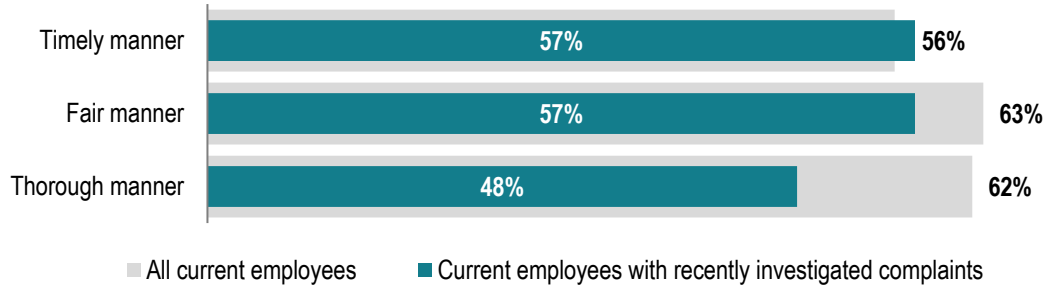
Current Employees. Current MDH employees tended to have positive perceptions of the HR division's review, or **intake**, of complaints. Among the 1,477 current employees who responded to our survey and had not filed a complaint with HR, 75 percent agreed or strongly agreed that, were they to submit a complaint to HR, the division would review their complaint allegations and appropriately determine whether to investigate. Among the 53 current employees who had submitted a complaint to HR, those who indicated at least one of their complaints resulted in an investigation reported more favorable views of HR's intake process than those who indicated their complaints did not or may not have resulted in an investigation.[4]

When asked about HR's **investigation** process, current employees' perceptions tended to be less favorable than their perceptions of the intake process. As Exhibit 2.1 shows, around one-half to nearly two-thirds of current MDH employees who responded to our survey agreed or strongly agreed that the HR division had investigated or would investigate their complaint allegations in a timely, fair, or thorough manner. However, the handful of current employees with complaint investigation experience were less likely to agree that HR's investigation process was fair or thorough as compared to all current employees.

[4] Throughout this chapter, our discussion of current employees with experience submitting complaints or whose complaints HR investigated is limited to employees with complaint experiences exclusively in or since 2022. In other words, when discussing complaint experiences, we generally did not include the perspectives of current employees who submitted complaints under HR's previous leadership.

Exhibit 2.1

Percentage of Current MDH Employees Who Agreed or Strongly Agreed That the HR Division Investigated/Would Investigate Complaint Allegations in a:



Notes: "All current employees" includes responses from roughly 1,572 employees. "Current employees with recently investigated complaints" includes responses from 21 current MDH employees who said they had submitted complaints to the HR division that resulted in investigations.

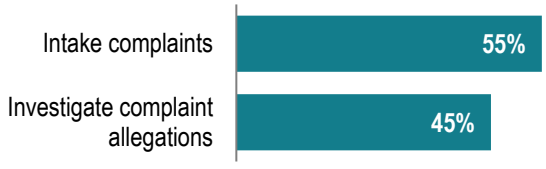
Source: Office of the Legislative Auditor, based on our survey of current MDH employees, 2024.

In response to our survey questions, some employees shared positive comments about the HR division's complaint management, while others expressed frustration. For example, when asked what the HR division does well, some employees said the HR investigators withheld judgement when listening to them, asked for additional evidence, or provided timely responses. Some employees, however, expressed that the division could reduce the lengthiness of some processes, shared concerns about whether the division managed issues in a fair and objective manner, or said the division could communicate better.[5]

> They were quick to respond and compassionate while listening.
>
> I answered "unsure" to many of the questions because all I know is that I made a complaint, it was shared with labor relations staff, it took several weeks for them to investigate, I was never asked for additional information and no one was asked to provide information as a witness, and then I was simply told they were done.
>
> **— Current MDH Employees**

Exhibit 2.2

Former MDH Employees Who Agreed or Strongly Agreed with the Statement: "While at MDH, I had confidence in HR to…"



Source: Office of the Legislative Auditor, based on our survey of former MDH employees, 2024.

Former Employees. As shown in Exhibit 2.2, a greater portion of former MDH employees who responded to our survey reported having confidence in HR to **intake** complaints than to **investigate** allegations. A few former employees expressed a perceived lack of transparency about whether HR had investigated complaint allegations, which could explain this decrease in confidence. On the other hand, a few former employees reported that HR was professional in its complaint management and provided timely responses.

[5] State law places some limits on the information investigators can share about complaints and complaint management. *Minnesota Statutes* 2024, 13.43, subds. 2, 4, and 8.

Unions. We corresponded with representatives from three unions that together represent nearly 80 percent of MDH employees, none of whom shared negative perceptions of HR. When asked how MDH's HR division compared to similar divisions at other agencies, one union representative shared that they thought the HR division was performing similarly to or better than others. This representative also expressed that, based on interactions with the HR division, they generally thought the division addressed complaints in a fair and thorough manner. A representative from the second union shared that those in the union were not aware of "any widespread issues" with the HR division. A representative from the third union shared that union staff and members had not had "any negative experiences" with the HR division.

HR Investigators. MDH's HR investigators spoke positively about the HR division's processes. All four investigators told us they generally believed the division's processes were fair and thorough. Some investigators commented that they thought the division's processes were consistent with MMB standards. Additionally, investigators emphasized that the division's processes were unbiased and included checks and balances, such as collaborating during complaint intake, reviewing each other's investigation efforts, and using separate investigators to present an investigation's findings and potential discipline options to decision makers (per MMB guidance). Furthermore, each investigator told us they felt adequately trained in division processes.

Complaint Submission

As mentioned in Chapter 1, complainants can use different avenues to submit complaints to HR. For example, complainants may contact HR division staff through e-mail, HR's online form, or a scheduled meeting. Employees may also submit complaints to other MDH staff, such as their supervisor, who should then direct the complaints to HR.

Employee Understanding of the Submission Process

The first step to effectively managing complaints is to ensure that employees know how to submit them. If employees do not understand how to submit complaints, the HR division may not be aware of their concerns and thus unable to address them.

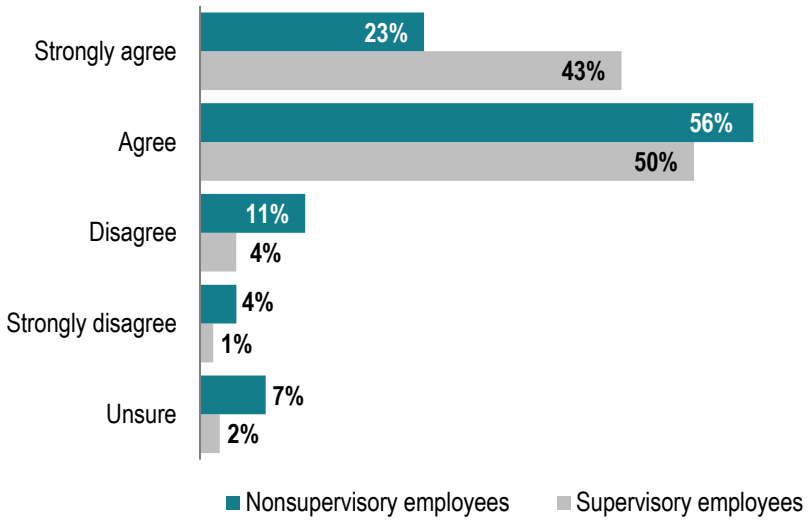
MDH and MMB provide training and information to MDH employees about how to submit complaints. The HR division publishes monthly newsletters and other online resources that are available to all MDH employees. Our review of these resources from February 2023 to August 2024 showed that the division frequently provided information about how and where to submit complaints. For example, the division typically included in its newsletter a link to its online complaint form. Additionally, according to HR investigators, they share information about complaint management processes at division meetings and monthly trainings for MDH supervisors. Furthermore, as discussed in Chapter 1, state employees are required to annually complete training about certain state policies; these training sessions routinely remind employees that they can report concerns to HR.

The large majority of MDH employees who responded to our survey indicated that they knew how to submit a complaint, but some expressed reluctance to do so.

Of the current MDH employees who responded to our survey (1,578), more than 80 percent (1,284) agreed or strongly agreed that they knew how to submit a complaint about a personnel issue. However, compared to supervisory employees, nonsupervisory employees were somewhat more likely to indicate uncertainty about how to submit a complaint, as shown in Exhibit 2.3.

Exhibit 2.3

Survey Question: I know how to report a complaint about a personnel issue.



Source: Office of the Legislative Auditor, based on our survey of current MDH employees, 2024.

Of the 1,578 survey respondents, 144 said they considered but did not submit at least one complaint about an incident that happened in or since 2022. The reasons they cited for not submitting their complaints included:

> [I did not submit a complaint because I d]id not think anything would happen, was worried about retaliation.
>
> I didn't feel that I personally had enough proof and I was aware that at least one other person made a complaint, so I figure that would take care of it.
>
> **— Current MDH Employees**

- Fear, including of retaliation.
- The perception that submitting the complaint was not worthwhile or nothing would happen.
- The sense that submitting it was unnecessary because others had already complained.
- Apprehension about reporting issues that involved their supervisors or other upper-level managers.
- A preference to wait until they had more documentation.
- A preference not to involve others.

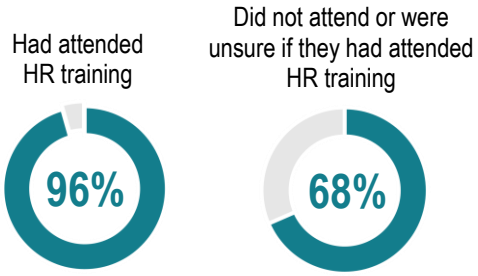
Supervisor Understanding of the Submission Referral Process

MMB requires supervisors to refer certain complaints to HR.[6] Further, it is important that supervisors know when to refer employee complaints to HR because supervisors appear to be common recipients of complaints. Of the current MDH employees who responded to our survey and said they had submitted a complaint (in or since 2022) to someone other than the HR division, 70 percent (33) said they submitted their complaint to their supervisor.[7] Some respondents explained that they submitted their complaint first to their supervisor because they were following what they believed was the appropriate reporting path. If supervisors are uncertain about when to refer or do not refer complaints to HR, employee complaints may not reach the division as expected.

Based on survey responses, training seems to be an important factor in supervisors' understanding of when to refer complaints to HR.

Exhibit 2.4

Percentage of Supervisors who Agreed or Strongly Agreed That They Knew When to Refer Employee Complaints to HR



Note: In response to our survey, 205 supervisors reported having attended an HR training; 92 reported they had not.

Source: Office of the Legislative Auditor, based on our survey of current MDH employees, 2024.

Overall, 87 percent (260) of MDH supervisors reported knowing when to refer employee complaints to HR, and optional HR training sessions appear to be a common source of this knowledge. Of the 205 supervisors who indicated they had attended an optional HR training, almost all said they knew when to refer a complaint to the HR division, as Exhibit 2.4 shows.[8] Of the supervisors who reported uncertainty about when to refer complaints, the majority (29 of 38) had not attended or were unsure whether they had attended an HR training.

RECOMMENDATION

MDH should require all MDH supervisors to attend periodic training about when to refer employee complaints.

Although MMB's required annual training includes information about complaint submission, additional HR training may improve supervisors' understanding of when to refer employee complaints. To help reduce gaps in knowledge among supervisors, MDH should consider requiring supervisors to attend HR training as part of the onboarding or promotion process.

[6] Minnesota Management and Budget, HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 4; and HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 5.

[7] A total of 47 respondents said that they had submitted at least one complaint to someone other than the HR division, either instead of or in addition to submitting the complaint to HR.

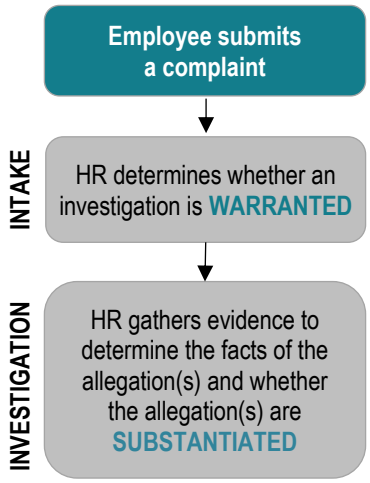
[8] We were unable to verify the extent to which supervisors and others at MDH have or have not forwarded complaints to the HR division.

While the HR division already offers training to supervisors, attendance is optional. Requiring attendance at training sessions would help ensure that supervisors understand the complaint process, even if they use it infrequently. The required training would also provide supervisors the opportunity to meet, ask questions, and establish relationships with HR employees. These interactions may increase the willingness of supervisors to approach HR with questions and direct others to the division, as appropriate.

> …conflict resolution between employees might be the most challenging part of supervising, and even though I really enjoyed and learned a lot from [state supervisor training], I think additional trainings in the areas that are both frequent and challenging would be helpful.
>
> **— Current MDH Employee**

Complaint Management

Exhibit 2.5
MDH HR Complaint Management Processes



For a typical complaint, the HR division's two main activities, which we broadly refer to as "complaint management" and show in Exhibit 2.5, are intake and investigation. During the *intake* process, HR determines whether a complaint's allegation(s) warrant an investigation. If HR determines it is warranted, the division opens an *investigation* to determine whether to substantiate the alleged wrongdoing.

The HR division does not have written procedures to help ensure consistency in complaint management.

Rather than develop their own procedures to manage complaints, the investigations manager told us the division generally uses MMB policies and its investigator training series. However, MMB's training series provides minimal guidance on complaint intake. Further, some MMB policies require state agency HR divisions to develop their own procedures.[9]

Currently, the HR division decides how to manage complaints during conversations between investigators and their manager. HR investigators told us their manager guides their complaint management decisions, such as determining whether to open an investigation or collect additional information.

Without written procedures, the HR division risks managing complaints inconsistently. Some HR investigators described their efforts as collaborative and shared that they use each other as resources when managing complaints. Each investigator told us that new investigators start by shadowing more experienced investigators. One investigator also said that she and her colleagues review each other's investigation reports. While it may be true that investigators learn from each other, they may inadvertently transmit bad habits or forget or misremember unwritten processes. For example, the investigations

[9] Minnesota Management and Budget, HR/LR Policy 1444, *Workplace Violence Prohibited*, revised March 4, 2021, 5; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 5; and HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 7.

manager told us that when they compiled investigation files for our review, they discovered that investigators were not consistently using certain complaint acknowledgement and closure templates.

Written procedures could also help mitigate risks associated with employee turnover. The investigations manager is the primary resource for investigators and the primary decision maker for how to manage complaints. If this manager were to leave MDH, they would take with them the experience, knowledge, and judgment that is currently critical to the HR division's complaint management decisions. Written procedures could help ensure that investigators manage complaints fairly and thoroughly regardless of leadership changes.

Finally, the HR division's lack of written complaint management procedures makes it difficult for HR to demonstrate that it manages complaints fairly and thoroughly. In our review of the division's complaint files, we frequently found that investigators did not clearly or consistently document certain complaint management activities, such as how they made complaint decisions and whether they communicated with complainants. In the remainder of this section, we discuss how the HR division's lack of written procedures contributes to issues in three areas of complaint management: rights and protections for investigation participants, complaint management decisions, and status notifications. We conclude by recommending HR adopt procedures to address these issues.

Rights and Protections

Employees who participate in the HR division's complaint intake and investigations are entitled to certain rights and protections. According to state law, when someone is asked to provide certain information about themselves to the state, they must be informed how that information will be used, whether they are required to provide the information and the consequences for doing or not doing so, and who else may access the information.[10] Additionally, state law and policies protect employees who submit complaints or participate in the division's complaint intake or investigations from retaliation.[11] Finally, the labor contracts that apply to most MDH employees entitle the subject of an investigation to union representation and the right to be informed of allegation(s) against them.[12]

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[10] *Minnesota Statutes* 2024, 13.04, subd. 2. This is known as a Tennessen warning, or more informally, a data practices notice.

[11] *Minnesota Statutes* 2024, 181.932. Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023, 2; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 5; HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 6; and HR/LR Policy 1444, *Workplace Violence Prohibited*, issued March 4, 2021, 5. We defined retaliation in Chapter 1 and discuss it in further detail in Chapter 3.

[12] Minnesota Management and Budget, *Agreement Between Minnesota State Employees Union, AFSCME, Council No. 5, AFL-CIO and the State of Minnesota, July 1, 2023 through June 30, 2025*, art. 16, sec. 2; *Agreement between the State of Minnesota and the Middle Management Association, July 1, 2023 through June 30, 2025*, art. 6, sec. 4; *Unit 14: General Professional Labor Agreement between the State of Minnesota and the Minnesota Association of Professional Employees, July 1, 2023 through June 30, 2025*, art. 8, sec. 2; and *Agreement between the State of Minnesota and the Minnesota Nurses Association, July 1, 2023 through June 30, 2025*, art. 15, sec. 2, A. These unions represent about 90 percent of MDH employees.

Delivery of Data Practices and Antiretaliation Notices

While investigators routinely documented delivery of required data practices and antiretaliation notices during *investigation* interviews, they did not document delivery of these notices during *complaint intake.*

During Complaint Intake

While the HR investigations manager told us investigators verbally provided complainants with required notices of their rights and protections during intake, the manager shared that they did not *document* these verbal deliveries. Because state law requires those who provide certain information about themselves to be informed of how the information will be used, HR investigators must provide data practices notices before beginning intake conversations.[13] Similarly, state law and MMB policy prohibit retaliation, and MMB guidance directs HR to inform complainants of this right.[14] In our review of the 82 complaints submitted in fiscal years 2023 and 2024, we did not find documentation that the HR division delivered data practices and antiretaliation notices during complaint intake.

The HR division lacks written procedures guiding the delivery of data practices and antiretaliation notices, and only within our evaluation period did the HR division establish the expectation that investigators use a template e-mail for intake. The written template, which investigators are expected to use to schedule intake conversations, includes data practices and antiretaliation notices.

If investigators do not consistently inform complainants of their rights and protections, some complainants may be reluctant to bring forward complaints or participate in investigations. For example, the investigations manager told us that many complainants expressed concerns about retaliation as part of filing a complaint. If those with information about an alleged issue withhold information or do not come forward, there is a risk that the HR division may not become aware of or have the information it needs to determine when to investigate complaints.

During Investigations

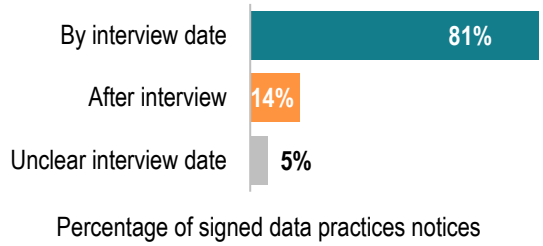
According to our review of the 20 investigations that the HR division opened and closed in fiscal years 2023 and 2024, the division documented delivering data practices and antiretaliation notices for the vast majority of these investigations' 74 interviews. For 81 percent (60 of 74) of these investigation interviews, interviewees signed and dated **data practices notices** on or before the date of the interview, as Exhibit 2.6 shows. In the remaining 14 cases, the participant either signed the data practices notice *after* the interview, or the interview date was unclear, preventing us from evaluating the

[13] *Minnesota Statutes* 2024, 13.04, subd. 2; and 13.43, subds. 2, 4, and 8.

[14] *Minnesota Statutes* 2024, 181.932. Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023, 2; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 5; HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 6; and HR/LR Policy 1444, *Workplace Violence Prohibited*, issued March 4, 2021, 5.

Exhibit 2.6

Most investigation interviewees signed a data practices notice by the interview date.



Note: The HR division conducted 74 investigation interviews over 20 investigations.

Source: Office of the Legislative Auditor, based on MDH HR division investigation files, fiscal years 2023-2024.

timing of the delivery of the data practices notice. The HR division documented providing interview participants with an **antiretaliation notice** in 93 percent (69 of 74) of investigation interviews.[15]

The HR division's relatively consistent delivery of data practices and antiretaliation notices during investigations may be related to the division's use of investigation templates that include these notices. The division has template scripts and notices—including for data practices and antiretaliation—for its investigators to use during investigation interviews with various types of participants, and the investigations manager told us that investigators use these consistently.

Employee Understanding of Required Notices

Inconsistent delivery of data practices and antiretaliation information could influence employees' understanding of important rights and protections. Among our survey respondents, 106 reported that they had met with HR investigators as a complainant, subject, or witness, in or since 2022. Although the majority of them reported understanding their rights and protections related to confidentiality or antiretaliation, about one-third of these employees said they either did not understand these elements in some or all instances or were unsure if they had understood. Furthermore, three-quarters (79) of these survey respondents said they did not recall the division providing them with a written or oral antiretaliation notice.

Subjects' Rights

Investigation subjects also tend to be entitled to certain rights during an investigation. To ensure that subjects understand why they are involved in an investigation, labor contracts generally require—and MMB training instructs—investigators to inform subjects of the allegation(s) against them.[16] Most labor contracts that cover MDH employees and MMB policy require investigators to also provide union-represented

[15] Unlike data practices notices, antiretaliation notices did not appear in each investigation file as a signed document. Rather, the investigation reports tended to include either a blanket statement that antiretaliation notices had been provided to each interviewee or a statement to that effect at the beginning of each individual interview summary. The only investigation reports in which the HR division did not document delivering antiretaliation notices were those investigations into speeding, which the division documents in a condensed investigation report. The investigations manager told us that investigators would still have provided antiretaliation information per their template and script, even though the condensed reports omitted mention of the investigators delivering these notices.

[16] Minnesota Management and Budget, AFSCME agreement, art. 16, sec. 2; and Middle Management Association agreement, art. 6, sec. 4.

investigation subjects the opportunity for a union representative to attend the subject's investigation interview.[17] A subject may waive this right in writing before an interview.[18]

The HR division informed investigation subjects of specific legal rights.

In our review of the investigations the HR division conducted in fiscal years 2023 and 2024, the division adhered to requirements to inform subjects of certain rights during investigations. The division allowed all eligible subjects to have union representation during investigation interviews. In the instances when a subject waived their right to union representation, the division's files supported that it received the subject's signed waiver. Additionally, HR's investigation reports documented that investigators provided subjects with information regarding the investigation topic or allegation(s) against them and allowed the subjects the opportunity to explain themselves.

Complaint Management Decisions

When managing complaints, HR investigators collect information to make decisions about alleged wrongdoing. For example, during intake, investigators gather information to decide whether to open an investigation. During an investigation, investigators decide whom to interview and what evidence to collect, so they can determine whether the complaint allegation(s) should be substantiated.

In its training series, MMB instructs HR investigators to consider all evidence before reaching conclusions. MMB's training also recommends investigators document their decision making and complaint management actions, such as in investigation reports. Such documentation can demonstrate that HR's complaint management is thorough and consistent regardless of investigator, complainant, and complaint type.

While the HR division's investigation reports were generally clear, concise, and objective, HR's general lack of procedures and limited documentation made it difficult to assess how the division reached various complaint management decisions. The division's investigation reports were generally consistent with MMB's investigation report template. The reports also demonstrated analysis of relevant evidence to support the investigators' determinations about alleged wrongdoing and did not include instances of investigators opining on allegations. While the reports themselves were generally appropriate, it was difficult to assess other aspects of the division's complaint management.

[17] Minnesota Management and Budget, AFSCME agreement, art. 16, sec. 2; Middle Management Association agreement, art. 6, sec. 4; Minnesota Association of Professional Employees agreement, art. 8, sec. 2; Minnesota Nurses Association agreement, art. 15, sec. 2; and HR/LR Policy 1376, *Right to Representation (Weingarten Rights)*, revised December 1, 2014.

[18] Minnesota Management and Budget, AFSCME agreement, art. 16, sec. 2; Middle Management Association agreement, art. 6, sec. 4; Minnesota Association of Professional Employees agreement, art. 8, sec. 2; and Minnesota Nurses Association agreement, art. 15, sec. 2, A.

We could not determine whether the HR division took consistent approaches when deciding how to manage complaints.

As discussed, HR does not have written procedures that guide investigators' complaint management activities or decision making. Instead, the investigations manager directs complaint management decisions. In the complaint files we reviewed, the HR division did not document their rationale for these decisions.

Opening investigations. Investigators did not clearly document the evidence they reviewed or factors they considered when deciding whether to open an investigation. Based on our review, HR opened investigations into slightly less than one-half of the complaints it received during fiscal years 2023 and 2024. In a few instances, we questioned why investigators did not pursue additional information during the intake process or open investigations. For example, in at least two instances there was little evidence that investigators continued intake or investigated allegations after the complainants left MDH. We question these decisions, as it does not seem reasonable to conclude that the issues stopped merely because the complainants left the department, especially when complainants named others, still employed, as witnesses or subjects.

Pursuing additional evidence. As part of MMB's guidance to consider all evidence before reaching conclusions, MMB instructs investigators to ask every investigation participant if they know of additional evidence or witnesses. Doing so gives complainants, subjects, and witnesses the opportunity to share relevant information, which investigators are to consider before reaching a decision about whether to substantiate an allegation.

Investigators did not appear to ask interviewees if they knew of others with relevant information in

59%

of investigation interviews.

While one of the HR division's investigation scripts includes questions about additional witnesses and evidence, it was unclear from the investigation files the extent to which investigators used these scripts. In more than one-half of investigation interviews (44 of 74), investigators' documentation did not indicate whether they asked the interviewees about others with information.[19] In instances when the investigators asked about and documented that the interviewees named other witnesses, investigators interviewed all additional witnesses named in 59 percent of the investigation interviews (10 of 17).[20] Although investigators may have been justified in not interviewing certain named witnesses, investigators did not document their rationale for these decisions, which is inconsistent with MMB's direction to document decision making.

[19] Occasionally, interviewees incidentally, rather than in response to an investigator's questioning, named others with relevant information. However, per MMB guidance, investigators should explicitly ask interview participants about other information or witnesses.

[20] We did not include instances where the description of a witness was not detailed enough for us to determine whether the investigator had interviewed the additional witness.

Status Notifications

Status notifications help MDH employees who submit a complaint or are involved in an investigation understand the status of the complaint. Because state law generally protects complaint data, investigators are limited in the information they can share.[21] However, the HR division may notify a complainant that investigators have received and reviewed their complaint. The division may also notify a complainant or an investigation subject when it concludes an investigation.

Complaint Receipt Acknowledgement

MMB's Respectful Workplace policy encourages state agency HR divisions to, "as a matter of best practice," acknowledge receipt of a complaint related to the policy.[22] This policy encourages HR divisions to include in their acknowledgement (1) the date the complaint was submitted; (2) information related to the division's authority to determine whether to investigate; (3) a statement that if an investigation is warranted, HR will conduct it in a timely, fair, and objective manner; and (4) a statement about data practices.

A complaint receipt acknowledgement can assure a complainant that the division has received and will review their complaint. An acknowledgement can also help a complainant understand what will happen with their complaint, including the communication a complainant should or should not expect from the division.

Based on our file review, investigators did not consistently document having acknowledged complaint receipt.

For fiscal years 2023 and 2024, investigators did not document having acknowledged 20 percent (14 of 69) of complaints.[23] While the HR division recently implemented use of a template to schedule intake conversations, the template does not provide information regarding the division's complaint management processes. Regardless, even in cases when investigators acknowledged complaints, we did not find evidence that investigators routinely used this template.

Of the 53 current MDH employees who responded to our survey and indicated they had submitted a complaint to HR in or since 2022, some reported that they had not heard from the division regarding the status of their complaint. About one-third (17) of these respondents said they were unsure whether the HR division investigated their complaint. Of those who were unsure, slightly more than half commented about the division's lack of follow up.

[21] *Minnesota Statutes* 2024, 13.43, subds. 2, 4, and 8.

[22] Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023, 4.

[23] While the HR division received 82 complaints in fiscal years 2023 and 2024, we excluded from this analysis complaints for which a response was either not possible or unnecessary, such as complaints submitted anonymously or speeding violations reported through state vehicle monitoring. We considered a complaint acknowledged if the division e-mailed with the complainant or retained notes from a conversation with the complainant.

Some current MDH employees' open-ended survey responses mentioned ways the division could improve its communication with complainants. Many respondents suggested the HR division should acknowledge receiving complaints. Respondents suggested the division explain its processes and what complainants can expect to happen after submitting a complaint.

Without an acknowledgement of complaint receipt from the HR division, complainants may be unsure whether the division received and is taking efforts to understand or address their concerns. Such uncertainty may undermine employees' confidence in the division to manage complaints fairly and thoroughly and may reduce employees' inclination to report issues to the division.

> I [feel] a little worthless when they haven't even acknowledged I sent in a complaint. Hopefully I did it the correct way.
>
> ANY kind of communication to reassure people that their concerns have been heard, are being weighed, and that HR is considering all possible responses/steps they need to take would be helpful.
>
> **— Current MDH Employees**

Intake and Investigation Closure

MMB's investigator training series establishes the expectation that investigators notify both the subject and complainant when they close an investigation.[24] MMB also provides a closure notice template that investigators may use.

For certain types of complaints, state law requires a similar *intake* closure notification when HR conducts intake and decides an investigation is not warranted.[25] Such a notice can confirm for complainants that the HR division took their concerns seriously and may help complainants decide if they want to pursue other avenues for their complaints.

The HR division notified *subjects* when it closed investigations, but it inconsistently notified *complainants* of both intake closure and investigation closure.

Intake status. Although the HR division adopted a complaint closure notice template in 2022, the division inconsistently used it. Among the 24 complaints the division received in fiscal years 2023 and 2024 and decided *not* to investigate, investigators communicated about intake closure with 46 percent (11 of 24) of complainants.[26] In three of these instances, the investigator sent a closure notice only after the complainant followed up to request a status update.

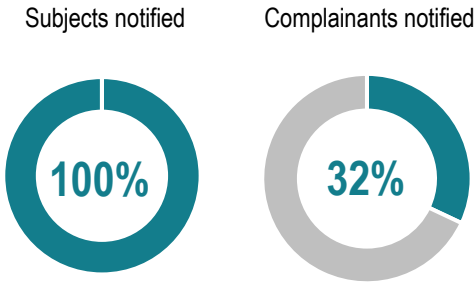
[24] Some labor contracts also require agencies to notify investigation subjects of investigation closure. Minnesota Management and Budget, AFSCME agreement, art. 16, sec. 3; Middle Management Association agreement, art. 6, sec. 4; and Minnesota Nurses Association agreement, art. 15, sec. 2, A.

[25] *Minnesota Rules*, 3905.0500, https://www.revisor.mn.gov/rules/pdf/3905/, accessed April 18, 2024.

[26] HR either coached or advised 2 of these 11 complainants as a means of closing their complaint. We excluded from this analysis 7 complaints for which HR could not have responded because either the complainant was anonymous or had left MDH.

Exhibit 2.7

While the MDH HR division notified all *subjects* of investigations closure, it rarely notified *complainants*.



Note: The HR division conducted 20 investigations involving 22 complainants whom the division could have reasonably notified of investigation closure.

Source: Office of the Legislative Auditor, based on MDH HR division investigation files, fiscal years 2023-2024.

Investigation status. The HR division more consistently provided investigation closure notices to subjects than complainants, as Exhibit 2.7 shows. For the 20 investigations HR completed in fiscal years 2023 and 2024, the division notified each investigation subject through either (1) a notice describing the discipline or coaching for the subject as a result of a substantiated investigation, or (2) an investigation closure notice in the cases when the division did not substantiate any of the allegations.[27] In contrast, the division notified only 7 of the 22 complainants of investigation closure.[28]

The inconsistency with which the HR division delivers status updates to complainants may be a result of its lack of written procedures to guide investigators' processes. Currently, the division has no procedures for when to acknowledge complaint receipt or notify a complainant that it has closed an intake or investigation. Additionally, the division does not formally track any of these communications.

If the HR division does not notify complainants of key status updates, complainants may be unsure whether their concerns have been addressed or if they should pursue other options to resolve their issues. It may also reduce trust in the division. Although law limits the details the division can share about complaints, status updates are allowed.[29] A general notification about closure may alleviate uncertainty, assure complainants that the HR division reviewed their concerns, and, if their concerns persist, allow them to pursue additional support or action elsewhere.

> I received a phone call from an HR representative…. However, I have heard nothing from HR since then. As a result, I am unsure of how they handled it and whether or not anything is being done.
>
> I am not sure the reported complaint was addressed…. I was told basically I would not find out if there was any investigation as it is protected info. This leaves me with a lot of mistrust.
>
> **— Current MDH Employees**

[27] As we mentioned in Chapter 1, it is possible for a complainant to raise issues about multiple subjects. For this analysis, one of the investigations included multiple subjects, but HR provided the investigation closure notice only to the primary subject of the investigation. The discipline notice is administered by the disciplinary decision maker in consultation with HR.

[28] We excluded from this analysis seven complainants for whom a response was either not possible or unnecessary, such as speeding violations reported through state vehicle monitoring. The number of complainants does not match the number of investigations because some investigations involved more than one complainant. In only two cases did HR notify the complainant independently; in the remaining five, the complainant was included on the subject's discipline notice because the complainant was the subject's supervisor or another upper-level manager in the subject's division.

[29] *Minnesota Statutes* 2024, 13.43, subd. 2, classifies the status of a complaint as public information. However, details of the investigation outcomes and discipline decisions remain not public until the disciplinary action's final disposition.

Recommendations

As we have discussed, the HR division's lack of written procedures poses risks to the division's complaint management, especially by making it difficult to demonstrate that investigators act fairly and thoroughly. Without documented expectations, investigators may inconsistently provide complainants and subjects information about their rights and protections. Investigators may also consider different information when deciding whether to open an investigation or interview certain witnesses, which may result in inconsistency across investigators, complaints, and complainants. Furthermore, investigators' communication with complainants and subjects about the status of their complaints or investigations may vary. Such discrepancies can ultimately influence MDH employees' perception of the division and their willingness to share concerns with HR.

RECOMMENDATION

The HR division should establish complaint management procedures that require investigators to:

- **Issue, and document the issuance of, verbal and written data practices and antiretaliation notices during intake conversations and investigation interviews.**
- **Consider certain factors when deciding whether to (1) investigate complaint allegation(s) and (2) interview people identified as having relevant information, and document these decisions.**
- **Notify each complainant when they receive and close a complaint and at any other determined points, and document when they issue such acknowledgment(s).**

We recommend the HR division establish written procedures to guide investigators' complaint management. Such procedures would help ensure the division's complaint management is consistent, fair, and thorough. In particular, developing procedures in the following areas could address issues identified in our evaluation.

Rights and Protections. Due to the limited evidence we found that investigators routinely delivered required notices to intake participants, we recommend that the HR division require investigators to consistently use intake and interview scripts and templates that include information about rights and protections. Investigators should consistently document providing these notices. Investigators should also be prepared to discuss and answer questions about these notices to ensure investigation participants understand the information.

We also recommend the HR division create and provide written resources about rights and protections to intake and investigation participants. Investigators could provide a know-your-rights fact sheet during an in-person meeting or send the fact sheet via e-mail before virtual meetings. Participants could refer to this resource if they later have questions or other concerning experiences.

Decision making. Because it was unclear whether the HR division followed consistent processes to decide how to manage complaints, we recommend the division document procedures that identify factors investigators and their manager should consider when deciding whether, for example, to investigate a complaint's allegation(s). We recognize that a complaint's unique circumstances may necessitate different approaches, but procedural guidance would encourage greater consistency across decisions.

Additionally, we recommend the HR division decide the extent to which investigators should be required to document their complaint management decisions. While MMB guidance encourages investigators to document complaint management decisions, the division should decide for itself the level of documentation it requires and develop a procedure that reflects those expectations.

Status Notifications. Because HR inconsistently (1) acknowledged complaint receipt and (2) notified complainants of intake and investigation closure, we recommend the HR division establish a procedure that requires investigators to provide status notifications at predetermined points. The division should require investigators to notify every complainant when the division receives their complaint. Such notifications can preempt complainants' potential questions, ease their worries, and increase trust in the HR division. The procedure should also require investigators to track or document when they provide the acknowledgment.[30] By tracking delivery of complaint receipt acknowledgements, the division can ensure continuity of efforts, especially if the division needs to reassign complaint or investigation duties. This documentation would also allow the division to evaluate the timeliness of its complaint intake.

Complaint Receipt Acknowledgement Components

1. The date the complaint was submitted.
2. Information related to the HR division's authority to determine how it manages complaints.
3. A statement that if an investigation is warranted, HR will conduct it in a timely, fair, and objective manner.
4. A statement about data practices.

— MMB Respectful Workplace Policy

Additionally, we recommend the HR division determine standard elements to include in its complaint receipt acknowledgements and update its template. We believe it is reasonable for the template to include each of the elements outlined in MMB's Respectful Workplace policy.[31] Further, we suggest adding an overview of general expectations for future conversations with and notifications from the division. A description of the division's complaint management processes can improve a complainant's understanding and may reduce follow-up inquiries that the division may not be able to answer due to data protections.

The HR division should determine and establish within this procedure the stages at which investigators must provide status updates to complainants. The division should decide whether it will notify complainants when it closes their complaint without an investigation. If it decides to issue notifications at such a point, it should do so uniformly. The procedure should require, and template notices should include, information specified by union contracts and allowed by statute.[32]

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[30] HR told us it is in the process of implementing a tool that investigators can use to document complaint management information.

[31] Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023. Although MMB explicitly encourages these elements in just one of its human resources and labor relations policies, the elements are widely applicable and would be useful information for all complainants.

[32] *Minnesota Statutes* 2024, 13.43, subd. 2.

OLA

Chapter 3: Retaliation

As described in Chapter 1, retaliation includes adverse actions against an individual because they reported a complaint or participated in an investigation into a complaint allegation. State law and policies prohibit employers or employees from engaging in retaliatory behavior.[1]

Key Findings in This Chapter

- There is little evidence that MDH's HR division consistently followed up on reports of retaliation.
- In their survey responses, some MDH employees indicated that they believed they experienced retaliation as a result of submitting a complaint to HR.

Preventing retaliation is an important employer responsibility. Employers who engage in retaliation may be required to compensate or reinstate employees who lost wages, benefits, or their positions due to retaliation. Additionally, when employees fear or experience retaliation, they may become less likely to speak up about wrongdoing they have witnessed or experienced in the workplace. Without employee reports, human resources divisions may be unaware of and thus unable to address retaliatory behavior, which may reduce employee confidence in human resources. A workplace free from retaliation is more likely to be one in which employees feel safe *and* are held accountable for their actions.

In this chapter, we review the efforts of the Minnesota Department of Health's (MDH's) Human Resources Management Division (HR division or HR) to address retaliation. We then examine employee experiences of perceived retaliation.

Retaliation

Adverse actions taken against an individual because they submitted a complaint, participated in an investigation into a complaint allegation, or opposed behavior that violated law or policy. Adverse actions include discipline, demotion, discharge, exclusion, threats, reprimands, reduced hours, and transfers to less desirable work, among other things.

Adverse actions may also constitute retaliation if these actions might deter someone from reporting a complaint, participating in an investigation, or opposing prohibited behaviors.

Protecting Employees from Retaliation

The Occupational Safety and Health Administration (OSHA) recommends practices to foster workplaces free of retaliation.[2] One practice is for senior leadership to demonstrate their commitment to take retaliation seriously.[3] For example, leadership can do so by ensuring that processes for reporting

[1] *Minnesota Statutes* 2024, 181.932. Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023, 2; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 5; HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 6; and HR/LR Policy 1444, *Workplace Violence Prohibited*, issued March 4, 2021, 5. We focused on retaliation against MDH employees for reporting a complaint to the HR division.

[2] Occupational Safety and Health Administration, *Recommended Practices for Anti-Retaliation Programs*, 2017, 1.

[3] *Ibid.*, 4.

retaliation are implemented and evaluated or by meeting with employees to create and implement antiretaliation policies and procedures.[4] OSHA also recommends that employers clearly define and make accessible the roles and responsibilities of those who may receive or address retaliation reports and investigate reports of retaliation using an established process.[5] OSHA cautions that failure to quickly respond to retaliation reports can discourage employees from raising issues.[6]

As discussed in Chapter 2, MDH's HR division does not have written procedures to guide complaint management. The investigations manager said they train investigators to bring employee complaints or fears of retaliation to the manager to determine next steps.

To evaluate efforts to protect MDH employees from retaliation for submitting complaints, we reviewed HR's response to mentions of retaliation in its fiscal years 2023 and 2024 complaint files.[7]

There is little evidence that the HR division consistently followed up on reports of retaliation.

Based on our review of the division's files, there were few instances in which HR undertook specific efforts to learn about or protect employees from perceived retaliation. According to our review, four complainants reported allegations of retaliation. The files show that HR asked questions about retaliation for only one of these four complaints. When describing their broader concerns, at least 13 other complainants mentioned fears or experiences of retaliation. However, HR seemingly followed up on a complainant's retaliatory concerns for only one of the complaints; in this instance, HR documented having asked who the complainant thought was being retaliatory and what they had noticed.[8]

> [The HR division could improve its complaint management by c]learly indicating how they will protect us from retaliation and then actually following through, putting real safeguards in place.
>
> **— Current MDH Employee**

Although reporting a fear of retaliation is different than reporting an experience of it, the State of Minnesota has a zero-tolerance policy for engaging in retaliatory behavior.[9] Therefore, it is reasonable to expect HR to follow up on all reports of perceived or potential retaliation.

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[4] Occupational Safety and Health Administration, *Recommended Practices for Anti-Retaliation Programs*, 2017, 4.

[5] *Ibid.*, 7-8.

[6] *Ibid.*, 8.

[7] We reviewed files for all 82 complaints HR received, as well as their associated investigation files. MDH has limited documentation of complaints that occurred before HR division management changed in the spring of 2022.

[8] Complainants sometimes shared these retaliation concerns during intake conversations. HR's documentation of these conversations generally did not include questions asked by investigators or enough context for us to determine whether they followed up on the complainant's mention of retaliation.

[9] *Minnesota Statutes* 2024, 181.932. Minnesota Management and Budget, HR/LR Policy 1432, *Respectful Workplace*, revised August 14, 2023, 2; HR/LR Policy 1329, *Sexual Harassment Prohibited*, revised August 14, 2023, 5; HR/LR Policy 1436, *Harassment and Discrimination Prohibited*, revised August 19, 2024, 6; and HR/LR Policy 1444, *Workplace Violence Prohibited*, issued March 4, 2021, 5.

RECOMMENDATION

The HR division should develop procedures to address retaliation fears or experiences that emerge through complaint intake or investigation.

The HR division should consider fears and experiences of retaliation as indicators of potential issues and opportunities to educate MDH employees about appropriate behavior, complaint reporting and management, and employee rights and protections. If the division continues to take limited action in response to retaliation concerns, employees may lack confidence in the division to protect them from retaliation. In turn, employees may become less willing to report fears or experiences of retaliation, resulting in HR being unaware of and thus unable to address it.

To ensure employees are protected from retaliation, the HR division should develop procedures for its investigators to follow when managing complaints that involve fears or experiences of retaliation, regardless of whether retaliation is a specific allegation or a concern that arises incidentally. For example, procedures could include questions to ask about the perceived retaliation and factors to consider when evaluating whether a retaliation risk exists. The procedures may also outline strategies to protect an employee and alleviate their fears, such as continued contact after complaint resolution. Although we recognize complaint circumstances vary, following such procedures can ensure HR manages retaliation consistently and thoroughly and takes measures to protect employees.

Employee Experiences of Perceived Retaliation

In our surveys of current and former MDH employees, we asked respondents about any retaliation they perceived and what made them decide not to report it, if applicable.[10]

In their survey responses, some current and former MDH employees indicated that they believed they experienced retaliation as a result of submitting a complaint to HR.

Among the 53 current MDH employees who reported that they had submitted a complaint in or since 2022, 10 of them indicated that they had experienced retaliation as a result of submitting that complaint. A handful of former employees also reported that they experienced retaliation while at MDH. Additionally, some respondents relayed instances of their coworkers experiencing perceived retaliation after reporting complaints. For example, one current employee said, “I have heard stories from

[10] For our survey of current employees, 2,007 employees received our survey and 79 percent (1,578) responded. Survey respondents included 300 employees who identified themselves as managers or supervisors, and 1,278 nonsupervisory employees. For our survey of former employees, we used a nonrepresentative sample consisting of former MDH employees who still worked for state government, as well as a small number of former employees who contacted our office about this evaluation. Of the 58 former employees who received our survey, 76 percent (44) responded and reported leaving the department in 2022 or later.

co-workers who have filed [a] complaint with HR who stated that they experienced retaliation after filing the complaint. … I think many feel that reporting complaints to HR is either futile or will put them at risk of further punitive action."

In general, respondents' descriptions of perceived retaliation, some of which we show in the box below, included changes in how they were treated by others; their workload; their employment status, position, or advancement opportunities; or a combination thereof.[11] For example, one employee said, "I am assigned more work duty. I requested [a] breakdown of my workload and have not received the requested written information."

> [I was i]solated from colleagues and supervisor…. I missed out on training and professional growth because of the isolation.
>
> ---
>
> After HR contacted my supervisor, he went out of his way to find anything to use against me.
>
> ---
>
> Three weeks after I filed the complaint I was fired for [a] vague reason.
>
> **— Current and Former MDH Employees**

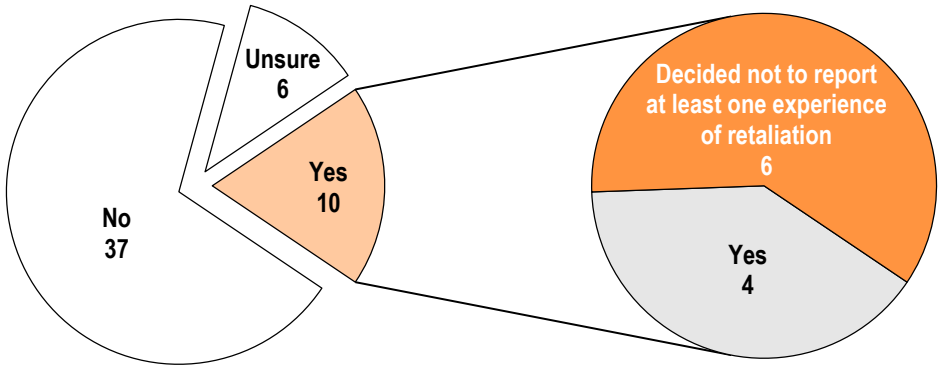
Further, a few of these survey respondents indicated that they chose not to report these instances of perceived retaliation to the HR division, as shown in Exhibit 3.1. This lack of reporting did not seem related to a lack of understanding about how to report retaliation. Seventy-five percent of both current and former MDH employees who responded to our survey indicated they knew how to report a complaint if they experienced retaliation at MDH. Instead, employees attributed not reporting perceived retaliation to their impressions of the HR division. For example, some cited a lack of confidence in HR or the perception that HR does not protect employees.

Exhibit 3.1

Current Employees with Complaint Experience (N=53)

Survey Question: Do you believe you experienced any retaliation as a result of reporting a complaint to the HR division?

Survey Question: Did you report this retaliation?



Note: This exhibit includes current employees who reported a complaint to HR only in or after 2022.

Source: Office of the Legislative Auditor, based on our survey of current MDH employees, 2024.

[11] We did not independently verify the details provided by survey respondents.

There may be a relationship between employees not reporting retaliation and the extent of the HR division's efforts to protect employees from it. As discussed earlier, in our review of the division's files, HR generally did not appear to conduct follow-up to understand alleged fears or experiences of retaliation. The lack of follow-up may lead some employees to not report perceived retaliation (as suggested by responses to our surveys).

When such retaliation concerns do not reach HR, the division may not perceive retaliation to be an issue and thus may not prioritize developing relevant division procedures to address it. In turn, employees may not know how HR protects them from retaliation, which may undermine employees' willingness to report concerns.

Retaliation Against Probationary Employees

Typically, employees who join a state agency or move to a new role within an agency must serve a probationary period.[12] The probationary period serves to ensure that the employee can successfully complete the duties of the position.[13] The initial probationary period concludes when the agency certifies the employee (i.e., makes them a permanent employee), does not certify the employee (i.e., dismisses the employee from their position or returns them to their previous position), or extends the probationary period.

Since state law and labor contracts generally include stronger protections for certified employees, probationary employees are particularly vulnerable to retaliation.

Since they are not yet permanent employees, statutes allow agencies to discipline or dismiss probationary employees without demonstrating the elements of just cause that we discussed in Chapter 1.[14] Through our surveys and conversations with current and former MDH employees, some shared that employees in their probationary period may face unique experiences with retaliation. We heard several examples of supervisors allegedly using an employee's probationary status to retaliate against the employee. We also learned that fear of such retaliation was a factor in some probationary employees deciding not to submit complaints to HR. Employees, including those quoted in the box that follows, shared that employees on probation who voiced concerns experienced or risked retaliation by means of noncertification.

[12] *Minnesota Statutes* 2024, 43A.16.

[13] *Minnesota Statutes* 2024, 43A.02, subd. 32.

[14] *Minnesota Statutes* 2024, 43A.02, subd. 30; and 43A.33, subd. 1.

My supervisors have, on several occasions, threatened us with the probation period if we challenge the changes in our work activities. This practice is unfair and inequitable.

I am aware of a staff person (who was in their 6-month probationary period) who recently reported a complaint against their supervisor to [the HR division]…. about a month later, the supervisor terminated the staff person who had reported the complaint.... [HR]'s job should include understanding and seeing the full picture of the timing of the submission of the complaint and then the termination request, as suspect and rife with possibility of being retaliatory on the part of the Supervisor- not to say that it is for-sure retaliation, however there is a question of was this retaliation, which should be enough to pause the termination from moving forward.... Supervisors have the power to terminate staff who submit complaints, particularly staff who are in their 6-month probationary period.

A colleague submitted a complaint about their supervisor…. They were in the probationary period of their full-time position. Their employment was terminated about two weeks after submitting the complaint, by the supervisor about whom the complaint was made, in consultation with HR. This made me question the commitment of MDH to the anti-retaliation policy.

I am still on probation so have no contractual protections against supervisor retaliation. I had one interaction with HR where I asked for a discussion with my supervisor to understand the reasons for probation extension and benchmarks that I needed to meet to get off probation. The HR representative was hostile to me and seemed more concerned with protecting the institution than resolving our issues.

— Current MDH Employees

RECOMMENDATION

The HR division should develop a procedure for examining instances of noncertification of probationary employees who previously submitted complaints.

While it is legal to dismiss a probationary employee without establishing the elements of just cause, it is not legal to retaliate against an employee for submitting a complaint.[15] As we mentioned in Chapter 2, our review of the HR division's files from fiscal years 2023 and 2024 showed that the division chose not to continue its efforts once a complainant left MDH. This practice, however, creates an opportunity for supervisors to preemptively dismiss probationary employees who they know or suspect have submitted complaints.

When a probationary employee submits a complaint and is then dismissed from their position at MDH, the HR division should investigate both the original complaint and whether the dismissal might be retaliatory. Even if such retaliation is difficult to prove, HR's procedures should include monitoring for patterns of behavior (such as numerous noncertified employees or frequent extensions of employees' probation under the same supervisor) that may suggest a supervisor is using noncertification inappropriately.

[15] *Minnesota Statutes* 2024, 181.932, subd. 1.

List of Recommendations

- The Minnesota Department of Health (MDH) should require all MDH supervisors to attend periodic training about when to refer employee complaints. (pp. 18-19)

- The Human Resources (HR) division should establish complaint management procedures that require investigators to:

  - Issue, and document the issuance of, verbal and written data practices and antiretaliation notices during intake conversations and investigation interviews.

  - Consider certain factors when deciding whether to (1) investigate complaint allegation(s) and (2) interview people identified as having relevant information, and document these decisions.

  - Notify each complainant when they receive and close a complaint and at any other determined points, and document when they issue such acknowledgment(s). (pp. 28-29)

- The HR division should develop procedures to address retaliation fears or experiences that emerge through complaint intake or investigation. (p. 33)

- The HR division should develop a procedure for examining instances of noncertification of probationary employees who previously submitted complaints. (p. 36)

OLA

January 29, 2025

Ms. Judy Randall
Legislative Auditor
Office of the Legislative Auditor
658 Cedar St. Room 140
Centennial Office Building
St. Paul, MN 55155-1603

Dear Ms. Randall,

Thank you for the opportunity to review and respond to the recommendations in the evaluation of the Human Resources Complaint Management for the Minnesota Department of Health (MDH). MDH is committed to a fair and equitable human resources complaint management process, as demonstrated through its investment in resources and process improvement initiatives.

We greatly value and appreciate your feedback as it identifies areas for improvement (i.e. training, documentation, and communication) and serves as an important tool for growth and development. Please be assured that we take your input seriously and remain committed to our efforts of continuous improvement in our work. We will use this opportunity to further refine our processes to enhance the quality of our efforts in complaint management.

MDH appreciates the time and attention employees, union partners, and enterprise collaborators took in providing honest, candid, and informative feedback by the survey tool used through the discovery process for this program review. The survey positively reflected our dedication to our valued relationships with union partners and are proud to see that reflected in their positive responses.

Recommendation:

Minnesota Department of Health (MDH) should require all MDH supervisors to attend periodic training(s) about when to refer employee complaints. (pp.18-19)

Response:

The survey validated our efforts in providing quality training to MDH supervisors and managers through our HR/Labor Relations training series, which launched August 2023, confirming our training is effective for those who have taken it. The MDH Strategic Plan 2024-2027, incorporates strategies to launch job-embedded professional learning communities for new supervisors that include human resources topics and leadership best practices. Strategies within the strategic plan will include opportunities to ensure all staff know about, have access to, and feel comfortable accessing internal and external resources to manage workplace conflicts. MDH intends to implement requiring new supervisors and managers to take these HR/Labor Relations training courses as part of their new supervisor/manager training plan, as early as March/April 2025.

Recommendation:

The Human Resources (HR) division should establish complaint management procedures that require investigators to:

- Issue, and document the issuance of, verbal and written data practices and antiretaliation notices during intake conversations and investigation interviews.
- Consider certain factors when deciding whether to (1) investigate complaint allegations and (2) interview people identified as having relevant information, and document these decisions.
- Notify each complainant when they receive and close a complaint and at any other determined points, and document when they issue such acknowledgement(s). (pp. 28-29)

Response:

MDH recognizes the importance of consistently documenting verbal notices/conversations, as well as written notices or acknowledgements sent via Microsoft Office meeting invites. The Labor Relations unit has already begun to implement steps uniformly to ensure documentation is saved in a consistent manner within case management files. The Labor Relations unit has drafted a complaint and investigation internal guidance document, which specifically notes which documents are to be saved within the case management files and will be used by each staff member, this document is in the final stages of finalization and will be completed by mid-February. Additionally, an agency-wide complaint and investigation procedure has been created, and will go to MDH's Policy, Procedures, and Standards Committee for approval this spring 2025.

As of October 2024, MDH has implemented verbal and written data practices and antiretaliation notices during intake discussions and meeting invites, consistent with existing templates that have been used since May 2022 for investigation meeting invites and used during investigation interviews. Additionally, all Labor Relations staff are currently expected to send written acknowledgment and closure notices for all complainants who have submitted complaints at the

time of complaint and closure of complaint, which has been added to the complaint and investigation internal guidance document for reference and consistency. This was reiterated to Labor Relations staff as being a requirement in October 2024.

Minnesota Management and Budget provided investigations training to enterprise-wide Human Resources/Labor Relations staff which now identifies an expectation that investigators include written statement outlining the justification for not interviewing named witnesses. As of November 2024, following MMB's training, MDH has incorporated this into its investigation process. MDH also implemented additional tracking standards to include noting why a complaint is moved to investigation, versus other means of addressing the concerns, in December 2024.

It is important to MDH to "ensure knowledge and understanding is shared across the agency, rather than held by a select few subject matter experts" [MDH Strategic Plan, 2024-2027]. We are committed to providing opportunities to increase knowledge and documented processes to ensure HR/Labor Relations staff understand the considerations needed to make sound decisions on whether a complaint is managed through workplace investigation, or through other performance management measures.

Recommendation:

The HR division should develop procedures to address retaliation fears or experiences that emerge through complaint intake or investigations. (p. 33)

Response:

In November 2024, MDH has begun developing additional resources to address employee concerns of retaliation, raise awareness of retaliation, instilling confidence to staff in coming forward to report retaliation, and to minimize instances of retaliation in the workplace. Resources include written internal news articles outlining the process for filing a retaliation complaint, defining what retaliation may include, and the process for addressing concerns. MDH also provided training to supervisors and managers in November 2024, during our monthly HR/Supervisor and Manager forum on complaint, investigations, and retaliation and is highlighting retaliation as a concern during HR/Labor Relations training series courses. MDH will continue its long-standing commitment to ensuring a workplace free of discrimination, harassment, and retaliation in the workplace.

Recommendation:

The HR division should develop a procedure for examining instances of noncertification of probationary employees who previously submitted complaints. (p. 36)

Response:

MDH has utilized a thorough review process for all non-certifications, since May 2022, which requires all non-certifications to come to the Employee and Labor Relations unit, within Human Resources Management, to be reviewed prior to taking action. This review includes verifying the employee has received appropriate training, resources, and/or mentorship, as well as confirming the employee has received coaching and/or redirection in the areas where their performance is lacking. Based on this information, the Employee and Labor Relations representative may provide guidance to proceed with a non-certification or may recommend additional performance management efforts be made to assist the employee towards success. The recommendation may also include a probation extension to allow for additional time. Due to the fact that Employee and Labor Relations is reviewing all non-certifications prior to implementation and are also the unit who manages the complaint and investigations process, complaint or investigation data is reviewed as a consideration in the recommended course of action. This effort reduces the likelihood that retaliation may occur resulting in unwarranted non-certifications.

We appreciated your staff's time and professionalism during this audit. We will actively address all identified recommendations and take the necessary steps to ensure timely remediation.

Sincerely,

Brooke Cunningham

Commissioner
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Forthcoming OLA Evaluations

Community Benefit Expenditures at Nonprofit Hospitals
Department of Employment and Economic Development Grants Management
Department of Natural Resources Land Acquisition
Guardianship of Adults

Recent OLA Evaluations

Agriculture
Pesticide Regulation, March 2020
Agricultural Utilization Research Institute (AURI), May 2016

Criminal Justice and Public Safety
Driver Examination Stations, March 2021
Safety in State Correctional Facilities, February 2020
Guardian ad Litem Program, March 2018
Mental Health Services in County Jails, March 2016

Economic Development
Minnesota Investment Fund, February 2018
Minnesota Research Tax Credit, February 2017
Iron Range Resources and Rehabilitation Board (IRRRB), March 2016

Education (Preschool, K-12, and Postsecondary)
Minnesota Department of Education's Role in Addressing the Achievement Gap, March 2022
Collaborative Urban and Greater Minnesota Educators of Color (CUGMEC) Grant Program, March 2021
Compensatory Education Revenue, March 2020
Debt Service Equalization for School Facilities, March 2019
Early Childhood Programs, April 2018
Perpich Center for Arts Education, January 2017
Standardized Student Testing, March 2017
Minnesota State High School League, April 2017
Minnesota Teacher Licensure, March 2016

Environment and Natural Resources
Aggregate Resources, January 2025
Petroleum Remediation Program, February 2022
Public Facilities Authority: Wastewater Infrastructure Programs, January 2019
Clean Water Fund Outcomes, March 2017
Department of Natural Resources: Deer Population Management, May 2016

Financial Institutions, Insurance, and Regulated Industries
Department of Commerce's Civil Insurance Complaint Investigations, February 2022

Government Operations
Grant Award Processes, April 2024
Oversight of State-Funded Grants to Nonprofit Organizations, February 2023
Sustainable Building Guidelines, February 2023
Office of Minnesota Information Technology Services (MNIT), February 2019

Health
Minnesota Department of Health: Human Resources Complaint Management, January 2025
Emergency Ambulance Services, February 2022
Office of Health Facility Complaints, March 2018
Minnesota Department of Health Oversight of HMO Complaint Resolution, February 2016

Human Services
Department of Human Services Licensing Division: Support to Counties, February 2024
Child Protection Removals and Reunifications, June 2022
DHS Oversight of Personal Care Assistance, March 2020
Home- and Community-Based Services: Financial Oversight, February 2017

Jobs, Training, and Labor
Worker Misclassification, March 2024
Unemployment Insurance Program: Efforts to Prevent and Detect the Use of Stolen Identities, March 2022

Miscellaneous
Minnesota Housing Finance Agency: Down Payment Assistance, March 2024
RentHelpMN, April 2023
State Programs That Support Minnesotans on the Basis of Racial, Ethnic, or American Indian Identity, February 2023
Board of Cosmetology Licensing, May 2021
Minnesota Department of Human Rights: Complaint Resolution Process, February 2020
Public Utilities Commission's Public Participation Processes, July 2020
Economic Development and Housing Challenge Program, February 2019
Minnesota State Arts Board Grant Administration, February 2019
Board of Animal Health's Oversight of Deer and Elk Farms, April 2018
Voter Registration, March 2018

Transportation
Metro Mobility, April 2024
Southwest Light Rail Transit Construction: Metropolitan Council Decision Making, March 2023
Southwest Light Rail Transit Construction: Metropolitan Council Oversight of Contractors, June 2023
MnDOT Workforce and Contracting Goals, May 2021
MnDOT Measures of Financial Effectiveness, March 2019
MnDOT Highway Project Selection, March 2016

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OLA | OFFICE OF THE LEGISLATIVE AUDITOR

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Saint Paul, MN 55155

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 02-10-2025

[0:05] >> Morning morning. I called the 2/10/2025 meeting
of the House Fraud Prevention
[0:11] and State Agency Oversight
Committee to order the quorum is present.
[0:19] Before we begin our meeting, I
just want to remind everyone that the committee expect it's
proper decorum at all times.
[0:26] All dialect goes to the chair.
Signs are not allowed in the committee room. There will be
no outbursts are clapping.
[0:33] There's no standing or sitting
in the walkways or iOS if accommodation is needed.
Please communicate with the
[0:39] sergeant at arms staff and there will be consequences
for disruption. Thank you to the action and I'm
staff who are present for
[0:47] helping to maintain decorum in
the committee room. So since this is our first
meeting with all of our members
[0:54] in attendance, we will begin
with the introduction of members and staff members. Please tell us your
district and committees that
[1:01] you're community to represent
and your professional background staff. We've looked

forward to hearing about your

[1:08] role in the house. So I'm yours. Get good called, but we start

with youth Le Pen to thank you.

[1:18] >> Thank you, Madam Chair.

So glad to be with you and be with everybody. So

Representative Dave Pinto from

[1:23] the southwest part of Saint

Paul, us to a professional background. I work as a

prosecutor with the Ramsey

[1:29] County attorney's office

outside the Legislature had a specialized in gender violence,

domestic assault, sexual

[1:37] exploitation cases for a number

of years. But for quite a while now, I've had a wide variety of

felony level cases, mostly

[1:43] felony level cases and some

lower level as well. And and then I have a policy expertise

in a number of the areas that

[1:53] of our state budgets as well as

so. Glad to be with you. I will have a general question

that may be open all asking.

[1:59] Madam Chair wants that your

actions are down if they want to be okay with you. But thank

you. Glad to be with you.

[2:06] >> And I can't thank you.

See Director, too. >> Okay. Steve Elkins, I

represent District 50 P which

[2:15] is the prestigious west half of

Bloomington and by Education. I'm an economist. I moved here

40 years ago to set airfares

[2:22] for Republic Airlines. But for

the last 25 years I worked in information. Technology is an

information Arctic.

[2:29] >> Represent Goodman. Good

morning. And it's a decision at this first meeting

representative agreement I

[2:35] represent 63 be which is not

the whole sort of strip of the South side of South

Minneapolis.

[2:42] My background, I am a I started

my career as a public defender, but I'm a voting rights lawyer

who has spent a lot of time

[2:49] thinking about the where sauce

systems and processes and allow public transparency and people

to participate. And I am also

[2:59] on a I elections, workforce, labor and

economic development and public

[3:08] safety and me all day at a

rally for the oil. See which

[3:14] side Representatives. >> Okay. Thank you,

Representative Eric.

[3:19] Thank you, Madam Chair. >> So represent a very rare

form Lee O'Neil for every one that fell to the last 12 years
in legislature and sometimes so
[3:28] common that. So I the reason my
name changes. I married a state Senator Jason rare and I have
spent over 20 years working in
[3:36] various nonprofits, big, small,
international, local, doing
[3:42] everything from the ground up
from photography and videography to
county into running
[3:50] international offices. The U.S.
office worked in Minnesota. Don't teen challenge and
Habitat for Humanity is ones
[3:57] here in Minnesota. So I'm very interested in the
topic today and I've been doing
[4:03] my digging in. I'll be doing a
whole lot more digging. So I appreciate that chair the
opportunity to serve with you
[4:09] on this committee. Thank you, Representative
South. >> Representative Isaac Schultz
or represent House district 10
[4:16] be which includes a large swath
of central Minnesota, including 5 counties from ice and comedic
black, spent 2 on and my home,
[4:25] the Morrison County in the
small town of Upsala. And I come from a family business of

auction years and happen to be

[4:33] a state champion in that

regard. And glad to be with you all this morning and throughout

the entirety of this

[4:40] legislative session. Thank you. >> Representative Hudson. >> Thank you. Madam Chair,

Representative Walter Hudson

[4:46] from District 38 northeastern

Wright County. My professional background is collecting mix of

different blue collar positions

[4:56] and various sectors, commercial

public safety, logistics, including management,

supervision, manager, logistics

[5:03] company, before coming here to

the legislature and of also done some work in media on

education, finance, judiciary

[5:09] and public safety mission to

this committee and very much look forward to the work that

we're going to do here.

[5:14] >> Thank you, complaining spice

to it, Anderson. Thank you. I'm Patty Anderson. I am the

vice chair this committee.

[5:20] I represent I what I would call

northwestern Washington County. So that's probably the best

description for that. I am.

[5:30] I have a I guess I'm a small

business owner. I had a variety of small and mid-size businesses throughout my career [5:37] and currently do still. And I'm also U.S. Representative Grant [5:42] says serve on the Legislative Audit Commission. And that's, you know, I have some background that to tell. Thank you. [5:49] >> So State Representative Kristen Robbins, I represent District 37 Day, which is western suburbs of Hennepin [5:57] County. So the communities of Maple Grove, Medina, Corcoran, Greenfield, independence, libretto and Maple plain. [6:03] I left my district and I'm delighted to be taking this committee and working with all of you. So really appreciate everyone coming [6:11] today. And now I would just like to start with staff introductions with RCA Heritage. [6:17] >> Kerry Kennedy, the committee administrator. Ben, if that the legislature since 2011 in various [6:23] capacities, and I'm excited to be working with you all for the session, [6:29] Mr. Johnson. >> Madam Chair members, Ben Johnson with House Research Department. I primarily staff

to public safety judiciary have

[6:37] been with the legislature since

2016. Before that I was a practicing attorney. I did both

civil and criminal practice.

[6:43] Thank you. >> Thank you. Madam Chair Aaron

Burr see with GOP caucus

[6:51] research. Are you in? >> Hey there. I'm Kate Miller.

I'm the Cle the Frog Committee.

[7:00] Yeah. From Carlton County, a

small town has come in so to just moved here about a month

ago. So happy to be here.

[7:09] >> John Miller, D FL research.

I have been with the legislature for years now in

part that I would say attorney

[7:15] in private practice center,

some public interest work. So thank you. >> Thank you. And I also have

the Democrats ca and knowing

[7:22] hair and we are grateful for

your work on the committee as well. And also like to

introduce our page Sierra.

[7:29] She's on our team and will be

with us all the time. So if anyone needs anything, please

reach out to sea air.

[7:36] Well, I'm going to introduce

our esteemed guests in just a minute. But I wanted to just

make a couple comments as we

[7:44] start this new work. It's a new
committee of the Legislature. And I'm delighted that it is
bipartisan.
[7:50] And I just want to point out
the need for this committee.
[7:55] So the last story ice on the
press was that we are currently sitting at about 610
[8:02] million dollars in fraud over
the last 6 years in the state of Minnesota.
[8:07] Not only is that an appalling
waste of taxpayers. Hard-earned money is also an indictment of
state agencies failures to
[8:14] serve the people who really
need services. The mission of this committee
is to ensure that taxpayer
[8:19] money is not going to the
greedy, but he's going to serve the needy. As I've said many
times since I was first named
[8:27] chair. This is not a partisan issue.
It is a separation of powers
[8:32] issue. The Legislature
appropriates money and we also have a duty to exercise
oversight of executive branch
[8:39] agencies tasked with spending
it. As the former U.S. attorney and
prominent Democrat Andy Luger

[8:45] noted last December, quote, I
think there needs to be a lot more done and people need to
have serious conversations and
[8:52] get to the root of this
stopping it before it happens. I just see it and no other
state has had a feeding our
[8:58] future. We did. No other states
have the kinds of problems we've had with government
fraud. But other states have
[9:05] problems. We don't have members. This is why we are
here to have serious conversations and get to the
root of the fraud so that we
[9:13] can put systems in place that
will stop it before it happens. I'm so thankful that all of you
have joined this committee and
[9:20] I look forward to getting to
work. So now, without further ado,
I'd like to introduce today's
[9:25] buzz. Oh, I'm sorry. Representative
can tell you. Yes, I said I would defer to you, please.
[9:31] >> Thanks for your question.
Thank you, Madam Chair. Yes, it's or 2 part question.
So the first is I had my
[9:37] understanding that the
committee will not be considering bills but sort of
more informational hearings. I may be wrong about that.

But if you could just clarify
[9:43] that, not all month follow-up
question. >> Yes, so we are certainly
open to considering bills and I
[9:48] would expect most of them would
be referred from state Gov. Some of the bills that have
already been introduced about
[9:53] inspector general and some of
the governor's provisions that are being brought forward.
[10:00] So they may be referred to a
committee that I don't believe that's been worked out. I also
have a bill that I worked on
[10:05] with the L a more than 4 years ago that I'm
hoping will of finally get a hearing in my own committee.
So I expect we will be hearing
[10:13] that bill. But most of the work
to your point will be a lot of oversight and discussion of
issues that been brought to
[10:19] light through whistleblowers
who are contacting me dozens. Every may be that it
doesn't last week that we've
[10:27] had dozens of contacts and we
want to start digging into some of the concerns have been
raised by the public.
[10:32] >> But thank you, Madam Chair
and into the 2nd half of that, I guess is given that

individual committees have
[10:39] jurisdiction over particular
agencies. How do you view the role this committee as compared
to so thinking about, you know,
[10:47] each of the committees has, you
know what, the Department of Education from public safety
and satirist things are coming up. And of course, those chairs
in those committees can review
[10:54] actions of the agencies.
It said, or how do you view this committee's work kind of
different from the committees
[11:00] which are more typically would
be handling things. >> But I think we'll be working
cooperatively with a standing policy committees. So clearly
they have oversight in their
[11:08] areas and our committee has a
broader role and this is being a budget year. They might not
have time to do the deep dive
[11:16] on some of the fraud issues or
the waste issues. So my
[11:21] expectation is that there will
be some overlap, but that will require, particularly with the
chairs of those committees
[11:28] throughout the process so that we're not duplicating effort,
but that we are maybe providing
[11:35] a deeper layer of and their committee has time

for. Okay, good. >> Thank you. And maybe Madam
Chair, if I can, I'll just note
[11:41] that my difficulties and I are
really pleased when the committee, as we said before,
and are looking forward to kind
[11:47] of to learning more and
exploring more. Certainly, we want to make sure that the
public funds are being used for
[11:52] public goods and and so will be
eager to have to continue the conversation.
[11:58] >> Great. We look forward to
everyone participating. There's a lot hitting. Thank you, Madam
Chair.
[12:03] Yes, ma'am. Representative
there. If you're just really quickly to that point, I would
turn everyone's attention to
[12:10] the legislative audit report.
It's in your purse folder on Page 7. This is a really good
illustration as to why this it
[12:18] is so incredibly needed.
And one of the things here is that shows
[12:23] the number of nonprofit grantee
organizations and just the Department of Human Services
alone and a five-year period
[12:30] had 592 individual unique
nonprofit organizations that

[12:36] received grants a little bit further down.

Department of Health was 462

[12:41] further down from there.

The Minnesota board or excuse me, State arts Ford was 597.

There is it's impossible for a

[12:49] committee to possibly do due

diligence on that many nonprofits, grandson, so on and

so on. So I'm really looking

[12:57] forward to this and having an opportunity, like I

said, over 20 years and various

[13:03] nonprofits all the way from

very small to very bank. And I'm very interested to see

how this process happens.

[13:09] So Madam Chair, I am very

grateful to be a part of this committee. I just wanted to

point that out again, Page 7 of

[13:14] the audit report. That's in

your packet. Thank you, representative for Eric. So the first and only agenda

item today is the presentation

[13:22] from the Legislative Auditor

entitled Oversight of State funded grants to nonprofit

organizations. We are very

[13:29] fortunate to have state Auditor

Judy Randall and Deputy Legislative Auditor and

director of program evaluation

[13:36] Jodi months and Rodriguez with

us today for their presentation. So ladies, please introduce yourself for the record and
[13:43] then proceed for your testimony. Thank you. >> Thank you, Madam Chair members for the record. My name
[13:48] is Judy Randall Legislative auditor, pleased to be here today and all this broadly happy to support the committee.
[13:55] However we can with the work that we have. John, as as you all have said, we're going to be discussing this
[14:02] report that we released in 2023 slated to oversight of state funding grants to nonprofit organizations. All know that's
[14:09] not the first kind of broad look at grant funding that we have done. We did one back in 2007 which resulted in the
[14:18] Office of Grants Management and the Department of Administration being established. And since that time we have done a number. I think we have lost track
[14:25] within the office of kind of one-off. Looks at how it's giving program maybe is handling their grants. And so
[14:33] I was really happy to have this report that we can present to you cause. It looks at a couple

of specific programs, but then
[14:40] it really takes a step back and
looks globally at how are we handling grants as a state and
and where there are problems?
[14:47] Why? Right and hearing those
voices from the agencies who are managing the grants as
well. I also just want to note
[14:54] that in your package should be
this kind of booklet. That is a
[14:59] new format of updates that we
have done. So in the past, we have released kind of one
page updates that may be also
[15:06] in your packet related to the
state and the grants. A report this year we did something
different where we just listed
[15:13] all the recommendations we made
in a given report and then in a back and forth working with the
agency, tried to establish what
[15:20] we try to confirm if those
recommendations had been implemented, not implemented or
something in between. And so we
[15:28] are also happy to talk about
that. I think it will really be a good tool for legislative
oversight, thinking about the
[15:35] the chair's comments in terms
of the separation of of government and the legislate

chair's role in providing that
[15:42] oversight. Our intention is
that this report is more useful for all of you. So you can
quickly look back, see what has
[15:49] and hasn't happened in response
to reports and then have a discussion
about why
[15:55] there are reasons why agencies
haven't implemented recommendations. And a lot of those reasons make
sense. And so I want to be
[16:02] clear that where it says not
implemented isn't like a shame and appointing figure finger.
It's a OK, what's going on.
[16:10] Maybe this is an area for the
legislature to have additional questions and conversations
just to that point. And then I
[16:18] promise we will get to the full
report. If you notice that this
[16:24] booklet is organized by entity
and at the and is the
[16:31] Legislature and it's all the
recommendations we have made for the legislature. And you
will note that a lot of them
[16:39] have not been implemented and
that makes sense, right? You have a lot of different
things to consider. Not just

[16:45] our recommendation. You know,
maybe it wasn't something you agreed with. Maybe it took too
much time. Maybe whatever.
[16:52] The point is that there are
good reasons why some of our recommendations are
implemented. And that is the
[16:57] place where I think there can
be additional conversation and additional legislative
oversight. So I just wanted to
[17:04] point that out real quickly.
But now we will turn to the real matter at hand. And if I
could, Madam Chair, I'll turn
[17:11] it over to deputy legislative
auditor months and Phaedra. Yes, yes. Thank you so much.
[17:17] Legislative auditor rental
welcome legislative. >> Deputy Auditor Rodriguez,
please state your name for the
[17:23] record for a seat. Thank you, Madam Chair. For the
Record, my name is Joey months and Rodriguez and I'm the
deputy legislative auditor for
[17:29] all these program evaluation
Division. Thank you, Representative, rare at for
bringing everyone's attention
[17:36] to this booklet you have in
your packet. I will be reviewing referring to a few
pages in there. If you're interested in more detailed

information south, just giving

[17:44] you a visual and this evaluation, we've

really research too many questions. So first, how

comprehensive where Minnesota's

[17:51] grant management policies and

how well that state agencies follow them.

[17:56] I want to know that some of the

wreck and are some of the findings that we have in this

report are based on the

[18:03] policies at the time that we

did this report and will be going over some recommendations

and some of the changes that

[18:09] have occurred since then. The second big question we

looked at was how well that state agencies follow the

wrecking are the policies that

[18:17] were in place. So briefly, some of the key

findings based on this work.

[18:24] We found that Minnesota's

grants management policies did establish many practices that

are important for effective

[18:30] management, but they generally

lack sufficient detail for state agencies and how to best

implement. In addition, a leaf

[18:38] on pervasive not compliance

with these policies in recent years.

[18:43] One of the reasons we

identified for this potential noncompliance is statutes
provided little authority to
[18:50] enforce state agencies,
compliance with them. So now I'm just going to step
back a little bit, provide some
[18:56] very basic information, some
context of the findings. And then I'll talk a little bit
about some of our recommendations and
implementation status us.
[19:05] So first, just a real breath
from or how it works or how the grant's work. In Minnesota.
[19:12] The legislature appropriates
money to state agencies for state funded grants agency that is responsible for
distributing and oversee
[19:20] McGrath. So in one example, the
Legislature awards funding to the Department of Public Safety
[19:26] for the Youth Intervention
program. The Department awards grants
for this program to many
[19:32] different non-profit
organizations, including, for example, Lutheran Social
Services, which then provides
[19:37] early intervention programs for
U.S.. Another example would be that
the Legislature provides
[19:44] funding to the Department of

Education for Early Learning Scholarship programs. The intern provide grants to several passed through
[19:51] organizations such as think
Small. And then those passed through
organizations provide the
[19:56] scholarships to eligible
families, but they're paid to childcare and early learning
institutions. So that would be
[20:02] the subject and tease. State agencies spent an annual
average of about 514 million
[20:11] dollars on state funding grants
per year to nonprofit organizations and fiscal years.
2018 through 2022. with a high
[20:18] in 2021 of 616 million
[20:23] state agencies awarded grants
to about 2,400 nonprofit
[20:28] organizations and that 5 year
period, the median amount Ward over the
five-year period was about
[20:35] $68,000.75. 1% of organizations
received a less than 440,000.
[20:44] The Department of Ministrations
Office of Grants Management was responsible for creating
statewide grants management
[20:51] policies and is now responsible
for updating them and acting as a resource on them.

[20:57] These policies spanned the life
cycle grants, though the cover the prewar, the act of grant
and the close out visas
[21:05] establish broad requirements
that state agencies must meet, but they also provide
flexibility on how to implement
[21:12] them. So, for example, GM require
state agencies to collect prop
[21:18] profit. I'm sorry, progress
report at least annually from state agencies, but they don't
establish any minimum standards
[21:25] for the format for the content
of those reports. State agencies are responsible for
doing that.
[21:32] If you're interested, the
policies that were in place at the time of our review are
summarized on in appendix a of
[21:38] our report. So as I noted at the beginning,
one of our research questions
[21:44] involve determining the
comprehensiveness of GM policies. When we did this was by
reviewing GM policies against
[21:52] recommended practices in grants
management. We reviewed reports by national
organizations and agencies and
[21:59] group the practices that we

found in 2.24 recommended practices. We found that GM's
policies partially reflected 17
[22:08] of those 24 practices. We have more information about
those practices in Appendix D
[22:14] of our report. So while OG and policies
partially reflected in many of
[22:20] these practices, we found that
they often lacked important detail.
[22:25] I'm going to provide a few
examples of that here.
[22:31] So as an example, GM policy
required to state agencies to complete a PRE award financial
review.
[22:38] But the policies did not
require the agency is to increase monitoring for
grantees that they found to be
[22:45] higher risk. As I noted previously, the
policy required state agencies
[22:51] to collect progress reports,
but it did not specify any specific information or
standards for those reports.
[23:00] Policy required agencies to
complete monitoring visits for grants over a certain
threshold. But those visits
[23:07] could be conducted by
telephone. They do not need to be on site. And as a final example, policy

required state agencies to

[23:15] consider certain information

about past great performance before awarding subsequent

through awards too different

[23:23] grantees. But the policy did

not establish a time frame in which to complete the clothes

that repeal.

[23:30] And I'll note that all of the

items on the right side of this chart are recommended

practices.

[23:38] So based on this review, we did

recommend GM strengthen its policies and provide more

specific guidance to agencies.

[23:45] We have more information about

that on pages. 35 36 of the report.

[23:51] I do want to note that since

our our report was released,

[23:57] the Department of

Administration has taken some action on this recommendation.

So, for example, based on a law

[24:02] that the Legislature passed

2023, GM made numerous changes to its PRE Award financial

review policy, including noting

[24:11] that agencies must develop

risk. Mitigation plans were not award a grant to entities for

which they have identified

[24:18] risks. Gm also establish a
timeline by which agencies must complete close out the U.S..
[24:25] We know that this is partially
implemented because they did not take others recommended
action such as establishing
[24:32] standards for progress. Reports
are requiring on-site monitoring.
[24:40] So as as Randall noted in this
report, we kind of went into depth reviewing a couple of
different state agencies.
[24:48] But for this presentation
today, I want to talk just a little bit more on enterprise,
wide issues that we found.
[24:55] So at the time we released with
the report, we had also done 8 financial or internal audit
control reports and to program
[25:04] evaluations within recent years
in which we look at grants, management, compliance
[25:09] and in looking across all of
those reports, we found repeat issues both within single
agencies and across state
[25:16] agency is and some of those
repeat issues that we found are listed on this site here
[25:23] in the amount of noncompliance
that we found. We sought to understand some of the reasons
behind it. So we looked at

[25:29] factors related both to state
agency pass city to comply with the requirements as well as
accountability measures
[25:36] surrounding those requirements. First, I'll talk a little bit
about state agency capacity.
[25:44] One of the first things we
found was that the legislature had funded grants management
activities consistently across
[25:51] the state. These and grant
programs themselves, which we believed could have affected
agencies, compliance with GM
[25:58] policies. Another factor we identified
was training. So while GM have
[26:05] provided some ad hoc training
on these policies, it didn't have in demand training or kind
has regularly scheduled
[26:13] training. Also, no agency
officials are required to take any training to manage France.
[26:22] And a 3rd factor was agency
management tools. As you can guess. There are many, many
documents that are required to
[26:29] manage management of grants. Some agencies use electronic
grants management systems.
[26:37] Others use a wide variety of
systems. In order to do this. I'll note that as part of our
review, we surveyed members of

[26:46] the Grant Government Council
that includes 40 grant managers ask Randy Contingencies in
Minnesota and only 40% of those
[26:54] managers said that they used
electronic grants management systems that meant that 60% are
using other kind of at the
[27:01] methods. So just as an example,
during our review and used a combination of e-mail online
systems, electronic documents,
[27:10] an actual physical documents to
manage their grants.
[27:16] Now in a good in addition to
state agency capacity, we look at just accountability measures
sense without mechanisms to
[27:23] hold agencies accountable.
They may have fewer incentives to comply.
[27:29] So in terms of inforcement
statues provided little authority for state agency
complete our 2 up, enforce the
[27:37] even see compliance with these
policies. There are several entities including only have
the authority to review agency
[27:44] compliance. That reviewing and
reporting is really the extent of these aged are these
entities authority
[27:53] that leaves the legislature is

essentially the only body with the authority to act when
agencies don't comply. But it's
[28:01] difficult for the legislature
to obtain comprehensive information and data both on
grants and on state agency
[28:07] grants management activities. Minnesota's only real source
for information on grants does
[28:13] the state Agency accounting
system. But that has very limited information available
and no performance information
[28:21] available in it. So this makes
it difficult for the Legislature and really the
public state agencies, anyone
[28:27] to review grant performance. So we made a number of
recommendations to the
[28:34] legislature. One of them had to do with
directing GM to develop a
[28:40] grants management management
training program and then requiring all state agency
grants management staff to
[28:46] complete that program. The Legislature has chosen not
to implement this recommendation at this point,
although I will note that the
[28:54] Department of Administration
has increased the amount of training materials that has
Anthony and on its website

[29:02] since we released this report. Couple of other recommendations
we had was to develop standards
[29:11] for consistently our 2 direct
GM to develop standards for consistently funding grants.
Note that the Legislature
[29:19] actually passed a law in 2023
themselves that directed agencies to be able to use a
percentage of grant funds to
[29:26] administer those programs. We also recommended that the
Legislature direct admin to develop recommendations for
improving access to data on
[29:34] grants. And also in 2023, the
Legislature directed and then to assess the viability of
implementing a single grants
[29:41] management system.
[29:46] And then last we recommended
that the Legislature increased external oversight of grants,
man and executive branch
[29:52] agencies. We have some
suggested options and pages. 49 50 of our report.
[30:00] We found that the Legislature
has made some changes that could provide greater
oversight. So, for example,
[30:07] it provided the Department of
Administration with the authority to suspend or D bar
grantees under certain

[30:12] circumstances. However, all
know that several of the duties that the Legislature provided
to the Department of
[30:19] Administration are
discretionary not required and that the Legislature has not,
for example, required any
[30:26] entity to more regularly audit
grants. So that concludes my
presentation on this report.
[30:34] I'm happy to take any
questions. Okay. Thank you both very much.
[30:39] I have many questions, but I
think I would like to start.
[30:45] >> The question by focusing on
some of the club complaints issues that you've referenced,
if we want to just go back to
[30:52] the slide where you talked
about things that affect agency capacity.
[30:58] What I found interesting is I
think there's more we could do there as a legislature.
Absolutely. But but when you
[31:07] dig into your report, you did a survey of staff and
agencies who are responsible
[31:14] for grants management and 80%
of the respondents said that they felt that the GM policies
were reasonable are very

[31:21] simple. And they also didn't seem to
think 70% strongly agreed or
[31:28] agreed that state agencies had
adequate resources and further. They felt like the
training was good,
[31:37] but they could do more. But
what was stunning to me was that the
training currently provided is
[31:45] for conflict of interest and
monitoring diversity, equity, inclusion and grants
administration. But there were
[31:51] no training modules on how to detect fraud
[31:58] or compliance or close out. So one member said financial
reconciliation training is
[32:05] needed and it's not being
provided at all that apparently anyone's
found.
[32:11] So I would love your feedback
on like that. Definitely. The legislature has a role to
play like should it's stunning
[32:20] to me to think we would need to
micromanage at this level from the state law.
[32:25] But do we need to put in law
have training on Friday to action and financial
reconciliation? Does it does
[32:34] the law that we would put

forward need to be that specific?

[32:41] Thank you, Madam Chair. I don't know that I can comment

on the specificity, but I do

[32:47] believe strongly that it would

be important to require training. One of the things that we have

noted across audits and

[32:56] evaluations in recent years is

that when we talk with grants managers, oftentimes they have

a lot of program knowledge,

[33:05] but they haven't necessarily

been provided with as much training as would be ideal

[33:10] on the policies and how to

ensure that they're following those policies. And so by

requiring them to take a very

[33:17] kind of base set of training

modules to ensure that they

[33:22] really understand what is

required of them, think that we will help them comply in a way

that they want to. But perhaps

[33:30] don't have the information. It really is. It is surprising

[33:36] the times that we go in and

people know their staff, they know what they're doing.

But there's this kind of little

[33:43] piece of the policy that they

just weren't aware of and they are not complying on purpose,

[33:49] literally did not know. And so

I I do think that requiring a set kind of baseline so that
everybody is starting with a
[33:57] certain set of information would be really
helpful.
[34:03] Thank you, Senator Brenda.
Thank you, Madam Chair. And I'll just add, I don't know
that you have to be that
[34:09] specific. >> In law as you are
suggesting, I think if to Miss Rodriguez says point, if you
[34:16] require training on the grants
management policies writ large, then that will help educate the
staff who are responsible for
[34:24] complying with the policies and
things like financial reconciliation monitoring those
are embedded in the policies so
[34:32] it would capture what your
point is as well. >> Thank you. I appreciate
that. I just have to say it's
[34:39] sort of shocking. It's not
already happening. So and it's been in the policies. So
perhaps we need to be more
[34:46] specific. My next question and
then I'll turn to members is
[34:51] it seems like there's quite a a U.S. continuing struggle
[34:57] to have agencies Flagg conflict of interest and
report that and have that in

[35:04] the files. Can you talk about
what you found on that and whether the recommendations
that were put forward
[35:13] starting to be followed if
you've seen any progress there? So I just love your update on
the conflict of interest forms.
[35:24] Thank you, Madam Chair. I I
will see that we have continued across audits and evaluations
to find issues with
[35:33] documentation of conflict of
interest with grant reviewers.
[35:39] You know, in terms of whether
it has improved, I can know that within our recommendation
updates, we have heard from a
[35:47] number of agencies that they
have established new processes to ensure that this is
happening.
[35:54] You know, for example, places
like the Office of Justice Programs that TPS, they have an
electronic system where it's
[36:03] part of a checklist. And so
it's really autumn eyes to make sure that the are doing every
piece of it. And we found that
[36:11] there are other agencies that
are starting to to meet it in that way as well. So I think
that that will be helpful.

[36:17] But we have continued to fine places where it's just not occurring.

[36:24] >> And Madam Chair, I may I just add a couple of I think some of the context might be helpful to to understand how it

[36:33] occurs, how the oversight, the lack of it occurs.

[36:39] The folks who are reviewing grants are lots of different people. Sometimes their agency staff, sometimes they're

[36:44] outside reviewers rights. You have different folks coming to review and then

[36:51] there's so there's a timing issue of having people disclose a conflict of interest with maybe a program. But then also

[36:58] you need to know whose application are you revealing? So then you need to have a list of the applicants and then have

[37:04] all the grant reviewers review it and then disclose any conflicts that it's certainly a feasible

[37:10] thing to do. And I just said that and you're thinking, OK, what's the problem? But getting the folks together getting on the information,

[37:18] it just requires a level of coordination that sometimes seems to be lacking. The other

thing I will say is that when

[37:25] we do file reviews, right where

auditors and so we are looking for documentation of it.

And there are times when the

[37:33] conflict of interest

disclosures might happen verbally at a meeting of the

reviewers. I know that this has

[37:40] happened for in the past on some, for

example, some committees looking at legacy proposals.

They get together, they say,

[37:48] OK, here, the proposals, does

anybody have a conflict? Let's let's discuss that now

and discuss if somebody has to

[37:54] recuse themselves. So sometimes

these things happen verbally. But that needs to be documented

for us to know for the public

[38:01] to know for you all to know.

So I again, I think what Ms Rodriguez said earlier is is

correct. In the at least the

[38:08] vast majority of cases where

people aren't aren't trying to not be compliant with the

policy. It's just they're not

[38:17] necessarily crossing their t's

and dotting their i's. And that's why training is

important. That's why

[38:24] you having hearings like this

showing you care about this and you know, the state things
that's important. Those things
[38:30] all added up to helping to
improve compliance. >> Okay. Thank you very much.
Met his magic is Madam Chair.
[38:37] Thank you. If I may just add
one other thing, another thing that I just want to provide for
contacts is that
[38:44] grant managers look very
different across the agencies. So in some cases that is their
only job. They do grant all day
[38:53] every day. And so they know
these policies in and out. But there are other individuals
that get kind of grant
[39:00] management pieces piled onto.
Maybe they do standards. Maybe they do policies, maybe
do these other things. And so
[39:07] it just becomes another piece
of an already full plate. And so I think that that's the
place where I think training is
[39:15] really important, especially if
it's, you know, a state agency where all we just got this
grant, we need somebody to
[39:21] manage it. You're going to do
it. If there's that requirement in
place that will have to take that step to say, okay, we need

to get them into this training

[39:29] before they take on that

additional role. So I just want to kind of give that in terms

of, you know, it looks

[39:35] differently depending on what

grant you're looking at and what agency are looking at.

[39:40] Thank. Thank you very much,

right, lead Pinto. >> Thank you, Madam Chair.

So I kinda want to make sure by

[39:47] my head on straight here.

So the report they were reviewing was the one

originally issued in February

[39:53] of 2023. And so when the chair

was quoting surveys of

[39:58] employees and all those would

have been conducted, I guess at least like 3 years ago, maybe I

could just clarify that these

[40:05] those super the maybe the chair

can clarify that she was pregnant. I can find in the

report by summit somewhere in that and the bound document.

[40:13] >> The 42 page. 42 43 in think

in that General direction and

[40:18] complex. >> General second place.

Thank you, chair. So so so in the February 2023, reports of

those would have been surveys

[40:25] from employees from several

years ago now. And I can see the testifier not in. And so
I'm just wondering to what
[40:33] extent. Well, Madam Chair is who we're
talking a lot about state
[40:38] agencies. Are we going to be
hearing from his Office of Management presenting today?
Will we be hearing from them?
[40:45] Because my understanding is
that, for example, they're sick. They're going to have a
standard training available to
[40:50] all state employees like later
this month could be wrong about that. And obviously don't work
there. The sub trying to just
[40:55] do some digging in advance.
But will a GM or their agency be presenting today on on some
of these findings? We can kind
[41:02] of hear directly. >> Thank you. Representative.
Can do. I do plan to have a GM
[41:08] in for a similar presentation,
but they are not here today.
[41:13] >> Thank you, Madam Chair.
And so I think that will be useful because I guess maybe maybe what I'll ask the lottery
team then is is to what extent
[41:21] like if agencies are doing
things. Is the concern about the legislature requiring the
doing of the thing like is it

[41:28] to what extent this year
findings of of implementation based on kind of what they're
doing versus what we're
[41:34] requiring them to do? That's
the kind of distinction on trying to understand
[41:41] as Rodriguez. >> Thank you, Madam Chair.
Thank you. Representative Pinto,
[41:48] I guess our our understanding
is that not all people who are being
required to manage the grants
[41:55] have all of the necessary
knowledge to do so. We see this,
[42:02] I would say in just about every
evaluation or audit that we find there's at least some
pieces that perhaps they're not
[42:09] aware of that they haven't been
trained on. And so we want to make sure that everybody has
the knowledge to do their part,
[42:18] to comply with regulations.
Again, I think that most people want to and by requiring them
to go through a basic set of
[42:25] training, they will have those
tools and be able to ensure that they are doing that
[42:31] and Mr. And >> thank you, Madam Chair,
Representative Pinto. And I would just add on the specific
question. And so you're

[42:39] correct. The recommendation had
been legislature require GM to do the training, to provide the
training and then legislature
[42:46] require all folks who manage
grants to take the training. And so what as Rodriguez
mentioned in her presentation
[42:54] was that while the legislature
didn't put those requirements in law, GM did go ahead as far
as we can tell and
[43:03] provide establish more
training. We haven't gone through and reviewed it.
So, you know, I can't totally
[43:09] confirmed, but our
understanding is that GM has developed the training and has
made it on demand so that it's
[43:15] more available to folks.
But it the legislature, there's still no work. Why are meant
for folks to take the training?
[43:22] So it's kind of partially done.
So GM seems like they stepped up and responded to that
recommendation without the
[43:29] direction from the legislature. But because grants managers and
agencies are not required to
[43:35] take the training, not all of
them do. Okay. >> And thank you Representive.
Thank you. Thank you, Madam

[43:42] Chair. And and then related to
that. I recall having heard the presentation of this report a
couple years ago now and the
[43:50] member, a lot of the focus
being that agencies were providing a lot
more review of competitive
[43:56] grants, been of the direct
appropriations, which I think makes sense in terms of
resources of the Legislature,
[44:02] decides to give money to a
individual organization. Want to see logically that the
agencies would say we've got
[44:07] limited resources. So they told
us to do this, I guess is that maybe first, if you can, just
either if you just expand on
[44:16] that a little bit, just help me
understand ex-wife with to the report. I continue. I see that
again as I did a couple years ago that that seemed to be kind
of a a common theme
[44:24] you might think. >> Thank you, Miss Randall.
Thank you. Mister Chair Representative Pinto. I would
say yes, that is a theme and
[44:32] has been a theme. Probably tons
O La started doing reports on grants management we have
consistently found I know since
[44:39] 2007 that agencies when when

deciding how to allocate scarce

[44:45] resources tend to not provide

the same level of oversight over grantees who have been

named in law. I will note that

[44:53] the GM policies still apply to

those grants and that agencies

[44:59] are still Rick wired by law to

implement that type of

[45:05] oversight that's outlined in

policies to all grants, including those that are

legislatively named. So so you

[45:12] kind of have 2 sets of laws, if

you will, at a little bit, not at cross purposes, but may

be sending a little bit of

[45:20] mixed messages because the

legislature has said, you know, you have to give $100 to duty

Randall Inc, right? And so on

[45:27] the one hand, the managers

like, well, OK, I got to do it right. And then on the other

hand, the law says you have to

[45:33] implement GM policies on all

grants, including the one where the legislature said you got to

give you the Randall income

[45:40] $100. So so both of those things, all of

those things are true. And yet

[45:47] we see less oversight over the

ones that are legislatively names. >> Thank you. And then the
measure has, yeah, thank you
[45:56] can do to get to these and
cement and maybe this is just just maybe to you, Madam Chair.
I know we've had we made so
[46:03] many changes in the last couple
years and so many improvements. And since the report came out
and thinking about that,
[46:09] the extensive grant
requirements and the 3 reward risk assessment of the
mandatory monitoring and progress reports. And and even
I was noticing the comment from
[46:18] mom from my agency leaders
saying your boy's really hard and we don't have the resources
to actually look into this.
[46:23] And so then given resources, as
I just maybe ask you, Madam Chair, if I if at some point
we'll hear perhaps some are
[46:30] non-partisan staff of just sort
of walking through the many, many changes and improvements
have happened since this report
[46:35] came out, but certainly urge
the committee to come to you, Madam Chair, to consider.
I'm kind of walking us through
[46:40] the accident. Got to be really
helpful. >> And thank you,

representative and oh, yeah, I think that will probably be
coming as part of our
[46:48] discussion with the GM just to
see how they're implementing the laws that were passed in
2023. So I think it is a paid
[46:55] that'll be thinking that
discussion. Representative Eric, thank you, Madam Chair.
[47:01] >> Good timing. Because I was
actually talk about some of the things that represent Pinto
just brought up. So I appreciate that. So in my 13
years here,
[47:11] auditor, Randall, I I've never
had review. So when Legislature decide this is who we are and
give money to as you just spoke
[47:18] to, I've never had in committee
lake. There are 9 90's over the
course of several years there
[47:25] audited financial reports.
Iran are reports there Iris determination, letter to know
that they actually are duly
[47:31] organized with the IRS or even
hear that they're doing organized here with the AG and
the secretary of state. I never
[47:38] had any of those documents.
And I you know, I look at the list that you provided, which I
referenced on Page 7, the vast

[47:44] number. I think you said 2500
nonprofits that are
[47:49] receiving grants now, not all
of those are legislatively approved, but a good number of
them are. So if the legislature
[47:57] is appropriating these and I have
personally brought up some of those things, but it certainly
isn't provided by the people to
[48:04] come in and want to ask those
questions. Yeah, I remember one time we
were reviewing something for
10 million dollars. And I said,
[48:11] well, Kylie, see or hear 9.90,
they didn't have anything with. They didn't have their audited
financials with. They didn't
[48:17] have that. They had nothing
with right. So as a lawmaker that
[48:23] used to create those documents
and work with auditing firm's, it did that. It was surprising
to me that none of those
[48:31] documents were provided. So let me just ask you, since
you've got us here in a captive
[48:37] audience, is that something
that you would recommend to the Legislature that maybe we
should take a look at their 9
[48:43] 90's, their audited financials?

They're in reports their IRS determination letter to make
sure that they're compliant
[48:49] with the A G S office and the
secretary of state's office before we even consider whether
or not one to just hand them
[48:55] 10 million dollars. >> Represent. Thank you,
Representative Eric Cantor
[49:02] Vandal. Thank you, Madam Chair,
Representative Eric.
[49:08] So it's a big question. >> What I would say is there
are a lot of things the
[49:13] Legislature has to consider
when allocating money when appropriating money.
[49:21] Our recommendation in 2007 was
for the legislature to not name
[49:27] grantees in law period and so
and leave that to the agencies
[49:34] that both have the program
knowledge of, you know, and can assess who could provide the
services that you want the best
[49:41] and also who have taken the
Grant management trainee and ideally and know how to review
financial statements and,
[49:48] you know, and all of that.
So, you know, while you
representative rare and have a lot of experience looking at

those, I'm not sure that

[49:54] everybody does. And so they

might not have they might not know what

they're looking at, right.

[50:00] And they might not know how to

write make the right decisions. So honestly, La is on record

[50:06] more than 15 years of same. Just don't name them and let

let the agency is go through

[50:13] that process and select the

entity that is best qualified.

[50:19] Representative. Eric, thank

you. Thank you, Madam Chair. >> Well, I appreciate that

because that's how I feel too,

[50:24] like I I feel like a very unique person here.

The legislature, not the only

[50:29] one that's ever worked in

nonprofits and that the only one that does finance. But one of the few that will put up

on my phone as we're going

[50:36] through a committee hearing and

say, hey, wait a minute, something looks off here so I

can do that quickly and look at

[50:44] that. That I would be a better

service, I think to the state of Minnesota,

[50:49] like take your recommendation.

Maybe we should stop doing that. Maybe one recommendation.

So something else is I was

[50:55] looking for your report.

I found quite curious and it's right on Page 2 side barely got

into the report. But

[51:03] it says that you reviewed the

data from swift and then you had to actually

compare it to you had to cross

[51:10] check all of that data against

the IRS of non-profit list. So you probably yes, I I go on

that website a lot because

[51:17] that's how I but I was shocked that within

swift, it doesn't even

[51:22] acknowledge that this is a

nonprofit. And maybe you should take a look at that. So can you

just tell I was shocked when I

[51:27] read that. And that's on page 2

of your report. Can you just talk a little bit about that

and maybe recommendations

[51:32] regarding that because that

seems kind of like square one to me.

[51:38] >> This had to get. Thank you,

Madam Chair and thank you for the question. Representative

Eric, I can tell you at the Ole

[51:45] we can talk data all day.

So I really appreciate the question.

[51:50] Yeah. So Swift is it's an

accounting system. It's not set up. It's not designed to

provide us with specific

[51:58] information about grants is not

a grants management system. We use it to provide

information on grants because

[52:05] it's really our only data. But it's not set up for really

being able to look at

[52:11] programmatic pieces of grants.

And so, you know, frankly,

[52:17] it's difficult to even tell

sometimes of something reliably is a grant in the system.

It's difficult to look at what

[52:25] has been awarded versus what

has been expended. It's difficult to tell what type of

solution has been awarded the

[52:34] funding. So it's just it's

really not set up to provide the legislature and others with

an overview of what happening

[52:43] in grants management. That's

really the reason that we provided that recommendation

that the legislature consider

[52:50] other forms of data for grants

so that you have better information, know that in

addition

[52:57] to Swift, there is a Web site you might

be familiar with called transparency, Minnesota, but a

lot of that is based on swift

[53:06] data as well. And so it does
have some information for the public on grants to different
organizations. But, yeah,
[53:15] you know, we had to do quite a
bit of work just to figure out, you know, pulling down
different databases and
[53:21] matching things in hand coating
to figure out which ones were
[53:26] nonprofit organizations. That answer your question.
[53:31] >> Representative Eric, thank
you, Madam Chair. Yes, absolutely. Agree that the
House that even possible
[53:37] when we're spending, I think
your report at 2.6 billion dollars to nonprofits over the
five-year period that you
[53:44] looked at them. 2.5 or 2.6,
excuse me. 2.6 billion dollars. 2, 2500 nonprofits, unique
nonprofits. And we don't even
[53:53] have a system too. Get to square one to say and I
rely swift. Isn't that system?
[53:59] But we don't have that system,
which is why you had to revert to cut his swift to say I which
one of these are even
[54:06] nonprofits. I wonder if that
this money has been spent or not spent or, you know, lake,
[54:12] we don't even have square one

here in Minnesota. We don't even have a grant management tool or a system that we use collectively
[54:20] in the state of Minnesota. And, you know, when I stirs for started looking at all of this and you talked about the Office of Great Management at the
[54:27] well, we've got a whole office of great management. They must do fantastic job. And, you know, they must manage all of
[54:33] this data as you're speaking to to that, come to find out. There's 3 people in office of Great Management, 3 people.
[54:41] And that's not their job at all. That all of that compliance and oversight and all of that, all the
[54:47] accountability is at the agency. And as you testified, some agencies have systems and some
[54:54] don't. And some use a good grant management tool and some don't. And so there's just this lack of consistency across all of
[55:01] state government is just astonishing to me that we haven't even gotten to square one, which is I don't know,
[55:08] have one tool where you can actually evaluate everything and figure out it. Is this a nonprofit? Is it not? Is it,

[55:15] you know, all of those things?

So I was reading through your report and it was just amazing

to me.

[55:23] So let me I'm gonna ask the

last question. Then I'll turn it back to excite you amenable

to ask Ms Vera left last

[55:28] question last question. I'm still just sitting here in

shock, quite honestly with the

[55:34] the testimony. But the last thing I was going to

ask is the most simple thing to find out how a non-profit is

functioning as a site visit.

[55:44] And you had mentioned that in

your report and in your testimony, both it well, sometimes their site

visits. And sometimes there's

[55:50] not. And sometimes it's just a

telephone call or are just a zoom meeting or something

rather not actually on site.

[55:57] And as we've seen in multiple

now reports, both news reports and some of

your reports that,

[56:07] well, I I think of J Cole's was

just at a site where he he has video of a completely empty

Baker Center. That's I think it

[56:14] received 7.8 million dollars. There's nothing in it besides

empty shelves in some empty

[56:20] boxes. So how long have you been? We're

recommending to the legislature

[56:27] that that would be an inclusion

in the rip kind of the mandated

[56:32] things that we do is actually

go on site and looking to make sure that these are both legitimate and there are

if they are legitimate, that

[56:39] they're performing the task

that they've been asked to do through the grant.

[56:45] Munson Rodriguez, thank you. >> Thank you. Madam Chair.

As MS Randall noted, the last

[56:52] time that we looked across

grants management in the state of Minnesota was in 2007.

And at that point we didn't

[56:58] even have OT. So that was the

point at which we recommended that there be an office to

establish standards across city

[57:06] agencies. So this was kind of

really our next follow-up. And that was when we looked

again, we

[57:13] found in trying to find best

practices are recommended practices for grants.

Management. We found it was

[57:20] quite difficult. There's not a

lot of there's not a lot of peer

review journals out there

[57:26] talking about how it spreads

specifically state agency should be doing monitoring.
So we really we look to other
[57:35] federal agency look to other
states. We looked at what different types of nonprofit
organizations we're
[57:41] recommending and that's it.
That's it was one piece that we pull out that we thought would
be a good addition to what has
[57:49] already been established.
I do want to note that Minnesota is ahead of the
curve. You know, we found that
[57:55] we when we did this, we were
one of I believe, a dozen states that even had statewide
grant management policies in
[58:03] place. We always want to strive to be
better. So
[58:09] that was a piece that we just
recommend it 2 years ago. >> Thank you. Ms Rodriguez,
Representative Freeman.
[58:17] >> Thank you, Madam Chair, and
thank you both. I actually saw
[58:22] this on its originally in.
I think we did a joint hearing and education finance and early
childhood a couple years ago.
[58:30] And in some ways it's the
challenge of of of doing this a couple years after the original

reporting. I think there's

[58:39] actually 2 the few things that

are Representative Rick product. I think that there's a

report due very soon about a

[58:47] statewide grant Grant

management system. One of the things in 2023 that as a

legislature we did was ask

[58:54] follow up on that

recommendation, actually asked what it would take and the

resources. And so I think that

[59:00] it would be great to hear from

them. It's unfortunate that they're not here today to sort

of give us more details on that. And the other thing, I

think that in response to 2 the

[59:10] they the point you made a

prisoner is they went from 4 f 4 people to

12 in response to this audit.

[59:21] The offense of grants

management did because I think that there was a recognition by

both in the auditor by the

[59:28] legislators, but that wasn't

enough. And so I think the piece of the a lot of the work

that was done, I think in state

[59:35] government, which I was not on,

I was doing that. And so we actually have the benefit of

being able to hear about some

[59:42] of those updates. Again, the
agency isn't here today to give us that, but I hope they will.
The other thing I'm really
[59:49] interested actually working
with you on is I do think we need to think about when I so I
decided I was like, oh, the man
[59:56] the 2 years ago, the main
takeaways are the legislature isn't appropriating enough or
inconsistently the when we do
[1:00:05] grants the resources to oversee
and sort of administer those
[1:00:11] grants. And when we name direct
grants it it makes it harder
[1:00:16] for the agencies to do that
oversight because we've already determined that we want the
money to go in there. And so I
[1:00:23] do think that thinking about
our practices, one of the things we have in state law in
the construction spaces,
[1:00:31] the responsible contracting
law, which says that we can't actually we shouldn't. Our the
state shouldn't give resources
[1:00:40] to folks who have violated in
addition to to labor laws, tax laws and other things.
And I think we should think
[1:00:47] about what that would look like

to expand that, right? Because if you have not followed any of our laws, we should think twice
[1:00:56] about whether in the future folks who could grant. So I think that I mean, just in talking about that been
[1:01:01] thinking a lot about that, I actually had a few questions about the conflict of interest piece, because, you know,
[1:01:08] I think that we can look right now to see what's happening at the federal level, which is a example of a modeling. How not
[1:01:17] to do it, right? We have and elect a billionaire who is in our our finance systems in the Treasury that has is rife with
[1:01:25] conflict of interests, Starlink, Tesla, Twitter's SpaceX, whatever you want to call it that acts. And when I
[1:01:33] think about Minnesota, I haven't. And I want to ask you
[1:01:38] this question when I think about of certain comfort of interest, I don't think we're talking about folks in
[1:01:44] government who have become close in just what you're talking about is the paperwork about a conflict of interest
[1:01:50] disclosure. So that's why I

would just ask that question
[1:01:55] along with this question, which
is I think that would be administered by the Department
of Admin has said is they
[1:02:01] actually believe that they're
following this, that that. >> There's a requirement that
every government worker conduct
[1:02:11] follow the code and that
there's a set of template. I went on that the online for
agencies to do the conflict of
[1:02:18] interest paperwork. And so my
question on the auditing from this might be a question for
the the Biden administration to
[1:02:25] is the issue that you're
finding actual conflicts or is the
issue with the paperwork not
[1:02:33] beings. >> Standardized just as
Randall, is that because thank
[1:02:39] you, Madam Chair and thank you.
Representative agreement. Typically what we're looking
for is the paperwork. So our
[1:02:46] first step is usually too, when
we're doing a file review, we looked we try to determine
whether they have appropriately
[1:02:53] collected conflict of interest
forms. That is often times what our findings are about is if

those have not been collected,

[1:03:02] if we have those collected, we

also look to see whether there are any conflicts that have

been disclosed and if so that

[1:03:10] if they have been documented as

appropriately handled so that would be the other piece.

[1:03:17] Thank you, Mr. And >> thank you, Madam Chair and

Representative Freeman and I agree with everything is

Rodriguez said and then I

[1:03:24] wanted to add 2 things. One,

the conflict of interest form. We weren't looking for it to be

consistent. So I don't think

[1:03:31] there's a role there for a jam

to make those forms consistent. It's it's whether it's been

completed and then course if it

[1:03:39] hasn't been completed or it's

the identified concerns, don't show appropriate

mitigation, then there's the

[1:03:46] opportunity for a conflict.

And while LA has not done a lot

[1:03:51] of work to track down, you

know, a specific reviewer's personal relationships to see

if there is a conflict. We have

[1:04:00] had a few reports in the past

that have identified conflicts of interest where somebody was,

you know, improperly benefited

[1:04:09] as a result of their government

position. >> Thank you, Representative

King, thank you. And to that

[1:04:16] question with that was where

those places where with sounds like it was found and reported,

which is good places where

[1:04:24] there was not paperwork or they

places where there might have been paid for. Can you find on

the conflict?

[1:04:30] >> Just out of Curiosity.

Thank you. Madam Chair, Representative Agreement.

[1:04:36] I'm thinking of one in

particular and

[1:04:44] >> it's a complicated. How

about if I talk to offline on its complicated. Thanks.

[1:04:50] Thank you, Miss Brenda Representative Schultz. Thank you, Madam Chair. So when

we're looking at both once in

[1:04:58] lot, maybe even recent changes

and then kind of looking back at the work that you've done

over time,

[1:05:04] how often are we seeing?

State agencies used progress

[1:05:09] reports and progress reports

effectively. So that dollars

[1:05:15] that have been allocated least

ensuring that it would be you.

[1:05:25] >> Does that make us? Thank

you, Madam Chair. Thank you, representative. I think that

that's a great question.

[1:05:31] I think that progress report

can be a wonderful tool to ensure that state agencies can

see whether the grantees

[1:05:40] moving forward if they're going

to be able to hit the goals for their grant. Unfortunately, one

of our biggest findings,

[1:05:47] I would say in most of the

reports that we've done is that there are issues with

collecting progress reports on

[1:05:54] time. We find a lot of issues

with fine getting the progress report at all. And we also find

issues with violations of state

[1:06:02] policy where the state agencies are

continuing to pay out to grant.

[1:06:07] He is even when they have a

progress report that is late. And so that's just kind of in

terms of obviously, if they're

[1:06:15] not getting the progress

reports, they're not using them to effectively manage the

grant. I think we have also had

[1:06:22] concerns about looking at the

way in which they are used.

[1:06:27] So again, we were all about
documentation. We oftentimes to
[1:06:34] not find documentation that
they have been reviewed or how they've been used. We've been
told that often times it's more
[1:06:41] informal. They read through it.
They discussed things with the agency. But, you know, I think
that that's something that
[1:06:47] we've pointed out in several of
our reports that we think that these could be used more
effectively to manage the
[1:06:54] grants. Thank you, Representative
Shoaf. >> Thank you. I think that you
answered kind of my my second
[1:07:00] question. They're just kind of
highlighting this fact that. >> A lot of this information
number one isn't being is it
[1:07:09] isn't being given to the state
agency that's granting it. Number 2. The state agency
[1:07:14] is potentially not even
reviewing it while still continuing payment.
[1:07:20] It's >> through. >> Either your recommendations
or looking at what is currently
[1:07:26] in state law, what should be pursued to close
that specific issue?
[1:07:34] >> Auditor and this Rodriguez, thank you, Madam Chair, thank

you for the question. I

[1:07:44] I guess I will say I'm not sure

that it is an issue that the Legislature needs to take up.

There is already a requirement

[1:07:52] in grants management policy.

That is the agency not hey, a grant to you when they

have a pass to progress report

[1:08:00] or if they have not turned in a

progress report that's already on the books. We just need to

make sure that that's being

[1:08:05] followed. And so the one thing I would

know as as an an talking

[1:08:11] through in my presentation, I

think there's space for the Office of Grants Management to

provide a little bit more

[1:08:18] support, 2 state agencies to

ensure that they have specific

[1:08:24] standards for their progress

reports to ensure that they're useful to ensure that they're

using them in a way that it's

[1:08:30] not just kind of checking a

box. We filled out this report and here it is. We we hope that

they will be using them to

[1:08:38] actually move forward and help them

achieve the goals of their grant. But I think that that's

really something that DM would

[1:08:46] be most qualified to do. It's kind of thank you, Madam
Chair, Representative Schultz.
[1:08:52] I think it's a great question.
I agree the requirement already exists. >> But I do think it gets back
to the recommendation about
[1:08:59] training for the grants
management staff for them to understand what they're
supposed to do when they get
[1:09:07] those products reports. I mean,
my my guess is that the nonprofits
who are submitting the progress
[1:09:14] reports that a lot of work into
them or at least some of them do, right. So we're asking the
recipient to do this work.
[1:09:20] And so I do think it's
incumbent on us as the state to review those
and to know what we're looking
[1:09:27] for. And I don't think that
that is always clear. I do know
[1:09:32] of things that had been
reported. You know, where it's like the exact same thing,
every quarter rate where it
[1:09:38] doesn't make sense. If somebody
had actually been looking at it or sometimes they report that
they're doing something that's
[1:09:45] actually not compliant with the

program, not on her. No, it's not a
intentional fraud type of than
[1:09:53] the grantee thinks that it's
part of the grand. It's covered. So they say that
they're doing it and then you can tell that nobody ever
looked at it because if they
[1:10:00] had or if they had understood
what they were supposed to do with that information, then
there would have been
[1:10:07] follow-up. And hey, no, that's
not an allowable expense. And so I do think there's that
gets back to this training
[1:10:12] component of okay, not just
look at it. Not just, you know. Yeah, yeah. They signed it.
The data that okay, good.
[1:10:19] But what are we supposed to do with
it? So I think it's a training issue more than anything.
[1:10:25] Thank you, representative
selfless question. >> Thank you, Madam Chair.
When I think about it and I think of what's transpired the
last several years, we've seen
[1:10:32] such rampant fraud in our state
in the hundreds of millions of dollars. I think it brings me
back to the fact that this is
[1:10:40] to Europe to your point like
these tools are already in the tool box. And so I'm curious if

you can provide any insight as

[1:10:48] to what agencies, even if you

can give maybe the greatest example of success that you

have seen for state agencies to

[1:10:56] kind of have a level of

accountability within their agency, whether it's dealing with an

individual employee's

[1:11:03] apartment, you know, at that

that's working through these processes. I think that

Minnesotans are really curious

[1:11:09] to know what accountability

measures are in place and to what extent those things are

happening within each agency.

[1:11:19] >> As Rhonda, thank you.

Madam Chair, Representative Schultz, go first and then

we'll see if Mister Rodriguez

[1:11:24] wants to chime in. I think the

the programs and the agencies

[1:11:30] that are most successful in

overseeing grants, I'm not saying they're perfect, but

that their most successful

[1:11:37] are the ones that that take the oversight

responsibility really

[1:11:42] seriously. And so it's not

about tune in to measures rate of an

employee of like a way you

[1:11:48] didn't find the progress
report. You're in trouble. It's more just like in the air
in those agencies of this is an
[1:11:56] important part of the ministry
in the programs. And we've talked to I've talked
about this and with the audit
[1:12:04] commission about in state
agencies having having a oversight mentality in
addition to supporting the
[1:12:14] organ, the grantees and in
addition to supporting the programs and having this
understanding that
[1:12:22] for the state to provide the
best service, the intended service to the people who are
supposed to be getting those
[1:12:29] services that is, you know,
hand in hand with ensuring the
[1:12:34] proper use of the funds,
providing that regulatory oversight. And I think
[1:12:40] in some places we've gotten
into a I don't know, maybe an
imbalance where we're really
[1:12:46] focused on on the program and
the supporting the folks and helping. And there's a place
for that 100%. But it can't be
[1:12:54] all of it because at the end of

the day, the state agency staff are responsible for ensuring
the state money is used
[1:13:00] properly. And so there has to
be a balance. And I think,
[1:13:06] but I think that's where that
is present are the agencies and
[1:13:11] the offices and the programs
where we find the fewest issues and where we we see that, you
know, the I's are dotted and
[1:13:19] the T's are crossed. And again,
it's not every is I'm not we're not
expecting 100% perfection,
[1:13:25] right? It's people. We
understand that. But again, I think it's the culture.
[1:13:32] Thank you, Miss Rodriguez, thank you. Madam Chair. I just
wanted to add that I also think
[1:13:37] that there's something to be
said for agencies. And I want to say that some agencies are
too small to do this. But I
[1:13:46] want to say that those agencies
that can >> have staff that have a
really good knowledge of the financial aspects of grants.
Management
[1:13:54] typically do well. And when those staff are in
really good communication with
[1:14:00] the program staff, they tend to manage their

grants. Well, so, you know, there's a lot of
knowledge that is required to
[1:14:09] manage a grant effectively. It's not always going to work
to have one person doing all
[1:14:14] those pieces. But when you have
people that are really experts and what they're doing, they're
communicating really
[1:14:20] effectively. I think that that
space is where we see that it tends to work well.
[1:14:27] >> So I know there's follow-up
questions. I just want to throw one of my own follow-up
questions and hair.
[1:14:34] So we've gone through that we
need more training. But there are requirements on
the books to do the close out
[1:14:42] evaluations to stop payment.
If you're not getting progress reports
[1:14:48] and it seems like enforcement
is not happening. So we've empowered GM to do that
[1:14:56] and it's not happening. Can you talk about, you know, in previous
conversations we've talked
[1:15:05] about and betting things in
people's job descriptions, making it more clear who's responsible
and then holding people
[1:15:13] accountable. Can you talk about how we could
better ensure inforcement could? Clearly the training is

happening on it and we may need

[1:15:21] more but it's already a policy.

So how can we enforce stop payment or do the progress

reports of those things that

[1:15:29] have been highlighted here?

Thank you is random.

[1:15:35] >> Thank you, Madam Chair

members. So yes, the legislature in 23 did in power

[1:15:43] and then really threw the

officer grants management to enforce policy and procedure

improvements. It is

[1:15:50] discretionary. So, you know, I think they have

the authority to do it. They are not required to do it.

They also, as as we've

[1:15:58] discussed, you know, previously

had 3 or 4 people, right. And they now have I think they're getting close

to 10 or 12. But for real,

[1:16:08] you know, enforcement, it

requires doing the types of things. La does great going

out, pulling a file review.

[1:16:17] You know, if so, if you want

external enforcement like that, it's a lot of resources.

[1:16:23] And so, you know, that's that's

one approach. And I'm looking in the

[1:16:29] report. I'm pages. 48 through

51. And I think maybe this is

[1:16:35] our didn't discuss week. >> We walk through some options
of of how
[1:16:40] the Legislature could increase
external oversight of grants management. So that's the
recommendation. And then we
[1:16:48] walk through how to do it.
So one, you know, increase GM's responsibility. So again, the
23 Legislature did add it as a
[1:16:56] discretionary authority.
So it's it's now in there. There are will house if they
want to use at another is
[1:17:05] looking at that role. Internal
auditors play within an agency.
[1:17:10] So it's not as external, but
it's at least an entity that's external to the grant for the
grant program and going in and
[1:17:17] having that be a priority to
say, OK, I'm gonna pull some random files and let's see if
we're doing it. And that's a
[1:17:23] really great opportunity for
continuous improvement for an agency.
[1:17:29] And then you could do an
independent oversight unit either within the executive
branch or O la. We're not.
[1:17:35] We're not looking for not
asking for that, but, you know, there's other options then that

you could you could do at the

[1:17:41] end of the day, though,

enforcement, you know, is really gonna come

back to the legislature because

[1:17:47] all of these entities, you know

it so well, if it's GM, the best they're going to be able

to do is report it back to you

[1:17:54] and reported to the agency and

say, hey, we're seeing issues here here

here, right? Let's clean up.

[1:18:00] Let's clean that up. But in

terms of, you know, enforcing compliance. I mean, one, that's something

that the agencies have to again

[1:18:09] promote from within. And and to

be clear, I I do believe we do believe that agencies want to

manage these grants. Well,

[1:18:19] and so some of it is educating

them on where they're failing and then some of it is bringing

it back to you all to decide

[1:18:24] how how you want to use that

information. >> Thank you, Representative

Freeman, thank you. And I guess

[1:18:31] this is sort of a question that

I think it's helpful here. But as we think about our work

are the as we think about both

[1:18:38] the agency staff and Office of

Grants Management are the same

[1:18:43] folks responsible for incident.

The oversight of both state funded grants and federally

funded grants because ICE or a

[1:18:52] federally funded. I assume that

there's a whole set of sort of labyrinth of overlay, but the

federal government puts and I

[1:19:00] know that as we think about

some of the most recent issues of fraud that we're seeing sort

of play the way through the

[1:19:07] courts, a lot of those have to

do with federally provided resources. Is it the same

infrastructure within our state

[1:19:14] agencies? It's random. >> Thank you. Madam Chair,

Representative Agreement.

[1:19:19] It's a great question largely

yes, you know, a lot of grants

[1:19:24] are split. Have some federal

funding have some state funding? >> But yeah, that the

[1:19:31] >> the management of grants is

largely done by the program staff and so program often gets

funding from state and federal

[1:19:39] and and yeah. >> Thank you. Just one more and

then yeah, presented a concept.

[1:19:45] He think you and I think the

for our work and as we think about it, right, we're thinking

about both where the funding is
[1:19:53] coming from. So their state and
federal dollars that com sort of like grants but sort of a
direct programs. Then there's
[1:20:03] the service providers, right?
And we're talking about non profits today. There's also for
profits that we both grant and
[1:20:12] then 2. And then there's also
government, both our state workers, as well as local
government, and then in some
[1:20:17] cases, and I was looking at
this slide on on your slide 3 in some places. It looks like
even then we grant to sort of
[1:20:26] we outsource the oversight and
say, like was a grant to an organ to and infrastructure
that grandson. I think as we
[1:20:32] look at some of the past
experiences right that we've seen in and learn, I think we
have to think about as the
[1:20:40] legislature, our job is not
just to think about the so what
[1:20:45] happens on the agency side.
But how are we thinking about saving federal dollars? How are
you thinking about our
[1:20:53] relationship to the providers,
whether it should be government providers or nonprofits are

vendors and how that affects

[1:20:59] again that sort of fraud in

conflicts? I think that is really helpful thing. It's a

relatively narrow as we think

[1:21:05] about some state funds to

nonprofits. We do need to think about to the whole set of

government funds and the whole

[1:21:12] set of providers in May.

Appreciate that. The question of the conversation. Thank you.

Representative Hawkins, thank

[1:21:18] you, chair. >> Listen to the conversation

this morning that the first thing that strikes me is that

it really feels like the next

[1:21:26] step here should be to hear

from the office of Grant Management. I'm hoping we can

do that is as quickly as

[1:21:32] possible so that we can learn

about, you know, what's in progress, what's already been

done? What's yet yet to be

[1:21:38] done? And then second, I just kind

of, you know, that somewhere

[1:21:43] along the way, all of us will

have a grant appropriation bill

[1:21:48] and thinking back on my 8 years

here, you're probably at about a half dozen of them. Each of

them has been different in

[1:21:56] quite a bit different. And I would probably say 2 things a lot differently on a lot of
[1:22:03] those. If I knew then what I know from reading all of the homework we had this weekend, and I think one of the outcomes
[1:22:10] of this is probably going to be have to be some kind of at least high-level education for our colleagues about how all of
[1:22:17] this works and what's appropriate and what's not appropriate. To just give one example, I've been caring
[1:22:23] a bill for the council on disabilities for several Sessions. Haven't got them any more money for it yet. But time
[1:22:29] just to provide money for them to administer grant program to help cities and counties improve the digital
[1:22:35] accessibility of their websites. And I've always up until now, you know, resented the fact
[1:22:41] that the Department of Administration always wanted to collect like 15% bigger shop, the top. That's why I looked at
[1:22:47] it to administer the grant program. And now I don't resent that anymore. And last session,

[1:22:54] they the council came to me and
said, you know, we think we can administer the grant ourselves
and say that 15% or whatever it
[1:23:02] was. And now I look at that and
say, can they really do they really have the capability in
their small staff to do do
[1:23:10] everything that needs to be
done or do they at least need a backup support from from the
office of Grant Management.
[1:23:17] So I really enjoy, you know,
I've been volunteering for this and I've already just over the
weekend for all the homework we
[1:23:25] had to do learned a tremendous
amount. So I'm yeah, I'm looking forward to the
restaurant rest of our work
[1:23:31] here. >> Thank you, Representative
Elkins and I concur that we need a culture change in the
agency's. We need a culture
[1:23:38] change in the legislature about
legislatively name grants and we can all work on that with
our colleagues together.
[1:23:45] >> Representative Eric as well.
Thank you, Madam Chair. To that point, I would recommend highly
that we listen to the auditors
[1:23:53] and say probably don't do it. We don't have the time to
really do it properly. You

[1:24:00] know, like I worked over 20
years and nonprofits and we really should every time you're
going to do direct
[1:24:06] appropriations to a nonprofit,
you really should look at 3 years worth of 9 90's. You
really should look at 3 years
[1:24:12] worth of audited financial
statements. You really should look at the salaries. And as I
surveyed sellers of the
[1:24:18] executive people because I've
seen also true of 9 90's or the
salaries of the top person is.
[1:24:27] >> We hire than the governor way higher than the governor.
[1:24:32] >> In Multan twos. And I would also say this, too,
since we're talking about this,
[1:24:42] there's a plethora of
nonprofits that get in excess of 50% of and charitable.
I don't mean hospitals. I don't
[1:24:50] mean schools, charitable organizations that get over 50%
of their revenue from
[1:24:58] government. If you think about
if you're going to do, if you're a local government and
you're going to a bonding
[1:25:03] project that local government
has to do a 50% match, then we'll consider it as a bonding
project.

[1:25:10] But you've got a whole bunch of
nonprofits and I don't have
[1:25:15] have the number for me because
I haven't done that. Doug May we should ask them to a look at
it. But there's a whole bunch
[1:25:22] of them that have executive
staff. It is way above what our governor's mansion and are
getting more than 50% of their
[1:25:29] money from government. But my
question actually, before we wrap up, I but just this
conversation is excellent.
[1:25:35] I've never had it my 13 years
here. The Legislature, this is unique. And I'm I'm I'm just
[1:25:41] I'm so excited to get to work
on this across the aisle as get this done because I don't think
that we have the time or
[1:25:48] expertise to be doing direct
appropriations to nonprofits. But anyway, so I my question,
though, is the so a little bit
[1:25:56] higher level, right on back to
that Page 7, which I love Page 7 of your report, I could live
in Page 7. It's so informative.
[1:26:03] So one of the things that you
calculated together and I don't know how you arrived at the
stat, I guess that's really the
[1:26:09] question. But out of the 27

unique state agencies that are

[1:26:15] giving money to nonprofits are

granting money to nonprofits. 25% of the recipients.

[1:26:22] 25% of the nonprofits we're

getting for more than one state agency.

[1:26:27] Now, I know that you are the

data experts and I'm and just amazed at what you're able to

do. That is but short of you

[1:26:34] going in and looking at this,

is there any way for agencies to say, okay, so like the top

of the list is Lutheran social

[1:26:42] services of Minnesota so they

have. >> 10 different state agencies

are getting money from, right.

[1:26:48] So are these 10 agencies and

coordinating and talking about this in collaboration? Is there

any hydration between state

[1:26:54] agencies whatsoever to leave in

know that other state agencies are also granting money, too?

You know, the next one, a

[1:27:01] couple ones down as clues.

I I only know clues because the I've heard them so many times

and different ones of my

[1:27:07] committees even further down on

the list. You've got University

[1:27:13] of Saint Thomas. So I mean that

invite university, Jonathan to my committee and ask him those questions. But 7 state agencies
[1:27:19] give money. The University of Saint Thomas is there. Is there anybody looking at this or even thinking about
[1:27:25] this, Mr. Rodriguez? >> Thank you, Madam Chair and thank you, Representative rare.
[1:27:32] I think the short answer is no, not that we're aware of first, as I said, the data to get to this. It's pretty
[1:27:40] complicated. One to, you know, most agencies are restricted in their access to this data. It's it's a need to know.
[1:27:48] And so they're not going to have data time. No other state agency is work.
[1:27:54] A couple of things that already are in place. So state agencies
[1:27:59] are allowed to share close out information. So after they have completed a grant, the are allowed to share close out
[1:28:07] information with other state agencies about that grant. They're not required to. And in our survey we found that
[1:28:13] they did it. I know that there is a provision that came in 2023 about doing evaluations on grants. One thing all note

[1:28:22] about that, though, is that it
is just it's by grants. It's not like a comprehensive look.
So 8 again, it it's very
[1:28:31] difficult to get your hands
around this information at a
[1:28:36] state quite well. >> Thank you, member
Representative Anderson has a
[1:28:42] question. If you want to just
finish up, representative out, especially with a quick
comment. So >> here's another place that we
need to go. I think members is
[1:28:49] this the high-level look at
things. And I would say to that, I know that in previous
conversations with the auditor,
[1:28:56] they don't go in and look at
like the things I was talking about like the they don't audit
than on night the or excuse me,
[1:29:02] the nonprofit they don't look
than i-ninety the audited financials, the salaries.
They don't look at how much they're getting from
government. That's our job to
[1:29:09] look at that or the agency's job. But they
don't they just track the money, too.
[1:29:15] Where were the money was spent?
But that's something that we could also do. In addition
to this high level, maybe these

[1:29:22] agencies should talk to each
other if they've got 10 agencies granting to the same
entity.
[1:29:28] Thank you. Thank you,
Representative Anderson. >> Thank you, chair and just
yet. Thank you. I'll be real
[1:29:33] quick center where over time
and that we want given in to paint my opinions
here. But I have a kind of very
[1:29:40] specific question about the
grant pathways. So when we have pathways where a grant us going
from a state agency, too
[1:29:50] Hass through man too another and A T
[1:29:55] is there any documentation wired with that in it is.
So there's there's there's
[1:30:06] policies and procedures that
are state agency needs to followers to be following.
That doesn't go to that next
[1:30:14] level. When you have now multiple layers here, which
is what we have a lot.
[1:30:23] >> Thank you, Madam Chair,
Representative Anderson. But yes, there should be
because there's usually a grant
[1:30:29] agreement are a contractor,
something between that pass through Grant the organization
and the sub grantee. So I'm

[1:30:35] thinking of when we did the
performance audit on the Board on Aging, the senior nutrition
program, that's kind of an
[1:30:41] example of this. You all
appropriated money to the board on aging and went to the area
agencies on aging, which is
[1:30:48] like the past to grant the
organization and then went to that meal providers and then
went down to that the elderly
[1:30:55] person who received the meal.
So yeah, there there there should be in there was
agreement between the area
[1:31:01] agencies on aging and then the
meal providers are the vendors. And then when we did that
performance audit, for example,
[1:31:07] we went down and looked at all
of those agreements and then Paul tests. >> Okay. Thank you. Thank you.
Thank you. Representative had
[1:31:15] said thank you, Madam Chair. As
[1:31:20] I consider everything that's
been presented here today and the discussion that we've been
having his members, it is
[1:31:25] really occurs to me that the court
issue here is incentives, you know, where the incentives
to do the right thing. And in
[1:31:33] private transactions, the

incentives are pretty natural, right? It's your money. You
care about how it spent where it spent efficiently, the
people who you engage with
[1:31:42] directly in a transaction are
accountable to you on the transactional basis here
because we have all these
[1:31:49] layers of bureaucracy that come
between where the money comes from, the taxpayer and work
actually meets the ground with
[1:31:57] people receiving services. Those incentives seem to be
pretty clearly blurred in terms
[1:32:05] of ensuring that money is being
spent efficiently. You know, when I asked my son to clean
his room, they can tell me did
[1:32:13] that's a report, its progress
report. But I have to validate by putting my eyes on whether
or not it actually happened.
[1:32:21] And it's been pointed out in
the report on multiple different occasions. I'll just
like this one area regarding
[1:32:26] him to eat when it comes to site visit.
When it comes to verifications. If I can be a grant to the Grey
says, quote, directly.
[1:32:35] According to GM policy, 15 of
the 16 empty grants over review required at least one
monitoring visit during the

[1:32:41] grant Lifetime and 13 required
annual monitoring visits or GM policy states that although
visits may be made in person or
[1:32:49] by telephone, that they recommend that that occur
in-person whenever possible.
[1:32:57] The policy also states that the
monitoring visit should include review of progress against the
grants, goals and discussion of
[1:33:03] any problems. Md did not provide evidence and
conducted monitoring visits for 14 of the 15 grants that
required monitoring.
[1:33:12] >> Visits. Obviously, that's an
issue. The other thing that I see pointed out is that the
potential of these monitoring
[1:33:19] visits being conducted by
telephone. My question would be how effective is that in terms
of if you're going to call
[1:33:27] somebody up and just kind of
asked them, hey, are you doing what you're supposed to do? >> Are you gonna be able to
catch something like was
[1:33:33] reported by Jake Holes in
recent weeks of alleged daycare center? That's very clearly not
actually operating as such.
[1:33:43] >> As Rodriguez service ran to. Thank you, Madam Chair and
Representative Hudson,
[1:33:51] I will say that LA is in favor

of on site visits and things that that's the best way to be
able to see that the grant
[1:33:59] program is is being implemented
and the way it's intended, I will acknowledge, of course,
that it's more resource
[1:34:07] intensive right to go do an on
site visit than to you could call
[1:34:12] all year grantees and one
afternoon, maybe. But you can't necessarily travel to all of
them. And so that is why in the
[1:34:18] grants management policies,
there are kind of thresholds at which, you know, you have to do
with such as monitoring visit
[1:34:25] annually are just once and all
of that. But I do think there is a role, too. Encourage flash
require onsite visits when
[1:34:35] grants reach a certain
threshold. And I think that question is what it what are
those threshold?
[1:34:42] >> Thank you. Representative
Hudson, thank you. Thank you. I don't see any more questions.
Thank greatly appreciate
[1:34:49] everyone. Oh, I'm sorry,
represent. >> The Pinto. Forgive me.
I did feel that no prom,
[1:34:54] madam chair. And this is a this

is sort of a broader point, I suppose does connect to the
always work. So, of course,
[1:34:59] the perhaps the most notable
scheme of fraud that a lot of us have been noting last couple
years is feeding our future as
[1:35:07] a chair. I think members are
where there's a a major criminal trial happening right
now. In that case I became
[1:35:12] aware over the weekend. I thank
you, Madam Chair and unknown also to the chair Bennett that
the Education Policy
[1:35:18] Committee's having hearing
tomorrow. I think that all is presenting and I really as a
this is a prosecutor that kind
[1:35:23] of freaked me out just to use
to use a technical phrase. And so I'd asked I don't know
if the U.S. Attorney's office
[1:35:30] has said we have no concerns
with the conflict. And if so, then additional problem.
They're the ones question in the case, if U.S. Attorney's
office has not signed off on
[1:35:37] that, but I guess I would urge
Madam Chair, I just want to bring up now that the chair,
Ben, it would postpone match.
[1:35:44] There's plenty of plenty of
other time, but I would hate to have a conviction somehow get

overturned on appeal. And the
[1:35:49] last thing we want to do is
have anything that we would do with the legislature, interfere
with a criminal charge relating
[1:35:56] to 2 alleged fraudsters.
And so it we would want to urge that that needed to be
postponed or at the very least
[1:36:02] check in with U.S. attorney's
office and some Adam Shoulder chat. >> Thank you, chair the Pinto.
I did see your note over the
[1:36:09] weekend. And my advice is that
the U.S. attorney for Lee knows how to contact her Bennett and
if they want to reach out,
[1:36:16] that's up to them. But quarter Bennett, but that's not
the jurisdiction of this committee. So and I just
mentioned
[1:36:25] we bet you can to thank you so
much. I would think. >> Probably there prosecutors
are pretty busy prosecuting
[1:36:31] multiple folks. I just I just
want to say it's a bit of a roll of the dice and I would
hate to have our legislature or
[1:36:39] the end of the folks
controlling the committees at this point have to be any
chance of interference. I
[1:36:45] understand that that obviously

telephones exist. They could do that. But I really I would
really, really urge that we not
[1:36:52] roll the dice on this, not have
any kind of gambles. You like I encourage the Pinto to contact
her Bennett directly. That is
[1:36:58] not the purview of this
committee. >> So with that, I appreciate
the great conversation today
[1:37:04] and I greatly appreciate the
testimony and the hard work of
[1:37:10] Office of Legislative Auditor,
Rental and Deputy Auditor Rodriguez. Your work is exemplary and we
all greatly appreciate it.
[1:37:18] And I would just like to point
out my colleagues that these are things that have been going
on since 2019, and it was
[1:37:26] reference that that this is
2023 report that the LA did. But I would just like to drive
to everyone's attention,
[1:37:33] which was in your packet there.
Update of their 2023 reports since the
changes were made for the
[1:37:40] opposite of grants management
that came out this month February 2024. And it is filled
with detail that all of us
[1:37:49] should be considering on

things. The opposite of grants management has implemented things they haven't and why

[1:37:54] that might be. So this is a very timely topic. It's not old news and I'm grateful that you came and presented to us today

[1:38:03] and with that members. Our next meeting will be on Monday, the 17th of February here at 8.15. Thank you very much.

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 02-17-2025

[1:40] >> And roll. And then I will
highlight some information I know is I'm interest. Having
listened to your discussion
[1:46] last week to level set, this slide
provides a very high overview
[1:53] of the grants landscape and
it's back as you are aware of the Office of Grants,
Management or GM as I will
[1:59] refer to. It is an office
within the Department of Administration that supports
state agencies in grants
[2:05] administration by standardizing
streamlining and improving grant-making practices.
[2:12] The only highlighted the other
day that their audit work discovered that GM is ahead of
the curve being one of only a
[2:19] dozen states that has statewide
grants. Management policies in place
[2:25] grants are financial
assistance, paid or services furnished by a state agency via
a 3rd party to an eligible
[2:33] recipient. Minnesota has a D
centralized state Grants management system which means
that ramp making authority and

[2:42] decision-making implementation
and performance monitoring of grants live with individual
state agencies. State grants
[2:51] are regulated by state law and
by policy. And the requirements span the full life cycle of the
Grant from PRE Award through
[3:00] active grants to Post award and
close out the 13 Policy framework
established and maintained by
[3:09] GM covers requirements for
requests for proposals. Conflict of interest
application review risk
[3:18] assessments. Grant's execution
grantee reporting monitoring
[3:24] payments. Financial
reconciliation grant flows out and final evaluation.
[3:32] This slide shows a very
high-level summary of how GM fulfills their mission to
standardize streamlined and
[3:40] improved state grant making
practices and increase public information about state grants
opportunities. So this you'll
[3:47] just see gives just a very kind
of the high touch points of the work that GM does in terms of
policy, development, training
[3:56] and guidance that's practice as

risk analysis and reduction. And I'll go through this all in
more detail as we move through
[4:03] the presentation. Gm was created in 2007 based on
well, a recommendation. This
[4:12] slide illustrates the capacity
of the office since 2007 when the only conducted the
2023 program evaluation that
[4:21] was discussed last week, GM was
a team of 4, 3, of which were
[4:27] dedicated to administering
admins own portfolio of about 130 grants totaling just under
60 Million. That left one team
[4:36] member to do the entirety of
policy work training and technical assistance for the
entire state enterprise.
[4:43] That one team member developed
the first iteration of GM's 13 policies conducted numerous
trainings annually to both
[4:51] state grants, administrators
and grant recipients and provided technical assistance.
Repeated efforts for this fun
[4:58] for the funding of this office
where so successful in Till 2023.
[5:04] The expanded office is now led
by an enterprise grants managing director with teams
focused on policy and

[5:10] compliance and admins own grant
portfolio management as you can see from the slide
or G M S funded for 12 members
[5:19] with 8 positions currently
working in the expanded office. Additional positions will be
filled as the officers
[5:25] implement implementation work
continues. And then once all of those
positions are filled, the
[5:31] vision is that the office will
drive innovation, alternative strategies and collaboration
across sectors to improve state
[5:39] grants, administration and
outreach and they will do more data collection and analysis
that will inform steps for
[5:47] state granting agencies to take
in order to establish outcome measurement and reduce system
barriers.
[5:55] Before we move into the
expanded compliance and oversight measures enacted
during the 2023 2024 by
[6:02] Biennium. I just wanted to
highlight that GM is also a resource to the public in
seeking grant opportunities
[6:09] through the website. Men dot
Gov. Slash brackets.

[6:14] So moving into the expanded
oversight. We would like to thank the
Legislature for the substantial
[6:21] investments made to the grants
landscape during the 2023 2024 biennium. These investments
related to additional
[6:29] compliance and oversight were
to alleviate the potential for fraud, waste and abuse in state
government programs.
[6:36] While various state agencies
also saw individualized investments related to grant
making the legislative changes,
[6:43] I will highlight provided GM
with additional oversight of state grants, including the
power to terminate a grant 15
[6:51] to be not in the best interest
of the state and the ability to suspend prohibit grantees for
receiving grants from for
[6:58] costs. I will talk to these
investments in compliance and accountability in detail over
the next several slides.
[7:07] First, the Office of Grants
Management has strengthened oversight.
[7:12] These changes the changes
highlighted on the slide were all new requirements located in
the 2023 State government

[7:19] finance bill. So starting with
an expansion of 4G M there was strengthening of 8 of
admins grants, oversight
[7:27] authority within GM by
requiring agencies to fully cooperate with GM on grants
oversight. It also authorizes
[7:35] rulemaking if and asked me that there was a strengthening of
GM's authority to establish and
[7:41] enforce versus only proposing
grants management policies.
[7:47] It also gives GM the authority
to suspend or Jabar grantees for up to 3 years because and
requires agencies to submit
[7:56] their grant contracts for
approval prior to issuance for certain contract amounts.
[8:02] Grant agreements are not valid
unless approved by the Commissioner of Administration
[8:07] and authorizes GM to oversee
grant management systems.
[8:13] Agencies must report to GM at
request on the status of any grants and it authorizes GM to
audit grants.
[8:22] And then finally, as I
mentioned previously, it authorizes the Commission of an
administration to terminate a
[8:29] grant, if not in the best

interests of the state, moving into requirements, a
grantee performance evaluation.
[8:38] This was also something that
was discussed last week with the legislative auditor.
[8:43] There was a discussion that
focused on parts of the 2023 Ole Reports that indicated that
25% of nonprofit grantees
[8:53] receive grants from multiple
agencies. This brings up the issue about opportunities for
collaboration and information
[9:00] sharing about grantee
performance in April 2024. GM launched a
new grant, the evaluation site
[9:09] where agencies are now required
to upload performance evaluations for grants over
$25,000.
[9:17] This requirement applies to
grants issued after 4/1/2024.
[9:23] and Eaton says must upload the
evaluation within 60 days after the close out of the grant
[9:30] as grants are completed,
agencies will soon be uploading these evaluations into the new
system.
[9:36] This will allow other granting
agencies and the public to see information about grants.
Most grant evaluations will be

[9:45] posted an or by the summer of
2025. in this process, grantees may
also submit their own written
[9:53] response to the evaluation for a little bit more context
related to the evaluations.
[10:02] The state of Minnesota's
grantee evaluation policies are aimed at helping agencies drive
understanding about the
[10:09] benefits grant-funded
activities provide some Minnesotans. They also offer insights into
the impact of agency grant
[10:17] making efforts and supports are
responsible stewardship of public dollars.
[10:23] The required performance
measures that you will see in the form to include a
description of grant purpose
[10:30] proposed an actual grand
outcomes, a measure of compliance with reporting
requirements,
[10:37] high-level monitoring and
financial reconciliation results
[10:42] note of an result issues or
termination. An agency satisfaction with the
grantee timelines, quality of
[10:50] work and overall performance. A reminder about the
decentralized nature of grant

[10:56] making in the state and that
this is a baseline which means agencies may have additional
evaluation requirements are
[11:03] processes in place right now. Agencies are working
and weaving these new
[11:08] requirements into their
workflows and grant materials. So you could be wondering how
will these evaluations be used
[11:16] when determining future grant
awards templates and best practices
are in use for use are
[11:22] currently under development. We're in the process of
developing training and supports for this work.
[11:28] We need to better understand
what agencies are currently doing to consider past
performance within their own
[11:35] processes and are examining best
practices in the public and private granting communities
such as how foundations are
[11:43] doing this and waiting past
performance and making decisions about grant alerts.
[11:51] The next topic I will cover is
the concept of administrative funds. So the in the new
requirements there is an
[12:00] authorization that agencies can
retain funds for grant administration if the grant

appropriation as otherwise

[12:07] silence. This applies to new

legislatively needing to grants

[12:12] and competitive grants and

agencies can use up to 5% for

[12:17] legislatively named France and

up to 10% for Newt competitive grants.

[12:22] I want to focus really on for a

couple of minutes on how important this requirement is.

As you heard me talk about it

[12:30] and as you'll hear me talk

about, there are many compliance and oversight

aspects that grant make that

[12:39] grant making staff within

STAJAN sees state agencies have to comply with and that doesn't

go without funding. So it was

[12:46] incredibly important that this

was implemented to allow for

[12:51] the adequate staff capacity who

can then be properly trained to make sure that all of this work

is happening appropriate

[13:01] moving into prewar and risk

assessment. So this was the largest new requirement that

was implemented in the new

[13:09] statutory scheme. After the 2023 session, the

growing GM team focused its

[13:16] work on the implementation of
the Preah Ward Risk Assessment statute. That was back to
January 15th of 2024.
[13:24] the work entailed an expansion,
a policy of GM policy number 0, 8, 0, 6, creation of a tool
kits and training and rollout
[13:35] of new requirements to state
agencies. The requirements include
financial review of grant and
[13:42] business subsidy recipients.
It defines brands as $50,000 or
[13:48] more defiance, a grant. He has a
political subdivision, a nonprofit or a business entity.
[13:57] It requires granting agencies
to perform a PRE Award risk assessment to determine if the
potential grantee could perform
[14:05] their required duties. It requires information as
Apple applicable, including
[14:12] history of performing duties
similar and if those duties will be at a significantly
increased scale or require
[14:20] significant changes to the
present operate operation of the organization.
[14:25] It requires grantees to submit
their most recent form. 9.90, or board reviewed financial
statements

[14:33] requires a business entities.
Most recent federal and state tax returns, current financial
statements certification that
[14:41] the business is not under
bankruptcy proceedings. And the disclosure of liens on assets
[14:47] requires evidence of good
standing with the Minnesota secretary of state and most recent independent
audit reports if otherwise
[14:55] required in statute. It requires certification that
none of the grantees public
[15:02] officials, board members or
staff with access to grant funds have been convicted of a
felony financial crime in the
[15:09] last 10 years. It also authorizes agencies to
require additional information
[15:16] for new grantees to provide
enhanced oversight as necessary.
[15:21] That's what that GM developed
supported state agencies to effectively and swiftly
implement been Dupree. Award
[15:29] risk assessment requirements and content of the tool kit
included a workflow for each
[15:35] type. A grantee to help
agencies ensure all required steps are followed.
[15:41] A PRE Award risk assessment
checklist, sample letters for agencies to communicate with

potential grantees financial

[15:50] review forms. Chris Plante,

plates, tip sheets and oversight and internal

controls. And an FAQ

[15:59] agencies have been steadily

conducting these assessments. And it is clear that these

efforts are working to mitigate

[16:06] identified wrists. I want to

point your attention to there's a 2 pager in your packets.

The first page just flows over

[16:15] kind of what GM is in high

level. And on Page 2 in the Blue Dark blue area,

[16:22] we've collected data from 5

state grant making it and sees we will be collecting more data

from additional agencies

[16:30] through the end of the month.

But this is our early risk assessment, data analysis.

So you'll see that over 1500

[16:38] Priya word risk assessments

have come when completed. There have been 56 instances

where agencies have needed more

[16:44] information to satisfy

concerns. You'll see that 3 grants were terminated with or

without pause based on that

[16:52] Korea word risk assessment.

And there were 46 instances that additional information did

result concerns when request.

[17:05] So I am going to just quickly

walk you through GM's website just to show we are. Some of

these documents are located.

[17:15] The first have that you see

here are all of GM's policies. So this is where state grant

making staff can go to

[17:22] reference the policy, a brief

description. They can click on it. It has all of that kind of

documentation of what that

[17:31] policy and tails. The new tool kit at the top is

under 60.9, 8, 1, That's the

[17:40] preah word risk assessment

statute and you'll see that there are links to all of the

forms and templates that I

[17:47] described. So this is where

you'll have the sample letters that agencies can you is.

And this is the content

[17:56] overview for the risk

assessment. So it's just kind of the booklet that agencies

can follow in doing that.

[18:01] And then you'll see documents

like this where it's an actual checklists that it has

instructions for agencies and

[18:09] they can go through and

identify and document when they do that risk assessment.

So this is the proper

[18:15] documentation that agencies

will have in doing that risk assessment

[18:30] and then turning back to our

presentation. This is related

[18:35] to that, the training that has

been developed as part of this tool kit. So on this slide,

you'll see that there's an

[18:43] overview of the new statue

overview of the competitive grant requirements, single soul

source requirements and

[18:50] legislatively name

requirements. And then it goes through those sample template

and checklists in more detail.

[18:56] So agencies have kind of proper

resources to understand how to do this work

[19:04] in this spree award risk

assessments. And it also includes the authority for

state agencies to not award

[19:13] grants upon completion of that

risk assessment. And the process is set out in detail

[19:19] if the agency determines there

is a risk that a competitive grant, he cannot perform the

duties of the grants. There's a

[19:26] process outlined for not a

working. The agencies must contact the

grantee and give them 30 days

[19:32] to respond and satisfy the

agency's concerns or develop a plan with the agency to satisfy

their concerns.

[19:41] If the agency still has

concerns, they can choose not to award, they must notify the

grantee and include the process

[19:48] for contesting that decision

and they must notify the Department of Administration the grant he can contest the

decision not to war no later

[19:56] than 15 business days after

receiving the notice and then the agency has 15 days to

consider the contest and either

[20:04] choose to reversed or continue

the decision not to award. The final decision by the

agency may be challenged as a

[20:13] contested case under chapter 14

within 30 business days of written notification of the

final agency decision.

[20:21] If the agency determines there

is a risk to a legislatively names grantee the process is a

little bit different.

[20:28] Similar agencies must contact

the grantee and give them 30 days to respond and satisfy the

concerns or develop a plan.

[20:36] But the agency still has

concerns. The agency must delay award of the grant until
adjournment of the next regular
[20:44] or special legislative session. The agency must contact the
grantee admin and shares of the
[20:52] ranking members of House Ways
and Means and Senate Finance committees with evidence of
their concerns and reasons for
[20:59] not a word a grant. He can contest this
decisions similar to the
[21:04] competitive grants no later
than 15 days after receiving the notice and then the agency
has 15 days to consider the
[21:11] contests and either reversed or
continue to not award. The Legislature then may
reaffirm the award of the
[21:19] grants or re appropriate the
funds to a different grantee based on their analysis.
[21:26] If the Legislature does not
provide direction to the agency, the funds revert to the
original appropriation source
[21:34] agencies may also grants funds
to a grantee to help them with this financial review
requirements. So to get an
[21:40] audit or develop financial
documentation and the funds are subject to enhanced monitoring
additional reporting and other

[21:49] reasonable requirements. So moving into the training aspect,
[21:57] so additional capacity and GM has allowed them to expand. The training offered to state agencies.
[22:05] Gm is rolling out more courses and platforms to enhance and expand the number of state employees trained on grants.
[22:12] Policy requirements aiming for content, tailored to different levels of state experience and familiarity with GM Grant
[22:21] policies. Gm is planning for learning pathways, diversify content and
[22:26] broader access. Currently, GM has 9 on-demand trainings on its website, 7 of which were produced in 2024,
[22:35] nearly 300 state staff have attended one or more of the 9 virtual and in-person trainings that GM delivered since
[22:42] 7/1/2024. 7 more virtual trainings are scheduled for the remainder of
[22:48] fiscal year. 25 including 2 this month and the course offerings include overview of Grant administration
[22:56] financial reconciliation in grants management or grant monitoring and grant evaluation

[23:02] when she is working diligently
to make an introduction to grants. Administration 3 course
training series available in
[23:10] the state's online employee
training system. By the end of this month,
[23:15] it would be reasonable that
this series could be made mandatory. And the series includes much
one of which is state grant
[23:22] making basics munchel to grant
administration overview and Moto 3, 0, G M Grant Policy
framework.
[23:31] We also have dozens of
trainings template and other materials that you saw in my
brief walk through the website
[23:37] and are prioritizing updating
and the contents and making the website more user-friendly.
[23:42] This will be a priority in the
upcoming Biennium. I did want to highlight specifically our
financial reconciliation
[23:49] training because that was a
topic of discussion. Last week the financial reconciliation
training was developed in 2013.
[23:58] That training has been provided
in person and virtually by GM to executive branch granting
agencies at a minimum of on a
[24:06] biennial basis. There is also

an online training on financial reconciliation on Jam's website.

[24:13] The training is periodically updated and refreshed to reflect policy revisions and helpful case study materials to

[24:20] support training participants with skill building. Recently, GM were to DHS in 2023 to customize and refresh

[24:28] the straining to support to training tracks one for supervisors and managers and one for grant staff. The custom

[24:36] ice trainings were provided in the spring of 2023. Gm will be providing virtual training and financial

[24:42] reconciliation in March and April up coming to a cross agency audience.

[24:50] The other aspect that had been received funding in the 2023 2024 Biennium was related to a grants enterprise grants

[24:58] management system study. Some of the conversation last week focused on the need for a

[25:04] single enterprise grants management system admin was appropriated funds to conduct this study of the feasibility

[25:11] of utilizing an enterprise grants management system. Consultants has been conducting

its study over the last 11
[25:18] months and discussions with
impacted agencies is proceeding and will be followed by
convening Mmb minutes and admin
[25:26] another impacted agencies to
discuss next steps. The grants management
feasibility study was to
[25:34] determine if a single system is
feasible. It will also examine available technology options
recommended changes to
[25:43] organization controls and
processes staffing and other needs high level system
requirements
[25:50] estimated cost and
implementation broke. Now
[25:55] I want to hop over to the oil a
recommendation and implementation updates by oh,
yeah.
[26:03] The work that has taken place
since the 2023, 2024 legislative sessions to build
the oceanic theme tackle
[26:12] significant work assigned by
the Legislature and recommended by the or late has been
substantial.
[26:19] I would like to highlight some
of the work now, particularly in areas that receive

discussion last week

[26:25] since the 2023 legislative

session, GM has made important progress on implementing the

new controls and oversight of

[26:33] state grants. We have

accomplished this work by updating GM policies that at

all Executive Branch State

[26:41] Grant making entities

increasing GM staff and expanding wrist related risks

related assessment, training

[26:50] and technical assistance. Gm updated its grants

management policies and procedures at applicable to all

agencies to reflect the

[26:58] statutory changes and GM strengthen certain

policies including adding

[27:04] specificity to the policy

Korea. Word Risk assessment. Gm updated over 40 ton plea

documents to reflect reflect

[27:12] the policy changes and to

assist agencies and policy compliance.

[27:17] All GM policies that govern

state grant making and corresponding templates are on

our website as you said.

[27:24] And that concludes my formal

presentation. I really thank you for your time and I'm happy

to stand for any questions.

[27:31] Thank you very much. Miss
Christensen. We actually >> have a lot of questions.
So I appreciate it. But
[27:37] members, I was told that the
mikes weren't working properly when we first opened the
meeting. And so we are going to
[27:44] just quickly have you restate
your name for the record and we are going to have to be approve
the minutes.
[27:49] >> Thank you, Madam Chair.
My name is Stacy Christensen for the record and the deputy
commissioner at the Department of Administration.
[27:55] >> Thank you very much. We'll
get back to the questions vice-chair. Anderson, would you
like to approve the minutes?
[28:01] I will move. Bennett said that
approval the minutes from our meeting last week. Thanks.
Thank you.
[28:12] So Vice Chair Anderson has
moved approval of the minutes from a 10th 2025. And is there
any discussion seeing men,
[28:20] all those in favor, aye?
Those opposed the minutes are approved. Thank you. I
apologize for that interruption
[28:27] in our business. So if you
don't mind, I'd like to start with some questions and then

open it up for discussion.

[28:34] It was a very excellent

presentation. Appreciate your time and being here and all the

work that your office is doing.

[28:41] I'm glad to see those numbers

increase in staffing cause. I do think that will help quite

a bit.

[28:48] Part of me wish I would have

just interrupted a long way, but I didn't want to interrupt

your flow. But if I have so

[28:54] many questions, so maybe if we could just go back.

[29:03] So so first, you talk about

these 13 policy frameworks and you do have 9 policy trainings.

But

[29:12] in each of those frameworks is

their trainers. They're going to be an attempt to align the

training with those frameworks.

[29:18] Could you just talk about that

for a little bit? Sure so. >> Thank you, Madam Chair.

I I think that the on each

[29:26] policy is probably I don't want to say not as

important as the other, but a

[29:32] lot of the policies overlap.

And so there's not necessarily going to be one dedicated

training per policy because

[29:40] sometimes a policy is one page.

And so it doesn't kind of contemplate an entire training
on that policy. So if you
[29:47] consider kind of an overview of
grant administration that is probably going to entail most
of the policies, some of the
[29:54] policies that are more detailed
like the Pre Word Risk assessment that needs its own
dedicated kind of training
[30:00] module, if you will. So the 9
trainings don't necessarily
[30:05] align with the 13 policies
because not all of the policies are kind of created equal.
If that makes sense.
[30:12] That does. Thank you. >> So I mean, ask one more
question that open it up because I could I could take
the entire time myself and I
[30:18] don't want to do that. But when
you talked about the new to us on slide 6 and the expanded
oversight and the changes from
[30:27] 2023, I I did a deep dive on that
over the weekend. I have a lot
[30:35] of questions just based on
that. But but one of them is that you can terminate a grant
if it's not the best interest
[30:43] of the state. The my
understanding based on the conversation with the LA last

week is that that is completely
[30:49] optional that you made, but not
that you must. There's no threshold by a grant award is
automatically suspended.
[30:58] Do you think some language is
sufficient or how how do you
[31:05] view that role for GM? >> Thank you, Madam Chair, that
that is an excellent question.
[31:11] And you're absolutely correct.
It is just discretionary duty and it is comment to GM just a
couple of times recently
[31:21] related to grants that are in
place. So we don't have a lot of data with that new
requirement to know. And,
[31:29] you know, it should be
something mandatory. But, you know, certainly within kind
of the legislature's
[31:34] discretion, you know, that that
could be pivoted to something that's not just discretionary
but mandatory.
[31:43] >> Thank you. In one fell up,
how many grants have you use that authority to terminate
since you've got the authority
[31:50] in 2023, thank you. Madam
Chair. I believe it's been 3, 2, or 3 week. And could you
quickly describe what those

[31:57] were and for what reasons they
were terminated? Thank you. Madam Chair. I will have to get
that information from you.
[32:03] I don't have that kind of at my
fingertips right now. Great. Thank you. Alright, opening it
up to member questions.
[32:11] Representative Hawkins, thank
you, Madam Chair. I I I.
[32:16] >> Glad we're here talking
about this has been a good process so far mean and I the
way I look at this, this is the
[32:22] kind of the way things ought to
work. The problem was identified. We commission the
oh la to study it and come up
[32:30] with recommendations. A
response to the OLES recommendations. The
legislature made changes to the
[32:36] legislation. Legislation we
appropriated resources to allow
[32:42] is Kristen Center staff to beef
up their staff, create the training resources and it's,
you know, and in the end,
[32:50] you know, the implementation is
obviously going really well. And we were already one of only
12 states that had a program
[32:58] like this at all. I think by

the time this process plays itself out, we're going to end
up being the exemplar that
[33:06] other states look to for for
how to do this. Right. So this is the kind of work that I find
really satisfying. And I can't
[33:14] claim to played any role in
this one. But this to me looks like a an example of the
process working out the way
[33:20] it's supposed to. >> Did you have any questions
for Missus, Christensen? I'm sorry. Did you have a
question for Ms Christensen?
[33:28] >> No, I I think Miss
Christensen is a rock star. We isn't the only with the
informant, which we quite were
[33:34] both members of the Minute at
Technical Advisory Committee's data sharing committee and
she's one of the co-chairs of
[33:42] that committee. And that also
is very, very satisfying work. So. >> Thank you, Representative
Elkins, the other members,
[33:50] Representative. Anderson, thank
you. I have some questions about the study and a single
grants management. You said
[33:57] there talking. They're working
on things. I don't know when that started.
[34:04] Where are we at in that process

completely? When is that going to be done?

[34:11] >> Thank you, Madam Chair,

Representative Anderson. We're wrapping up work. It

should be the kind of first

[34:17] step of the feasibility of it

should be wrapped wrapping up very shortly.

[34:23] Representative and thank you

said the feasibility portion. >> I'm beyond that. So let's

say that obviously it's

[34:31] feasible. So beyond that, what

about actually put it in a

[34:36] state grant management system,

something that is

[34:41] the legislation as it was

heading towards and also on top of that within whether it's

your website or or another

[34:51] website probably would have to

be within your office. What people can actually see all the

different agencies that happen

[35:00] and awarded grants dollar

amount there. 9.96, everything

[35:05] that is required for Graham stepped in to get,

including in the and

[35:10] you know that whatever is being done now to

tie it up, you know, in the

[35:17] end. So it's public information easy to reach by the public.

[35:24] Is that part of this? And we're
it that is there. Is there a movement to do that within your
agency? Has that part of the
[35:32] cold grants management system
potentially the state like that's why was it because
that's I think what is needed.
[35:39] So thank you, Miss Christensen. >> Thank you, Madam Chair,
Representative Anderson. Yes, that is part of that kind
of implementation, roadmap
[35:47] discussion. That ad went admin
is going to have to work very closely with them to be in
minutes on kind of
[35:54] talking about next steps and
how that process works through its its way.
[36:01] Representative Anderson, think
it's what's the time frame on that. I mean, this was passed 2 years
of us. I'm wondering what the
[36:09] time frame as so. We say we wrap up the
feasibility study.
[36:15] >> By when you know, and then
what would be the time for him to actually be able to create
the system that was asked to be
[36:23] created potential that
Legislature, Mr. Cushions and Madam Chair,
Representative Anderson,
[36:29] the the >> legislative requirements was

to conduct a feasibility study

[36:36] II. And so that will be

wrapping up shortly. And then the discussions will continue

related to whether and if that

[36:44] is feasible and how that

implementation works. I don't have a specific timeline on

bats. It's a substantial

[36:53] undertaking to do something

like that, both financial and, you know, capacity wise.

So those discussions are just

[37:00] going to begin to happen once

the study is concluded. >> Less than representative,

thank you. And then getting his

[37:08] staff. So you're up to 8 staff

in op is now. When did those you know, we were at for 2

years ago? When were those

[37:15] people added? Did you go right from 48 last

in the summer of 23 year where

[37:23] they just happened recently? >> Madam Chair Representative

Anderson, we started by hiring

[37:29] the Enterprise grants

management director, and then she went and hired staff

accordingly. So she built the

[37:38] office one she was brought on

board.

[37:43] >> Can you get tell me when I mean, are we just now at 8,

4, where we at 8

[37:50] the summer of 23? >> It's Christensen, Madam

Chair. We were representing Anderson. We were at it shortly

after the summer of I mean,

[37:59] probably into the fall winter.

But yes, they the staff has been on board for a bit now.

[38:04] >> Okay. Thank you. Let thank

you. And I just didn't follow up to that regarding the

Enterprise grants management

[38:10] system. I also wanted to better understand

[38:15] I get it to study. But you

mentioned you've had a consultant working on the

study. Can you tell me how many

[38:21] people are working on it and

how much you are paying for the study?

[38:26] >> Madam chair, I do not have

that information at my fingertips. There were I

there's one topic hated staff

[38:34] member with an GM that is the

kind of project manager with the consultant. I don't know

off the top of my head. How

[38:40] many how many individuals

within the consultants organization are working on it?

Our enterprise grants managing

[38:47] director. We have an assistant

commissioner that's overseeing it. And and the cost of the

study was approximately

[38:56] $800,000. That was what was appropriated

to us.

[39:01] Thank you. Okay. Well, no one else that

I'm sorry, Representative

[39:08] South. >> Thank you. Madam Chair, Ms

Christians and I just taking from your your entire

presentation seeking to

[39:18] understand it case upon the

information that we heard last week from the legislative

auditor

[39:25] who bears the responsibility

for the grant management practices within each

individual state agency.

[39:33] Is that your office or is it

the grant managers within an individual state agency?

[39:45] >> I'm sorry to Miss

Christensen. Thank you, Madam Chair, Representative Schultz.

It is decentralized. So the

[39:52] ultimate authority in grants

management sits within individual state agencies to do

manage their grants. The Office

[39:59] of Man's Grants Management, as

you saw, provides kind of technical assistance and

training and best practices to

[40:07] make sure that staff have the

information and capacity knowledge that they need.

But it does the responsibility

[40:14] to manage the grants do set

within individual agencies. >> Representative Schultz,

thank you, Madam Chair and Miss

[40:21] Christensen. So given that and

the vast variety of state agencies that we have with a

whole bunch of different

[40:27] processees, you touched on this

very light in your presentation, but how much do

you have to change your

[40:34] training, modules or seminars to stick to given

state agency

[40:44] Missus, Christensen? >> Madam Chair, Representative

Schultz, great questions. So the training that GM

provides Israeli that baseline

[40:52] of what the policies say with

the cabbie out in every training. But every agency can

set their own policies that are

[40:59] stricter. They have different

procedures. We receive requests from individual agencies.

As I highlighted, DHS had

[41:07] requested to kind of develop a

more Chater training to that particular agency based on

their requirements. In that

[41:15] situation, GM would work with

the agency, tried to understand what their additional policies and procedures were and to help
[41:22] the agency do that training.
But the kind of training that is available on the website and that is just conducted
[41:29] generally is the baseline
training policies and then of course, telling agencies you may have your own kind of
[41:35] stricter policies that you have
to comply with. >> Representative Schultz,
thank you, Madam Chair. And I
[41:41] think these answers have added
additional questions for me. A part of that would be
throughout the trainings that
[41:48] you've already provided.
You mentioned that you have trained about 300 state employees. Minnesota has
[41:55] according to what I'm finding
right online. 55,000 state employees. So of the 55,000,
how many touch and assist in
[42:07] the management of grants and
how does that compare to the 300 that you have trained to this point?
[42:16] >> Miss Christensen, Madam
Chair represents felt great questions. So we tried to do a little bit of digging to prep

[42:21] for that question. It's not an
easy answer. So the closest that we could get is kind of
looking at the latest payroll
[42:29] snapshot. There are about 225
individuals in state government
[42:35] that have kind of the grants
classifications series. That is
[42:41] a bit misleading because we
also have managers and supervisors that maybe grants
managers. We also have
[42:48] individuals in different
classifications that, you know, they manage other kind of
responsibilities are programs,
[42:55] and then they may get a grant
and they've been kind of other duties as assigned. They know
manage that grant. So it's the
[43:02] snapshot tells us, you know,
they're o'clock, you know, the classifications around 200.
But there we probably know that
[43:09] there are more people that that
touch grants, management and the state.
[43:14] Thank you, Representative
Schultz. >> Thank you. Madam Chair.
I I guess one question I would have would be their grandson
come from a number of different
[43:22] state agencies. Are there any

state agencies that have been complicit and getting this
training on board and any that
[43:32] we should be directly concerned
about today? >> As Christians have been
share, Representative Schultz
[43:38] and not that calm some my and
that's certainly not, you know,
[43:43] we know the people that we
train. But we you know, I think every state agency has been
participating in some sort of
[43:51] training module. Also, I
wouldn't say that there's anyone in particular that comes
to mind.
[43:58] >> Thank you. And
representative can to get you in just one 0nd. But that
raised a question for me. Ms Christensen in your powers
that be delegated in 2023.
[44:08] It says that the commissioner
has the authority to review grants management practices and
establish and enforce policy
[44:15] and procedure improvements. So but in response,
Representative Schultz who indicated that really it's the
agency's responsibility to
[44:23] enforce these policies. So clearly you've been delegated
enforcement authority by the
[44:29] Legislature. How do you in

practice you your wallet?

[44:34] Enforcing grants, best

practices on the agency's. >> Thank you, Madam Chair.

Great questions. So I think as

[44:41] we kind of are moving into the

additional expansion of the office and you know, now that

we've kind of develops the

[44:49] required trainings and updated

the policies, we're going to move more into that compliance

area and doing some additional

[44:56] data collection that we will

require from agencies to basically tell us how they're

doing. And then we'll be able

[45:03] to have a better landscape to

kind of individual lies, technical assistance or, you

know, if we need to do auditing

[45:10] or any of that work based on

the data that we receive or don't receive from agencies.

So that work is going to be

[45:17] continuing into the next

Biennium. >> Thank you, Representative

Hawkins, thank you, Madam

[45:23] Chair. This time, I do have a

question, Mr. Christensen,

[45:30] in part of the Great Deal that

the success that you've achieved so far and acted as if

the same time the legislature

[45:36] was strengthening statutes.

We also made an appropriation to let you go from one employee

to 4 to now 12.

[45:44] I do anticipate and coming to

us to ask for additional resources to complete the

remaining work. Or do you think

[45:51] you have enough people right

now to complete the remaining work that's on your plate?

[45:57] >> As Christians and Madam

Chair, representative cans, I believe that the offices

adequately staffed for the

[46:03] current requirements that the

Legislature has given to GM to

[46:08] to kind of care. >> If you wouldn't mind, I was

going to turn to Mr. Johnson

[46:14] hit some information about a

previous question, Mr. Johnson.

[46:19] >> Madam Chair members, there's

just a question about the appropriation related to the

Enterprise Grants management

[46:24] system just for specificity.

The Legislature appropriated 735,000 in fiscal year 2024

201,000 in fiscal year 2025.

[46:37] For that purpose. The total

appropriation is 936. Obviously

[46:43] the Department of
Administration may or may not use all that money. Anything
that's not use would cancel. It is a one-time appropriation.
[46:51] Thank you, Mr. Johnson. >> I want to go back to a
comment that the LA made when
[46:57] she was here last week that I
still am. It's still resonating with me
today. During your
[47:05] presentation. You've gone
through a lot of areas where you're talking about providing
best practices, collaboration.
[47:13] I took some notes and that's enforced. I can't read
very well right now. But but
[47:19] but your posture is certainly
to provide support to the agency's training to the
agencies. And I think that's
[47:25] important. But the sense of accountability
and I think the la used the
[47:31] word we we need to be more
skeptical
[47:36] as we work with grantees and
agencies. She I think what
[47:42] suggest that and we've done so
much to hand out money and so much to provide training.
But there's been less on the
[47:51] accountability side. And and

one of the things that that struck me is in in the list of
programs.
[47:57] There's no training on Friday
prevention. There's no training on Friday tech shun. So
[48:04] I'm concerned that we're still
not taking this seriously. We have the highest amount of
side related to COVID in the
[48:12] country and 610 million and
counting last time there was a calculation. So I appreciate
the need to train. I think
[48:21] that's important. But I was
actually hoping to hear a little more robust discussion
on the accountability side,
[48:30] which still we have not heard.
Could you talk about how you are going to hold agencies
accountable and if
[48:39] do you need more legislative
authority to do that in your mind? Thank you.
[48:45] Thank you, Madam Chair. >> Great question. And I don't
want to speak out of turn at all. But I know that and then
be an internal controls unit is
[48:55] in the process of developing
exactly the training that you have talked about, the kind of
fraud or red flags, fraud,
[49:01] prevention of act, that type of
type of work which sits squarely in the internal

controls realme. So GM has

[49:08] really focus their training on

policy, compliance and oversight moving into kind of

our brand new authorities that

[49:18] we never had kind of that

enforcement authority before. But now we do so. We are hoping

to partner with Mnd in their

[49:26] internal controls unit to

really dig into those exact topics that you're talking

about. And and, you know,

[49:33] make sure that that kind of

fraud prevention and internal controls training in. Well, Bob

says it's a bit outside of GM

[49:40] scope. And so we're happy to

kind of partner with and then beyond that work going forward.

[49:46] >> Thank you for that answer.

So I don't understand why it's outside of your scope to meet

internal controls is essential.

[49:54] 2 grants management. So do we

need to provide more specificity? And that's why is

this just not like

[50:03] the first round of grants?

Management and oversight.

[50:08] >> Thank you, Madam Chair.

I move. My understanding is that kind

of mnd is always had the

[50:16] statutory authority over
internal controls and that that kind of delineation and
authorities has been has been
[50:25] clear, the authority that GM
has is related to kind of state
[50:32] grants policy. And so that's
why I think it just becomes incumbents for GM to partner
with and then be on kind of
[50:40] developing that training going
forward. >> Thank you for clarifying
that. If you don't mind, I I recognize this another
question. But I'd like to turn
[50:48] Mister Johnson, Mr. Johnson, to
do outline for us the different statutory authorities for and
then be having sort of the
[50:55] internal controls peace and GM, perhaps not. And is that
something we would need to
[51:01] clean up in statute or
clarified? Because it seems to me that if you don't have
[51:07] are you don't perceive you have
the authority like what are we doing? We
created this whole new agency.
[51:13] >> If there's no internal
controls like it's honestly stunning to me, Mr. Johnson, can you help us?
[51:20] >> Madam Chair, a famine, have
to get back to you on that one. And then be traditionally does

have a lot of control over the

[51:26] sort of day to day in and out.

Obviously the finances that generally is there control.

But in terms of your specific

[51:32] question, I'm gonna need to do

some research and it. >> Thank you. I appreciate

that. Because this seems to be

[51:39] one of the benefits of that

committee honestly is that we discovered these lapses in

statute

[51:45] where where we really need to

fix things and better align them so that everyone's rowing

in the same direction. So I

[51:51] look forward to that response

and maybe working in that Representative Green Men.

Thank you, Madam Chair, and

[51:57] thank you for the presentation.

And I guess. >> Some of it is about our work

on this committee and that do

[52:04] have a question. But it seems

to me that when we're talking about and we're talking about

some of the business model of

[52:11] fraud that we saw, whether it's

your future and whether whether it's the autism centers in many

cases are talking about is not

[52:18] a grant but providers of

services, right and say guess Mike, First question is does
the officer grants management,
[52:26] do you oversee? >> Senator Al. >> Medicaid, federal funding
federal food funding. Is that
[52:33] to have in your purview? It's Christensen. >> Madam Chair, Representative,
great question. No, not at all.
[52:40] And and I think that that is a
really important distinction. That kind of the big fraud that
we've seen recently is related
[52:48] to Medicaid, federal aid.
It is not related to state grants. And so it really does
fall outside of on GM's scope.
[52:59] >> Representing thank you.
I appreciate that. And I think we have looked obviously the
legislature in response to the
[53:07] 2007 and the 2023, all audit
has been doing a lot to ensure
[53:12] that when their state grants,
we're setting up all of the process and procedures in place
and you have done a lot.
[53:19] I think that there's more
conversation to have to me. It seems like as we're thinking
about the work of this
[53:26] committee and why we are all
here at 8.15, in the morning on Mondays and want to be here is
looking at and digging into

[53:35] whether we're talking about the
business model in future future. Whether we're talking
about the autism centers,
[53:43] whether I'm to look at one,
what what that fraud looks
[53:49] like, what that products like,
what it looks like that for those providers, overpayments
of Medicaid and then
[53:58] and then sit back into and have
a conversation about what our state government city agencies
need to ensure that there
[54:06] there's crypto verse 8 feels
like we got to start with the problem. I think that this has
been a really tough and
[54:12] important conversation. But I
do think we got it when we're talking about state grants for
everyone conversation on are
[54:18] talking about the federal
provision of Medicaid or food programs. That's obviously a
different mechanism. And so we
[54:26] should dig into those
individually so that we can come up with the right
solutions to those problems to
[54:32] protect the taxpayers and the
folks who are entitled to those benefits. >> Thank you, Representative
Green Man. I appreciate the

[54:39] distinction. And I would note
that in some of these cases, the pastor money from the feds
is then sub awarded 2 different
[54:47] grantees. So I do think there's
some overlap, but there is also a distinction. And I appreciate
you raising that
[54:55] to listen to the question.
Representative Schultz. >> Thank you. Madam Chair just
left today with ultimately.
[55:01] And this kind of comes from our
conversation last week with the legislative auditor
[55:07] talking about how we need a
culture change within agencies. And in part today, we're
hearing
[55:14] this week, you know, the Office
of Grants Management provides the training, but at some level
it's left to within the agency.
[55:22] But it's some level it's at and
then the but at some level, GM has enforcement mechanisms.
So that's where our testify or
[55:31] to name is Christian sent.
What are the enforcement mechanisms that the Office of
Grant Management has so that
[55:38] Minnesota taxpayers can know
that we're not just passing the buck around state agencies.
[55:44] >> Missus, Christensen, Madam

Chair, Representative the it. And I think that the
distinction that was made
[55:50] previously is important that
it's related to kind of state grants. And so in situations,
you know, we can, you know,
[56:00] cancel grant if not in the best
interest of the state. If it comes to our attention that
there's something going on,
[56:06] we can do additional data
collection. We can do additional kind of
investigation in state
[56:11] agencies. But I think that in,
you know, kind of at least and in the Medicaid space, we have
0 ability to enforce that.
[56:20] That is a solely different kind
of mechanism that is not related to state grants at all.
I think in that, you know,
[56:29] some of the other bigger ones,
you know, feeding our futures, for example, that was federal
aid that was provided to the
[56:36] Department of Education that
comes with its own terms and conditions related to the
federal aid program. And so the
[56:46] ability of GM is becomes
nuanced depending on the type
[56:51] of federal money, even if it is

kind of seen as a grant.

[56:56] But in the Medicaid space that

is there is no kind of ability for GM to enforce and there.

[57:03] Representative Schultz. >> Thank you, Madam Chair.

And this is just going to be just a quick follow up. You

know, it can be made mention

[57:10] about feeding our future and

Medicaid fraud while at the same time realizing that over,

you know, and and for the

[57:16] purposes of your agency for our

conversation for the state policy that we need to get

right. I'm so glad we've had

[57:23] conversations to bring us here

this morning. There was a billion dollars

handed to nonprofit

[57:30] organizations, at least that

much. I've I've seen figures larger than that in the last 2

years. And so ultimately,

[57:37] I my understanding is, you

know, based upon what I'm reading in statute,

[57:42] you have the authority to

enforce the policy and procedures. That's what I'm

reading here. And

[57:48] ultimately we need to have someone who's going to buck the

system. And and, you know,

[57:56] so far, you've said that only 3

of these grants have been terminated if they weren't in
line with that ultimate example
[58:04] of best interest of the state.
And we were really needing to find that solution so that
we're not seen the the buck
[58:12] passed around. It's Christensen, which could
respond.
[58:18] >> Yeah, thank you, Madam
Chair. And I think it just my wrist response to that is we're
not seeing kind of that those
[58:25] big levels of fraud in state
grants and kind of that that billion dollar pot of money
from state grants to
[58:31] nonprofits. And I think that
that's kind of why additional enforcement
hasn't been needed. The the big
[58:39] fraud that we're seeing that
has come to light has been in Medicaid and other federal aid
programs.
[58:47] >> Thank you. I would like to
just follow up on that with a quick point here. And I'm
looking in my notes, but it
[58:56] seems that you do have more
U.S. authority
[59:04] just looking for it. It says
[59:10] a grant agreement must by its

terms permit the commissioner to unilaterally terminate the
grant agreement prior to its
[59:18] completion. If you determine
that further performance under the grant would not serve
agency purposes or is not in
[59:25] the best interest of the state.
So we're not just talking about just best interest of the state
just agency purposes. It says
[59:32] the grant agreement must come
play, contain this unilateral termination authorities.
So do all grants
[59:38] currently as part of best practices being
written by the state contain
[59:44] that unilateral termination
authority. >> Madam Chair, grants to with
state DOT with state
[59:51] appropriations, contain that
completely which.
[59:56] >> And and also early in your
presentation. I think you mentioned in and correct me if
I'm wrong that you oversaw
[1:00:02] about 120 grants for 60 million
dollars. Is that what I heard?
[1:00:07] You say? Madam Chair? Yes.
That is Admin Department of Administration zone grants
portfolio.

[1:00:13] So but your office has broader
authority over all state grants. Am I correct? And I'm
sure that's so what is that?
[1:00:21] You know, first because I was
struck by how small that is, especially the article that
we'd all seen from the
[1:00:26] Minnesota reform or that shows,
you know, more than a billion dollars in just legislatively
name to Rance. So so it was a
[1:00:35] little bit, I think, surprising
to hear you say 130 grants for 60 Million. So please give us a
better sense of the scope of
[1:00:44] your agency. Thank you, Madam
Chair. So yes, that is just admins limited grant portfolio
and we have.
[1:00:51] >> You know, kind of small arts
and cultural legacy, grand, some grants to public
television. Our grant portfolio
[1:00:57] is very small in the whole
scheme of things. And in looking at kind of the whole
landscape, there are 30 to
[1:01:06] state grant making engine see
is and 775 grant programs that
[1:01:12] are subject to jams policies.
The Department of Agriculture Mdh deed DPS, Department of
Health and Mendota all have

[1:01:22] over 50 programs each. We have
an incomplete picture of
[1:01:27] grants, you know, at one time
because it kind of its fluctuates in fiscal year 2022.
23, the state executed an
[1:01:37] estimated 17,000 new grant
contracts and manage 30,000
[1:01:43] active grant contracts. So
we're looking at, for example,
[1:01:49] the data that we have from 9
agencies has a total value of
[1:01:55] about 140 Million. But that,
again, is an incomplete picture. We don't have kind of
all of that data collected.
[1:02:03] >> Thank you. Guests and
140 million sounds incredibly low, honestly. So I think
provided that the whole picture
[1:02:11] to us as a committee would be
incredibly helpful. So if you can get that to us all, make
sure all the members get it.
[1:02:18] But I think there's a much larger scope
here than I I think the public
[1:02:25] was maybe understanding.
And I want to just make sure that the public really is aware
of the huge amount of work that
[1:02:33] we are at granting out through

nonprofits and and that we need

[1:02:39] to get a handle on this.

So I encourage you to provide that Mr.

[1:02:45] Complete accounting of not only

the agency's 2 overs overseas,

[1:02:50] and that's a lot in the number

of grant programs, but the dollar amount as well. So thank

you for that representative

[1:02:56] came in. >> Thank you, Madam Chair.

And to a certain degree, I really appreciate actually

the conversation about whether

[1:03:03] it makes sense to provide

services through grants to nonprofits. I think that's more

of a conversation for us as a

[1:03:10] legislature as a policy

conversation. Many cases I'd say weather and I think some of

those a billion dollars of

[1:03:19] grants and hundreds of

millions. Another biennium is childcare is housing is food

programs. And I was turning to

[1:03:26] and I think I remember

represent Anderson. You saying it was your favorite page and

in May only on it pH 7, but

[1:03:33] where talks about Department of

Human Services, Education, Health did commerce the the

amount of grants and in many

[1:03:41] cases that's a policy choice
that we have made. Not all of those I think our legislative
grants. But when we are
[1:03:47] legislatively directed grants
to fulfill the need with
[1:03:53] outsourcing it to a nonprofit,
think we do it in other ways to for profits. There is a
question if we want to provide
[1:04:01] whether it's child care, food
aid through our schools, which are our public entities,
we could do that. And in many
[1:04:09] cases we have provided to do it
privately through a non-profit. I think that that's a that's a
really good and important
[1:04:15] conversation we should be
having because when we when it is a government entity, we have
more transparency and oversight
[1:04:23] just built in. Whereas when
it's a nonprofit or for-profit, frankly, they have their
independent board and they have
[1:04:30] different sets of incentives.
And so I think from a policy conversation I'm interested in
that of what's the best way to
[1:04:38] provide the services people are
asking for and need in a way that is both most transparent
and also most accessible.

[1:04:46] And so I think to that point,
both representative shots and kind Robin sets to me a
question of that we should be
[1:04:53] asking is a policy as
policymakers and I'm looking forward to the conversation.
[1:04:59] >> Thank you, Representative
Goodman. And that's one of the values of having this committee
at the time to have these. >> Deeper conversations.
Representative Pinto, thank
[1:05:07] you, Madam Chair. Yeah, this is
getting rapidly relief philosophical, if you like.
And I think it in good health, the ways I agree with you
because had meant to to go in
[1:05:15] this. I've got a couple of the
things we just don't represent women to play. I mean, if we
think if we think to ourselves as help that we all do, the
people in our society of
[1:05:21] certain needs to meet rate, so
needs that that that that need to be met in various ways.
And certainly one way to do
[1:05:28] that is think about private
charity. One way to think about that is is government in
government and government programs. And then there's
potentially this their way of
[1:05:36] saying, well, we're going to
outsource to nonprofits and maybe in some ways has been

some tension between those 2. We should have landed on this one. But then there are some
[1:05:42] disadvantages to it. This represented 3 men talked about. And I do think some real advantages to having work done
[1:05:49] within government and all the controls on all the checks and all that. So just sort of that's an interesting point
[1:05:55] thinking about those those frosties. But I wanted to just go back to the point of things are consulted made about about
[1:06:01] when termination of grants occurs or when folks are prevent against Madam Chair, you brought this up as well and
[1:06:07] wonder if if the commissioner could talk further about this, there were 3 that were terminated as being not the
[1:06:13] best interest of the state.
Yes, I have the sense that there are probably other examples along the way where,
[1:06:19] you know, even before an award is made, you've got even so maybe a organization is legislatively named. But then
[1:06:26] they have to provide certain documentation. I think I'm aware of places where organizations action been

[1:06:31] prevented from receiving the
grant because it turned out they could meet hurdles to
have. Is there is there something that prevents folks
receiving funding organizations
[1:06:38] receiving funding besides just
that termination, the best interests of the state where
kind of the hurdles along the
[1:06:44] way this Christensen? >> Thank you, Madam Chair,
Representative, great question.
[1:06:49] And and this is something that
is a significant barrier. We don't currently have
authority to not a word to a
[1:06:56] potential grantees. So the
statutory scheme is for grantees. And so someone that
is knew that that authority
[1:07:04] doesn't exist. So that is
something that at Mendez is hoping to pursue, to make sure
that, you know it the situation
[1:07:12] to situation exactly as you
described it and that, you know, you don't have to
currently be a grantee. You
[1:07:18] could also be a potential green
tea and still have that same authorities.
[1:07:24] >> Representative and thank
you, Madam Chair and and commissioner show. I know
that's true for you. I guess

[1:07:29] believe it's the case. But
please. And this may be some just want to get back back to
it's about is that with
[1:07:35] individual agencies, there are
a number of hurdles that are set up, gets provide that and
I-90 if the state had to
[1:07:42] provide indication that the
sure their finances are adequate and I guess so.
It does seem like there are pre
[1:07:49] award hurdles that are with it,
but maybe more decentralized. But if you could just expand on
that,
[1:07:56] it's Christensen. >> Thank you, Madam Chair or
represent Pinto? Yes, and so are our grant making scheme is
not its reimbursement based.
[1:08:04] So, you know, grantees have to
set up a budget and a work plan. And that all has to be
kind of filtered through,
[1:08:10] you know, that the individual
state agencies, and then, you know, to some extent, you
know, receipts have to be
[1:08:16] provided invoices. And then
there is that kind of look by the agency to make sure that
they are actually receiving
[1:08:22] that money. So, you know, the
Korean word risk assessment could go through and, you know,

the the agency chairman's there

[1:08:29] by a ball. And then there could

be a situation where, you know, they submit something and they

want reimbursement. And the

[1:08:36] agency says he and no, not

quite. I'm sensing something straight. So certainly along

the way there are stops,

[1:08:44] you know, that that could be

made. So it's not that, you know, the full award of the

grant is kind of provided on

[1:08:50] the front and it is

reimbursement based based on the work being completed. >> Along the way they think and

the families have Madam Chair,

[1:08:57] I can't. Of course. Thank you,

Madam Chair. And so then blasting this actually get a

written agreement who sent this

[1:09:03] to me. This will be a A A A A

jump ahead. Mister Johnson's research, there's a and B

statute, 16.0 5, 7, that says

[1:09:13] that MB is responsible for the

system of internal controls across the executive branch and

in particular that it's

[1:09:19] responsible for, quote, to

safeguard public funds and assets and minimize incidences

of fraud, waste and abuse.

[1:09:25] At least it seems like in the

statutory scheme it is and then bees responsibility. It's a
case that's helpful. Maybe
[1:09:32] something we want to look at as
a committee, madam chair, but but that does seem like
some informations in statute now. Thank you and thanks to
the commissioner.
[1:09:39] >> Thank you, representative
into just one 0nd. I just want to follow up and that I
appreciate that point about the
[1:09:46] difference between GM's
authority to terminate grants for says agencies.
[1:09:51] And I do know that in the 2023
in by agency authority, it says
[1:09:58] that agencies who require
different different information to determine whether there's
substantial risk that the
[1:10:05] potential grant he cannot or
would not be able to perform their required duties. The
agency can get 30 notice for
[1:10:12] asking for additional
information and then they still must either create a plan to
satisfy the concerns or not
[1:10:20] awarded grant. So the agencies apparently have more authority
to not a word to the potential
[1:10:25] grantees, then the GM and maybe
that's something we should better align. So I think that's

something we can look at.

[1:10:31] Would you like the authority to

2 after previous assessment say no, you're not getting the

money.

[1:10:38] >> As Christians and thank you,

Madam Chair, we appreciate the statutory scheme as it exists

right now. Really? Why wouldn't

[1:10:44] you want that authority? Madam Chair, we believe that it

is working it as best, you know, fit with the agencies to

make those determinations and

[1:10:53] and each grand contracted.

They also already agencies have the ability to do that

termination. And you know,

[1:11:00] something rising to the level

of not in the best interest of the state. We feel best.

That's what the Commissioner of

[1:11:06] Administration. >> I appreciate that

clarification. I would note that you do currently have the

authority to enforce all of

[1:11:14] these policies. So if you feel

that the agency is not terminating and they should,

you could still override that.

[1:11:21] And and I think that's what we

as members are looking for is we want you to take a more

active role. And so it's

[1:11:29] surprising to hear that answer,

honestly, but I appreciate it. And I go to represent Anderson

and then I have another

[1:11:35] question. Thank you for a second. >> There's a for representative

pinch of this, a 4th way,

[1:11:42] too, which is direct dollars to

the individuals to make their own choices about what they

buy, food they care except to.

[1:11:51] So I just want to point that

out. But I agree this and we should at full staff of

discussions about this. So and

[1:11:57] I think we do try to do some of

that directly to refundable tax credits, not sort of thing, but

that's, you know, the way that

[1:12:04] we avoid all of us, actually.

So, but let me just up. So.

[1:12:09] >> Can you tell me why? So?

It sounds to me like you really a look at sure mission as

setting policies, procedures

[1:12:18] training for >> staff statewide. And I

understand what you think you

[1:12:25] with that. Can you tell me why,

though, for the example of the MD the feeding their futures?

So that was federal money to

[1:12:32] get the Medicaid, but that was

then dumped state grant making, even though it was federal

[1:12:38] dollars. So why isn't

[1:12:44] and agents your agency if that
occurs again, because this is now, you know, you have new
powers since since 23, why
[1:12:52] would you have no feel that you
have no authority because their federal dollars
[1:12:58] do we need something different
to change something different? And then also, you know, this
spent a lot of criticism of it.
[1:13:07] The agency is because he's been
there are now site visits. And it was very obvious that
this fraud is occurring in all
[1:13:12] these programs of someone, just
what it showed up it is that something that you
[1:13:19] I thought about putting into
the policies and procedures and the recommended and that
optional and not? We'll let you
[1:13:27] we'll tell you 2 weeks in
advance that we're going to come and visit you, but
actually
[1:13:33] random site visits like a lot
of the regulatory. Can you answer office to many
questions and one, but we're
[1:13:42] live in a time. >> It's Christian said you,
Madam Chair, Representative Anderson, it I will try to
answer all of them. If they
[1:13:48] don't hit on them is please

stop me. So that with the mte

[1:13:53] that was a federal aid program

which comes with its own terms and conditions. So the the

those have to always be look

[1:14:02] and the agents at what GM

doesn't have any insight into what those are. So the agency

has to be responsible for

[1:14:07] knowing what kind of the those

terms and conditions there following with that particular

program, the other nuance in

[1:14:15] that situation. And I can't

speak for Mte, but there was litigation, my understanding,

you know, that was involved.

[1:14:23] And that was complicating that

matter as well. And so and you know, to your question, you

know, with these additional

[1:14:30] authorities, could something

have caught been caught sooner than it was possibly? I think

we just don't know the answer

[1:14:37] to the question because they

were involved in litigation at that point as well with with

regard to the UN announced site

[1:14:46] visit. So I want to make an

important distinction that the GM policy right now

[1:14:53] as information about monitoring

visits and that is where the both the state agency and the

grantee prepare in advance.

[1:15:01] They get, you know, kind of all

of their documentation and order. They go out and, you

know, they they look at things

[1:15:06] and they do kind of, you know,

look at finances and that type of thing. So that takes a

significant amount of planning.

[1:15:12] And I think, you know,

something that has come to our attention recently. And I think

what you're describing is an

[1:15:19] unannounced kind of

verification, this it and that is not anything that is either

in statute or in policy right

[1:15:27] now. Right now, policy talks

about monitoring and their rigorous requirements around

Manhattan. And, you know,

[1:15:34] we don't believe that an

unannounced monitoring is going to be very efficient for anyone

because there's no time to

[1:15:39] plan. But I think that it's

worth having, you know, as a policy discussion, should there

be something related to an

[1:15:46] unannounced verification visit?

I think that's kind of a a different kind of tactic that

that could be examined.

[1:15:54] Representative Anderson, thank

you. I would. >> Highly suggest that Syed I
have a business that I'm regulated by an agency to
oversee and the board of
[1:16:03] cosmetology and they come
regularly announced the end of
[1:16:08] it. I'd like to ask okay, so,
but that's exactly what he's done every way, you know, all
these other things and that
[1:16:16] would have solved all these
problems early on if we have that sort of thing and that and
I guess it's a question for us
[1:16:24] is for legislate. You know, how
do we make sure that that's happening and whether that's
something that you put in as
[1:16:31] recommended or we put that in
statute. But that sounds a lot of this,
including the medications.
[1:16:39] >> Thank you. Miss Christensen
educator a plat and >> sheriff is ending. And yes,
I think it that is worth a
[1:16:46] conversation for kind of the
policy makers on what you know. Again, I want to make that
distinction with Medicaid that
[1:16:53] that's outside of kind of what
we're talking about, really get a state grant. So that would be
a different conversation.

[1:16:59] Thank you. Thank you. If I may
follow up on that, so I mean, we don't
[1:17:04] >> have to put that in statute.
You could put it in policy. Is that correct? But you are
choosing not to put the unannounced monitoring site
visits in policy at this point.
[1:17:13] >> Madam Chair, it is a
convert. It is kind of topic that has just come to our
attention within the last
[1:17:19] couple of weeks. I don't think
that any decisions have been made. You know, not not to do
that. You know, I definitely
[1:17:26] think that the legislature, if
they wanted to mandate that could certainly put that in
PSA's statute.
[1:17:32] >> Thank you, Miss Christensen.
I do think we could mandate it. My concern is that I feel like
with all these little things we
[1:17:39] put in statute, we are so
micromanaging to me. It's sort of common sense like I don't
know why we would have to man
[1:17:45] and mandate that. But if we do,
I certainly am happy to look into it.
[1:17:52] But I do encourage you to use
the authority you have been given. You have broader
authorities and I thank you

[1:18:00] acting on and I I certainly
hope that you will seize that rather than wait for us to
micromanage you cause. I think
[1:18:08] it could. It could become more
of a burden. But I do. I know there's
another question, but I had
[1:18:14] when I wanted to get to as
well. We talked a lot about these pre
risk assessment spree ward risk
[1:18:21] risk assessments and that trainings. And my
understanding is that neither
[1:18:27] of those are mandatory, but
they are recommended. So could you speak to what is mandatory?
What is recommended and
[1:18:35] and if it's not mandatory, is
that something you're looking for us to require? Is that
something you may still require
[1:18:41] in your own? >> Madam Chair, the Opry Award
Risk assessment process is
[1:18:48] mandatory. That's in statute.
That is something that agencies have to conduct the training
around how agencies kind of get
[1:18:58] up to speed on that. That is
not anything that is is required in statute. That was
something bad. I believe the
[1:19:07] oil pointed out in their

reports that the legislature could require certain certain
types of training are certain,
[1:19:16] you know, training topics.
And that, you know, certainly is something that you could all
discuss.
[1:19:22] >> So, but you don't think you
have the authority to require it currently.
[1:19:28] >> Madam chair, the authority
that GM has is related to policy kind of enforcing policy
and grant contract agreements,
[1:19:37] not specifically related to
training. Individual state agencies could certainly
require that they're, you know,
[1:19:45] particular staff, you know,
they can mandate agency's mandate training all of the
time for their employees.
[1:19:53] But the kind of broader
training requirements, I believe that's what the
Legislature.
[1:19:58] >> Thank you. I appreciate
that. So that second question I had was you mentioned that
there was grant money that you
[1:20:04] give out to help the grantees
[1:20:11] sort of get up to speed
financially in financial best practices. Maybe if they have
an audit requirement or if they

[1:20:18] have to provide additional financial statements to you.
How much is given out on top of
[1:20:27] the grant for this financial
help to grantees and how do you track that?
[1:20:33] >> Man in chair, great question
that the on that requirements
[1:20:39] sits within the grant dollars
that is appropriated to the agency to give to the grantees.
So there isn't a similar to the
[1:20:48] administrative funds. It would
be kind of a hold back. So if a grand t as part of their budget
and work plans side, we need
[1:20:55] some help kind of doing this,
you know, gathering our financial documents kind of
doing that. That would be part
[1:21:01] of their grant. So there isn't
additional kind of appropriation that is given to
and then above and beyond that
[1:21:09] grant, it would be, you know,
part of their budget would be kind of doing that financial
kind of risk assessment with
[1:21:18] the agency. So an agency would
state individual state agency would determine if that was
going to be part of their grant
[1:21:24] dollars. >> Great. Thank you. So so
perhaps I think that would be a helpful sort of walk through

for us. The agency does the

[1:21:33] pretty risky assessment and then reports to you and then if they need more

help, the agency uses some of

[1:21:40] that, I suppose in grant money to say no, we're going to help

you on the financial side to

[1:21:47] strengthen finances before we

award the grant. Could you just walk us through the press is

where do you interface with

[1:21:53] that pre risk assessment

process? Madam Chair? Not at all. >> That is completely with the

agency and and the grantees.

[1:22:01] So the only kind of touch point

we would have is if we received notification from a state

agency that they are not going

[1:22:09] to award the grant and that's

just a notification. We just received that. And then they go

through that kind of inter of

[1:22:16] process of the grantee provides

more information. The agency makes a determination and then

it could move into a contested

[1:22:23] case process if the grant he

wanted to pursue that. >> Thank you, sir. When did you

get involved in the 3 you did

[1:22:30] terminate. How did that happen? Madam Chair, my understanding

is the state agency notified us

[1:22:37] that they wanted admin to kind

of utilize that authority.

[1:22:42] They explain to us the

situation and then we we did that. It was not part of the

prewar at risk assessment.

[1:22:51] So the agency could have

terminated it, but they asked you to do it in step. Madam Chair, that excellent.

All right. Thank you for

[1:22:59] clarifying that. I'm sorry. Who's next?

Represent Pinto. >> Thank you, chair. Maybe just

building off of that then

[1:23:08] commissioner. And so that you

received notice from agencies when they, in fact, are not

wanting to award. And in

[1:23:15] addition to those 3, it sounds

like there's a number of examples where they've given

notice it is in fact, the case

[1:23:21] as he shaking hands, maybe just

to clarify that. Do have you received such notices from

agencies besides those 3?

[1:23:27] Just those 3? >> And I'm sorry, I Miss

Christensen, Madam Chair,

[1:23:33] Representative Antone. Not that

I'm aware of. Okay. >> And then kind of thank you,

Madam Chair. And then I guess

[1:23:39] just a thought that's coming to

me. And at this point in the conversation, build enough

represent 3 months earlier, I said, I do think it does feel like we've got sort of a number [1:23:47] of different issues here, you know that, you know, feeding our future, Medicaid, et cetera, not kind of not passing [1:23:54] through this process. And so I do think, Madam chair, to the extent that we can, and it's possible future here in this [1:23:59] are just team that that be would be really helpful to understand that. I wonder, in fact, if at least as part of that, having a former U.S. attorney Andy Luger come in, [1:24:08] we just had a thought, not sure if your consideration, but I it does feel like understanding the problem deeply. I think [1:24:13] it's been very useful. These first 2 hearings to kind of as representative can said, you know, we there was an early [1:24:19] report that we requested and then changes were made based on the kind of see the results of that that's really useful in [1:24:25] one area. But it does feel like there's some other areas that that this doesn't connect to and from can understand that problem. And we understand better how to sell that to some [1:24:32] thoughts. And thank you, chair. >> Yes, I appreciate that.

Representative can tell. He's definitely on our list for

future hearings, OK? Yes,

[1:24:38] thank you. Was there another question?

Okay. So I have one more if you

[1:24:44] will indulge me just back to

the 5 to 10% that they can we.

[1:24:51] So it's the agency that

receives the 5% for managing

[1:24:57] the grant or 10% of its

competitively awarded. Is there.

[1:25:03] >> A similar scheme for what

the grant even retains for

[1:25:09] performing the grant for the

administrative side or is that just up to each individual? Can't grant

contract how much that the

[1:25:17] grantee it's allowed to use for

administrative costs. >> Madam Chair, I.

[1:25:23] >> I believe it's the latter.

I don't want to speak out of turn. I'm not. You know, I

don't have that technical

[1:25:30] answer, but I believe it would

be part everything is part of the grant contract in kind of

all of the terms and conditions

[1:25:37] that are grant he has to

follow. So you're correct in that the kind of 5.10% for new

grants that's for the state

[1:25:46] agency to do all of the kind of
administration work that I've talked through,
[1:25:51] how a grant he is doing.
The work is really set up in
[1:25:56] their budget and work plan
that's approved by a state agency. So that could lay all,
you know, salaries and
[1:26:04] expenses. And, you know, kind
of all of those budget lions, you know, we could certainly
get you more information about
[1:26:10] what what that might look like. >> Great. No, I did expect it
would be up to individual grantees. But I just wondered
if that was a more systemic
[1:26:18] look at that. But see, I think I have one
more question
[1:26:25] and then we will let you go.
But this has been very helpless. I think I think just
to to close it out, I would
[1:26:31] like to know clearly my personal view is
that we should change to must
[1:26:39] uncertain requirements, but that clearly and you don't
want a lot of new authority.
[1:26:46] So how would what are the ways
that that we can make help you
[1:26:52] being more effective at
managing state grants and and

[1:26:58] do you believe your purview
includes all agency grants? Not just the ones managed by
the Department of Amman.
[1:27:07] >> Madam Chair, to your last
question. Yes, our our purview is certainly broader than kind
of our own portfolio. In terms
[1:27:14] of the, you know, grants,
grants, management authority.
[1:27:21] >> We believe that with the
certain are the specific requirements that are in statue
right now. We have the right
[1:27:26] compliment of of staffing and
capacity. I think with any
[1:27:31] additional requirements, we
would have to look at what sort
[1:27:37] of other staffing capacity
might be necessary. And we we
[1:27:43] spent, you know, these new
statutes have only been on the books poor, you know, a year 2
years. So we've spent a lot of
[1:27:50] time trying to just implement
that. As I alluded to, we're really hoping to get more into
how we can do this better now
[1:28:00] that, you know, we're going to
be higher. A couple more people. We have the funding to
do that. We want to make sure

[1:28:06] we're hiring the right kind of
people to do the right work. So, you know, I think that the
this isn't the end of the
[1:28:12] conversation and how we're
trying to implement the statute. We're just getting
started. So I really appreciate
[1:28:18] this conversation, you know, to
get your insight into that as well. >> Great. Thank you, members.
It's been a great discussion.
[1:28:27] I appreciate everyone being
here and we will look forward to next week's hearing
[1:28:33] and Miss Christensen, we really
appreciate your work. I look forward to I am working on a
bill to kind of strength and
[1:28:39] some of them stunned the Maze.
2 must or shall. And so I would
[1:28:45] welcome your feedback on that.
But that members, I believe we are adjourned. Thank you

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 02-24-2025

[0:02] >> Good morning. It is 8.15,
and kind to order the House
[0:09] Committee on Friday prevention
agency oversight. We have a quorum present and
vice chair in December to the
[0:18] minutes of February 17th. >> 17 hard to believe it's
getting Leah most end of
[0:25] February. I move approval of
the every 17 minutes. Madam Chair, thank you, sir. Any
discussion.
[0:32] All those in favor say Aye.
Aye opposed minutes are approved. Thank
you. And today I would like to
[0:39] welcome to the committee, the
acting commissioner of DHS,
[0:45] Serene Gundy. Thank you for being with us.
She has been in strong maybe 2
[0:51] weeks time. Thank you, Madam
correctly. But she's been a long time person at the
department. So deep knowledge
[0:59] and we look forward to your
testimony today. >> Thank you, Chair Robbins for
the record. My name is sharing
[1:07] Gandhi and I'm currently

serving as temporary commissioner but the Department of Human Services. I have been [1:14] at the Department of Human Services since 2017 serving in various roles, including Chief Compliance Office, Assistant [1:23] Commissioner and Deputy Commissioner. I came to DHS from the private sector with 22 years of [1:32] experience in healthcare, public affairs working for providers, namely hospitals, nursing homes, surgical [1:39] societies and trade associations. A significant portion of my career has focused on quality of care, [1:48] process improvement and compliance. At DHS. I led the creation of a compliance oversight structure [1:56] in order to help improve compliance and strengthen our internal controls. [2:03] Now, this work is work that is never done. It is you have to take it with the continuous improvement mindset. And so it [2:11] DHS, I continue to champion process improvements and strengthening our internal controls. [2:18] And I look forward to working

with this committee as long as I am serving as temporary
Commissioner,
[2:29] Minnesota is a state that is
committed to helping people and we're committed to providing
services that improve the lives
[2:36] of Minnesotans. Early childhood programs
provide valuable education to
[2:41] Minnesota's children and
service the work force behind our workforce.
[2:47] They provide care for children
while their parents go to school and work
[2:53] fraud in these programs is
unacceptable. It is not a victimless crime.
[2:59] It hurts the people who need
our services and it erodes public trust in government to
people who steal and misuse
[3:06] public dollars should be held
accountable to the fullest extent of the law.
[3:12] Dhs takes seriously our
responsibility to monitor for non-compliance and prevent
detect and investigate fraud.
[3:22] We are always continuously
improving how we approach supporting and protecting these
programs.
[3:29] Today. I'd like to cover for
the committee how we operate now because it's important to

start with accurate knowledge

[3:36] of our program, integrity, work

and DHS is often unknown successes.

[3:42] I also want to cover how the

state has continued to strengthen its approach to

program integrity in early

[3:49] childhood programs over the

past 5 years. And the governor's

recommendations for this

[3:55] legislative session,

[4:00] DHS prevents protects and

investigates fraud in early long learning programs, namely

the Child Care Assistance

[4:09] Program or See CAP which helps

families pay for childcare. So parents can work, go to

school or look for employment

[4:18] and the Great Start,

Compensation Support payment program, which supports

childcare and early education

[4:25] workforce by increasing compensation and

benefits to recruit and retain

[4:31] this vital work force since stepping in as temporary

commissioner. I have been

[4:36] meeting with OIG managers, the DEP with the DPS

Commissioner Bob Jacobson and

[4:44] Superintendent Drew Evans. We have a strong team in this

state and are eager to do more.

[4:55] Currently, there are about 1800

licensed child care centers and about 58 half his family.

Childcare providers about 3600

[5:06] providers are enrolled in see

cap.

[5:12] Sorry about that. Let me know SIs better.

[5:21] Every year licensing conducts

annual unannounced visits to childcare providers. While

Licensors are not see cap

[5:29] investigators, they do report

directly to see cap when they observe conditions are

violations in the program that

[5:37] are suggestive of fraud or

other secret kept program violations.

[5:43] Whether it's an obvious sign of

fraud or errors and record keeping Licensors are trained

to report these findings to see

[5:51] cap for review and possible

investigation as warranted

[5:59] on site on-site visits made by

licensors. These make a

[6:05] difference by assuring direct

accountability.

[6:11] We also use tips received and

information from our data

[6:17] analytics program in order to
determine when investigations
[6:22] are warranted. Since 2020, the Childcare and
investigation unit has
[6:27] recovered 2.4 million dollars since 2021. They have referred
on average about 5 cases a year
[6:36] to law enforcement for criminal
investigation. And since 2021, they have
stopped payments to 7 to 79
[6:44] providers. If I can interrupt
you just for a moment and members feel free this a longer
presentation. So if you have
[6:51] questions just notify us and
you can jump in. So I just want to follow up on this slide
before we move on
[6:59] that cases where they have
stopped payments.
[7:04] How many of those were referred
for criminal investigation?
[7:11] Chair Robbins. We would need to
get that number for you. Okay. Thank you. And then. >> Are those were there any
changes and licensure and those
[7:19] where they put on suspension or
revocation or anything else like to know? You know, once
[7:25] what, what's the threshold at
which you step payment and, you know, in those

instances, if you could give us
[7:32] more detail on that, yeah, I
would be happy. I mean, in terms of this specific 79, we
would need to go back and look
[7:40] at the records and determine
what we can share. But in terms of stop payments,
[7:49] I can give you that information
that our threshold that so under state law, DHS can only
act to stop or NC CAP payments
[8:00] if the provider is operating
after receiving an order of suspension re vocation or
decertification,
[8:09] if the provider intentionally
gives false information on billing forms or submits false
attendance records, if there's
[8:17] a credible allegation of fraud, if the provider refuses access
to attendance records
[8:27] and I think I cover that also a
little bit and might be getting ahead of
that. Thank you. That is
[8:33] helpful context issue. And
we've been to that question. >> It's a manager. You actually
I'm seeing maybe on that
[8:39] getting to this. But just the
there's a reference to referral
[8:44] the criminal investigation, the

slide. And then there's also the childcare audits and
investigations unit and just understanding to what extent is
the unit is the unit looking
[8:52] only a criminal fraud cases
versus are there other kinds of situations where payments may
be stopped? The site's criminal
[8:59] fraud, like other surf,
understand the scope of the unit and what part of it is as
for criminal fraud versus other
[9:05] things going on. If that
question make sense, chair and testify. >> Discount
[9:10] Chair Robbins, Representative
Pinto. Yes, the investigations unit can take a number of
administrative steps and I'm
[9:18] going to cover those as we move
forward. And then they also if they see if they believe there
is fraud, president will reform
[9:27] refer it to law enforcement for further investigation and
prosecution
[9:33] and with the front. Thank you.
Thank you. Please continue.
[9:41] When DHS received concerning
information about a provider, it goes through this workflow.
And I thought this might be
[9:48] helpful for the committee to
understand the process that we use in our Office of Inspector

General.

[9:57] So for the first step is that

there's an internal or administrative inquiry process

to evaluate the concern.

[10:06] If it's determined that car

crime may have been committed, the case is referred to law

enforcement for further

[10:12] investigation. If it's not clear, then a civil

or administrative regulatory

[10:20] examination continues for investigation. If it's not

clear a crime has been

[10:27] committed, but there's

problematic behavior of full civil investigation begins this

examination. This examines the

[10:36] behavior in relation to our

program's rules, regulations, procedures and the statutory

framework.

[10:44] If at any point in this

process, the investigation uncovers criminal activity,

then it is again referred to

[10:51] law enforcement for further

investigation and prosecution potentially

[10:58] if there's improper conduct.

But it's not criminal conduct than the inspector general

pursues appropriate civil

[11:06] remedies. If the case is referred to the

criminal investigations to the

[11:12] BCA, it'll p presented for

possible charging by a prosecutor at the end of the

investigation.

[11:19] And that does not prohibit a

our office from additional

[11:25] civil remedies.

[11:30] So going a little bit deeper on

fraud investigations, criminal fraud, and that is

defined as the intentional

[11:39] deception of a person or entity

for monetary or personal gain.

[11:45] Dhs has ongoing relationships

with state and federal law enforcement to prosecute fraud.

[11:53] Investigations are based on

tips, complaints and data analytics team which allow DHS

to take a risk based approach

[12:02] to focusing its resources on

investigations. When DHS find suspected fraud,

it refers the case to the BCA

[12:12] at the Minnesota Department of

Public Safety, a law enforcement agency so

that they can conduct a

[12:18] criminal investigation. And DHS also works with federal

law partners such as the FBI

[12:29] up. Excuse me, Vice Chair Anderson, thank. >> Thank you. I meant as a

commission, I had a question

[12:37] could say you said earlier that

when this occurred and those suspected fraud that you can

cut off to payments and do you

[12:47] do that right away? You kept

the payments right away when they're suspected fraud when a

case is different.

[12:54] >> Yes, statute or yeah, we are

allowed to for credible

[12:59] allegations of fraud. But do you typically do that?

[13:05] I think week, Madam Chair representative on

its side, right? Yes, so it's

[13:14] safe. It's a case-by-case basis

made by looking at the facts.

[13:21] Thank thank you. >> Representative Anderson and

to follow up on that. So of

[13:27] of that number of cases that

are referred for fraud investigation, how many

[13:34] do you stop payment on or have

you stop payment on in the last year of of the ones that have

been referred for a fraud,

[13:40] credible allegation of fraud?

How many of you step payment? >> Let me see if I have that

data

[13:51] at this. And yes. >> Yeah, I have the number of

the 79 payments, but

[13:58] specifically the way that
you're asking for the data to be looked at, I don't have that
number handy can get it for you
[14:05] if you thought. Great. Thank
you. >> All right. And that are. >> Representative or thank you,
Madam Chair. So so back on
[14:12] slide 4. You said that you'd recovered
2.4 million dollars. When you
[14:18] say recovered. Do you mean you
actually when to those agent or went to those day care
providers and got money back or
[14:25] you just payment recoveries are getting.
[14:33] >> Getting money back. And then
there's also in addition to recoveries, there's a avoidance
of ongoing pain. That's that's
[14:42] a separate Category. Representative. Eric, thank
you. May be a need to have a
[14:49] thank you, Madam Chair, OK?
So you've actually so I'm assuming that was through a
criminal process because you
[14:55] wouldn't have the power to
actually going in and their bank accounts or
anything like that. So
[15:02] can you let me know? I know that the chair asked the
same thing kind of about how
[15:07] many criminal investigations

there have been. And you talked about it going to the BCA.

But have you sent any to the

[15:15] the FBI or some of our U.S. attorney

folks here? You know, the ones

[15:21] that we're dealing with the

dealing with feeding our futures has anything from the

see cap crossed over into

[15:27] feeding our future. This county, Madam Chair, representative,

[15:34] I think I'm going to try to

keep track of the several questions there starting with

the feeding our future. Since

[15:43] since that case broke, our team has been

taking all of the information

[15:50] that we are able to get and making sure to look at

those individuals, make sure we

[15:57] have all of the right

identifying data to have the right person. And then we've

looked in our programs, bossi

[16:04] calf and the Medicaid program in order to see if any activity

was taking place in DHS.

[16:13] That was concerning. And so far we have not found

any activity that we were not

[16:20] already watching and taking

action on. But we continue to

[16:25] evaluate that and 4 and because

of a

[16:32] because of this process and the
ability to take action when there's credible allegations of
fraud. Currently we have
[16:41] stopped payment to 55 disqualified. 26 and also
provoke some license holders.
[16:51] Thank you, Representative or Representative King that.
Thank you, Madam Chair. And
[17:02] >> when that House building,
thank you, Madam Chair. And I
[17:07] just have a question as we're
thinking to that and just go back out of the we're talking
about both sort of cetaceans
[17:16] for noncompliance. We're
talking about fraud. Can you give a sense of the whole
panoply of things you might be
[17:23] looking at where so that when
we talk about referrals to criminal fraud, how much of
that is in the scope of the
[17:33] entire things you spend looking
at for child care centers for Sea captain centers.
[17:40] This can share Robbins
representative. Yes.
[17:45] >> On average when we look at
concerning issues that come up
[17:50] about 80% are non compliance or
administrative investigations.

[17:59] About 20% get investigated for

their for fraud.

[18:07] All right. Let's continue.

Thank you with the 2

[18:24] chair Robbins member of the

committee. So I believe we were here on referrals to the BCA.

Yes. So when we refer a case to

[18:32] the BCA, if the BCA accepts the

referral, they conduct a

[18:38] criminal investigation into the

suspected fraud. Dhs investigations into the 8

BCA investigations typically

[18:48] occur. Concurrently, we are looking into the

compliance matters and the BCA

[18:55] into criminal matters. Dhs can take administrative

action like stopping payments

[19:01] and disqualifying the program. The BCA then works with county

attorneys to prosecute cases of

[19:09] fraud. If they're able to build

a case that's strong enough to prosecute, if you would mind of

a 2 trip just for a second.

[19:17] >> When I was reviewing the oh

LA reports from 2019, there were 2 BCA investigators

embedded

[19:24] in T H S. Is that still the

case or are they separate that you refer to them

[19:32] Chair Robbins? >> They're not in it. >> Yeah. So I'm told that
they're no longer embedded.
[19:39] I know that we do fund
investigators in the BCA for the see cap program.
[19:46] >> And you know why that change
was made to 9 and that the BCA continue to keeping to BCA
officers within that healthcare
[19:54] investigated unit unit.
[20:02] >> Chair Robbins, I have a
colleague that does know the answer to that. Perfect.
Thank you very much.
[20:14] If you would mind stating your
name for the record. Thank you. >> Good morning. Madam Chair
members. My name is Tom Johnson
[20:21] and the deputy inspector
general for the program. Integrity Oversight Division at
the party and services.
[20:29] >> Great. So my understanding
is there used to be 2 BCA officers embedded with that
childcare investigative unit
[20:36] and that is no longer the case.
Can you explain how that transition took place? >> Yes, absolutely. Madam chair
members that change took place
[20:44] in 2018 or 2019 when there was
a decision to make it clear
[20:49] separation between criminal

investigations and administrative investigations.

[20:54] Dhs is the administrative

festive agency. The BEA says the criminal investigative

agency. So we work very closely

[21:00] with them, but they're no

longer embedded. It just pays the BCA, too.

[21:07] The investigators on of and

their agency. Thank you.

[21:12] Le Pen to hand yet. >> And thank you, Chair Nextel

this note since I was around 2019, a recall that at the time

we funded 2 additional BC

[21:20] investigate. Maybe this is what

the commission was referencing to be working with DHS, but but

put them at the BCA. So I don't

[21:28] know if that might have made

for investigators in total, but we just sort of madam chair

members that recall that was one of the things that that we

did in 2019 was to have

[21:36] dedicated BCA, you know,

resources than to pay for additional resources to work on

this. But then that way they're

[21:43] working with other agents at

the BCA. >> Thank you, chair. Thank you,

Representative Anderson. Thank you, Mister. My

understanding is you see a

[21:50] generally in this case to a

smart criminal rather than financial fraud

[21:55] and that that's their specialty

really said as a criminal. And so maybe that was part of

the logic care that your b***

[22:07] because the 2 different things

in many cases. So is that to

[22:13] the I don't know if we have your

title of. But my question is to

[22:18] is that your understanding,

too, Mr? Johnson, thanks. Chair

Chair Robbins representative.

[22:25] Just want to clarify that.

A financial fraud can be criminal as well. Yeah,

[22:33] yes. Thank you, Madam Chair,

Representative, you're exactly correct that.

[22:38] >> The BCA is a criminal law

enforcement investigative agency and is just as

administrative. That was the

[22:44] reason for the for the clear

split. >> Thank you, Representative

King. Thank you, Madam Chair.

[22:50] And I appreciate that

clarification because it's going to send is actually lots

of criminal financial fraud.

[22:56] And one of the things that may

be useful in this context is one of the changes that the

governors did was actually

[23:05] consolidate a lot of the

financial fraud converse from commerce and at the BCA.

So one of the things that might

[23:13] be useful to look at is is some

of those questions of how fraud from a criminal perspective

financial fraud is dealt with

[23:20] through the BCA. That might be

an interesting thing to to look at because I know it's been a

topic of lot of the conversations. We've had

misclassification fraud,

[23:27] some of the financial fraud

that overlaps with this stuff. Think just as we talk about us.

[23:33] >> Great. Thank you. So so just

be clear. There are no longer BCA agents embedded in DHS, but you work

with 2 or 4 dedicated agents,

[23:42] which numbers. >> Madam Chair, we DHS has a

contract with the BCA. We pay

[23:48] them to fund for investigators.

There are no longer embedded with DHS. >> Thank you for clearing that

up.

[23:54] Thank you. We can return to

your testimony Miscount. Thank you, Chair Robbins.

[24:03] >> While DHS works closely with

our law enforcement and prosecutorial partners, we also

take administrative actions for

[24:11] noncompliance. As we've been
discussing, we take administrative actions
for all program integrity.
[24:18] Violations are administrative
action include warnings,
[24:23] correction orders, stipulated
provider agreements, monetary recoveries, fines, payment,
withholds or stop payments,
[24:33] suspensions and
disqualifications.
[24:43] Addressing non-compliance and
fraud begins with prevention.
[24:49] The early and often program was
established by bipartisan legislation in 2019 in response
to the OLAY'S reports on see
[24:59] kept fraud. It provides technical
assistance to new programs and ensures earlier program
integrity, oversight than in
[25:07] the past. New centers received
for visits from their license
[25:13] served during the first year of
operation with Joint Licensing
[25:18] and see cap investigator visit
in the 3rd quarter, including an attendance record
review.
[25:25] The first licensing visit is

unannounced technical assistance. Visit subsequent
licensing visits are announced
[25:35] if there are violations, a
correction order can be issued or another action can be taken,
including referral for further
[25:43] investigation.
[25:49] Moving along the continuum, the
DHS OIG Licensing Division Licenses Center based fans and
family
[25:57] Childcare services across the
state Licensors conduct annual
reviews and investigate
[26:04] complaints to determine
compliance with Minnesota laws and rules licensing protects the health
safety and rights of those
[26:12] receiving services by requiring
that providers meet minimum standards of care
[26:18] for the physical environment.
Examples of licensing functions include health and safety
protections. Overseeing
[26:25] capacity in Ray shows ensuring facilities have
adequate physical space for
[26:31] healthy learning checking to
make sure staff have completed the required training and clear
background studies. Licensors
[26:39] are often the first eyes on the

program and they may see things that are concerning and refer that for investigation.

[26:50] The OIG Childcare Audits and Investigation unit identifies prevents and investigates fraud and compliance with see cap.

[26:59] The ultimate goal of this work is to protect taxpayers and families participating in the program.

[27:07] We may take administrative action as we've discussed and refer credible allegations of fraud to law enforcement.

[27:15] >> Thank you, Representative or thank you. Thank you, Madam Chair. >> Commissioner Von D I was just wondering so during COVID

[27:22] we were told that. >> In-person visits were suspended. And so when did you

[27:29] return to actual in person visits? Not over the phone sent hold that over the phone is another substitute for actually

[27:35] being in person to visit, which is excited how you would see Ellis violations over the phone.

[27:40] But when did you actually return to in-person visits? Not just over the phone or Zoom

[27:46] Commissioner County. >> Madam Chair, we will have to get that for you. I don't I

[27:53] don't have that date.

[27:58] Madam Chair, representative or so Commissioner Don T are you

currently doing in person

[28:05] visits? Not just by zoom or

over the phone. Madam Chair? Yes, okay. And

Madam Chair, Representative

[28:14] acts. I think you talk to me to

see you and I might have to 2 different

air. So

[28:21] dew was it in the last? >> Maybe year or 2 years that

you return to that. These I know during COVID you were

doing that. And and the reason

[28:28] I ask is that Jake Holes, you know, did it

quite interesting story and

[28:34] went multiple times a day care

centers that we're receiving quite a bit of money in the

millions.

[28:40] You know, there's video go

looking through windows where it doesn't look like there's

been a day care center there ever. So I'm just wondering

when when you know, after this

[28:49] year is done, he said in the

first year you made the first visit is announced in all the

other visitor announced an I

[28:56] don't know if that's in person

or over the phone over zoom, but

[29:01] as a been a year or 2 or are

less and that they've actually return to physically in-person

visits, not over the phone and

[29:07] not by some commissioner kind Chair Robbins representative. >> I don't want to give you an

exact date because I don't want

[29:14] to give you the wrong date.

I would like to get you the correct date. But it has been a

while that we have been doing

[29:20] in person visits. And I am

familiar with the J Cole story. I know that our licensors have

conducted unannounced visits to

[29:29] the centers that he's talked

about. And there were children present on each of the

occasions that we went. We've

[29:36] also talked with the reporter

about the proper location and

[29:42] or to use to get to the center.

And so we have not had the same

[29:48] experience that that reporter

had. And we've shared what we've seen and the accurate

hours of operation and doors to

[29:57] access the facility with the

reporter. Representative Eric, thank you.

[30:04] Ok, thank you. Well, we'll just

have to revisit that. >> So the other question I had

is we talked about data

[30:09] analytics to find fraud.

Can you expound on that a little bit? What kind of data

analytics to actually use?

[30:16] Commissioner Gandhi, Chair Robbins representative.

[30:21] >> Data analytics can include

things like a billing amounts

[30:30] and any of the data points that

we collect on centers. I I

[30:37] would want to be careful about

listing everything and I don't know all of the details of

what's behind it. But we use

[30:46] the data that we have to look

for anomalies to look for

[30:53] correlations, look for data

that might be more indicative

[30:58] that something is concerning

and we need to look more closely into it. What's helpful

with data analytics is it is

[31:08] not a it's based on data.

So it's another avenue for us

[31:14] to to check to focus our resources

where we're most likely

[31:20] to have a challenge to have a

problem. So it rounds out the information that we get from

tips and from licensing

[31:29] and last question,

representative, especially for now. Thank you, Madam Chair.

Okay. So then

[31:36] when you received all that data

back and you've got people analyzing it. >> What half what does what

happens with the employees that

[31:44] dew point out thrive? What what's the next step after

the employee brings it to their

[31:49] supervisor and they say I think

I see fraud. Then what happens? Commissioner County.

[31:56] >> Chair Robbins

representative. Then I would go back to that slide where I say

we've identified a few slides

[32:02] ago. We identified that there

is something concerning than it is handed over to our

investigations unit or it

[32:10] actually first, we look at it,

do review and assessment to see

[32:15] if it if there are concerning

items that weren't for their investigation and then it'll

either go down the

[32:22] administrative route, the a

criminal investigation route or

[32:27] both. Thank you. Please continue with

your testimony.

[32:35] This slide shows the

collaboration that we have across systems

[32:41] at DHS and with our local

partners. So our early and often team,

[32:48] as I just discussed, works

closely with applicants for child care center licenses.

And newly licensed providers

[32:56] offering technical assistance

to reduce airs, increase compliance and strengthen

program integrity.

[33:08] Sorry about that. It's a little

bit. I don't see the are either of the screen here.

[33:16] Next OIG licensing the

licensure establishes oversight to support child care being

provided in the healthy and

[33:24] safe environment by qualified

individuals and that care meets

[33:29] the needs of all children in

their care. Licensing staff checked for compliance and have

a range of actions to take for

[33:37] non-compliance, including

referrals to investigations,

[33:43] Child Care Assistance Program

provider Investigations Unit investigates and takes

appropriate action if child

[33:50] care providers violate rules or

laws relating to the state's program. Actions include

administrative remedies to stop

[33:59] and recover payments and make

referrals to law enforcement agencies for criminal matters.

[34:06] >> And if I could interrupt you

on that and that point earlier, Representative Eric had talked

about how you recovered the 2.4

[34:15] million. I wasn't exactly clear and that

could you restate how you recover the money

[34:22] from a provider. >> Mr. Assange or members?

Yes, we recover funding in

[34:29] various Wayne's. If the

providers continuing to operate, we should monitor

recovery and we reduced their

[34:35] future payments in order to end

up collecting amount that we've received. The provider is no

longer operating in see cap.

[34:43] Then we issue a monitor cover

order and asked them today. >> Thank you. Could you

elaborate if someone has been

[34:51] they're allegations credible

allegations of fraud to the point that you're recovering

money,

[34:57] why are they allowed to

continue to operate? >> Madam Chair, thank you for

that question. We don't

[35:02] continue to pay if there's a

credible allegation of fraud and we stopped payment, there are no future payments going to them. In that case.

[35:08] We would just issue an order asking them to requiring them to pass back the money.

[35:16] >> So what would be the scenario where you are recovering it from them and they continue to operate.

[35:24] >> Madam Chair members, CS, the those will be the providers that fall into the 80% of not fraud. It's 80%. Their

[35:30] compliance issues, park charity issues and example might be they are actually serving kids, but

[35:37] they're not keeping adequate attendance records. There's no suspicion that fraud is going on there serving kids.

[35:44] They're getting payments.

But we do monitor recovery to because of non-compliance for attendance, record keeping.

[35:53] >> Thank you. That's helpful.

But presumably, if they're not keeping adequate attendance records

[36:01] to the point that you need to recover money,

[36:06] you find that that's not fraudulent. It's just bad record keeping. But yet you're

they're they're they're being

[36:13] overpaid, correct? >> Madam Chair, correct.

There are cases where they just

[36:18] aren't good at keeping records.

But there is no suspicion there are actually providing

services. So that would not

[36:24] raise thought a lot of fraud

and criminal investigation. But administrators Leawood

recover money for

[36:31] noncompliance. Me for not

complaints. >> Thank thank you. And to that

point, how do you verify

[36:39] attendance? I know they keep

the records but

[36:44] the rating the oh LA reports

from 2019, it seemed like there was a for

wear. People would be billing

[36:54] for the enrollment amount.

But no one was really terrifying. If that enrollment

about matched physical children

[37:03] showing up every day or that

the days days were just given for like a month or 2 at a time

and knowing really checked

[37:12] where the kids actually showing

up. So can you talk about how you verify

[37:17] 10 kids are showing up every

day or, you know, maybe a child

[37:23] is there for 5 days and then

the next week for days. How do you know once that? >> Madam Chair? Yes. Thank you

for the question. We used

[37:30] various investigative

techniques. One is to that announced visits to see are

there actually kids here?

[37:37] We also use surveillance

mechanisms, cameras basically to see how

many kids are entering each day

[37:46] with then over a period of

time, we compare those video records to what they built and

that is typically how it can

[37:53] apply cases of actual fraud

where their billing for services that were not

provided.

[38:00] >> And are those surveillance

tools used only in cases where

[38:06] fraud is suspected or more of

that? >> Chair members to use more

broadly to sent some to certain

[38:14] investigation. We don't know if

it's fraud or if it's something lesser income or noncompliance

issue. So we use the cameras to

[38:21] help us determine is that from

happening so that it's used before we determine there's

actual fraud happening. It's
[38:27] one of our main tools for
identifying fraud, actually. Thank. Thank you. >> And I know there are people
of questions. I want to just
[38:33] turn to Mister Johnson. I think
to do have some thoughts on the be capturing
[38:39] overpayments that you want to
share with the committee. >> Madam Chair members, I think
it's largely been covered at
[38:45] this point. There was an
earlier question about recovery going always through a criminal
matter. That's not required.
[38:50] There is an administrative
process that the agency can follow, that the statute that
describes what they can do and
[38:57] what actions they can take.
And that can include what was just described in terms of
issuing orders to recover
[39:02] money. Thank you, Mr. Jensen. >> And I have one follow-up
question on the attendance
[39:08] peas. Do you use and electronic
check-in system or is that
[39:14] something generally required of
providers?
[39:20] >> Chair Robbins that is in the
governor's budget recommendation.

[39:27] >> Thank you. It was also in
the oil recommendations back in 2019. So that's something that
I think people have been
[39:33] seeking for a long time. Thank you. Let's see who's also
on the list. Representative Eric, thank you, Madam Chair.
So I'm just trying to get the
[39:41] concept of this recovery money. >> So how much sea captain was
paid out paid out since 2020?
[39:50] You said you recovered 2.4
million dollars, which is about 600,000 per year, which is very
small. So how much was actually
[39:57] paid out since 2020 and TCAP
Money Commissioner Connie?
[40:03] >> Chair Robbins, I would need
to get a calculator and do the math. But the program is
[40:11] around. It has gone from I
think around
[40:16] over 200 million to over
300 million a year, both state
[40:21] and federal share and local
share.
[40:28] >> Just about and yes,
representative or maybe you think you mentioned. So we're
we're talking about an
[40:35] infinitesimal amount of money
recovered if you're paying out 200 to

300 million dollars per year.

[40:43] And you've recovered about

600,000 in some of that apparently is

just a reduction of future

[40:50] payments. And then you said

something about you actually like send the bill back or

something to the Sikh. Have

[40:55] agents are providers who

actually pays you back?

[41:00] Not just not just pull back

from future payments, but who actually pays you back again?

That's only 2.4 million

[41:08] in 4 years when you're paying

out 200 or 300 million per year

[41:14] Commissioner kind

[41:20] Chair, Robbins representative. >> We we we

[41:26] >> have stopped payments.

We have prosecutions that recall that require payment in

in order for me to tell you

[41:34] what we received back overall

of the same years that that you're asking for, I would need

to go back to the team and Paul

[41:42] additional data for you. >> But I think this is

important. I mean, it was from

[41:47] their slide. That chair that,

you know, since 2020, they've recovered 2.4 million dollars

[41:53] when they're paying out 200 to
300 million per year. Madam Chair, that just seems like an
absolute drop in the bucket
[42:00] 600,000 per year recovered money. And most of
that is probably just not that
[42:05] pain future payments. It's it's
just infinitesimal. Senator, thank you. >> Thank you. Please continue
with your testimony.
[42:12] Commissioner County Chair
Robbins, thank you. So the next.
[42:18] >> Next item on this slide that
I want to just mention this. Part of the pieces that work
together are OIG Data Analytics
[42:26] Office which analyzes the
provider service and billing data recipient benefit data to
identify unusual patterns.
[42:35] An outlier service provisions. The BCA, as I mentioned, the
first cases of suspected fraud.
[42:45] The OIG excuse me, the first
cases of suspected fraud to the BCA and they conduct the
criminal investigations and
[42:53] work with prosecutors. And then also DHS works with
counties to investigate
[43:00] recipient fraud.
[43:07] So we've been talking about
this a little bit already, but there are a range of

violations that I can that take
[43:16] place. So licensors conduct
annual unannounced inspections of licensed child care programs
as required the Child Care
[43:25] Development Fund the inspections. Can it hurt
her at any time during the
[43:30] calendar year they reviewed the space, the
policies, procedures and
[43:35] records for compliance, licensing violations. Maybe for
a variety of noncompliance.
[43:43] There are items such as
cleanliness the program having equipment in disrepair, not
maintaining child staff ratios,
[43:53] not following medication,
administration or behavior
[43:58] that is not in line with
policies and procedures.
[44:04] Some licensing violations are
referred for further investigation to the program,
integrity and over division.
[44:11] These situations can include
missing or incomplete attendance records. No staff
are children present when a
[44:19] license or attempts to conduct
an unannounced visit during the hours when the center is
approved to operate. And when

[44:28] the program is operating
outside of designated days and hours
[44:33] and example, that usually meets
the the criminal definition of fraud would be billing and
receiving serve it funding for
[44:41] services that are not provided.
[44:54] As we covered a little bit
earlier, DHS does not have the authority and Minnesota law to
stop see cap payments to a
[45:01] provider just because they do
not be it licensing requirements. If a provider's
license is active, licensing
[45:09] violations alone do not affect
their ability to receive payments.
[45:14] >> This candy, if I may
interrupt and that, so I find that a bit confusing. So you do
have the right to stop payment
[45:22] when there's been a suspension
or revocation. >> For some others suspect,
[45:29] suspicion of fraud. So if they have serious license
violations, why when that lead
[45:35] to a suspension or revocation
that could lead to stopping payment.
[45:41] So you just Madam Chair, you
just said serious licensing violation. And it's it's
important to look at the facts

[45:50] of a violation to determine the
nature, the severity and the frequency of it. So licensing
violations alone.
[46:00] >> Don't give don't alone. >> I mean that there's fraud in
the program. However, they can
[46:08] catch our attention depending
on the circumstances of the violation
[46:14] and have our investigators look
more closely into it. So licensing violation could be
something could be given for
[46:26] water on a bathroom floor. Plastic bags stored on a low
shelf where children can reach
[46:35] it. Those wouldn't be things that
would rise to credible allegations of fraud and have a
stop payments.
[46:43] >> So I understand that I
wasn't suggesting that a license violations mean fraud.
What I'm suggesting is I'm
[46:50] trying to get to is at what
level of licensing violation. Is it severe enough so that you
would suspend or revoke a
[46:59] license or even put them on a
conditional licensing status? So internally, since it's not
spelled out in statute, you
[47:06] must have sort of benchmarks
are thresholds where something rises to a serious violation

that would trigger

[47:16] conditional licensing a suspension revocation.

So could you explain

[47:22] what that internal metric is? >> Chair Robbins, if I'm

following you what I believe

[47:30] the the second bullet in sub

bullets cover what you're asking so we can with holder

and see cap payments. If

[47:39] there's a credible allegation

of fraud, if they're operating after

receiving a suspension

[47:47] revocation or decertification, if they intentionally give us

false information or they

[47:54] refuse to let us access

attendance records. But I understand that. So what would

lead to that? Second bullet?

[48:02] What rises to the level of

suspension revocation or decertification

[48:11] Chair Robbins? A melt treatment

would be one example.

[48:17] Anything else

[48:28] I can. I can chair Robbins.

I would be happy to go back and get a comprehensive list from

are OIG legal counsel. Thank

[48:37] you. I would really appreciate

that because one of the things I I didn't preparation for this

hearing that I believe we sent

[48:44] to you perhaps was we pulled the list of the

top see cap payments from last

[48:51] year where they got over a million

dollars. So so these are just the top.

[48:57] There's a whole lot more under

that. But we just that let's look at the ones with a million

dollars in see cam payments in

[49:03] 2024. >> And there were many with serious violations and the

2 that J Cole visited that you

[49:11] seem to thank you are okay.

Had serious violations and one

[49:19] of them had 36, one of them had

95 violations and some are more serious than

others. But another one had the

[49:28] conditional license. This is

they had their conditional license for 2 years. And then

it was just reinstated last

[49:34] June. So I'm very concerned that serious

license violations are

[49:41] happening. But it's unclear

[49:46] by your own admission, what rises to the level that

would require suspension or

[49:52] revocation. So understanding that for the

committee is very important

[49:58] because if we're paying out

millions of dollars just in the last year where they have
[50:06] dozens of violations, I don't know what it takes to
highs to the level of end up
[50:12] suspense and so that these
payments are stopped. So and and clearly you keep saying
statute doesn't require that
[50:18] statute doesn't require time
actively looking at things we should do in statute to
strengthen your authority to do
[50:23] that. So, but I need a little bit
more clarity on your current
[50:29] process for getting to
suspension revocation or I disqualification. So so I know
you'll get back to me and that.
[50:37] But I just want to say that
this is sort of the nub of what we're trying to get it here.
So I really appreciate
[50:45] follow up on that for the
entire committee, not just to my office. Thank you, Chair Robbins.
[50:52] >> So the licensors look at, as
I said, the nature, the
[50:58] severity and the frequency of
the violations. We
[51:04] we work to be very thoughtful
and careful about not
[51:14] the about maintaining access to

childcare, where there aren't serious
violations. If the
[51:23] that, you know, we want to make
sure height, high quality childcare is provided. And most
of our providers
[51:32] do provide high quality child care. The licensing violations like
we were discussing can be can
[51:41] can have a whole range of
seriousness and frequency. And so the licensors look at
each individual cyst situation
[51:50] based on the facts when a entity is put on a
conditional license that allows
[51:58] for more frequent visits, more
checks by the LICENSORS and more technical assistance to
help that
[52:06] child care provider coming into
compliance again. This is for
[52:12] our Hard Working, Honest,
upstanding child care providers
[52:18] who are doing their very best
to serve the children of Minnesota. And we want to be
there for them helping them to
[52:24] do that. When we have a bad actor that
is not complying and not
[52:32] working to improve the quality
of care or include improved

[52:37] compliance with our requirements, attendance
records, billing, et cetera.
[52:45] Then we take more severe
action. >> Great. Thank you for that
answer. I appreciate that.
[52:52] You know how many child care
providers currently have conditional licensing status
[52:58] Chair Robinson? I do not. It would be helpful to know
that. Thank you, Representative
[53:04] Goodman. >> Thank you, Madam Chair.
And I appreciate this is somebody who does not Senate
committees and think a lot or
[53:11] understand a lot about how we
licensed child care centers. It occurs to me that we're
talking about a set of things
[53:18] when we're talking about
licensing violations. Oftentimes the problem you're
trying to fix right is not a
[53:25] problem that withholding
payment is the right solution. So paperwork violations, some
safety violations. On the other
[53:34] hand, we're talking about fraud
and we're talking about over billing or whatever else that
is probably the best tool.
[53:40] So I guess it feels like we're
so that when we talk about and denials openly saying this is

not the committee of
[53:46] jurisdiction and I don't sit on
it. But when we talk about the
[53:51] problems with trend of sex for
licensing, we talk about folks
[53:57] with us a sense the tension or
revocation or dissertation for those licensing issues that are
not fraud. What tools do you
[54:06] have to actually fix the
problem? And then when do you decide? But we're not trying to
fix. The problem were actually
[54:13] trying to do is either shut
down the center, make sure that that folks are going someplace
else.
[54:19] Commissioner County Chair
Robbins representative. >> The list of tools that we
have of are warnings. We have
[54:29] correction orders and technical
assistance to help you helped to provide come into
compliance.
[54:37] We have stipulated provider
agreements. And then if it's a, if it's a
financial matter or or for non
[54:47] financial managers, we can also issue fines. We can have a tip,
monetary recoveries, payment
[54:54] withholds. We can also have

suspensions, conditional license, temporary immediate
suspension and
[55:03] disqualifications. So those are
the range of administrative actions.
[55:11] Yes, follow-up. Representative
King, thank you. And I I appreciate that because I think >> the goal, our goal should be
to make sure that we're using
[55:19] the right tools to fix the
right problem. And so when we have have issues of fraud,
right, we're not trying to fix
[55:25] that were 10 shut that down
when we have issues of non-compliance and we are known
to hear from the other side.
[55:33] There's oftentimes too much
that we're requiring people to comply with the weather.
It's paperwork, whether it's safety violations, whether it's
also tough things. We want to
[55:40] make sure that we're using the
right tool to get the right result. And so I can imagine
that stopping payment forward
[55:47] trying to do is fix a safe
family connection might make the problem worse. So just as
we think about it, and as we
[55:52] think about our colored
committees of jurisdiction, it feels like when we talk
about fraud, we want to make

[55:59] sure one we're detecting that
as soon as possible. We're going through the process where
recovering those resources and
[56:05] we're showing on the center's
when we're talking about other things and really making sure
that our committees of jurisdiction and focused on it,
that they have the right tools
[56:13] to fix the right problem, but
wanting to make sure that when you have a hammer, everything
doesn't look like a male.
[56:18] So appreciate this
conversation. >> Thank you,
[56:25] Commissioner. Great Gundy.
Please continue. Chair Robbins members of the
committee,
[56:33] High Winds, Light payment with
[56:42] that's OK sign.
[56:51] >> This slide shares the
journey that we've been on to enhance program and Craig
Reedie in the Child Care
[56:59] Assistance Program. We have to apply a continuous
improvement mindset. As our
[57:07] environment is always changing.
New tools become available and the strategy of bad actors gets
more sophisticated
[57:16] in a slide. Here is a

high-level look at our milestones. In 2019, the
legislature passed and the
[57:23] governor signed into law see
cap integrity improvements. Also in 2019, the cross
divisional early and often team
[57:33] was funded 2020. The OIG
completed a continuous
[57:38] improvement project. I believe that was something
Chair Pinto was referencing
[57:46] earlier and 2021. The OIG created a
data analytics team to better
[57:54] help DHS detect potential
non-compliance and potential fraud for further invents.
That's to gay shun in 2023.
[58:03] The legislature passed and the
governor signed enhance months to limit on public funds
statute, including allowing the
[58:11] state to temporarily withhold
payments based on credible allegations of fraud involving
any state or federally funded
[58:20] program. In 2024 point, Nader was hired
for limit on public funds.
[58:27] And today I'm here to ask for
your support for the governor's request for a comprehensive
anti fraud package and
[58:35] electronic record keeping

[58:42] before we get to our 2025
package, I want to provide a little more detail on the
enhancements we've made over
[58:48] the past 5 years. In 2019,
we've strengthened administrative sanctions by
expanding the use of
[58:57] administrative sanctions to
quickly stop payments issued disqualification notices to non
compliant providers
[59:05] and close or terminate see cap
registration for non compliant
[59:10] providers. Enhanced record keeping
requirements by clarifying
[59:16] what's required on attendance
records and creating a methodology and tool for
overpayment calculations
[59:23] added more prevention measures
for provider oversight through the early and often team
developing a change of
[59:30] ownership process for license
holders and researching the electronic record keeping tool,
which is now requested in the
[59:39] governor's budget and strengthened our work with
law enforcement by updating
[59:47] contracts with the BCA and
funding additional BCA agents

[59:52] to investigate fraud. Representative Schultz, excuse
me.
[59:57] >> Thank you. Thank you, Madam
Chair. And so on this slide and just kind of been curious
[1:00:03] when you're reviewing all of
these records and then hopefully providing oversight
to what extent to the staff
[1:00:10] that your agency pour over the
reports that are sent to you,
[1:00:16] Commissioner Gun. >> Chair Robin representative
can use a little bit more about
[1:00:21] report sent to us represent
Shield. >> Thank you, Madam Chair.
I'm just looking here at this
[1:00:27] slide and just the record
keeping and the reports that are required when people are
receiving these dollars.
[1:00:35] To what extent is your staff
reviewing the information is given to you and really digging
into the data
[1:00:42] Commissioner Ken? >> Chair Robbins
representative, we have a data
[1:00:49] analytics team that is helping
to look at that at a large scale. And then we also have
our unit that will look at
[1:00:58] anything that is flagged or

seems concerning based on a tip, a complaint, a licensing visit

[1:01:06] in order to determine which items to look into further investigate.

[1:01:12] >> Represent Schultz have chair what I'm hearing, what you're saying there. I'm hearing that you need an additional tip

[1:01:19] before you are able to identify within your agency based upon the review of the report that you're given to really dig into

[1:01:28] something deeper. Is that accurate? >> Commissioner Don share Robbins representative, that is

[1:01:35] not accurate. That's that is part of the story. The data analytics team that is able to review the records that comes

[1:01:42] in to us is the is another piece. No further questions. Thank you.

[1:01:48] >> I had a question just going back to an earlier discussion we're having when you talk about the

[1:01:55] record keeping requirements currently, are you paying 4 the

[1:02:00] number of enrolled children and then verifying that those number of children

[1:02:06] come to the day care for the Child Care Center or do
they submit records of who came
[1:02:13] for the 2 week period and based on who physically
tended they are paid? Which way
[1:02:20] does it work?
[1:02:28] >> Chair Robbins, I would like
to check with our team to find out specifically the process
and the steps in the correct
[1:02:36] order. >> Great. Thank you. I think
that's very important because the a report and internal
controls from 2019 flag,
[1:02:44] that is a real problem. That
payments were just going out based on the number of children
that they were enrolled or have
[1:02:51] capacity for. And based on that
that drove most of the overbilling that we saw back in
that era. So if that is still
[1:02:59] the way payments are being
processed, that would be a big concern and thinking something.
I think we would want to change
[1:03:09] whether through statute or
through agency policy. >> The pen to thank you, Madam
Chair, Yannick, maybe pride.
[1:03:15] And I believe this is correct
that the payment is currently required to be made based on
actual attendance. Well,

[1:03:22] I guess we'll find out about
kind of mechanically how that works. I believe that there's a
federal rule that's gone into
[1:03:28] effect that requires the
payment be made based on enrollment, which are just
point out in all this discussion. We always want to
compare to K 12 education right
[1:03:36] now. We don't. Our school
districts don't have to sort of count each child when the child
shows up that instead, it's
[1:03:42] based on enrollment. But I
believe that that's correct. But the agency I know will will
correct me provide more information, Madam chair.
But I think that that's that
[1:03:49] that's the case that's based on
attendance. And I know that there was quite a lot of is
done in 2019 and sense to kind
[1:03:54] of make sure I'm sure the
systems have been discussed. Thanks, Dave. I just look
forward to that. Paula. Thank
[1:04:01] you. Please continue to Robin's
of. >> Well, Representative Pinto
was sharing a what he
[1:04:08] understands to be true. I
received confirmation from the Department of Children, Youth
and families that that is

[1:04:14] correct. Can you restate it? What is

correct

[1:04:19] that we pay based on and attendance,

[1:04:26] miss it pay based on

attendance. They submit the number of kids who have been

attending or it's sort of a

[1:04:37] list every 2 weeks or every

month. Is that a reimbursement model ours at pros forward

looking

[1:04:45] chair Robbins, I'd like to ask

Jennifer Summer felt from DC Why app to come up so that she

can provide that trip picked.

[1:04:51] Thank you,

[1:05:03] Mr. Bell, please State your

name for the record and Chrissy. Certainly thank you,

Chair Robbins members. My name

[1:05:08] is Jennifer Summer filled in

with the Department of Children, Youth and Families.

And Yes, we pay based on enrollment. I have to go back

and verify that billing

[1:05:17] cadence, but I believe its

monthly the bills go to counties is my understanding

through any C squared and it is

[1:05:24] the counties that works of the

payment process. Thank you. So contrary to what.

[1:05:30] >> Commissioner can you just

stated? She said it was based on attendance. You just stated
was enrollment. Can we clarify
[1:05:35] that for the record for the
U.S. base in attendance? My apologies. I said the wrong
thing. Yes, representative can do is correct, though, that
there is a federal rule
[1:05:42] requiring payment based on
enrollment. Okay. Wonderful. Thank you for
clarifying. Please continue.
[1:05:49] Commissioner County, thank you. Chair Robbins
members of the committee.
[1:05:55] >> Continuing on diving a
little bit more into a couple items on the timeline.
[1:06:01] This slide talks about the 2023
[1:06:06] enhancements to the limit on
public funds. The state took additional action to expand
agency's ability to go after
[1:06:14] bad actors with less red tape.
The Legislature passed and the governor signed into law
enhance minutes on on the limit
[1:06:22] on public funds. This expanded
DHS has authority to take action against a provider based
on actions taken by DHS
[1:06:32] and other state or federal
agencies. We know they're bad actors who
cross program areas and this

[1:06:40] expanded our authority to take action. Based on that,
[1:06:47] we can withhold payment based
on credible allegations of frogs in programs administered
by any state or federal agency
[1:06:55] or suspend dis N roll or
exclude providers from the DHS program based on another
agency's credible allegation of
[1:07:03] fraud or pending
investigations.
[1:07:09] This also provided funding for
a limit on public funds coordinator and one training
position. The second because
[1:07:17] training position has been
allocated to DC Wyeth's.
[1:07:25] So this year, the governor's
budget includes comprehensive multi-pronged proposals to
strengthen the state's ability
[1:07:33] to prevent detect and address
fraud and human services programs.
[1:07:48] >> Vice Chair Anderson, I have
a quick question on the previous. The 2023 limb with
for the is added in statute,
[1:07:58] strengthen limits to receive
that little hole with called payments across agencies or is
just something that the agency
[1:08:07] didn't turn Mr. Khan. >> Chair Robinson

representative. This is the

[1:08:14] recommendations for the 2025

budget.

[1:08:19] >> I'm so she's looking at the

slide where it says 2023 limit on public infants. Enhancements

[1:08:25] Commissioner, again, apologies,

chaired Robbins. Representative, can you state

your question again?

[1:08:31] Thank you for these. They expanded ability

inevitability thus that.

[1:08:38] >> Bottom left in the top,

right where these things that were done internally idea just

where these things put into

[1:08:46] statute. Commissioner, did this

happen? That's my question. Thank you, Commissioner Connie

[1:08:53] Chair Robbins representative of

they were addressed by the Legislature acts

[1:09:01] in statute which it OK? Yes,

statutory changes. Okay. Thank you. Thank you and

Representative, Eric.

[1:09:09] >> Thank you. Madam Chair.

Just really quickly. Just so that I have a little bit better

contact. So

[1:09:14] how many employees are there in

the city kept division? And secondly, you've been talking

about the data. It analytics

[1:09:20] team multiple times. How many

is the team? Is it to people how many people are on your

data data analytics team and

[1:09:28] then if you answer that and

then circling back. So if you if there was 200 to 300 million

per year since 2020, that's

[1:09:36] over a billion dollars worth of

see cap money that's gone out and you recover 4 million out of probably 1.2

billion

[1:09:46] Commissioner County Chair Robbins representative.

[1:09:53] >> I I believe that our see cap

program has about 25 staff and it sent. Correct.

[1:10:10] Thank you, Mr. Jones, I'm

pleased to say a name for the record you can. >> Madam Chair members, Tom

Johnson, deputy inspector

[1:10:17] general of the Department and

services are see cap investigations. Team has 4

investigators, one supervisor

[1:10:24] early and often. >> Disney. >> Really it off in team.

As for investigators and one

[1:10:32] supervisor and our grant audit

team has 400 or someone supervisor.

[1:10:37] And there's a manager for the

unit. >> Representative, are you?

So I'm confused then. So you

[1:10:44] keep talking about a data

analytics team. So who's the data analytics? You see that
fraud. Investigators in a super
[1:10:50] for and won a supervisor for
Muncy. So who do you who are you talking about? When you can
talk about this data analytics
[1:10:57] team, Mr. Jones. >> Madam Chair, Representative,
that is the OIG did and
[1:11:02] analytics unit and they are the
unit that does Dayton, Linux and systems workforce as well.
They didn't system. So there's
[1:11:11] a team within the OIG that
serves the entire a wedgie. >> Okay. Thank you. Okay.
Thank you, Madam Chair. 6
[1:11:19] really quickly. It's so so how
many are in that team? And so they serve like all of DHS for
all of state government are
[1:11:25] like how far reach here we're
talking about like DEET and Ali, all of the all of state
government or
[1:11:32] Mr. Johnson. >> Madam Chair, Representative.
Now they serve the OIG. It just gives me at DHS only
the DHS OIG and I don't have
[1:11:42] the number of staff on that
team, but we can certainly get that for you. >> Madam Chair, I think I would
be very important because we're
[1:11:47] talking about this data

analytics team nonstop. Basically as their reason why
they don't have pride in.
[1:11:54] We don't even know how many
people are. Is it isn't one person, is it
10 people or is it 20? I don't
[1:12:00] know. We don't know. So I think
this is a really important point. Madam Chair that we get
back. Yes, I look forward to
[1:12:05] getting that answer. Thank you.
Thank u N. >> This is not a leap into.
Thank you. Thank you. Thank
[1:12:11] you. Chair into just following
up on the questions about the 2.4 million recovered and then
the size of the program.
[1:12:17] Of course, part of the reason
the program is a size that is because there's tremendous
need. And we know that in the program as it is, he's not
meeting the needs of
[1:12:24] Minnesotans for early learning
and care. But could you just talk about I'm just trying to
put the 2.4 million contacts
[1:12:30] is. Is there a number that that
you've tried to recover and then have been like as it went
for 2.4 million compared with
[1:12:37] the amount that you've
identified as being that you'd want that should be recovered

the ball and yet has not done.

[1:12:43] And if you have information

now, but what I'm asking, Commissioner, good.

[1:12:50] >> Chair Robbins

representative. We would have to go back and gather that

information free if they could

[1:12:56] do that. Madam Chair. Yes,

thank you. Do appreciate hearing back to you on that

Representative Shots.

[1:13:03] >> Thank you. Madam Chair will

just kind of following the line of questioning from

Representative Eric. I mean, even if you don't have the

exact number for a sigh,

[1:13:10] we would even find just a minor

amount of solace and just knowing a range. Are we talking

about her point? We're talking

[1:13:16] about a handful are talking

about 10 people. Are we talking about 100 people? Because I

think ultimately when we get

[1:13:22] down to it here we're talking

about are people reviewing reports, are people doing site

visits? Are people getting into

[1:13:29] the details as to whether or

not there's fraught in these instances? And that's what

Minnesotans care about

[1:13:38] Minnesotans care about whether

or not we are actually diving into the data. I think that
plenty, especially in our side
[1:13:44] of the aisle have been worried
about people showing up for work and we want to know are there
even people that are doing this
[1:13:50] job. So can you please give us
even a range of what what the number of employees? I totally
understand that there are
[1:13:58] people who come and go and
leave certain parts of state government put. But can you
please give us a range as to
[1:14:04] the number of people who work
in this space? >> Commissioner County Chair
Robbins representative, I
[1:14:11] appreciate your drive and push
for the facts. Facts are very important to me and that
Harden's me because we are
[1:14:20] happy to get you the facts and
to continue to work with you. Once we have the facts at hand,
I think then we can decide what
[1:14:28] more needs to be done in this
state to strengthen program integrity. Overall, our Office
of Inspector General has 406
[1:14:38] people in the licensing
division. 91 in the program, Integrity, Division. And, you
know, more than a few handfuls

[1:14:48] in the data analytics. It
depends on how you a look at the data, but I think
it's somewhere around 40,
[1:14:57] but they might fall into
different categories of doing more than one job. But I would be happy to get
with you on that so that we can
[1:15:06] determine how to what we're
doing now. What's working now, what you want us to do
differently in the 5th future
[1:15:13] so we can keep the integrity of this program
high and we can serve
[1:15:19] Minnesota's children well. >> Thank you, Representative
King, thank you, Madam Chair.
[1:15:24] And and I appreciate this
conversation. I think when I think about what Minnesotans
want, they also want to ensure
[1:15:30] that our kids, our youngest
learners, have access to to care and that that care it's
provided. I know that
[1:15:36] Representative Pinto talked
about it. They're being folks who need care and don't don't
get it when I think about
[1:15:45] fraud. I think the most
important thing we're doing here is making sure that we're
protecting and ensuring that
[1:15:51] Minnesotans have access to the

care. In this case, our youngest learners have access
to the care that they're
[1:15:56] legally entitled to and that we
as a as a legislature in his estate have decided to to to
provide. And so to me, that's
[1:16:04] that is really why we need to
root out fraud is that we are focused on those kids and those
families that need it and
[1:16:11] deserve it. When we think about
the data analytics. And I think that that's sort of the
question of a nasty, I know
[1:16:17] that there's both people.
There's also technological tools. And again, this is a
place where we have seen the
[1:16:23] governor and the governor's
budget and they hope will here and be able to hear the those
pieces because I think that
[1:16:29] they have been in response to
the conversations I've been having over the last couple of
years in the legislature and
[1:16:36] say they feel like there's a
lot of pretty a foreshadowing, but particularly in the area of
how do we use the tools.
[1:16:44] We know that fraud is a a
business model that is out there, not just as it's
targeting government, but that

[1:16:51] it is targeting families.
It's targeting seniors. It starting everyone. And so as we
think about what we're trying
[1:16:57] to look at, it really saw them
with government tools to us government aid. We really need
to really understand that
[1:17:03] business model. A piece of that
is the data analytics. A piece of that is the people. And so
look forward to that
[1:17:09] conversation with all the tools
we can bring to bear to, to ensure that our kids get the
care that they need and our
[1:17:16] families due to. Thank you. >> Thank you. Representative
Goodman, I I would just like to
[1:17:23] say that I agree with the the
concerns that, you know, we are tame out fraud. And
we're also talking about
[1:17:29] needing childcare for families
in Minnesota. We are the fraud Prevention and
agency Oversight Committee and
[1:17:36] the agency oversight part deals
with licensing violations as well as that the criminal fraud
case and both are very
[1:17:44] important. So I appreciate this
conversation. I appreciate the partnership we want to have
with the agency to make sure

[1:17:51] that Minnesotans childcare the slots available but also
more than the slots that it's a
[1:17:59] safe environment. Look at more
to that. Please continue with your governor's
recommendations.
[1:18:04] >> Thank you. Chair Robbins
agree and appreciate this committee's support and
interest in this topic.
[1:18:15] So the governor's package
includes increased staffing in the agency's program, integrity
and oversight operations to
[1:18:24] increase capacity to
investigate alleged fraud for every dollar we spend on an
investigator, we have an
[1:18:33] average return on investment of
a $1.89.
[1:18:39] This means that that every dollar spent on an
investigator results in a
[1:18:45] $1.89, of revenue or cost
avoidance cost avoidance would
[1:18:51] be, for example, preventing
improper payments from being made.
[1:18:56] The figure is based on actual
data from the last 5 years and revenue includes monetary
recoveries, fines and
[1:19:06] restitution from criminal

conviction. We also are asking for
increased staffing in our
[1:19:14] program, integrity and provider
eligibility and compliance unit to strengthen controls on the
front end for provider
[1:19:23] enrollment, which helps protect prevent
potential fraud from occurring
[1:19:29] and increase staffing for our
internal controls Audit investigations unit.
[1:19:41] The governor's package also
includes statutory licensing payment, withholds and data
sharing that clarifies our
[1:19:49] authority. We want to make it easier for
agencies to share data so that
[1:19:55] we can take action faster. We want to expand authority to
immediately suspend a programs
[1:20:03] license if a controlling
individual, not just the license. Holder is criminally
charged with offenses such as
[1:20:11] fraud or theft allow for payment withhold when
there is a criminal conviction
[1:20:17] related to fraud involving
another state or federal agency
[1:20:24] allow for payment method
withhold when a license is revoked or suspended by DHS or
another state or federal agency

[1:20:34] and allow for payment withhold
when an entity or associated individual has a background
study. Disqualification
[1:20:49] representatives, thank you.
So are you commissioner, are you saying that you
[1:20:55] >> don't have the authority to
prohibit kickbacks right now and that
[1:21:00] you don't have the authority to for payment with colds when
there's and and suspension.
[1:21:07] Or is that what you're
[1:21:14] Commissioner, Candy? >> Chair Robbins
representatives, this is expanding and making it easier
and clarifying our authority.
[1:21:23] So allowing allowing this to
take place, allowing us to take actions when some of these
activities are happening in
[1:21:31] other agencies. So we have some ability but not as much
ability as we would like to be
[1:21:39] able to take action. >> Vice chair and thank you.
But I mentioned I would like
[1:21:45] the information as to why you
don't think you, you know why you don't think you have the
authority
[1:21:51] for this now, especially on
some of these things, kickbacks, when this fraud and
one government program to not

[1:21:59] be able to I had to do something other at
that would be good information. I think the whole committee
[1:22:06] would be interested in that.
So thank you. Thank you, Commissioner,
Connie. And I would also note one of the things you just
stated is that it was for
[1:22:14] program suspensions, but we've
already discussed at length that you can step payment when
there's a programs when there's
[1:22:20] a suspension of licenses that
different than him program suspension,
[1:22:27] Chair Robbins, my understanding
is that we're looking to broaden so that if these things
are happening in other state or
[1:22:35] federal agencies, we can take
action. As for the kickbacks, that is.
[1:22:42] >> A federal federal rule.
And we it's my understanding
[1:22:49] that we do not have the
authority in state statute to
[1:22:55] take action based on that. This candy at I would say that,
you know, we're happy to also
[1:23:02] work with you on clarifying the
statute on that. Certainly that's important. That was one
of the big issues back in the
[1:23:08] 2019 LA report where they

flagged kickbacks of 200 to $300

[1:23:15] person in some of these cases.

And so this has been something we've been well aware of since

2019. And it's stunning to me

[1:23:24] that the work and in turn

controls has not fixed this yet. And it also seems to me that if

there are credible allegations

[1:23:33] of fraud is one of the triggers

for allowing him to stop payment in a kickback certainly

would rise to the level of

[1:23:39] credible allegation of fraud.

So I I don't know why that's not already subsumed under

that. Could you comment on that

[1:23:47] Chair Robbins, thank you.

We very much appreciate your interest in supporting this.

We had a bill last session that

[1:23:54] did not pass and would be very

happy to work with you again are in 2023 session. Excuse me

and would be very happy to work

[1:24:04] with you on that the session. >> Could you just elaborate

more specifically? Why kickback doesn't rise to this credible

allegation of fraud,

[1:24:18] Mr. Johnson, Madam Chair

members. Yes, 2 facts are illegal under federal law.

There's nothing in state

[1:24:24] statute that prohibits

kickbacks yet. We hear and see the kickbacks are happening
[1:24:30] in a variety of sectors,
including health care, Medicaid, human services.
So they're happening and
[1:24:36] there's nothing we can do about
it. We brought the bill several times and it is not passed in
the past.
[1:24:42] Thank you, Mr. Johnson. So why
does a kickback or evidence of kickbacks not constitute
credible allegation of fraught
[1:24:53] Chair Robbins? It commissioned
it. >> I believe that it would.
You know, I think that that
[1:25:00] we're getting into a legal, a legal rationale and reasons.
And so that's something this if
[1:25:08] we if we could explore further
with our attorneys and provide you with information, we would
be happy to do that.
[1:25:15] >> Thank you, Evan. Appreciate
that. Because to me, I get that it might be a federal statute,
but still we have a general
[1:25:21] flank get authorization for you to stop
payment when there's a credible allegation of fraud and I think
kickback would certainly fall
[1:25:28] within that Representative. Eric? >> Thank you. So help me
understand this. You just said I think that it's federally

illegal to do kickbacks,

[1:25:37] but you can't stop it here in

the state of Minnesota because it's not it's illegal in the

state of Minnesota. So if it's

[1:25:45] federally illegal and you

you're getting some money, is federal money coming through

Minnesota in all kinds of

[1:25:52] different forms and fashions

for DHS, billions and billions of dollars come from the

federal government.

[1:25:58] Help me understand why we think

here in Minnesota we can't stop kick back to when it's

federally illegal to do so.

[1:26:05] Help me understand Commissioner Don T. >> Chair Robbins

representative. I believe the

[1:26:12] issue is that we are not able

to prosecute it effectively.

[1:26:21] Representative Act. The DHS isn't going to be

prosecuting of. You certainly

[1:26:27] can turn it over to your federal partners, the FBI and others

just as what happened with Edr

[1:26:35] futures. And, you know, I remember a decade

ago when there were and I talked to somebody who

literally saw this at the

[1:26:44] airport, there were >> suitcases full of millions

and millions of dollars and we

[1:26:50] couldn't substantiate for sure
how many hundreds of millions of dollars came out see cap.
But there was at least some
[1:26:58] and that was a decade ago.
So now you're saying that we know that we have kickbacks.
We have kickbacks, pervasive in
[1:27:05] state government. There is a federal law
prohibiting it, but we don't have the authority to stop it
here in Minnesota. I don't
[1:27:12] understand how those 2 can be
in the same sentence. Madam Chair, I I don't understand
[1:27:19] this at all. Like I did there.
He said they have relationships with the FBI and others.
It was throughout their
[1:27:24] pervasively, threw out there
presentation. And yet we know that there's kickbacks. We know
it's federally illegal, madam
[1:27:31] chair. >> And yet we don't have the
authorities on how to stop it. I don't understand this man.
Thank you. Representative
[1:27:37] wrecked so Commissioner County,
maybe if you could just respond to the part about working with
our federal partners and why
[1:27:42] that's not happening because
that is a violation of federal law by did not state law. And then I'd like you to finish
up the presentation. So you a

[1:27:50] quick response commissioner
going to come? >> Chair Robbins, a
representative. I would like to
[1:27:56] ask Director Johnson to answer
the question, but I just want to clarify that,
you know.
[1:28:06] >> There's the ability to invent the to prosecute
federally and state. And so
[1:28:14] if we were to clarify and we were to put into law a
similar in Minnesota to the
[1:28:21] anti-kickback statute, that
would give our prosecutors more
[1:28:27] tools to go after this on a
state level as well. It doesn't it doesn't mean that we aren't
going after it on the federal
[1:28:35] level on a flight director to
speak to that. Thank you, Mr. Jensen.
[1:28:40] >> Madam Chair members, thank
you for that question. We work very, very closely with
multiple federal partners,
[1:28:46] including the FBI, Housten
Health and Human Services OIG
[1:28:51] and the Office of the U.S.
Attorney on issues where we see kickbacks. The good news is that
[1:28:58] good or bad news is when a
provider is giving kickbacks, they most

likely are doing other partner

[1:29:05] attorney violations open to

including fraud. We have the authority under state law to

take action on many of those

[1:29:11] things. Just the kickback

portion under state law. We have no authority to take

any action.

[1:29:17] But that's not saying we're not

doing anything. We work very closely with our federal

partners, FBI, Health and Human

[1:29:22] Services, AG and the office of

the U.S. attorney on issues like kickbacks.

[1:29:29] >> I appreciate my colleagues

want to jump in here. Let's keep it quick side likely to

finish the presentation. Rep Le Pen to thank you, Matt.

Thank you. Madam Chair yet.

[1:29:37] So I did want to just get into

that decision. May be one thing is just if we could define with

using the term kick back in a

[1:29:42] thing of beauty to actually

define that term. That's correct for the testifiers or

who brought that up first.

[1:29:48] But if confirmed confirmed that

it was in the U.S. live in the trial case, it may be a tax

rise. Can do that chair,

[1:29:54] Mr. Johnson, would you want to

define kickback for U.S.? >> Madam Chair, Representative
Antone members kickback very
[1:30:01] generally. This is not a legal
definition is when a provider offers an incentive to someone
to provide services. So
[1:30:09] we see things like a provider
saying send your kids here and I will pay you X amount per
month to come to my. Send your
[1:30:17] to your senior parent to our
adulting and we will pay you X
[1:30:22] amount per month. Even if those
services are provided that is a kickback. Under federal law
prohibit it
[1:30:28] worst case scenario was state
pay the people for access to that person's billing and they
bill for services are provided.
[1:30:36] In those cases. We do take
action at the state level. We we can refer them to law
enforcement for fraud, state
[1:30:44] law enforcement, whether Self's
attorney general of the Bureau of Criminal Apprehension can
investigate and prosecute.
[1:30:51] It's just the kickback portion
that the state level we have no authority to take any action.
[1:30:56] >> Thank you. Directly chair.
Thank you. Just that one. Yeah, I think Houston, of

course it's on yet to my mind
[1:31:01] the gap is that state level
criminal prosecutions illegal under federal law. You can take
administrative action. And my
[1:31:08] understanding is that you very
often do the challenge if you if you want to criminal
prosecution of the state level,
[1:31:13] that's right. It was up rescue,
having the elements be very clear. This is an area, even as
you described it, I thought to myself, you know, it's sort of
you gonna do business with with
[1:31:20] certainly with private business
and where there's going to be some kind of bonus. So how do
you define exactly what a kickback, what's not and that
it's complicated. And so we
[1:31:28] want to make sure to have that
tool for state local prosecution. >> Thank you, chair. Thank you,
Representative Hawkins. Yeah,
[1:31:33] thank you, Madam Chair. I mean,
just continuing the same line. I'm I'm not the lawyer in this
group, but I know that for a
[1:31:39] good example, representative in
Green Green and I have been working on him basically
incorporating aspects of
[1:31:46] federal antitrust law into
state law specifically because, you know, if the feds don't

have the resources at the end
[1:31:54] of indication, too, to
prosecute these cases, then we need to express it authorizing
language in our statutes to
[1:32:03] allow our AG to bring bring the
cases. And I think that's what we're running into here is it
is well, basically is that if
[1:32:11] it's in December, simply a
violation of federal law but not state, then the feds can
bring a prosecution, but maybe
[1:32:17] it may not have the resources
to do it. But by putting it into state law, it gives us the
explicit authority to pursue
[1:32:24] them as well. Thank you. >> Yep, that's just finish the
presentation. Thank you.
[1:32:29] Commissioner County. Please
proceed to Chair Robbins. >> Background studies so
addressing increasingly complex
[1:32:37] fraud cases effectively
requires coordinated Houston Authority and regulatory tools
across TH S language changes
[1:32:46] into 45 C 14 2.45. See 15 will
enable DHS to disqualify people
[1:32:53] under active investigation for
fraud from working in programs serving children and vulnerable
adults that have access to

[1:33:01] billing and from receiving
public funds. I knew background studies
disqualification would prohibit
[1:33:09] an individual who is under
active investigation for fraud from holding any position
involving ownership management
[1:33:17] or control or billing
activities in the program for which the background study is
conducted.
[1:33:23] New authority will enable DHS
to disqualify people under active investigation for fraud
from working in programs,
[1:33:31] serving children and vulnerable
adults
[1:33:38] for the Department of Children,
Youth and Families. The Governor's Budget invests 5.4
million in fiscal year. 26,
[1:33:47] 27 and 2.8 million in fiscal
year. 28 29 to enhance program
[1:33:52] integrity, ADC Wiac. It includes 4.9 million
[1:33:59] and 2.9 million in 28 29 for
the implementation of a
[1:34:05] statewide electronic attendance
record keeping system for see cap. It's not only necessary
infrastructure.
[1:34:14] This is not only necessary

infrastructure needed to implement other changes
required by a new federal rule.
[1:34:21] But it also is supports
program, integrity and fraud prevention. Once complete, the
system would provide the state
[1:34:28] with data on attendance in
programs in a consistent and timely manner. The current
practice is often manual and
[1:34:35] varies by local agency. This would provide a standard
across all agencies, a similar
[1:34:43] effort for electronic it
attendance record keeping is currently in prop process for
early learning scholarships.
[1:34:56] The Department of Children, Youth and Families
is interest in transition.
[1:35:02] They were established July one
of 2024 along with the well planned and
thought full transition of
[1:35:10] staff to DC why off through
6/30/2025. I want to mention
[1:35:15] that the OIG functions that
will be trance will be transitioning toward the end of
this year
[1:35:23] are listed here on this slide.
[1:35:32] And in closing, I just want to
reiterate, the DHS remains committed to our responsibility

for monitoring noncompliance in
[1:35:40] our programs and rooting out
fraud through strong oversight are
OIG helps to protect the health
[1:35:47] safety and financial integrity
of this program. Dhs works to prevent and detect
fraud as quickly as possible.
[1:35:56] We investigate any credible
evidence of non-compliance and fraud, referring criminal
actions to law enforcement for
[1:36:04] investigation. And I would be remiss if I
didn't emphasize and applaud
[1:36:10] the vast majority of child care
providers to provide high quality care and education to
the state's children.
[1:36:18] They are the valued work force
behind the workforce, allowing parents to go to work and to
school and to look for work.
[1:36:27] They should be commended for
the work they're doing. And we have to be careful not to
overburden them as we target
[1:36:34] the bad actors. As I've mentioned, successful
program, integrity requires a
[1:36:39] continuous improvement mindset
built on a thorough understanding of the facts and
where we are today. And we look

[1:36:48] forward to partnering you as we
move forward this session to continue to make this program
stronger.
[1:36:56] >> Thank you. I just in
conclusion, I just want to go back to one thing that has
stuck with me that has been
[1:37:01] bothering me. So we were
talking about what rises to a
[1:37:06] suspension, a disqualification so that you
could stop payment and on the
[1:37:13] violations side. And I know you'll get back to
me with what the different thresholds are. But the only
thing that you said it was
[1:37:21] maltreatment and that very much
concerns me. So I wondered when you are
looking at what leads to
[1:37:29] conditional license, what leads
to suspension? What are those factors like?
Is that the background check
[1:37:36] issue like ideally, I'm
honestly stunned to hear you have in your list of things
that you can't suspend someone
[1:37:46] who is under active
investigation for fraud, that that's not a already
possible feet to disqualify.
[1:37:53] But in terms of safety for

children, background checks for staff,

electrical outlets not being

[1:37:59] tamper proof, medication

procedures not followed unsanitary can to conditions

instant bottles not being

[1:38:05] labeled. Those are things.

When I go on your look at you have a Web site, the DHS

licensing information look up

[1:38:12] site. It talks about all those

violations, all of them in the ones that we're paying a

million dollars to or and

[1:38:19] that's just the ones I looked

at over the weekend. So there are multiple serious violations

going on at all of these

[1:38:26] centers. And I get they're not

all just paperwork. I get that. That's our paperwork and we can

deal with that. But there are

[1:38:33] serious health and safety violations

going on. So to me, as I used to have

kids into health care, I would

[1:38:42] think those rise to serious

violations that would at least lead to conditional licensing

or suspension. So could you

[1:38:48] help me understand, like is it?

[1:38:54] How do you get there and how

can parents when they go in your DHS lookout website

[1:39:00] and are looking at their child
care center, other child care centers they're considering. How can they have comfort
[1:39:08] in understanding that all these
violations are are being adequately looked
at? I mean, once a year visit
[1:39:16] for some of these things may be
as insufficient. Please respond. Sorry. That was
a lot to Chair Robbins.
[1:39:24] >> Thank you. Thank you for
your concern. And I think all of us that have children and
have had children in that child
[1:39:31] care want that assurance that
the quality of care is happening. And
[1:39:38] our licensors and I would like
to ask our director to come up
[1:39:43] to discuss it in much more
detail than I can. However, what they do is they
do. They provide correction
[1:39:52] orders and technical
assistance. The most important thing for our well-meaning
childcare centers is to have
[1:40:00] them and support them in
Prague, providing the quality of care that we need for our
children. However, when that's
[1:40:07] not possible, additional steps
are taken. And chair Robbins, I'd like to have

a director. Dotson discuss

[1:40:16] that. She heads up our

licensing division. Kate, thank you. Welcome to the

committee. Please state your

[1:40:22] name for the record. Glad

you're here. >> Thank you so much. My name

is Alyssa Dotson and I'm the deputy inspector general for

the licensing division that

[1:40:28] oversees the licensing

compliance. We have multiple tools as licensors that we can

use to address violations when

[1:40:35] they are Kerr. So in the

Licensor is on site. There may be things that the licensor is

providing kind of technical

[1:40:43] assistance in a moment to say

things like we had mentioned before. There's water on the

floor is a slipping hazard.

[1:40:48] The license are would ask that,

hey, can we might add up and can we address that right now?

So that doesn't continue.

[1:40:55] If they are issued a correction

order for any violations. The Licensor is following up to

make sure that that program has

[1:41:01] come into compliance spending

may order additional corrective action, toner to come into

compliance with these such as I

[1:41:08] think you mentioned, if like
infant bottles are not labeled the licensor, wouldn't wait
until the next in your view to
[1:41:14] double check that they follow
up with the provider to make sure how have you come into
compliance with this to make sure that that risk has been
meeting mitigated. So at times
[1:41:22] they are addressing it
immediately. If there is something so serious that it
poses a imminent health and
[1:41:28] safety rest of the children and
then we have tools that we can come in and we could issue
things like a temporary
[1:41:33] immediate suspension, too
interrupt services and shut down that program immediately
because there was an imminent
[1:41:39] risk of harm. While the
investigation is ongoing into what was going on more so than
just maltreatment, we can issue
[1:41:47] a conditional license
suspension or revocation for licensing violations as well.
For each of these, we look at
[1:41:53] the kind of what the severity
of the violations are, the frequency of how often they are
happening. Are these repeat
[1:42:00] violations or that the nature

of kind of what type of violation is as well? And each
of these scenarios is so
[1:42:07] nuanced and so complex that
it's not as easy to say this type of violation equates to a
conditional license. We look at
[1:42:14] the history of the program, the
compliance of the program, whether they sometimes the
programs have self identified
[1:42:20] and corrected something before
we even get out there. It's still a violation, but it's
already been corrected. That's
[1:42:25] different than a program that
we've asked for corrective action and they have not come
into compliance with that corrective action. So for each
of these, we look at kind of
[1:42:33] the specific violations, the
nature, the frequency, the kind of severity of those violations
and that have different actions
[1:42:40] and tools that we can take from
there. >> Thank you. So there isn't
sort. And I get everything. It's very nuanced. And I
appreciate that. You do not
[1:42:49] just wait to the next yearly
visit to follow up on some of these things. Absolutely.
But
[1:42:54] but to that point, so so

serious violation seems to be the trigger.

[1:43:00] But yet we're still struggling

to find out what constitutes a serious violations. So so do

you have some sort of rubric

[1:43:07] based on frequency or severity

that kind of leads to severe violation, or is it just up to

each license to sure

[1:43:16] who goes on these inspections? >> There's not a rubric that

equates to this type of

[1:43:22] violation equals a conditional

again because of those those nuances in there. So licensors

coming back. And they're

[1:43:28] discussing that with their

supervisor or with the manager of that unit and were driving

towards that, you know, kind of some sort of consistency within

that as well. So it's not up to

[1:43:35] each individual license are

necessarily they will discuss those with their supervisors.

And for each of those, what

[1:43:43] might you know, everybody has a

different definition of what severe might be in there.

And so just by saying a severe

[1:43:48] violation, we want to get to

what is the impact on the children in care? What's the

impact on their health, their safety or their rights? And

that helps drive us to what

[1:43:56] that's a very of that licenses
as well. Again, using the example of the water on the
floor that was cleaned up,
[1:44:02] that's been mitigated. That
risk is not ongoing versus if you might have a staff percent
were several staff. People who
[1:44:08] I have never had a background
study. The program did not come past current study. We could
for those staff. We could order
[1:44:14] that those staff are
immediately remove to remove that risk as well. So we
different tools that we can take based on what the
violation is. Thank you.
[1:44:21] That's very helpful because >> I struggle honestly with
what we need to put in statute
[1:44:28] and what we need to just I know that there are nuances
and you guys need to figure
[1:44:34] out, but it's it. On the one
hand I'm hearing, well, we need to have kickbacks in statute
and like, really like bison
[1:44:41] that already covered, right,
that they we have to put that or or that you say you don't
have enough authority. But then on these background
disqualification things,
[1:44:48] it seems obvious to me that that should
already be in place.

[1:44:54] And yet, apparently that's not
ongoing. So I just I I look
[1:44:59] forward to future conversations
because I really think we want to put things in statute that
really strengthen your ability
[1:45:07] to enforce and provide great
childcare in Minnesota. Yet there is a tendency to
micromanage to the point that
[1:45:16] it's really hard. So so I think
we need to find a way to make
[1:45:21] sure you have the statutory
authority you need, but then you need to exercise it because
my concern is that
[1:45:28] the host of things that I think
to the average person would rise to serious violation that
seemed to not be getting there.
[1:45:35] So maybe some sort of approved
brick of at least training for your staff's its uniform on
what rises to serious violation
[1:45:42] might be something we can work
on together because I think parents have an expectation of
[1:45:49] the quality of the child care
and to the violations were seeing or not. And I'm sorry we
are out of time. I'm one minute
[1:45:55] over. Forgive me. The committee
is adjourned. We look forward to it.

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 03-03-2025

[0:06] >> And we are calling the
meeting at the House Agency Fraud Prevention Agency
Oversight Committee to order
[0:17] it looks like we have acquire
him. So I would like to ask for approval of the February.
25 Minutes.
[0:24] Representative Eric, do you
approve the Minutes Salute. Madam Chair, thank you. So
Representative Eric knows the
[0:30] approval of the February 24th minutes. Is there
any discussion seeing none? All those in favor
say aye. I opposed
[0:39] minutes are approved. All
right. Today we would like to welcome
to the committee, the
[0:46] commissioner of the Department
of Employment, Economic Development at their limit and anyone his
staff you would like to bring
[0:54] with you. He is coming to
present about how Dede handles grants management oversight.
We very much look forward to
[1:01] your testimony. Thank you for
joining us.
[1:16] Welcome to the committee

commissioner. Please state your name for the record. >> Madam Chair, members of the committee, my name is Matt.

[1:22] Their luck and I service commissioner of the Department of Employment and Economic Development. And I'm accompanied by a couple of colleagues who are also

[1:30] prepared to answer questions and sister. >> Great. So we'll have you start your presentation. And I know members you have in your packet, the slides

[1:38] available, very sick slide packet. So we look forward to that. But members do we welcome questions along the way because

[1:46] sometimes it's hard to remember things till the end. So feel free to know if you want to ask a question. Thank you,

[1:52] Commissioner. Please proceed. Thanks, Madam Chair.

[1:57] >> So just to give you a high level of the grant making

[2:03] function at the and hopefully this will be a helpful addition to kind of the conversations you've had already with the

[2:10] legislative auditor with GM with DHS. We, of course, a deed are focused on our mission of empowering the

[2:16] growth of Minnesota economy for

everyone. And we do that through a wide variety of
programs. But when it comes to
[2:23] grant a particular, as you can
see, we have programs that involve nonprofit says
recipients as well as
[2:30] businesses 30 that are competitive grant
programs totaling 163 Million.
[2:36] And again, that time frame, as
you can see is up by 23.4 and then direct appropriations and
the number of 136 valued at a
[2:44] larger some 268 Million. And then beyond those, we also
administer dozens of other
[2:52] economic development programs
focused on businesses, cities, counties, cetera, extensions,
broadband, infrastructure.
[3:01] So the slide about our
responsibility, a deed is partly about setting the right
tone. And as you can see in the
[3:08] first bullet, we take this role
very seriously as good stewards of the precious taxpayer
dollars that are entrusted to
[3:16] us. And you could look at this
a sort of just a throwaway line, but it's a very important
one because it's about setting
[3:22] the right tone at the top and
striking the appropriate balance between as you can see

in the next bullet, ensuring
[3:32] that we are efficiently delivering funds to designated
recipients to achieve the ends
[3:39] that the legislature has told
us to achieve. But while also ensuring that stringent
financial oversight to protect
[3:45] taxpayer funds from fraud and
mismanagement. And I recall in watching the
[3:51] initial hearing you have been
sent water, Randall, there was a key moment. Someone asked
about Representative Saltzman
[3:59] Avenue. Actually, my
representative, I should add and central Minnesota about
[4:05] in what circumstances are
agencies doing things in a very effective way. And auditor
Randall noted that it's
[4:14] important to have both those
goals in mind of both the fish
[4:19] and delivering, but also a
certain amount of skepticism and taking that oversight
function seriously. And then I
[4:27] think the other answer from the
deputy was that it's passed in, especially in larger agencies.
If you have some separation of
[4:34] duties and you have a finance
department that is interacting very closely with your

programmatic operation. And I
[4:40] think we have that deep. And then finally you can see
when we identify challenges
[4:46] from an organization that's
operating in good faith. We do look to work with them to
bring them into compliance with
[4:51] our policies because and this
is somewhat similar to this cause. I think you had a DHS
about compliance issues versus
[4:59] fraud issues. If it's simply a
matter of compliance with an organization that's trying to
do the right thing but might
[5:05] have just gotten it wrong.
We want to work with them in a collaborative way to help get
those services moving and doing
[5:13] it the right way. >> Thank you if you don't mind.
Representative Eric has a question.
[5:18] Thank you, Madam Chair. So you
would not end the legislative auditor. And when you started
your presentation, it made me
[5:24] think about the conversation
that we the committee had that the legislative auditor and she
was she had a very strong
[5:31] opinion about a legislatively
directed grants. >> And that on the front end.
[5:40] >> Well, I will say I know that

we the Legislature do not do our due diligence. We don't look at 9 90's. We don't look
[5:46] at audited financials. We don't make sure that there's IRS determination letter. We don't make sure that they're registered with the secretary of state or the attorney
[5:54] general. We and indeed I know has you can see from your first slide 136
[6:03] directed appropriations from the legislature and it is yet another 68 million dollars, which is a significant amount
[6:10] of money. And in the last Biennium, we had 1.1 billion dollars of legislatively directed funds to nonprofits.
[6:18] And again, those processes did not happen. Nobody looked at the salaries of those CEOs and or executive directors are CFOs
[6:29] are, you know, the top people. Nobody looked at that even though it's clearly spelled out on the 9.90. So my question to
[6:36] you is, but since we know the legislature isn't doing that,
[6:42] is there anything that you do at deeds to look at some of those documents after we've done legislatively directed
[6:49] Grant? >> Madam Chair, yes,

commissioner, thank you.

[6:55] Yes, we do require that even

[7:02] recipients that are named the

legislation still have to go through the same prewar risk

assessment as other grantees

[7:09] that we may have selected

through a competitive process. So the 9 90's, the art of

financial statements, the IRS,

[7:15] 5, 1, C 3 status, those are all

required, but only as a matter

[7:20] of getting the grant contract

in place, not as a matter of of

[7:25] identifying the recipients.

And I would say I don't know if we are officially on record as

favoring one approach for the

[7:32] other. I will say that we have

high confidence in the systematic that we go about

conducting competitive grant

[7:40] process is because we can take

a holistic look to see. Do we

[7:45] have good geographic

distribution as a central Minnesota has a greater

Minnesota Commissioner. I'm always looking to see are we

[7:53] trying to reach all parts of

the state, including the Metro as well for us. And we have community reviewers

that also participate in our

[8:01] processes to help give
additional insight on on what amounts to a good portfolio of
recipients. And when you have a
[8:07] legislative directed Grant's, I
don't know necessarily that there is that holistic look.
And I would add to that some of
[8:15] my perspective that I bring to
this might be similar to yours in that I've come into this job
having previously been and
[8:21] executive director at a
nonprofit foundation based in Little Falls. And I guess back
to the notion to about the tone
[8:30] of the top and and taking the
oversight function to see. I want to see from the
nonprofit side, the vast
[8:35] majority of nonprofits have the
view that we did, which is we better get this right, because
this is very important
[8:43] responsibility that were being
given to deploy taxpayer dollars and you hope to do it
well and then have a good
[8:50] reputation that allows you to
do more of that work in the future. >> Representative Eric, thank
you, Madam Chair. I appreciate
[8:57] that. And I appreciate that.
You worked as an executive director of the nonprofit.

I have as well worked.

[9:03] I don't know, probably

collectively about 20 years either in churches are

nonprofits and have put,

[9:09] but my share of 90's together

or have been on the staff's eye doing audits and being that

compliance person on the

[9:16] inside. So I appreciate that.

And I do know that

[9:22] when we do so. So I've served

on different committees and one of them I've served. It was an

oversight committee for deed

[9:29] and Ali and and all of that. So we had the

workforce development funds, but something that we do the

legislature very strategically,

[9:37] as we do, try to say, you know,

geographic fairness. And, you know, we we

try to put out all those

[9:44] parameters and my concern from

the legislature, you know, and we've got to

Hunter one of us. So we've got

[9:50] to order one different

priorities. And when we just say, well, we're just going to

send this 1.1 billion dollars

[9:56] worth of funds to these

nonprofits. None of that happens because we don't we

don't sit down in a committee

[10:02] room and say while we need to

make sure that greater Minnesota in the metro and you

know, this diverse group and

[10:07] you know, are all accounted for

in this 1.1 billion dollars that we don't do that. We thurs

we don't have that kind of

[10:15] function here at the

legislature. I wish we did. I wish that we did. What you're

describing is looking at 3

[10:21] years worth of 9 90's, the

audited financials, making sure you have an IRS determination

letter making sure that they

[10:26] are actually registered here in

the state of Minnesota as a proper nonprofit. I wish all

those things were vetted and

[10:32] done at the you know, here at

the legislature when we do the structured appropriations.

But it simply is not the other

[10:38] thing that we don't look at.

And I don't know if you look at. So here's my last question,

Madam Chair. But

[10:45] we also do not look at how much

money these top executives of

[10:50] these nonprofits are making.

And as I've been preparing and looking at, you know, for years

now, but more specifically for

[10:57] this committee, I'm seeing

salary people that far exceed what the governor

makes. And the reason that's

[11:03] important, as you know, being a

commissioner, any local government, whether

it be county city township,

[11:12] if they want to pay somebody in

that local government more than the governor

[11:18] for years and decades and

decades had come to the legislature to the subcommittee

employee relations and petition

[11:24] and basically request of the

legislature to do so. And yet when I'm looking at 9 90's, I

see salaries that far exceed

[11:31] the governor. And nearly everyone there are

very few that don't make a

[11:36] $14050,000 or more and multiple

people. So these are all

[11:41] concerns. I think that we have

on this committee and I'm sure you don't even look at that

because that's not something

[11:48] that we legislatively direct

you to do. But I I appreciate what you do. And I'm glad that

you do look at those things

[11:55] after we do a directed

Appropriations. I thank you for that. But Madam Chair, there's just there's so much to talk
[12:02] about were checked, but nonprofits, but I'm glad that they are actually doing some due diligence because
[12:08] we've had other state agencies here that do not. So. Thank you, Madam Chair for that time. Yes, thank u N.
[12:13] >> Representative, thank you. Madam Chair. Just want to correct something on the record and we say in the chair knows
[12:20] very much that big fan of shifting to competitive grants. Much more accepting where to look for talking to you.
[12:25] Madam Chair, you and I talked about that. I think this is something we can share a lot. But I did want to just correct that last year, the funds that went to deed that legislative
[12:33] directed ones before the committee pass those out, they did review the most recent 9 90's for the 5, 1, C 3 status
[12:41] of the financial statements, registration with the SEC or a state or train general. Several other things. Again, that's not to take away. I would like to shift its grants. I do want to
[12:49] say the direct appropriations

that really was a review of a number of the documents that
were referenced. Thanks. I'm looking forward to getting
to hear the rest the
[12:55] presentation. Thank you, chair. >> Thank you. Chair Pinto just
to clarify who reviewed that that was done in the committee.
[13:00] >> Yeah, my understanding Madam
Chair is that the committee had all those documents in front of
them before the appropriations
[13:06] went out. I don't know exactly
some of those details, but I do know that there's some real
frustration among some of the
[13:13] organization's gets takes a
long time for the funds to get out because in addition to the
legislature identifying them,
[13:18] there is still the process that
we put in place these last couple years that even when an
organization is identified,
[13:25] it's not like that immediately.
A check was at that organization. Then we require
the agencies to go through a series of steps as well.
Thank you, Representative
[13:32] Freeman, thank you, Madam
Chair. And I appreciate that. And I just >> also to the question of
sifting from legislatively
[13:40] appropriated grants which we
heard. We spent a lot of time talking a grandson, this and

the last for weeks in 2023 to

[13:48] 2021, I sat on the workforce

committee in the House. There was a proposal that was both a

former DEA commissioner plus

[13:56] chair nor at the time I believe

the past of the House floor, but was a rejected in

conference by the Republican

[14:06] Senate to shift our our the

grants to a competitive model.

[14:13] So I think that there are there

have been in the past. I know, and probably before that, that

was just when I came into the

[14:18] legislature efforts to actually

say an address. That problem that the the all recommended.

I will note that sitting in

[14:28] committee and the last for

weeks, there have been a lot of legislatively appropriated

grants proposed by both sides

[14:34] of the aisle. But we have

mostly just been hearing them proposed by GOP years and some

pushback in public safety in

[14:42] workforce in others. So I think

if if if if there is bipartisan

[14:47] support for moving forward with

a proposal that I think it's been around for a long time to

shift

[14:54] grants from direct
appropriations from the legislature to competitive
grants. I believe you'll find
[15:01] it willing partner on the side
of the aisle. And in fact, Democrats have been the one who
championed that the House
[15:07] passed. >> Thank you, Representative
Rudman to the point, Representative, Erin.
[15:12] >> Just like looking to that
point, I represent Pinto. Thank you for saying that.
I I think that's unique to that
[15:18] committee. I've served on a lot
of different committees for 13 years and we have never had any
of those documents presented to
[15:24] the committee. So I just want
to be clear that that might have been a very new thing
[15:29] because I have served on the
committee and that did not happen for especially for
workforce development funds and
[15:35] it legislators lovingly call it
the the the Legislature slush fund, which is a sad thing.
But that's what it's been
[15:42] lovely called for the last 13
years that I've been here. But in any case that that
process that was done that you
[15:49] described is not pervasive

across the legislature, it apparently was unique to just
that slice. And I just wanted
[15:56] to make that clear. Madam
Chair. >> Thank you. And I just won a
tournament since we're having this robust conversation among
ourselves here. I my freshman
[16:04] term, I served on the reports
development committee and I was stunned having just come out of
the nonprofit world myself,
[16:12] that people who came in asking
for workforce development funds literally could not identify
basic things that were
[16:20] supposedly in their 90's.
And that really concern me. And I'm glad to hear that
because I've not have done it
[16:25] since my freshman term. I'm
glad to hear things are moving in the right direction. So and
I'm sure Jack continuing to
[16:31] work on that. So please
continue to presentation. Commissioner. >> Thank you. My favorite kind
of hearing has been.
[16:38] >> And we are not a shy group
commissioner.
[16:44] >> Great. So this slide touches
on some of what you were just discussing. You'll see in the
slides ahead that we show kind

[16:50] of a typical competitive grant
process but want to acknowledge in the second bullet there that
because we have a wide variety
[16:56] of grant programs, the
administration process may look slightly different due to the
structure. The program has
[17:01] established a legislation, but to the discussion must have
we do apply the same oversight
[17:07] and controls on both
competitive grants and direct appropriations as part of the
process of getting to the
[17:12] contract. So first for competitive
grants, we have to do a request
[17:18] for proposal. We developed that
RFP based on what is in the law.
[17:24] And then once we have it, we
posted on our external website for a minimum of 45 days.
And then we tried to get the
[17:31] word out through e-mail blasts
and we encourage our interagency and external
stakeholder partners to
[17:36] circulate the our piece to
their networks as well. Because, of course, the first
step in getting a good representative, highly
competitive pool of applicants
[17:44] is making sure that the right

people know about an execution of conflict of interest. As you can see,
[17:51] state grant policy requires procedures be in place to prevent individual and organizational conflicts of
[17:56] interest. We have additional conflict of interest farms at the operational level. For example, if at the time of
[18:03] contracting or if you're adding or changing any partners. David, first grant to stuff a lot of compensating partner,
[18:08] information form, I'd ask antes to disclose any actual potential or perceived conflicts of interest with
[18:14] inning some grantee contract or vendor or trainer to be compensated.
[18:19] And we also require the grant review or certify they don't have a conflict of interest before the before. The begin
[18:24] reviewing grants. And I can attest to this just on this very day after this meeting. I have a couple other ones and
[18:31] then the Minnesota job Skills, Partnership board. And I know that part of the package that comes up
[18:37] beforehand is here's the

agenda. Here are all the applicants for the funds.

And here's the form that you

[18:43] must check the box to indicate

that based on this list of applicants, you don't have any

affiliations that could

[18:50] constitute a conflict of

interest. And there's a separate enough to separate

former separate boxes checked

[18:55] whether you are a deed staff or

if you are and non governmental

[19:00] member of the M G S P port. >> Commissioner, if I can

interrupt you there, this issue of conflicts has been a

continuing theme that the LA

[19:09] has found in different

agencies. And so when a conflict of

interest form is filled out in

[19:16] the conflict exists, how do you

handle that? >> Well, I can't say that we

have encountered many of them.

[19:22] I think the central principle

is transparency. So awareness, disclosure and recusal would be

the main approach. If we

[19:32] identified that a conflict did

exist after the fact that we somehow didn't know about, then

you'd have to probably examine

[19:39] other remedies where there

should be something to do with stopping for the payment, et cetera. I wonder if my
[19:45] colleague, deputy commissioner majors, if you would be okay with that if I might like him to add on that. Thank you.
[19:51] Please state your name for the record. Good morning, Mark. Major step to commissioner for workforce development you.
[19:57] >> The Madam Chair, I was just kind of at a point to the
[20:02] commissioners statement, is that exactly did say around and
[20:09] if we do see a conflict, but the recusal peace will happen will definitely occur. And depending on the summer,
[20:15] the individual may, if it's if it's a boating scenario, may or may not, actually, it's lead to the meeting all itself.
[20:24] And but there have been that to my knowledge, been too many instances of that. I know. So.
[20:30] >> Great. Thank you. I just want a quick follow-up. So so if a conflict is found prior to the gun being issued, the
[20:37] expectation is that people would recuse themselves from the decision. Yes, that's great because that

is not to across the board.

[20:43] We're finding that they just

acknowledging the conflict is where some agencies leave it.

So the fact that you would

[20:49] require each week you so I

think it's a a good best practice. And when

the second and secondly,

[20:57] when you review cause, I know

you say you treat that legislatively name grants the

same as you treat competitive

[21:04] grants. So do you, in fact,

looked at look at whether their conflicts for legislatively

name grants as well.

[21:13] >> Madam Chair, members of the

committee, we do look at that. We will take this. The team or

teams will take the steps of

[21:21] actually looking at the

staffing, seeing if there's the same name of individuals

who may be the director of

[21:29] versus also individuals

providing the program services and then we'll follow up and

actually ask questions, are you

[21:35] related? What's the

relationship like a look at if individuals are

being paid or not paid? So

[21:43] there's an investigation that

does go on after even as we're going through the process of
determining whether or not
[21:51] there's conflict are now. >> I thank you, Representative
Freeman, thank you. Madam Chair. I just
wanted to clarify something.
[21:59] I think in this context we need
to language needs to be precise. But I believe with the
we heard the only when they're
[22:05] talking about conflicts of
interest was actually talking about the people working filled
out. I don't believe I've ever
[22:12] heard them. And you can correct
me if I'm wrong to say that there's actually a conflict of
interest in interest
[22:18] issue, but they are actually
finding conflict of interest that exist that have not been
reported. But there's a
[22:24] paperwork issue which leads to
again, we're talking about the problem. When we talk about the
solutions, we should be really
[22:30] clear with the problem. So we
need to make sure that the paperwork gets done. But my
understanding is that we're
[22:35] actually not talking about a
conflicts of fish or interest issue like we're seeing at the
federal level where people are

[22:42] getting billions of dollars of
grants and then in government making decisions. >> Thank you, representative.
And I would note that because
[22:50] the paperwork is usually absent
in these cases that we just cannot verify whether conflict
exist and that's why the LA
[22:57] continues to raise that.
Representative Schultz. >> Thank you, Madam Chair and
commissioner. I think that when
[23:03] I look at your report and lead
up to this meeting, this is the area that probably needs the
most attention for purposes of
[23:09] our discussion here. So last
week when we had DHS here, they know they have like
basically none and office of
[23:17] Inspector General right within
their agency with they have 400 employees doing this work.
It certainly doesn't appear
[23:26] like you are touching the same
amount of money. But to what extent and can you go into
detail in regards to, you know,
[23:34] who is pouring over this
information and trying to be as specific as possible as to the
extent to which your agency is
[23:42] is diving in to these conflicts
of interest and what just be very thorough and that

process for us to understand to

[23:49] make sure that there's nothing

that we should address legislatively to fix that.

[23:55] >> Well, maybe up, Commissioner

Madam Chair. Thank you, representative. I might answer

at somewhat of a high level.

[24:00] I know you do want to go in

more detail on. So I might look to my calling again and to

answer the question of who does

[24:07] what exactly a part of the

reason that Deputy Commissioner Mark Majors this year. He leads

our Workforce Development

[24:13] division and it is the

employment and training programs unit within his.

That is primarily the one that

[24:20] does workforce development

grant making. And they had, I think, 12 or 13 competitive

grant programs they did in the

[24:26] last biennium. And so it is I

believe as part of the prewar risk assessment when okay,

you've you've made it through

[24:34] the selection process and been

named as potential grantee. But now to get to a contract,

you have to provide us those

[24:40] financials. You have to provide

us the 9, 90 cetera in order to actually get to a contract that

have the dollar start flowing.

[24:48] And that's also where you need

to flag. Whether you have any affiliations or your

organization has any

[24:53] affiliations that could

constitute a conflict on the I guess going back one step

chronologically to the

[25:01] selection process. That's where

you can also have conflicts now for legislatively appropriated

[25:08] legislatively named recipients.

That's not an issue there because we're not reviewing

were not deciding who is

[25:13] receiving at the rather the

Legislature U.S.. But when it comes to the competitive grant

process is they're the

[25:21] reviewers need to be

identifying if they have any affiliations that would cause

them to not be objective in

[25:27] deciding who receives funds so that the commissioner,

[25:33] sure things thanks,

Commissioner Madam Chair, representative.

So

[25:41] it's very comprehensive

approach. >> To doing the selection

process from who's doing what

[25:50] primarily when an RFP is

submitted, we have what we call grams
coordinators, who are program
[25:57] staff and they were able makes
go through, make sure at least
[26:02] at a minimum that the
application meets the basic requirements to submit it.
An RFP request for proposal.
[26:11] At that point, as we kind of
once we get the actual application, they will. After
that, they handed off to
[26:18] individuals who do the review
of the Sharpie. And again, I mean clues to individuals
from communities, reviewers as
[26:25] well as staff as well as other
individuals who are skilled at looking at request for
proposals.
[26:32] At the same time we have our
team, which is our contracts team and our fiscal team who
are doing their pre or risk
[26:39] assessment work simultaneously.
So you have to review the application at the same time to
review of the vote paperwork.
[26:50] And then there was that fiscal
team and current contracts to well, look at the 9, it will go
through and make sure other
[26:59] agencies register with the

secretary of state and so on so forth. And then at that point, the
program team as well as
[27:08] physical team work with the
director of the Employment training program to make a
determination about the words
[27:15] that so you have to different teams who are looking
at the people work at same time
[27:20] and they will come together and
make assessment way in the background. We are
also our fiscal office, which
[27:29] is separate from the employment
training team, which they are also working with at the same
time on any other issues that
[27:35] may be rising to do to
determine if there are any issues. So you may have
different parts of the working
[27:44] on a request for proposal
program at the same time. But it's usually craft
cordinator and contracts person
[27:51] who is looking at the
paperwork. But our fee, it's a little complicated, but I hope
I explained it well.
[27:59] Thank you, Representative
South. >> Thank you, Madam Chair and
thank you, Assistant commissioner and commissioner.
I was surprised to hear the

[28:05] commissioners say a moment ago
that that there hasn't been many instances of conflicts of
interest arising and and so on.
[28:15] I'm curious, I'm glad to hear
that there's 2 different teams reviewing the information in
the reports that are sent to
[28:21] you the kind of looking at your
process then if there hasn't been issues around conflicts of
interest,
[28:31] can you kind of share for us?
Is there any key takeaways that you have that we should be
implementing other areas of
[28:36] state government that its help
make your agency successful?
[28:43] Madam Chair, yes commission, I would say on the frequency
question whether we see
[28:51] conflicts, part of it maybe relates to
where I sit in the process.
[28:56] >> For a lot of the grant
programs, I'm getting the finalist recommendations after
they have been through lots of
[29:02] the community viewers and
they're the ones along with our own staff who would have had to
identify if they had any
[29:08] conflicts. But it in an example like the minister
jobs because partnership board were I do get to be a voting

member on the final list there.

[29:17] I see a lot of recusals.

So I think the system is kind of working as intended. When

people acknowledge that they

[29:24] have an issue, then they will

simply step back either from the vote or from participating

in the

[29:32] the discussion. So in terms of what changes I

would recommend, I guess,

[29:38] feel like that transparency

approach is a good one. And if, as Representative Greenwood has

noted that the paperwork has

[29:45] just been an issue, I guess

it's partly a matter of having good systems in place to

capture all the paperwork and

[29:52] then be able to pull it up.

If there is any question after the fact and then it's not a

one and done situation. So as

[30:00] we noted some yet on the same

slide, a new conflict could

[30:05] arise to, but based on a change

in staff. And so you need to refresh those periodically as

well. Instead of just saying

[30:13] you've done it once and called

Good. Thank you, Representative,

Eric.

[30:18] >> Thank you. Madam Chair.
So you were talking about you are revealing reviewing the
90's, the audited financials
[30:25] and all the other documents.
I'm just curious like when you say are reviewing them and
you're looking for may be red
[30:32] flags are reasons either grant
or not grant. What exactly are you looking
for?
[30:41] >> Madam Chair, representative,
I mean, at a very basic level, it is do you have your
nonprofit status? Because if
[30:47] you don't then and I don't
think we can proceed with payments and there have been
cases where they may have lost
[30:54] it temporarily. And so we then
paused payments. And then if they get it restored and
everything else appears to be
[31:00] in order, then we can resume. >> Is that all represent?
Just one follow-up. Thank you.
[31:08] Thank you, Madam Churches.
So >> I mean, that's just the IRS
to termination letter. And you can go on the IRS website and
just see whether or not they're
[31:15] active or inactive. And there's
a whole history there. But you said you reviewed audited

financials and I 90's and I'm

[31:22] just curious as to what are you

looking for and those that would be a determination, a

judge, a determining factor

[31:30] moving forward. >> Madam Chair, commissioner

2nd half,

[31:36] it opened a look quickly. Thank you. So I believe we'll touch on

this a little bit, too, in the

[31:42] subsequent slides. But one

thing we do with the financials of not just do they exist, are

they reliable and have they

[31:49] been audited by a 3rd party?

And then we look at financial ratios, for example,

[31:56] current ratios, absent asked

cetera, to ensure that that

[32:01] those are in a healthy range.

And I don't believe it's an automatic denial if you don't

have them in the healthy range,

[32:09] but then it potentially can

kick us up to classify that can

[32:14] TS higher risk in which case we

would then take some additional measures which could be

technical assistance working

[32:21] with them or of the deputy

commissioner has arranged a number of instances with small

grant he and sort of a mentor

[32:29] or larger, a nonprofit that has
more financial capacity to work
[32:34] with the smart City. >> Thank you, Commissioner Vice
Chair Anderson. >> Thank you. And all think
that this is I apologize.
[32:41] I have to go to a legislative
audit commission meeting that we have to the U.S.. >> But I
[32:48] >> I just ask that you later
because I see it's later in your slides. Talk about the
outcomes because
[32:54] >> we know that we have. >> You know, billions of
dollars in grants that they're
[33:00] going out. It's it's scary.
Some of these entities don't
[33:05] even have basic financial
information, you know, or their paperwork is out of whack
candidates, wonderful that
[33:12] you're doing what you're doing
and you're and that we need to do more and more of that.
But it it just goes to the
[33:18] point of how if you have
organizations that can't even get their own paperwork in
order
[33:25] and asking for public dollars,
you know, what kind of outcomes couldn't possibly they they
they give us. And I look at

[33:34] these nonprofit says Grant is
as vendors that are taking out. You know, they are doing things
that we asked them to do.
[33:42] And if they can't even do basic
things like have their, you know, their
nonprofit status up to date,
[33:51] they certainly can't provide
services. And so I hope that as this, you
know, as we try to tighten up
[33:58] everything that we actually
start looking at, what outcomes are we getting for these
dollars? Because I think we're
[34:05] gonna find that we're not
getting our money's worth for a lot of this. So thank you.
[34:10] >> Commissioner, is there a
later slide about outcomes that you want to jump to? Well,
well, bystanders and is still
[34:16] with us. >> Madam Chair, if I may, yes
to respond and not quite sure
[34:21] which side of this for sake of
time, I would just share a few thoughts. One is that it's a
threshold requirement that they
[34:32] have the paperwork in place
before we can make the grant for then your point is if finances are challenging
financial management of the
[34:40] challenge, how can he actually

deliver services? Well, and that's a fair question. But one
thing that I observed from my
[34:47] time at a foundation where we
were working with non-profit grantees, who existed to do
good work in community was you
[34:55] often have leaders of
nonprofits who are very passionate about homelessness,
very passionate about nutrition
[35:01] for a passion, about veteran
suicide prevention. And they know that working because they
are veteran and they haven't
[35:07] got an MBA or they haven't
gotten accounting degree. And so we would work with them
to do capacity building so they
[35:14] could get the financial peace
in order to then be able to use their passions and talents on
the kind of programmatic side.
[35:20] So that deed also to the extent we
have the capacity to assist
[35:26] those nonprofits, we want to do
it because ultimately the nonprofit's playing an
important role in the
[35:31] landscape. I mean, they they
account for a significant employment in the state, but
also they're providing services
[35:37] that are critical in our

communities. And so that's where we're trying to strike
that balance between oversight
[35:43] and assistance. And then when
it comes to actually measuring lives changed or people
assisted, you know, that's of
[35:51] course important. And that's
partly where the site is. It's coming to make sure that
something is happening. But I'll tell you also that both
from our perspective at the
[35:59] state agency and also
throughout plan to be it's tricky to know what is it that cause someone's
life to be meaningfully
[36:08] impacted or not? If you're talking about
nutrition, maybe it's clear
[36:13] like was food provided. But if
you're talking about employment, we have other ways
of measuring that that a person
[36:19] get a degree that the complete
the course are they ultimately employed. But whether it was
clearly because of this
[36:28] intervention or because they
had a parent that, you know, really help them move along
that spectrum. Those things are
[36:35] somewhat hard to determine.
But we want to make sure at least that the things that the
grantee said they would do in

[36:41] the grant contract are, in fact
being done. >> Thank you. What I would it
says along much broader
[36:48] conversation. So I want to ask
yourself, thank you for coming and thank you. Thank you. Representative
Hawkins, thank you. Madam
[36:55] Chair. I had a lot of discussion this
morning about paperwork. But how much of the paperwork,
Israeli completing online form
[37:04] where you would have an ability
to have the system checked to make sure that feels are
completed before an application
[37:11] is is complete. Free sample in
the form is just something that gets printed out at the end
once all of the data has been
[37:18] injured. So and really getting
at is to what degree are we able to enforce the
requirements through through
[37:25] the System Commission? >> Madam Chair, Representative,
I'll give a brief answer and
[37:31] I'm I turn to my colleague that
leads more the grant making work. You're right. That people
were probably as a shorthand
[37:37] for lots of digital forms these
days and you'll find them all on our website. We do rely
heavily on bee standardized

[37:45] features of this process
established by the Office of Grants. Management was a great
partner to us. I think at the
[37:51] same time we're trying to be
accessible. So if there's an organization that for some
reason is uncomfortable or
[37:57] isn't able to do it
electronically, want to give them the paper option as well.
But I think one of the topics
[38:04] he touched on in the past also
was a transparency, Minnesota. That's a website where you can
look up the grantee and see who
[38:12] are the other agencies that may
have received funds from them. And then that's part of our
checklist process is if you see
[38:17] that we're working with an
entity that has received funds from another agency, you can
reach out to them and find out
[38:24] where that was the performance
satisfactory from your point of view. But Deputy commissioner things
out about it. Thank you,
[38:30] Commissioner Madam Chair. >> Representative out kids a I
think the other piece, which is
[38:36] a we're a little we're
transitioning our grants management system at the
[38:42] and for for the better. And I think we work that we do

work with paper quite a bit.

[38:50] And I think that it allows us to really kind of

work with our grant he back for

[38:58] what they are submitting.

So there's a little bit of rights on paperwork, but we

also have what's called a work

[39:04] Force one, which is our our

database, where we can collect information around what is

occurring with an individual

[39:12] and are sorry and for, for

example, and we utilize that tool to understand their role

in numbers. We also understand,

[39:20] you know, we're with funding

people, individuals are receiving and we use the

information that we collect in

[39:25] that system. And are we do work

or their grantees to monitor how

[39:32] other delivery services where

they are in the process of delivering services so well,

no, at a moment's time. How

[39:40] many people are rolled in a

particular program, you know, at any given time.

So we and that's required by

[39:48] actually, it's a legislation

that all grantees use our we're fortunate system so that we can

document their services are

[39:56] delivered. >> Thank you. All right, please
proceed. Commissioner,
[40:01] thank you, Madam Chair. >> So on to the rant review
function. And we have touched on some of this in the
discussion that has already
[40:07] occurred. But as you can see,
once the rp closes, its staff then review the submissions to
just ensure first of all,
[40:14] that they meet the minimum
requirements, such as did they follow the rules of the
application, staying within the
[40:19] page limit, have they included
a budget document and so forth. Then we have grant review
panels that review and score
[40:27] the proposals and recommendations are
submitted up to me for review
[40:33] and approval. And I get to have
the final authority over those were decisions. And I will say
that because we have a thorough
[40:40] process because I get a memo
that outlines all the steps that were followed in the
process. I do a final check and
[40:47] sometimes I'll ask questions,
but to a significant degree and pleased with the
recommendations to come to me.
[40:53] And then that's where we I

would sign off and we would
[40:59] then move on to the next step Community. Realtors are part of
that last step that we talked
[41:09] about and preceding slide.
We have a goal that all grant review panels consist of
approximately one quarter
[41:14] people who earn on the staff. And we believe that community
reviewers make for a more
[41:19] inclusive process and better
funding decisions. I've said in other venues that did staff are
very talented. And we are also
[41:28] located all across the state.
But this is another way that we can get perspectives from a
variety of backgrounds and from
[41:34] a variety of communities when
it comes to deciding who receives the funds that are
available to us.
[41:41] So when opportunities arise, we
put out an application for community reviewers and the
applicants are asked about
[41:47] their qualifications,
experience related to the subject matter of the RFP.
And then those reviewer
[41:53] dedicate about 20 to 40 hours
of the course of 2 to 3 weeks to review and score Grant
proposals. I believe it's the

[41:58] case that one reviewer doesn't
look at the whole slew of
[42:03] applicants depending on how big
of a program that is rather, let's say you have 100
applications. One reveal my to
[42:10] 10 and another might see another
10 and there will be some overlap in those. And so then
you line up the average scores
[42:19] so that you can see where where
the applicants shake out.
[42:25] >> Thank you, commissioner.
To community reviewers. We'd see compensation.
[42:33] >> Madam Chair down dodgy
government relations director ad there was we received some
money for a foundation to award
[42:42] stations. They were in the
amount of about $100. Don't know if we still have funding
left. Maybe a little bit a
[42:50] little bit funding that were actually funded by
the Legislature to provide
[42:56] know. >> Thank you. And what was the
foundation that provided the statements?
[43:03] Let's get back to you on that
represent and that's why just case, thank you. Great. Thank you very much for
explaining that process.
[43:12] Did you have more comments on

that or >> just the one last bullet,

Madam Chair I make is that the

[43:18] community reviewers as well as

the deed staff, also have to submit a signed conflict of

interest form before receiving

[43:24] a grant proposals to review 2,

again indicate that they don't have affiliation that would

cause them not to be objective.

[43:33] So now PRE Award risk

assessment. First, we check with

unemployment insurance to

[43:39] ensure that the employer

itself, the applicant is up to date, was not standing deaths

related to unemployment

[43:44] insurance. Then we do the

transparency check on NBC's Web site. As I mentioned to see if

a grantee has worked with other

[43:51] agencies and ensure that no

contract termination occurred, the Department of

Administration has a site for

[43:59] suspended or Gabbard vendors. I think we also looked at the

system board management on the

[44:04] federal level to see if there's

any similar department

[44:11] verification of tax exclusions.

Check the secretary of state website to sure that they are

up to date there

[44:18] view the risk assessment form

that has information, including the

[44:24] financials that we talked

about. So here we get into the ratio, she the acid test, which

I think is

[44:31] current assets minus

inventories over current liabilities. I might be wrong

about that debt equity ratio

[44:38] sheet and then review by our

deeds finance director to ascertain the risk level

depending on where they land on

[44:47] those ratios. And also, I'm not

sure it says in here, but we try to assess the

[44:54] the quality of their financial

management system. Let me just having a good system in place

that is not paper for your

[45:01] finances is critical. One thing

that's really important to us is being able to segregate

[45:07] sources and uses including

staff time assigned to any given grant.

[45:13] If all the money just goes into

one big bucket, that's not good. You want to be

able to ensure that Stafford

[45:19] spending 10% of their time on a

given grant is then charging it back to that particular source.

And this again takes me back to

[45:28] my days at a nonprofit when we

had multiple sources, some governmental, some from plan to

be an in each case, the re

[45:35] strings attached. And so you

need to make sure you work. >> They interrupt you for just

a second representative.

[45:43] Thank you, Madam Chair. And I

think I may have my question. Maybe that was a different

patient. My question was so

[45:49] this is pretty where risk

assessment. I think many of these were put into place in

2023 last term, which is great.

[45:54] And I I think it's corrected.

This is the surprise to direct appropriations and to discredit

me sort of any any time.

[46:01] Money is going out the door,

whether we directed a competitive again defended the

grants. We've we should be shifting that way. Can you just

confirm that the supplies

[46:09] either way? >> Madam Chair, Representative,

Correct. Okay. Thank you.

[46:15] Thank you. Please proceed.

I'm sorry, Representative, Eric. >> Thank you, Madam Chair.

Just really quickly. So you're

[46:21] talking about making sure that

the money is not in one big general fund. So do actually
review their chart of accounts.
[46:30] >> Madam Chair, representative.
Yes, basically. And we review the depth that we go into, I
guess depends on circumstances.
[46:39] But we certainly and we'll get
into this in a subsequent slide to only reimburse if they can
provide the receipts, so to
[46:48] speak for the expenditures that
they're claiming. Now we have some authority to do cash
advance. But even then they
[46:55] have to provide lots of
documentation. And yes, we we can go as deep
into the financials as we need
[47:04] to is my understanding that the
commission will do anything to that. >> Yes, thanks, commissioner
and chair representative.
[47:11] We do have a process that when we look at the financials
and if we commissioner colluded
[47:18] to it, we will look and see if
a grant to the house we deem
[47:23] them to be physically ready to
take on a grant and we will categorize them as priorities
in terms of hi, medium and low
[47:33] level we generally will do in the 1st
quarter. The first 2 quarters

[47:38] of the grant year is actually
go out and see, we'll evaluate their systems. So we'll look at
their ledgers will look at
[47:46] their policies or procedures. And this is or and this is to
assist that organization to see
[47:52] if there may be some challenges
so that we can handle early and often and any organization.
That's new to the portfolio.
[48:00] We also take part say it will
have that same strategy right now in reviewing their their
their system's early enough.
[48:08] So that because there are new
to our region CLT their new property due to our portfolio.
So those are some of the subset
[48:15] do occur early before you're
too far down the road into the regret.
[48:22] >> Thank you, Madam Chair.
I mean, I know we don't do that at the Legislature. We don't do
site visits to look at there,
[48:27] you know, whatever computer
system they're using, whether it's in our are, you know,
except, you know, whatever it is, Quickbooks. And to actually
look at the Trump accounts to
[48:35] make sure they have all those
appropriations problem is the revenue streams separated out.
So I another reason why

[48:42] probably shouldn't be doing
directed appropriations or the legislature cause. I don't
think anybody's going to want
[48:47] to got to a site visit and go.
Let me see your systems that in all that better. Thank you.
Yes, I'm glad to hear you are
[48:54] doing that work, commissioner,
so please continue. >> Thank you, Madam Chair.
And I think maybe just the last
[49:01] bullet that had mentioned.
But if that set of valuations,
[49:06] I want you to a recommendation
that they be named as high risk. Then we have the
opportunity to take additional
[49:13] measures, some of which we've talked
touched on. >> Thank you. I did have a
question regarding that's with
[49:19] any level of the risk
assessment where you deem it to high-risk or will you out was
just try to work with people if
[49:25] they come back as high risk. >> I believe we, Madam Chair, I
believe we have in some cases
[49:31] not gotten to a contract
because we weren't satisfied with these items if the
commission.
[49:38] >> Or Madam Chair? Yes, I agree

with that. We have had instances where they were just
agency may have been too much
[49:45] of a virus that we did not
proceed with an award. We do take the substance much as we
can
[49:52] to make sure to give them to
opportunity, to cure as situation if they can. But at a
certain point, then we have to
[50:00] move on to speak to and we do this
again, voting this assessment, voting and
direct appropriations so we
[50:11] don't treat either differently
in our strategy. >> Thank you. One fella for me.
So then when you deem someone
[50:18] to high-risk so that you don't
proceed with the contract, is that flagged by you in the
transparency, Minnesota system?
[50:24] So other agencies are also
aware of that.
[50:32] >> Madam chair, that I may have
to go back and check with my team on differs from. Thank
you.
[50:39] >> And Madam Chair, if I may
just add, as we're having this conversation now, I'm
remembering we've had cases
[50:44] where nonprofits have simply

said, Well, thanks for naming, assess potential grant. He but
we will, you know, respectfully
[50:52] decline to go to contract because we can't
really do it. So that's I guess
[50:58] an example of the system
working. This also is where we sometimes get inquiries from
the other direction, saying
[51:07] wide eatery, making it such a
pain to business back going. And we really don't want to
ever unnecessarily impede the
[51:17] process of getting to a
contract because those services really are important and
community. But it's just always a balancing act.
[51:27] Next slide. Thanks, Madam
Chair. So moving on the next 2 steps to completing an executed
grant agreements. So they
[51:33] submit the risk assessment
worksheet. And this is used to determine if we need to place
the special conditions as just
[51:39] referenced. And this is before
any dollars flow. And if
[51:45] we're in a good place to grant,
he will receive a notice in the mail that they've been approved
for an award. And they also
[51:51] receive an official paper award
letter, although maybe that goes

electronically to. But I get to

[51:56] see the letters and signed them

and then grant he registers as a vendor with the state.

They submitted updated work

[52:03] plan to reflect the final award

amount if it's different than what was requested because

sometimes

[52:10] if you apply for 250,000 but approved a set of grantees to

that

[52:17] go beyond the amount have

available will say I will approve you for 200,000 and can

you still work with staff?

[52:22] In some case, the not probable

say actually no below a certain level, it's not worthwhile for them to proceed.

But in most cases they do agree

[52:32] to work at that small level.

And then the grantee preseason signs of finalize grant

agreement for and provides a

[52:37] copy the email to deed and also

identify that in this process of the work

plan. This is somewhere that we

[52:46] also sometimes can be perceived

as an impediment. But we are

[52:52] working hard to make sure that

what the nonprofit says they're going to do it much more

detailed terms

[52:57] aligns with either what was in
the RFP and the legislation that shaped the RFP or what was
in the legislatively directed
[53:05] appropriation because sometimes
there will be a difference of interpretation. You might
perceive the the the earmark
[53:14] one way the non-profit might
perceive it another way. And if the nonprofit ultimately
is proposing activities that we
[53:20] don't think aligns, then we
will say you got to revise this and sometimes that can involve
multiple volleys back and forth
[53:29] and sometimes we don't get to a
satisfactory conclusion. If we don't think we can, you
know, verify that they're doing
[53:37] well loss S and then the amount of us
[53:45] on to grant agreements. So we
negotiate this with the grantees. The agreement covers
a wide range of terms and
[53:52] responsibilities. We don't make
payments until the grant agreement is signed by all
parties and work. The grantee
[53:59] does prior to a grant agreement
being in place is not reversible type of their sorry
for that.
[54:06] And I'm not sure if we have

this in subsequent slides but the structure of our contract, the
grant agreement substantially
[54:15] follows the kind of template
from officer grants management.
[54:21] >> Madam Chair, I'm sorry.
Representative Schultz, thank you. Madam Chair. Commissioner,
this is just a quick question
[54:26] here. You you work through a
whole host of grants. Is there a certain what is the threshold
for the amount of money that
[54:35] grant who would have to receive
to go through your full process years there? Is there a
threshold where they don't go
[54:42] through this rigorous process
Commission? >> Madam Chair, Representative,
I'm not aware that there's a
[54:49] threshold where they wouldn't
go through the prewar risk assessment, but there are
gradations when it comes to
[54:56] monitoring and with respect to whether
they're new to our portfolio. As the deputy commissioner
said. So everyone has to go
[55:05] through the basics. But then if
you are new to our portfolio, you get a little more
attention. If the grant is of a
[55:11] certain size were required to

do in Aurora policy is to do a little bit more monitoring.
[55:20] Thank you. Please proceed to
the next slide. Thank you, Madam Chair. So next slide
here. Reimbursements grant
[55:26] payments are processed on a
reimbursement basis. Meaning the non-profit does the work
and then submit evidence that
[55:33] they did the work to us and
then we send money to their account afterward. In limited
circumstances, we are
[55:41] authorized to do cash advances.
But even then again, lots of
[55:46] validation and verification is
required. It's simply a matter of timing.
[55:52] And you'll hear in the
nonprofit sector sometimes concerns about how long it
takes groups, how long it takes
[55:59] the process of providing us the
receipts U.S. reviewing, validating, etc, and then
telling our fiscal department
[56:05] to send the dollars that is a
certain delay. And the nonprofit has to have the cash
flow to work with assets to
[56:13] survive during that period of
time. And again, we don't want that to take any longer than it
needs to. And we don't have a perfect record of getting

everything processed quickly.

[56:21] But we're trying to strike the

balance as best we can. >> Commissioner, if I minded to

do so with other agencies,

[56:28] there seems to be different criteria for when

they can stop payment.

[56:34] And is there a certain criteria

that deed uses to decide who

[56:40] can stop payment to a grantee? >> Well, Madam Chair, thank

you. I would look to my

[56:48] colleague in just a moment.

I mean, I believe the grant agreement boilerplate language

has quite expansive powers for

[56:57] us to terminate a contract under a wide range of

circumstances.

[57:04] So I think our powers are

extensive. They're but >> deputy commissioner will do

it. Thank you. Think

[57:11] Commissioner Adam Chair you it? It depends give you the law

school kind of argument pair

[57:19] there could. There could be

certain scenarios where, as I mentioned earlier, that

grantees are required to submit

[57:25] information into or call

workforce one, which is our database so that we can cross

check to make sure that

[57:32] we see that the agency is
delivering services. We start
[57:37] to see an ongoing process work
over course of time that agencies not submitting
information and workforce on.
[57:45] We will call question as to
what it's occurring and work with that grant t
[57:51] in addition, we will see if they're not
meeting their proper paperwork.
[57:57] So the progress reports a
timely matter with her. But there wasn't. Sergeant
Wright continues our records,
[58:04] but their requests for payment. So those will be some
incidents, but it
[58:09] it depends on the scenario.
But those are kind of the bigger on some not submitting
paperwork in a timely manner
[58:15] and also not inputting data
into work. Force one for us.
[58:20] >> Perfect in. You don't have
to not have to tip your head that it would be great to know
when how many instances you've
[58:27] stopped payments in the last
year or 2. Just to understand that it
would also be great to see a
[58:34] copy of that boilerplate

contract language about your authority to stop payments if
you could just tap that sent
[58:39] over had appreciated. Thanks, Madam Chair.
[58:46] >> So carrying on through the
slides at the bottom there you can see we review each request
for reimbursement against the
[58:53] approved grant budget
expenditures to date and the latest grant progress report
before approving payments.
[59:00] I think it would add also partly in relation to the last
conversation there that
[59:06] this is where we get into the
judgment calls of grants management because we don't
default automatically to every
[59:13] infraction being automatic
disqualification, stopping payments. We know that in a lot
of cases the services being
[59:19] provided are critical to
community or we wouldn't be in a grant agreement in the first
place and we have to weigh will
[59:26] stopping payment which is, of course, important
to protect their funds. Does
[59:32] that scale of impact outweigh
the interruption of services?
[59:41] >> If you don't mind
representative or cause questions. Thank you. So you

said that you are looking for

[59:46] receipt before you send

reimbursement. Do you mean like literal receipts or Damien like

reports about receipts as and I

[59:53] used to do all the things I'm

I'm like, is it you know the receipt from when they purchase

a piece of equipment? Is it a

[59:59] payroll report like what

exactly do you mean by the word receipts, Commissioner? >> Madam Chair, representative

in turn to my colleague and I'm

[1:00:07] not seeing those, but I know

when I was on the side of submitting them, it was both of

those things. Was that mix of

[1:00:14] things? Because, yes, if you

bought a I thing the widget, then you need to show that you

had done so and provide

[1:00:20] evidence for a plane ticket to

go to a training, et cetera. But also on the staffing side

to show the time sheet that

[1:00:28] says, what's your salary rate?

And I spent 2 hours doing this and that's allowable within

this particular funding source,

[1:00:36] that cetera. So those are the kinds of

things that I recall we sent in

[1:00:41] and that I believe now we

review on the deed signed. >> Deputy Commissioner, thank

you. Madam Chair,

[1:00:47] Representative for Workforce Development

grants. Specifically we work. It's our

reimbursement. The document

[1:00:57] that all our agency site often

certified to that that these are the expenditures and now

you're seeing the slide as we

[1:01:03] move through the process,

you'll start to your about monitoring. I mean, we go out

and do our monitoring. That is

[1:01:09] when we kind of do a cross

check of those receipts against C R B R a reimbursement forms.

That's very specific to work

[1:01:19] first on how we approach it

because as you can imagine, for every pencil purchased and

for e, you know, for all staff.

[1:01:27] And if we had a a receipt, we

would never get payments out for, you know, 300 plus

grantees that we work with on a

[1:01:34] monthly basis. So it's about

it. It's a certified certifying component that are each

executive director. There does

[1:01:41] need staff sign off when they

submit that are reimbursement. But then we go back and we're

if we have outdated or

[1:01:48] monitoring which we're going to

go into a second. >> Thank you. Thank you.

Representative had said

[1:01:55] thank you, Madam. Sure. Just on

that piece regarding the reimbursement process and the

delay between when

[1:02:03] reports of services being

rendered have been offered to you and then you go through

your process to determine

[1:02:09] whether or not to release the

funds. When we talk about if having an impact upon the

community,

[1:02:18] it occurs to me that there's

less of a danger of that. If a higher percentage of the

funding for that organization

[1:02:26] is coming from philanthropic

private sources, they don't have to rely so much upon

getting props reimbursements

[1:02:34] from the state and your

experiences. We've sent a broad range of percentages of how

much of an organization's

[1:02:42] budget comes from state grants

as opposed to private philanthropy.

[1:02:47] Is there an avid average or a

trend or what are you seeing amongst youth, the

organizations that you're

[1:02:52] working with Mr. >> Madam Chair, Representative,

thanks for the question.

[1:02:58] And again, now refer to my

colleague, invite him to weigh in on this since he probably

sees a little bit more closely.

[1:03:05] I will say from the perspective

of one nonprofit executive director when that's what I was

our share of governmental

[1:03:13] sources versus non vary a lot,

depending on just the the year

[1:03:19] that we're in, because, of

course, during COVID, we had small business relief grants

and child care, emergency

[1:03:25] grants, et cetera. And so you

would have seen that percentage kind of balloon temporarily.

But fortunately, I was at a

[1:03:32] nonprofit which happened to be

a foundation which had an endowment center, which gives

you a lot of financial

[1:03:38] security, which many nonprofits

don't have the benefit of. And I think the philanthropic

community does try to assist

[1:03:45] there and providing somewhat

more flexible resources we have and say that government money

of some of the hardest money to

[1:03:52] work with because we need to

have these strange because, you know, all the taxpayers,

our board of directors, so to

[1:03:58] speak. So it's it's beneficial

to be sure if the nonprofit has a variety of sources, some of

which are more flexible than

[1:04:06] others. But in terms of

averages of governmental versus non, I don't know if the deputy

commissioner might have a view

[1:04:13] on that. >> Madam Chair, representative,

I don't have the actual percentage on that.

[1:04:20] But I would just echo the point

that the commissioner says that we actually really encourage

our grantees to have flexible.

[1:04:27] And it's for the exact reason

that you just highlighted if there's a delay in payment,

that they have resources that

[1:04:33] they can go to to cover their their cap

during that time while they're

[1:04:39] waiting for reimbursement. >> Thank you. Please proceed me

again. Giant step it up here.

[1:04:46] So we'll we'll try to let you

proceed and finisher presentation. >> Thanks, Madam Chair, and we

appreciate all the good

[1:04:52] conversation. So officer grants

measure policy requires men to

[1:04:57] submit written progress report

at least annually and the we choose to have them quarterly.

So GM's requirements are a kind

[1:05:05] of the baseline. And then we

have room to just according to our needs, the progress report

summarizes activities and

[1:05:12] outcomes for a given period

with the narrative statistic on financial elements.

[1:05:18] >> Et cetera. >> And can include information

on outcomes, activities,

[1:05:24] lessons learned and financial

information, etc. And I'll say to that, this is an area where

there's an ongoing discussion

[1:05:30] in the philanthropic community

about what's the best kind of evaluation report because

[1:05:36] nonprofit spend a lot of time

producing. And then you kind of wonder who's reading them

[1:05:42] and would it actually be more

beneficial to have a conversation or can you have

both? Because, you know,

[1:05:48] there's incentive on the part

of the grantee to just say everything's great

everything worked out

[1:05:53] beautifully, but you want to

have a good enough relationship where you can reveal that?

Well, we have some difficulties

[1:06:00] in this way. And hopefully if you have sort

of a good faith relationship,

[1:06:05] you can reveal that in a
constructive way as opposed to getting in trouble and and
being kicked out for the future
[1:06:12] because oftentimes the grant,
he wants to maintain an ongoing relationship for future
opportunities
[1:06:19] onto monitoring lots of words
here, but we'll try to just highlight some of the key ones.
So we do at least one visit
[1:06:26] before final payment on all
grants over $50,000. So here we get into those gradations,
Representative Schultz and we
[1:06:34] do annual monitoring visits and
grant of over $250,000. The purpose is to ensure progress
against the goals and address
[1:06:41] any problems or issues before
the end of the period and effective is it couldn't can
cover topics, including but not
[1:06:47] limited to compliance,
challenges, faced cetera. And I want to acknowledge, I
believe all of these are
[1:06:55] prearranged monitoring visits,
unlike with in the child care space. I don't believe we do
the unannounced drop-in type.
[1:07:04] Well, I think the vice the
chair of the committee mention that were cuffed algae does

that in certain cases. But ours
[1:07:10] are up to the monitoring Friday
where we are, you know, ranging ahead of time so that folks can
get their ducks in a row and
[1:07:17] have their their paperwork
present if that's what's needed to show that they're on track.
[1:07:23] >> And just to clarify, those
are in person monitoring visits or they're done by teams are
some other technical
[1:07:30] assistance. >> Madam Chair believe it's a
ex and I would. But the deputy commissioner to comment.
Thanks, Commissioner Madam
[1:07:37] Chair, just kind of taking on too,
with the commissioner says that we actually have a monitoring
guide that we produce fruits of
[1:07:46] our programs. And those are
sent out 30 days prior to are monitoring visit. So is the
commissioner mentioned this
[1:07:54] gives the grant he the
opportunity to get the information that they
need. So when the team and it
[1:08:02] usually we have a monitoring
team for workforce development, it would be either it could be
one person or could be a couple
[1:08:09] people depending on the scope
of the review. But when they're on site that

they do actually look at the

[1:08:17] paperwork now, they may do some

preliminary work in advance and asked the agency to Smith, did

you know ledgers or something

[1:08:23] like that in advance? So the

team can look at that. But they do have to do and up on site

for site for between 15 and

[1:08:33] over the to 15 start to 50 out

anyway says they do do on site

[1:08:39] Ruiz. Thank you, Madam Chair to proceed. You can

see in the second to last

[1:08:47] bullet we do financial

reconciliation at least once before the planet final payment

is made, which involves looking

[1:08:54] at the request for payment,

checking out that supporting documentation, et cetera, which is somewhat we

discussed already. And

[1:09:02] the final hole at first, I

guess, too, a risk assessment again is if we had identified

them as high risk, we would do

[1:09:10] a monitoring visit within the

first 2 quarters of the country when it comes to close out,

grantees must submit their

[1:09:18] final payment requests within

20 days. And in addition, final payment request to have

to submit a final report on

[1:09:24] outcomes which summarizes
activities and and what was accomplished over the grant
period. We then reviewed the
[1:09:31] request and the report and do a
close out a valuation in terms
[1:09:36] of whether objectives were met
and then successful grantees received a call that clothes
are notice confirming
[1:09:41] completion and that all
documents will be placed in the grant file. And it's the policy of the
state to consider a grant
[1:09:48] applications are grant
applicants past performance before awarding subsequent
grants to them.
[1:09:55] >> And commissioner, if I may,
if the grants closer to do you shun is not meeting standards,
do you still make the final
[1:10:04] grant payment the commissioner?
[1:10:10] Thank you, commissioner. >> In general, it depends on
what the maps a better chance
[1:10:16] by her or represent in general.
We will. But it depends on what
[1:10:22] the circumstances may be. If it's something where unable
to verify and expenditure,
[1:10:29] we see an irregularity, then we
will have will convene with our

[1:10:34] partner or the agency to
identify with the charges and make a determination at that
point. But I don't top make it
[1:10:44] a call to me and says we're
seeing that happen. We went to a close.
[1:10:50] >> Thank you. >> I find it concerning.
I feel like the point of these
[1:10:55] close out the valuations is to
make sure, especially if this is the only time you're
reviewing the financials as at
[1:11:02] the end of the period that it's
important that if things are buttoned up, that you would
[1:11:08] withhold payment until it's
pec. So I encourage you to, you know, consider that to you,
[1:11:15] Representative, Eric. >> That's really what they so
is all this information, public data. And then secondly,
how many and that staff members
[1:11:24] to have the monitor all of this
grand activity and like almost 400 is actually
over 400 million dollars.
[1:11:34] >> Madam Chair, representative,
in terms of it being public data, I believe what's on
transparency, Minnesota now is
[1:11:42] simply what agencies a given
nonprofit may receive funds
[1:11:49] from. I don't believe that the

contents of the evaluation materials are available there.
And I'm not sure if that's
[1:11:56] changing so you wouldn't get
the the inside scoop necessarily on. We were
disappointed with the
[1:12:02] performance related to X, Y and
Z, which also relates Madam Chair. To your comment about
[1:12:09] is the final review just to
kind of a pro forma rubber stamp process. And I would say
no, if if we see that, that
[1:12:18] we don't have all the necessary
paperwork, et cetera, then we wouldn't make the final
payment. But if it's a matter
[1:12:24] of, well, everybody did what
they promised to do. And it just wasn't quite as effective
of an intervention in the
[1:12:30] world. That's different.
We wouldn't necessarily hold that against them. So again,
that's kind of where the judgment call comes into place.
And then your final question
[1:12:40] about the number of staff
reviewing it. I don't know quite how to
answer that here at the desk
[1:12:46] because we would need to figure
out how much time you have some people that are dedicated
specifically to the grants

[1:12:52] management and then you have
other people in our administrative and financial
services that play a part in
[1:12:57] it. Deputy commissioner, might you
be able to share just a little bit about your staffing and who
does what within your division?
[1:13:05] Sure. Thank you, Commissioner
Madam Chair. I was a committee. It goes to a number of reasons
when we get our reimbursement.
[1:13:14] As I mentioned, there's a staff
member whose call the grant coordinator who will review that
reimbursement request
[1:13:22] and again, going back. They're
also going to look at our week again, the work Force, one
system to evaluate if they're
[1:13:29] seen a progression of work that
occurring. There's a little bit of a when you look at that
reimbursement quest doesn't
[1:13:37] really match the amount that
they're asking for where the where they are in terms of the
grant to meeting their goals.
[1:13:43] So we knows, for instance, or
maybe requests for Sun start activities. And we may not see
actually high number moments,
[1:13:52] the first a couple months
because they're starting a packed rant. But if we, for

instance, either requesting 50%

[1:14:00] of their dollars and that 1st

quarter, and we do like we will start to ask the questions and

we're not seen that they're in

[1:14:08] rolling of ration are putting

information into work Force one. So that team will start

that process.

[1:14:14] Then you look at it and then so

there's already before monitoring to start. There is

little bit of a scrutiny of

[1:14:21] what's being requested. Then

you'll get to the monitoring team, which says

[1:14:27] to back a look at the numbers.

But it's grown over the last couple years and they'll go out and do the

on site. And then as the

[1:14:36] commissioner mentioned, as well

as that, there are fiscal team, there's another group of folks

that are not tied to workforce

[1:14:44] development that is looking at

any reimbursement. So the number of people that are

looking at a reimbursement,

[1:14:52] there's it goes to quite a bit

of a process. So we'd have to if you want actual numbers, we

can come back to you with that.

[1:15:00] >> Representative Eric, thank

you. That's helpful. You know, represent shelter, talked about

the Office of Inspector General

[1:15:06] within DHS. It's they had mentioned to us that

they have about 400 and I don't know how many folks are due

tonight came to visit you and

[1:15:14] of deputy commissioner. No, I'm

not even with my niece and just kind of wanted to the building

with her and and talking to

[1:15:21] folks. How many people are a

deed in total? Just we have a sense as to how big this

[1:15:27] because it's 431 million

dollars that flows through that footage was.

[1:15:33] >> Madam Chair is can you

representative roughly 1500 at deed in total?

[1:15:40] >> Great. Thank you. All right.

So I think we're at the end but maybe of a few more closing

comments.

[1:15:45] >> I wish I didn't know.

That is the presentation. >> Fantastical. We really

appreciate you coming.

[1:15:53] Appreciate that. The work and

the rigorous process you seem to have in place. And I look

forward to some follow-up in

[1:16:02] the future. I there's a whole

nother area like to learn more about it. How you determine

eligibility for some of the

[1:16:08] other programs, not necessarily

the grant programs. So perhaps you could have you back at a different time to talk about

[1:16:14] sort of you, I and some of the COVID programs and how how that went and and how any continued follow-up you have on

[1:16:23] that because I think there is some concern about eligibility issues across state agencies that, you know, our committee would like

[1:16:30] to take a look at. So perhaps we can do that in a different time. Thank you very much members. We are adjourned

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 03-10-2025

[0:04] >> Good morning. Call this
meeting of the House Fraud Prevention and State Agency
Oversight Committee to order.
[0:12] Welcome to our new time in our
Newroom. Thanks to everyone for your flexibility as we
accommodated the needs of
[0:19] another committee this morning.
[0:25] >> Do have so we will move the minutes of
the last meeting.
[0:33] Thank you. Representative
vice-chair Anderson. Vice Chair Anderson moves the
minutes of the 3/3/2025,
[0:40] meeting. All those in favor say
aye. I those opposed
[0:45] minutes are approved. All
right. So today we have a
[0:51] presentation on the overview of fraud problems in Minnesota from Bill
Klein. He's a fellow with that
[1:01] think tank the center of the
American experiment. And he has done extensive research on this
over several years. And so
[1:10] we're happy to welcome you to
the committee to share with us your findings. And if you would mind beginning
by stating a name for the

[1:17] record. >> To build on with the center
of the American experiment.
[1:26] >> Thank you. I believe you
have a slide presentation which has disappeared since we set it
up there. It is excellent.
[1:33] >> Trying trying to be as a the
intensive is my colleagues at the center. I did want to have
a couple of pictures here.
[1:41] They'll street to my discussion
here of fraud, waste and abuse abuse in Minnesota. So one of
the things that I did this
[1:48] probably start a year or so ago
was trying to answer the question of how much fraud
waste and abuse is going on and
[1:55] has gone on in state
government. And so I put together what I call the fraud
waste and abuse tracker
[2:02] where I've looked at incidents
where state government has been either defrauded or there been
incidents where people have
[2:09] been accused of taking money.
They weren't necessarily entitled to or more money than
they were entitled to and
[2:16] trying to come up with the
bottom line number and building off of an earlier a set of work
that the senator did on the

[2:23] scandal tracker. I started with
the year 2019, the previous tracker went through the 25th
2018.
[2:29] And so from 2019 until the
present, we have a total and
[2:35] the >> skip ahead here. One, I have a guy here to help fill
I was and what it would.
[2:49] And then a thing. Sorry, sorry.
[2:55] >> 601. 0, 6, 111 million
dollars. So 611 million dollars
[3:01] is a total of and I have 27
incidents that I've I've
[3:06] cataloged here. And of course, the biggest one
is feeding our future. And there's a trial going on in
downtown Minneapolis will
[3:14] resume on Wednesday. It's been
going on for over a month now of the person who's accused of
being the ringleader of the
[3:22] gate keeper of the feeding our
future fraud. Her name is Amy Buck. She was the founder of a
nonprofit who operated food
[3:29] programs through state
government to feed presumably poor hungry children. And the
U.S. attorney, the Department
[3:37] of Justice for the federal
government has accused her and her co-defendants of stealing

250 million dollars. And this

[3:46] happened through largely a

program operated during the COVID years and it occurred in

2020 2021. January 2022,

[3:58] we had a rate by FBI agents and

Treasury agents and others. 200 federal agents descended on

the Minneapolis Twin Cities

[4:08] area raided dozens of

locations. And I just wanted to point out, is taking almost 3

years to get to the point where

[4:16] we're having this trial of the

person who is accused of running this organization.

So it's a very slow process.

[4:22] And I know one of the questions

that I'm frequently asked is how much money has been

recovered.

[4:28] And I get this question a lot

and the answer. I've seen various accounts of it between

[4:34] 50 million, 60 million, maybe

even 66 million dollars of the 250 million have been recovered

and returned to in this case.

[4:43] Federal taxpayers, which if you

can do the math is only a fraction of the total amount

involved in the fraud.

[4:50] A couple other things I want to

point out about the fraud is that this was the Department of

Education and the and

[4:58] it went on, as I said, starting

in 2020 and through the January 2022. And

[5:06] most of the others are dealt

with from other agencies. And I'm going to get to this

interagency, this enterprise

[5:12] view level of fraud later in my

remarks. But

[5:18] and as far as I can tell, the

250 million dollars number was a number put out by the U.S.

attorney when the first

[5:24] indictments were handed out and

those were handed out in September of 2022. And the

numbers never been updated,

[5:31] even though there have been

dozens and dozens of additional indictments there up to 77, 0

persons have been indicted in

[5:38] the case. But the numbers ever

been updated. As far as I can tell, it's really meant to

cover feeding our futures share

[5:45] of the take. There are 2 other

large nonprofits involved in the end, all talk about the

later. And if you included

[5:51] them, none of them have been

indicted. There's nobody associate with these other

nonprofits who've been charged

[5:56] with any criminal wrongdoing,
but they've both been shut down by the Department of Education
are no longer allowed to
[6:02] participate in the program.
In one instance, some of the principles of the program have
been banned from participating
[6:10] food programs. And the 3rd
example, which I've included a lawsuit from the state attorney
general, he took the
[6:18] extraordinary move of filing a
civil lawsuit against the a nonprofit and succeeded in
getting a court to order its
[6:26] dissolution. So it no longer
exist and in any corporate form. And from my research,
though, the big 3 plus a few
[6:34] other smaller nonprofits that
were also shut down by the State Department of Education
in the wake of the scandal puts
[6:41] the total above or about 500 million dollars.
So I've included the number
[6:46] here because it's the number
put out by the and the U.S. Department of Justice. But
again, by my research, I think
[6:53] the total number for the food
fraud probably is double that around 500 million
[6:59] see cap program. I understood

you got into this program with

[7:04] a prior hearing that you held

of this committee. So I'm not gonna spend a lot of time on

that. What would point out,

[7:09] though, that and I know you

also talked about this at a prior hearing. J Cole's of

Channel 5 KSTP did a series of

[7:17] reports following up on this is

a report that the legislative auditor put out in 2019, but he

did a follow-up report here,

[7:27] I believe is last January, just

a couple of weeks ago, 6 weeks ago where he visited some of

the top

[7:35] earning, if you will, a child

care facilities in the metro area and found no children and

no adults. The several times he

[7:42] visited during working hours.

And again, there was some controversy about that is an

accusation of the it was

[7:49] mistaken and one of the

addresses. So I saw a report where he went back to the

address listed in public

[7:54] records. Still no children,

still no adult. So this is a number that was put out by a

whistleblower back in 2019.

[8:03] I haven't updated it. I've been

trying to keep track of it, but you could tell the see cap
program and childcare subsidies
[8:08] by the state continue to be a
problem. The new way again, the next 2
items items, 3, 4, are
[8:17] addiction, recovery services
and the one called new ways the subject of a lawsuit I believe
knew it was the one who sued
[8:25] the Department of Education and
the accusation there's overbilling. And that's a number
[8:30] >> that I put in there and that
the
[8:36] has been thrown out, what what
they may have overbilled the state government for these
addiction services. But again,
[8:42] that's a subject of litigation. And the actually it's the it's
the one. It's one of a couple
[8:48] of down Evergreen recovery.
Sorry, it was a couple of down. Evergreen recovery is accused
of taking again. It's a
[8:56] overbilling case, 30 villa,
3 million dollars out of the Medicaid program overseen by
Department of Human Services.
[9:06] And that's the subject of
litigation by the Department of Justice Against Evergreen
Recovery. And also there have

[9:13] been criminal charges levied in
that case as well where the Department of Justice has
indicted a couple of executives
[9:20] with the fur and again care.
Levin is the one behind the
[9:26] investigation of this addiction
recovery company for last couple of years. They did
report just last week on a new
[9:32] set of the searches that were
undertaken by the FBI evergreen, the homes of
Evergreen executives. And
[9:40] there's a possibility there
could be more criminal indictments in that case.
And just want to bring that to
[9:45] your attention since I last
updated this, I haven't found anything to add to increase the
dollar amount, but they're been
[9:52] new developments in the number
of these cases. So that's just might my quick introduction of
the of the fraud waste and
[9:59] abuse tracker. But I did want
to mention early-on that happy to make this interactive.
We do have to wait to the end.
[10:06] If you have burning questions,
they go along because under the cover, a lot of ground. And if
you have a question about new

[10:11] are evergreen and that was 10,
20 minutes ago the and if you got something now I'd be happy
to take some as we go, Madam
[10:18] Chair. >> At thank you, Mister Glenn.
And the point that I really
[10:23] want to to address in specific
examples of that study you've done in
these different programs,
[10:30] but I think it's something the
committee has deep concerns about is the business model of
fraud.
[10:36] And so in my research, in testimony
before the committee and in
[10:41] meetings with whistleblowers, what seems to occur
[10:46] is that vulnerable people in
our state >> are preyed upon.
[10:53] >> By people who are greedy and
want to make money off them. And so they sign people up for
services that may or may not be
[11:01] received. And then they either
over Bill or Bill for services not rendered or
[11:09] add in additional services that
may not be necessary. And then
[11:15] people who really are in need of
services either don't get the services
[11:21] or are sort of kept in the loop

so that they don't really get better and continue to be get
signed up for services when
[11:29] they don't recover. And that seems to be the
business model that I am
[11:36] discovering as I work through
all these different programs. And as we have testimony on the
record or off the record.
[11:44] And so I just wondered if you
could speak to what you have seen as sort of like that pattern of
fraud and how it develops.
[11:53] And if you've had a similar
encounter of of of of a sort of business model where people are
preying on the vulnerable
[12:01] citizens in our state to either overcharge a charge
for services, not rendered MRI?
[12:08] >> Well, I can certainly give
you some examples of people involved in the feeding our
future and from where that was
[12:14] the case. But I'm going to
direct you down a little farther on my tracker to item
number 18 and it looks fairly
[12:21] innocuous. It's a Medicaid
fraud. 2.6 million dollars, not the biggest fraud on the
list by any means. This was a
[12:29] case brought by the state
attorney General Keith Ellison within his office. He has an

office for the unit, the

[12:37] medical Fraud, investigative

unit and it is what it says. They investigate fraud against

the Medicaid program programs

[12:45] primarily run by the Department

of Human Services. They investigate fries, even

charges. They prosecute cases.

[12:51] This was a case from a couple

years ago and in fact, it was a investigation. I included the a

press release from the attorney

[12:59] general in the packet. I don't

know which one it is in the packet, but it's in there.

But it was called pit stop 66.

[13:08] And it was the primarily invest

investigation of fraud originating in the feral area.

45 minutes south of here and

[13:17] what the the found and they

named the investigation after this P I T it stands for

Medicaid provider, interpreter

[13:25] and transportation. So these

individuals who are indicted in this case were accused of

[13:32] conducting an entire portfolio

of fraud. And so what they were doing is

they had medical providers,

[13:39] people providing medical

services. You describe to the low-income vulnerable members

of the faribault area

[13:46] community. They would literally drive

them. I forgot what the limit

[13:51] is. Stay. You can get

reimbursed. It's 60 miles per hour. So they would they would.

Thank you, Madam Chair and

[13:59] representative a rare they

would they would rather 59 miles to an appointment so that

rather than find a provider and

[14:06] terrible wrote on they would

they would provide. Then with an appointment up here in the

Twin Cities area, they would

[14:11] rise on the 59 miles bill for

the 59 miles. Again, these are members of the communities.

They require interpreter

[14:19] services. They would hire an

interpreter and the interpreter, the driver or the

medical provider would all work

[14:25] together to provide these

services. But at the most expensive way you can imagine.

So there was not just the

[14:32] distance, but say a van full of

people that we charge or individual rides. And

[14:38] you mention the business model.

And again, some of the business model in says it consisted of

identity theft where they would

[14:47] get the whole the identifying
information for people who are attending bona fide medical
appointments to get their names
[14:53] or addresses Social Security
number and then they would bill for appointments that were that
may have been scheduled,
[15:00] but the patient was never
notified of the never occurred. So it was over billing double
billing. And this was their
[15:07] business model. They the figured out the scenes of each
of these individual programs,
[15:13] the interpreter reimbursement
program, the transportation program reimbursement for
medical appointments and
[15:20] combined them into a single
seamless fraud that they would go and build the state for
multiple times for a single
[15:27] appointment or multiple times
for unemployment that never occurred. And and, you know,
the
[15:32] to the credit of the state
government, the Department, Human Services and the attorney
general's medical fraud,
[15:38] you know, working together,
brought a prosecution against these folks. So there's a I
think, an example of what we

[15:44] were describing where that it
wasn't just a matter of cutting corners here. And there it was.
That was their business plan
[15:53] that was with the executed and
they did so for as long as they could before they got caught.
[15:59] Thank you, Representative,
Eric. >> Thank you. Madam Chair of
this is fascinating. This is
[16:05] actually fascinating. Thank you
for being here today. And in presenting that. I just I
wanted to circle back with
[16:10] something just really, really
quickly because I haven't been able to find the
video clip. But I remember
[16:17] watching live the very first
press conference that attorney General Lugar had.
And I remember very clearly him
[16:24] saying we know that there's
been 500 million dollars of fraud
happening today. I can prove
[16:32] 250 Million. And that is exactly what you
had said that you all through all your calculations and
through all of your tracking of
[16:39] all of this, you arrived at the
same number and I know will be will be speaking with rep with
any lugar soon so that he can

[16:47] come in, tell us themselves
himself. But I cannot find a video clip to have searched for
hours looking for the there.
[16:54] You know, I looked on the Web
site where he house's press conferences. But
[17:01] Mike, my question, so let me go
to another point. So thank you for that. To my second point is
when we had see cap, we have
[17:08] the conversation here about see
cap. We asked him specifically about how much have you
recovered. And they were very
[17:14] proud to say they had to point
4 million dollars over the since 2020 recovered during
that same time they had 1.1
[17:22] billion dollars of see kept
money go out. So they're very excited. They had recovered 2.4
million and seek help money
[17:29] back. But the problem is most of that was
just curtailing future
[17:34] payments. They really haven't
recovered anything as you've been going through all of these
this deep dive on on this.
[17:42] You also mentioned about 60 or
70 million maybe had been recovered with feeding our
futures.
[17:47] Have you can you talk a little

bit about anything that's been recovered?

[17:53] >> Yes, Madam Chair, Mr.

Gore Representative Eric. So a couple of things in there

and some of them are

[18:00] interrelated. So the recoveries

and again, this is one of my eternal frustrations with the

State Department. Education is

[18:07] the don't believe they're in

the recovery business, that they have outsourced all of

that to the state to the U.S.

[18:14] Attorney's office. And it's the

same with the with the attorney general to his credit. He has

filed dozens of lawsuits

[18:20] against these nonprofits who

have been implicated in the scam and he succeeded in

shutting many of them down

[18:25] dissolving their corporations.

To my knowledge, he's recovered exactly $1000 in the

recoveries. These are civil

[18:32] cases and his object is to to,

as you point out, stop the bleeding. And I will only 1.2,

I come back about recoveries if

[18:42] I leave. One message here

behind this morning is the key mission should be to stop the

money going out the door to

[18:49] begin with. And so you look at

the feeding their futures scandal, whether you look at it
from the inception of April
[18:56] 2040, when they had already
identified the people who would be future fraudsters and denied
their applications from the
[19:03] get-go to where they were sued.
And we're in state court and some rulings went against them.
They had actually stopped
[19:11] payments to feeding our future
in March or so of 2021 and then
[19:17] end up having some setbacks in
court and resume payments and had they
[19:23] taking a different path.
That was another 100 million dollars that went out the door
after they resume payments to
[19:28] these organizations that they
knew were committing fraud against the state. But as for
the recoveries
[19:34] and winds handy again, the EU
disappointed it's only 2025% of the total. But on the other
hand, yeah, have to understand
[19:41] what the state is up against. Most of that money probably
came from bank accounts that the seized as part of the
searches that were conducted in
[19:49] January of 2022. There's other things where
there was an office building on

[19:55] Lake Street in Minneapolis
where they seized it to forfeiture and they sold it.
They found a buyer for they
[20:01] found a buyer for an office
building on Lake Street. And they sold it for a couple
million dollars. And that was part of the recovery. Some
vehicles, again, vehicles.
[20:08] As we know, you buy a new car,
you drive it off. The lot is worse. A significant percent
less. So these are all used
[20:15] cars. A robot is news car, new
cars by the defendants. But the same thing with the real
estate. They seized quite a bit
[20:23] of real estate. Again, it's in
Minnesota, Kentucky, Ohio,
[20:28] Colorado. But the biggest
problem is where the biggest problem are 2 things. One is
money's just been spent was
[20:35] spent on Las Vegas junkets
where 1, 1, person involved in the case rented a Ferrari for
the weekend
[20:44] high-end hotels. It also
involves the spending of just mundane things. Mortgage
money's money at Home Depot,
[20:53] pain you're credit card bills.
And then millions and millions of dollars sent overseas.

So money has been sent to
[20:59] Africa to Asia, invested in
crypto currency. That money is
[21:04] never going coming back and
each other and again, more than half. I said there were 70
people indicted more than half.
[21:11] 37 have now pled guilty in the
case and 5 additional defendants were acquitted at
trial to or acquitted. But 42
[21:20] is the number of convictions we
have in the case. And every time there's a guilty plea or a
courtroom conviction, one of
[21:26] the things in the order is
forfeitures and restitution and
[21:31] they're on the hook for
whatever the Department of Justice determined or a jury
determine was their share of
[21:38] the take. But, you know, it's blood from
a turnip. How do you after the
[21:43] arrests and seized in the ID,
get this money if it's in and Senator Brodeur's and is in
cryptocurrency and again,
[21:51] you look through some of these
and the pattern is just as we eye mention, the evergreen
recovery. And Carol Evans,
[21:57] most recent report, this most

recent actions by the FBI, the unsealed search warrant and
it was the same thing except,
[22:05] you know, slight variations on
the theme is that of a Lamborghini in Las Vegas.
It was private just to the
[22:11] Hamptons and the charging millions of
dollars on the company credit
[22:16] cards. So if it's just for
those disposable items and
[22:21] again, every time they do in
these raids, a fine and the lows for cash and
jewelry and stuff like that,
[22:27] it has resale value or
intrinsic value. But a lot of it money was just got just got
spent is not going to be
[22:34] recovered. >> Thank you, Mister Glenn, I'm
going to turn to Rep Representative Pinto. >> Thank you, chair. Just in to
do things for now. One is it
[22:43] occurs to me says we're talking
about the the assistant attorneys general working on
that Medicaid fraud scheme. Just wondering, Madam chair of
if you can, sir, I think you
[22:50] and I talked with the
separately. But here having those folks come in and
specifically, Sarah, been hearing somebody talk about
their work kind of secondhand

[22:59] to hearing from them directly,
which is not to rip on this at all, but just sort of want make
sure to highlight that Madam Chair, that we should consider
having the assistant attorneys
[23:05] general in. And I think is that
something you're considering Madam Chair? Yes, we are
considering a thank you. Thank you. And then the other
thing was just process wise.
[23:12] Madam Chair, if you can provide
guidance when Mr, Gandhi sort of doing a presentation and
have time for member questions
[23:18] at the end. And I've got quite
a few with my colleagues do as well. And it's something we're
kind of. You can just give some
[23:24] guidance for certain how we
should be for the I'm very happy to do that and want to
listen to him the full way through and to be able to ask
him a few questions. But I want
[23:31] to know what your preferences. >> But I think it's good if you
have questions on a particular
[23:36] item, he's discussing to raise
it at that point. But we don't want to get too far in the
weeds. We want to finish the
[23:42] presentation. So, you know,
just, you know, all rain it enough. It seems like we're
getting too far afield. But the

[23:49] ideas is has is he's discussing
a particular case, for example, if you have questions on that
particular example, feel free
[23:56] to to signal that. >> And then maybe chair, then
just as a follow-up to that then. So then assuming we're
not asking all those questions
[24:03] on the way, there will be time
at the end that ask about your questions. Yes, great. Thank
you so much. Thank you, Mr. Dylan, thank you, Chair Vice
Chair Anderson.
[24:11] >> Thank you. I do have a
specific question about the terrible case. So
[24:18] I understand that raft or to
them and the fact that with the actual providers with Jen that,
[24:25] >> these services or even using providers that they were given
to the Twin Cities.
[24:34] >> Mr. Go on that. Madam Chair. Again, the details
of that. I don't have a life
[24:41] fingertips. I want to see the
answers both, but I don't want to speak out of turn. >> And I would just be for
members to your packet. There's
[24:48] a very detailed account of it
in the attorney general's press release that I think speaks to
that. So.
[24:54] >> Right. And Madam Chair and
representative and as I believe, if you go to that, if

you can Google that press

[25:01] release, there's a link in the

press release to an actual indictment that was filed that

has played more detail. And so

[25:08] again, I don't have to said my

my beck and call. So I'm not going to go out on a limb and

answer definitively.

[25:16] Thank you, Mister Gotti's

continue with your presentation and I represent Pinto. I think

I will resist who have returned

[25:22] to my actual presentation here

and the eye been hung up on the feeding our future because it's

the biggest one, but did want

[25:28] to mention a couple of other

items which I alluded to earlier this morning. But try

to get to that 500 million

[25:36] dollar number that

Representative Eric was referring to. I think if you

look at the data, it's hard to

[25:41] come to a different conclusion. Legislative auditor put out a

very, very detailed report on

[25:48] form Education's handling of

just a feeding our future, nonprofit it rich in detail

finding out who said what when,

[25:57] who knew what when dollar

amounts heavily sourced and the

[26:02] large bibliography they had a chart in there that
showed the total program
[26:07] spending is actually 2 programs
as the child and Adult Care Food program and the Summer
Food Service program. They're
[26:14] both from the U.S. Department
of Agriculture. But their local agent in Minnesota is the
Department of Education.
[26:21] The details well with the
school and stuff. So they're the agent for the USDA here in
Minnesota. And they showed a
[26:27] chart of the total dollars that
went out from those 2 programs in Minnesota to all recipients
and their hundreds 100's of
[26:35] nonprofits, churches, YMCA,
these schools that participate
[26:40] in one or both of these
programs, heavily daycare related for obvious reasons and
total together the total amount
[26:48] of dollars that went out for
the year 2021, which was the peak year of the fraught,
[26:55] the total amount of money that
went out the door in 2021. To just feeding our
future was 42% of the total of
[27:05] the 2 programs. So short of
half 40%, 2 fifths of all the dollars that went out in that

one year went to one nonprofit

[27:14] other hundreds 100's of

nonprofits from memory. The number of different sites Re is

over. 1000 reaches in the

[27:22] thousands. This one nonprofit

is the middleman for hundreds of sites, took out over

200 million dollars from the

[27:29] program. More than 40% of the

total. If you add in the next 2 largest nonprofits, these

middlemen who courtney between

[27:39] distribution sites and the

Department of Education, you get to more than

two-thirds,

[27:47] actually 70%, 7, 0%, of all the

dollars that would to these 2 programs to feed low-income

hungry children were taken out

[27:54] by 3 nonprofits, one of whom is

in court starting again on Wednesday on trial for multiple

counts of fraud and money

[28:02] laundering conspiracy. The

second largest one was called partners in nutrition, and it

did businesses partners and

[28:09] quality care. It was the second

largest nonprofit and the 3rd largest one was

called Youth Leadership

[28:16] Academy. And I mentioned that I

had put into the packet a

[28:21] lawsuit filed again by a

different set of people at the attorney general's office.

They have the fraud unit.

[28:27] They also have something called

the charities division, which oversees non profits in the

state, you know, get back to

[28:33] that as well. But they sued in in state court in a civil

lawsuit to dissolve the 3rd

[28:39] largest tissues leadership

Academy Youth Leadership Academy actually had been shut

down a month before the FBI

[28:46] raids by the part of education.

They took the extraordinary step of banning the officers of

that company from participating

[28:53] in these food cases. The Youth Leadership Academy,

Sue them in state court may be

[29:00] in federal court too. Last of

those cases. And again, the attorney general sued them and

had the corporate entity

[29:07] dissolved and the partisan

nutrition and use a leadership academy. Their names have come

up over and over again in the 2

[29:16] trials that have been conducted

in the fraud case. One was conducted last spring starting

April ended in June of 7

[29:23] defendants, 5 who were quick
for were convicted, 2 acquitted and the current case that began
in early February. Their names
[29:32] have come up over and over
again. But nobody associated with
either of these entities has
[29:37] been charged with any criminal
wrongdoing. And I don't know if anybody suggested that criminal
activity took place. But again,
[29:45] if you look at the attorney
general's lawsuit, you look at the evidence that has come out
in the feeding. Our future
[29:51] trials is clear that these 2
entities were not operating
[29:56] within the parameters of the
program rules and have both been banned from participation.
So how do you categorize that?
[30:02] It's not. Rob is a waste and
abuse not having a dollar associated
with these 2 individuals.
[30:09] I think they're part of that
500 million that I cited for my work and perhaps the U.S.
attorneys work as well, but not
[30:16] part of the 250 million that
U.S. attorney has assigned to feeding our future.
[30:22] >> Mr. Gaunt. That could

interrupt for one moment. Just to provide some context
for the members. I did some work on this over the weekend.
And the group you're referring
[30:30] to partners in nutrition. >> They. >> Total
[30:37] 214 million dollars between the
years of
[30:43] 2017 2022. Before they were
shut down 214 million for this group.
[30:50] The other group Youth
Leadership Academy also known as guard our Family Services.
Interestingly, they started in
[30:56] Fy. 21 with just $21,000
[31:02] in Fy. 22 that went from 21,000
to 26 Million.
[31:08] And so their total was just
under 27 million in those 2 years. And they were the
subject of the attorney general
[31:16] lawsuit that honestly just was
resolved share in December of
[31:23] 2024, the resolution of that
settlement was that they were
[31:29] required to dissolve, but all of their assets,
interestingly, rather than going back to the state,
[31:37] going to be allowed to go to a
new nonprofit. So I think this is an ongoing concern members
and something will, of course,

[31:45] see attorney general about one his staff comes. But clearly
they've done great work in the
[31:51] attorney general's office in
identifying this. But those 2 totals, 214 million from the
partners in nutrition. And
[31:59] another 27 million from Di Youth leadership. Academy
were not counted in that
[32:06] original 250 Million. So just
to provide some context of the scale here. Thank you, Mr.
[32:15] >> Representative Eric, thank
you, Madam Chair. Just really quickly to that point on that
in the same document we have in
[32:20] front of us, I again, you know,
having worked many years and nonprofit, it was astounding to
me that this the group Youth
[32:28] Leadership Academy also known
as guard. Our family services, had 2 board members.
[32:35] >> So if anyone had even looked
little bit behind the curtain, Madam Chair, just just a peek
behind the curtain, they would
[32:41] have said something is up here. They're
not registered. So they failed
[32:46] to register with the attorney
general, one red flag. They had 2 board members,
[32:52] 2 red flags. Revenue just skyrocketed.
So so quickly, like you said,

[32:58] they landed at 27 Million.

So it's not that hard. You know,

like the oversight is and how

[33:04] hard we should have to rip Mr.

Ones Point the state failed to do

even the bare minimum of

[33:12] looking behind the curtain,

Madam chair and this is a prime example of it. Thank you for

that.

[33:18] Thank you. >> Mr. Khan, please continue

present Smith, Madam Chair. So but to your point that you

just made, quote, the U.S. that

[33:27] the outgoing us a chain, the

former U.S. attorney, Andy Luger, the 250 million dollar number

is Florida on a ceiling and

[33:35] also quote, him in an exit

interview he did right before he left office in January.

Minnesota has a fraud problem.

[33:42] And I put up the just happen to

have his photo from that press conference that we've

referenced a couple of times

[33:49] Dino Winter, who's now with the

Star Tribune. But the time she wrote for Mister Reformer and

she did interesting deep dive

[33:55] into a lot of the number.

A lot of the people who had at that time been indicted in the

case and found that nearly half
[34:03] of the people who have been
indicted in the food fraud had other businesses taking money
out of the state government.
[34:10] And you mention the kind of
business model and the the business model seems to be this
portfolio again of all the
[34:17] programs. And so just so I I don't forget them here.
And the reason that allows so
[34:23] the including but not limited to
child care, adult day care, autism clinics, personal care
assistance programs, if there
[34:31] was a state program that
provided money to nonprofits or even for profit, stay had.
And
[34:37] and we mentioned the
interpreter services, the transportation services, and we
have heard well, and in fact,
[34:42] one of my items there is a some
cases, some indictments in the Autism clinic case. And there
are connections between many of
[34:51] the people who are indicted
feeding our future. They own childcare. Business is the only
adult day care businesses.
[34:56] In some instances they were
accused of stealing. Maybe

[35:01] hundreds of thousands are a
couple of million dollars from the state through the food
programs and they had other
[35:07] businesses, perhaps a legitimate, perhaps
not taking millions, if not tens of millions of dollars.
[35:14] And I wanted to call your
attention to another item on the tracker, which was the
subject. And I have the summer
[35:23] you put the I'm not very good with this.
[35:35] Well, as in the article and it
was done about feeding our
[35:40] future defendant who had been,
she's one of the few people appear on my tracker more than
once. She was indicted as part
[35:48] of the federal case in 2021
where she was involved in a group defrauding the state
through interpreter services.
[35:55] She worked for interpreting
company and she was indicted in that case and again from
memory. It was 50,000 $100,000.
[36:03] She was accused of taking for
that. She took millions out of the food program as part of the
feeding our future scan.
[36:09] And she was indicted in that
she has pled guilty in both cases. So I want to call your
attention the fact that she had

[36:16] been indicted in federal court
by the U.S. Attorney's Office for one scam. While the other
scam continued and she
[36:23] continued to receive money from
the Department of Education. So what we have here, including
everybody failure to
[36:29] communicate from the old movie with the anyway. So we
have this and NPR news article
[36:37] in your packets that talks
about defending our future defendant number 33
[36:43] and how she was double dipping
from from the program. So it just seems that agencies are
talking to one another and not
[36:50] sharing information with one
another. And again, I've been following this for years.
There were a couple of hearings
[36:56] that were held by the state
Senate a couple of years ago when this
was still a fairly fresh
[37:01] scandal. And what they had done
is brought in the leadership, then leadership not there
anymore. Then leadership of the
[37:09] State Department education
answer questions about their oversight of feeding our
future.
[37:14] They told their story and I've

seen we're either this committee or other committees
here at the House or the Senate
[37:20] have brought in leadership from
the leadership from the Department of Education or is
yeas UK shun are human services
[37:28] where the message has been?
Well, just because somebody has been accused of or indicted
from stealing from one agency,
[37:37] that doesn't mean we could stop
the money going out from our agency in this queue says
either due process or
[37:44] limitations and state law and
hopefully we can get that resolved where it's more
important to get the money from
[37:51] not going out the door that it
is trying to recover 8 years later, trying to bring cases in
court that can take years to
[37:58] prosecuting, get to get to a
verdict on. It would be much easier and much better for
everyone involved to not let
[38:06] the money go out the door.
So there needs to be some sort of enterprise wide level where
we we do
[38:13] something and I know we'll get
to this in the where the solutions portion of the of the
hearing.

[38:18] But I just want to emphasize
there isn't anybody at that level today we've talked about
the legislative auditor who
[38:26] does great work. We've talked
about that attorney general who does work in both overseeing
nonprofits to the charities
[38:33] vision and in just a gating
Medicaid fraud to that unit. We have the U.S. attorneys
office who's done great work in
[38:40] prosecuting the feeding our
future. They have their silos. So and what we've seen is
fraudsters who work every
[38:47] program. There is multiple
programs and made seeing various levels of success.
Again, a recurring theme.
[38:56] It is defrauding one program taking
money from another. I know you
[39:02] had the really come in and talk
about her. Her report from a couple years ago about grants
oversight and from her report.
[39:10] And if again, from memory do
something like 27 different state agencies give out grants.
[39:16] And so when you have a
situation where somebody has been defrauding or abusing one
program, the other 26 need to
[39:23] hear about that. There needs to

be a universal list of the do not defraud list of people we
shouldn't be giving money to.
[39:30] Is this been well established
that they've been abusing your ripping off of one of the other
programs? So we so we need to
[39:37] do that. And I I talked about my list and how
it was put together. There's
[39:43] nobody really in state
government or at the federal level who's in a position to or
as an incentive to try to come
[39:49] up with a global list. All
we've done is scour public services to try to come up with
ones I believe should belong on
[39:55] here. The question I get a lot is why
not? Why isn't next on the list? Was that in Lars on the
list wasn't ensure on the list.
[40:03] Lots of other stuff. Southwest
Light rail would certainly qualify as abuse or waste.
[40:10] No hint of criminal activity,
civil lawsuits. It's it's
[40:16] epidemic in the statement.
So as a 5 Paul problem and I hope you do get to talk to Andy
Luger because he did that great
[40:21] interview. He talked about how
this was the largest, then speaking of feet in the future.
This is the largest single

[40:27] COVID related fraud anywhere in
America. And he said it didn't happen
other places. I've been
[40:33] contacted by people in other
states. I did a television interview in Alabama where they
had almost identical this
[40:40] fraught, but it was 6 million
dollars. It wasn't 500 million dollars so that it happened.
But it didn't happen at this
[40:48] scale anywhere else in America.
So again, and we have this
[40:53] going across state government. We have these great
institutions that are doing
[40:59] great work in Minnesota.
I'm sure their cases to be made for getting more resources to
the IT. Attorney General's
[41:05] office is in these 2 areas to
giving more money to the office
[41:10] of legislative auditor. Their
probe proposals floating out there to create a inspector
general for the entire
[41:18] executive branch to to
consolidate this and one place in state government. I know my
colleagues sitting off to the
[41:26] wings here, Bill Walsh and I
both are a number of an idea where we would give more power

to the elected state auditor to

[41:34] go after fraud at the at the

state level rise and that the local level. And so I'm happy

to talk about the pros and cons

[41:41] of of all of that. But I know

there are many member questions. So I've got more to

say, but all think I'll say it

[41:47] in response to queries. >> Thank you. Appreciate that,

Mister Glenn, I know that

[41:54] you've said you'd have a

section on solutions. So is that your discussion about

empowering the elected state

[42:02] auditor? Did you have more to

say on that? Before we go to questions? >> With with your invitation,

Madam Chair. So I talked about

[42:09] those and those entities.

You need somebody who has an enterprise wide

perspective who lays it in a

[42:14] silo of the specific agency or

a specific program or, you

[42:20] know, again, I would argue even

the specific branch of government, the legislative

audit does great work. But the

[42:27] proposals I know many bills

have been heard in advance with the idea of creating this

[42:33] the inspector general for the

entire executive branch and which does solve the
enterprise wide problem that
[42:40] they would presumably be
empowered to go after any state agency to ensure compliance to
prevent fraud. But make sure
[42:48] that and we heard this from
grants management, everybody's on the same page on the same
rule book.
[42:54] My concern about that is personnel is policy and what we
saw in the see cap program.
[43:00] And again, I don't want to to
use the word relitigate that a fiasco. But you had somebody
serving in the inspector
[43:08] general position in the
Department of Human Services who, again, in my opinion,
didn't seem all that is fired
[43:15] or interested in investigation
are inspecting. And so nothing really happened with that.
And there were some indictments
[43:23] and convictions in court.
The legislative. I did an excellent report which I quoted
from here this morning. But
[43:30] that thing according to the J
Cole's the media reports school continues. And that doesn't
seem like he's ever been
[43:36] fundamentally addressed.

And so if you have somebody in a position of inspector general, so we are counting on [43:42] to go after fraud, ensure compliance with rules, regulations, laws that make sure that standards are being [43:48] met and they're not interested or they have other agendas. In the end, you just created another position in the state [43:57] bureaucracy. So I'm a little concerned about that as the the silver bullet approach, maybe we need more of a all the above [44:04] approach where you do put more staffing resources to the auditor. Again, why I like the idea of empowering the state auditor, [44:13] this elected to the position already exist and its elected. So you have the concern of to whom is this [44:21] person responsible? So the inspector general, again, my opinion of the DHS wasn't [44:28] responsible are answerable anyone. So and when that person didn't do the work or didn't like the approach that was [44:35] being suggested, the nothing happened. So the inspector general for the state executive branch, presumably they report [44:42] to the governor. I don't I

don't know if it was. I don't have that for me. Was there a
Senate confirmation aspect of
[44:48] it to that would be helpful.
But depending on who gets put in that position will make or
break the the position. It's a
[44:55] it's a great person who's
really going to go after fraud and look at making sure money
[45:02] goes out. Doesn't go out the
door more concerned than say future prosecutions. It could
be super helpful and saving
[45:08] resources for the state and
they're going to be up for re-election or election next
year so they can spend the next
[45:17] 18 months or so going to the voters making
their case on why that personally, a better state
auditor go after state fraud
[45:25] and they would be answerable
every 4 years to the electorate. If the electorate,
the voters, the citizens of the
[45:31] state, didn't think they were
doing a great job than the pixel many due to do the job.
But when you have somebody who's appointed are appointed
by an appointee, then it's a 2
[45:40] steps removed from from any
level of accountability. So I have that and because I
have the floor, Madam Chair,

[45:48] I'll I'll just go ahead and go
through my red flags because Representative Eric brought
them up. We had over and over
[45:54] again, the instance where
somebody had been incorporated literally yesterday and was
suddenly billing for thousands
[46:00] of meals per day. They didn't
have food service license is they didn't have any of those
niceties. Didn't have a border
[46:06] directors, but they were
incorporated with the secretary of state's office had not
applied to receive. They
[46:12] tax-exempt status from the IRS,
but they're already building the state government for
services rendered.
[46:18] And again, that's another one
tax exempt status. In many cases, a nonprofit loses their
taxes and status with the IRS
[46:26] because they haven't filed tax
returns. Easiest path to have your
status revoked and I forgot his
[46:33] 3 years. You'll find return
that your status is revoked pretty much automatically.
The IRS form 9.90. If you read
[46:40] a few of them, they're not that
complicated. Won't take the lead long to fill out. So I

would recommend that before

[46:47] state government gives out

grants to nonprofits that they require that this nonprofit

will have existed long enough

[46:56] to have filed and made public a

full year's worth of tax returns. That 12 months you'll

have to file calendar year.

[47:03] You can file fiscal years, 12

months tax return had been filed with the IRS. That does

stuff like list the board of

[47:10] directors and the compensation

of officers and executives and

[47:16] he'll basic information about

who this organization is and what it does. And it was seen

to be that that level of due

[47:22] diligence would be an automatic

before state money would go out the door. But we had these

examples of people in

[47:28] tax-exempt status or revoke

status. People who had just incorporated had never filed a

tax return. Again, we talked

[47:36] about registration with the

attorney general's office and the charities division. And that was a red flag as well

where people that are around

[47:44] but had and hadn't taken that

step. And so they weren't on the radar. The attorney

general's office who could have

[47:50] looked into this, but the

attorney general's office deals with charities. The purpose, as

I understand it of that office

[47:56] is to regulate as a consumer

protection effort to make sure that donors, people, mom and

pop and regular folks like

[48:06] everybody in the room here

writing checks to the Red Cross or Salvation Army, that

everything is on the up and up

[48:12] and and that they know their

donations. Their charitable contributions are going to the

cause for which the

[48:18] organization exists and organization that is

nothing but a conduit for

[48:24] government money seems to be a

qualitatively different thing. And I know we have these terms

and they're all used

[48:30] interchangeably, nonprofits in

geo's on governmental organizations. One of the ideas

I've had for a while is to have

[48:37] a to tear. It isn't quite the ad

but represent bifurcated system where you have people register

as a charity whose intent is to

[48:46] raise money from private donors

to do what we think of his charitable work to you,

[48:54] the help sick people to do
distribute food. A lot of these other things, but those same
things that become government
[49:02] operations as well. Government
responsibilities where they have
[49:08] in a lot of instances delegated
it to nonprofits to conduct. And if you look at feeding our
future and he's others names
[49:15] that we've mentioned, there are
100% government-funded. All they did was take money from
state government.
[49:21] Sometimes it's county
governments. Some of these nonprofits, I remembered
digging into the men. They were
[49:27] getting money from at least half a dozen different
agencies. They would take money
[49:32] from the Department of Human
Services, Department of Health, the Department of Employment,
Economic Development there on
[49:38] the job training programs.
They were taking money from the part of education for the food
present programs were taking
[49:44] money from the legacy, the
legacy program for cultural and arts programming. And then they
were also taking money from
[49:50] county governments and city

governments. Again, I know you can do with that at this level,
but again, whole portfolio.
[49:58] But the one thing was known,
not one dollar from a private donor. They had this lot a lot
of contracts with government
[50:04] agencies. And it seems to me
that that's a quality Lee qualitatively different kind of
organization, one for which I
[50:12] don't think the charities
division of the Attorney General's office was really
designed to oversee perhaps that needs oversight
through Department of
[50:18] Administration Management,
Budget Department revenue, something like that where they
have looked into
[50:25] these folks who don't take
money from small dollar donors, private donors who are only
taking money through government
[50:31] contracts and regulate them in
a in a different way. And again and getting a little
off topic myself here, I
[50:38] discovered the existence of a
something here in Minnesota and it's in other states as well.
[50:45] I call it the nonprofit
for-profit and technically it's called a public benefit
corporation. And we have

[50:52] something called the Minnesota
Public Benefit Corporation Act, perhaps not seeing it exactly
right. But it's a for-profit
[51:00] company. It's incorporated the
same as you would. And that's corporate see Corporate LLC,
something like that. But it
[51:10] wants to operate and get the
benefit of the doubt of being a nonprofit. And so they're not
in the t***** business of
[51:19] trying to make a buck but to
serving the public. But the problem I have with it is it
doesn't have the level of
[51:25] transparency that actual
nonprofit asked for nonprofit yet to file that form 9.90.
If you're a nonprofit, you're
[51:33] supposed to register with the
attorney general's office and the very handy search tool.
We can search a nonprofit and
[51:39] you get a ton of financial
information for each one. But if you're a private company
[51:44] whose incorporated as this time
near a hybrid public benefit corporation, you
are legally a non. A for-profit
[51:53] companies do not have tax
exempt status. You do not have to make your tax returns
public. You do not have to have

[52:00] this registration with the
attorney general's office. I don't think so. The amount of
information, the transparency
[52:06] of the operations of the
nonprofits, again, the food is food.
Sherry, I did an investigation. One of these companies and the
incorporated as a food charity
[52:15] and somehow didn't spend a
dollar on food. I figured this out by reading their form 9
90's, the FBI agents in the
[52:23] auditors who testified in
federal court in the last week did the same thing. They went
through 9 90's. They had access
[52:29] to all the bank account records
of a lot more data than I had. But they can figure this out
through fairly
[52:36] easy. Looking at basic numbers
at the sting was not on the up and up.
[52:42] >> So Mr. Going if I can jump
in. Your did did any of the groups that were part of
feeding our future? The other
[52:47] groups listed on that tracker
here? Are any of those these public benefit corporations to
your knowledge or are they on
[52:54] the profit? >> They're all in on this case
are excuse me, Madam Chair, to my knowledge, all of them

are nonprofit the public

[53:01] benefits. That thing came up in

a different context and it was with the Department of

Employment, Economic Development. And so I know if

we want to get to that has very

[53:10] deep in the weeds, just a

couple of other recommendations and to ask for recommendations.

And again, I am super careful

[53:18] saying this. I have huge and I

I know if I know all of you personally by huge about

respect for each of you

[53:23] personally as individuals and

as state representatives. But I would have if not in

statute, a House rule and I

[53:32] would hope the Senate would

adopt a similar rule that if you are an elected

representative currently serving, you are not allowed to

serve on the board of any

[53:39] nonprofit or public benefit

corporation receiving state funding.

[53:44] It seems like a pretty basic.

I heard a lot of interest, a provision. And and again,

[53:52] I'll go back to my days along

with Mr. Walsh of being at the Department of Commerce where we

had

[53:58] working under us again, government outsourcing

government functions to the private sector. We had a number
of these community action
[54:05] agencies working for the
Department of Commerce's Energy division. They were handing out
the light heap grants
[54:11] and for the most part doing
good work. But there was one in located Minneapolis who the CEO
and his son ended up going to
[54:18] federal prison because their
mismanagement of that and a weird creature of I believe,
1960's, great society. These
[54:27] community action agencies by
law have to have elected officials on them and their
boards. So they did. And again,
[54:34] it creates an obvious public, a
conflict of interest. And again, no legislative earmarks.
You know, we've had we've had
[54:42] just we can get into that if
people want to about how there are written into session
law, appropriations directed at
[54:51] a single nonprofit and which
bypasses all that grants management stuff, all that
agency over say stuff we
[54:58] discussed earlier and then my
statewide ban list. If you've cheated one program, then you
don't get money from any other

[55:03] program but that the
legislative earmarks, again, we have we had processees that
department Commerce. One is
[55:09] there. We have processees in
all 27 grant making agencies that go through and do some of
this due diligence we've talked
[55:17] about before part to prom with
feeding our future was all that got delegated to the feeding
their future through a contract
[55:24] they had with the Department of
Education. And so driving around, looking
at the sites would have would
[55:29] have raise red flags should not
allow these locations years earlier than they were shut
down. But again,
[55:37] I would recommend and it's
something I think the feds had adopted at one time were
Congress did not allow your
[55:44] marks from members and I would
recommend the same thing. Thank you, Madam Chair. Thank
you, Mr. Gunn, representative
[55:50] or >> thank you, Madam Chair, that
there's so much there on the
[55:55] start line. So one day as we've been kind
of mowing through some of these
[56:02] items in the sots in these kind

of proof for nonprofits for weeks now,

[56:08] something that we've been

talking about is the salaries of the Thai Leah's highest paid

people in the nonprofits.

[56:16] And I as I've been reviewing

nonprofits, some of them are reasonable. And I've actually

been doing this work in the

[56:22] hair, a committee. So I serve

inherited this budget as the higher Ed tear. But every

single not every single entity

[56:31] that is organized as a

nonprofit has come before our committee. And so I've looked at their 9

90's are audited financial

[56:37] reports to make sure they have

an Iris determination letter, make sure that they have a

current status, make sure they're registered with the

secretary of state and the

[56:44] attorney general. But one thing

I've added to this list is the salaries of their highest paid

people, which of course you can

[56:50] see and then I-90 and many of them

[56:55] are way above the governor.

And the reason that's important is because, as you know, the

subcommittee on employee

[57:01] relations exists in the

legislature so that if any and a local government wants to pay

anybody more than the governor,

[57:10] they had to come to the

legislature and get permission to do that. And it had to be an

action that we took in the S E

[57:16] R now last buying that was done

away with, unfortunately, the SE ares authority was

gutted,

[57:22] but nonetheless, that had been

standing policy for decades. So that's one thing that I'd

like to add your list is that

[57:29] we actually somebody review the

salaries of the highest-paid people within these nonprofits

and many of them make

[57:38] what the governor makes, if not

2, 3, 4, 5, times more. Another thing that you would

kind of gotten to is the

[57:45] charitable work for says kind

of government works charity as we think of Lake. They're, you

know, doing grants to nonprofit

[57:52] our grants show foundations are

doing fund-raisers, not they're getting money from individuals

[57:59] as opposed to existing only to get government

money in government grants and

[58:05] then doing the service kind of

like a government NGO, a non government

organization doing government

[58:11] work. So another thing that we've
been talking about, you guys want to get your feedback on
those. Those 2 things to the
[58:18] other thing is making sure that
we're looking at how much government money they're
currently getting as are coming
[58:24] from or grants from the state. Some of them that I've looked
at in my committee,
[58:30] maybe about a quarter or
government grants. Some of them are 70 like and they go one read
time ahead. That's over 70%
[58:38] government money coming through. So those are 2 quick things
that I've ever I wrote down
[58:44] everything that you said and I
and I do like them. But I just wanted to get your thoughts
about looking at the salaries
[58:49] of the highest-paid people and
then the looking at the percentage of government money.
And I guess I would add one
[58:55] other thing because of the
legislative auditor said it. And the Officer Grant
Management said it, which is
[59:01] the capacity to use the grant.
So if you've got say a nonprofit that they're in their
previous year had a revenue of
[59:07] 1.0, 5 million and yet they're

coming to the state for 10 Million. Maybe there's an
issue there. I rode race that
[59:13] in the Energy Committee last
Biennium. But in any case the capacity to use the grant,
[59:19] I would love feedback on those
2 things. Madam Chair, thank you. Representative Eric
M are gone. >> Madam Chair, Representative
or Erica? Yes, definitely the
[59:26] red flag salaries at the
nonprofit level. I mention the community action,
Minneapolis. That was a red
[59:33] flag that you look at what the
CEO of that nonprofit was getting compared to his peers,
nonprofits, it was
[59:43] disproportionate. So there was
definitely a red flag there and that person up serving some
time in federal prison because
[59:49] of a defrauding that nonprofit
who almost exclusively worked with
state programs. They did not
[59:56] just the energy program but a
bunch of other different programs head start that sort
of thing.
[1:00:01] I also see exactly the
opposite. We have a mention profits who didn't exist
yesterday and today they're

[1:00:07] billing for serving thousands
of meals. Many of them never file a tax return. So they came and went the for
berths into existence and they
[1:00:16] died an unnatural death.
And you never got around to notifying the IRS in between.
So there was nothing
[1:00:23] that was one of my
recommendations that they be around long enough. You have a
9.90, to look at. A lot of these came and went before they
could even filing 9.90 and then
[1:00:31] when they never will. So
there's that. And I saw other examples were people did file 9
90's, but you can tell it was
[1:00:39] somebody did it look like it
took him 10 minutes to do it. They had our revenue number had
a expenses number. None of the
[1:00:47] expenses were itemized. The
mighty God for salaries. They might have gone for food.
We don't know. There's only 3
[1:00:53] numbers in the entire tax retur
revenue expenses and the net. So not all of them are as
diligent as they are supposed
[1:01:01] to be under IRS regulations are
as they should be for your purposes and trying to vet
them. And so some of them would
[1:01:08] list no salaries of that line

would be slick blank because really all that all that was
lumped into this other category
[1:01:14] or or or that. So I did want to
make a related point. I think
[1:01:20] about salaries at the NGO level
and some of them are again done
[1:01:25] in a way that they can skirt
the pay limits. You know, as a deputy commissioner, I was
limited to the dollar amount.
[1:01:33] I could be paid in state
government and and many nonprofit executives
make
[1:01:39] many times that sometimes 7
figures and, you know, maybe the
organization's large enough to
[1:01:45] justify that. But it's
certainly something worth a question or 2 in a committee
hearing about, but also on the
[1:01:52] other and something that we've
seen where by outsourcing
[1:01:57] government functions to
non-governmental organizations, you not only escape the law
about how much you can pay
[1:02:04] executives, but you also take
advantage of their ability. The NGO's ability, the
nonprofit's ability to hire at

[1:02:11] the bottom end of the scale.
So somebody's doing the same work somebody would do in state
government or county government
[1:02:19] or city government delivering
the services. They're able to get somebody on their payroll
and pay them lower than the I
[1:02:26] forgot what they will because
the state level at GS scale from my days in the feds
[1:02:32] or they're using volunteer
work. You're not paying people. So people who would be paid if
they're working for county government to deliver social
services, they're counting on
[1:02:40] volunteers to do that. That
leaves more not more profit on the bottom line for a
nonprofit. So
[1:02:47] when you outsource government
functions to non government organizations, you there's a
whole
[1:02:53] list, a whole portfolio
pantheon of laws that you get to skirt
[1:02:58] and then quickly refresh me and
what your other point was, I can round up and represent
wrecked last point that will go
[1:03:05] to tap into. >> I think you hit it. I was
just talking about the great capacity. So I talked to vote
but the senators are getting

[1:03:12] from government overall.
If it's more than say 50% kind of like when you do a bonding,
you have to match.
[1:03:18] That's the salaries which you
spoke to. And then they're even capacity to even use the grant.
[1:03:23] >> That was a 3 and madam chair
of the ongoing I wrote a piece on our website last week.
You know, we think this is
[1:03:31] horrific stuff at the state
level. 250 million, 500 million dollars out the door.
[1:03:37] The EPA Environmental
Protection Agency is is looking at 20 billion dollars who are
sent out the door again.
[1:03:45] Same story. This is a Delaware
company founded just a few months ago. Didn't have any
employees. They got a 2 billion
[1:03:54] dollar Grant Grant was the
basically no streaming. So again, when I was an analyst
here at the House, I would look
[1:04:02] for those earmarks, the scene
that I was kid caught my eye for capacity building, sir, for
capacity building purposes
[1:04:09] because that's just you can use
it for whatever you want. And again, we need to tighten
up that you're giving money.
[1:04:15] And, you know, you're getting

the results that you are seeking from that Grant. >> Thank you, Chair Pinto.
Thank you, Madam Chair, and
[1:04:22] thanks for your lawn. And you
know my desk another, you finish your presentation.
I think bunches of a number questions want to make sure to
benefit from your information.
[1:04:29] So make sure to get to the
questions if you're able to keep your here and just really
focus to be most appreciated.
[1:04:34] So the first question is just
about your back on because you're you're here. I'm sharing
your expertise with us in just one of the source of that
expertise. And my understanding
[1:04:42] is that you're a researcher and
that is part of that. You review reports, news articles
in court filings sort of what I
[1:04:48] might call secondary research.
You don't yourself have a background in academia or and
forensic investigation or law
[1:04:56] enforcement or prosecution.
I think you've been I have an MBA, some schools it, by the
way, go go Cavaliers and then
[1:05:03] as well work in energy policy.
The plenty Ministration worked in the House Republican Caucus
worked it. It's the but just
[1:05:09] could you just sort of the

source of your expertise and that you're sharing with us, Mr. Khan.

[1:05:15] >> Madam Chair, Representative

pitch to chair Pinto. I'm I'm glad you brought up our shared

experience of the Darden School

[1:05:21] because remarkably enough, a

lot of what I put to work is that stuff that you and I

learned in first year

[1:05:27] accounting I took a corporate

finance track. I don't know what your expertise was, but I

took a corporate finance track

[1:05:34] in my second year and is a

representative for Eric's Point. You know, you don't need

to have a CPA. I do not have

[1:05:40] the CPB only a CPA if you know

how to read a balance sheet if you know how to read an income

statement. A cashless

[1:05:45] statement. If you look through

prospeccht, I then you you see

[1:05:51] the red flags with a lot of

these organizations. And again, that's why frustrated with the

public benefit corporation that

[1:05:59] I don't think I'm gonna be able

to look at their tax returns as a guy who I spent a little over

years, a corporate controller

[1:06:06] in my corporate life filing

those tax returns was at the Sarbanes Oxley Act. I had the

sign and the lot and some
[1:06:14] document that all the numbers
on our financial records are true and correct. So are
relying on that experience in
[1:06:22] particular. But I I mentioned once or twice
being a deputy commissioner Comer's, we had grants that we
were giving out 2 nonprofits
[1:06:32] and I was on the hook for, you
know, whatever went wrong with that. And and, you know,
testifying on behalf of
[1:06:41] department commerce on our
budget bills and you all the money we sent out the door
being on the other side of the
[1:06:48] legislative auditor report.
As much as I praise the work of the legislative auditor's, not
always comfortable be on the
[1:06:54] other end of the receiving end
of of their their hard work. And then having been a staffer
here for many years in helping
[1:07:05] committee's review bills,
construct bills passed bills and I did a lot of the vetting
for our communities, whether
[1:07:12] was ways and means or chair or
flows jobs committee of the nonprofits who did get earmarks
and those trying to make sure
[1:07:20] that we were putting money out

the door to organizations we were going to regret later on.
[1:07:26] >> Happen to thank you, Madam
Chair, and thank you, Mr. Go on. And actually, that's
that's hopefully to my next question. I I we shouldn't have
to confirm this, but I know
[1:07:34] you've got of that political
background. You described you also describe this research
background. I'm assuming that
[1:07:39] you say that you're here as a
researcher, providing accurate information and
complete information for us to
[1:07:45] make the best decisions.
You know, you you put your put your finger on the scale one
way or another guiding things.
[1:07:51] There's not a political agenda.
There's a trying to inform us of the best information agenda
or perhaps I want to give you
[1:07:57] the opportunity to to to to
assure us kind of how we should be thinking about you,
[1:08:02] Mr. Glenn, a. >> And Madam Chair,
representative tonight, I'm not sure I'd answer that how you
should be thinking about me.
[1:08:10] I really I really and every my
work for the center is a policy fellow to be as accurate as I
can. Anybody who's read my work
[1:08:17] and I think in get the gist of

of my political leanings of my ideological leanings, which I think explains unfair detail to you this morning. Again, when I write stuff for the website, I try to have everything, which is why I don't think I mentioned it by included as page 3 of the fraud tracker, citations ability RV page for each and every item that I put down there. So you represent up into your your your research staff can go and verify this. And if I made a mistake and I not infallible called to my attention on the happy to correct the record, correct the tracker which we keep this posted on our website and there's a number I type wrong or a wrong linked to the source document then be happy to to fix that. I see my view I or my role here today. Is that being the view of one of our policy fellows? I'm trying to recommend recommend to you what I think is good public policy as it relates to grant making and the regulation of nonprofits and some for profits in the state of Minnesota so that taxpayer money can be

preserved for the things that we all agree we should spend
taxpayer money on and when they
[1:09:29] dollars stolen in fraud, that
dollars not available to feed a hungry child or to house the
homeless or to build a road or
[1:09:36] any other things that we do a
state government. And so again, more than normal life, trying
to keep the sarcasm a out of
[1:09:44] the my speech year because I
think this is a ultra serious topic that deserves. And I
believe you're giving it a
[1:09:50] spirited deserves in terms of
what are the solutions, how do you keep money from going out
the door? So
[1:09:56] in the future, the equivalent of the
611 million will go out the door and not be available for
you to appropriate for other
[1:10:02] purposes. >> Thank you, Mr. Gunn the
champ and just interrupt for one nominees. Yeah, I and I
appreciate your solution
[1:10:10] suggestions because the
solutions that you suggested to us are things that other people
have testified before. The
[1:10:17] committee from different
quarters have also suggested in terms of enterprise wide
[1:10:23] flagging of grants that our

problem in one area and so other agencies know about it,

limiting

[1:10:32] the salaries are making sure

they've had 9 90's for a certain length of time

inspector general. So I do

[1:10:39] think we're hearing from abroad array of people who care about

this issue in our state chair

[1:10:45] Pinto, and that it's

interesting to me how much sort of.

[1:10:52] >> We're we're sort of circling

around some of the same solutions regardless of who the

presenter is. So Chair Pinto,

[1:10:57] thank you. Thank you, member.

Appreciate it. Can cure my me though. I don't remember those

topics haven't come up in prior presentations, but maybe I'm

like like the limiting salaries

[1:11:04] and things like that. But I >> can your Miami when when

that was not the limiting of salaries, I don't recall, but

certainly the La talked at

[1:11:10] length about the need for

Enterprise wide grant management system and flagging

1, 1, agency has had a problem

[1:11:17] so that other agencies are

aware of it. And we've had other people talk about the

need to be to be able to shut

[1:11:25] off payment earlier to require 9 90's.

[1:11:30] So I think maybe not every
suggestion matches exactly. But I think we are finding from
the different testifiers who
[1:11:37] presented and more to come that
we're getting quite a laundry list of things we can do to
strengthen grants and service
[1:11:45] providing in the state of
Minnesota. >> But your your floor take.
Thank you, Madam Chair. Yet I
[1:11:51] intend these are a couple
questions to be put to be really short, actually in that
he's got a slightly more complicated. And I what I heard
Mr Gone say ultimately is that
[1:12:00] accuracy is really important,
which is really good. I was surprised, actually, I should
have a kind of maybe heard a little bit of that. There may
be as a certain political goal
[1:12:08] or in pushing certain solutions
on maybe just set that aside. I'm going to hang on to the
idea that and I'm guessing,
[1:12:13] madam chair, that that is the
most important thing to us that we receive accurate information
from our from folks are in
[1:12:19] front of us as experts. And so
I guess that's the feels like a slight tension there. But in
case will move on from that.

[1:12:25] So I'm going to make it to the
to the tracker than and I'll just note that these
are across a wide variety of
[1:12:32] dates and you've got the date's
obviously here. One thing that jumped out at me was that, you
know, we've made many reforms
[1:12:39] through the years. I'm
thinking, especially in 2019. 23, 24 and some of these, you
know, predate those reforms.
[1:12:46] The Dino winter article that
you Mr. Clyne referenced as you can is a great quote from a
Republican, a Republican Sen.
[1:12:53] I'm talking about progress
since 2019 and saying the DHS, quote, has made a great effort
to combat fraud and says they
[1:12:59] have a very robust antifraud
departments such good. And just to say that recognizing some of
these may have predated reforms
[1:13:05] that may have addressed some of
the things that led to them, they go to each of the lines,
say startling first line with feeding our future. I think
important to acknowledge the
[1:13:12] good work of our state
Department of Education and identifying concerns and and
moving to stop payments
[1:13:18] obviously blocked by a court.

But those important thing for them, that's line one. I want to dive into line, too. So what [1:13:24] is the source of the 100 million dollar figure? I see a footnote and sort of which says that's a lesson [1:13:31] about a report from 2019 page 7. So I'm going to that [1:13:36] auditor reported. You can just talk about the source and it's it's what's Page 7 says is that there was an investigator who [1:13:43] alleged 100 million dollars a year per minute. You're 100 million dollars in program. Is that is it that investigated [1:13:51] this? The source of the 100 million dollar figure in your chart. >> Mr. Khan and resource. My figure is the source cited [1:13:59] the bibliography page, OK? >> Champion to thank you so much, Madam Chair with that [1:14:04] section. So yeah, so that page then to confirm it was an investigator in the program that it's so good to look at [1:14:10] that page. The report has a lot of other peaches and the rest of the report. From the same date, I note that the source [1:14:16] states is 3/13/2019. The rest of the report says that that same investigator that you

relied upon, Mr. Go on as an
[1:14:24] investigator who made other
allegations a another allegation was unsubstantiated.
The legislative auditor found a
[1:14:34] 3rd allegation was found to be
misleading this in the very same report. And then finally
and actually there were other
[1:14:40] investigators who think
provided some information they were found by prosecutors to to
want to charge people before
[1:14:48] there was enough evidence to
come with concludes Restatements just to say
everyone, the pressure on
[1:14:53] prosecutors want. Prosecutors
said everyone knows is not evidence. And so bottom line is
that our legislative auditor in
[1:14:59] the very same report, just 2
pages prior to Page 7 says there was not evidence to
substantiate the allegation of
[1:15:06] 100 million dollars. So given
all that and just struggling, so why is that figure? Is it
that you didn't know about the
[1:15:15] other pages in the report for
you knew about them? A new clue did it and why was it in your
tracker,
[1:15:23] Madam Chair? >> Representative Pinto.

Yeah. So I spent I don't know. Good. 20 minutes trying to
explain how 250 million
[1:15:32] probably was more 500 Million.
But I went with the number
250 million because that was
[1:15:37] the source. I could cite that
other people could look up and the same is true with the
other. 26 think you're looking
[1:15:43] at number 2. So I picked
100 million dollar number. I looked I actually spent quite
a bit of time thinking about
[1:15:50] this one, because I found a
number of cases that were prosecuted and resulted in
state courts where people are
[1:15:57] convicted and given prison time
for frauds. And, you know, again, trying to
add the number together over
[1:16:06] all of those cases and that we
have the J Cole's report who had included from recollection.
I'll have that a report from
[1:16:14] the tens of millions of dollars
from organizations where he can't find children or
employees at.
[1:16:21] And we again, that's 5, 6, 7,
years removed from the incidents and the and described
in the see cap report.

[1:16:30] You had media reports say shuttle media
reports and I forgot with a
[1:16:36] number of 100 100's of millions
of dollars in cash leaving from the Minneapolis airport to go
to overseas. So it's a number
[1:16:46] that's been out in the public
domain for a very long time. And perhaps we can quibble with
a different number,
[1:16:52] be appropriate. Perhaps a
larger number would be appropriately talked about how
a more than a billion dollars
[1:16:58] has gone. 2 recipients from
this program and the urban, I think fairly serious
questions raised about
[1:17:06] individual providers who get 8 figures out of the program.
So as a place holder, what do
[1:17:12] you put here when you're trying
to come to a bottom line? So that's the that's the number
I've chosen. Representative Pinto.
[1:17:18] >> Thank you. Thank you.
Chairman. Do one more. And then we'll go to Representative
Green Monday. I think I'll ask a question of just have a
comment. Why if your goal is
[1:17:27] accuracy? And I found your
answer earlier. Interesting. I really thought you're going
to say, listen for this purpose. I am Mike Michael's to

inform policymakers the public
[1:17:35] for information. And I found
interesting you you talked about kind of pushing towards
solutions, but I would assume that your goal is actually see
if it is. Why do you even need
[1:17:43] a number like it? Isn't your
goal to inform people of of of the of the truth? I heard
early, I didn't hear anything
[1:17:50] where you provided any kind of
nuance on that. So I guess I'm just I'm trying to understand
like and if you're unless your
[1:17:58] goal is to achieve a political
point, what even need to sort of out of numbers in that way
versus to inform the public and
[1:18:04] policymakers with the most
accurate information, possible 100 million dollars is not
accurate, according the only.
[1:18:09] So Madam Chair, Mister Glenn
Representative Antone, you're going to move on from this
topic. But other than feeding
[1:18:17] our future, the Child Care
Assistance Program is the number one program I get asked
about.
[1:18:22] >> And so I went and talked in
some detail about how it didn't include ensure. I didn't
include men, Lars, I didn't

[1:18:30] include the Southwest Light
rail. I didn't include a lot of things that people ask me
about. But for me to have
[1:18:38] something that I try to put
forward as working towards comprehensive
list of fraud, waste and abuse
[1:18:44] in Minnesota, social benefit
programs and not have a number for the child care. I don't
think it would be as accepted
[1:18:54] as it is today. If I had just
left that blank as I left linked to autism thing for a
long time because I didn't have
[1:19:00] a number to put toward. >> And 5 for commentary.
I thank you. And I will continue listening request just
a minute at the end for final
[1:19:06] comes as minority leader.
I will just say, Mr. Van, that's the difference between
an unbiased research or that we
[1:19:12] can rely on right and a
political partisan that we can't. Is that what you do is
you put accuracy and
[1:19:17] completeness and honesty as the
very top goal, even if it's sort of not as convenient for a
story, maybe try to tell that
[1:19:23] is the difference between chair
to animals. >> Tapinto I chair I have to

respond to the advice I would

[1:19:29] like to be in the line called

the decline by the lead. Mister Guan. I'm speaking and I

would like to respond

[1:19:39] Chair Pinto for the last 6 years. I have

sat through

[1:19:44] hundreds of committee hearings where the majority at the time

from your party brought in

[1:19:52] Testifiers from a very obvious political perspective

and we never impugned the

[1:20:00] motives of those testifiers.

We understood their perspective

[1:20:05] and we took their data and

asked respectful questions. And I I find this appalling and

I'm apologizing on behalf of

[1:20:14] the committee, Mister Khan and I agree that we have

testifiers from different

[1:20:19] perspectives and every single

committee in this body. And we are all well aware of that. So I I would just like to get

committee back on track.

[1:20:28] I feel like our committee has

done a great job of trying to be bipartisan, trying to drive

to solutions that we can all

[1:20:35] support for the good of the

institution. And that is the mission of this committee.

And we are going to focus on

[1:20:42] that. Representative Green Men. >> Thank you, Madam Chair.
I appreciate that. And I
[1:20:47] actually went, as you're saying
that thinking about florist speech is going after lots of
organizations with tweets and I
[1:20:54] 90's. So I think when we talk
about the work, it's important that we know the information
we're getting. And this is the
[1:21:01] first conversation we've had
about these numbers, which I've
[1:21:06] heard repeated over and over
again and this committee and others. And so I think it is
important to understand and
[1:21:12] understand the questions as in
why the LA reports in 6 million dollars are reporting
100 million dollars in the in a
[1:21:22] tracker that then gets
repeated. What I will ask usually want to go back to
something because I think there
[1:21:28] is something you and I agree on
when we're talking about I should
[1:21:34] government and should wet as we
provide services. What does it mean when where providing the
services through nonprofits
[1:21:41] doesn't stop it for nonprofits.
You said private the the public benefit corporations, private

vendors and all of those cases.

[1:21:50] I think the point you make is

and I think it's a good question to ask is, is that the

most efficient is that the most

[1:21:57] transparent? Is that the way

that we can and should provide those services? And I think

that question is raised when we

[1:22:04] think about, as we think about

feeding our future, which was a pandemic era,

[1:22:10] one time a grant and how it

differs actually from our pay

[1:22:16] and school meals program.

One is is delivered directly through government through our

school districts to the schools

[1:22:23] that are providing meals and

another as you spent a lot of time describing it as we have

seen both in the news and then

[1:22:30] the the prosecutions was not just

nonprofits and for-profit

[1:22:36] providers, but also nonprofit

oversight of those nonprofit and for-profit providers.

And so thinking about those

[1:22:43] structures, I think as you

brought up, I think is an important thing is we think

about the best way to both

[1:22:50] protect the benefits that folks

should be getting that we have. The policy makers have decided whether it's child care or or I

[1:22:59] food or housing or whatever it is and ensuring that work, we're protecting those resources that provide for

[1:23:05] those for those. It's I think that that's a worthwhile question ask. I think we have been having it of how are

[1:23:11] providing whether it's grants, funds are directly through government. But I just want to say that that's not something

[1:23:17] we spent a lot on talking about here. But I appreciate that. My question is actually also on this track or something we

[1:23:22] haven't talked about yet. And I just had a few questions about where the numbers are coming from. Looking at number

[1:23:30] 4, the front, a frontline worker bonus pay. Wondering where you got that 45 million dollar number and what what it

[1:23:40] stands for. Mr. Gone.

[1:23:45] >> Madam Chair, Representative. So again, that's another Ellie report on the front line worker pay and again, back to

[1:23:53] represent the Pintos point when there's many numbers in a report would be a pick.

[1:23:58] And so I tried to pick the
number here that represented something clothes that matched
closest to the idea of fraud,
[1:24:07] waste and abuse money that
should have gone out the door to program cells much larger.
And again, the oil. I had a lot
[1:24:14] of criticisms which I don't
know if they're they have merit or not about the haste in which
the program was implemented,
[1:24:21] the perhaps lack of direction
from the legislature about the parameters of the program.
I understood in the context of
[1:24:29] COVID-19, the urging of the
[1:24:34] everyone involved a Department
of Labor or the state legislature, the governor
trying to get the money out the door as quickly as possible.
And when that's your goal,
[1:24:42] sometimes corners are cut.
Sometimes people who got money who weren't necessarily
eligible for it was a self
[1:24:49] reporting system. As I've said,
much of state government is on the honor system. We assume
that everybody is operating in
[1:24:56] good faith until proven
otherwise. And so the source of a document is the source cited
in the Billy Archie pH.

[1:25:04] >> Thank you, Representative
Greene, thank you, Madam Chair. And I appreciate that. And
looking at the 16 17 of the
[1:25:12] only report I sent along with
Representative Anderson on the audit commission and so know
this intimately. I was also on
[1:25:20] the conference committee that
passed the bipartisan agreement that brought in unemployment,
the refilling, the unemployment
[1:25:28] trust fund as well as this
front line worker pay. And one thing I will just say for folks
who didn't follow that is
[1:25:35] they're there was a
particularly in the methodology of this report, one of the
biggest and that the deal I
[1:25:41] raise that I raised as somebody
on the conference committee that the bill author raised
folks in both bodies was that
[1:25:48] there were some very
intentional policy choices made about. And when we talk about
the eligibility numbers,
[1:25:55] the problem with the LA is
report. The problem with that 9.1% number is that that
required employer verification,
[1:26:04] which is what the oil laid in
their audit. But in the bill that we passed the Legislature,

we very specifically rejected

[1:26:13] amendments and rejected

employer verification because of what we're worried about,

which actually showed up in the

[1:26:19] a late report, which was employers either wouldn't

respond, which a 3rd of the

[1:26:26] folks who got the survey's do

just didn't respond. And we didn't want to prevent these

nurses and frontline workers,

[1:26:33] these grocery store workers,

these these folks from the 16 month delay that this bill, a

report was us took 16 months

[1:26:42] for 300 surveys. So there was a

policy choice that we made for

[1:26:47] 2 of the 6 eligibility criteria

so that the government didn't

[1:26:53] dealine deal are verify the

whole set of things identity and whether they got you, I

whether they had their adjusted

[1:27:00] gross income, all of these

things, what they didn't and what could and government can

verify was that they spent that

[1:27:07] 120 hours in close proximity.

And that was what what what the the legislation ask for self

Attestation that the challenge

[1:27:16] of the whole airport. And I

don't know if you've got a chance to watch that. I think
we had a two-hour hearing about
[1:27:22] it or listen to some of that.
But the problem was by using an employer verification and then
calling that the making an
[1:27:30] eligibility determination
that's actually was inaccurate with what the legislature
passed, no can take issue with
[1:27:36] with the legislature passed.
But that's not the either the role of their late word.
This or that sort of
[1:27:43] after the fact that the
question I have is why you chose. So there wasn't a couple
of different, I think in
[1:27:49] reflection. >> Of the. >> Olay's
[1:27:56] some of the feedback about the
employer survey methodology, they did 3 projections. They
did a projection that accepts
[1:28:04] employers services accurate and
says, you know, if there's a disagreement with the employer
and the employee doesn't
[1:28:10] matter, employers, right, there
is a projection that does not accept the employer service is
accurate, which
[1:28:16] reflects the will of the
legislature and what we put in the bill which does not require

employer verification. And then
[1:28:21] there was a project number 3,
which was set to split the baby inside for places where the
[1:28:27] feedback between the employer
and the employee it when the question is about
the lead of the 120 hours and
[1:28:33] postscript proximity, we're
going to take that out because that's probably something the
workers know best them out. I'm wondering why you chose it.
Looks like it has the top
[1:28:42] number and why you chose
decided to chose to do that is because the other 2 numbers.
[1:28:47] >> Mr. Dylan, Madam Chair,
Representative. Yeah, again, you have the support for county
pages is voluminous report.
[1:28:55] I didn't want to leave readers of the tracker with the
impression that the entire program was fraud. That
certainly wasn't true. And the
[1:29:03] delays report supports much of
the good Works Department leader did, but much of it,
whether it was done
[1:29:09] in haste or without clear
direction or they misinterpreted the direction
that you
[1:29:15] I believe you have clearly
given to them. I want to put a number that I

felt actually captured,

[1:29:23] perhaps not fraud. So much is

the waste and abuse of the program and that's the number I

chose and listed in my indot.

[1:29:31] >> Last question we have to

more people and we need to wind it up. Thank you, Madam Chair,

anything. >> We spent an hour. I'm not

asking any questions to try to

[1:29:38] make sure that we've got and so

they could dig in. I would say

[1:29:43] that's sort of my concern with

the slogan of waste, fraud and abuse is we know what Friday is

and we're seeing it, whether

[1:29:51] it's prosecutor, whether it's

using of the tools that you've talked to, the luminous Lee

about the attorney general,

[1:29:58] the inspectors general here in

Minnesota, the U.S. attorney. But we we know what that is.

The waste and abuse seems to

[1:30:06] be. And when I heard you say to

the closest thing that the 9 point one numbers, the closest

thing to the waste, fraud and

[1:30:14] abuse with the 9.1 number is

saying that one we we do not

[1:30:19] and I accept that self

verification that the legislature passed. And also if

there's a dispute between the

[1:30:26] worker and the employer, we're

going to do police work for I don't know if you followed up

with a deal alive, but they actually reached out to some of

those employers who said things

[1:30:34] like no, they weren't in 120.

They they didn't spend that time in close proximity because

they had to wear a mask.

[1:30:41] Clearly not the legislative

intent or or letter of the law. I will say that there is a

number in here that talks about

[1:30:49] fraud indicators. Mets 0.2%.

And what deal I said in their letter was that's probably an

accurate or as close to an

[1:30:57] accurate number. Now, 22%, any fraud is is too much.

[1:31:02] But what we know and if you

look at an insurer in in all your deep diving, if you look

at private industry, if you look at folks who do this 0 is

not a number. Anyone has we

[1:31:12] there is a across the board as

we think about markets, we think about targeting senior

citizens reaching about small

[1:31:19] businesses. Fraud is a target

as a mark. A government in this

[1:31:24] case is the mark. And so 0.2%

is is a number that I think is is where around were industry

standard is the thing I will
[1:31:32] say. The thing that makes this
very hard is like 45 million dollars as part of the
610 million dollars and what it
[1:31:39] sounds like under the slogan of
waste, fraud and abuse. And this happens with with my
colleagues across the aisle to
[1:31:46] is that it's just an
opportunity to this policy that you don't like. I get it.
We all we sit here and there
[1:31:55] some those we we like some
things we don't like that doesn't make it waste and
abuse. That just makes it
[1:32:00] something you disagree with. And I think
that the challenge with any of these numbers, like the
100 million, the 41 or
[1:32:09] 45 million, all of the other
numbers on this chart feel like they have been cherry picked
and in some cases I would I
[1:32:17] would call this a
misrepresentation. We might disagree on that. But and
putting it under this slogan of
[1:32:24] waste, fraud and abuse in the
specially looking at and I know we're talking about where this
coming from doesn't matter,
[1:32:32] but I have not been familiar really

familiar with the organization for you, but I did check
Twitter and it doesn't feel
[1:32:40] like it's a your tweets.
You know, calling the governor
[1:32:45] of fraud. You are a fraud and
every post my estimate of your IQ drops. Another point like
the thing that I want to make
[1:32:52] sure we're doing here is
actually taking seriously the how do we protect people?
How do we protect the services
[1:33:00] and the resources to those
services and how do we make sure that we harden government
as a mark and what? This
[1:33:06] 610 million dollars with
100 million see cap. That's just, you know, the closest
thing you can find 45 million,
[1:33:14] which is at the closest thing
to throw down the closest thing to raise from abuse. You know,
you started naming policies.
[1:33:21] You don't like the beam in Lars
ensure we heard about Southwest 8 layout whatever it is.
Those are we should have a
[1:33:27] policy conversation about what
and how government service people but to lump in and we
see this happening at the
[1:33:34] federal level to lump in

everything arbitrarily and cherry picked that folks don't
like
[1:33:41] and Callaway's from abuse as a
political tool is neither going to serve people. It's not going
to rest deliver services better
[1:33:48] and it certainly won't get to
the problem of provider fraud that we have been talking
about. And I think that the egm
[1:33:55] that the governor of them
really focused on and that we have a governor's package
about. So I guess that I would
[1:34:00] leave my comments at that that
think this is a number that's very hard to to. >> Do you have a brief
response, Mister Klein,
[1:34:06] otherwise I want to move on
here. I know you want to learn and share, but it might be
something I wrote in my
[1:34:13] written remarks. I don't think
I said out loud. >> Was just to the point of
trying to do due diligence.
[1:34:19] So we have the personal care assistance
program. Again, another billion dollar program.
[1:34:25] It has 4 over 40,000 clients,
40,000 for some families. This is life saving where you
have a disabled child at home
[1:34:35] and you want to keep the family

together. You don't want to put this child the facility that
you're able to do that because
[1:34:41] you have personal care
assistance who are able to with some states sub city come into
your home and take care of
[1:34:47] your, whether it's a elderly
person or a child with disabilities. It is a
lifesaving. You have 40,000
[1:34:55] clients and depending on the
source you site for the number of people who are
available to provide that
[1:35:02] service 100,200 1000 by some
measures, its teen number one
[1:35:10] profession in the state of
Minnesota, more than public school teachers, more than
nurses, more than some other
[1:35:17] people who working professions.
You would imagine to be much larger. And if you are the State
Department in charge of
[1:35:24] overseeing the program, how
Hurst you fight you, police or or manage 40,000 work sites and
100 to 200,000 providers.
[1:35:33] Well, you do the best you can. So to the point of the tracker
and what I'm trying to
[1:35:39] accomplish here is put a spotlight on waste, fraud
and abuse.

[1:35:45] Again, I'm sorry, wasted so
much time. We spend so much time at the beginning trying to
figure out what the real number
[1:35:51] is for the feeding our future
because it's not this number. So for every prosecution you
have for fraud in the state.
[1:35:58] How much fraud have you missed?
Have you got half of it? Have you gotten a 10th of a
cent?
[1:36:04] And what we've heard from
feeding our future is the best example where I've spent years
studying it. We have 77,
[1:36:11] 0 people indicted. Most of the
pled guilty or been convicted. The Department of Justice has
cited there probably another
[1:36:19] 200 to 300 people who have been
investigated, who still might be indicted at some point.
Nobody's saying we got it all.
[1:36:28] And so to suggest that not only have we not gone ou overshot
the mark that the actual amount
[1:36:33] of waste fraud and abuse in
Minnesota State car, it is much smaller than what I presented
here. Biased or not. I don't
[1:36:41] think I can agree. Representative Schultz. >> Thank you, Madam Chair.
And it spend just a fascinating
[1:36:50] discussion this morning to kind

of here, I think for the first time, at
least this year, a moment where
[1:36:56] it appears like the DFL in this
body is more focused upon
[1:37:02] either saying that there wasn't
any fraud or trying to dispute the numbers rather than to
admit that the state of
[1:37:09] Minnesota has had the largest
fraud anywhere in the country over the last several years.
And that's just of the fraud
[1:37:16] that we know. I mean, I
appreciate Mr. Gone coming here today because it in case the
members were too focused on the
[1:37:23] other side of the aisle.
I'm trying to dispute his numbers and dispute the
different things he brought. He brought
countless different ideas that
[1:37:31] I know members around this
table brought up that we haven't yet considered that
should be considered during this legislature. So I'm just
I'm I'm curious. I mean,
[1:37:38] I know the governor Walz's
tried to cover up the fraud, but is that what's happening
right now within within the DFL
[1:37:45] caucus? Because right now with
the things that we've heard, you know, we've had we've had

[1:37:51] instances where he's saying,
you know, should we have nonprofits as an example, have
a full tax year before they're
[1:37:57] eligible? Should they be
registered with the attorney general, in essence, providing
greater oversight through the
[1:38:03] Attorney General, Mr. Gaunt has also said should
we be enhancing the role of the state auditor? If you go back
to the founding of our state,
[1:38:11] the state auditor would have
had a lot of these controls in place that at some point
probably been peeled away from
[1:38:17] them. I mean, he has offered
countless different examples of things that we should be
considering. So I just want to
[1:38:23] say instead of covering up
fraud with this committee should continue our focus to
ensure that that we are
[1:38:29] exposing more and fixing the
problem in our Fried proves Prevention committee. Thank
you, Madam Chair.
[1:38:35] >> You represent vice-chair,
Anderson UNLV. >> And I'll be brief to I'm
gonna come on and a couple
[1:38:43] things represent Greenman
mentioned just briefly touched on some thoughts about if we're

going to provide.

[1:38:51] >> Sirte States services may,

but we need to do more through state government rather than

through through some of these

[1:38:59] NGO's, a non profits. And and

actually, I tend to agree with you on that. So

[1:39:05] because we have seen huge,

huge, huge, huge, huge problems

[1:39:10] as we hire, like all the

vendors, but whether they're nonprofit. So there are no

businesses. It's been a huge

[1:39:16] problem. And I I also want to

quickly test

[1:39:21] waste, fraud and abuse, waste

and abuse are, you know, as I've been saying in the OIG

meeting, said that their

[1:39:27] subjective somewhat, I would

argue that this number is way too low if we're going to

include waste and abuse and

[1:39:35] probably way to offer going

include fraud. Yeah, it's you

[1:39:41] know, we can't we it's

disingenuous to say that the only fraud that occurred is

that which has been prosecuted

[1:39:49] because we know it's much more

as a prosecutor and we not significantly significantly

higher. And I'd also want to
[1:39:57] point out that the south as
light rails, not on this Friday tracker and and I absolutely
think it should be if it's
[1:40:03] under waste that several
billion dollars that would, you know, exponentially
increase this number. So
[1:40:11] it's bad. But but I think most
of us here want to do something about it. We want to find a
solution. And I thank you for
[1:40:18] bringing some of your ideas.
I do want to mention in regards
[1:40:23] the OIG bill. I mean, we're still looking at
options. But the the House OIG
[1:40:30] bill, as has the inspector
general on to the legislature parallel to the legislative
auditor, the Senate. It Bill
[1:40:37] has it what are really within
the executive branch, but actually under under the eye
and said that a group that
[1:40:45] would be created of
legislators, House Senate members and I under an
administrative law, judge,
[1:40:53] we all know this cannot be
under the governor. We all know that what and out and we're not
targeting any specific

[1:40:59] governor. But under the
governor's that it has failed being within. We have a little
agency OIG said have answered
[1:41:08] too commissioners who are up
for appointed by the governor appointed by commissioners and
that has failed. So we're
[1:41:15] trying to find an alternative.
And and I know there's several people on this committee that
are helping work with that.
[1:41:21] And so any ideas you have, I
appreciate it. So we have just a few minutes and I'll wrap it
up so.
[1:41:27] >> Yes, thank you. And I I have
to leave. So Vice Chair
[1:41:32] Anderson, I will turn the
committee over to you. And Representative Elkins, it's
your your app. Please keep it
[1:41:38] brief. >> Thank you. I'll be very
brief. So one might my favorite quotes and you probably
familiar with this one is that
[1:41:45] if you torture the data long
enough, it will confess take on a miss Ronnell Qos. And you
know, my my big concern about
[1:41:53] the tracker is that time.
You know, there's a lot of cherry picking at the numbers
in here as we've been

[1:41:59] discussing. And the bottom line
on this is that it's conveying an impression, this impression
that there's over 600 million
[1:42:07] dollars, it did to be game.
That could be a potentially applied against closing the
future budget deficit. And
[1:42:15] that's just not the case.
A lot of these programs are one time. The vast majority of this
month, this money is actually
[1:42:21] federal money. Not that we
should care any less about it. But if they can do, if the
impression is being conveyed
[1:42:27] here is that all we have to do
is to eliminate fraud and we can balance the budget. We're
doing ourselves a, you know,
[1:42:34] a horrible the service. About a
week ago, I bumped into a veteran Capitol reporter in the
Hall and the reporter asked me
[1:42:43] about the status of my zoning
reform bills. But why had I took the opportunity to, you
know, ask about his further
[1:42:50] interest in covering our
committee and that reporter just chuckled and said to be
know, as soon as I read the
[1:42:56] body letter, I just realized
that this was just another going to be another dog and

pony show. So if the body
[1:43:02] letter was exhibit A, I think
this tracker is Exhibit B. And I you know, I would I'm
looking forward to the the time
[1:43:11] that the that with this
committee can kind of get past the ground, the grandstanding
and actually dig into some of
[1:43:17] the policy prescriptions that
we ought to be considering because I'm reading all of
these reports that we're all
[1:43:23] reading. There's lots of good
ideas in there on how to address this stuff. And I you
know, I'm a lot you guys know
[1:43:31] that and I love digging into
the solutions and I want us to get to that point as quickly as
we can.
[1:43:39] >> Thank you, Representative
Antone to thank you. Madam Chair of the I think, you know,
keep this chart. I know he's a
[1:43:44] cause. The chair is is out and
you filling in. But I'll just say that when I saw this on the
agenda, I was skeptical of
[1:43:50] Mitt, but I want to make sure
to come in with listen with an open mind. And what I seems to
me that we found in the
[1:43:56] questioning and looking at at

this document is that there is, in fact, what I heard is trying to push a particular agenda.

[1:44:05] And we only look at a couple of lines in detail the mine to in line for an found that those are numbers that have been

[1:44:10] chosen, in fact, in the case, a line to have been identified and let it bother as being wrong. But the idea as well, we have to include some sort of number

[1:44:18] apparently to achieve a particular purpose. And and I guess it just want to recognize we've just spend an entire

[1:44:24] hearing hearing from someone who was looking at reports and then providing information to us. It's especially important

[1:44:31] that we be able to rely on the accuracy, the information that we receive. If we're going to address fraud and we need to address Friday, it should be with real facts and real

[1:44:39] numbers with people who have a real expertise that has been sorely lacking. That has been sorely lacking here and agreed.

[1:44:45] We want to talk about specific proposals in 5 weeks in the committee that has not happened yet. I hope that it will happen

[1:44:51] and want to get more of that

with the chair go on. But I really do want to say there is
it is absolutely critical that
[1:44:59] we rely on actual accurate
information in the work that we're doing. And when we're not
doing that, the definition of
[1:45:05] fraud, deception, that is
wrongful resulting gain. This is a deception. We're
going to anybody who say
[1:45:10] 610 million dollars ever,
again, 100 million dollars is wrong in total is wrong and it
is intended to achieve a goal
[1:45:17] and result in gain political
gain. That is fraught with this just happened here has been
fraught members as let's not
[1:45:22] have. What do I hope this is
the last time this committee or any other sort of the conduit
for deceptive information for
[1:45:27] the center of the American
experiment. That should be the last time. Thank you, chair. >> Thank you. Rep some Pat Henry by that title and that is
[1:45:34] fraud, waste and abuse. And if
we are going to define
[1:45:40] >> this, okay has only things
that have been prosecuted and convicted. Okay. That's one of
the different thing. I would
[1:45:47] again argue, fraud, waste and

abuse. I think everyone knows in the state of Minnesota.

[1:45:53] >> That it's many, many, many

times higher. >> And the 600 million dollars

that is on this. So that's it.

[1:46:00] And we're we're adjourned. So thank

you

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 03-17-2025

[0:02] >> Welcome to the March 17th
meeting of fraud Prevention and State Agency Oversight
Committee.
[0:10] >> I >> wish you all a Happy Saint
Patrick's Day. Notice a little
[0:15] green around the room. Nice to
see that. So first we're going to start with approving the
minutes from March. 10th
[0:24] Representative Eric, if you
attend reviewed the minutes from March 10th. Yes, Ma'am
Salute. Thank you. Is there any
[0:30] discussion it? >> Chair Pinto, thank you,
Madam Chair, and just request
[0:35] and you find it now just a just
at the line, which is the committee heard an overview
requests to just say the
[0:43] committee heard the
presentation entitled and then the title overview of the
minister for a problem. If that
[0:48] makes sense because it's the was the title of the
presentation. >> The jury having to make that
amendment. Thank you so much,
[0:54] Madam Chair. Any other
discussion seeing none.

[1:01] That's the LA has taken down
the amendment. And so the minutes as approved all those
in favor. Aye. That's post.
[1:08] Thank you. All right. Excellent. So we would now like
to welcome to the committee
[1:14] presentation from the
Department of Human Services, Behavioral
Health Administration
[1:21] and very delighted to have you
all here in committee. So I'm not sure it is Commissioner
County. Are you going to be
[1:28] starting here? Okay. Great
lighted to just introduce yourselves for the record and
we will start going through
[1:35] your presentation members. We are going to have questions
relevant to a slide have
[1:41] questions at that time. But
then we're going to try to move through the presentation and
then state the buck of questions for the end of that
[1:49] is amenable to everyone.
So we'll see how that goes. So good morning, please state
your name for the wreck and
[1:54] begin your presentation. >> And chair, good morning.
I'm Theresa Steinmetz. I'm the
[2:01] assistant commissioner of the
Behavioral Health Administration. Happy to be

here.

[2:06] So I just want to start off stating that Minnesota is a

state committed to helping

[2:13] individuals and that we at the

just and in the state and we have a House administration are

committed to providing services

[2:21] that improve the lives of

Minnesota. We know that fraud against

these public programs is

[2:27] unacceptable. It's not a

victimless crime by any means. And the individuals that within

our administration were trying

[2:34] so hard to support our those

most impacted when it occurs.

[2:40] So starting July 31st in 2024,

DHS establish the Behavioral

[2:45] Health Administration. That was

a time when split apart. How a scene and behavioral

health.

[2:51] This was a really important

change for many reasons. We're currently in the midst of

a national behavioral health

[2:57] crisis and a national opioid

crisis. And we're seeing more and more individuals needing

services than ever before

[3:05] provider share that these

individuals have more complex needs. Putting a strain on our providers during the midst of a [3:12] national workforce shortage as well. Having a behavioral health administration that allows for [3:17] focus support on behavioral health in Minnesota is a really great change. This restructure has also allowed for a more dedicated [3:25] focus on procedures and oversight of important work like grants and contract administration, which we know [3:33] and the administration has been an area where improvements have been the didn't see a chance for some time. [3:40] I struck Shane children, family, an adult mental health services and substance use disorder services into its [3:46] administration. Dhs is much better able to develop a strong leadership team which again can allow for focus direction over [3:54] the operations area with an emphasis on monitoring grant and contract compliance. [4:00] We are better able to focus on the increase in behavioral health needs and Minnesota. Specifically after the [4:06] pandemic, we're able to work more closely

with the DHS central grants and
[4:11] contracts team to redesign the
grant process ease within the administration. And we're also better able to
work alongside the DHS Health
[4:20] Care Administration on several
new areas of Medicaid waivers and state plan amendments and
also work more closely with IG
[4:28] for grant oversight. There are multiple functions
within the Behavioral Health
[4:35] administration. Individuals
with mental health and substance use needs require a
robust system of care. They
[4:42] really need access to services
and support within the community as well as in
residential settings,
[4:49] BHA must take a strategic look
at gaps in the system to continue to move towards
increased access, better
[4:55] practice and evidence-based
interventions while at the same time ensuring they're being
good stewards of state in
[5:02] federal funding, monitoring
compliance and intervening when their concerns of misuse or
fraud.
[5:09] Some of the key functions
within both mental health and substance use program areas

include policy development and

[5:15] oversight systems

transformation, and support of best practices, funding and resource allocation

[5:23] data collection and reporting community engagement, education

and technical assistance,

[5:29] crisis management and support

and then Grant management and contract administration.

[5:44] I have a long career working

with and in other states and really want to just highlight

and share that Minnesota has

[5:50] many more innovative programs

and support of dollars specifically at the state

level, focus on mental health

[5:57] and substance use leads that a

lot of other states that funding shows a dedication

to and allows for individuals

[6:04] to receive care that others

aren't always able to access.

[6:11] And again, I just want to

highlight a couple of those successful programs, although

there are many and what they've

[6:17] accomplished so far, the fact

that over 300,000 individuals are at least 25% of those

enrolled in Medicaid receive

[6:25] some type of mental health or

substance use related service is really impressive. And we

also have additional support of
[6:32] grant funding that we track in
the mental health information system, which shows at least
another 35,000 individuals who
[6:39] are reported to be receiving
some type of support.
[6:45] A couple of the specific
program areas that I wanted to just highlight is the Scott
County Coordinated Response
[6:53] Team. So Scott County received the
Circle of Excellence Award for
[6:59] their great and are they launched their response
team in 2023 to really help
[7:04] bridge gaps in services in
their community. This partnership between Scott
County, Scott County Sheriff's
[7:11] Seven's Police Department and
shocked the police department was created in order to have
social workers who are trained
[7:18] and engagement and outreach and
de-escalation connect with individuals in their jail
settings and also those in the
[7:25] community that they had
engagement with, that we're struggling with mental health
challenges. It's been a really successful
program and just show some of

[7:32] the great work in Minnesota. We also have the school and Behavioral Health Program which
[7:37] serves our 20,000 students. Reports show that the individuals in the schools
[7:43] struggling with mental health can receive the school-based service and they've really shown improvements on task
[7:49] behavior, increased emotional regulation, a decline in school absences and better decision making.
[7:58] >> One of the exciting things about this variant are up to one moment. Vice Chair Anderson has a question. Thank you,
[8:03] Frank. Thank. Yeah. >> Question so and the number of people in what do we have?
[8:10] Have we look to date across states? I mean, what? It's not a when that we have. You know, 25% of Medicaid
[8:19] enrollees are in. But to have the programs that still it's a win
[8:24] if that's actually working, if we're actually seen progress. So do we have any kind of data comparing Minnesota to other
[8:32] states? Maybe they don't have these programs as to the percent of our folks that, you know, just just

[8:40] looking at and like, you know,
I know you don't to homelessness, but that's a very
good example. Could we have
[8:45] less homeless people? Is that
actually working or we just creating the system? So do you
have that data
[8:53] instead, many that any
comparison to see if these things are actually working?
[8:58] >> Madam Chair, representative,
we do have data that shows the impact of the programs when it
comes to behavioral health.
[9:04] It's really difficult to south
cars and effective relationships because are so
many things that are going on
[9:10] to support individuals and
their recovery. I do not have that. They do
with me at the to put my fingers today. But when you
look at those engaged in
[9:18] treatment and Minnesota is
higher with engagement and services that it can offer than
other states, just having
[9:25] access is very important and
the state so we can definitely get more
of that state to state
[9:31] comparison and share it with
you and having multiple access to

treatment programs is also an

[9:37] important step to the

behavioral health system. >> That's it. Thank you much.

I would I would like to see

[9:44] that. I think this questioning

going on, you know, everywhere about everything, you know, do it.

2 programs actually work.

[9:51] You know, it's sad when people

are enrolled. So when the people act, you know, helped

write, actually the numbers

[9:59] change. So it would be very good to see that. So thank

you.

[10:04] Thank you, Representative Rick. >> Thank you. Madam Chair.

So I used to work at Minnesota, Adult and Teen challenge.

And I can tell you that there

[10:11] are metrics to know that the

people that graduate from there to finish the program do very

well. So depending on the

[10:18] study, anywhere between 75 86%

[10:24] remain sober after 5 years.

That's a very simple metric. You can definitely produce

metrics,

[10:31] especially with people that

have sobriety issues, mental health issues. You can see are

they not homeless? Are they

[10:40] stable? Do they have

employment? There are many, many, many metrics that you can use. So I I reject that idea
[10:46] that we we don't have metrics
can have metrics. Madam Chair, I think that that's
[10:51] not a good answer. Madam Chair,
I would just point that out. >> Thank you. Thank you.
This time it's please continue.
[10:58] >> Okay. So the last
highlighted area I want to talk about on this slide is the Behavioral Health Fund.
[11:05] So the Behavioral Health Fund
is again, a unique fund in Minnesota that provides funding
for substance use disorder,
[11:12] comprehensive assessments and
treatment services to eligible medics. Minnesota residents,
[11:26] this slide illustrates a
high-level organizational chart within the behavioral Health
administration below each of
[11:33] these areas listed here are
multiple units, teams and staff to pour in. We're at the administration.
[11:39] Those individuals within those
walls really play multiple roles and carry multiple
responsibilities due to the
[11:45] nature of the work we do of the total staff and
teachers, which is approximately 210. There are

about 50 grant managers and

[11:55] again, Kerry responsibilities

such as systems Transformation, Grant Management and contract

administration.

[12:02] >> Jake, could you restate

those numbers? I was looking for something. How many in the

department and how many are

[12:08] grants managers? >> 210 in the administration and 50 our grant managers.

Thank you. Not only grant

[12:15] manager slow carrying multiple

roles

[12:21] within the administration.

Currently we oversee approximately 90 grant programs

at any given time with about

[12:28] 1000 contracts supporting all

of that work.

[12:35] One of the strategic decisions

that we made

[12:41] and implemented specifically

within the last 6 months is to strengthen the leadership over

the operations section.

[12:48] We know that in order to

continue to make necessary improvements, it's important to

have dedicated leadership.

[12:54] It's specifically supporting

the grants, contracts and process improvement area.

[13:01] So the deputy assistant
commissioner is now overseeing all the operations areas with
support for me as the assistant
[13:07] commissioner and I've taken on
more of a lead and all of the programmatic areas overseen the
program, directors, fiscal
[13:14] directors so that those process
improvements can be the number one focus of that team.
[13:21] We've also hired a contracts
and compliance unit manager who has experience with audits to
support improved oversight of
[13:28] the grandson, contracting
process, worsening of processes,
procedures and compliance
[13:33] monitoring within the new unit.
What's really an emphasis on staff training, development and
support to make sure that all
[13:40] necessary documents are
completed, applauded in our contract immigration system.
And that time lines are being
[13:47] met. One important all within our
grant management and contract
[13:54] work is that of the grant
manager as a grant manager, the staff oversee the
grantmaking process which I'll
[14:00] discuss in a minute. They have to build

relationships with the grantee, provide direction and
coordination on all phases of
[14:07] the grant life cycle and
monitor the oversight of the grant. This includes things like site
presents Financial
[14:14] reconciliation invoice,
oversight and approval reporting and the final close
out evaluation.
[14:22] The contract specialist will
for staff includes being the liaison between the contracts
and legal compliance
[14:30] giving direction on all phases
of the contracting process. Again, ensuring that all state
and federal laws and
[14:36] regulations are being followed with federal grants that come
into the department's. There
[14:42] are also additional
requirements and a specific allowable populations that can
be supported that we need to
[14:48] pay attention to the contract. Specialist must
assure that the U.S. are fallen
[14:54] and also coordinate and manage
the RFP process draft and execute the contracts and
amendments and provide the
[15:01] technical assistance
monitoring. And general counsel tape consultation to all

teachers, staff related to

[15:07] contracting processes. >> Thank you if you don't mind.

Representative Frank has questions. Thank you, Madam

Chair. So

[15:15] in that process, we I've been

talking to a few folks with within DHS and there's concerns

that

[15:24] maybe less than 25% of the time

that progress reports are actually received. And when they are, they're not

reviewed. And they just kind of

[15:34] go into a circular file and

over really looks at them. So can you talk a little bit

more about your process

[15:40] from Shireen RFP going through the

grant process and progress

[15:46] reports a reconciliation?

Because I'm I'm hearing from people on the

inside that those processes

[15:53] aren't really being done.

Just curious what you have to say,

but MS tenants

[15:59] and chair representative. >> So I've been here for 6

months now. And I can say that

[16:05] those processes have been

rolled out in the recent past and that they are being

executed. We meet with the

[16:12] leadership team. We're pulling
information out of the contract integration system and really
making sure that the documents
[16:19] that need to be completed are
uploaded into that system. So when they're missing or if
they're not in there, we can
[16:25] move back with the staff or the
individuals overseen those contracts, making sure that the
performance reports again or
[16:31] see upload it and the system. I haven't seen that those
processes are being followed.
[16:38] And again, there's always room
for improvement and making sure there's checklists for the
staff, making sure that the
[16:44] oversight is easier. I think part of the challenge
when you have a lot of transition of staff is that it
takes awhile to learn how to
[16:53] monitor contracts and monitor
grants. And so we need to make sure that we're providing the
necessary training and
[16:59] technical assistance, even the
new staff are able to do that.
[17:04] >> Representative Rick, thank
you. Really quick. A follow-up. So is all the information back
into the contract grant and
[17:11] immigration system? I was told that there was some

in crucial data that had been

[17:17] removed, hasn't been returned

now so you can track grants more effectively.

[17:23] This tenants, Madam Chair, Representative. >> I don't know anything that

has been removed, but a guy

[17:31] thing here, 6 months from my

perspective and what I've been shared with from the staff,

everything we're needing is in

[17:37] there. One of the the struggles with a

system like that, though, is that the staff have to

upload everything themselves.

[17:43] So you have to have checks and

balances in place to make sure that that's happening. It's

really easy to forget to do

[17:49] some of that when it's a lot of different humans

needing to remember to upload documents, which is why we are

now having our can try and

[17:57] compliance unit manager in

place making sure they're checking and then assisting of

the staff isn't cutting it up.

[18:02] Loaded in there. >> Thank you, cements. I just

wondered if you say you've been

[18:09] there 6 months, what was your

role previous to this? >> Sure. So I do. Madam Chair,

I do have 30 years experience

[18:16] working in mental health and

substance use mostly in the state of Wisconsin. But I loved
that state moved here 6 months
[18:23] ago to really take a leadership
role within this administration. I come from a
similar poll in Wisconsin where
[18:29] I was overseeing the Bureau of
Prevention, treatment and Recovery just focused on all
the community-based programs.
[18:36] We also had 1000 grants and a
smaller staff and had systems in place. So I'm really hoping
to bring that expertise and
[18:43] experience to implement in this
administration as well. Thank you. And my understanding is
that.
[18:49] >> That you do rely heavily on
the
[18:55] deputy assistant commissioner who's overseeing all these
behavioral health programs.
[19:00] Is that what you testified at
minute ago? >> Madam Chair and know we have
reorganized a bit since I've
[19:07] come. So when I first moved
into my role, the deputy assistant commissioner was
overseeing all of the program,
[19:14] directors and operations as well. And
then management levels below

[19:19] that we have restructured so
that the deputy assistant commissioner can focus just on
the operations section. More
[19:26] intently was support for me,
obviously. And then I am now overseeing all of the program
directors so that that person
[19:34] is not spread South end and can
really focus on improving in leading the
processes that we need to
[19:42] continue to implement when it
comes to grants. Contracts tracking monitoring, developing
the training programs necessary
[19:49] first step. Thank you. >> Please continue.
[19:56] All right. >> This chart really
illustrates the dramatic growth in grants over the past 10
years.
[20:03] And if you look at the numbers
on there, it shows and output increase of over 333%. When you
look at that trend weather
[20:13] really consistent our similarly
consistent staffing throughout all of those years. So it's
just an important illustration
[20:20] of the additional amount of
funding that is coming in the last few years from the state,
which is amazing to support
[20:27] mental health and substance use

programming as well as from the federal government with our
COVID related dollars.
[20:37] >> Had they steer. Anderson,
thank you. Generally where what our these this a he huge, huge,
huge exponential increase.
[20:47] Okay. So 24 to a Muslim, hundreds
different grants. So what are
[20:54] generally these grants? And
they generally federal dollars or both our
state
[21:03] this 10 minutes. >> And chair representative,
they're both. So there was a lot of state legislative
dollars that went through in
[21:10] the past Sessions, which again,
is a great a testament to the support that
Minnesota against the
[21:17] unofficial South mental health
and substance use needs. And there was also a lot of
federal grants attached to our
[21:23] mental health and substance use
block grants to support covid-related challenges.
We know that with the pandemic
[21:30] mental health and substance use
and increased exponentially and the federal government gave
additional dollars to help with
[21:37] that as well as the state

legislative. >> I just think thank thank

you, Madam Chair. So but

[21:44] between like let's say, 23 24,

that's not COVID, right? So that increases all state now

dollars misstatements.

[21:52] >> Madam Chair, representative.

Yes, the 23 I would say is the majority of the legislative

dollars that came through.

[21:59] >> And if I can follow up on

that, are there still federal COVID dollars in the system or

his that all gone through?

[22:05] Are you still dealing with one

time COVID money in any of these programs? >> Madam Chair, we do still

have one time COVID related

[22:13] funding from the federal

government that was attached to the mental health and substance

use pot grants those and in

[22:20] September of 25, however, there

is potential that they would get extended a year

[22:27] Consolidated Appropriations Act

funding has recently and just within the last couple weeks.

And that was the first

[22:34] additional pot of federal

funding that came to states. And then the arpa dollars came

after that.

[22:41] >> So what how are you

differentiating with the one-time money so that it's not
creating ongoing applications?
[22:48] >> Madam chair, that's a great
question. And part of what I've really been trying to assess
since I've come here, really
[22:54] what's the sustainability plan
for those funds when they were distributed? I think they were
really given to a different
[23:01] programs that were already in
existence to help expand and increase access.
[23:06] And a lot of those you can use
as infrastructure development, grants to kind of get up and
running and expand services
[23:13] that then we'll be Medicaid
billable in the future. So I would say that's one of the
strategies is providing the
[23:19] technical assistance to those
providers to see what time continue. That's not the case
with all of them. And so then
[23:26] the discussions are about how
do we transition to different services supports? How do we
support the
[23:34] the lesson in funding as it
comes forward? >> Thank you for that. I would
love to get sort of that actual
[23:41] accounting of where that money

went and how much is left in?

[23:46] I'm interested in a follow-up

question on. You said some of the money was used for

expanding infrastructure so

[23:54] that you could create future

Medicaid, billable services. Could you explain what that

means?

[24:00] >> Madam chair, when new

funding comes into a state, oftentimes it takes time for a

new program to get up and

[24:06] running. So that's what I mean

when I'm talking about infrastructure development.

Time to hire new staff. Time to

[24:12] train the staff time to get

supervisors in place for these clinical services. And then

once your staff is on board,

[24:19] you can start actively scene

treating individuals with support and treatment services.

That's how you get to the

[24:25] sustainability peace because on

Medicaid can be billed or other insurances.

[24:30] >> Terrific. So I would love to

see what programs you are investing in that will create

future Medicaid, billable

[24:42] opportunities like that.

So one of my concerns is that in 2017, Minnesota became one

of the first states to have
[24:48] that early intensive
development and behavioral interventions for Medicaid services. And then
in 2019, they added the peer
[24:55] recovery services which is
eligible for Medicaid. So we are rapidly growing compared to
other states. What is eligible
[25:03] for Medicaid and those are the
programs what we've seen, a lot of problems. So it
concerns me to hear your
[25:09] continuing to do that. >> As sort of a model of
wanting to expand Medicaid even further when we don't have a
handle on how those programs
[25:17] are being run right now and we've seen double billing.
We've seen triple billing like there are serious problems in
the Medicaid expansion programs
[25:24] we've already done and you see
the growth. I mean, that coincide to it 2019.
[25:30] It was the start of the sheer
recovery services. And that's one of the big pots where this
is going.
[25:39] I have concerns. So I would
just love a list of what you're planning on expanding. And and
so we're able to track that
[25:46] going forward. Thank you. >> I'm sorry. Representative
Freeman, thank you. And good

[25:51] morning. There is a few minutes
late. I have a question. But before any question about
the sort of growth? Because I
[25:59] since I have been in the
Legislature, you know, I came in during the pandemic and I
know one of the places of real
[26:06] bipartisan focus has been on
dealing with a mental health crisis, the substance of this
crisis that both came in with
[26:15] opioids enough that not all and
also with the pandemic and I think the residue of the
pandemic. So I guess this does
[26:21] not surprise me. One thing I
just wanted to clarify, because I think that there's some
confusion and I actually agree
[26:27] with Representative Anderson.
It would be helpful. I think what she asked would be to see
sort of how we compare to other
[26:34] states in terms of how we are
responding to that crisis. But I don't think I heard and I
think just to clarify what
[26:42] Representative Eric said is
that you don't have metrics. I heard you say that you could
provide those for us have to
[26:47] the fact that I just wanted to
clarify, make sure that that that I was hearing that

correctly, that you said you didn't have a your fingertips,

but you'd be able to provide

[26:54] them. >> This time it's Madam Chair,

Representative. Yes, we do have metrics. I just do not have

them here with me today.

[27:02] So we definitely come for them. >> Thank you. Representative

can think you and I appreciate

[27:07] that. I think the question I

have and you know, we're we're focused on the resources, not

the problems are communities.

[27:16] And that's sort of the nature

of of this committee were not in a in a DHS and HHS Health or

Human Services Committee.

[27:25] Can you talk a little bit

about? And I think because we've been we sort of see

things that are disconnected on

[27:31] this graph, too. What we're

hearing another spaces. I know I remember one of the great

successes of the 2022. a

[27:41] session was the bipartisan

investment in mental health. I know that was a really big

party for many in all 4

[27:48] caucuses, actually. And then I

know that since we've been trying to get a handle on one

of the kinds of things we're

[27:55] doing to invest in communities

all over the state to handle this, this crisis we're seeing.
Can you talk a little bit?
[28:01] And I know that that's not the
jurisdiction is committee, but since it got brought up
this rise, can you talk a little bit about what you've
seen in the last 4 years that
[28:09] would give rise to the need for
more services in our community and and what is actually
happening in our community that
[28:15] we're trying to address this time. It's Madam Chair,
representative. >> That is a great question.
And I think that's always the
[28:21] balance of when you're working
in mental health and substance use. The need has risen
immensely. People need
[28:29] treatment. They need report.
They need services and supports at a rate that you have never
seen with this mental health
[28:36] and substance use crisis that
we're currently in. And it is a balance between making sure you
have checks and balances,
[28:42] certifications, policies and
procedures in place for those providing the supports to the
individuals, but also making
[28:49] sure that the people in
Minnesota aren't struggling. We are putting out resources

for harm reduction to try to

[28:55] lessen the deaths from overdose

and with opioids. We have

[29:00] investments again. I know here

in recovery supports it is a best practice and also require

certification, which we're

[29:08] hoping to move towards so that

there are more oversight in place. But those service and supports

our he is so that individuals

[29:16] can move into recovery and also

[29:21] continue to reduce harm.

Right? I mean, the suicide rates are increasing death by

overdose is increasing. And we

[29:28] need to have support out there

to meet those needs. There's been I know, just some

funding in that has gone into

[29:36] culturally appropriate services

that we have grants that are supporting an expansion of that

really looking at the more

[29:42] impacted communities throughout

the state trying to provide supports and the community

members are actually providing

[29:49] the support. So a lot of

funding goes to target again. The interventions that we know

our best practice, their

[29:55] studies everywhere. What is

helpful? What is not their strategy is that national
levels and we really try to
[30:01] embrace those as we expand
supports and services. >> The campus to represent her,
then we're going to move back
[30:08] to the presentation. My
question is directly to the presentation. So on the slide
that we have in front of us,
[30:15] my question is. >> Does the agency have
transfer authority? In other words, if are there, do you
have the legislative authority
[30:24] to transfer money between these
contracts this tenants?
[30:30] >> Madam Chair, representative,
not typically if the contract is flagged for a certain amount
of funding or are you
[30:37] requesting if one grant he
isn't utilizing their funds? Could we give it to a grantee
of the same orientation?
[30:47] Yes. Representative Eric, thank
you, Madam Chair. >> So right. So are you able to
move funds after you'd let
[30:54] these contracts between the
contracts? You have the legislative transfer Authority
[31:00] to move money around and that
way. Can you move money around in your contracts, immigration

system,

[31:07] this tendency? >> Madam Chair, representative,

I believe the contract integration system isn't

necessarily the tool we use for

[31:16] funding transfers. That is a

different system within the department. The contract

immigration system is really

[31:22] about tracking all of the

necessary components of a grant in order to manage the

compliance.

[31:29] >> Representative Eric, thank

you, Madam Chair. So in that contracts, you had said that

since you've been there in the

[31:35] last 6 months that all

important financial data has been put back in. Because in my

notes, I have that February of

[31:43] 2024, the chief financial officer

asked for that data to be

[31:49] removed. And I guess since then

it's been re integrated in. But you're able to see the

total amount of the grant

[31:59] that was appropriated were left. And

then you can see progress

[32:04] report to you can see how much

of its been spent or reimbursed. And then you can

see the bottom line of how much

[32:09] is left. So my question is, do
you so whatever is left, if there's too much and left,
can you transfer to a different
[32:17] contract, this tenants, Madam
Chair, representative? >> That's a great question.
And I think really it would be
[32:24] better well suited for our
fiscal staff. We do have a fiscal database. I know we have
a budget director within that
[32:31] the Behavioral Health
Administration that helps oversee that and works closely
with our financial office in
[32:38] DHS. That is not a piece of the
contract immigration system. I apologize if I was confuse
said that in a confusing way
[32:47] before there are 2 separate
system, some of the money stuff can happen, but definitely a
question for our financial
[32:54] stuff. >> He's missed and that's fine.
Might follow up on that just for a minute. You bring some
fiscal step up. Fantastic.
[33:03] I bought. Wow. She's coming up.
Just Representative Eric had assumed that the data that was
taken out of the contracts
[33:12] integration system in February
of 2024 has been restored. Is that true?

[33:18] >> Madam chair, if the
information that you are referencing was fiscal in
nature, that would be something
[33:25] I have to look into unless
maybe someone else knows I wasn't here when it was removed
or I don't even know what that
[33:33] was at that point in time.
So I'd have to do some more research unless anyone in the
teens. >> Thank you. I just want the
record to show that we don't.
[33:40] We're not clear whether it's
been restored and that Commissioner Gundy, thank you.
Shares up and say your name for
[33:46] the record show. Rob ensuring
Gandhi, temporary commissioner for the Department of Human
Services. I am not aware of any
[33:54] data that has been removed from
the contracts integration system. I would be happy to
look into that further. And as
[34:02] assistant Commissioner
Steinmetz said, the contracts integration system is the
source of truth for
[34:09] our documents related to
individual contracts. And our
[34:16] as she also stated, our CFO and
our and our finance staff,

[34:21] team news, other state systems
to track the money. So I'm not aware of any financial data
that was removed from the
[34:29] contracts integration system.
And if I'm wrong, I will correct that. Great. We look
for to just to follow up on
[34:36] that. So welcome. Please stay
tuned in for the record. Thank you. Thank you. Chair Robbins
members, Alice Billion budget
[34:43] director of the Department
Human Services. I am responding to your
question, Representative Eric
[34:49] on our ability to transfer
money between grants. >> In any instance of assessing
whether we're able to weave a
[34:58] look at what the legal
authority behind the money is. Some grants have say specific
Riders, Santa acts,
[35:05] tax entity for why a lot of
money and at the Y Z fiscal
[35:11] year. And that instance, if
that all the funds haven't been spent, that cannot be
transferred because it's
[35:18] rendered for specific purpose
for a specific entity. In other instances, funding is
appropriated to us. The fan,

[35:26] a larger budget activity where
multiple grants live and in those instances, funds can be
transferred between grants
[35:33] depending on the need. And and,
you know, the RFP in
[35:38] competitive contracting
process. Thank you, representative, back
to just one follow-up.
[35:43] >> Thank you. So really quickly
said the chart that we're looking at that and how many of
these contracts because you've
[35:49] got an exponential growth in
contracts and you and your staff like you
pointed out are fairly flat.
[35:55] So of these contracts, many are you legally able to move
money between? Is that a small
[36:02] percentage is a big percentage
like this? There's a big concern that money is being
moved
[36:09] and not always following the
rules is I'm just trying to figure out like how much of
this money is actually
[36:17] that there's a transfer
authority by the legislature already built into this.
And how much does not do happen
[36:23] to know Lake, which is which Ms

Bailey? >> Terrapins, Representative

Eric, I could get back to you

[36:30] on the percentage. I would say

in any case for remove money, we make sure that we have legal

authority to transfer funds.

[36:38] But I can, you know, get back

to you on the question of what percent of the total grants

were able to do that.

[36:46] Thank you moving on. Thank you for your time.

[36:52] The statements that's latest.

[37:01] >> So it's the last oil a

report was published in 2024.

[37:14] again, there are multiple stops

in order to implement a grant making process and fulfill the

requirement of grants

[37:20] management. This slide is just

illustrating the flow when it comes to a grant all the way

through contracting and close

[37:26] out. It lays out the sequence of

about 50 steps needed to do the work. We start with the

creation of the request for

[37:34] proposals which includes the 10

steps listed inbox. One we move on to the next 15 stops related

to review and selection process

[37:42] ease then on to the initiation

of the contract. And then finally, the ongoing grant

contract management through

[37:50] close out in that last slide.

So we were just really trying to show the stops. And the site

called the life cycle of a

[37:55] grant which is fairly complex. >> Thank you. I'm just going to

jump in here. So that LA had

[38:01] many concerns about the

conflict, conflicts of interest, both with that

community reviewers and with

[38:10] the grant managers themselves. And that's been an ongoing issue.

There was the 2024 report that

[38:18] like that. But there was a 2019

report and between 2019 2024,

[38:26] Commissioner Harp said head

presented extensively about the

[38:31] Swiss watch theory of the case

and that everything was humming along wonderfully and clearly

by 2024, many things had not

[38:39] been fixed. So could too speak to how you are enforcing

the conflicts policies in light

[38:48] of the 2024 recommendations.

And you know where you're at and that is there's still more

work to do is act

[38:57] actually being enforced.

Now, if you could provide just more detail on that.

[39:03] >> Madam chair, that is a

really great question and actually moves us right into
the next slide where we're
[39:08] talking about what's been
improved and process improvements since the 2024 on
it.
[39:15] One of which is the conflict of
interests that have not been completed, not been mitigated,
that there was a conflict.
[39:22] And so I can talk a little bit
about that throughout the side of her face.
[39:28] So since the last well, a
report was published in 2024. BHA has implemented many new
processes, procedures and
[39:36] training of existing procedures
for staff. We have established quality
control measures that require
[39:42] all RFP documentation be
uploaded into the contract immigration system. And that
actually has to happen before
[39:49] the contract administrators and
grant managers can start working on them. So we put some
kind of safeguards in place to
[39:56] make sure that things get
uploaded. We've also established quality
control measures that require
[40:02] that all RFP documentation be

uploaded into the contract immigration system

[40:08] we've created and deployed

standardized tools and templates to help the grant

managers maintain compliance

[40:14] with all requirements. One key

important one that is the conflict of interests.

[40:19] We've hired a contracts and

compliance manager and will add quality assurance specialist to

support compliance and quality

[40:27] assurance in the grant and

contract processes within be a chance. There's also been a huge launch

of an extensive training

[40:35] program for all be AJ Grant

managers. We've featured more than 25 modules now that span

across all the phases of the

[40:44] grant management so that

individuals can watch them re-learn them and attend the

trainings.

[40:50] We have also launched an

extensive R. We've also monitor compliance with the grant and

contract requirements. The

[40:57] monthly reports that are now

being generated from cso. Again, as I shared earlier,

those reports are being

[41:03] distributed to leadership.

We talk about them in our leadership meetings. We make

sure that everyone in the

[41:08] administration is completing

what needs to be completed when it comes to grandson, grants

and contracts and then

[41:14] uploading and then the system

as well. >> We've also

[41:21] implemented a streamlined

clothes out evaluation process which uses the integrated for

within the system and train

[41:29] staff on how to assess the

grantee performance. We started holding weekly

luncheon learns, as I said

[41:35] earlier, contracts and grants

can be complicated, especially if you're new staff within the

administration. So really

[41:42] trying to put together a

mentoring, coaching and learning system for all of them

to help support each other with

[41:48] the leadership of our experts

in those areas,

[41:53] I was lucky enough to be able

to move into my role, supporting the work that had

already started within the last

[41:59] couple years and continue to

strengthen it as we move forward again, rearranging some

of the staff to have

[42:06] dedicated focus to our systems
and process improvement that again, we need to continue to
build and work on within the
[42:12] administration is of
importance. >> Thank you. Just before we
move on, I appreciate this.
[42:19] It looks like a lot is going
on. But to this specific question of are you requiring
the community review groups to
[42:31] identify conflicts and then
resolve them? And secondly, requiring grant
managers to state
[42:40] if they have any conflicts and
then are they moved to other grant portfolios if they indeed
have a constant.
[42:47] >> And chair, yes, we are.
And we actually have started doing some spot checks of all
of that work. And we can say
[42:54] that for we tested 20 different
request for proposals since April of 23
[43:00] and BHA actually achieved 100%
compliance in completing the
[43:05] conflict of interest forms and
then uploading them into the system as well. We've also
really focused again on the
[43:11] training and support for the

conflict as flag, how to mitigate that, which means
transferring to other
[43:17] individuals, making sure those
community members are reviewing an application that might be
coming in. So those have
[43:23] happened. Thank you at. >> Yes, just one 0nd. And then
you're up providing all this
[43:31] training program managers and
making it available to them. Are they required to take it?
[43:38] >> And chair, yes, most of the
staff are if they play a role in grant management, they are 2
of the most Iranians and they
[43:45] are asked to go and then we
track was attending. If they weren't able to make it that
day. For some reason, we do
[43:50] have recordings that we can
offer or have them do a one-on-one connection with the
the material expert,
[43:56] but it's not required as part
of their job currently, Madam Chair, I don't believe
it's mandated in their position
[44:04] descriptions at this point in
time. But I don't know that anyone who places rolls isn't
attending their supervisors
[44:11] would talk to them. We would
make sure that we're encouraging that and that they

are attending. >> Thank you. Yes, it's just
been one of the lays consistent
[44:18] recommendations. Is that the
grant management training? It's required side. Just like
to
[44:24] explore that. I'm sorry.
Representative Eric? Yeah, thank you, Madam Chair.
So to the to the slide.
[44:34] >> You've done what you talked
about. A lot of process improvements here. One of the
major concerns both in the
[44:40] media and with some of the
folks we've been talking to is not just double billing that
sometimes triple and quadruple
[44:47] killing. In other words, it thus county state, federal
grants get billed and then also
[44:54] Medicaid gets build. And so one
example is
[45:00] of either double billing are
incorrect. Billing was a report about evergreen from Carolyn
was one of the examples.
[45:09] Things like one person build 203 hours in one day
[45:15] and things like that. So I know
you've got to slide later about billing, but I just it really goes into this
training. That seems like an
[45:23] obvious overbilling. But I also

have concerns not just about double billing, but triple and quadruple Bellinger. You've got
[45:31] that the county, the state, the federal government grants or build. And then also Medicaid is built in the morning if
[45:37] you're going to be talking about that at all. But specifically in that car, 11 story than it's a pretty be his
[45:44] overbilling, which is one person being billed for 203 hours in just one day
[45:51] for treatment, someone if you could address some of that, if you've dealt with any of that in this training
[45:56] this tenants. >> Madam Chair, Representative. Yes, that is definitely part of the trainings and discussions. It is a complicated situation
[46:05] when Medicaid is being billed directly to the program's rate and then you have a grant as well. But one of the things
[46:12] that we would discuss and train with our staff is making sure that
[46:18] federal funds specifically are always legally supposed to be the pair of last resort. So it's really important that
[46:25] our contract specialist in grant managers are understanding what is allowed

to be built a Medicaid and then

[46:30] what grants should be used for.

So they need to make sure they're monitoring that as

well. And part of the oversight

[46:36] site visits and work that they

are doing as they go out. We also have budget proposal

center talking about and 0

[46:43] billion and trying to put more

specific billion processes in place. So that billing with her

in 15 minute increments,

[46:50] which would also increase the

safeguards and prevent that from happening as much as it

has in the future.

[46:58] Thank you. One last question

for you. And this felt. So I think she just said that

[47:04] it happened in the past.

I just wanted. >> You know, I >> I'm wondering since that has

happened in the past where

[47:11] you've had double billing Trump

of Belen, quadruple killing. Does the contracts immigration

system even address that or do

[47:18] use a different system? Is it

in swift like where? Where is this information house? You

someone could actually look at

[47:24] it and say, oh, well, this bill came in and it

went, they tried to Bill,

[47:30] you know, 3 different grants
and then also Medicaid. How do you even see that this tense?
[47:39] >> Yes, Commissioner County
Chair Robbins representative or Eric. This is the challenge of data
systems that don't talk to each
[47:48] other. So it is more labor
intensive to catch that. Yes, the Medicaid payments go
out through a different system.
[47:55] The contracts integration
system is built on a platform called agile apps. And as I
stated earlier, it's more of a
[48:03] document repository at this
point in time. Ultimately one of the things we
would like to see the state of
[48:11] Minnesota have is an end to end
solution that allows from the
[48:17] initiation of grant funding. >> Coming into the state to be
able to manage it throughout
[48:23] and Ty it to the back end
payments and then it would be much easier to catch those
things and put safeguards in
[48:30] place and hard controls.
That would stop that from happening.
[48:37] Okay. Thank you. We will
probably follow up on that, but let's continues for now.
Thank you, Jack.

[48:48] >> The DHS behavioral grants
management internal controls and compliance audit of March
of 21
[48:54] had what is illustrated on the
slide. 28 recommendations for the administration to rectify
and then the next grand,
[49:03] a word processes evaluation
report from 2024. Included another 4.
[49:08] We're just putting a stop here
to illustrate that. We're happy to report that as a February
2025 of those 32 all
[49:15] recommendations. 26 have been
totally closed out and resolved at this point in time.
[49:21] The 6 that remain open, which
are from the March. 21 report are in the final stages of
close out. And so within the
[49:29] next couple weeks, though,
should be rectified as well. Again, it takes time to improve
a system, put in processes and
[49:36] procedures put in tracking
systems, check lists all of the things we need to do,
[49:42] but really wanted to highlight
the most of the past findings have been closed
at this point in time.
[49:49] >> So if I could follow up on
that, when you say close, you mean you have satisfied the

oh, LA recommendations,

[49:56] madam chair. Yes. >> That would be and how you

close to finding new implement what they recommend that you

do. So once it's implemented,

[50:03] you can close to find him. >> So when they recommended

requiring community

[50:09] conflict forms and resolving

those are resolving conflicts with your great managers,

you're comfortable saying that

[50:16] that is fully resolved. >> Madam Chair, I would say a

gun. There's always room for

[50:22] checks and balances and

improvement in the system. We have processes procedures

and policies in place that the

[50:29] contract administrator Zahn,

Grant managers need to follow. And there's always room for

human error and not following

[50:37] something forgetting to upload

that for getting to do it. So I am all about systems change

and improving processes.

[50:44] I don't think you're ever 100%

in your work where you need to go. So I would continue to work

on it and prove it. Make sure

[50:51] we're monitoring a until the

point where we know that it's being done every single time

consistently. But we have the

[50:57] process in place. We did a spot
check for the 23, our piece that went out and all of those
conflicts of interest were
[51:04] done. So we are making
progress. >> Just to follow up on 2
points that you did say that
[51:12] all 20 conflict of interest
forms, what upload it. But you didn't say the conflicts were
resolved. So can you
[51:18] differentiate there for me? >> Madam chair, they would have
been resolved if they flagged
[51:24] any conflict of interests and
again, then they're uploaded in the system. So if the conflict
of interest exists, we would
[51:31] medicate that by again, not
having that community reviewer review that application.
That happens all the time when
[51:38] grant interviews are happening.
If we have individuals that are working in the administration
that have ties to that
[51:45] organization and fill it out,
they wouldn't mind they would monitor those grants. We would
resign. So those things are
[51:51] being litigated. Okay. >> And to that 0, one of the LA
be recommendations. We haven't talked about a single source or
sole source contracts.

[52:00] And the recommendation, you know, was for much more clarity on that and for there
[52:06] not to be any conflicts.
Could you talk about how you address that and what percentage of your grants and
[52:12] contracts are still source versus competitive? >> Madam Chair, I would have to get that person says exactly
[52:19] for you to provide. >> My >> experience. And what I've seen in the administration so
[52:26] far is that there is not a large amount that's U.S. little stores. There are some funding allocations that are your march
[52:34] for certain agency is and go directly to them. So that is a different venue that you have to follow.
[52:39] But most of the sole source would need to be because that is the only entity that can provide the service if the
[52:46] administration was doing that on their own. It is a different process again, if someone stated and legislation to be
[52:52] getting that funding. >> Thank you. And I understand that and we are working bipartisan way here to create a culture where we do not have as
[53:01] many legislative name grant.

So we will continue to try to partner with you on that Chair Pinto.

[53:07] >> Thank you, chair. Yes, doors that lead to us. That last sentence up just a just press. And I just want to go back to

[53:13] the conflict of interest issue for a second. As it stated in the only report what they were den, a fine was sort of gaps

[53:19] and paperwork with tech. She helpfully on the slide in front of us. But they I guess I'm not aware of their having been actual conflicts that were identified and I could be wrong

[53:29] about that. But if you could just sort of clarify that, we're talking about gaps in terms of certain documentation,

[53:37] rather than it being something that will actually found where there was, in fact, a conflict, whether internal staff and outside reviewer,

[53:44] it's 10 minutes. >> Chairman happens if I could answer that question, Commissioner Candy. Yes, Chair Robbins lead Pinto. Yes,

[53:53] you're correct. The allay when they find that documentation isn't present, then they say that, you know, they can't

[54:01] confirm whether we have addressed it or not. But you're correct. They did. We did not

receive any findings for
[54:09] actually having a conflict of
interest. And thank you. Thank you, Chair Vice Chair
Anderson, thank you. I just but
[54:17] point out that that will lead
us that typically look at that in the first place. So they
look at the paperwork. They
[54:23] don't look at whether a
conflict actually exist. And that's more of a time legal
investigatory, you know,
[54:30] issues such as what we do now. Is that the answer? So thank
you. I thank you. Please
[54:38] continue its Time Inc. >> 5.13, is showing that the
Jansen much work to improve its
[54:45] grant oversight in the recent
past. And although there are still improvements to be made,
the resolution of the audit
[54:50] findings on the slide is a
great start to better oversight and compliance with the grant
cycle requirements.
[54:57] The result has findings seem to
be centered around internal controls and compliance
monitoring as well as record
[55:03] keeping personnel and training
and grant application and award process is
[55:08] we continue to ensure documents

are completed and stored appropriately and assist
system. Again. These include
[55:15] completion of the conflict of
interest forms and also mitigating any conflict of
interest that might arise.
[55:21] Yes, I can also share that the
position descriptions have been updated related to grant
management and training has
[55:29] occurred for all staff tools in 10 plan, something
standardize and are being utilized throughout the
Behavioral Health
[55:35] administration. Dha is put in place procedures
at all levels to support the
[55:43] required practices when it
comes to grant monitoring for using the contract immigration
system and are pulling
[55:50] information from that system to
monitor that the documents documentation is present in the
system.
[55:56] Again, we've started sending
out notices to staff and supervisors tracking progress
on completion before due dates
[56:03] of those grants and contracts. And we're utilizing our
leadership meetings to talk about progress on those
completion reports as well
[56:12] doing all we can to continue to increase the visibility of the

need to make sure that this is

[56:18] done in an appropriate manner

and that everything is completed so that we can do all

we can to ensure good grant and

[56:24] contracting processes. I shared a little bit of these

data points before. But again,

[56:31] I just want to be stressed that

we're really happy to report that when we did the test and

Paul the compliance check

[56:37] again, that of those 20 RFP is

published since April. 23,

[56:42] we had 100% compliance and

uploading the conflict of interest forms to CS

[56:48] and our contract closeout

process also has shown improvement in that area,

[56:53] completing the evaluation at

the close outs, which has financial reconciliation, many

different pieces to it,

[57:01] reaching 97% of those close

requirements for July 31st, ending contracts and those that

just ended in August. We had

[57:10] 100% compliance

[57:15] and I will turn it over to

Commissioner kind.

[57:25] Say that some of the questions. >> Oh, yes, sorry, commissioner

got me. So I was reading on

[57:31] something. Please continue.

Chair Robbins members of the committee while Teresa was talking about

the work that is done within an

[57:40] administration to oversee

grants. I also wanted to share the additional work does Don in

operations to support our

[57:49] program areas. >> So this slide provides an

overview of the different

[57:55] levels of support and that that aid in providing

oversight and controls in the

[58:02] process. Our contracts and

legal compliance division has attorneys and contract

Cordinator years who help make

[58:10] sure that our contracts meet

the requirements set out for state contracts so that they

are legally enforceable

[58:18] and meet all the requirements

that both in statute and that

[58:24] the Office of Grants Management

buyers. We also have the Central Grants

office, which is newly

[58:31] established it started in 2022.

with just a couple staff and

[58:37] then thankfully the legislature

appropriated funds so that we

[58:42] could have a more robust

central grants office and that was in 2023
[58:49] and the Central Grants Office
is the division that owns the contracts, integration system
that supports it. And they also
[58:58] develop policies, procedures,
training and technical assistance for our grant
managers across the
[59:05] organization question. >> Vice Chair Anderson, thank
you. Can get this is not
[59:11] department adamant. This is a
separate. This is within DHS APS. Can you if you do the
Spanish side talk about what
[59:20] admin it's doing and what
they're you're looking at a statewide grants. Pension
system. Yeah. Yeah. I actually
[59:26] have a slide that cover that.
Thank you. The continued Commissioner, Ken thanks.
[59:32] >> Chair know thank you. Chair Robbins.
[59:37] The next box down under the
Central Grants Office is our Office of Internal Controls and
Accountability. That's where
[59:45] our internal auditor Sept and
this area has recently
[59:50] developed a grants audit unit
and they are going to work on
[59:55] regularly testing our internal

controls and as well be available to audit grant.
He's whenever we have flag
[1:00:04] something that is a question or
concern. And then lastly, the compliance
office at DHS houses, all of
[1:00:13] those areas, the contracts and
legal compliance division, the Central Grants Office and
the Office of Internal Controls
[1:00:21] and Accountability. >> And they have oversight 10
with the program areas and work
[1:00:28] directly with process control
champions to support the internal controls that are
taking place within the program
[1:00:36] areas and also provide a way
for any concerns that are
[1:00:41] happening in the program, areas
to have an independent place where those concerns can be
reported.
[1:00:49] So the next slide I wanted to
cover cause. I know the Department of Administration
came to this committee and
[1:00:56] presented on their controls.
So I wanted to just share with this group. Housing connects
with that.
[1:01:04] So the Department of
Administration centrally for the state of Minnesota sets the

rules and has been implementing

[1:01:13] from an enterprise wide place.

The 2023 grant requirements and

[1:01:19] DHS on its side on our side as

an agency have been

[1:01:24] in close contact with them each

step of the way, making sure that we're doing what we need

to as an agency to comply with

[1:01:33] those enterprise requirements.

And so I won't go through all of these, but I just wanted to

flag for you that we have

[1:01:42] completed each staff and we are

on track to be ready to go

[1:01:47] April 2025. As required with

grant he evaluations as well.

[1:01:53] The last item number 12, I

wanted to flag for you because I have heard

[1:02:00] some legislators think that

when the grant dollars increase for in agency, the staffing can

increase. And I wanted to let

[1:02:08] you know that that's not the

case for DHS. So we have not implemented that because it

conflicts with how we receive

[1:02:17] funding and there are our

legislative chairs and analysts who have not been supportive.

And some of the legislation

[1:02:25] specifically says the DHS cannot use the
funds in that way.
[1:02:31] And on top of that, we actually
have some technical challenges
[1:02:36] because of our budget
structure. So just wanted you to be aware that as you see
that exponential growth in
[1:02:42] funding, that we are not able
to take that administrative costs.
[1:02:47] Thank you, Representative rare. Thank you. Madam Chair. Just
really quickly on the previous slide, you said something that
caught my attention.
[1:02:56] >> In the 4th bullet point down
for office of internal controls and accountability. You said
that these are that this will
[1:03:03] happen. So is has any of this been
implemented or is this like
[1:03:08] where is this in the process of
actually happening in being in effect,
[1:03:16] commissioner again? >> Chair Robbins
Representative. Eric,
[1:03:21] are you specifically asking
about the grant auditors?
[1:03:26] >> Representative Eric, thank
you, Madam. Madam Chair. So I you had said something
about in this bullet point that

[1:03:31] these things will be happening. Are some of these not implemented yet like where we at in the process of this of of actually having really good
[1:03:39] accountability and internal controls. We've got so many examples like it
[1:03:45] talk for an hour or 2 or 3 of things that have gone sideways. And it's been all over the media from KARE 11 to Kcp 5 in
[1:03:54] other places where we've got fraudulent activity, double billing, all kinds of different things. So I'm asking you,
[1:04:00] when has this gone into effect? And if it has not, when will it go into effect? This literally that
[1:04:07] point down Commissioner Guns? >> Chair Robinson Representative Eric. They are
[1:04:14] in effect now. Last question, Representative Eric, when did it go into
[1:04:21] effect? Commissioner County Chair Robbins representative air which item
[1:04:28] Representative Eric. >> Let's go will appoint one that you conduct internal audit
[1:04:34] and coordinates with external auditors with L a S and so on FBI
[1:04:41] Commissioner Candy. >> Chair Robbins representative Eric, that has been in place

[1:04:47] since the internal control in
since the internal audits division has been in existence.
And that is I don't know 30
[1:04:56] years or more. >> Commissioner Gandhi, could
you elaborate how many audits
[1:05:02] are conducted every year
internally?
[1:05:08] Internal audits of the audits
referenced here conducts internal audits and coordinates
external audit. So the internal
[1:05:14] audit, internal audit, I would say,
are probably 10 or fewer a
[1:05:20] year. It depends on the comprehensive
nature and what's being audited
[1:05:27] and the amount of time that it
would take to conduct it. This is a particular concern to
me on this internal controls
[1:05:35] aspect. I have here
presentation commissioner hopes it gave in 2019 when there was
a freshman
[1:05:43] and she swore they were
bringing in all these Sigma 6 lean experts and they hired new
consultants and they've moved
[1:05:51] the internal financial controls
division under the CFO. And I have list of things she said
they were doing in 2019

[1:06:01] have not seemed to solve the
problem. So
[1:06:06] I guess I'm looking for if I'm still here in 6 years
and look back on this
[1:06:12] presentation today, how will we
see measurable progress in
[1:06:17] cutting down on the fried and
the abuse in DHS? Because I get
[1:06:24] there are processees that
you've been working on, but that's what we were told in
2019. And many of the
[1:06:31] recommendations from 2019 were
not followed up on, even though we were told they were. So how
how can we do better as a
[1:06:40] legislature and providing
oversight to ensure that these are
happening? Because clearly
[1:06:47] there's been continued issues. So I I would
welcome your feedback. What can
[1:06:53] we do better to make sure this
is actually happening? Commissioner Gotti, representative or Chair
Robbins, thank you very much
[1:07:00] for that. And we have. >> Continuous improvement is by
its very nature, something that
[1:07:08] you never stop working on.
So we are always working to strengthen our internal

controls.

[1:07:14] Since I have been at DHS, we

have followed through on recommendations. Every

recommendation. We have a

[1:07:21] detailed audit tracker that our internal

audits team keeps that that

[1:07:27] keeps all of the LA S a chest S

findings, every single one,

[1:07:33] including our internal audits

and follows through on those working with the program areas

to their resolution

[1:07:41] and DHS. We are a large agency.

25 billion dollars and we are

[1:07:49] payment. Accuracy is greater

than 99%. But even a small error

[1:07:56] is large in magnitude and every

dollar counts. So it's it's not surprising that it makes news

and catches the attention.

[1:08:04] It doesn't mean we are working

on it. And what I would say in terms of

[1:08:10] help from the legislature would

be that the more complex we

[1:08:15] make programs and we make

funding the more challenging it is to have accuracy. So it's

very important that we subtract

[1:08:28] requirements that aren't adding

value and focus on the ones that are really going to make
sure that we have program
[1:08:36] integrity and high quality. All right. Please continue.
[1:08:49] So as I move into talking about
fraud, just want to reinforce
[1:08:55] that Minnesota. We should be
proud of Minnesota as a state that is committed to helping
people.
[1:09:02] >> And that we're committed to
providing services that improve people's lives and fraud
against these public programs
[1:09:10] is unacceptable. It harms the
same people that were trying to help.
[1:09:17] So going back to a question
that you posed in the letter to
[1:09:22] us to present today. You wanted
to cover payment withhold since
[1:09:28] payment. Withholds are a
temporary action to stop payments to providers during an
investigation.
[1:09:37] And >> there are several factors
several out times when TH S
[1:09:44] make issue of payment withhold
when there's a credible allegation of fraud. If a
provider doesn't provide access
[1:09:51] to a program, a record if

there's false or misleading information and to protect the
public welfare
[1:09:58] and Minnesota statute defines
what a credible allegation of fraud it is.
[1:10:08] >> How often do payment
withholds happen? Here are the totals across the 5 years.
It's about 725 times over the
[1:10:18] past. >> 5 years. And in that time
we've done about 4,000
[1:10:24] investigations. So the governor's payment
withhold proposal would help
[1:10:34] with some gaps that we see. And I think before we were
discussing, why can't DHS to
[1:10:42] some of these things already? And by expanding the current
law, as the proposal does,
[1:10:50] we can take action without
being told by a court or at least reducing the likelihood
that a court would tell us that
[1:10:58] we're acting arbitrarily or
without the proper authority.
[1:11:05] So, for example, if >> under number one, we're
talking about criminal
[1:11:12] conviction related to fraud and if Somebodys already been
convicted of a crime and
[1:11:20] there's not an ongoing
investigation, then we can terminate them for

that from the program. But they

[1:11:27] have appeal rights and then the

appeal rights allowed the money to continue to flow. So this

provision would allow us to

[1:11:35] shut off the money while the

administrative action is pending. And in each of these

areas, there's sort of detailed

[1:11:42] legal new, lots U.S. that our

staff are saying would make it stronger and less likely to be

overturned by courts or face

[1:11:51] questions by courts. >> Can you say Vice Chair?

Anderson, thank you. Have

[1:11:58] you know, very interested in

this, obviously have has that actually happened that you are

[1:12:04] stopped by a court? I mean,

even like Peter, Peter, they weren't actually stopped by a

court. So they say they were,

[1:12:10] but they weren't, you know, so, but has that actually happened? The court heard say no, even

though there's fraud, you have

[1:12:17] to continue paying them or is

this little? I guess that's one question and happened. How many

times so Commissioner County

[1:12:25] that chair Eric Vice-chair

understand? I think what we have. I mean, I think

the challenge is that.

[1:12:35] >> We are we don't want to
waste waste, state resources, trying things that we don't
have authority. So at DHS,
[1:12:44] we tend to not take action
unless there's clear authority to do so. So
[1:12:52] so we, sir, so. >> Madam chair, so knowing
that. So you're saying no, that's courts haven't actually
stopped that. They haven't
[1:12:59] prevented you from withholding,
Mr. Again. >> Chair Robbins, vice chair.
I would need to ask our legal
[1:13:06] team that question. Okay.
What we're trying to do is strengthen our ability to take
action against the bad actors
[1:13:13] and I'd ask for your support
for that. >> Thank you. I do have a
question. So this the
[1:13:19] governor's proposal, but my
understanding is you already can withhold payment when
there's a credible allegation of fraud. Is that not already
true?
[1:13:31] Please continue. We'd also like to
[1:13:38] >> have a proposal that would
allow us to be more transparent with our payment withhold
information. Currently that is
[1:13:49] payment withhold is classified

as confidential data. So this would mirror the
current authority of the
[1:13:56] commissioner to disclose and in
and it the existence of an investigation explained
[1:14:05] in terms of anti kickbacks just
quickly to define what a kickback is. It's when an
individual or entity offers an
[1:14:15] incentive to another person to
induce that person to receive an item or service that is
eligible for public funds.
[1:14:23] Reimbursement it backs are federally illegal
[1:14:29] and existing federal law
prohibits the use of kickbacks. Dhs and state law enforcement
partners can still react to a
[1:14:38] kickback, but there also must
be evidence of fraud. This proposal fills the gap
that prohibits the state from
[1:14:46] taking action if there's only a
kickback. >> First of all, just a moment.
Vice chair Anderson, so is not
[1:14:55] a kickback already credible
evidence of fraud, not necessarily chair. So can
you give me an example when a
[1:15:03] kickback is not credible?
Evidence of fraud, chair Robbins?
[1:15:09] >> Yes. So for example, if AM 2

that he is

[1:15:15] soliciting a soliciting participants by

paying them to participate,

[1:15:23] but they're actually providing

the services and appropriate services are

being delivered and the funds

[1:15:33] using the funds being used to

solicit or entice people to use

[1:15:39] their services are not coming

from state dollars or other dollars that are not

[1:15:47] allowed for that. Then then

that's an enticement. But there's not necessarily an

improper payment that we can

[1:15:55] act on. And that's not fraud. >> And use it. We we can

discuss that after AG

[1:16:04] Commissioner Vice Chair

Anderson. >> Thank you. Yeah, I mean,

that to me is abuse. That to me

[1:16:10] is, you know, you haven't no

way of knowing. I mean, you could you know, you're you're saying

it's it's direct funds. But if

[1:16:18] you look at some of its

financial, the dollars that come in from somewhere, you

know, within that organization.

[1:16:24] But to me, that's a clear

abuse. And if it's looked at as a kickback

[1:16:29] federally, it's illegal and
clearly at stake, you know, just because it's a federal
statute doesn't mean it's not
[1:16:35] illegal in Minnesota. It's a
federal issue. So I just I don't understand
[1:16:42] again, I I what support
whatever can happen to tighten things up. But I also believe
that it's already
[1:16:49] tight and not to have avoided,
you know, the the vast majority of the fraud that we've seen
here over the last decade or
[1:16:58] whatever. So thank you. Commissioner County Chair Robbins, vice chair.
[1:17:03] >> I appreciate your support.
And I would like Minnesota to join the other 36 states that
make kickback illegal so that
[1:17:10] we have stronger ability to go
after that. >> Commissioner and you'll be
happy to know that my bill is
[1:17:17] currently awaiting jackets.
So we look at that in the hopper and it may be the first
bill our committee years.
[1:17:22] >> In a bit of a serpent.
And thank you, Madam Chair. Yeah, I will note that the
administration's proposal will
[1:17:28] be having an informational
hearing on it going to be introduced on Thursday and it's

giving informational hearing in

[1:17:33] state Gov. And I think so just to say that

that is on its way as well. And this is part of the

administration's broader

[1:17:39] proposal regarding these

issues. >> So, yes, and the

administration is also going to present the governor's proposal

here at our committee. But I do

[1:17:46] not believe that he has been

set for working on it, OK? Yes, are still waiting, waiting

for language, which we haven't

[1:17:52] seen them. Please continue. >> Chair Robbins. So these are

the additional proposal

[1:18:01] elements and that we're going

to ask for your support to pass in the governor's antifraud

package. And as you noted,

[1:18:09] we will be back here to share

more information on that. Thank thank you. You can now

like to Welcome Superintendent

[1:18:16] Evans.

[1:18:31] >> Welcome to the committee.

Please to tune in for the record to contend. Thank you.

Madam Chair, members of the committee, my name is Drew

Evans and the superintendent,

[1:18:37] the Minnesota Bureau of

Criminal Apprehension. And thank you for having me at your

committee today.

[1:18:43] I was asked just to provide a

brief overview. Know a lot of what you're focusing on today

here has interaction with have

[1:18:49] Medicaid in particular. And so

we'll talk a little bit about how that works from there.

But one of the items that we

[1:18:55] wanted to get an overview of

was now a recent addition order tried to transition, I should

say, got to a new process that

[1:19:04] we're working on. One thing

that we've recently done through the administrative

process through the governor's

[1:19:10] executive order ordering U.S.

to combine all state law enforcement resources into one

particular entity to ensure

[1:19:17] that we have adequate resources

addressing a few different things that come by. And the

cameras Fried bureau with the

[1:19:22] Minnesota BCA is financial

crimes fraud section at the BC and that was completed on

February 7. That team now is

[1:19:30] working together in unison,

unable to take additional cases that involve state front for

criminal investigation. What

[1:19:37] that does is it creates a

singular got coordinated response to identify and
disrupt and hold offenders
[1:19:43] accountable for some of the
state program present. You're talking about this unit just
because we're in front of this
[1:19:49] committee very often focus on
for mean areas, insurance fraud
[1:19:54] work that has been done
traditionally by the cameras Friday will now be conducted by
this new section, which is the
[1:20:00] BCA financial crimes and fraud
section. And I do want to continue just to reiterate that
they're only focusing on
[1:20:06] criminal fraud. There's a
credible allegation of criminal fraud that gets referred to
this unit. And this is for all
[1:20:12] of the different things that
they cover. Also wage theft and misclassification crimes that
have been done and some form or
[1:20:18] fashion by both of the previous
units prior to combination traditional financial crimes in
on. As we continue to need to
[1:20:26] look at that. As I was sitting
here, I was reading an article that just last year alone to
the Federal Trade Commission,
[1:20:33] Americans reported 12.5 billion

dollars in individual fraud to them. And so this is a growing
area. That's not any state
[1:20:41] government program fraud that's
just fried includes individuals that we see in. So this is a
growing area of crimes that we
[1:20:47] need to continue to focus on. And lastly, state program pride
that will be covered by this
[1:20:54] particular unit. This also as part of this work
and part of this transition,
[1:21:01] we've been working with the
Department of Human Services. We've worked together with
contracts with them for a number of years, traditionally
focused and see cap, which I
[1:21:09] know you've had discussions
about here. But we've also had programs in other state
agencies such as deidh looking
[1:21:15] at unemployment fraud related
issues there. Also recently, we completed a contract with
the Minnesota Housing Finance
[1:21:23] Agency related to some COVID
related issues that they were experiencing. We also have
agents that are assigned to the
[1:21:30] Social Security administration
and analysts there. That was a little bit unique. It's it's
it's a in a sordid disability
[1:21:39] determination office that looks

at that. But it's a federally run program. So it's all really federal fraud. They're a little
[1:21:45] bit more insular. The partnership with the DHS, though, as we recently re engineered our contract with
[1:21:52] them so that we can expand our focus not just becomes looking at sea, kept fraud. And so the new language is all really any
[1:21:59] government-funded program at Friday's identified this unit can then take a look at that along with them. One notable
[1:22:05] exception that will note that somewhat related. Today's that does not include move from coal, Medicaid fraud control
[1:22:12] unit that's run by the Attorney general's office. And the suspected Medicaid for criminal fraud continues to get referred
[1:22:19] to the Attorney General's office. However, our new unit is working to strengthen our relationship now with the
[1:22:25] Attorney general's office that the Fuego unit, Medicaid fraud control unit. We have long work together with them both at the
[1:22:31] Commerce Fried Bureau and the BCA when they need to conduct search warrants and do things that license law enforcement

[1:22:38] have to complete. We provided
assistance to them. It's been kind of one-offs as that the
work that they need to do that
[1:22:45] particular work that we assist
them with. However, we're looking for ways that we
potentially can strengthen the
[1:22:51] collaboration between them, as
I just noted with a number of Americans that are experiencing
individual fried fraudsters.
[1:22:57] Certainly Eric Nas taken the
programs that they wish to target in their process.
And so we can more readily
[1:23:03] identify people across
spectrum. We want to work together with them to be able
to do that and identify if
[1:23:10] they're involved in multiple
programs to take the case. That makes the most sense from
there
[1:23:16] and that madam jurors real
short and sweet and this particular but happy to answer
any questions about that word.
[1:23:21] >> Thank you. I have several
questions. Then we have a list. I'm I'm not sure who this is
poor. So I just want to talk
[1:23:28] for a minute about 5 in the
autism centers. That's something we haven't addressed

it today. And that's of great concern to me.

[1:23:34] So my understanding in just a

quick go back to couple the

[1:23:40] earlier slides. Have you

stopped any payments to many of the this is service providers

or have you revoked or put on

[1:23:48] temporary suspension any of the

licenses? But those providers,

[1:23:53] Commissioner County Chair

Robbins, we have been our Office of

Inspector general has been

[1:24:01] doing audits, in-person audits

of all providers. They have

[1:24:07] completed 219 visit so far and they have taken various

actions as appropriate,

[1:24:15] including including those items that you

mentioned. So

[1:24:23] south payments have been

stopped. Licenses have been revoked. Can you fix, you know,

be more specific?

[1:24:31] Commissioner County? It's so

the IDB I it. Yeah. The autism

[1:24:36] services are not a licensed service.

[1:24:42] So have you stepped payments to

any of them? Commissioner Robbins?

[1:24:51] I am I'm hesitating because

payment withholds are private

[1:24:57] and I would need to to check on the data and see if

it's large enough sample that I

[1:25:05] could share with you, OK?

I respect that. So I just wanted to

[1:25:12] and talk about couple of the

examples that are particularly concerning concerning to me.

One is a smart therapy center

[1:25:21] in Minneapolis and they were

given 14 million dollars since

[1:25:26] 2023 at the leads. One of the problems is that

[1:25:35] they became a feeding our

future site. And so they provide to some

centers, but they also became a

[1:25:42] feeding our future site. And one of the people involved

in that pled guilty in the

[1:25:48] feeding our future, you know, investigation and

charging. So are they still

[1:25:56] providing autism services for

the state

[1:26:06] Commissioner Connie Chair Robbins. So

[1:26:11] this is a a says, a criminal investigation

[1:26:17] by the FBI. What I can confirm

for you is that DHS had both of

[1:26:24] the programs that that the U.S.

attorney issued search warrants

[1:26:29] for on its radar and we
participated in the investigations
[1:26:36] and continue to provide state money to those 2 sites that were in
the search warrant.
[1:26:46] And do they continue to provide
that to some services
[1:26:52] Robbins payment withhold
information is private
[1:26:59] somehow? I think that's
important that we understand. I mean, there are several
examples of
[1:27:07] overlap between top defendants
in the feeding our future cases and several other organizations
that provide
[1:27:15] alright related to it is centers. And
[1:27:22] I I respect that there's a
process, but I think to the
[1:27:27] extent it may be it is making
that data public. And I'll be the first one to sign that
bill, because it's very
[1:27:35] concerning that these centers
may continue to be receiving
[1:27:40] state dollars and there were
evidence in the search warrant. If you've read it as I have,
you know, that their evidence
[1:27:48] is of kick back up services not

being provided of many of the things we keep seeing over and over again. So I would hope
[1:27:55] that payments have been stopped. And if they have and I hope you will continue to look into that.
[1:28:01] >> Chair Robbins. Yes, we we are very actively looking into
[1:28:07] anybody that has been connected to feeding our future and indicted. Starting when that information became available,
[1:28:15] DHS was very carefully reviewing Medicaid payments are
[1:28:21] grants, et cetera. We have found about a half of
[1:28:29] half of that. >> Half of the ones we've looked into had no connection whatsoever that we were able to find to DHS programs, the other
[1:28:38] half that have connections.
We have taken action depending on the program. I'm not speaking specific to ebb I but
[1:28:46] depending on the program we've taken actions to disqualify people from our programs to revoke licenses and to stop
[1:28:55] payments. And we are continuing to review anybody that's
[1:29:00] connected to that fraud because

Friday is absolutely unacceptable. And we also like
I mentioned, are doing audit of
[1:29:12] all of the the IDB I sites that
are in person,
[1:29:18] thorough audit of the programs. >> Great. I appreciate that.
And if you can share with us
[1:29:25] who's been disqualified, who's
had a revoked license for you've stopped payments, maybe
not by name if that's not
[1:29:32] permissible but just abroad. Overview, especially since,
[1:29:40] you know, tie anything tied to
feeding our future. That would be super helpful for the
committee. And I have more questions but I
will turn to representative or
[1:29:49] form. Thank you, Madam Chair. I
thought they had others on the list before me but really
quickly.
[1:29:56] >> We were talking to an
outside expert about investigating fraud. And one of
the things that was pointed out
[1:30:02] that was incredibly important.
And I appreciate that. You've got Superintendent Evans here.
That's he's one of my faves.
[1:30:08] And one thing that's really,
really important is that when fraud is suspected by your
front line people and they see

[1:30:14] something that doesn't look
right like a 204 hours being billed in one day that they can escalate that to
a specific person. That's not
[1:30:22] their direct supervisor.
But outside of that, that's a really important thing. So its
my understanding that that
[1:30:29] hasn't Ben the course of action
here in Minnesota and that that had led to a lot of problems, a
lot of fraud in Minnesota.
[1:30:37] So with all of this change in
all of this restructuring in new departments and all of
this,
[1:30:42] the very basic stuff, can you
explain to us the very basic steps you've got a frontline
worker, this suspect, something
[1:30:48] that see something who did they
escalated to and then what happens? And then the second
part of the question is,
[1:30:54] if somebody in the organization
then retaliate against that whistleblower,
[1:30:59] who would who does that
whistleblower then go to to get protections and make sure that
they're not threatened their
[1:31:06] jobs or and threaten their
livelihoods are not threatened but they are actually
protected. Can you tell us how

[1:31:12] that happens? Those 2 parts. >> Commissioner can chair Robbins representative rare yes

[1:31:19] there quite a few avenues for reporting if frontline staff

[1:31:24] has concerns. So DHS has an internal confidential hotline.

[1:31:30] That is one avenue that goes directly to our internal audit office. Our

[1:31:36] compliance office, actually, it now goes directly to our compliance office.

[1:31:42] We also our our staff are also instructed to report anything

[1:31:50] that's appropriate to the office of the Legislative auditor as well as to the BCA.

[1:31:58] And then in addition to that, staff are able to

[1:32:05] I can report to mmb. I know on occasion they will go to the

[1:32:13] office of the legislative auditor and it might not be something that the legislative auditor

[1:32:18] looks into what the legislative auditor refers that back to us

[1:32:23] without providing any name information and we look into the matter and then close the loop with the legislative

[1:32:29] auditor. So there's several different

avenues that employees can take

[1:32:35] to report concerns in terms of retaliation.

Retaliation is prohibited.

[1:32:42] And it is very important to me

that we not do anything that is

[1:32:50] retaliatory because employees

reporting issues are how we keep program integrity. So

retaliation would be looked

[1:32:59] into by our HR department and

also can be looked into by the

[1:33:07] M M B a sort of the internal controls

and HR functions of the

[1:33:14] Minnesota Management and

Budget. >> Thank you. Chair Pinto and

Representative Dream and Madam

[1:33:23] Chair, Representative Green Men.

Thank you. Madam Chair in guests have a question for for

the picture. Commissioner of

[1:33:33] INS Director Evans get it

right. And >> superintendent and the U.S.

[1:33:41] it's early. It's Monday

morning. One of the things that I think

we've seen sort of coming back to the behavioral health space

in, you know, new way and other

[1:33:50] places in this overbilling >> is also sort of related

issues. And I want to talk a

[1:33:55] little bit about Cairo's
because it was a an issue that the legislature actually spent
some time dealing with and
[1:34:02] passed a law to wear. What we
saw there in addition to the overbilling was the
misclassification of workers
[1:34:09] who were hired as independent
contractors. It made it harder to, I think, to get to the the
over billing issues. But it
[1:34:16] also was both wage theft and
also defrauding the the state
[1:34:21] from unemployment insurance,
taxes and the tax withholdings
[1:34:27] and all of those ways that
misclassification actually drains public coffers. And one
of them in that he's with the
[1:34:34] legislature did was say in this
model with pure recovery support specialist in just
mandated that that they are
[1:34:42] employees, which I think makes
a lot of sense when we're talking about the most
vulnerable folks, what was
[1:34:47] being told and actually my
neighbor had a job like this where he was a career, appear a
part of his peer support,
[1:34:55] recovery specialist and was

told only he only got paid when he build and he didn't get paid
when his supervisors having
[1:35:03] meetings of him on his trips to
and from and also was being pressured to over Bill.
[1:35:09] When we did that, Cairo's then
shut down. When we when we intervened in that business
model, that was both defrauding
[1:35:18] workers and defrauding
government Cairo's shut down. And I'm wondering, as you are
in this new configuration,
[1:35:26] which I think is actually
really helpful because a lot of these issues have many
components, right? And as you
[1:35:32] said that when we think about
fraud in the business model of fraud, there is often a there
government is the mark workers
[1:35:39] on the mark. There may be
consumers of the mark. It also fits together. I'm wondering as
you do this consolidation,
[1:35:45] how in areas like this where I
think there is some vulnerability enough, the
workforce, there's some
[1:35:51] vulnerability in the billing
how you are structuring a restructuring are thinking
about these places so that we
[1:35:58] can look at all of the

elements, including the wage theft, including the misclassification, including
[1:36:04] the billing fraud and and how your approaching on. >> Superintendent evidence that Chair Robbins represent human.
[1:36:11] Thank you for the question that really that I think you answered a lot of it as you're going through exactly some of
[1:36:17] the things that we need to look at. Part of what we need to do a better job at is take a really holistic approach to
[1:36:23] fraud across the various schemes that can often times, you know, wage theft. And this classification are not
[1:36:29] necessarily, you know, true pride, but somebody is a victim of this fraudulent activity that led them to a position to
[1:36:35] be in to begin with when it comes to this. You know, certainly those are policy considerations for all of you to make as to whether or
[1:36:41] not to intervene in a part its model year reference that you noted, it certainly makes it easier for us is criminal
[1:36:48] investigators to prove a fried in that mechanism if their employees, there's more paperwork, this the lacking of

[1:36:54] paperwork, a number of
different things that we can look at and support. So
individual sole proprietors.
[1:36:59] But also there's a lot of sole
proprietors that do really wonderful work in a broad
spectrum of businesses and saw
[1:37:05] that something that you can
kind of play to answer your question more specifically.
We're doing a few things out of the gate, trying to do a better
job to help agencies across the
[1:37:13] board to learn from the
investigations as they occur. One as we started to build,
trying to relationships with
[1:37:19] and then be internal controls
that works across the enterprise with the internal
controls teams within the state
[1:37:25] agencies. We've had some
initial conversations and what we'd like to see is and they
already have ongoing meetings,
[1:37:32] but that we feedback as a
feedback loop into those internal control meetings, what
we've learned as part of it,
[1:37:37] it's outside of the scope of
this particular meeting. But part of the governor's
budget recommendations for this new unit is just 3 positions,
one as a as a forensic

[1:37:46] accountant that would look at
the financials to help it. Our teams along the way, 2 is
to kind but funding to contract
[1:37:55] with 2 attorneys generals.
And it really gets to the point of your question, one is so
that they be available in
[1:38:00] greater Minnesota to conduct a,
you know, prosecutions at the request of county attorneys
that these types of, you know,
[1:38:06] prosecutions kunce really strap
a small attorney's office. However, 2 is that as we
conclude cases that are either
[1:38:14] declined, we can't for their
case or its concluded with a successful prosecution. It's to
work together with our team to
[1:38:21] provide information as a
feedback loop, not only to the state agency that referred to
criminal fraud. So if there's
[1:38:26] process improvements that they
can look at systems, etc, but then also again, for the
enterprise as a whole so that
[1:38:32] we can really help learned from
the state agencies. As you know, state government is very
large. And so we need to figure
[1:38:38] out how with the centralized
unit we can provide that few back of information across the

enterprise. And that's how
[1:38:43] we're starting. Think about it
now, in addition to working together with that and then a
number of the different trade
[1:38:50] associations. One thing that I
think is important along the way, as you know, fraudsters,
if they would put their talents
[1:38:58] to use and the traditional 9
criminal environment, they probably be fairly successful
people. And so we did to
[1:39:04] continue having conversations.
And they say that from the perspective just last week is
meeting with a number of stakeholders, one of the state
agencies related to
[1:39:12] misclassification and away and
the contracting world that people have been working to
thwart some of the things that
[1:39:19] you've already put in place to
assist with guy which left misclassification not getting
you. I insurance, et cetera.
[1:39:27] And so and it's adjustments
along the way. So that feedback confessed to be continuous.
This a one time thing. This is
[1:39:33] something that needs to be
built into the fabric an ongoing. >> Thank you. One more
Representative. Ben, thank you.

[1:39:39] Madam Chair, been waiting a
while to get my questions and so appreciate that. And to that
feedback loop question, you
[1:39:47] know, in the contracting world
in the construction contracting world, one of the things that
we see and are dealing with is
[1:39:54] if there is organizations that
are may be cited by the ally or maybe criminally looked at then
what we see happen is maybe
[1:40:03] they dissolve. And then this,
though, some of those actors re show up in different with
different companies. I have
[1:40:09] heard from some of my
colleagues who work in the the to just face that. That is one
concern, I think with the Cairo
[1:40:17] sun, the new way is that if
there are folks in there, businesses that are either
because they are under
[1:40:23] investigation or because their
their business model, which was based on illegal behavior is
shut down that them they show
[1:40:31] up in other spaces in the
construction space. We actually have been dealing with some of
that. I'm wondering if their
[1:40:37] recommendations you have
because to your point is it folks are perfecting a business

model of a fraud and one of

[1:40:44] their marks is government.

It feels like dealing with those folks and putting them

out of business is important.

[1:40:51] Other recommendations you have

or maybe as you're thinking about it, that will help us in

the space of time to

[1:40:56] construction to deal with.

Folks are popping up with different legal entities and

potentially coming back into

[1:41:03] the space, especially in the

space where I've heard it might be happening to pretended

Evans.

[1:41:09] >> I can start and then maybe

more specific for DHS related to this particular hearing.

But Madam Chair and Representatives, thank you for

that. I think is you probably

[1:41:16] noted in the construction

industry that the and fixes are sometimes many a

nuanced as you're referring.

[1:41:24] So sometimes it's very specific

to the particular type of fraud is being committed or ordered

flakka follow through. And

[1:41:31] that's being done in this area.

I think one of the things in the conversation that we

started to have and this isn't

[1:41:36] specific to DHS is that with
numerous different financial systems within state
government, different grant
[1:41:42] programs that there needs to be
a better way to create a trusted identity process.
In other words, that we know
[1:41:47] the same individuals across
different government programs in that process, that type of
activity that you say is
[1:41:55] definitely a concern. And when
you're able to form different, you know, elsie's fairly easily
and pop up again, we need to
[1:42:01] better able to understand then
who is it that's responsible for those particular entities
to see if somebody has been
[1:42:07] disqualified across the
spectrum. Dhs know certainly deferred of them has done a lot
of work in this space already,
[1:42:14] but we are talking to them not
just as an adviser, and I know this is front of mind for them
to try to figure out just that
[1:42:20] and not just for DHS. We
certainly don't want a fraudster that's been
disqualified and DHS to be getting state funding in a
different program. So I think
[1:42:28] this is an enterprise

discussion that we need to have to make sure we know exactly
who is receiving money in our
[1:42:33] state programs. >> Thank you for that
superintendent. I'd just like to follow up on that because I
think is a very important point
[1:42:39] representative agreement.
I think there is great concern that some of the groups that
have been put out of business
[1:42:45] are going to reconstitute.
And some of that. I know the attorney general last spring
shutdown, 17 nonprofits and I
[1:42:55] have some of those resolutions
here for me. >> But there is no
[1:43:02] evidence, you know, that anyone has left the state or got out
of business. So I think that's
[1:43:07] something I hope your new
office will keep an eye on as do those 17 that were shut down
by the attorney general
[1:43:13] reconstitute themselves and
then an unrelated man or the attorney general did to a
settlement with dark our family
[1:43:21] services and the settlement,
interestingly, was rather than that the money go back to the
state. It was required to go to
[1:43:31] another 5, a one C 3. So all the assets of Guardar
were supposed to be given to a

[1:43:39] different 501, C 3. And I've
not seen what or if that has happened, but that would
definitely be something to keep
[1:43:46] an eye and that we're asking
them to reconstitute. So I have
[1:43:51] concerns about that. And just
to go back to the cameras have one more question there.
So my concern
[1:43:58] about the KIRO situation is
that this was known for a long time. I mean, there are news
reports going back to 2022
[1:44:05] about how they were billing
under statute. As you know, killing is supposed to be one
to one for services and for
[1:44:13] transportation and for the pure
counseling. And there were reports that they were doing
group, that group services
[1:44:20] group transportation, and that apparently didn't rise to
the level of stopping payment
[1:44:28] or taking action by DHS. So that
in March of 2023, the Alliance
[1:44:35] for Recovery Center
organizations, Arco actually polled the nonprofit. We focus
Recoveries membership, which is
[1:44:43] necessary for them to keep
going for state Medicaid services. And they pulled it

saying that they didn't meet

[1:44:49] the standards. So even though

the state didn't take action, this accrediting group dead.

[1:44:56] And in response, I find this

stunning, Kyra says lawyer threatened to

sue the state and Commissioner

[1:45:04] Hearts Ted personally granted a

certification so they could keep billing Medicaid.

[1:45:10] That's what happened. So DHS

actively overrode this process

[1:45:16] decided to keep billing

Medicaid and in 2024 until payments are

cut up. They paid just in the

[1:45:23] first 6 months of 2024. 5.5

million dollars to Cairo's and then the state apparently

shut up payments on September

[1:45:31] 6th and then the group shut

down on September 19th. The bad had been a pattern.

People had known about it.

[1:45:39] It had been in the public

record since 2022. Yet we kept paying them. And this is my

concern about the to autism

[1:45:49] centers. I don't know if

there's currently being stopped payment or not. But DHS

[1:45:54] in this instance over wrote by

have personal certification

[1:46:00] from the commissioner to keep
paying this. Can you please address that and help us get
confidence that those types of
[1:46:07] situations are not ongoing? Commissioner Chair Robbins?
[1:46:14] >> I will speak in generalities
and say that because I cannot I
[1:46:19] can't speak for past situations
that I was not. >> Intimately involved in the
United Internal compliance at
[1:46:27] that time. Commissioner, what
was your role before you became acting commissioner?
[1:46:33] I was deputy commissioner and
then chief compliance officer.
[1:46:38] So you George involved in that
decision? No. Okay. So please continue to
Chair Robinson. What I know is
[1:46:46] that DHS works very hard under
Commissioner Harps Ted also under me.
[1:46:52] >> To >> comply with rules,
regulations and to ensure that
[1:46:58] people get the treatment and
care that they need. So I am aware of a different situation
where we had a large
[1:47:07] residential provider that was
not that was cutting too many
[1:47:12] corners that wasn't following

the rules and that had some quality of care issues. And if
we had taken action
[1:47:20] to stop payment, we would have
had hundreds of people from the rubble, people who didn't have
a place to go. So instead what
[1:47:30] DHS did because they knew that
large organization was looking to have a buyer to sell to
another organization that was
[1:47:39] high quality with DHS did in
that instance was to allow the payments to continue and to
step up visits to make sure
[1:47:48] that people were getting
quality of care until that transaction could take place.
So sometimes DHS does need to
[1:47:56] make a judgment call on the care that's being provided
and the harm that would happen
[1:48:03] and balance those. But it is
very important to first and foremost, not harm people and
second, make sure we have
[1:48:12] program integrity in our
programs. Thank you. I appreciate that.
So so back to the DOE one to
[1:48:18] one billing. Is that something
that's now on your radar? And are you
[1:48:24] >> monitoring that with
different to recovery specialists and different

transportation providers,
[1:48:32] et cetera? How are you
addressing that? Because that seems to be a a a problem in
the billing system in several
[1:48:39] programs. >> Chair Robbins, yes, that is
on our radar and we are working
[1:48:46] to tighten legislation as well as our
[1:48:52] our requirements are rules are
guidance on how billing is to
[1:48:58] happen. >> Okay. Well, I appreciate
that. But I just want to note that 20 a sex statute to 54 be
point 0, 5, 2, is very clear
[1:49:07] about the one to one billing.
And I've seen that in multiple reports that you think
something needs to be
[1:49:13] strengthened in statute. So whatever that is, please
send it to us because to me,
[1:49:19] the statute is very clear and
that this continues to be a problem is of great concern.
I think
[1:49:28] that certainly we're happy to
work with you and tightening statute. But I think the
authority is clearly there
[1:49:33] already. So I hope that that is
followed up on. >> Yes, Chair Robbins, thank
you. That was clarified.

[1:49:39] That was strengthened last

session. Thank you. >> Thank you. And so do you

currently think it's sufficient

[1:49:45] or do still think there's more

that's needed? >> Well, so there's more that's

needed across many aspects is

[1:49:54] is in the governor's anti fraud

proposal. But the billing language is clear now.

[1:50:01] >> All right. Thank you very

much members. It's been another very interesting hearing.

I appreciate Commissioner Kindy

[1:50:07] and your other Testifiers and

Superintendent Evans and assistant Commissioner

Steinmetz though they are.

[1:50:14] Thank you all for coming.

Have a great day. Thank you for joining us.

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 03-24-2025

[0:03] >> Good morning. Welcome to the
March 24th meeting of the Fraud
[0:10] Prevention and State Agency
Oversight Committee. Glad to have you all here.
I know we have a quorum and I
[0:18] would like to ask a
representative salts for approval of the minutes.
[0:25] Madam Chair, I move adoption of
minute. It's great. Representative Saltzman to
adoption of the March 17th
[0:30] minutes. Those in favor say Aye
motion. Okay. All those in favor say aye.
[0:36] I those opposed minutes are adopted. Right this
morning. We have a very full
[0:42] agenda members. We are honored
to have with U.S. commissioners from the Department of
Management and Budget, Public
[0:48] Safety, Human Services. It
administration, education and
[0:53] children, youth and families.
So we have a lot to get through.
[0:58] We are going to go to the
commissioners presentations in order to listed on the agenda
and I'm asking commissioners to

[1:07] keep it to a bout. Hopefully 10 minutes just
because we have so many to get
[1:12] through and then members we
will ask clarifying questions
[1:17] at the end of each section.
So each commissioner can address those immediately.
And then we'll
[1:24] move onto member discussion of
the whole package as there's time at the end, which I hope
there will be. So I know I'm
[1:31] one of them biggest offenders
of over questioning. And so I'm gonna try and keep my questions
minimized as well. But this a
[1:40] very important consideration of
how we are going to systemically address fraud in
state agencies. And so we want
[1:48] to move through the packages
quickly as possible. So with that, we are happy to have to
Pinto presenting the bill this
[1:55] morning. Chair Pinto to your
Bill. >> Thank you so much. Madam
Chair, the bill, the the
[2:01] anti-fraud package put together
by the administration isn't house filed to 603, copies been
distributed to members. It's
[2:10] gotten a little bit complicated

because the different pieces are moving separately, the
different committees. And so
[2:16] the version in front of
members, I think to provide your little bit of time to put
together. And so there's both a
[2:22] large pack it in a separate
package, this estate government. In any case, I'm
honored to be the author, the bill. I want to hear from
the commissioners regarding the
[2:29] details of it. But I just know
that it builds on work that we've all been together over a
number of years. And in particular last term, a lot of
progress is made. But with
[2:36] that, Madam Chair, turn, thanks
to that to the commissioners. Thank you very much. >> Thank you. Chair Pinto.
So first, I think we'll turn to
[2:43] Commissioner Aaron Campbell.
Please stay tuned in for the wreck and begin your
presentation. Thank you.
[2:48] >> All right, good morning.
Chair Robbins lead Pinto and members of the committee.
For the Record. My name is Erin
[2:54] Campbell, and I'm the
commissioner of Minnesota Management and Budget. I'm here
with several of our agency partners today to present the
overview of the governors

[3:02] Antifraud package. As you all know, the state of
Minnesota, it provides critical
[3:07] services every day for the
security benefit and protection of all Minnesotans Minnesota's
estate committed to help Ian
[3:14] people and we're committed to
providing services that improve the lives of Minnesotans
[3:19] fraud against these public
programs is unacceptable. It's not a victimless crime and
to same people that were trying
[3:25] to help with these services, the financial stewards of these
public funds. We take fraud and
[3:30] misuse of public funds very
seriously and are is committed to safeguarding those public
funds as long as there have
[3:38] been programs aimed at helping
people. There have been fraudulent actors looking to
steal from those who need them most. The fraudsters have got
more sophisticated and our job
[3:47] is to stay one step ahead of
them. Do executive action, budget and
policy. We're taking a holistic
[3:53] approach to equip state
agencies with the resources and tools to better detect fraud,
take action and investigating
[4:00] whole fraudsters a comical the proposals will be outlining

today. Build on investments

[4:05] made in 2023 to improve the

state's capacity to detect and respond to fraud. Like

expanding the Office of Grants

[4:13] Management at the Debt

Department of Administration and broadening Department

authority

[4:19] establishing an inspector

general at the Department of Education's and providing the

Department of Human Services,

[4:25] more tools to improve controls

oversight and contract compliance.

[4:30] They also come in the context

of significant successful fraud prevention efforts at the

Department of Revenue at that

[4:37] from 22 to 24 have prevented

263 million dollars in fraudulent refunds

[4:44] force compliance with state law

that resulted in 1.4 billion dollars in revenue being

collected that would have

[4:49] otherwise have gone to at those

trying to avoid payment. Save the state. 1.8, 0

4 billion more than 600 million

[4:58] dollars a year by stopping the

positive force in compliance. The items you'll hear about

today falling to 3 court

[5:04] categories, stronger
investigative and enforcement authority, better detection
oversight, increase criminal
[5:11] penalties. I will speak broadly to
elements within each of these areas. And then my colleagues
and I will provide more
[5:17] detailed information on
specific proposals to provide better detection
oversight. The state would use
[5:24] AI to compare information that
detect Medicaid payment discrepancies in real time.
[5:30] Strength in the IDB I Autism
Center oversight by requiring licensing
[5:35] and internal controls and
oversight capacity with an M M D and clarify the Department of
Education's ability to ensure
[5:41] charter school's compliance
with procurement policies.
[5:47] The governor has issued an
executive order to integrate the Department of Commerce
Fraud Bureau agents into the
[5:52] centralized financial crimes
and fraud section at the BCA dedicated to investigating
financial crimes and fraud.
[6:00] The proposal also has invested
for every capacity to the attorney general's Medicaid

fraud, investigatory unit

[6:06] responsible for investigating

the proper prosecution. Medicaid providers who submit

false claims for reimbursement.

[6:13] The package also seeks to

provide clear and expanded authority to stop payments and

sanction bad actors by enabling

[6:19] agencies to withhold payments

from potentially fraudulent actors. If there's a credible

allegation of fraud

[6:26] prevent bad actors from getting

state contracts across multiple agencies and the bar entities

from receiving state funds.

[6:35] The governor's anti fraud

package includes proposals to create a new theft of public

funds statute to increase

[6:40] criminal penalties by 20%

compared to current law and near federal the federal

anti-kickback laws and the DHS

[6:47] space and give the attorney

general's authority to pursue criminal charges.

[6:54] Now we'll get into the specific

proposals. Each of my agency partners will discuss the

proposals for their agency and

[7:01] all quickly cover the one that

pertains to and then being the governor has proposed a

range of additional investments
[7:08] here at the time and get you to
meet the public's expectations for oversight responsibilities
related to state finances.
[7:14] And the state workforce highlighted here on the slide
are too relevant. Parts of the proposal we're eager to add
additional capacity to our
[7:22] internal controls team,
especially the opportunity it presents to add more training
that and the systems with the
[7:28] goal of for their building, a
culture of compliance across the state agencies,
[7:33] the additional staff focused on
the financial resource. The policy is, well, I was to
provide better support for
[7:40] agency partners in that their
understanding and implementation of these
important statewide policies.
[7:46] I'm happy to stand for
questions. Otherwise I will turn it over to Superintendent
Evans.
[7:53] >> Thank you, Commissioner
Campbell. I think if we don't have any specific questions
right now, we'll move on to
[8:00] keep going. Thank you.
Superintendent Evans, please stay tuned in for the record. >> Excuse me. Good morning.

Madam Chair, members of the
[8:07] committee. My name is Drew
Evans and superintendent, the Minnesota Bureau of
Criminal Apprehension, a component that was referenced
by Commissioner Campbell's.
[8:14] Why well underway and we'll go
over that briefly on February,
[8:19] 7th of 2025, the Bureau of
Criminal Apprehension, Financial Crimes and Fraud
Section combined with the
[8:26] Commerce Fried Bureau to form
one large a financial crimes and fried section to address
all types of criminal fraud in
[8:33] the state of Minnesota. This
ensures a focused approach utilizing resources,
efficiently, efficiently to be
[8:40] able to disrupt and hold
offenders accountable for committing criminal fraud
across the state of Minnesota.
[8:45] As part of this in your packets
today, you'll see a language that improves. I kind of
transparency in terms of
[8:52] reporting efficiencies that are
to be gained and the consistency in our approach
different team skews me.
[8:59] It also creates a has noted

this new fraud section and that is under way. It's going well.
And we are currently except in
[9:05] cases in our traditional types
of crimes that the teams have investigated. Also fraud
involving state government
[9:11] program agencies innocent. This new section is focusing on
insurance fraud and wage theft,
[9:18] fried and state government
programs, traditional financial crimes and fraud committed
against individual Minnesotans.
[9:24] And then the out of that
program that was historically on and a couple of different
agencies last at the Congress
[9:30] tried to rob just over the
committee. Part of the work that we're doing here is really
to to tackle all these
[9:36] different types of crimes.
One of the things that certainly through your work and
others have noted is that
[9:41] fraudsters are not stick in
terms of where they wish to commit there frauds. And it's
against state government
[9:47] programs of its against
individual Minnesotans. I referenced in committee last
week, you know, 12.5 billion in
[9:53] reported individual fraud was

reported to the financial a different Federal Trade
Commission last year, which is
[10:00] a probably a very small amount
of fraud because it's a voluntary reporting. Also note,
as you see every single day,
[10:06] I was just noting, did Jordan
before I got in here today, as I'm sure many of you have
gotten the fast pass
[10:11] notification on your phone's
fraudsters are becoming increasingly sophisticated.
I know what it is. And I almost
[10:16] fell for it this week and was a
story that we're looking at. So this is part of what we're
doing to combine all these
[10:22] resources together, not just to
address state program for, but those other broader raised
to make sure that we have all
[10:28] of the experts in the state of
Minnesota working together combating fraud in whatever
form it may be as part of the
[10:34] governor's budget
recommendations as well. There's one forensic accountant
to help us address the
[10:40] increasingly sophisticated
financial schemes that we see that an account dedicated to
that team. And then 2 attorneys

[10:47] generals that would be assigned
to that team as well want to be able to provide our
prosecutorial risk assistance
[10:54] at the request of county
attorneys agencies. These cases are often very large and
especially in greater
[11:00] Minnesota, where they're
smaller offices. They would provide assistance in that
process and then secondary to
[11:06] provide advice to our team.
And as they approach these to think of new and innovative
ways to approach the
[11:12] investigations with the
fraudsters and then 3rd, to be able to provide feedback
to state agencies at the
[11:17] conclusion of those
investigations with us to be alright, feedback to tighten
programs, to be able to figure
[11:23] out ways to improve so that we
prevent fried in the future if that was identified in one of
the agencies. Also with this
[11:30] new unit, I do think it's
important as we're working through this. This is not an
inspector general's office the
[11:35] way this works. This this is
that we're doing what we've always done when criminal fraud

is identify where crime is

[11:42] identified, whatever it may be,

that is referred to the BCA and will conduct a criminal

investigation. This unit will

[11:49] work closely what the inspector

general's that exist and state agencies and that function,

whatever it may be moving

[11:55] forward in those agencies and

that is critically important have both components, criminal

investigation and the civil

[12:02] regulatory investigation and

detection that must occur in state agencies were that

subject matter? Expertise is

[12:08] critically important. The last part of the BC part of

this proposal is a new theft of

[12:15] public funds, certainly and we

have I've prosecuted people for theft and theft statute that

exists. Currently, art theft

[12:22] statute is been cobble together

over many years. It's complicated some ways. And

because this has been such a

[12:28] focus, we're proposing a new

staff to government funds with the top tiers being up 20%

increase in penalties compared

[12:36] to the other. The current

statute. The idea behind this is that it makes it very

simplistic. But if it is,

[12:42] it's a public funded program.

But there is a stand-alone statute that makes it very easy

for us to pursue investigations

[12:50] and criminal charges with our

prosecutors in that process. And then those increased

penalties simply reflect the

[12:56] seriousness of stealing state

government program funds, whatever form they might be in.

And I'm happy to take questions

[13:02] on Madam Chair as well or I

will turn it over the permanent Human Services. >> Thank you. Superintendent

Dan Evans of Representative

[13:09] Eric says. >> Thank you, Madam Chair.

Good to see you. Superintendent Evans, I'm just curious.

I know that as feeding our

[13:16] future and all of that was

happening, it went up to the feds. How will this change

compared to what federal law is

[13:23] and and really the structure of

a lull that because we have plea bargains, downward

departures, we have good time.

[13:31] That's in much, much more

access than the federal government. Can you just help

us understand how close are we

[13:38] getting to the federal if this

was some federally Superintendent events?

[13:43] >> Madam Chair, Representative,

where I to to love answered in 2 parts. The first is a good

question. So part of the

[13:49] reporting that needs work are

now in state agencies are doing that as part of the governor's

executive order is any

[13:55] potential misuse of government

funds getting duly reported. We have a strong relationship

with the oil. They will do

[14:01] their investigation as they

always have a report. Criminal fraud to us now when they

discovered in that process.

[14:07] But we will see just well have

that discussion on the front end of a criminal investigation

should be launched or the all wished D*** the process and

that we will then do an

[14:15] investigation of that criminal

fraud as well. And then the question about the federal

government, how that works,

[14:22] we'll still utilize them.

Some of these pride programs are passed through money years,

federally funded program,

[14:28] sometimes mixed with state

money. Sometimes it stand along federal money. We work daily

with our federal partners

[14:35] whether its inspector general
and dad DHHS and Department of Human and Health and Human
Services not rioted, different
[14:42] federal programs work together
with them and the FBI since this team has formed into one
stand-alone team. I've had
[14:49] discussions with both the FBI
and just last week that the attorney general's Medicaid
fraud control unit that the
[14:56] state side and then also with
the United States attorney's office, has the form, I mean,
get permanent leaders. I with
[15:03] the attorney general's office
in particular for Minnesota. We'll have those discussions as
to what makes sense more
[15:09] pointedly to your question.
Probably about the pride itself. I don't know that of
time. I had the federal
[15:15] penalties are certainly more
serious than state line. That's true, really across the
board for a variety of types of
[15:22] crimes and what we do with
those cases in other arenas where we're used to doing this
and making it every single day
[15:28] is looking at those different
areas and and communicating with did that the U.S.

Attorney's Office for this

[15:33] state of Minnesota in

determining the best course between our federal partners.

And so this isn't designed to

[15:39] replace year federal penalties.

This is to increase to identify that in particular, in most

cases where the threshold is

[15:46] and that typically our federal

partners are looking for large, larger cases before they're

willing to take that. So this

[15:52] reflects an increase in

penalties for those lower-level tear cases that may have not

been taken before, but will

[15:58] still take both routes

depending on what's most appropriate for that case. >> Thank you, Representative

Anderson, thank you. But

[16:06] several questions. So, Katie, let's let's do one or 2.

We need to move on. Think it I.

[16:13] >> I think this is my

understanding is an excellent job with I guess, crimes

against persons, right? So

[16:18] that's typically I guess that's

the best description. And

[16:24] and by bringing, you know, this

piece in together, which is essentially insurance fraud,

70% of its insurance fraud took

[16:32] that that was done over
commerce into best what's left
[16:37] because I my interest is fraud
against government programs. That's where my interest is.
And it seems that we're adding
[16:45] just one percent to that, you
know, an entity that really hasn't done hardly any Friday
gets persons. In fact, I might
[16:54] also understand is that the
that a lot of things that were referred to to the BCA really
weren't taken because they
[17:03] didn't meet the threshold
requirements, didn't. Yeah, things that came out of the
right to do something in the
[17:08] distance. But what is what
change besides having one forensic accounting that's
working on all sorts of stuff.
[17:15] But what actually added here
before that public programs?
[17:20] >> Superintendent Evans, Madam
Chair, Representative Anderson, it's a good question so that
it's traditionally you're used
[17:26] to seeing the BCA for crimes
against persons, because that's often what gets the most
attention. But we've run a
[17:32] financial crime and fraud

section for a very long time and worked on that. We come and Minnesota Financial Crimes Task
[17:37] Force and we have 16 agents and individuals that are doing that work. Now. They've been doing fried work with state
[17:43] government programs and contracts that we have in the process. The commerce tried your way, as you correctly
[17:49] stated, have a statutory requirement that required them to do 70% of their time on insurance fraud and then 30%
[17:55] for other types of financial crimes by combining them together.
Regain a number of official
[18:00] says, for example, as a stand-alone agency, they had to address digital evidence.
It's in. It's everything we do
[18:06] have some digital evidence components led to agents that did that work at the BCA.
We have a full digital
[18:12] multimedia evidence unit that does that work. The agents don't have to do that work to do their traditional
[18:17] investigations. There's a whole bunch of us and minutes straight of tests that are associated with

[18:22] running a guy, a law
enforcement agency that's becoming increasingly
sophisticated as more and more
[18:28] requirements are there. Those
will be centralized. So that frees up additional time.
There's a number of different
[18:34] things that we look at that
when we look at across the board by combining were able to
gain efficiencies and that
[18:39] process and were able to then
utilize that time. And I don't think about it as individuals.
I think it is ours available to
[18:45] be able to address state
program pride. Also, as I noted, we have contracts with
some state agencies to do this.
[18:51] And as we get into this work,
if we discover that one particular program or agency
has a large volume that are
[18:57] getting referred, we'll have
conversations with that agency about contracting as well so
that it doesn't take away from
[19:03] that important work of
insurance fraud, waste that financial crimes in that state
program pride. But we have been
[19:10] doing some of that work in
combining together. We will gain capacity in that process

by working together

[19:17] in that from there. So they've

already been taking cases. I don't know what does being

reference. We don't take from

[19:23] inspector General's. I'm not

aware of any threshold requirements for us that we

haven't taken cases. But as

[19:29] that goes will certainly do

that. The requirements and state statute right now in your

packets, we have a framework

[19:34] that's been laid out as to what

the unit would be required to do. And that would be any case

that's $100,000 or more in lost

[19:42] this unit would be required to

investigate it. That's 100,000 or less. That's still be

reported. But we may triage

[19:48] that local agency or determine

whether or not in there. So we bake that. And so there's

some assurances for you that

[19:54] that work is being done and

we're confident that the capacity is there. >> Thank you, Representative

Freeman, thank you, Madam

[20:01] Chair. And I really appreciate

how the h*** you have been talking about this the last

couple of months as this has

[20:08] come together. A question I

have about some of these these frauds that are sort of
[20:15] encompass a lot and then
specifically thinking about misclassification fraud where
there may be wage theft.
[20:21] I think of this new statue that
theft of public funds, the theft against the you I trust
fund or tax withholdings would
[20:28] be included. And I'm wondering
how you're thinking about frauds like that that have a
couple of developments that may
[20:35] be both civil and criminal and
how this new consolidated entity that now won't just be
BCA, commerce fraud and maybe
[20:42] the agencies can actually more
efficiently, help us fight to all of the tentacles in front
like that superintendent
[20:50] events, Madam Chair,
representative the men bank. >> Another great question.
So this also doesn't take away
[20:55] any of these civil authorities
within the regulatory agencies that exist. So there Ben
meetings, as you're probably
[21:00] aware and misclassification
crimes and taking a look at that now and a task force
that's put together with the
[21:06] Department of Labor and

Industry also of commerce, both those agencies guy routine that there is civil and
[21:12] regulatory functions and misclassification. This team has people that are assigned to that working group from RBC,
[21:19] a financial crimes and pride section there. Part of it, I joined that to better learn about the work that's being done there and they're trouble shooting in identifying ways to
[21:27] hold people accountable and it will come out of this section for criminal actions related that misclassification of wage
[21:33] theft and then also the civil regulatory approaches that those agencies that also we have operated, Minnesota,
[21:39] Human Trafficking investigators, task force that team has been traditionally only worked on sex crimes due
[21:45] to funding limitations. But in the last year you get the last biennium. He provided us additional resources that we
[21:52] can do labor trafficking as well. So that team will work together with this team has to win a wage theft
[21:57] misclassification turns into a labor trafficking case and they will either work together past

overturned trafficking team.

[22:04] >> Thank you. Thank you,

members. I think we'll move on to Commissioner County. Thank

you. Welcome Commissioner.

[22:09] Place to tune in for the record

to begin your testimony. >> Good morning. Madam Chair,

members of the committee,

[22:15] my name is Shireen Gandhi and

I'm serving as the temporary commissioner for the Minnesota

Department of Human Services

[22:23] for the Department of Human

Services, components of the governor's anti fraud package.

It's important that we start

[22:30] with accurate data of our

program, integrity, work that necessarily goes on behind the

scenes. We don't want to build

[22:37] new approaches on the backs of

speculation or conjecture. We need to build them on the

backs of facts.

[22:44] A few facts to keep in mind of

where we are today. The DHS is Office of Inspector

General Overseas 390,000 care

[22:54] providers. 142,000 of those are

entities. In the last 5 years,

[23:02] DHS has conducted more than

4,000 investigations stop

[23:07] payments to more than 600
providers referred more than 400 cases to
law enforcement
[23:15] and has recovered about
18 million dollars a year on average
[23:22] for the amount spent on
investigations that that's an arrow by of the $1.89, for
every dollar invested.
[23:31] So with that in mind, what are
the challenges that we face to doing more and how does the
governor's anti fraud proposal
[23:39] address these challenges? So take each of these bullets
on the slide.
[23:45] The first challenge the number
of providers and payments DHS
[23:50] overseas are rapidly outpacing
our staff. This proposal at staff to
program integrity, operations
[23:59] with the track record of a
positive are I as I stated for a $1.89, for every dollar
invested
[24:07] challenge, the bad actors
continue to get more sophisticated. So we need to
step up our game 2,
[24:14] we must continue to improve and
evolve. Our oversight and detection efforts as fraudsters

evolve their methods.

[24:22] This proposal leverages private

sector expertise by funding a contract to conduct prepayment

reviews of selected claims

[24:35] before they are paid. And what

this does is give us an earlier intervention so that we before

that we have to use payment

[24:43] with holes challenge. It can be difficult

to share data across agencies

[24:49] to take action early. Currently

the limits on receiving public funds statue

[24:56] allows DHS to take action when

providers have been excluded by other states are federal

agencies. That's not timely

[25:05] enough. This proposal expands authority

for data sharing to investigative and other

relevant data allowing agencies

[25:14] to act more quickly to protect

public funds and not wait until it disqualification has taken

place in another agency

[25:23] challenge bad actors us exploit

loopholes and shortcomings of the current statutes. For

example, DHS may immediately

[25:32] suspend the license if the

license holder is criminally charged with theft for fraud

against a DHS program.

[25:40] This proposal expands the scope
to include not only license holders, but also controlling
individuals and expand the
[25:49] scope to a charge of fraud or
theft against any state or federal agency.
[25:56] This proposal also allows for
the authority to disqualify people are under active
investigation for fraud from
[26:03] holding any position of
ownership management control or billing for which the
background study was conducted.
[26:12] Challenge the growth in autism
diagnosis has been growing across the state, creating an
increased demand for services.
[26:21] As a result. The number of the
IDB I providers has grown as well.
[26:27] Dhs does not currently have the
authority to address child maltreatment that occurs in
these providers.
[26:34] In the news last spring, there
was an egregious child abuse case. The DHS did not have the
authority to act on and had to
[26:42] wait for local law enforcement
to investigate and charge the crime.
[26:47] This proposal establishing
provisional licensure allows DHS to provide a faster

response protecting children

[26:54] and families provisional licensure which is

a step along the path to full

[27:00] licensure gives DHS more tools

to check controlling

[27:05] individual's quality of care

and billing practices

[27:10] challenge. Dhs discovered that

substance use disorder providers had billing practices

that resulted in some providers

[27:19] providing two-time based claims

the partially overlapped. The one-hour you met.

[27:25] This proposal would provide

clear statutory authority to stop this practice by aligning

statute. With guidance for time

[27:33] based Colts from the Minnesota

Department of Health Rule and the CMS claims Manual.

[27:42] And there's one more proposal

for DHS. That is a partnership with minute to leverage

technology and artificial

[27:49] intelligence to give us tools

to use data in new ways. And I'd like to turn it over to

Commissioner Tomes to discuss

[27:56] that one. Thank you,

Commissioner Tom Slocum to the committee. Please State your

name. >> Thank you. Madam Chair and

committee members. Thank you
[28:04] for giving me the opportunity
to testify this morning. For the record, my name is
Turks homes and I'm the
[28:10] commissioner of Minnesota.
It services and the chief information officer for the
state of Minnesota.
[28:16] Like my colleagues, it is
committed to advancing the state's anti fraud prevention
efforts.
[28:23] The request and the governor's
proposed budget proposes advancing our fraud detection
and prevention efforts by
[28:30] utilizing a proactive scalable
data-driven approach. Using
[28:35] modern artificial intelligence
and machine learning capabilities. We know bad actors continue to
evolve their attack methods and
[28:44] its technology capabilities
evolve. We also need to adopt the ways we combat fraud.
This proposal represents a
[28:52] significant advancement of
proactive data-driven fraud prevention at the state.
[28:59] Just as a point of contacts
globally. People have been defrauded over 1 trillion
dollars over the last couple

[29:08] years. You know, truly sty
staggering number much of that.
[29:13] He's come by the forum of what
is referred to as authorized payment fraud.
[29:21] Superintendent Evans kind of
alluded to that. I seem to get a question every week from
someone asking me, you know,
[29:27] is this real? You may have
received an easy pass invitation to pay for I told,
you know, while driving
[29:34] recently, 1 trillion dollars, a
25% increase in consumer fraud
[29:40] in the United States by
advancing the state's data and analysis capabilities through
the use of data were ounces.
[29:48] We will increase our ability to
analyze data from different systems and to do so.
Practically
[29:54] this proposal also seeks to
invest in market leading tools and capabilities to proactively
analyze in rich data to detect
[30:03] bad actors in suspicious
activity. United States 65% of large companies are increasing
investment in fraud detection
[30:12] capabilities over the last year in order to ensure maximum
effectiveness pulled and

[30:19] approach is required.
Artificial intelligence is a powerful tool to fight fraud,
but it requires both strategies
[30:26] for maximum effectiveness. The proposal is for a pilot
program to use artificial
[30:32] intelligence to flag anomalies
for Medicaid providers to the Department of Human Services.
This pilot is a critical first
[30:40] step to build this capability
across the executive branch agencies and programs
[30:46] with recent in VAT of ants,
Munson artificial intelligence and data management. Now is the
time to do more. We have an
[30:53] opportunity to provide new
tools and cutting edge technology to enhance
continuing oversight of
[31:00] Minnesota's Medicaid program.
Safeguard public funds and establish Minnesota as a leader
in data-driven fraud
[31:08] prevention. The artificial intelligence
fraud prevention tool market.
[31:13] The providers that provide
tools in this space is expected to roll over 16% in the next
year.
[31:22] This new proposal builds upon
past investments made by the Legislature, including the

state Government Finance

[31:30] Committee to enhance the way

state agencies manage identities of users increase

accessing state programs and

[31:38] services essentially adding

capabilities to do identity verification when citizens

residents visitor sign up for

[31:45] services with the same, the 2023 legislature made

significant investments to

[31:51] build a modern identity and

access management system that will support improved by Dan of

identity verification

[31:57] capabilities that over time

will any enable enhanced fraud prevention across the state

programs?

[32:04] Madam Chair, that was concludes

my my statements and would

[32:10] welcome or stand for questions. Thank you. I do have a quick

question. So

[32:16] >> many groups have reached out

to me to talk about helping managed fraud in

detection, using AI tools that

[32:25] I've met with several of them. So there's a lot of off the

shelf products out there,

[32:31] some of whom are used very

robustly in other states. Are you planning on

[32:38] as you look at request for
proposals for this pilot project? Are you looking to
build it internally? Are you
[32:46] looking at products that are
already in use in other places?
[32:51] >> Madam Chair Committee
members, thank you for that question. I Minnesota. It
services of the flat last 5
[32:57] years, 6 years. Our approach a
policy as it relates to
[33:03] solutions. He's been something
that we refer to as rent buy build if there's a market-based
solution that we can procure in
[33:11] the marketplace and rented and
those are typically cloud-based services. We look to rent that
we can't rent it. But there's a
[33:17] vendor of a solution that we
can by then then we look to buy it. And really only as a last
resort, you know, do we look to
[33:24] self develop solutions as it
relates to this particular solution? We absolutely to
partner with them in the
[33:30] marketplace to procure
something that already exists. You are in the financial sector
or in the retail sector.
[33:35] You know, many of us from our

credit card companies. If there are some specials credit card transactions, we get a text
[33:41] message notifying us are asking
us, is this really you these types of tools and capabilities exist in the marketplace and
[33:47] are continuing to evolve as
evidence by that 16% growth in the marketplace? Our attention absolutely would be to not do
[33:55] anything. >> And so the money is being
housed in DHS, 6 million in the
[34:00] first 2 years of the biennium
and then 5 million each year in the tales.
[34:06] Will you be making these
decisions? Will commissioner done to be making these decisions? Who who spends that
[34:12] money? >> Madam Chair Committee
members. I think it, you know, as it relates to so many of these efforts, it's it's truly
[34:20] a partnership that requires a
holistic and comprehensive approach. Everything from the case management capabilities
[34:27] that the 2 things that have
been flagged as suspicious and the need to follow up which, you know, is a heavy business
[34:33] side activity as well as the
crucial no data warehousing and making sure that data is

available for these b*****

[34:40] based solutions. And and so we

will partner heavily on the U.S. decisions that need to be

make made as it relates to

[34:46] implementation. >> All right, representative

interest, because I'm so I am

[34:53] looking at more. You talk about

managing identities. And I understand that, you know, fake

names like feeding our future

[35:00] and others. Are you looking at

is that the main focus of this so that you're actually looking

at, do these people exist that

[35:08] are good is services or are

they eligible in the case of some of the Medicaid, for

example, is that the main focus

[35:15] of this or you also looking at

individual programs, are biller

[35:21] paper pays? I guess that are

that are all said the numbers have jumped through the Roof

Commission.

[35:28] >> Madam Chair, Representative,

thank you for that question. It's really a holistic

approach. This particular

[35:33] aspect of it is really focused

on artificial intelligence and machine learning capabilities

to make sure that there are

[35:39] robust vendor market based
capabilities that analyze both good transactions as well as
bad transactions to flag
[35:47] anomalies and make sure that
those things that our flag have appropriate follow-up. I think
a robust brought prevention and
[35:55] detection mechanism don't
require is really a holistic approach. And in the last
legislative session, there was an investment made related to
just identity verification as
[36:03] people sign up. We want to get
as preemptive and as far upstream as possible to
proactively make sure that
[36:09] people are signing up are the
people that should be signing up in the identities of
verified to the full extent. But that also the abilities to
the ability to flag
[36:17] transactions as they're
occurring in real time for follow-up into fall next to the
types of transactions that,
[36:24] you know, not just permeate the
Medicaid system but really state programs in general as as
other organizations both
[36:31] nationally and internationally
are doing. >> Okay. Thank you. Thank you,
Representative Eric.

[36:37] Thank you. Madam Chair, I have
2 questions, one for a commissioner on the and one for
commissioner Tomes.
[36:44] So Commissioner Gandhi, you it
said that you've that you've had 18 Million. >> Per year recovered. And I'm
wondering what your total.
[36:53] What is the total of your
annual budget, including federal money. >> That would change year over
year. Right now. This year are
[37:02] our budget is about.
25 Billion. >> Thank you. And I have a
question for commissioner at
[37:10] the site. Representative Eric,
thank you. And then Commissioner Tomes. And so I'm
really having a hard time
[37:16] understanding how your grant
interface with computer programs that were built in the
late 80's and early 90's that
[37:22] are still green screen fp. And they have the wheel of
death every single day for
[37:28] people that use them. How do
you possibly interface with all of that ancient technology with
AI? I don't understand how the
[37:35] 2 I mean, why can't we just fix
these ancient technologies that we've we built back in the 80's
90's and should not be this

[37:42] square one? I don't understand
how this works. >> Madam Chair, Representative,
thank you for that question.
[37:50] I think there's there's a lot
to unpack in that question. Maybe I'll start on the telling
and work my way forward towards
[37:57] the data site. I think
modernization of a legacy
[38:03] systems that include what we
refer to in our spaces, significant tech that. But
really, you know, that more
[38:10] calls, no significant debt as
it relates to just service provider capabilities in
general
[38:16] is in extreme priority of ours
and has been over the last 5 to 6 years. We've been able to
modernize the driver and
[38:23] vehicle system completely
modernization of the system that runs the main suspect on
the Department of Corrections.
[38:30] Huge scale modernization at at
at the and so modernizing these
[38:36] large systems is continuing.
And as part of the governor's current budget proposal is
modernization of the child
[38:41] welfare system, one of the

elements that really hasn't huge impact on counties as it relates to this, a tech,
[38:48] that laden system that we referred to internally and counties understand under the name of SSI asked which,
[38:53] you know, is is usually problematic. We're incredibly hopeful that as a part of this legislative session were able
[38:59] to move forward, that child welfare modernization, not for the sake of modernizing technology, but for the sake of
[39:05] serving children better as it relates to these technologies. There is a huge distinction, though, as it relates to older
[39:13] systems, tech and data, the capability to still get at
[39:18] transactions exist, no matter how old the technology is, our ability from a technology perspective in today's
[39:25] technology marketplace to interface with those systems to analyze transactions is not there. The barrier comes in and
[39:31] how those systems serve people in both our employees within the state and how they serve people that are interacting
[39:36] with them. You know, that's

where the hugest tech that realize outside of the rest of
those systems simply not being
[39:44] funded, a functioning or being
susceptible to cyber cyber crime. So the tech technologies
and capabilities to interface
[39:50] with the systems are quite
robust and ability to implement and are based artificial
intelligence capabilities to
[39:57] interface with the
transactions, the flag transactions of something
that's readily available in the marketplace.
[40:03] >> I just have a quick follow
been quick. Tellepsen will go to Representative Hawkins.
Thank you. So I'm
[40:11] so S S I S takes you know, you
go to any county in the poor folks using that it takes 70%
of their time because you have
[40:20] a green screen of keys and the
wheel of death. It takes them forever to do it.
So I think that seems to be a
[40:27] high priority. But there's not
just S s I S there's also 5 other programs that are as
equally bad the counties have
[40:33] to use that came in and did a
presentation, another one of my committees. So I don't see this as a huge
solution. Also, I would point

[40:39] out that the money recovered
out of 18 million out of 25 billion annually is
[40:46] 0, 7, 2%. That's how much money
is recovered. I'm sure that within that was going on
project Lee. So it's just a
[40:53] drop in the bucket. Madam
Chair, thank you. >> Thank you, Representative
Elkins, thank you, Madam Chair.
[40:59] So I think one of the points
that commissioner tells us making is that no matter how an
operational systems
[41:06] our modern there are, you still
have to extract the data out of them and into an analytical
data where house and that work
[41:14] can be done and semi
independently of the front. And you're kind of what you
structure the data and the
[41:19] analytical systems. So you can
point analysis, tools point I at them in any case and that I
think that's the word that that
[41:28] is going on right now is
improving the and a little capabilities for the day of the
take out of these currently,
[41:35] ancient, hopefully sometime in
the not too distant future modern operational systems.
[41:41] >> Thank you. Thank you for

your testimony. I think we'll move on at the moment to

commissioner of Department

[41:47] administration commissioner

ground ball.

[42:06] So members, if you're confused,

it's the last slide on your packet because the order of the

testifiers on the list is

[42:12] different than the order of the

packets live. So please proceed. Commissioner grab out. >> Good morning. Chair Robbins

Representative Joe and

[42:20] committee members. I'm to my

ground ball and the commissioner of the Minnesota

Department of Administration.

[42:25] The governor proposes

additional safeguards related to state grants. Specifically

the proposal expands authority

[42:32] to suspend or D bar grantees to

include potential grand teens.

[42:37] This is an effort to prevent

entities who have not previously receives state funds

but have engaged in or been

[42:43] convicted of the barman to

worthy causes from becoming recipients of state issued

grants in the future.

[42:51] The causes for department

include serious issues such as crimes as investment, fat, bribery or

fast suffocation of records

[43:01] among other serious convictions

and violations. The proposal would expand the

definition of grant he to

[43:07] include potential grantee,

which ensures that admin can exercise its Devine meant to 40

for existing grantees as well

[43:16] as potential grantees. The proposal also amends

existing obligations on state

[43:22] employees to require a report

of violations of grants laws or rules.

[43:27] Current law has mandatory

reporting requirements in place for state employees related to

all unlawful activity.

[43:35] This change clarifies this

required reporting as related to violations specific to grant

laws or rules.

[43:44] The governor's proposal also

strengthens the authority of state agencies to share data

with one another related to

[43:51] suspected or confirmed fraud

and public programs. If the access promotes the

protection of public resources

[43:59] promotes the integrity of

public programs or AIDS in the law enforcement process.

[44:09] Thank you, commissioner to

represent her. Thank you just really quickly. So you said
that state employees now are
[44:15] required to report violations
of the grant laws or rules. What happens if they don't?
[44:22] Commissioner the governors of
package would make that reporting mandatory.
[44:29] The if they don't there be an
investigation into that activity, either be inquiries.
There would be I we would take
[44:37] steps to examine the up the employees behavior and what
actions are appropriate.
[44:46] >> Representative Eric and then
what happens if a supervisor told them not to report it.
What happens to the supervisor
[44:51] have commissioner that chair?
Excuse me, Chair Robbins Representative Eric.
[44:57] >> I imagine the scene and to
shun the same thing. There would be to take, though.
That's to give your very seriously there be an
investigation. We would find
[45:05] out what happened. Who said
what when, what was understood what was not justified. And
you'll remember that current
[45:11] law right now require employees
too reports, too, that allow
[45:17] when they suspect criminal

activity. The governor's package right now requires

employees at any level. 2

[45:25] reports to the BCA when the

suspect possible criminal behavior self,

[45:31] that behavior we take very

seriously. We follow up thoroughly and take action

appropriately.

[45:37] Thank you, vice-chair Anderson.

Thank you. >> So are you saying right now

you give grants to people who

[45:46] have been and that's have been

convicted of embezzling state funds or fraudulent. And

there's nothing that stopping

[45:55] you from doing that across state. Government management Commissioner Chair

Robin Representative Anderson,

[46:05] right now, current law allows

us to cancel a grant. It's not in the public interest. So

that's pretty broad authority.

[46:13] Of course, we would not issue a

grant to anyone that we know of

[46:18] or have information that engage

in any kind of questionable activity. So that is not

something that the that we do

[46:25] in the Strand State grants.

Space. Commissioner, thank you.

So you're part of this proposal

[46:33] is too give you authority that

who currently have for this

[46:39] potential grantees, that urban to stop them that have already

been convicted of embezzlement

[46:44] fraud against state, except so

that's a proposal commission chair Robbins

representative Anderson.

[46:52] Yes, this proposal is to expand

this. The authority that we have right now. We are allowed

to cancel a grant if it's in

[46:58] the public interest. So a grant

this expanded authority allows us to D bar a grantee potential

grantees. So grant he was not

[47:08] ever receive funds, D'Ivoire

them, eat cake them Celeste because they've applied and we

have information that they've

[47:14] engaged in these activities.

So yes, it's it's expanding the authority.

[47:20] Thank you commission that you

need that authority. You don't have that authority now to stop

these people from getting

[47:28] grants. Commission Chair

Robbins Representative Anders Anderson. That is correct.

Right now. We do not have the

[47:34] authority to D bar. >> Our tension, grantees.

So we can debe our current

[47:40] grantees. We can cancel a grant
if we see this not in the public interest, but if we have
an entity or person coming to
[47:47] us for the first time, their
potential granted, they haven't received anything. We can say
8, we're looking. We see that
[47:53] this person, this person was
entity. There's some serious issues there. We are going to
the bar that put them on and do
[47:59] not do not give grants list
essentially. And right now we don't have authority for
potential grantees.
[48:07] >> Okay, thank you. I just
don't understand because we do competitive grants processes
and you have the authority to
[48:14] to just the agencies have the
authority to choose. And so this may be an automatic choice
to chowan be giving public
[48:23] funds public grants to people
who have investment dollars commit fraud.
[48:30] Ok? Thank you, Commissioner Jay
Chair Robbins Representative Anderson.
[48:35] >> We do if we have any
information now we do not give grants
[48:41] entities or persons that we
have information that engage in any kind of nefarious activity.

Okay. We are expanding this
[48:49] request for authority to D bar
grantees. So I think the difference is DVD barring a
grantee is putting them on E do
[48:57] not give list that applies to
everybody and it's different than
canceling and barring of that
[49:04] current grantee. >> Okay. I if I could follow up
for a moment. So my
[49:10] understanding is there is no
debe our list at the moment that that's one of the things
that people have been wanting
[49:16] to produce. So that agencies
know across the enterprise who's been a bad actor, who is
not. So are you saying there
[49:22] currently is a deep our list
out there? I Chair Robbins. My
understanding is yes.
[49:30] So how would we know who's on
that list? The agency's ask each other. And that's my
understanding. And and I want
[49:38] to make sure you the correct
information. I can follow up with some additional
information. Yes, I'd be very
[49:43] interested that because my
understanding from the oil and other testifiers is that that's

one of the issues we're trying
[49:48] to solve is that there hasn't
been the ability to create a Dubai list and if it already
exists, I would very much like
[49:55] to see that. So thank you.
Alright. Next, we'll move on to Commissioner Brown. Thank you.
[50:02] >> Hey, good morning. Chair
Robbins and other members of the committee and to keep
around the commissioner of the
[50:07] Department of Children, Youth
and Families. The Department of Youth and
Families was created to was
[50:13] established to create a
sustainable public face for children's issues in state
government with a line comes in
[50:19] policy, improving the front
door for services, easing access and navigation for
families and improving
[50:25] services. Overall. In June of this year, program,
integrity, licensing and other functions from the DHS Office
of Inspector General will
[50:33] transfer to the Department of
Children, Youth and Families creating our own OIG headed by
recently hired Inspector
[50:40] general ensuring DC wife applies the
highest standards of integrity, monitoring and fraud prevention

to our programs as a key

[50:47] priority of mine and of the

governors. Increasingly accordingly, DCF

has 2 provisions in the

[50:53] governor's. 26 27 biennial

budget intended to address fraud and misuse of public

funds.

[51:00] The first provision is the DC

with portion of the governor's fraud prevention packages.

The completion of a multi-year

[51:06] effort to implement electronic

attendance skews an electronic enrollment and attendance

record keeping for the Child

[51:14] Care Assistance Program or seek

app providers. Currently, the state does not require

electronic record keeping which

[51:21] results in inconsistent and

variable recordkeeping practices. This is not

conducive to effective program.

[51:27] Integrity monitoring 2019 reports from the Office of

Legislative Auditor and

[51:32] Internal DHS report recommended

that see cap adopt a statewide electronic records system as a

tool to improve program

[51:39] integrity. These reports stated that paper

records could be easier to falsify any lack credibility

and that using electronic
[51:47] records may reduce
administrative burden, make it easier to consistently collect
data and enable investigators
[51:54] try to identify trends and
outliers early and prevent potential fraud and misuse of
public funds.
[52:01] It would also give the
department the ability to proactively address issues
before they escalate and
[52:07] continue to shift the focus of
the department's program, integrity efforts towards
preventing fraud rather than
[52:12] enforcing consequences after
from had been committed. Well, the recommendation came
in 2019. There is no way to
[52:20] immediately implement
electronic record keeping approach. So the Child Care
Assistance Program and the
[52:25] Office of Inspector General
staff put together a plan of action at the request of the
legislature. Dhs provided a
[52:32] memo in 2021 with information
on implementing an electronic record keeping system.
[52:38] The memo stated that the first
step in moving towards an electronic system required us

the state to establish a

[52:44] centralized see cap provider,

registration and renewal system between 2021 2023, DHS staff

and leadership plan for a

[52:53] statewide provider.

Registration and renewal system received funding in 2023.

[52:58] That system will be implemented

in April and the agency is now ready to move to the final step

in implementing electronic

[53:05] attendance record. Keeping for many providers, the process

of keeping electronic

[53:11] attendance records won't be new

to see why it has been using electronic attendance and

enrollment records for the

[53:17] Great Start, Compensation

support payment program. Currently the governor's proposal

requires of the same electronic

[53:23] attendance record keeping

system to be used by all providers receiving see cap and

one corporate the electronic

[53:29] system into MC Squared, which

is the state system for payments for childcare payments

building.

[53:37] One of the first steps I took

when at DC Laugh was establishing our chief

compliance officer to take an

[53:43] initial look at processes and
procedures for compliance across grant programs and other
aspects of our work to identify
[53:50] ways of enhancing our work
across the agency. The initial high-level scanned
identified gaps in compliance
[53:57] staffing accordingly. The governor's
proposal also includes 2 FT in the DC waive compliance office
to enhance the agency's
[54:04] internal process controls grant
monitoring and data analytics to improve oversight of public
programs.
[54:11] These positions will enhance
the agency's capacity to effectively monitor programs
and other entities receiving
[54:18] public funding, prevent
negative audit findings and ensure that TCU athletes its
statutory obligations to move
[54:24] bad actors from public programs
on program, integrity violations occurred. One position will serve as our
limit on receiving public
[54:31] funds, coordinator and the
other FTE will serve as the agencies of recipient
monitoring and data analytics
[54:37] coordinator, the 2 of TV's will work closely
to coordinate their work,

[54:42] to develop agency-wide programs
and initiatives to ensure that the CIA has both meeting its
regulatory obligations and
[54:48] providing broad based support a
programmatic teams and the monitoring efforts. And that
concludes my testimony. Thank
[54:55] you. Thank you, Representative Shull.
[55:00] >> Thank you. Madam Chair and
Commissioner Brown. What I'm looking at this and hearing you
speak a lot about the
[55:07] specifically looking at the
electronic attendance record keeping system, you know,
thinking about the see kept
[55:12] fraud that we've seen of her.
We've heard we've seen the stories about plenty of these
com companies, com nonprofits,
[55:21] childcare providers, where they
were fraudulently
[55:27] saying that there were more
students or kids present there. Some curious what, what are the
mechanisms that are going to be
[55:35] in place with your electronic
attendance record keeping system to keep it from not
being the providers who are
[55:42] providing those answers on
record Keeping Commission.

[55:47] >> Thank you, chair and
representative. So with the electronic record keeping
system, it will allow for
[55:54] additional data for the city to
analyze. So one of the pieces that we're excited about is
on-demand anomaly checks.
[56:02] This will with the new system
that will allow for an automation and attendance
records for anomalies, being
[56:08] able to track a different
trends and be able to flag individuals and entities much
more quickly than and then,
[56:17] you know, in person walking
through some of the paper records that currently exist.
[56:22] >> Madam Chair, yes, I'm not
sure the commissioner understood my question. My
question is, is that the
[56:27] provider that's going to be
doing the electronic checking in or is it the parents who are
going to be checking in the
[56:33] child? Because the fraud that
we have seen in this space has been these providers saying
that they have dozens or
[56:41] hundreds of kids on site and we
haven't seen a number one.
[56:46] We've seen stories that have

just said this is absolutely not what's happening. And so
number one, I want to make sure
[56:52] that we have the mechanisms in
place that are doing this. And then in addition to that, I
want to also hear what the
[56:59] agency is going to do to
ensure. You know, we've talked a lot about site visits.
Is the agency going to follow
[57:05] up on the actual what the
parents are saying with site visits to ensure that we aren't
seeing more frightened the
[57:12] space to you. Thank you,
Commissioner. >> Thank you. Thank you, chair
and thank you, Representative.
[57:17] Thanks for clarifying that
question. So indeed, what we've looked at with the electronic
record keeping is that there
[57:24] are mechanisms for parents to
log in themselves and check their child in and check their
child out, which does.
[57:32] >> Remove the provider.
Falsifying information.
[57:39] >> Last follow-up
representative show. Yes, thank you, Madam Chair. I heard
you say that there are the mechanisms, but is that the way
the program's going to work?

[57:46] Yes or no commissioner? >> Thank you, representative.
The system is not yet
[57:51] implemented. So that's where we
are. If we receive funding for this and we work their process
with an RFP, those mechanisms
[57:58] will be spelled out much more
clearly. >> If I could follow-up, I I'd
like to just go along with what
[58:06] representative sort of thing
for a minute. So as part of this to plan to increase actual
site visits.
[58:14] >> Thank you. Chair the
electronic record keeping system proposal that we have
forward does not include an
[58:20] increase in site visits for
child care providers. What it does is allow us access to data
to review information that we
[58:29] have on providers and the
childcare system. >> Thank you for that answer.
I I honestly I'm very concerned
[58:35] about that. So what we saw in
the autism center that the the
[58:41] warrant that was issued in just
December of 2024, is parents
[58:47] were checking in children who
were then found to be in attendance at their regular

public school.

[58:56] So if it's all just data,

nobody's checking by site visits, we won't know

[59:03] if in fact, the children are in

the child care or if they're doing something else. So site

visits has to be a component,

[59:12] effective management. And

that's been a failing of the current system. And if this is

not fixed, all the new record

[59:20] keeping in the world isn't

going to solve that. So I highly encourage you to

look at that component of it.

[59:29] Let's move on to Mister Jet.

Welcome to the committee.

[59:38] >> Excuse me, Madam Chair,

members of the Morning. My name is which at have the privilege

to serve. Commissioner 6,

[59:45] thank you for this opportunity

to present the Minnesota Department of Education's

components of the Governor's fraud prevention program,

integrity. Commissioner,

[59:52] if I could just ask you to be a

little closer to the microphone.

[59:58] So we've had trouble with that.

I can hear the messages they get to you.

[1:00:03] Yeah. Taken him a starter.

Madam Chair members. Good morning. My name is Willie Jett
and I have the privilege to
[1:00:10] serve as commissioner of
Education. Thank you for the opportunity
to present the Minnesota Department of Education's
components of the government's
[1:00:16] fraud prevention program,
integrity package. I'll be covering investments
and enhancements you're
[1:00:22] proposing for fraud, waste and
abuse prevention by our Office of Inspector General as well as
investments.
[1:00:28] The legal team improved
oversight of the charter school sector after again, his education
commissioner to start of 2023.
[1:00:36] We partnered with the
Legislature to fund set up our it team at the Department of
Education
[1:00:42] in 2024. Legislature passed
much needed clarification and authority around the ladies
mission to combat fraud,
[1:00:49] waste and abuse in the
department's programs in 2023. The Legislature also
passed some critical oversight
[1:00:56] and COVID policies for charter
schools and in that Russian space, however, as a continuous

[1:01:03] improving organization to
believe that more can be done, which brings me to our fraud
prevention program, integrity
[1:01:09] proposals for this legislative
session. First, we're proposing $550,000
can leak for 3 f to ease and
[1:01:17] softer advancements. Second we're proposing one
investigator added to it like
[1:01:23] to teen and disposition will
increase the capacity to do it to investigate fraud, waste and
abuse and more quickly address
[1:01:30] complaints. And 3rd, we're proposing to
legal counsel positions under Office of General Counsel.
[1:01:37] This will focus on nutrition
charter schools. One position will provide legal
advice and support to ensure
[1:01:43] and he is certain maximum
regulatory authority over nutrition program.
Participants,
[1:01:49] the other legal counsel, I'm
sure the agency is effectively exercising acquired oversight
[1:01:54] of charter schools and is
addressing program integrity and later challenges. And finally, we propose funding
for software advancements to
[1:02:01] paid. I tease in-depth
investigations, furthering the capacity of the

half U.S. to track cases and

[1:02:08] conduct financial analysis of

programs. We're also proposing policy for

it in charter school program,

[1:02:15] oversight as though it progresses through

its second year where every Dana, 5 critical areas in last

year's legislation to build off

[1:02:23] of. And this includes expanding the

org's jurisdiction around the incident of theft and abuse and

some protections for the

[1:02:29] investigation process.

Investigative data in good faith reports and this is

improving the ORG'S access to

[1:02:36] program participant records

enhancing the sanctions. Indy has available

[1:02:41] when the sanctions may be

applied and clarifying right of appeal. These changes will support a

more robust in DEO IG to

[1:02:50] further prevent fraud, waste

and abuse and enhanced program integrity. And our final portion of this

package sets forth expectations

[1:02:57] for charter schools by hand.

Graham Hansen, fiscal oversight, improving

transparency and justify need.

[1:03:04] And this includes clarification

on state procurement law requiring submission of the

annual charter school audit

[1:03:10] team the requiring the recording

publication of meeting Minutes on school websites.

[1:03:16] The market needs and demand

studies in schools move or many graves sites and programs.

[1:03:22] Again, I just like to thank you

for the opportunity to provide an overview of the governors

come the fraud prevention program, integrity package.

[1:03:28] And we strongly believe that

these investments and policy proposal build off of work

already done, especially in

[1:03:34] 2023 2024 and help combat

fraud, waste and abuse, especially probably some abuse,

integrity and in these programs

[1:03:43] with that concludes my

testimony. >> Thank you. I can represent

vice-chair, Anderson. Thank

[1:03:50] you, Commissioner jet. >> It's you're getting my

understanding is most of these positions haven't within the

OIG or not. Most lot of them

[1:03:59] aren't filled correctly.

So it sounds like you're filling them the existing

positions. And and they also

[1:04:07] cut right now. Can the OIG I

refer cases to law enforcement

[1:04:13] or isn't being done to my

understanding is that has to go to the commissioner that they
don't actually have.
[1:04:19] I'm a lot of they don't have
legal authority. They don't have authority to directly on their
own independently for cases to
[1:04:27] law Enforcement Commission. >> Madam Chair members. So the
first question, I believe you
[1:04:33] talk about staff member of
staff. And so we're almost fully staffed. And when I went
to things, I'd like to say if
[1:04:39] we've recruited highly trained
staff and they have decades of experience currently, we have 7
staff that are hard right now
[1:04:45] in a few more and final stage
of the hiring process. And then the second question to
ask in terms of cash and has
[1:04:56] changed within. >> The the right now to create
this
[1:05:02] proposal, I just the empty OIG
have authority on their own on
[1:05:08] independently to refer cases to
law enforcement. My understanding is they don't to
do everything they do has to go
[1:05:14] through the commissioner. >> Commissioner, Madam Chair
members. So yes, they can from
[1:05:20] time to question and they do

directly. I can report that law enforcement, they work with law enforcement all the time.

[1:05:27] And so, yes, they can't answer questions. >> Those changes okay now and the cost representative of can

[1:05:35] do this. Madam Chair, commissioner size that you it must.

[1:05:40] Madam Chair members there sanction authority lies within the commission. In terms of that's a question. Okay.

[1:05:48] Did you have a follow-up saying not in my life and just answered my question. Thank you. All right. So the commission,

[1:05:55] Representative Hawkins, thank you. Madam Chair. I would disagree with the proposition that you

[1:06:03] shouldn't be able to cross check child care enrollment data with school enrollment.

[1:06:11] I've no doubt that that's not possible now, but I think that's something that is to be aspire to as part of the work

[1:06:20] that is being done in the DC why AF and education. In fact, I'm in.

[1:06:26] >> The Education Department's student logic to it all in the education data system slides.

It's probably one of the maybe

[1:06:35] the best example of effective

data sharing among state agencies.

[1:06:40] And and I when I read the front

line worker pay study, I

[1:06:48] probably took away big being

the that the information technology geek on the panel

had different diss a different

[1:06:54] lesson and then many of you may

have. But what I what I read that one, I saw an

extraordinary 5 month effort by

[1:07:01] 4 agencies. Dolly deed a minute

and a department of revenue to

[1:07:08] assemble data from 3 different

agencies in order to administer

[1:07:13] a program. And and, you know, part to the

extent that there are issues

[1:07:19] and that program, a lot of them

were just because there were provisions in state law that

made it difficult for them to

[1:07:25] share the data, which is why

I'm caring the data sharing part of this. The governor's

package here.

[1:07:31] But I don't think that we I do.

I don't not disagreeing that. Yeah, we should site visits are

going to be an important.

[1:07:38] There's a lot more that that we
can do 2, you know, more
[1:07:43] effectively ruled out for and
make all of our agencies more efficient. If we can just do a
better job of breaking down the
[1:07:51] silos that curve and down our
agencies from from sharing data in these obvious use cases that
we ought to be pursuing.
[1:08:01] >> Thank you, Representative
Elkann. So will your data sharing provisions include that
opportunity?
[1:08:07] >> Thank you. At least when it
comes to fraude, I think there should be more pride than that.
Back to we, you know, when the
[1:08:13] governor was first elected, he
created this a blue room, the council on it reform.
It was have private sector,
[1:08:20] half public sector. And it was
so effective in examples like
[1:08:25] the memoirs Replacement
Project, which was done in less than a year on time and on
budget by buying off the shelf
[1:08:31] software that we now have a within the
the Technical Advisory
[1:08:37] Commission, which is how we
institutionalize the book. We now have a data sharing work

group that is looking at

[1:08:44] exactly this issue. And

Assistant Commissioner Kristen said he's in the back over.

There is a vice chair of that

[1:08:51] committee and the regular

participant. And I think we're going to be successful in

identifying a lot of good

[1:08:57] examples like this. And part of

that work is skies going to be identifying and eliminating the

barriers and state law more

[1:09:05] generally that prevent that

kind of effect of data show. Thank you.

[1:09:10] >> All right, Representative

Hudson. >> Thank you, Madam Chair.

My questions are for

[1:09:15] commissioners got Em tome.

So there's a member who has a question for commissioner jet

that should probably go before

[1:09:21] this. >> Thank you, Commissioner Jeff

will invite Commissioner Gandhian Tome up. Please.

Thank you,

[1:09:43] Representative Hudson. >> Thank you. Madam Chair,

Commissioner Homes in the absence of a statewide grant

management system that shared

[1:09:52] by all the state agencies.

Do you have any concern about compatibility of these

disparate systems that exist in

[1:09:59] the different agencies and its

ability up on your task of effectively analyzing

data

[1:10:07] commissioner terms. >> Madam Chair, representative

that that's a really great

[1:10:12] question. I don't know if it

would be quantified as concerned as much as just

inefficiencies and extra

[1:10:18] complexity, extra layers as it

relates to the number of different grant management

systems, the grant management

[1:10:26] systems that exist in the

state. And and I would need to follow up to verify this 100%.

But I think all of them are

[1:10:33] under based solutions that

that, you know, they're not home built solutions. And as

such have had a certain degree

[1:10:39] of modernization, probably not

incredibly age from the tech that perspective. So the

ability to interface with the

[1:10:46] system's what we refer to as

api's ability to get at data from disparate systems is like

it is very high, so confident

[1:10:53] in being able to do it. Just

the complexity of not being able to interface with one

system, but maybe being,
[1:10:58] you know, having to interface
with 10 or 12 different systems. And that's where the
resources to create robust data
[1:11:05] warehouses that hold these
types of transactions. The data sharing that represent of
Altman's references is so
[1:11:11] important because there's so
much data that we have in so many different places. Birth
and death certificates, records, unemployment
verification capabilities at
[1:11:18] the income verification
capabilities at the Department of revenue and and our ability
to holistically bring so many
[1:11:24] of these department let so many
of these different data sources together to create this robust
capability to analyze data is
[1:11:30] is important. So that sarta
long-winded way of answering a question. A concern probably
know just the extra complexity
[1:11:39] and the efficiencies of having
to so many different. >> Representative Hudson, thank
you, Madam Chair, and thank you
[1:11:46] for I appreciate the detail.
So what I'm hearing is that the job would be easier if we had a
single source, a statewide

[1:11:54] grant management system. >> Madam Chair, Representative,
I certainly would defer to the
[1:12:00] Department of Administration
from a business perspective. What what is easy for us, you
know, or easiest for us from a
[1:12:07] technology perspective, you
know, is not necessarily always the correct lens to look
through. I think the correct
[1:12:12] lens to look through in most
instances and in all instances,
[1:12:17] you know, the need to meet
business needs. >> I think that 100,000 foot
level and I think my
[1:12:24] commissioner, a beer would
concur. >> The fewer systems in
particular when they do the
[1:12:29] same things, the better the
better for a lot of reasons, you know, more effective for
the state, cheaper for the
[1:12:35] state. Easier more
complexities. But but grant
[1:12:41] grand making mechanisms across the
executive branch, you know, vary widely from to
organizations to individuals,
[1:12:48] you know, things like, you
know, the by programs or or even Bates. Just a lot of

different complexities

[1:12:54] associated with that said,

look, you can get necessarily for all grant making 2 to one

system, but the least systems

[1:13:01] the better. >> Thank you, Representative

Hudson last question. Thank you, Madam Chair. So I have to

questions. I ask you the same

[1:13:08] time for commissioner got me.

You mention around 400 referrals that you've made a

suspected fraudulent activity.

[1:13:16] Who did you refer those 2 and

of them? How many resulted in criminal investigations or

convictions? That question on

[1:13:24] the second is you mentioned

that the department has recovered 18 million dollars

was. Does that represent money

[1:13:30] that's been clawed back after

grants have been administered or just savings from payments

that were stopped. Commissioner

[1:13:38] County. >> Chair Robbins representative

puts in. >> The 18 Million.

[1:13:45] >> Represents recovered larger

than that. It's about 35 million the year. That's

either avoided. Are we? So are

[1:13:52] we seek to recover? >> And then >> the first question

[1:13:58] is Representative Hudson do

want to restate yes, thank you, Madam Chair. Thank you,
Commissioner County. So the
[1:14:05] first question was of the 400
referrals that you've made. Who were those made to him?
Did it result in criminal
[1:14:11] investigations or convictions
or how many of them roughly? >> Commissioner County Chair
Robbins Representative Hudson,
[1:14:19] we routinely refer to the BCA
FBI HHS OIG. So if if you'd
[1:14:27] like the specifics on where I
can get back to, I don't happen to have those off the top of my
head.
[1:14:34] >> And I and >> the convictions, I would say
I probably a high number
[1:14:41] because, you know, once they're
vetted enough within DHS to
[1:14:47] seem to have potential for fraud, then it
goes on. And I would have to
[1:14:53] ask the prosecutors to come up
with the numbers of what percent or what the specific
numbers are that actually
[1:15:01] resulted in successful
prosecution. I do have a question as well
regarding that, some of the 400
[1:15:08] referrals, how many did to stop

payment on when they were referred

[1:15:15] Commissioner Robbins, we we

work collaboratively with our

[1:15:21] law enforcement agencies.

We would stop payments on as many as possible if it is not

going to

[1:15:31] impact the investigation or tip

off the people that we are investigating.

[1:15:37] Great. If you could provide

that number for me. How many were stopped payments? Just the

high-level number, not

[1:15:43] individual cases. That would be

great. Thank you, Vice Chair Anderson. >> Thank you. And also the

numbers that represent the pups

[1:15:51] and asked for so all of that

400 referrals for that they go to and how many were actually

prosecuted. That would be very

[1:15:59] good on that. So I have a

couple questions. The regulation that's proposed in

here regulate and autism

[1:16:08] centers. What is done in other

states currently and it's are

[1:16:13] they regulated these entities

regulated Commissioner County?

[1:16:19] >> Chair Robbins Representative

Anderson, I would have to research that our or if there's

staff that up research that

[1:16:26] that know I might ask them,

[1:16:31] looks like that. Get back to

you. Thank you. Back to us on that because I'm really curious

as to what is going on in other

[1:16:38] states and then I there was a

news story recently where you

[1:16:43] are quoted as saying that and

IG and independent OIG is not

[1:16:49] legal or if there was concern

about that. But you and concern which

surprised shocked me that that

[1:16:57] that was the case. But can you

explain your position on that Commissioner County Chair

Robbins vice-chair Anderson?

[1:17:04] Yes, so the administration is

open to working with

[1:17:10] with everybody on good ideas

for the IG. The

[1:17:15] the point that I was making in

the letter is just that this is a complicated matter with the

federal government and the

[1:17:24] specifics matter. So we need to

make sure to get that correct, working with attorneys and

federal relations experts so

[1:17:32] that we don't run into any unintended

consequences. Absolutely

[1:17:39] support all good ideas for

strengthening program, integrity in the state

of Minnesota, including various

[1:17:48] configurations of it. Okay. Thank you. >> Thank you. I have a

follow-up question regarding

[1:17:55] that letter as well. So I was

honestly surprised about it. And one of my concerns is that

there seems to be a lot of

[1:18:08] shuffling of that people on the DAC, the deck chairs.

So would people go to that?

[1:18:17] It is office from DHS or would

people, but it just be an open process where people from

anywhere can apply for these

[1:18:26] positions. Chair Robinson, not sure that I

understand that question.

[1:18:33] So my understanding is that in

the Senate over this issue, there was quite a lot of

concern race that people from

[1:18:40] the department would go to the

new inspector general office. And that continues to be a a

point of debate. And so I'm

[1:18:50] just wondering what the

department's position on that is what you want. Staff from

DHS to go over to any new ad

[1:18:57] that's created or would it be

solely responsible for the hiring

[1:19:05] Chair Robbins? What what I

think is most important is that

[1:19:10] we. >> I'm state law with what

works with our federal obligations. And so I think we

need to work with federal

[1:19:18] relations experts and attorneys

that understand the intricacies of that and they will help us

understand what we need to do

[1:19:27] it, DHS to maintain our federal

obligations and then what is possible with a and

independent. For example,

[1:19:36] I G the specifics for many of

whom moves over are not as important as making sure that

we are doing the best that we

[1:19:45] can and Minnesota to have

program integrity and meeting our federal obligations.

[1:19:51] >> Thank you. Yes, I sure that

my understanding is it's it's done in other states and that

it's very possible to have to

[1:19:58] federally required. It

requirements met while they're still an independent office.

So I hope we can continue to

[1:20:05] pursue that. >> Additional questions.

Representative Freeman, thank you, Madam Chair. And just

actually on this question of

[1:20:13] separation of powers car looked
into it. Another issue that I was working on creating the and
C 4, which is nothing to do
[1:20:19] with this. But in unlike other states, I don't
other states constitution are structured. But we have Article
3, which is about the
[1:20:26] distribution of government
powers. And so a lot of time with nonpartisan staff with
Matt Gehring. But if you read
[1:20:34] the powers of the state
government divided into 3 distinct departments, the
reason of the LA has to be
[1:20:40] advisory is that they're
exercising legislative authority and we can't have a
legislative or legislative
[1:20:47] appointments to an executive
function that has been a longstanding read into the
Constitution. It put some
[1:20:53] limitations on what we do.
I don't think it prevents us from having an inspector
general that office that
[1:21:00] operates in a way that we want.
But we do have limitations of the Minnesota Constitution and
article 3 to just to spend a
[1:21:07] lot of time and that in my
life. But beyond that, I'm interested. We haven't talked a

lot about the sober home pieces

[1:21:16] of this is their plates to DHS.

And I know new way and other things have been in the news.

I have a few constituents have

[1:21:25] come to me. Both folks are peer

recovery support folks who have been it's a taking advantage of

by by companies as well as

[1:21:35] residents, participants of the

sober home. So I think have put been put into positions that I

would say our exploitive,

[1:21:45] if not fraudulent. And I'm

wondering. >> As in reading this bill, the

pieces that we that are we

[1:21:52] adding to prevent the double

billing to prevent some of the abuses we've seen in some

rooms. Can you expound a little

[1:21:59] bit more on that? Because I

know that's right in the news recently. Commissioner Ground.

[1:22:04] >> Chair Robbins,

Representative Freeman, thank you for that. Yes, the H S a

would like to strengthen our

[1:22:12] oversight over these new

services that the new Medicaid

[1:22:17] services that we've expanded.

So it is important to have

[1:22:23] licensure. I mean, there's so

there's the IDB I there's housing, support, services,

SUV,

[1:22:30] and depending on the service,

we want to be sure that we can enroll providers. We have the

right oversight over providers.

[1:22:38] We have either licensing or

getting on the path to licensing provisional

licensure.

[1:22:45] We want to tighten up to

billing and make it very clear

[1:22:50] using the Minnesota Department

of Health's rule and CMS standards so that there is not

misinterpretation of the

[1:22:57] billing Representative Green. >> I appreciate that. And they

particularly reading this 100

[1:23:05] paid well. Appreciate that part

that gets really explicit about the double going at lease, I

think a new way and we want to

[1:23:12] prevent other places. I just

want other questions have going to another part of DHS about

some of the things that I keep

[1:23:19] hearing about in terms of

long-term care and more. And I'm looking at the area

around 8.11 to eat or 80 skews

[1:23:29] me Page 80. But the pieces

around particularly section 2

[1:23:36] in return for purchasing
leasing ordering or arranging they're inducing are
participating. Ordering of food
[1:23:42] goods facility is both a
kickback peace. But also we've just I've heard a lot of
stories about inflated going
[1:23:49] about long-term care facilities
that have relationships with food providers or others,
contractors where the whole
[1:23:58] price goes up because of value
based Boeing and I am not an expert in this area, but I have
heard in a few different spaces
[1:24:07] about and I'm wondering what
the bill as I look at these these sections, what powers
this give us a deal with that
[1:24:16] because we know that the costs
of long-term care, particularly the long term care private
facility in the pot public or a
[1:24:23] private equity is getting in
the game, want to make sure that the building is staying
true to the market value that
[1:24:29] of the services being provided. >> Commissioner County Chair
Robbins represent bit green
[1:24:36] men. I also I'm not an expert
in long term care billing, but I appreciate that that we
have been working closely with.

[1:24:47] Our experts are subject matter.
Experts in that area as well as our program, integrity experts
to make sure that we put strong
[1:24:55] language in there. That's that
helps us both from a monitoring standpoint and from following
up on any
[1:25:04] concerning billing activities. >> Blessed are ye just just to
comment, because I think in
[1:25:11] every place where we see
government become a profit center or mark, it's not always
fraud.
[1:25:18] >> But often it is. But in
other cases, it's a situation where if there is money to be
made, I think we need to really
[1:25:25] make sure that we have the
provisions in place to make sure that those contracts are
market rate. And when I see
[1:25:32] private equity get into a
government provided services, it makes me very nervous
because their whole job is to
[1:25:40] maximize profit for their
shareholders for getting out. And so I just want to make
sure, especially in the the
[1:25:47] industries that we have seen
targeted for private profit and private equity, that we're
being really, really careful

[1:25:55] about how we're structuring
those contracts and the
[1:26:00] oversight of those contracts
and say appreciate the pieces in this bill. I look forward to
learning more.
[1:26:06] >> Vice chair and just thank
you. I Everett technical question of the Medicaid
expansion when the dollars are
[1:26:12] coming through for expanded
services for Medicaid. What what are the requirements from
the facts? I'm around fraud
[1:26:22] prevention. Are they just
letting us serve execute these programs on are on that list,
[1:26:29] Commissioner County and this year, Anderson. >> I thank you for that
question. Yes, the
[1:26:37] requirements are the same.
So we in terms of >> making sure that we are
paying accurately and taking
[1:26:45] reasonable efforts to detect and prosecute fraud.
However, when we have when the
[1:26:54] legislature has enacted these
programs without their control
[1:27:00] such as licensure that allow us
to move upstream to do more on
[1:27:06] the enrollment phase on the
visiting ahead of TIME training

[1:27:12] and providing more guardrails
for the program's up front. That's the piece that I was
speaking about.
[1:27:19] >> So the front then vice chair
under. So that's what I'm real case. But that the like the
recovery centers are that the
[1:27:27] Autism Center specifically
we're talking about potentially licensing them. I will find out
what's done in other states.
[1:27:32] How much of that is reimbursed
by Medicaid? What percent of these programs are actually
reimbursed.
[1:27:39] >> Commissioner to state versus
state dollars, Mr. Gandhi. >> Chair Robbins reprot
vice-chair. Anderson, I I don't
[1:27:48] know the percent off the top of
my head. How much is the state share versus the federal share
[1:27:54] of the licensing costs? Okay, C Fs.
[1:28:00] Is that something that we're
picking up or is that something that the Pats would share or
pay for commissioner can share
[1:28:09] Robbins Representative?
Anderson, we do have in our Bill state fund dollars for
increasing licensing and
[1:28:19] various activities. Exactly for
this reason because the state

[1:28:25] does need to support that.

What I don't know is the

[1:28:30] if their what level of federal

share there is for that. But for example, with the E I

ddi providers, we end housing

[1:28:39] stabilization support

providers. We are making plans to

designate those high risk.

[1:28:47] And in the governor's package

is funding for the increased

[1:28:54] licensing visits, site visits

those activities that will help us on the front end. And so

very much asking for your

[1:29:02] support in passing those

provisions. Okay. Thank you. Thank you. So I I have another

question since we have time.

[1:29:14] So my concern just writ large

and maybe the smarter you chair Pinto, I'm not sure.

[1:29:20] >> Is that we're spending a lot

of money. We're doing some

[1:29:25] licensure which I think is

needed. We're doing it and data

[1:29:30] analytics. But it doesn't seem like we're

doing anything on holding

[1:29:38] agency staff accountable.

So so many of these problems have been because people in the

agencies,

[1:29:46] many of whom are very well

intended. But they didn't catch this or when it was caught.

No one was held accountable.

[1:29:55] And I don't see anything in

other proposals that I've had with the la about.

[1:30:02] I forget which side was but

that they want they want to do more training. They want to do

more. Financial control is

[1:30:08] great. No one is saying you get

a mandate employees to take this training. That's that's

something that the L has

[1:30:14] repeatedly asked for. We

haven't said that we're going to change job descriptions.

We're not going to

[1:30:23] say that if someone has

violated these policies, they're going to be fired.

The other commissioner

[1:30:29] testified well will

investigate. We'll see what happens. So I'm looking for

where is the accountability for

[1:30:36] state agencies to if you can

point that out to be. >> Thank you, Madam Chair.

Yet I think we want to start

[1:30:41] with the understanding that as

far as I'm aware, there's been no allegations of wrongdoing by

state employees. Right? So

[1:30:47] there's no. I mean, each of

these incidents have involved outside actors.

[1:30:53] >> Organizations behaving

wrongly, including individuals involved. Those organizations

been gets it wrong to a state

[1:30:58] employee is an end to clarify,

please. Yeah, I believe that is correct. But stayed in place to

oversee these programs and have

[1:31:06] a responsibility to ensure that

grants are managed properly. We have not been held

accountable when they fail to

[1:31:13] do that. >> And Madam chair, I mean,

what out on, though, to I've

[1:31:19] got to get that first light us

up. If you think about the buckets of this package, you

know, first item detection oversight, if you don't have

the detection ability mean

[1:31:28] enhanced detection ability,

then puts the employee, put state workers in a better

position as state leaders in a

[1:31:35] better position, a much better

position to act rate as you first have to detect that it's

going on. And I guess I just to

[1:31:42] deal with a couple of specific

things that you mentioned, what I recall, the prior

testimony is in fact, state

[1:31:48] employees involved in in grants

and grants management to make a decision by France do. In fact,

Chris have received training to

[1:31:55] receive training. It's

something that all those employees are receiving.

We can get some clarification on that. If you are part

recollections are different.

[1:32:01] We've got a bunch of

commissioners here. My understanding is that that is

in place to the questions that

[1:32:07] that went to commissioner about

state employees being required to report. If there's a grant

some sort of violation, we

[1:32:16] don't know. I guess I say this

as prosecutor, right. Facts and situations vary widely. If all

we have the second find that

[1:32:23] exact slide. All we have is that yeah, a

state employee fit fails to

[1:32:29] report a violation of a grant

to rule. We've just say it that way.

I don't know that that

[1:32:34] immediately. We know that that

person who failed to report that should be should be, you

know, family prosecutor fired,

[1:32:41] right? Maybe they didn't report

it because, in fact, they somehow, you know, they didn't have the opportunity to or
[1:32:47] something like all we know is that exact cause. Just those words say, guess what I heard the commissioner say is as with
[1:32:52] any employee situation, we look into what the employee is doing. If the employee does something that they're not supposed to do, we're going to look into that. I think we all
[1:32:59] know in any enterprise that we work in, you don't automatically say will immediately somebody gets fired. When a particular thing happens, we have to we have to
[1:33:07] look at those situations.
So what I would say is if we start with the understanding no wrongdoing by state employees,
[1:33:14] we may say there needs to be great need to be greater tools. I understand maybe you're concerned about there being
[1:33:19] particular accountability.
I think that's where we have to kind of get to specifics to my mind and say in this particular
[1:33:24] situation, what happened in this situation. That's where we've got the only providing reports back to us. And that's
[1:33:30] what I think we need to look at

it. But ultimately we we are a state that is providing a lot

of support to make sure that

[1:33:38] Minnesotans can thrive in their

lives. And there are people who are taking advantage of that.

And we absolutely need to work

[1:33:43] all of us together to make sure

that anybody who's trying to take serious advantage of that

is being caught being held

[1:33:49] accountable and the 3 buckets

that are up there before. I think this is a package that

does the school.

[1:33:55] Thank you, Representative,

Eric. >> Thank you, Madam Chair.

So Commissioner Gandhi, you had

[1:34:00] talked about 4,000

investigations and 400 referred to law enforcement over what period of time that

per year or is that over since

[1:34:10] 2020? Because I know when we've

had you here before you said that in seek, have you

recovered 2.4 million dollars

[1:34:17] since 2020? And so I'm just curious as to what period of time

[1:34:23] Commissioner County Chair Robinson Representative

Eric since 2020.

[1:34:29] Any follow-up. Thank you, Madam

Chair. Well, that's a huge difference between because your

last number year, 18 million

[1:34:35] was the average annual

recovery. So now we're conflating 4,000

investigations, which really

[1:34:45] are only about 1000 per year. And you have nearly 500 in the

I G S office.

[1:34:56] That means that I'm assuming

then the 400 referred to law enforcement is 400 since 2020.

Is that correct? Commissioner

[1:35:02] County, Madam Chair,

[1:35:08] when you when someone comes

Madam chair to give us statistics and facts as was

stated

[1:35:14] and you say I have 4,000

investigations, I have 400 referred to law enforcement.

We've got 18 million per year

[1:35:21] recovered. Those numbers are conflated.

They are not the same time frame whatsoever.

[1:35:27] It should be 1000 per year

average 100 defer to law enforcement on

average when they have nearly

[1:35:35] 500 people in this

investigative unit for DHS and they paused back 18 million

dollars per year

[1:35:42] out of 25 billion dollar

budget. 25 billion dollars. So this

makes no sense to me

[1:35:49] whatsoever. And I think I heard
the commissioner also say that she has an increase in Fte is
for site visits. I like to know
[1:35:56] how many fte Zahn, I think on a
plan to go all the way up to fever or falls in international
falls and bemidji. I mean,
[1:36:04] are they gonna do site visits
all over the state are virtually commissioner Candy to
adjust the site visits
[1:36:12] Chair Robbins representative
Eric. >> Yes, our employees that do
site visits go all over the
[1:36:19] state of Minnesota now and with
the increase in the number of providers and services. We need
to increase that number because
[1:36:27] they are on the road all the
time represent her. And what would
that number be in this
[1:36:35] proposal?
[1:36:44] Commissioner Gary Chair Robbins
representative Eric in this proposal we have.
[1:36:52] >> We have staff for.
[1:36:59] >> I have it by area. Saw give
you the numbers as I have that now, if you would like them in
a different format, we can go
[1:37:06] back and get it for you. But we have a one staffer,

substance use disorder

[1:37:13] treatment services changes.

We have 8 for improving support

[1:37:18] of recovery housing options. We have 59 staff for detecting

preventing addressing fraud and

[1:37:26] human services. We have 36 devoted to Bei Dbi

Provisional licensure and

[1:37:33] program integrity. We have 45

for program, integrity, investigative analytics

infrastructure and we have to

[1:37:42] for background studies

disqualifications

[1:37:47] commission to represent her.

Thank you. So. >> Are all of these? It's over

100 are they are all going to

[1:37:56] be doing site visits and

verifying that the electronic death tax. I know that there is

a move. Everything that you

[1:38:02] talked about, not you

personally, but this whole presentation is about what

we're going to fix everything through AI we're gonna

[1:38:08] even though are underlying

programs are terrible. New built. And you know, there

ancient and they're built in

[1:38:13] the 80's in the 90's and a

green screens f keasean the wheel of death. So we're going

to put a eye on top of these
horrible programs.
[1:38:23] So how many of these people are
actually going to go out physically do site visits to
see that they're actually our children at an unannounced, I
should say, unannounced visits
[1:38:32] to make sure they're actually
children in those programs being served, that there's
actually kids in the autism
[1:38:37] centers being served, that
there's actually people being served and that, yeah, I D I
programs like are are these
[1:38:44] additional month? I haven't
added up but it's more than 100 going to be actually doing site
visits specific.
[1:38:52] >> Commissioner County Chair
Robbins Representative Eric, the numbers that I have our
holistic to support program,
[1:38:59] integrity within DHS. I would
need to go back to staff to at to find out which specific ones
will be added to licensing and
[1:39:09] audits that would go out and do
the visits. >> Thank you. I have a question
following that. So you said 59
[1:39:16] for fraud and 45 for program
integrity are those. In addition to the I believe in an

earlier hearing, you said there
[1:39:23] were 491 people in the OIG
office currently. So those are
[1:39:28] new staff in addition to the
491 in the DHS OIG office.
[1:39:34] >> Chair Robbins? Yes, that is
correct. Are OIG office
[1:39:40] includes Licensing background
Studies program, integrity,
[1:39:46] data analytics. So there's a
number of areas and our budget
[1:39:51] as has been discussed, has been
increasing and the programs that we oversee are increasing.
So if DHS in terms of
[1:40:00] operations, we have about 1.7%
of our budget.
[1:40:09] All right. To point, let me let
me get the number exactly right here right now in
[1:40:17] in 2022, our operations in it,
which includes all sorts of
[1:40:24] internal controls, including
finance, et cetera, was about 2.7% of the DHS budget
[1:40:32] by 2027. That will be going
down to 1.9% of our budget.
[1:40:38] So very slim, operational
oversight for a large program. And so, yes, we are asking for

increased FTC's.

[1:40:47] >> Thank you. So we have 3

questions left will try and go Lightning fast. Representative

Elkins.

[1:40:52] >> Thank you, Miss Madam Chair.

I think if there's one theme today and Representative Eric

Heat that bring it up, but them

[1:41:02] we're the the the agency's

especially DHS and ECU. I F our

[1:41:07] operating under ancient systems

built in the 1980's and they need to be replaced.

The last time I asked chair

[1:41:15] newer, what was the current

estimate for how much that would cost the said? Well,

somewhere in the range of 800 million to a billion

dollars,

[1:41:23] almost everything that we're

talking about today is going to require in for investment in

improving the capabilities of

[1:41:30] the people in these agencies to

be able to do their jobs and ferret out fraud.

[1:41:35] And I'm concerned that we're

spending up a narrative here that if all of these people

were just a little bit more

[1:41:41] conscientious week at that

immediately ruled out out hundreds of million dollar of

dollars in fraud that we could

[1:41:47] apply towards balancing the

next budget. One, the opposite is true. If we really want to

be serious about rooting out

[1:41:54] fraud, we're going to have to

make some significant investments here in giving

these people better analytical

[1:42:00] tools to do their jobs. >> Representative vice chair

and thank you. Not be quick

[1:42:07] out. We gravity wasn't here,

but I do want to or not I the 2 revenue per process. I think a

really good so and the belt is

[1:42:15] theirs is here for the record

it. So I don't know if you had a question for her. No, I

don't. I just I think it's good

[1:42:21] that we're sharing data.

I'm with individual individuals. And I think it's

good that we're taking away the

[1:42:29] the prepay, the child tax

credit. So those are really good things.

[1:42:34] I agree that this is a data

problem. Every individual

[1:42:40] that's receiving services

should have some sort of unique identifier it at school.

I that Jake, just a beginning

[1:42:46] services for this and either

for different autism centers, billion for the same thing get
that's, you know, we should
[1:42:54] have these basic things.
I don't think it's going to cost a billion dollars to do
it. But I think that needs to
[1:42:59] get done. It would be done in
any private. This isn't it obviously doesn't exist here.
But I think we also have to
[1:43:04] deal with the culture when
there are problems and we knew there were problems. Some of
the things that we've seen
[1:43:10] publicly are the biggest things
that, you know, the huge in the end,
[1:43:15] we knew about it as it was
going on and we didn't do anything. Okay. So there's got
to be a ton of staff that we
[1:43:23] haven't heard about. That's
going on. And that's just it's got to
stop. People are losing and
[1:43:29] have lost 8 in the state
government to manage progress. And we see that all up and down
government. That's part of
[1:43:36] what's happened. The federal
level and we have that going on here is we have to fix these
things. I do think there are
[1:43:42] some good things in here that I

could support their other things. I don't think, you know, they doesn't change the

[1:43:48] culture. We have to change the culture. We find fraud. We have to act on it immediately.

[1:43:54] Immediately. We need to find it do it or through whatever but state this but got to act right away. So I know a very limited

[1:44:02] time. We'll turn chair. Thank you. Thank you. We are out of time but Turpin to I'd like to give you just a closing comment on your Bill.

[1:44:08] >> Thank you so much, Madam Chair. And I'll just note, there's a 2024 report by the credit monitoring company experiences that two-thirds of large U.S. companies are

[1:44:16] increasing the investments to fight fraud. And that's our state can be no different. This is a really good package,

[1:44:24] UCC, the 3 components of it. And I just want to emphasize office again, this has been a multi-year effort. We can be

[1:44:29] really proud of the work we've done in past years. And I want to make sure we're proud of the work that we do this session as well to do what's right, not just in our public programs,

[1:44:37] but all different ways that

Minnesota to being being defrauded. And I too want to

make sure the fighting that.

[1:44:42] I appreciate the time the sky

this morning. Madam Chair, for your work. Thanks all. >> Thank you. And thank you to

all the commissioners and

[1:44:48] Testifiers who came. We greatly

appreciate your time coming before the committee. Have a

great day. Thank you. We are

[1:44:54] adjourned

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 04-07-2025

[0:01] >> And welcome to the April 7th
meeting of that House fraud Prevention and State Oversight
Committee.
[0:09] We're glad to have you here.
Hope you all had a good weekend. Looks like we do have a quorum.
So we're going to go ahead and
[0:17] approve the minutes from the
March 24th meeting Representative Hudson with to
move the minutes from March
[0:25] 24th. I will Madam Chair, a great Representative. Hudson
moves the minutes from March.
[0:31] 24th is any discussion. All right. All those in favor
say Aye. Aye. Those opposed nay
[0:39] and then it's our adopted.
Thank you very much members. We have a great presentation
today on how the state use the
[0:48] COVID money that we receive
during the pandemic from the federal government
[0:54] and then state appropriations
that came in on top of that and first step, we are going to
have that commissioner of
[1:02] Minnesota Management and Budget
and her staff join us. So please welcome to the committee
Commissioner Campbell. And

[1:10] you guys can get set up.

I believe you have some slides

[1:23] members, this attack in your

packet as well. Just go ahead, state your name

for the record, McClatchy here.

[1:31] Look forward to your testimony. >> All right. Well, good

morning for the record. I'm

[1:36] Erin Campbell and the

commissioner at Minnesota Management and Budget. Thank

you. Chair Robbins and committee members for the

opportunity to present today on

[1:44] the funds the state received in

response to the COVID-19 pandemic. I'm proud to report that both

the Coronavirus Relief Fund and

[1:51] the American Rescue Plan

received unmodified opinions or clean audit reports for single

audit for all yours. Today.

[1:58] It with no material weaknesses

are required repayments Maurice and more recently, I'm

especially grateful for team's

[2:06] efforts to help Minnesota

townships complete final reporting and avoid returning

nearly 1.5 million to the U.S.

[2:13] Treasury. The spring marks 5 years since

the initial response efforts

[2:18] began here in Minnesota kind of

sense, claimed the lives of more than 17,000 Minnesotans
and over a million Americans
[2:25] from emergency health measures
to economic stabilization. Every level of government was
called on to act quickly
[2:31] decisively and that an
unprecedented scale you'll see more than 76 billion in federal
funds came to Minnesota in
[2:39] response to the COVID-19
pandemic. 13 billion of this went through our state
government.
[2:45] This presentation is intended
as a broad overview of the pandemic related funds that
came to Minnesota and we
[2:51] followed by deeper dive on
unemployment insurance from this time at the committee's
interest, additional agencies,
[2:57] specific presentations could
follow at a future hearing with that identified or state budget
director on a Monday to
[3:04] continue with the presentation. >> Welcome to the committee, at
least if it that your name for
[3:09] the record. Good morning. Madam chair,
members of the committee and numbing. He's assistant
commissioner and state budget
[3:15] director with Minnesota

Management and budget. As the commissioner noted, I'm here today to provide an
[3:20] overview of the federal
funding. The state has received in response to COVID-19.
[3:29] So to sort of level set the
universe of funding that we generally consider. When we talk about federal COVID funds,
[3:36] funds were largely talking
about funding appropriated in 5 bills passed by Congress that provided funds to states to
[3:43] respond to COVID. I'm going to walk through them fairly quickly without going into significant detail about their contents. But to give you
[3:49] a so just to refresh all of our
memories and give an overview of the sort of timing of events,
[3:56] the first bill, the Coronavirus
preparedness and response Supplemental Appropriations Bill passed on 3/6/2020.
[4:04] The bill was relatively small
providing 8.3 billion dollars in emergency funds focusing largely on public health
[4:11] response. Later in March, Congress passed
the Families First Coronavirus
[4:16] Response Act which provided
paid sick leave tax credits and free COVID-19 testing expanded

food assistance and

[4:24] unemployment and increased

Medicaid funding. The bulk of the funding that

the state has received tower

[4:30] has been from the last 3 bills

on this list. The Coronavirus Aid Relief and

Economic Security Act. More

[4:38] commonly referred to as the

CARES Act with the 2 trillion dollar stimulus bill provided

loans and grants to businesses

[4:46] expanded an inch. Unemployment

aid provided direct payments to families, supported health care

providers and provided funding

[4:53] to state and local governments. Then in December of 2020

[4:58] coronavirus Response and Relief

Supplemental Appropriations Act, which is also known as the

Consolidated Appropriations Act

[5:05] passed. >> And provided about

900 million dollars for pandemic-related economic.

Really this included about

[5:11] 325 billion for small

businesses 166 billion for

[5:16] additional stimulus payments.

Funding for increase you. I benefits schools,

universities, vaccines and many

[5:23] other programs. And finally, the American

Rescue Plan Act or arpa passed
[5:28] in March of 2021. Of that
estimate of about 1.9 trillion dollars. It contained a variety
of funding for economic relief,
[5:36] education, public health and
local government. So with that backdrop, the
looks of it to how much of my
[5:42] how much money did Minnesota
received through these COVID relief bills.
[5:47] This slide provides an overview
of all of the federal funds flowing into Minnesota through
these federal relief bills,
[5:53] dividing those dollars into
what came to state government for administration versus those
that flowed directly to other
[6:01] recipients. This information comes from a
organization called federal
[6:07] funds. Information for states
are F I S in total effort by estimates
that Minnesota will receive
[6:14] about 76 billion dollars in
federal COVID relief funding that 13 billion has come to
state government while about
[6:22] 63 billion has flowed to other
recipients. We'll discuss more of the state programs in
detail, but I wanted to

[6:29] highlight some notable funding provided to other recipients. So of this 63 billion, you can

see the line label economic

[6:37] assistance. And that's about

52 Million. Almost 80% of the money flowing to non state

recipients.

[6:45] This includes about 17 billion

dollars for the Paycheck Protection program, which was

in a federal program

[6:52] implemented by the Small

Business administration. It allowed businesses to apply

for low-interest loan, which

[6:57] was partially or fully forgiven

if a business kept employee counts and wages stable.

[7:03] Also in that 52 billion for

economic assistance. Funding to other recipients is about

14 billion dollars in economic

[7:09] impact payments. We commonly

think of a stimulus payments. There were 3 rounds from the

cares Act the time

[7:18] Chris, a duck and arpa and then another notable such

funding stream flowing outside

[7:25] of state government. You can

see on the Health and Human Services line was about 2.2

billion dollars provide that

[7:31] health care providers for a

funding stream known as the provider Relief Fund.

[7:38] So with that, I would think the

remainder of my presentation will focus largely on the funds

flowing to state government.

[7:45] Looking at the graph on slight

edge there, image on slide 4. You can see

that the relative distribution

[7:53] of the funds that the state has

received about 3.9 billion of the total

has been received through some

[8:00] flexible funding mechanisms.

Specifically the coronavirus Relief Fund from the Cares Act

and the State Fiscal Recovery

[8:08] Fund from the American Rescue

Plan. Health and Human Services is

the next largest category of

[8:14] spending. Roughly 3.8 billion,

the largest items in that

[8:19] category of funds. Our over

2 billion dollars in enhanced Medicaid matching funds.

And then I'm not surprisingly

[8:27] significant public health

funding to support the response to COVID-19.

[8:35] So with that overview not going

to walk walk through some of the larger funding streams

incorporated in these numbers

[8:44] starting with our taxable
resources. As you just saw, Clarksville
funds have played a significant
[8:50] role in the state's COVID
response. The first allocation of
flexible funds came to the
[8:55] state through the Coronavirus
Relief Fund. Minnesota received 2.2 billion
dollars in the Coronavirus
[9:02] Relief Fund through the Cares
act of that 1.1 6 billion went to
local governments and just over
[9:08] 1 billion dollars came to the
state. So in order for an expenditure
to be elegant, elgible use of
[9:14] the coronavirus relief and
works as the radiation that the crf it needed to be unnecessary
expenditure incurred due to the
[9:23] public health emergency but not
previously budgeted for by the state.
[9:28] The table here illustrates how
we spent the state's allocation. Almost a quarter of
our word
[9:34] funded activities to support
education during the pandemic. There was also significant
spending for testing support

[9:41] for at-risk populations,
business relief and other response activities.
[9:46] There is much more information
about the state's crf spending available on many of these Web
site. We have both summary
[9:52] reports as well as the request
forms that were submitted to the Legislative Advisory
Commission for Review.
[9:58] And in terms of timeline, the
Crf was really for activities from March of 2020 through the
End of calendar year 2022.
[10:08] So then the next source of
flexible funds received by the state was the American rescue
plan. State Fiscal Recovery
[10:15] Fund on slide 6. The State Fiscal Recovery Fund
allows for broad uses including
[10:22] revenue replacement for
expenditures obligated between March 2021 and December of
2024.
[10:29] notably the funds could be used
for tax cuts that service our pensions or as the state match
to drive down some other
[10:36] federal funds. For example, we
couldn't use state fiscal recovery funds as the state
match for Medicaid expenditure.
[10:44] Minnesota received 2.8 billion

dollars and of that 2.3 billion. Roughly 80% was
appropriated by the legislature
[10:52] to replenish the unemployment
insurance trust fund due to significant layoffs or
early in the COVID-19 pandemic.
[11:00] The state's you I trust fund
relied on and advance from the federal government to continue
operations and benefits.
[11:06] Generally the fund is
replenished or increases in taxes and assessments paid into
the I trust fund. But through
[11:12] this federal funding and the
Knicks, I additional general fund appropriation,
replenishing the fund and
[11:17] paying back federal advances
the state and avoided some of those increased costs to
employers.
[11:23] The state also the remainder of
the 2.8 million was appropriated from the state
Fiscal recovery Fund for COVID
[11:29] immediate response through a
mechanism in named in state
[11:35] law. The COVID-19 flexible
response account which paid for things like
summer learning emergency
[11:40] healthcare staffing work for

stabilization and childcare and similar to the Crf. We have
many reports on our website
[11:49] laying out the allocations from
the fact that COVID flexible response account.
[11:57] In addition to state
government, local governments also receive significant
flexible funds totaling about
[12:03] 3.3 billion dollars. About 1.4 billion of that was
allocated to cities and towns.
[12:08] And about 1.9 billion has gone
to counties.
[12:17] I think, look, pivoting back to
the funding that the state has received. As you saw in the
earlier slide, education
[12:23] was a significant area of
federal investment. About 2.1 billion of the total has come
to the state through 2 programs
[12:30] shown and by the acronyms as
sir and gear after stands for
[12:35] the elementary and secondary
school emergency relief. It was about 2.1 billion
dollars that came to the state.
[12:43] And of that 90% was Formula
Funds distributed to districts based on title one allocations
and the remaining 10% was
[12:52] allocated in state grants at 06:00AM

[12:57] the funding went towards
activities that address Florida learning loss as a result of
the pandemic as well as funds
[13:04] to respond to COVID-19,
including maintenance of operations and staffing things
like COVID response
[13:12] training staff on sanitation,
sanitation supplies planning for closure, education,
technology, mental health
[13:18] supports and things like
improving air quality systems. And he also had some
flexibility over that remaining
[13:26] 10%. And some of the ways that
they located flexible funds included after-school programs,
summer enrichment, multi-tiered
[13:34] systems of support for schools, expanding rigorous course work
and public engagement with.
[13:41] In addition, Minnesota received
105 million dollars to the Governor's Emergency Education
Relief program come prefer to
[13:49] by its acronym of GEAR, which has been used to provide
school, aged care, technology, access, mental health, training
and response.
[14:04] So in addition to significant
education funding, the state has received significant funds to support
the child care sector.

[14:11] The Department of Human
Services received about 720 million dollars in child
care, specific funds and 700
[14:18] and 9 of that came through 2
large grant programs. The first
[14:23] pilot is 324 Million. A child
care stabilization funds. These funds Lamb supported
provider, Stabilization and
[14:31] workforce development grants as
well as training programs and other provider supports
[14:37] the remainder came through
increases to the Child Care Development Block. Grant the
Child Care Development Block
[14:42] Grant sometimes called see Cdbg
is an ongoing funding source that the state receives from
the federal government.
[14:49] However, in COVID, we've
received a bomb up in the amount of funds that we
received. This increase was
[14:55] used to increase rates in the
Child Care Assistance program to make grants to providers and
buy down the waitlist for the
[15:02] basics, lighting few programs. I highlight that. In addition
to these childcare specific
[15:08] funds, Minnesota has used over
125 million of our flexible funds to support the child care

industry.

[15:21] Not surprisingly, we have also

received a significant amount of federal funding to support

public health response. These

[15:28] like these activities are to

connect with us from the Department of Health. About 983 million dollars in

federal funds was appropriated.

[15:36] What was awarded to Minnesota

from a variety of federal funding bills

[15:42] pay for things like community

and school testing, vaccine preparedness and local and

state public health capacity

[15:47] building. Minnesota has also been awarded

are we also spent 193 million

[15:53] of the Coronavirus Relief fund

and 75 million from our our Lex Abul allocations. So those are

2 big flexible pots protect

[16:00] COVID testing and vaccine

response. FEMA has also funded

vaccination contact, tracing

[16:06] testing and other direct

response for over 300 million dollars. This is sort of an evolving

area of

[16:16] our COVID funds on most of our

funds have been spent. There is some that under there under the

terms of the legislation on the

[16:23] award, there is extended to the
ability to spend and these some of the CDC grants have the
ability have the ability to be
[16:31] spent through June of 2026,
however, in March 25th of this year just
[16:37] published a couple weeks ago,
we were notified by the federal government that but more than
220 million dollars of those
[16:44] grants would be canceled
effective immediately. The
[16:49] the Department of Health to
take some really immediate measures to stop spending of
those dollars. There is
[16:56] currently a temporary
restraining order against that grant cancellation. However, we
are monitoring the situation
[17:03] closely to understand how it
will play out
[17:12] the final sort of specific
funding stream that I wanted to share with you all in some
enhanced Medicaid match because
[17:19] that represents some of that
some of the most significant funding that flow to the state
as a result of these COVID
[17:25] funding bills. First is a 6.2 enhanced federal
matching rate for state medical

[17:31] assistance otherwise called MA,
which is our Medicaid program for spending from January 2020
through March of 2023, which
[17:38] then was followed by a gradual
phased down from April through December of 2023.
[17:45] The match came with
requirements to not just in the role individuals expect except
in specific circumstances.
[17:51] So in total, the state received
about 2.9 billion dollars in this enhanced 6.2% match.
But the costs of what we call
[18:02] the continuous coverage
provisions of not disavowing folks with about 1.4 billion
resulting in a net savings of
[18:08] about 1.5 billion dollars from
February from fiscal year 2020
[18:13] through 2025. there was another enhanced
Medicaid matching rate in the
[18:19] American Rescue Plan Act which
provided a 10% increase on federal matching rate for home
and community-based services
[18:27] from April. 1st of 2021, to
March 31st of 2022 states are required to use
these dollars to expand,
[18:35] strengthen or enhanced hcbs
services during that time period of 4/1/2021. through

March 31st. 2024

[18:44] Minnesota received about
667 million dollars to this provision and the state
reinvested this amount in
[18:50] services and supports if and a combination of rate
increases service expansions
[18:56] and supports to people to live
in their own homes as well as some system reforms. I know
that for the
[19:03] that each to the home and
community-based services f map that 10% from the expenditures
of those dollars were something
[19:10] that were a part of the 2021
biennial budget. So we know worked appropriated by the
legislature and directed by the
[19:18] Legislature. So like all federal funds,
federal COVID funds are
[19:26] included in the single audit
every year. And then the has served as the lead agency on
the audit of the 2 large
[19:32] flexible funds that are passed,
a fiscal recovery and the coronavirus relief. And as you
heard from the commissioner,
[19:38] we've received clean audit
reports for both of these programs in all years. And no
material weaknesses in internal

[19:43] controls were identified

[19:51] in preparing for this for this presentation where

that you are interested in the

[19:57] status of on obligated unspent

COVID funds. As I sort of alluded to

earlier,

[20:04] many funds in the COVID bill

cut COVID funding bills were appropriated with the ability

to spend into future years and

[20:09] for uses that were broader than

specific COVID covid response.

[20:15] All of our major COVID Eric

France have been fully obligated with the federal

government meaning that there

[20:20] is an agreement with unapproved

use plan. There are several agencies that

are still spending. Federal

[20:26] COVID funds will discuss some

of those on the next pide. But as I mentioned before in

recent weeks, the federal

[20:33] government has canceled some of

our existing agreements for work underway at the Department

of Human Services and the

[20:38] Department of Health. A court

has temporarily blocked the cancellation, but we are we are

monitoring it closely to see

[20:46] how it evolves. It would now in general, if the
[20:51] federal funding bills that
provide funds for specific purpose dictate the time period
they're allowed to be spent on
[20:58] and the allowable activities.
If the state agency or local government or other recipient
in this case isn't able to
[21:05] spend all of the funds by the
time established in the law, they are returned to the
federal government. They don't
[21:11] stay with the state.
[21:18] So I think just mentioned some
COVID funds have the ability to be spent on broader uses for
many years into the future.
[21:24] This slide shows the vast
majority of funding streams of some ongoing activities as well
as the deadline for spending
[21:30] them. I won't walk through line by
line to highlight a couple.
[21:36] The second mind. The Capital
Projects Fund is a federal award being spent across the
Department of Education and the
[21:42] Department of Employment and
Economic Development. In this case deed has significant
contracts under way for
[21:50] broadband development and and

the E has of almost 50 million dollars in the final stages of
grant awards for multipurpose
[21:58] community facility projects
which I believe than they anticipate to announce shortly.
[22:04] We also have and on 2 lines
down from that, the the healthy line about 230 air million
dollars in unspent, CDC finds
[22:14] the Department of Health to the
grant program called the Epidemiology and Laboratory
capacity Grants which folks off
[22:22] and just cause y'all see grants and those are the funds they
were under. I'm available to be
[22:28] spent through June 30th of
2026. in this is that the one of the programs are the
findings with canceled by the
[22:35] federal government on March 20
that the 2025 and is pending temporary restraining order.
[22:43] The the cancellation of those mdh
Nance required mdh to take some immediate actions to stop the
work that was underway,
[22:51] including asking grantees to
stop their work as well as issuing made a layup notices to
about 170 staff. But we are on
[22:59] during the legal work that
closely the law of the Human Services
line for Substance Abuse and

[23:05] Mental Health Services
Administration block grants had about 30 million dollars on
spent but obligated. And in
[23:11] this case they were. They're also canceled by the
federal government in March 25th, but are pending legal
action.
[23:21] So with that, Madam Chair,
happy to take any questions from the committee. Thank you so much for your
presentation. We really
[23:27] appreciate it. >> I have several questions of
my colleagues already lining up here. So I'm just going to
start with a couple things that
[23:36] I think will be really quick
and then well have a broader conversation first and this
list on your last slide page,
[23:42] 14 of the COVID grants with
unspent funds. Could you send
[23:47] us a detailed list of that in
each budget area are however it's laid out. I think that
would be really helpful to all
[23:56] of us to understand what
potential other cuts could be coming if the federal
government classes back early
[24:02] and also what's still and
obligated out there. And, you know, I I think as we're
all in budget negotiations in

[24:08] our other committees, that's
good information to have. Secondly, on that slide, the
small Business credit
[24:15] initiative, it says 97 million
was awarded. The first tranche received was 30 Million.
And of that 5.9 is an obligate
[24:23] ID. And maybe, you know, when
you're deep cuts come up, we can have them revisit.
This is why if it's not your
[24:29] area. But I just wondered what what happened to the money that
was awarded but not received?
[24:36] Is that still out there
somewhere? Because that's a lot of money or is that it's already not in
play.
[24:44] Madam Chair, I see my Holley
talking. Yeah. Thank you.
[24:50] Welcome to the committee.
Please state your name for the record. >> Thank you. Madam Chair,
members of the committee.
[24:55] My name is Kevin about you.
Come in relations director for the state Small Business Credit
initiative we've received as
[25:02] this is the first tranche and
as we spend down, I think once we spend close like 80% of that
first tranche, then we can
[25:09] receive the second and then

same with the 3rd. So we're expecting to receive it and 3
veterans.
[25:15] >> And you're still expecting
to receive it even though the federal emergency is lawn over
and they're taking money back.
[25:23] So you still think that money
is coming? >> Madam Chair, yes, at this
point. All right.
[25:28] Excellent. Thank you to my colleagues,
Representative Hawkins. >> Thank you, Madam Chair.
And in the same vein, I'm
[25:36] trying to get my arms around and maybe it's here and I'm
just not seeing it. But are all
[25:42] of the funds that the
administration is trying to claw back of a of all of those
funds? How many and how much of
[25:48] those funds have been both
appropriated and obligated because pretty unprecedented
for an administration to claw
[25:55] back funds are not honored.
Grants that have been both appropriated and obligate.
[26:07] >> Ms been gate, Madam Chair,
Representative Elkins. So the the funds that are being clawed
back to our obligated with the
[26:15] federal government, meaning
there is this approved use plan. I would. I agree that in

general the day

[26:24] historically we don't see

significant claw backs of funds where we have is, you know,

sort of an agreement with the

[26:30] federal government in our

review of sort of past rescissions and empowerment.

That's generally before

[26:37] happens, you know, after

congressional appropriation. But before an improvement, a

sign which is not to say that

[26:42] cancel cancellation of a

federal grant. It has never happened. But this is this is

fairly unusual in on President.

[26:50] Thank you. If you would mind going back to

slide 12,

[26:57] I've been to the questionnaire. So

[27:03] I appreciate that the audits

have been clean. And I think in general,

[27:10] there's been a lot of good work

done by the state and a lot of areas getting the COVID money

out the door.

[27:17] But that being said, we also

have had unprecedented fraud

[27:22] in particularly the feeding our

future and in child care programs. So is any of the my

understanding was the feeding

[27:30] our future money was federal
COVID money. So how how do you square this
circle?
[27:39] Madam Chair, the that funds that we're talking
about specifically here are
[27:45] those 2 big flexible pots, the
coronavirus relief fund and the state fiscal recovery funds,
the funds that were within
[27:53] shouldn't that were and then be
the lead agency leads the audit process.
[27:59] And with 2 specifics of if feeding our future, it
tougher to serve others,
[28:05] including my colleagues at the
Department of Education. But so it's just to say these
are this is not a comprehensive
[28:13] list of all of the federal
grants. I appreciate the clarification
to dissipate. Very clear.
[28:18] It's a clean audit on the
flexible funds that you received, but not the broader
scope of federal dollars,
[28:25] ABC, because in your earlier
statement, Commissioner Campbell, I think you said the
total week at 1.6 trillion
[28:33] in the state somewhere. But we
sure in your opening line there was a number I didn't at them

quickly.

[28:41] >> Madam Chair, looking to see.

So I think you might be talking about the 1.5 million

[28:47] it related to Minnesota

townships complete. I don't think so. But we in Minnesota

received 76 billion in federal

[28:56] funds and about 13 billion came

through state government. So the single audit, the scope

of the single audit does not.

[29:04] It is pretty prescribed and

that doesn't include all of those funds it. So when we when

we speak to the I modified or

[29:12] clean audit reports for single

audit, that is a that is a week and we

can get you what the scope is

[29:19] for those the sun lot as what's

included and what's not. But it it would not include

France is feeding our futures.

[29:26] As you likely know, the lay has

done a number of I thought it's

[29:32] of probably like 6 to 8 audits

of

[29:37] various federal funds, COVID

era federal funds programs. And so

[29:43] there's also the existing not

it's in those places. >> Thank you. And so this is

roughly around the 13 billion

[29:50] that the state received. Madam Chair, this site is in

reference to we think back to

[29:56] fight for to the biggest act of flexible

funds.

[30:03] The 4 billion dollars managed

by that. I mean, minutes at a management and budget. Got it.

[30:11] Terrific. Thank you so much. Representative Rick says thank

you, Madam Chair. So back on

[30:19] Page 12 per side 12. When you say Clean audit

reports initially I thought you

[30:25] meant the L a but who exactly

performed those those audits for you?

[30:32] Madam Chair representative

wrecked the single audit is probably headed by the state

auditor Fu.

[30:40] >> Madam Chair, Representative

Eric, I would just add that

[30:45] with the the state single audit

we put out for RFP East to be

[30:50] done by the L a they declined

to do that. And so we put it out for an RFP in that state

auditor is the person that the

[30:59] entity who is currently has the

winning bid for that, that RFP

[31:04] and so has done in the last

several years. >> Representative or thank you,

Madam Chair. Well, OK, so the

[31:12] state auditors, so let me ask

this then. So since the state auditors jurisdiction is local

governments,

[31:19] what's the nexus between these

funds they were talking about on

slide 12. Do they all go to

[31:26] local government? Is that okay?

Maybe you could just differentiate that for U.S..

[31:31] Commissioner Kim. >> Madam Chair, Representative

Eric in in this case the audit

[31:36] is is about again, we'll get you the scope

of what's included in the single audit, but its state

government, federal funds,

[31:44] federal funds that have been

it's grant the state grants. And so

[31:51] France made with federal funds

and it is not unique. I would I

[31:56] would encourage you to not like

consider the nexus with local government because it is much

broader than that

[32:07] representative or great one more questions.

So back inside 11 in our work

[32:13] here, the 5 humane we've had. >> Quite a bit, in fact, not

even some of it having been

[32:18] public yet because we've been
talking to whistleblowers of all U.S. weekly. Well, I think
between the chair and myself
[32:24] weekly and a few other members
to have and listening in on of some whistleblowers within
state agencies
[32:32] and they're great concern with
one of their great concerns all say is listed on page or a
slide 11, which is the home of
[32:41] health care based services. So we've had multiple
whistleblowers concerned about
[32:46] fraudulent activity within
those. Can you just tell us about, especially during the
COVID era, what was done to
[32:53] prevent fraudulent nonprofits
or a nonprofit like entities? We've also heard that there's a
well sees that kind of a show
[33:02] that have formed. So can you just tell us about
those kind of stop gaps that
[33:09] you've you've used on the specifically those funds,
[33:14] Mr. Campbell are listening
either one.
[33:19] >> Chair Robbins and
Representative Eric, I think that we would probably need to
follow up with our colleagues
[33:25] at the Department of Human

Services to get you that information that we have that

information with us here today.

[33:34] Thank you. Gender. I'm looking forward to

hearing from again is gone.

[33:40] So. >> I'm sure she'll come at Rep

Representative Hudson them representing U.S..

[33:48] Thank you, Madam Chair. So I'm

interested in. >> Just kind of trying to

understand contextually from a

[33:54] big picture, what these kind of

relationships look like between the federal government and and

the state when you're getting

[34:03] at. And this is probably

unprecedented, the amount of subsidy that week out all at

once during the COVID air.

[34:09] I mean, 76 billion dollars.

That's billions of dollars more

[34:14] than the state budget that we

passed and the last biennium and something impact of that

[34:20] state and local government

operations, particularly when it does start to taper off,

which presumably everybody knew

[34:27] at some point it was going to

write a lot of his one-time spending. You mentioned the situation

with the temple, a restraining

[34:35] order and funds that were to be

caught back and that one of the impact she cited was 170 staff
members who had to be laid off
[34:43] given the uncertainty of what's
going to happen going forward.
[34:48] What was the plan from the
start? Like at some point, the money wasn't going to be
there anymore. So when when
[34:54] you're bringing on in this case
170 people knowing that the work is likely to be temporary,
[35:01] is there any sense is there a
plan to wind it down or to cut or to land the plane so to
speak, or is the presumption
[35:09] that somehow some way we were
going to keep funding going?
[35:15] Madam Chair representative, I
think for more detailed explanation
of what the Department of
[35:21] Health to come share that with
you. I would say in that. >> In general, like the plan
without these funds would
[35:28] expire in June of 2026. 0, that
was it was about 15 months early and that over the course
of those 15 months, there are
[35:37] ways for for state agencies to
manage through more closely through things like staff
attrition or reassigning staff

[35:47] to other projects. Mdh in
particular has a lot of evolving federal funding
streams. So with the is the
[35:54] abruptness, the fact that we
received a notice on a Tuesday that was effective the previous
Monday that make this
[36:00] particularly disruptive by for
more detail. I have you can connect you with the Department
of Health.
[36:07] Thank you, Representative. >> Thank you, Madam Chair.
I appreciate that. And so is
[36:14] that you're telling me are
suggesting that that's kind of the standard practice of how
these things work, that when there's one time spending, if
it involves the hiring of
[36:22] staff, is some sort of a plan to
[36:27] through attrition, wind
staffing down over a period of time to make it a softer hit.
Is that is standard practice or
[36:35] do we have enough experience
with this sort of transition to even say that there is a normal
way of doing it
[36:42] is making. >> Madam Chair Representative,
I think that the practices vary
[36:48] from state agency to state
agency and in in some cases agencies hire more temporary

positions and another cases

[36:58] agencies hire permanent

positions. In this case, there was sort of a blending,

but it is something that

[37:04] happens from time to time that

we have the different agencies manage differently. But

[37:14] so that different agencies

manage differently. It is not totally out of the norm to have

one time federal dollars,

[37:20] but I would for that Ceppt specific

plans for the Department of Health. I want to make sure

that they're able to answer

[37:26] that for you and this camera and >> Chair Robbins,

representative Woodson. I would

[37:32] just say that there are a

number of different ways in which agencies can manage these

types of situations that might

[37:38] be not feeling behind

vacancies. It might be that they began to reduce staff over a

period of time. It might be

[37:43] that they reduce services over

a period of time. We would expect that agencies

are preparing for those moments

[37:51] as they can. This as as budget

director M***, you said, was a little bit unexpected.

[37:56] But but there are and I would

say agencies do have some tools in their tool box in order to

to 10 have a softer landing.

[38:05] >> One more represent pets.

Thank you, Madam Chair.

[38:10] Kind of related, but it's a

little bit of a topic ship. So you've mentioned or you

pointed out in your

[38:17] presentation that the a lot of

these funds were

[38:23] your mark per say for certain

time periods to do certain things.

[38:28] Presumably that means that this

time period 5 years later was thought out way in advance.

[38:35] It was any rationale ever

provided for that, that we are anticipating that this

emergency, these emergency

[38:43] funds are going to be required

for years and years and years down around.

[38:49] Madam Chair, representative the these federal funding bills had

no.

[38:56] >> Trillions of dollars

invested in them and not all of them or take for specific

emergency response. Some of

[39:02] them had much broader uses.

So, for example, these the

[39:08] grants from the CDC, the

Department of Health they were at could be used on more
specific COVID response,
[39:14] but also had allowed that uses
for things like strengthening state and local public health
capacity. And so
[39:21] I think they obviously can't speak for
Congress. And the the allowable
[39:29] uses in there grant program
certainly are broader than the COVID health emergency in
particular, which I think
[39:36] aligns with the vision of us
longer expenditure, period.
[39:41] Thank you, Representative Green
Men. >> Thank you, Madam Chair and a
few questions and they're
[39:48] probably not the public.
Get back to us questions. But just to to note on the
question of the so the the
[39:55] broader uses, the COVID funds,
some of them and as we think we think about it, but we're still
dealing with the impacts of
[40:02] COVID, whether it's the public
health question of the small business question, the impact
on individuals, the mental
[40:08] health crisis that we have.
I hear about it from businesses that are recovering employers

that recovering people who lost

[40:17] that that period of a year or 2

of work. So as we think about it, I think it was wise for the

federal government in in 2020

[40:27] 2021. To understand the

magnitude of the crisis required not just directly

responding to and getting folks

[40:35] tested in the vaccine, dealing

with the time when when folks can be in school or the

businesses. But also the

[40:42] long-term impacts that I think

are going to be reverberating through the economy and our

public health system and

[40:48] frankly, our schools for

decades. So I think when we think about to climb back of

these funds, what it is saying

[40:55] is coming back, going back on the

commitment to the long-term

[41:02] recovery from the pandemic.

And as we get through it and we're only, you know, 2 or 3

years on the other side of the

[41:11] vaccine. So that being said, you know,

we're talking about especially

[41:16] in this flexible funds, funds

that what I think that I'm understanding correctly funds

that were so that minister some

[41:24] through local government, some
threw private providers, some through nonprofit,
Anderson, directly to individuals, at least in the
76 million dollar billion
[41:32] dollar number, which is a lot
and a lot of different pathway is. And it's a lot of different
pathways that one to directly
[41:39] support people. And I'm wondering if
it's hard, we're talking a lot
[41:44] about the dollars. And I know
that that's because you're meant to be. And that's your
job is to talk about the dollars and say, no, you don't
have this at your fingertips.
[41:52] But I do think it would be
worth when we talk about these programs and we talk about the
audits of the programs to talk
[41:59] about the the services and the
people that they eat provided.
[42:04] So we think about PPE and
long-term care and hospitals, we think about housing supports
for folks who are on for 4
[42:12] facing eviction childcare.
My sister was a frontline worker. She was a nurse during
that period. And so childcare
[42:18] us saying open was partially as
a result of these funds and

[42:23] then she worked in long term
care, served clients shorts with in geriatrics. So seeing
really the difference between
[42:31] the 5th when the investment
came in with PPE when the investment came in to support
both nurses and and nursing
[42:39] assistants. That was
life-saving. And so I just I think when we talk about these
dollars, it would be helpful to
[42:47] as we move forward, make sure
we're talking about the people, the programs and the providers
that the funding went through,
[42:55] because I think that that will
give us as we think about oversight. A much clearer
picture of the mammoth effort
[43:02] that that is represented here
in the U.S.. Thank you first, Representative
cells.
[43:10] Thank you, Madam Chair. >> During the course of this
session when this committee has
[43:17] met, we've talked a lot about
fraud prevention weeks, talked a lot about the policies that
were in place and a lot of
[43:24] times it comes back to your
agency is being the the major
[43:29] stopgap. Every different agency

has their their own different set of rules of regulations in order to prevent fraud. And so
[43:40] when we're thinking of the vast amount of money that went through the state of Minnesota, whether directly from and then
[43:49] be to local units of government, whether to other state agencies. What of your fraud prevention measures were
[43:58] used on things like the the rental assistance that was
[44:03] provided or the front line pay? One of your procedures would
[44:09] have been used during that period of TIME Commissioner Campbell.
[44:15] >> Madam Chair, representative shelves. >> And then be provides.
[44:21] >> A central source of policies and procedures around both on
[44:28] the finance side and on the human resources side agencies
[44:33] need to implement those policies and procedures. We also have our internal controls unit, which is team of
[44:39] 5 people. They help agencies make sure that they're doing and risk
[44:44] assessments, making sure that

they said internal controls, making sure that they're
following up on all reports.
[44:50] But they do not do that work
for them. And so it's really like in all instances, we
provide a framework and
[44:59] >> assistants to agencies,
technical assistance to agencies and it is up to
individual agencies to
[45:05] implement policies, make sure
they've got good internal controls in place that are
reasonable for whatever programs they are implementing
[45:11] and making sure that that they
are. They're doing the legwork
[45:17] associated less with whatever
those policies and procedures and internal controls are
Representative Shoaf.
[45:23] >> Thank you, Madam Chair.
So let's take the lie and MH FAA as an example
[45:30] through the last few years.
To what extent has your agency
[45:35] gone to ensure that that they
are following your recommendations and ensuring
that we're not seeing fried and
[45:43] their spaces? Commissioner camera.
[45:48] >> Chair Robbins represent
Schultz. As I said in in all cases, we set the policy and

provide technical assistance to

[45:55] agencies as they needed.

These are agencies that have teams of finance financial

management. They've got

[46:02] internal control, an audit

staff and they we expect that we help

them understand what the

[46:09] policies are. We create the

policies and that they come to us as they need assistance.

[46:15] >> The for the fall of all

right. Representative Rick,

[46:20] thank you. Madam Chair, just I'm back on slide 12 trying to

understand this and you kind of

[46:28] caught my ear. When you said

you put out an RFP for these audits. I had 2 questions. So

[46:34] who in the state has capacity

to do such audits? Because use of the always kind of turned

you down to do this. And so you

[46:41] it was awarded to the state

auditor. So when the state has the

capacity even do such an audit

[46:48] and secondly, of these 2 funds,

so our and the crf funds,

[46:53] how much are we talking about

in total Commissioner camera?

[47:00] >> Chair Robbins representative

are all defer to the state

[47:05] budget director. Again, the

total. What I would say is that the single audit is not just

the COVID era funds. It's it is

[47:11] a much broader subset of

federal funds. This and a lot of to something that we do

every year.

[47:18] And I think that there probably

are a limited number of

[47:24] entities in the state who could

do the single audit. But it's been

a couple of years since we put

[47:30] out that RFP. And I think we

could follow up with you and get you, you know, just some

information on, you know,

[47:37] responses and qualified or

qualified entities. Some of that information. I don't have

that that Handy.

[47:45] >> Thank you, representative.

Yes, thank you. On a caisson. I've really got my curiosity

going. Unfortunately,

[47:51] south, the single audits.

Maybe I'm just may be any more understanding of what the

single audit are. You said you

[47:58] do them on a regular basis.

So do you always put out our piece for these types of

detour? Is us

[48:04] help me understand the auditing

process and there can't be that many folks

in the state of Minnesota that have the capacity to do

billions of dollars of deep

[48:12] audits like this and kind of

what are you looking at it, these audits? Because when I

talked to the L a, you know,

[48:18] I used to work in accounting.

And so we talked about some of the stuff I had clients and I helped them

go through sales tax audits and

[48:26] a few other things and worked

in nonprofits and throughout its. And so I have some capacity

understands if you would

[48:32] explain what exactly you're looking at. Because when

I talked to the auditor, I said, OK, so you you look at

these buckets, but you don't

[48:39] look at these buckets at all in

the not looked at buckets were way more interesting to me, for

example,

[48:45] the nonprofit that was so nonprofits to

receive grants, nobody looks at the salaries or how much grants

are getting from other state

[48:55] agencies. That's not even

looked at by anybody. So then I said, OK, I should probably

look at that. So what is looked

[49:01] at? What is it like that? And can you just walk me
through just a little bit of these audits and what happens
[49:08] Mr. Campbell, Chair, Evans representative or >> so the fact that the single
audit is this is required by
[49:18] the federal government and its
looking at financial income plans report on federally
assisted programs. And that
[49:24] includes all federal assistance
expended by state agencies that are determined to be part of
the state of Minnesota is
[49:31] primary government. And so >> the eye, I think you're probably right
about the number of entities
[49:37] that are available to do this type
of work. I just don't have that information handy. So we will
follow up with you
[49:46] on on that piece. So we're
looking at sort of like the big functions of state government
or fund are federally funded.
[49:53] And so and and we and he's not doesn't determine that that's
determined both by the federal
[50:01] government and then by the
auditor. And so there's a process that they go to decide
to decide what's what's in
[50:07] scope and and what isn't.
And so we we do have we actually just
got the sun God up crolla

[50:13] Tivoli recently. And so again,

with Clinton modified. And so we could provide you for

years if you'd like the single

[50:23] audits and and what what their findings

have been.

[50:30] I'm not sure. I think that in

order to get a lot more detailed, we'd need team

members from Mnd who are really

[50:37] close this. They'd be on the

financial reporting in the county inside of our agency to

come in. We can come and sit

[50:43] down and talk to you if you'd

be interested in understanding that a little bit better. Representative Eric?

Absolutely.

[50:50] >> I would absolutely like to

see the process. So if this state auditor is

working with the federal

[50:55] government to decide what is

and what is out of the out of that, there isn't like a

standard boilerplate kind of this is

what we look at. I would

[51:03] definitely like to see that and any reasons why certain

things are put in or left out.

[51:08] I definitely want to see that. I want to say, look, you know,

the process are reconciliations

[51:14] really important to make sure

that they are actually reconcile properly to the
right. So us,
[51:22] you know, is it to the level
where you're actually looking at? Will we be considered like
source receipts? You know,
[51:28] how deep are we going or re
just looking at? Yeah, I mean, there's all kind of levels
about its right. So I really
[51:33] like to look at that and see
that because, yeah, when you first talked
about it and you said you had
[51:40] clean audits it I just assumed
out of Ole Miss been doing it. I know I did. You have this all
the other process. I don't live
[51:46] in the land of health and human
services. So this is interesting in and a little
concerning. I think I'd like to
[51:55] learn more. Thank you, Madam
Chair, thank you. So I think will wrap
it up by one last question for
[52:02] myself and then we'll invite
you Cox Monday to come up. >> So when you're on slide 5,
you were talking about how
[52:10] under the crf funds it was sort
of this federal guidelines that
[52:18] they were expensive is that

were necessary because of the pandemic that had not
previously been budgeted for.
[52:26] I think that's an important Kathy Ott. But then in later
discussions, you know, you
[52:34] talked about how well, but
there's also really broad use of the grant money and we used
to for capacity building and we
[52:41] used it to do different things
that will have ongoing cost. What I'm trying to figure out
is how much of this
[52:48] extraordinary amount of money
that came into the state. I was really use for one time
sayings and how much of it has
[52:56] now created future obligations, you know, was one of the
reasons we're looking at a
[53:02] deficit. So I'm wondering if
when you're doing the forecast, when you doing all these things
of all that increase in
[53:09] Medicaid amounts increase in
spending for schools, capacity building in agencies
with tech and other things.
[53:18] How much of what was really
intended to be one time, even if it was an extended use
up to 2026, it was still
[53:26] roughly one time. How much of that is really
creating ongoing obligations to

[53:32] the state and how can we
quantify that? Madam Chair, The M
[53:39] so the >> I'd say in general, the
funds have paid for the federal
[53:46] funds are going to set aside
from the general fund forecast. And so the
[53:52] the forecast doesn't assume the
continuation of these programs.
[53:57] They're not an agency based
budgets. There are some programs that have been enacted
since these funds have expired.
[54:05] 2 you because we learned about
how effective and valuable they
[54:11] are I would offer. And as an
example, I talked about child care, stabilization grants and
Minnesota
[54:18] relative to some of our peers
preserve childcare providers
[54:23] because we both to leverage the
federal resources and then in the later legislative sessions
appropriated ongoing general
[54:31] fund supports things like that
provider. Great START compensation payments which is
now AM
[54:38] a state program. But that is something that I am
[54:44] was it sort of has was

incorporated in the general fund projections now several
years ago. So the the funds
[54:52] provided one time support. And then to the extent the
legislature has chosen to make
[54:59] those permanent to through
general fund dollars, that's in the
[55:04] in the forecast. But by and
large, that hasn't happened. That as we discussed
[55:11] in other venues, that drivers
of the deficit we're facing are really more long term spending
and revenue trends that are set
[55:18] their separate from the the end
of significant COVID funding. >> Thank you. That's very
helpful. So just be cleared.
[55:25] The federal 77 billion or
whatever was isn't on the general Fund ledger. It's
completely separate.
[55:33] And so it shouldn't be
impacting at all the 6 billion dollar deficit. So how do we
square that? Then when, for
[55:40] example, the grants are cut off
early
[55:45] staff is being cut or providers
are being told they won't have this money available
[55:52] its it's not on the books at
all for that. The General Ledger for the general fund.

[55:57] >> Madam Chair, if you think
about the the state budget. >> Is over 100 billion dollars
when you look at all funds and
[56:04] federal funds is about a 3rd of
that. But those are counted for separately from the State
General Fund and the Joe the
[56:12] General Fund forecast in court. It incorporates our
obligations, you know, at him
[56:22] under state law for general
fund funded programs.
[56:27] >> So this would upend the
offense but not the general fund. Got it. Okay. And then
one more question. When you say
[56:35] you, you don't monitor how
agencies are complying with policy. Just put the policy out
there.
[56:41] Did you when all this money
came in? Did you provide policies for the agencies to
understand like you're getting
[56:50] this much money for this to
where 5 year period,
[56:56] how help them get to
Representative Hudson's question, help them understand
the difference between I'm
[57:03] going money and their
responsibility, their versus one time money because my sense

is a lot of this was then

[57:12] turned into ongoing obligations

is starting to break down. You could send us for what was

the one time money that came in

[57:19] from the feds and how that is

now being seen in ongoing obligations

because

[57:26] maybe because the legislature

said so. But but like it's it's created ongoing obligations

because if it was really a

[57:34] one-time money, it shouldn't

the that disruptive to know it's winding down. But it seems

like it's very disruptive.

[57:43] >> As chair Robbins, we can

follow up with additional information. I I would say that

again in this case, the agency,

[57:53] I would argue, did not have the

chance to wind it down because they about those funds. They

expected to have those funds

[57:59] for well over a year in this. In this case, the

funds they receive notification

[58:04] on a Tuesday that as of the

previous Monday, the funds have been turned off. And so I think

that that is a unique

[58:13] circumstance, I guess is what I

would say.

[58:19] >> Certainly agencies take if I
can just trips then of the money that's supposed to expire
on September 30 S by December
[58:26] 30th of this year. We know that
money is winding down. How are they preparing for that?
I just feel like we haven't
[58:33] really had a a solid answer on
what steps are they taking to
[58:38] end those obligations because
they know it's winding down for what policy guidance are
you giving them?
[58:48] >> Chair Robbins. What I would
say is what the conversations that
we're having with the agency is
[58:54] our our about and making sure
that they have a plan in place
[58:59] to wind down, making sure that
they have adequate resources to pay for all of the closed down
costs, their costs associated
[59:08] with layoffs, severance, all of those sort of things.
I think that we would have to
[59:13] get a little bit more
information on how many employees are actually
supported by this versus hot.
[59:21] The services that are
supported. Those are really 2 separate things in terms of how

we are talking to. And if it's

[59:27] just money out the door to Ted 2 Minnesota news, that's

obviously important. But that's

[59:34] more of a communication around

how we can talk to communities who are impacted by about what

they can expect from us.

[59:39] And then in the event that

their employees that are supported by those resources,

that is a situation where we

[59:46] really have to be thinking

about how we're tapering down to a soft landing. Those are

the conversations that we're

[59:51] having with them right now,

asking them to do those risk assessments and making sure

that they have a sense of a

[59:57] plan in place, too. So that said that it is not so

a prop so that that even if it

[1:00:05] isn't expected that they that

they have done a little bit of planning and that in that

space. But generally speaking,

[1:00:12] I would say agencies do know

and this is regardless of federal funds are not because

they're also state funds that

[1:00:17] are appropriated on a

short-term basis, honor all the time. Agencies know

[1:00:22] that that if they're hiring short term that, you know, we

have options in place like a

[1:00:30] temporary on classified

employee position, for example, which is a three-year

appointment or less. So if if

[1:00:37] the funds are short term, then

they might hire in that category as opposed to and a

permanent employee position,

[1:00:45] they might hire contractors

there. Now there are a variety of ways in which agencies

handle that generally. I would

[1:00:51] say that that understanding or knowledge is

not new to state agencies. They generally

[1:00:58] have an understanding of how to how to work in this space,

where they're limited,

[1:01:04] short-term limited resources

available to them. And agencies have been historically managing

in situations like this

[1:01:11] for very long time. >> I I appreciate that because

what I'm hearing in some of the other committees, ice Irvine is

that a lot of the onetime

[1:01:20] requests they're coming, even though we

all knew it was one time money for various things. They're

coming back and asking for

[1:01:26] ongoing appropriations. And so

it doesn't feel like culturally

[1:01:31] that's been communicated.

Well liked. A lot of this was one time money and I'm very worried about the increases the [1:01:38] plus-up sport, as you talked about the Medicaid eligibility. That's [1:01:44] unless people really fully understood that was for a temporary period. That's going to cause a lot of problems for [1:01:52] providers for it patients. And if people build capacity [1:01:58] because we did a lot of capacity building, assuming that would never go away. Now, what are we why to [1:02:04] be invested all this capacity building when it was one time money that we knew would. And and now people have all [1:02:10] this capacity and there's no money. So I feel like maybe there were mistakes made even if there was the flexibility [1:02:17] for capacity building. We overbuilt this capacity and the money is gone. And now people are coming back to us and all [1:02:25] our committee saying, but we need this to be ongoing. We need this and and I don't honestly fault them. It's like [1:02:31] what we created this problem and are pulling the rug out from under them. So I have deep

concerns about this from the
[1:02:37] budget conversations. I'm in
another committee's. So I just think that we have to do
a better job as a legislature.
[1:02:44] And as the agency's
communicating to people like this was never intended to be
ongoing into the extent we
[1:02:51] encourage capacity building
without any foundation knowing the money would go away.
[1:02:56] That's a grave mistake on her
part. >> Chair Pinto, thank you,
chair and thanks to the south
[1:03:04] to the testifiers. Just a
chance. The I guess just going up in
the last piece. Madam Chair,
[1:03:11] I want to hear from the test
vote on this. I mean, I recognize the funding was one
time, but of course, their
[1:03:16] ongoing community needs.
That was the talk about child care. For example, Andrea,
familiar with that that we were
[1:03:22] we kept that sector in a much
more stable than many other states because of the funding
that was received. Are there
[1:03:28] other examples that you have?
I'm just trying to make a distinction here where, you

know, the fact that there's a

[1:03:34] request coming back for ongoing

funding to my mind is an indication that actually we've

done a fight an ongoing need.

[1:03:40] Can you just sort of comment on

that as opposed to I guess that other point about, you know,

I'm

[1:03:46] we have to just talk about

meeting that that those kinds of needs

[1:03:51] is 90 Madam Chair, Representative

Pinto.

[1:03:59] >> I think with a magnitude of

things that we funded with the COVID relief dollars, there

were certainly a lot of

[1:04:07] a lot of things but with COVID

funding where we identified a community need, I think, you

know, we're on

[1:04:15] things like some educational

things. Like multi tiered system. Subset court was we

learned was a sort of a really

[1:04:23] effective tool for our schools.

That then was followed by serve

[1:04:29] more conversation at the state

legislature in state dollars, things like and shelter

funding. We there were huge

[1:04:37] gaps in the shelter system and

we were able to sort of support
[1:04:43] some of those your COVID
dollars and it really highlighted to ongoing needs
similarly. And I think food
[1:04:51] support is another good example
that I would. >> Right now, thank you, chair
and left Christian. And then I
[1:04:57] know some of our colleagues
have other questions, but I really need to get to the
presentations. If you can hold those questions to up to date
and then if you can stick
[1:05:04] around, we'll try and figure it
all out at the end. All right. >> Thank you, Chad. Thank.
Thank you, chair around.
[1:05:09] And so I think that's a really
important point is that the one-time funding does not mean
that it was one tiny defect
[1:05:16] identify there's ongoing needs.
But the other distinction that I want to make you just
understand is the difference
[1:05:21] between one-time funding that
are scheduled to run out. And I guess I was here, you
talking about the current
[1:05:26] volatility at the federal level
are affecting things that it's one thing to sort of know well
in advance that funding will be

[1:05:31] running out, even if there's an
ongoing need. It's another thing to have, you know, funds
impounded unexpectedly or
[1:05:37] contracts broken. Can you just
talk about her to the challenge in in dealing with that and the
distinction between those
[1:05:42] things? I guess I'm trying to
figure out how you can even plan around that when there's
that level of kind of chaos
[1:05:48] going on, Commissioner Campbell. >> Sure, bins at the
Representative Pinto, I would
[1:05:55] say that that that lack of
predictability is is a real challenge for agencies to plan
around. I think that it's been
[1:06:03] eye-opening and the last couple
of weeks here and I think agencies probably have more
urgency around
[1:06:12] trying to plan for this work.
It's it's hard to do when you've been given resources and
are expected to do something
[1:06:17] and and also at the safe,
potentially for quite a long period time yet
[1:06:23] and also at the same time
needing to be scaling that work down. We want to make sure that
agencies and employees
[1:06:34] as much that that weekend tend

to that work has carefully as possible so that so that and it
isn't so abrupt. So people have
[1:06:43] more ability to plan whether
its employees are community or the agency themselves. And and and just what, when,
when resources are expected to
[1:06:53] last until a certain time, and
then there suddenly gone, certainly that sort of pens
[1:06:59] work. And I can tell, you know,
at at Mgh really, you know, for the entire region seat sort
of through
[1:07:05] it became an all encompassing
task for them for for several weeks and continues to be in
for a lot of our colleagues and
[1:07:12] so. >> Thank you. Thank you, chair.
Thank you. Thank you for your testimony today. I'd like to
invite to conserve deed and his
[1:07:19] team to come on up and if you
wouldn't mind hanging around, we may have additional
questions for you. Thank you,
[1:07:53] Iceland. >> Welcome to the committee
commissioner. Please state your name for the record making
testimony. Thank you. Chair
[1:08:00] Robbins. My name is on the
road. Deputies commissioner at the Department of Employment
and Economic Development and I
[1:08:05] see many members of the jobs

committee. Here are the work that our house workforce.

Sorry. That's the other body.

[1:08:13] But since not everybody on this

committee is a member of the House Workforce Committee.

I'm going to start my

[1:08:19] presentation just with a little

bit of a primer, a new life for, but for just for context

to that.

[1:08:25] So the basic policy as

contained in Minnesota statutes is here. The public good is

promoted by providing workers

[1:08:32] who are unemployed through no

fault of their own, a temporary partial wage replacement to

assist the unemployed worker to

[1:08:39] become are employed. Now, those

are all those words are important in the context of the

Minnesota DUI statute. It's no

[1:08:47] eligibility based program.

They must be primarily weight off, although in the case of a

quitter and discharge where the

[1:08:52] worker did not cause their own

unemployment, they may be eligible. It's a temporary

program up to 26 weeks. But we

[1:08:59] will talk a little bit more

about that out during economic downturns, partial wage replacement, about

half of the weekly wage up to

[1:09:08] up to the statutory maximum,
which currently has $914 per week. And then the purpose is
to become are employed. So a
[1:09:15] person must be able to work
available for work, looking for work or something substantively
similar such as training.
[1:09:22] I think something that will be
a kind of important note as we go through our presentation
conversation today is that
[1:09:29] unemployment insurance is a
federal state partnership was created by the Social Security
Act of 1935. And while states
[1:09:36] have flexibility to adjust
certain program predators, they don't have flexibility and
all of them states must conform
[1:09:42] to federal law. They must
administer the program in compliance with the federal
guidance and administrative
[1:09:48] funding is federal and
conditional upon that conformity and compliance.
[1:09:54] Again. As we go through the
federal during recessions, the federal government will
frequently create additional or
[1:09:59] extended benefit programs.
The purpose of that to be promoting economic security in
difficult times.

[1:10:06] So you guys multiple benefit
programs in one always on are what you might call regular
you. I and then there's a
[1:10:12] variety of other kind of want
to taint Hillary programs but related programs, there's
combined wage. So if you have
[1:10:19] unemployment in multiple
states, there's a mechanism for kind of interstate
coordination. There's
[1:10:24] unemployment compensation for
both federal employees and service members. Those are
administered by the state,
[1:10:31] but they are funded by the
federal government to require participation from the federal
government and significant
[1:10:37] parts of the work flow. And
then there's trade readjustment allowance periodically. Generally in the
case of an economic downturn,
[1:10:44] you'll have a variety of
additional or extended benefit programs that are meant
essentially to either extend
[1:10:51] the duration of unemployment
compensation when, you know, when additional work may not be
available for somebody seeking
[1:10:58] to re-enter the workforce, and
at times there will be additional kind of supplemental

payments provided to increase

[1:11:06] the amount of of kind of a

weekly benefit amount that's available. Those are generally

they're not always federally

[1:11:12] funded. So the state will do

the work, but the federal government will pay that will

pay the cost.

[1:11:18] And we'll talk about today for

for some good amount of time or the pandemic specific programs

you may have heard of some of

[1:11:26] these acronyms or programs, but

pandemic unemployment assistance, pandemic, emergency

unemployment, unemployment

[1:11:32] compensation. And then there

were a couple think pieces of additional benefit payments

that increased the value of

[1:11:39] benefits available during the

pandemic.

[1:11:44] Going into the details a little

bit more as I think we all might run. You know, it just to

kind of settle a little bit of

[1:11:50] context. You know, there was a

federal choice made in early

[1:11:55] 2020 to use the unemployment

insurance system nationwide as an emergency response, there

was a massive surge in layoffs.

[1:12:03] There was a need for economic
assistance for tens of millions. Americans and the
federal government didn't really have tools to deploy
funds that scale. So the
[1:12:11] decision was made by
policymakers both in 2020 and in 2021 to run a large amount
of federal assistance through
[1:12:19] state. You I programs, you
know, there's not as I mentioned earlier, it's a
federal state partnership.
[1:12:25] There is no national federal
law that pertains. But there are 53. And that number is not
near because American Samoa,
[1:12:33] Puerto Rico and the District of
Columbia have unemployment insurance systems, but 53 individual
administrative body step over
[1:12:40] that will run these programs. And just as a reminder to, you
know, just in terms of House
[1:12:45] stark, some of the, you know,
the kind of surge in unemployment, the unemployment
insurance request was this is
[1:12:52] the Great Recession, which
which many of us probably remember in 2009, just
juxtapose the kind of a number
[1:12:59] of claims with what we saw
during the initial claims with what we saw during the

pandemic. You know, what we

[1:13:04] really saw was near, but not 1,

8, 9, 10 x increase in initial

[1:13:10] the initial pandemic claims. And, you know, I would say that

as far as Minnesota's response

[1:13:16] goes, you know, we were one of

the first states that was able to to roll out many of these

federal programs. I will go

[1:13:22] into more detail as to why that

might have been, but just by the numbers, right? Because I

think it's important to

[1:13:28] remember what this actually

meant in terms of just volumes that the committee so that the

committee members have kind of

[1:13:35] context. All right. We had

about 1.3 million applications for benefits and 873,000.

Minnesotans received at least

[1:13:44] one payment, which is a pretty

stark number. If you if one remembers that the state has

about 5 million people,

[1:13:50] about 14.8 billion dollars in

total payments. And that's in contrast with about 800 million

in 2019. Now, most of that

[1:13:59] money was federal. About 10.4

billion of it was federal to state paid for the other

component.

[1:14:06] And again, just to
contextualize that, that's about 353 million bags
of groceries. That's about
[1:14:12] 18 million rent payments,
right? So this was a critical lifeline for Minnesotans as
they confronted the economic
[1:14:20] challenges of the pandemic. So what's going to little bit
more detail on specific
[1:14:26] programs that were created
under the and are basically the 100 federal law?
[1:14:33] So there were 3 based programs
that were created. And what I mean by a based program is sort
of it's a program that would
[1:14:41] make one eligible for
unemployment insurance, kind of at the time of application will
go into supplemental programs,
[1:14:49] which would extend ones
eligibility. So the first was pandemic
emergency unemployment
[1:14:54] compensation that provided
extended benefits following the exhaustion of regular you why?
And but to repeat PC kids that
[1:15:02] it's peuc. The that with that program was
primarily intended for folks that are did preps filed for
unemployment in 2019. And then,
[1:15:12] you know, as they confronted

the challenges of unemployment caused by the pandemic, they were going to run out of weeks
[1:15:19] of benefits. This basically was a federal program that allowed folks to continue to collect benefits so that they could
[1:15:25] continue to make their rent and put food on the table. Extended benefits basically is the next Richard benefits that
[1:15:31] provided for extended benefits following exhaustion of both regular you. I am peuc
[1:15:37] and then there's a new program that was created called pandemic unemployment assistance. And that was a new
[1:15:42] eligibility program that was limited to 2020 2021 for applicants who weren't eligible for regular you. I generally
[1:15:51] that would have been somebody who is self-employed or independent contractor, but they became unemployed and lost their income due to the pandemic. That was a new
[1:15:58] program that was created for the purposes of pandemic relief.
[1:16:04] There were supplemental programs created as well. So these would basically be add-ons to an initial 2 initial
[1:16:10] unemployment insurance claim lost wages assistance,

supplemented benefits in regular you. I PUA Peuc or
extended benefits and that
[1:16:19] would have been an additional
300 a week that foreign applicants that was eligible
for the base program that ran
[1:16:26] through fall of 2020 federal pandemic unemployment
compensation Fpuc supplemented
[1:16:33] that similar. We supplemented
benefits in those programs. At first it was 600 a week.
Later was 300 the week again
[1:16:40] for each week. That one was
eligible for based program. That program what ran a little
bit longer, basically from the
[1:16:45] end of lost wages assistance
through fall of 2021. And then there was mixed
earner, unemployment
[1:16:52] compensation. So that was $100
weekly supplement that was kind of of only available for some
of the self employed
[1:17:01] individuals who are forced to
go into a smaller you. I account. So they had some you
old utility, but they weren't
[1:17:06] eligible for PUA. That was
meant to be a kind of a bridge program, I think, to to help
with kind of help with economic
[1:17:15] support there. And then they're worth your

first few other pieces where

[1:17:21] the feds reimburse the state of

Minnesota for policy for policy changes that ordinarily would

not partake.

[1:17:28] So normally unemployment

insurance has awaiting week. You must your wait one week

prior to receiving your first

[1:17:34] benefit that was waived during

the pandemic and the federal government pick picked up the

tab on that.

[1:17:40] Additionally, there was

generally speaking in Minnesota, nonprofits and

interment allergies of

[1:17:48] government may choose to be

reimbursing employees for the trust fund rather than pay

rather than tax paid employers.

[1:17:54] So they pay on the dollar for

dollar basis back what they incur and you why expenses the

federal government paid for

[1:18:01] some level of 3 of the relief

of those charges back to employers. They also paid for

shirt work.

[1:18:08] So I don't think it's just I

don't think of folks. I think folks probably remember that

many states struggled in terms

[1:18:16] of delivery of services as it

related to unemployment insurance. Know there's a few
reasons for that. I think part
[1:18:22] of that is that states are
required to implement the federal programs in conformance
with those federal U.S. deal
[1:18:28] instructions. That guidance was
often slow to come during the pandemic. And I think, but I think that
kind of proximate reason for a
[1:18:36] lot of these challenges was
that many states and historically failed to update
their business processes and their technology systems in the
run-up to the pandemic that led
[1:18:44] to a lot of delays and errors
that I picked a Florida headline here. But, you know,
you can choose many states
[1:18:50] around the country where that
was the case. I would say that that that was not the case in
Minnesota. And I think it's
[1:18:57] worth noting that you're good
business process reinforces program integrity. So part of
the reason why Minnesota
[1:19:03] historically invested in these
in and again, good business process, improving our
technology stack. So it was
[1:19:10] always been a very seasonal.
Stay for you. Why? You know, we have a lot more claims in

the winter when the oftentimes

[1:19:16] construction and those

industries kind of wind down during the winter. That means

that we've always had to sort

[1:19:22] of surge our volumes, which

doesn't leave those which doesn't lend itself to solving

a problem with people. Test

[1:19:29] one's itself to solving a

problem with better business process and technology that can

scale. So that means we built

[1:19:35] our program to scale up and

busy season. You know, in the pandemic, that

was you. I could probably add

[1:19:41] 100 varies to this statement.

It was a very, very, very busy season. But it didn't actually

require our program to break

[1:19:48] our existing management

processes or controls and that wasn't the case. In other

states. You heard examples

[1:19:54] probably have some states where

they were trying to manage certain you. I programs using

things like Google forms.

[1:19:59] That was never the case here in

Minnesota ran through the I processes and we were able to

adjudicate in line with the

[1:20:05] normal way that we manage this

program. I want to talk a little bit now
about sort of a couple of the
[1:20:11] different factors for kind of
potential integrity risks in
[1:20:16] unemployment insurance
programs. The first of cybercrime, this and there's
really kind of 2 buckets of
[1:20:22] this. One is what we call a
count imposters. Those are when, you know, a fraudster
will create an account using a
[1:20:29] stolen or synthetic identity to
fit your to file a fraudulent you. I claim so don't pretend
to be. They'll pretend to be
[1:20:36] Evan Row filing for the first
time and then you go. And then they'll try to direct the
payment to their bank account.
[1:20:42] So though, use, you know, Pei
that's been obtained from data breaches or social engineering
to try to get a claim.
[1:20:49] But another type of cybercrime
is account hijackers. So that's where a cyber criminal might
take over an existing you.
[1:20:56] I count that somebody already
has by stealing log-in credentials through phishing or
malware, credential stuffing
[1:21:02] its, you know, you get a text

message saying that, you know, you're you, I claim is pending
and they try to make make take
[1:21:10] you to a spoof site to do that.
They'll do that to a degree direct benefit payments to
change the contact information
[1:21:15] or to walk out legitimate
users. Again, you'll see that what if you get an offer as
password change, change,
[1:21:21] direct deposit, who tells it
like here in Minnesota, you know
there. And this is I think,
[1:21:27] general best practices for
these for these types of programs. But what types of
controls that we have in place
[1:21:34] obviously identified identity
verification in change mongering, right? You verify
ID's with authentication,
[1:21:40] use a variety of data analytics
tools to to monitor for suspicious patterns and you
validate the data and you cross
[1:21:48] matches with what you have. You also have to kind of keep
an eye on threat monitoring anomaly detection. So analytics
to detect suspicious patterns,
[1:21:56] monitoring of various web
analytics tools. And then it's about a coward protection
recovery. Some of that's just,

[1:22:02] you know, upgrading and making
sure that you've got good processes for those pieces.
It's also a bit of education.
[1:22:09] Things like saying DUI program
will never text will never text you. So please don't text
somebody back. If I if I if you
[1:22:16] if you get a random text from a
from somebody that you don't know, misrepresentation is a
different factor. Now, this
[1:22:23] occurs when an applicant or an
employer knowingly makes a false statement or
representation. They
[1:22:29] deliberately failed to disclose
material facts and the application or they knowingly
withheld information to obtain
[1:22:35] or provide the receipt of
unemployment benefits, the types of controls that we
have in place in Minnesota.
[1:22:41] You know, I think are your
weekend. It's not one thing. You want to have multiple
things here. Confirmation of
[1:22:47] faxes represented. There's sort
of a two-sided nature to the unemployment insurance system
and that employers have an
[1:22:53] account and they can raise
issues if they see something that is incorrect. We also we also will, you know,

contact employers when somebody
[1:23:01] files a claim. So that is one
vector to prevent prevent bad actors from from stating things
that are not true.
[1:23:09] All records our appeal and can
be taking up taking up all the way to the Supreme Court of the
United States. If one takes it
[1:23:15] that far, there's reporting
portal this which I've included on the right just for
visibility and call-centre.
[1:23:21] We you know, we do get a number
of tips through that way. We randomly audit cases and
then there are administrative
[1:23:27] and criminal penalties for
people who are not, you know, who who seek to prove who seek
to take advantage of the
[1:23:34] program just in terms of the overall
purview of the performance of
[1:23:39] the stage. According to the
Department of Labor, Minnesota has one of the worst fraud
rates in the country. That's
[1:23:44] why our state is green, not
red. We have some of the highest paid and accuracy rates
in the country and we exceed
[1:23:50] federal standards on that
front. And I would say that we

substantially exceed fit federal standards on your peer
in federal review, been of
[1:23:57] benefit timeliness and quality
audits. The program is reviewed frequently and extensively.
You know 2022. The oh, LA did a
[1:24:06] did a review of and again kind of pandemic
related technology efforts and
[1:24:11] said, you know, the You I
division regularly conduct state analysys. These processes
were effective in quickly
[1:24:17] identifying walking the
suspicion s*** out. Some are simple. You know, we make continuous
investments and technical
[1:24:24] tools, improve business
processes and monitoring. Yeah, I would say that it's it
is sort of a part of the
[1:24:30] program's DNA to continue.
We took that to continue to operate its capital stack and
make sure that the that the
[1:24:36] technology there is available
to support Minnesotans now and into the future.
[1:24:41] And the program is reviewed by
multiple agencies each year, including the IRS, Social
Security Administration,
[1:24:47] third-party information.
Technology officers were part of a single audit. So it is it

is highly reviewed. And,

[1:24:54] you know, we work really hard

to to address items that may come up.

[1:25:01] That's a quick overview of the

focus of some of the work of the program than happy to take

your questions. Madam Chair,

[1:25:08] Great. Thank you very much. >> Representative Eric to Jeff.

A question or know for sure.

[1:25:14] >> Again, I'm sorry. I thought

you knew was on the list. Okay. Well, I will be the first

start. First of all, thank you

[1:25:21] for your work. And I remember when the

unemployment program was

[1:25:28] announced and the scrambling

that was going on to make sure benefits got out there and I

know it was a big lift for that

[1:25:36] the D team. So thank you for your work on

that.

[1:25:45] I don't know really how to

square the circle. I guess one of the things is the only

report was very focused on just

[1:25:53] the 2 areas that you identified

about the imposters in the hijackers.

[1:25:58] And they noted in their report

that they did not evaluate

[1:26:03] deeds efforts to prevent or

detect fraud committed by employers who are individuals
who misrepresent their
[1:26:10] eligibility. So that report,
well, it was very good, was also very narrow. And so I just
want to
[1:26:17] reflect more on what they
didn't look at, which is
[1:26:23] your efforts to prevent fraud
committed by employers, individuals who misrepresent
their eligibility and the jail
[1:26:29] report from pandemic that just the pandemic
program, not the regular you.
[1:26:37] I showed that Minnesota had
26.3 million dollars in overpayments
[1:26:43] of that. They recovered 2.9
million and that's in the fried
category. In addition, non
[1:26:51] fried just over payments was
55.3 million of that. They've recovered 13.3 million.
[1:26:58] So clearly when we're not just
dealing with the narrow subset of imposters and hijackers, there
was a huge problem in
[1:27:07] unemployment fraud for just the
pandemic program. The regular
[1:27:12] you I program in those same
years also had in fraud, 9.7 million in overpayments of

and

[1:27:22] in on Friday, 91.3 million in

overpayments. So there is a huge

[1:27:28] situation going on with our

ability to confirm eligibility.

[1:27:38] And as as the auditor noted, they didn't

really look at that.

[1:27:44] So could you walk us through

more what you do specifically to detect fraud committed by

employers or individuals who

[1:27:53] misrepresent their eligibility? >> Thank you. Thank you, Madam

Chair. Now, I guess all these

[1:27:59] all old just start kind of by

noting the bifurcation of sort of fraud in on fraud over

payments, right? I'm just just

[1:28:06] because I think that might be

helpful for members. So, you know, overview of non

fraudulent over payments do

[1:28:12] occur. Right? And I think the

end that generally an overpayment was written when we

when we learn something new

[1:28:20] about an applicant's file that

might not have been true at the beginning, most of the in most

of those cases, it's an honest

[1:28:27] mistake by an applicant or in

poor or an employer in some cases. And what happens in

those cases, we will write an
[1:28:34] over payment to the applicant's
file that over payment will be recovered through, you know,
either kind of a production in
[1:28:41] their benefit through reduction
in their benefits as they kind of go forward, right? Somebody
that is the road to a 2 and
[1:28:48] Apple, you know, to to their to
an application on that. It's, you know, again, we we want the
greatest level of accuracy
[1:28:54] possible at the same time there
is there are there is a there is a tension between timeliness
and you know, and complete
[1:29:03] accuracy, right? So for non
fraudulent over payments, those are generally recovered
through a kind of through
[1:29:09] administrative means through
the program just to go back to, you know,
some of the controls on what we
[1:29:16] call misrepresentation or
fraud, right? I think these are the these are the tools that
the department uses to prevent,
[1:29:22] you know, to prevent new fraud.
You're kind of fraudulent vectors for claimants. Now,
again, I think to go into a
[1:29:31] little bit more detail, right?

If you are an employer and you receive a letter, you are
generally receive a letter in
[1:29:37] the mail and you receive a
notification, your you I count if somebody is applying for
benefits under the program,
[1:29:43] you have that as an employer
can raise an issue to the unemployment insurance division
saying, hey, something isn't
[1:29:48] right here. You know, this
person is claiming you why, but I didn't fire them. They
quit or they did. They did
[1:29:54] something to that effect that
will then kind of raise a fact-finding kind of a a kind
of a fact-finding process,
[1:30:01] which you will be adjudicated
by the division and then and then essentially, if either
party disagrees with the
[1:30:09] outcome of that into the
kitchen, they can appeal to a I know, too, that to unemployment
insurance law judge, who will
[1:30:16] then review the facts of the
case and then make a determination based on that
fact or if they disagree with
[1:30:22] the decision of the I judge, it
can be appealed to the Minnesota Court of Appeals and
so on and so forth. So having

[1:30:29] it there. I mean, it's a it's a
tough first, a quasi judicial process that becomes a judicial
process, right? So there is a
[1:30:36] vector for for that to occur. Now, there are also there are
also instances where, you know,
[1:30:43] where we find that somebody did
misrepresent the record. I can speak a little bit to
some of the administrative
[1:30:49] penalties there. So if you are,
if you know we're going knowingly misrepresented the
facts are fewer you when you
[1:30:56] are applying for benefits, the
program charges will what the 40% administrative fee on on
the the value of the benefits
[1:31:07] that were received through that
month through mist through misrepresentation. And we will
work to collect, though we will
[1:31:13] work to collect those benefits
in kind of get that back over time for truly egregious cases.
There are also criminal.
[1:31:20] There are criminal penalties
and we have referred several dozen cases to county
prosecutors for for judicial
[1:31:28] action where it is warranted.
Now, again, I think, you know, there's again attention view.
We can't have county

[1:31:34] prosecutors have limited
authority. So we do what we do efforts those administrative
functions significantly.
[1:31:40] And then I think another way in
which we unit in which we work to ensure integrity overall is
through random audit. A
[1:31:49] sampling of of you, why cases
are audited? You're kind of in a statistically significant
manner and we worked and and
[1:31:56] items that are caught there are
are works of art are working
[1:32:02] with and work to be remedied. >> Thank you for that. So just
to confirm there was a lot of
[1:32:11] fraudulent and non fraudulent
over payment in the pandemic unemployment account
[1:32:18] and over the recovered amounts
were low. So on the fraudulent side, it
was 26.3 million and they're
[1:32:28] covered amount was 2.9 million. So when you see when you go
after it
[1:32:34] is the recovery that you're you
just tried to get back to that
[1:32:40] some of the benefit on a future claim or do you actually go and
try to get the money back?
[1:32:48] Madam Chair, Dame? >> Both, you know, we do have
to what we do have tools in the

[1:32:54] unemployment insurance law that
allows us to know that the to allow us to what the word means
and other kinds of another
[1:33:01] tools to to to be able to
effectuate that.
[1:33:06] And how often does that used? I'd have to. I'd have to.
I have to follow up with the exact numbers, but we do.
We do use those tools at our
[1:33:13] disposal. But again, as I
mentioned, you know, we've heard I think we preferred
[1:33:18] I want to say 60 odd cases to a
county prosecutor Jean Peters over the last few years.
Again, I think in terms of this
[1:33:25] wreck in terms of kind of miss
rep adult, he's going to have
[1:33:30] to adapt to get an exact
number. But these are tools that the program has its its
disposal and and does use.
[1:33:37] >> Great. I have more
questions, but without a Representative Saltzman
represent agreement. Thank you, Madam Chair, Mr.
Rowe.
[1:33:44] So when we're looking at
Minnesota, you know, the reports, if you just go to the
new story suggests that between overpayments and fraud, that it
was around 430 million dollars.

[1:33:53] And then, you know, kind of the
following this this line towards those who are overpaid,
you know, the totals for that
[1:34:02] amount of money, not even
specifically talking about fraud, but more so over
payments would be around
[1:34:08] 367 million dollars. So
specifically since those are over payments, what amount of
money has the agency been able
[1:34:16] to recover from the over
payments that were made? >> Mro, Madam Chair,
Representative Schultz. I guess
[1:34:23] I'm not. I'm not sure which
number you're quoting me in terms of like that, the
300 million dollar, I'm
[1:34:29] guessing you're referring to
one of the OIG reports thats right, which if that is the
case, I'll just note that those
[1:34:36] I think we're estimates that
the that the U.S. do well for him or the G a O those were
estimates that were made based
[1:34:45] on based on kind of sampling
methods that we're quiet very broadly. As I recall in the
appendix of one of those
[1:34:51] reports, you know, the U.S.
Department of Labor kind of racing pretty significant

concerns about the methodology
[1:34:57] of those reports in the way
that those things were applied. Again, I'm not I'm not trying
to I'm not trying to quibble,
[1:35:02] but I do think that those were
estimates that word that don't reflect the actual values that
the agency reported that the
[1:35:07] U.S. to do. Well, I think they
were estimates that were conducted by federal entities.
And, you know, I I do know of,
[1:35:15] you know, at least a few cases
where some of those there were some of the assumptions that
were made by those federal you
[1:35:21] kind of buy some of those
federal reviewers were not necessarily backed up by normal
practice.
[1:35:28] >> Representative Steele, thank
you, Madam Chair, Mr. Rowe, I find your comments a little
bit concerned, quite
[1:35:33] concerning, actually, in part
because I'm using the data, the federal data and then I
used AI and brought about these
[1:35:42] numbers in overpayments.
Okay. And I'm specifically looking directly at at the
payments that
[1:35:50] because of mistakes by the

claim or or the claimant and the employer. And that's how I
got to that number. Then I will
[1:35:58] just say that I didn't hear an
answer from you on how much money we've been able to
recover from that group of
[1:36:04] people. So that's that's also concerning. The next question
that I have for you here is
[1:36:11] that through this oversight and
you are questioning how they did this yet, this is the
program that has been
[1:36:16] established for every state to
do this. And you cited in this
[1:36:22] this very presentation that
you're proud of where Minnesota stands by comparison to the
other states across the
[1:36:29] country. So it's got to be one
or the other. He got it either celebrate where Minnesota
stands and believe in the data
[1:36:38] or not believe in the data
because this is specifically from 1400
[1:36:45] people or 1400 claims and to
1400 claims of which the program was far larger, then
that far more than 1400 people
[1:36:55] received that. So I just want
to level set us here. But my question for you for the
future, because we're that,

[1:37:02] you know, we're here for the
oversight to make sure that we have the policies, right thinking about this, Minnesota
U I program
[1:37:12] and I want to just kind of key in on vulnerabilities here.
Can you share for us through
[1:37:18] this program or through the
through the years that have
[1:37:23] passed since the time that
these dollars were rolled out. Who was it that identified the
vulnerabilities and what
[1:37:32] actions have been taken or what
should we is that this committee or as legislators
look to do to change the policy
[1:37:40] so that we're not seeing these
rampant over payments and to stop the fraud Mrs.
[1:37:46] >> Madam Chair, Representative,
thank you for clearing. I just want to make sure I understood
which, you know, there's a lot of different data sources out
there. So I just wanted to make
[1:37:53] sure I understood which one you
are referring to. So if you're talking about the one from a, I
think the one you're referring
[1:37:59] to that was kind of based on
that, you know, sampling of that's based on the sampling of
cases. That's from a U.S. deal
[1:38:06] report called the benefit

accuracy met, but benefit accuracy, measurement figure.
So it's a business process
[1:38:13] metric, right, that that is a
way that all states are kind of are in all states kind of go
through this and its use.
[1:38:21] Really, you take each case.
I think you think of Minnesota that take about 400 cases each,
you know, take about 400 you.
[1:38:28] I files each year an exhaustive. We ought to
write like basically go down
[1:38:33] with a fine tooth comb and find
like every small thing that might have gone wrong during a
during one of those. And it's
[1:38:38] used in many ways for business
process improvement in ways for the and used as a way for a
first aid for state you I
[1:38:47] agencies to improve their
overall performance. Now the
[1:38:52] real and because of that
bright, the federal government has set a target, has set a
target for, you know, basically
[1:38:59] 10%, you know, kind of a 10% of
a metric we're comfortably beat
[1:39:04] that. I think ours from memory.
The last one was about 7.8%. So we are one of the top
performing states on that

[1:39:10] front. And in Minnesota, most of those
improper payments are due to applicant air. Now, again, when
we identify those, you know,
[1:39:18] we will follow the applicant
overpaid and we will be and we collect and we can. We collect
those over payments back
[1:39:24] through through through
benefits because, again, these are not necessarily
fraudulent issues. These are issues where an applicant
through you through been a
[1:39:32] well-intentioned manner, you know, might have made you
made a mistake on the process.
[1:39:38] So again, that's why the
standard there's 10%, Minnesota comfortably exceeds that
standard. To your point,
[1:39:43] your second part of your
question, though, I would say
[1:39:49] overall, right, like we're you
know, we're we have to maintain constant vigilance, I guess is
what I think. I'm hoping this
[1:39:57] is responsive to your question.
But, you know, in terms of identifying challenges and
inter in identifying kind of
[1:40:03] improve, you know, making sure
that we are staying on top of kind of program, integrity,
risks that is work. That never

[1:40:10] really happens for the program.
And we're constantly upgrading our systems were constantly
upgrading our processes to make
[1:40:15] sure that we're doing the very
best that we have the very best we can. And that's a
responsibility that shared at
[1:40:21] all levels of the program from
the from the division director of the Tech on the team that
manages the product to your
[1:40:27] phone to folks who are kind of
on the front lines taking calls working and and the Judah
Cayden claims it's kind of a
[1:40:34] it's a shared responsibility
across the agency and it's something that the team takes
very, very seriously. >> Thank you, Representative
Goodman, thank you, Madam
[1:40:42] Chair. Thank you, Debbie
Commissioner, I want to
[1:40:47] >> go to this question of the
extended benefits, particularly for folks who are who are not
eligible like solo
[1:40:54] practitioners, independent
contractors that am I right in that those benefits were paid.
Were they paid by the trust
[1:41:02] fund or they pay by the Fed
federal government? >> Mr. Madam Chair,

Representative Grimm and those

[1:41:08] were paid by the federal

government pandemic. The PUA was effect was entirely a

federally funded program.

[1:41:14] >> Representative Dan, thank

you. And the reason I ask which will not surprise you is we've

been doing a lot of work

[1:41:20] together on the issue of

misclassification and when people when employers don't pay

into the trust fund when the is

[1:41:30] classify their workers, they

don't pay into the trust fund when they should. And both the

transom goes down and also the

[1:41:36] employees don't get the

benefits unless there's an enforcement action. I'm

wondering if that issue of

[1:41:42] misclassification

misrepresentation is in any of these numbers in terms of the

last to the state of that kind

[1:41:52] of misrepresentation, Mr.

Rep. >> Madam Chair, Representative

Riemer Agreement know I you

[1:41:58] know, that's that is something

that I think would need to be, you know, calculated and

assessed separately, which I

[1:42:05] know there are some

considerations under way on that front. >> Thank you. One more. Yes,
thank you, Madam Chair, the way
[1:42:11] for 45 minutes on the list.
And so so I'm right that the
[1:42:17] federal government doesn't
require us to track that. The state government doesn't
require to track that right now
[1:42:22] in our numbers, the issue of
misrepresentation related to employer misclassification
fraud is not in these numbers.
[1:42:32] And I'm just saying a guest
since we're wrapping up, there's been reports that it
might be up to 200 million
[1:42:37] dollars a year as a problem.
We have a bill that's currently in jobs to measure the impact.
I think that this is something
[1:42:45] I've started to work on the
labor side. But in this fraud prevention space figuring out
how much government is losing
[1:42:53] from employer
misclassification. It's the You I trust fund its workforce
development fund. It's the tax
[1:42:58] relief, the tax payroll taxes.
These are really important thing is something that
potentially this committee
[1:43:05] should think about looking at.

There's been reports on the outside, but because we don't require the state to track at
[1:43:12] the federal government doesn't require did seem to track it both the oil has recommended and I have a bill to make sure
[1:43:17] that we do because we need to know how much the state is losing in misclassification from.
[1:43:22] Thank you, Representative Elkins, real quick. >> I think in in this discussion it's important to
[1:43:29] acknowledge that any time you're dealing with the statistical process, which we're doing here, it's
[1:43:35] literally impossible to completely eliminate all fraud. And unless you spend more money to to to try and eradicate the
[1:43:44] fraud than that, then the fried that that that's that's occurring. And so I get it for you. I don't want to see us
[1:43:52] creating expectation that it's possible to get to 0 fraud in programs like this, especially from where we are, where we're
[1:43:59] one already one of the top states in the country and putting it out. Thank you.
[1:44:05] >> Thank you, Mister Time,

Representative Eric, very quickly. So case instead of my question, I just want to make a
[1:44:12] quick comment. So in my over is that over a decade of work with
[1:44:18] unemployment insurance and have gone and toured and talked and then your bills and all kinds of things for years,
[1:44:25] I actually really appreciate what you've done. And I know and to represent Elkins Point, I would love to eliminate fraud
[1:44:32] completely and misrepresentations and and all of that and human nature is human nature. But
[1:44:39] what I'd like to look at is actually some of the processes that you actually have in the the incredible technology that
[1:44:45] you have and look at that to say, maybe we need to duplicate some of these processes. And so
[1:44:52] as I'm kind of listening to you and remembering the depths and literally claims go as far as you know, administrative law,
[1:45:01] judge, and you have to have response from the company and John, back and forth in time. I'm thinking about maybe we
[1:45:07] should apply some of this for

like waiver services and other places where we're seeing tremendous fraud. So I appreciate what you're doing. I we have over over
[1:45:17] time. So I'm not going to ask me a question. I'll ask you offline, but thank you, Deputy commissioner and I appreciate
[1:45:22] actually, you're really appreciate the work that you do and understand the complexities. >> Thank you for timing.
I also have follow up questions
[1:45:29] as the chair Pinto. So we'll come out whether one final comment or Pinto. Thank you so much chair. And I'm just going
[1:45:35] to thank you, commissioner.
I clicked through it. One of the slides talks about comparing us to other states because that's come up. And I know the Trump administration
[1:45:42] made a lot of changes to federal websites, but I went in there still there something that they're they're Minnesota's in the top 10 in terms of accuracy. And it has
[1:45:49] one of the lowest crime rates in the country so we can be proud of the work of your agency. Thank you so much, commissioner. There's obviously more to do. I want to ensure we
[1:45:56] recognize that and compare to

other states of the week. Me very proud. Thank you,

chair. >> Thank you. And with that

members were adjourned. Mister

[1:46:02] Bill, I have several the

questions I plan to fire up with you. Thank you

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 04-28-2025

[0:03] >> Good morning. Welcome to that fraud

Prevention and state Oversight

[0:09] State Agency Oversight

Committee. It is 9 o'clock and I'm calling the meeting to

order acquire must establish. Today

we have the honorable Attorney

[0:18] General Keith Ellison to our

committee to present an agency overview and participating

discussion surrounding COVID

[0:25] related fraud. But first, we

are going to approve the minutes from April 7 CE

vice-chair. Anderson do approve

[0:33] the minutes based on. Anderson has moved

approve of the minutes from

[0:40] April 7. Switcher, all in your

packets. Is there any discussion seeing none? All those in favor

of approving the minutes from

[0:48] April, 7th signify by saying

Aye. I opposed the minutes for April. 7th are

approved.

[0:56] >> With that, we even have a

chair. Yes, ma'am. I'm sorry. I just realize that a vice

chair wasn't present that day

[1:01] and so you should pick somebody

else to many are ready. It's one of those little. Thank you
for catching that.
[1:06] Representative Eric. So
Representative Eric, would you like to move the minutes from
April's 7th. So move. Madam
[1:12] Chair, thank you.
Representative Eric lives that minutes from April 7th. All
those in favor say Aye. I all
[1:18] those opposed nay minutes from April. 7th are
approved again.
[1:25] So with that, we'd like to
welcome the honorable Attorney General Keith Ellison to
provide an agency overview.
[1:32] And we appreciate your coming
to the committee. Attorney general, please start with your name for
the record. And then we look
[1:38] forward to a presentation
members that slides for the attorney general were just
passed out a few minutes ago.
[1:46] Yes, representative Elkins. >> Madam Chair in our package,
there is a appears to be a
[1:53] transcript. Can we? What is that the
provenance of this, how it this created and then did anybody
check it to look for clues the
[2:01] nation's since it looks like it
was generated with AI. >> Thank you for asking that

represent Elkins. Yeah. Sweet

[2:08] ride through our staff to have

an official transcript may just

[2:14] as we were prepping for the

hearing and it is not an official transcript done.

So I just want people to have

[2:21] it in their packets because

when they may be referring to and I want everyone to see what

we're looking at, that it's completely an official. It was

our staffer to do the best we

[2:28] cut. Okay. Thank you.

Appreciate yes. Thank you with that. So it's all the tech

working for you.

[2:37] Okay, look, let's just give it

a minute. But Buck, I'm attorney general. If you want

to proceed, if you want to

[2:43] wait, it's up to you.

[2:52] Why would we do that? >> Madam Chair, I didn't hear

that. You are a friend to a

[2:58] transcript. Oh, I'm sorry.

We can make sure you get a copy of the transcript. Yes, its in

the packets and it was posted.

[3:05] I think it was posted online, but we

can for shake it to copy its. Just

[3:11] when we heard the audio

recording that was released from that defense exhibits, we

just did our best as is on our
[3:18] staff team. It's unofficial. So it's more as a point of
reference.
[3:24] >> Yeah, and I haven't read it.
This is the first I know that I was gonna have to address a
transcript.
[3:29] So just like you to know. >> Yet that sign and it's more
adjusting to it. But we just
[3:34] wanted people to have what was
that attempt at making a transcript? But it's an
official
[3:40] and that and we did posted online to the
committee Web site. And we did
[3:47] reference in our letter of
invitation to that. We would be addressing the audio recording.
Madam chair of this,
[3:55] it by step the Pinto. >> Thank you, Madam Chair.
I guess my ones I have is just
[4:00] that if it isn't official, we won't know if there are
questions based on it. We will know if they're based on
anything after it.
[4:07] If it's an official, we won't
know. We will know. That is correct.
So how would that work?
[4:12] >> Well, we'll get to it when
we get to that part of the discussion. But it is an

official a and we will be

[4:19] relying on the audio, Trent, it that's being played.

[4:25] It's so the transcript is just if people want to be for 2.

But but really what I want to

[4:31] get to represent Pinto is the

attorney general's presentation, which is the bulk

of the meeting where he is

[4:37] going to present about how his

office has worked to address the COVID fraud and the work

you do with all the state

[4:43] agencies. So please, Mr.

Attorney General. >> Please proceed. Good

morning. Chair Robbins and Vice

[4:50] Chair Anderson DFL Le Pen told and members of the committee. As you know, my name is Keith

Ellison and I serve the

[4:58] residents of the state attorney

General State of Minnesota. Thank you for inviting me here

today.

[5:04] I'm always proud to share the

work happening at the Minnesota Attorney general's office and

the ways we're helping our

[5:11] fellow residents in Minnesota. Your letter inviting me here

today asked me to provide an

[5:17] overview of the operations of

the Office of Attorney General Responsibility, too, represent

state agencies. I role as the

[5:24] state's chief law enforcement

officer, our duty to represent state agencies and ends in

civil and criminal matters and

[5:33] responsibility to provide

oversight of charities and businesses in our state.

[5:38] Allow me a minute to correct

the record on one Madam. Madam Chair in Minnesota, the attorney

general

[5:46] is not the chief law

enforcement officer in our model of state government.

[5:52] The Minnesota attorney general

is the state's chief legal officer. It's a subtle but meaningful

distinction. As I'll explain in

[6:00] more detail below with the

exception of Medicaid fraud county attorneys are

responsible for charging and

[6:07] prosecuting felonies in our

state. I'd like to start with an

overview of what the attorney

[6:14] general's office does and its

role in state and its role in state government

[6:20] as the state's state of

Minnesota. Steve Legal officer, the attorney general has 4 main

responsibilities.

[6:28] The AG represents more than 100

state agencies, boards and commissions
[6:34] in litigation and other
matters. This work is essential to the effective operation of
the state of Minnesota and to
[6:40] protecting the interests and
pocketbooks of the people. This includes defending the
constitutionality of a state
[6:47] law against legal challenges. Second, the Joe plays an important and
defined role in criminal
[6:54] prosecution. One way that we do that is by
Assistant county attorneys when
[6:59] asked primary responsibility for felony level prosecution
rests with county attorneys.
[7:06] But under this section 8.1 of
state law, when it county attorney needs help, they can
refer the case to the attorney
[7:13] general's Office for
prosecution. That's when we step in
[7:19] because of the investments that
the legislature is made in our office. In 2023, we've been
able to expand the kinds of
[7:25] cases we can take on 4 county
attorneys instead of primarily only
homicides
[7:32] in the last 2 years, we've been
also able to take criminal sexual assault, child

pornography, drug overdose and
[7:39] even wage theft cases. In the last 6 years, we've been
able to take cases for county
[7:44] attorneys and 39 different
counties in every corner of our state, several of which the the
members of this committee
[7:52] represent. I'm proud to say that in the
last 5 years we've help 39
[7:57] counties prosecute more than
100 criminal cases. And I'm proud to say that we have not
lost a case yet.
[8:06] We also share original
jurisdiction over Medicaid fraud with the federal
government, which I'll talk
[8:12] more about later in this
presentation. The attorney general serves on
several state boards, including
[8:19] executive committee, the State Board of Investment
in the Board of Pardons 4th.
[8:24] And finally, the AG is the
chief enforcer of states of the state of Minnesota is consumer
protection,
[8:31] anti-trust and charities.
Laws of our 430 talented employees.
Approximately 40% are
[8:39] attorneys. The remainder are

legal assistance. Investigators, mediators,
financial analysts and support
[8:46] staff all helping us fulfill our
charge as an office
[8:53] regarding agency
representation. The work we do on behalf of
more than 100 agencies boards
[8:59] and commissions is as varied as
the number of those agencies boards and commissions.
[9:04] For example, the Health and teacher
Licensing Division represents Minnesota's health related
licensing boards in litigation
[9:12] and administrative actions
related to the licensure and regulatory oversight of health
care providers and educators.
[9:20] The Division also investigates
complaints received by the boards alleged alleging
licensee misconduct and
[9:27] provides legal advice to the
boards. Transportation division.
That turns provide legal advice
[9:32] to Minnesota Department of
Transportation, other state agencies and the National Guard
[9:38] when they're involved in
construction projects and provide legal representation to
those entities. When

[9:43] contractors, subcontractors or
3rd party sued the state for construction related matters.
[9:50] The Division also protects task
tax payers by filing claims on behalf of in that and other
state agencies against entities
[9:58] that make false claims
performed effective work, failed to pay employees legally
mandated wages or otherwise
[10:05] fail to comply with contractual
obligations. There are 30 agencies boards
and commissions that are billed
[10:12] for the services of my office and over 70 that receive I
representation without direct
[10:18] billing through our general fund
appropriation. All of the work that the AG
does for agencies and all not
[10:26] agency work is reported to
publicly and to the committees of jurisdiction every October
15th by statute.
[10:35] I encourage all of you to read
this report. We're very proud of the hard
and dedicated work it the
[10:41] documents for all of our
communities and in every corner of the state
[10:46] billing, rates are set every
even numbered year per Minnesota Statute 0.1 5,

[10:53] we consult with the Minnesota
Management and budget to determine and hourly billing
rate
[10:59] from there, how to structure
these arrangements. Also known as partner agency agreements is
up to the AG in the agency
[11:07] board or commission. These agreements allow the AG
and its clients to reexamine
[11:12] the history of litigation over
the last several years in jointly estimate that amount of
representation is likely in the
[11:19] upcoming biennium so that all can plan and budget
accordingly.
[11:25] Larger agencies like DHS,
public safety, Minn DOT logically need more legal
representation,
[11:31] smaller agencies such as the
state lottery or the Minnesota Racing Commission historically
need far fewer hours of our
[11:39] assistance. The current billing rate is
$163 per hour for attorneys and
[11:46] 103 per hour for other work
like that of paralegals and analysts
[11:52] compared with the rates that
attorneys charge of private firms, the people of Minnesota
are getting the services of a

[11:58] talented pool of lawyers for
well below market rate. It's not uncommon for private
firms to charge up to $600 per
[12:07] hour and even more in your letter, you asked about
factors to determine whether we
[12:13] take cases. I want to emphasize that state
agency work of our office is mostly determined by the agency
board or commission.
[12:21] Our attorneys work with their
counterparts in those agencies to determine what work is
needed. Whether an appeal is in
[12:28] order or even what the odds of
success of a certain course of action might be.
[12:34] If the state gets soon, we have
to defend the state. If a board asked us to defend
the board any licensing
[12:41] decision, they may we do that
work. In other words, we don't take legal work to agencies,
boards and commissions. They
[12:48] bring it to us feeding a future.
[12:54] Another agency we represent is
the Minnesota Department of Education, Orrin G E
[12:59] the state agency that
administered the Federal Food program expansion during
the COVID-19 pandemic.
[13:07] The program that was defrauded

by bad actors as all know in 2020 COVID-19
caused massive health crisis
[13:16] hospitalizing 24,000
Minnesotans taking over 6,000 lives and our state.
[13:22] This health crisis was
accompanied by a messy, the massive economic crisis with
surges and food, security and
[13:28] housing insecurity. A number of extraordinary
measures were required to keep people fed. She people house
and keep people learning.
[13:37] One of those extraordinary
measures was the United States Department of Agriculture
program designed to get food to
[13:44] people quickly. The urgency of the need meant
that the federal policymakers
[13:49] intentionally reduce red tape
and other hurdles that would typically a company in a
program like this one
[13:56] legislation like the Family
First Coronavirus Response Act issued a number of waivers so
that the meal program operators
[14:04] could have the flexibility they
needed to continue to feed children. People are in trouble and the
federal government wanted to
[14:11] get them help fast. Fraudsters, unfortunately see
opportunity in any crisis.

[14:19] Light city folks going door to
door offering sham repair services after a bad storm.
[14:27] The COVID crisis was no
different. In November 2020 nde was the
target of a spurious lawsuit
[14:35] from feeding our future.
An organization that was later found to be at the center of a
scheme to defraud Minnesota's
[14:43] United States Department of
Agriculture funded school nutrition programs.
[14:48] Our office defended our client
in the E in that lawsuit. This was one of the thousands
of cases my office manages at
[14:55] any given time and we fought
h*** o* behalf of our client along with her attorney and he
bought founder and executive
[15:03] director of Feeding our future
aggressively litigated over in the East attempts to control
what they observed has the
[15:11] expansion, the food sites they made claims of racial
discrimination against Indi E
[15:16] leading to sympathetic stories
in the media in spring of 2021. And even an order of sanctions
being awarded by a district
[15:25] court judge against Indi E in
June of that year

[15:30] throughout 2021. Feeding our
future wasn't yet a household name.
[15:35] The lawsuit between feeding our
future and in D E appear like a dispute between a
community organization seeking
[15:42] reimbursement and an agency
doing its due diligence feeding our future was
submitting claims. But in the E
[15:50] the people were didn't add up. This kind of thing isn't
uncommon and is well within the
[15:55] capabilities of our talented
team of attorneys to handle in the course of their work.
[16:00] In fact, in April 2025 Media interview Joe Times and
the federal prosecutor who
[16:08] handled feeding our future Kay
said and I quote, it started out
actually is very little.
[16:17] That's the backdrop for the
December of 2021 meeting. I attended with some people who
represented themselves as small
[16:24] business people from the East
African community having some problems with doing business
with the state.
[16:30] This was one month before the
first federal search warrants are issuing 9 months before the
first indict federal

[16:36] indictments. The meeting was
recorded without my knowledge. I recently published an op-ed
in The Star Tribune to share
[16:44] what happened in that meeting.
That document is in front of you. And I'll recap and brief
here.
[16:51] I always meet with and listen
to my constituents. I meet with people all the time, including
people who don't agree with me.
[16:59] In the last few weeks I've met
with constituents in Morris, Minnesota, same clout,
Morehead, Duluth and all over
[17:06] Minneapolis and Saint Paul,
including several summers. I listen. I asked questions I
do my best to understand where
[17:13] folks are coming from. That's a
job in an elected official and I take it seriously.
[17:19] At the request of a friend and
member of the clergy, I took this December 2021 meeting in
good faith with people. I
[17:27] didn't know some of whom turned out to be
fraudsters. I did nothing for them and to
nothing from them.
[17:35] Some months later, some of them
were held accountable for their illegal conduct in the feeding
our future case as well.

[17:42] They should have been. But when I entered the room
that day, the scammers represented themselves as
business people with concerns.
[17:50] And so the engage their
government, which everyone has a right to do in this meeting. These scammers
tried to run the same scheme on
[17:59] me that they use to try and
fool the media, the courts and state agencies.
[18:05] They reiterated their claims of
racial discrimination because racial discrimination
is real in our society and has
[18:12] no place in our government. I said I look into their
concerns. But as the tape shows, I made them no promises.
They suggested that if I helped
[18:21] them, they contribute to my
campaign. But ice shut that down immediately and rejected
it as the tape also shows
[18:31] immediately after the meeting,
I went to my staff to get an update on the MBE case and
learn of the FBI's involvement.
[18:38] This was before the federal
investigation was public before search warrants. And
before any indictments,
[18:46] the issuing of a search warrant
is significant because it marks the FBI's
readiness to make their

[18:52] investigation public. The warrants represent a
finding by a federal court that
[18:58] there was enough probable cause
that the people in question have evidence that could help
to prove a crime.
[19:06] Once the search warrants were
executed in January, Twenty-twenty 2, again, a month
after the meeting in question,
[19:14] it became clear to the FBI and
then to my office that what feeding our future was up to
was far from routine.
[19:23] When that happened, we handle
that we handle our lane representing our client in
assisting the federal
[19:30] investigation. When asked the
FBI and the U.S. Department of Justice were there late
investigating prosecuting
[19:38] criminal fraud, a federal
dollars. We work in close cooperation with the federal
investigation, making sure that
[19:45] our efforts did not tip off
individuals under criminal investigation or otherwise
jeopardize the federal case
[19:53] in September 20 of 2022. 9 months after my meeting, the
DOJ issued 49 indictments.
[20:01] That number would rise to 70

and there have been 45 convictions to date.

[20:07] You'll note that both here and

in the op-ed I mention the lanes that are office occupies

in law enforcement

[20:14] here in Minnesota County

attorneys have original jurisdiction for felony level

state criminal prosecution.

[20:21] The Office of Attorney General

has authority under state law to participate in state

criminal prosecution or

[20:27] appeals, but only when

requested by county attorney or a signed by the governor.

[20:32] So the county attorneys in your

home counties by and large, the people who determine

whether or not my office is

[20:39] able to work on a criminal case

in those counties,

[20:45] this means that under the

current state law, there is no statute that would have allowed

my office to investigate and

[20:51] criminally prosecute feeding

our future. We have, however, in our lane

[20:56] under our authority as the top

enforcer of charities, charitable trust and nonprofits

in Minnesota shut down over 20

[21:04] charities created or revive to

particulate too partisan to perpetuate the feeding future front

[21:12] in March 2022. as a result of our thorough charities investigation, we filed for the dissolution of feeding our

[21:19] future itself. That case is still pending and go to count. I'm going to move on now to address other matters in your

[21:26] letter. But I will happily answered questions on feeding our future. And for I conclude

[21:32] Medicaid front in Minnesota until and unless the Legislature sees fit to

[21:38] expand their authority, the attorney general's office has original jurisdiction to bring a criminal case against someone in only one area of

[21:46] work, Medicaid fraud. I want to spend some time talking about Medicaid fraud

[21:52] control unit and the work they do. Minnesota's Medicaid fraud control unit has existed for 40

[21:58] years. One of 53 in the country every state has one has to DC

[22:04] Puerto Rico and the U.S. Virgin Islands. Each one of us is funded by a federal grant from the

[22:11] Department of Health and Human

Services Office of Inspector General. That grant covers 75%
of our funding and comes with
[22:18] conditions on what we can and
cannot do. It requires us to spend 100% of
our time investigating and
[22:26] prosecuting Medicaid provider,
fraud and the abuse, neglect and
financial exploitation of
[22:32] vulnerable adults residing in
certain settings with those federal requirements
come certain prohibitions,
[22:39] too. We're in the and we're the
investigators and prosecutors, but we aren't the
administrators of the program.
[22:47] For example, federal
regulations require us to be entirely separate from the
agency that administers the
[22:54] Medicaid program, which here is the Department of
Human Services, the Department
[23:00] of Human Services, also the
entity that refers the Medicaid fraud cases to our office so we
can prosecute it but we can't
[23:09] turn off payments on the front
end or bar a certain provider from enrolling with Medicaid or
continuing to receive payments.
[23:18] We also can't investigate or

prosecute fraud in obtaining benefits. Also known as welfare fraud or fraud and other public
[23:26] programs. Our investigators and prosecutors are good at what they do in their lane.
[23:32] Over the past 5 years, Minnesota has only spent about 5 million on our Medicaid control, Medicaid fraud control
[23:39] unit. At the same time, the unit one about 53 million in
[23:44] restitution and recoveries. We now talk about charities.
[23:50] You asked me to talk about my office's responsibility to provide oversight of charities and businesses in the state.
[23:56] We have a dedicated charities division housed in the Consumer Protection section of the office
[24:02] based upon the Legislature's increase in funding for the Charities, Division Enforcement efforts, the Division hired and
[24:09] on board 3 investigators, one regulatory analysts and 6 assistant attorneys general for
[24:16] the division in the last fiscal year. In the past fiscal year, the folks in this division maintain Republican, a public
[24:24] registry of charities, charitable trusts and professional fund-raisers that

operate in the state. They

[24:30] oversee and regulate charities,

charitable trust and nonprofits in Minnesota by enforcing

charitable solicitation,

[24:37] General Trust in nonprofit

laws. The charities division is

tasked to protect charitable,

[24:43] not government assets. So

unlike the Medicaid fraud unit which prosecutes people who

misuse of government funds,

[24:52] the charity division of the AG

Oath Overseas charitable organizations and works to

ensure that the money that

[24:59] people donate to these

organizations is being used for its stated charitable purpose

[25:06] since 2019 charities as a result over 50

investigations through formal

[25:11] civil tools, including

litigation or assurances of discontinuance, which is a

settlement of a prior case to a

[25:20] lawsuit. Meaning that issuance of

discontinuance is

[25:25] is a settlement of the case

before we file a lawsuit which often involve allegations of

fraud in self-dealing.

[25:32] So as an example in September of 2021,

[25:38] the Attorney General's office
secured an assurance of discontinuance with the
Minnesota nonprofit known as
[25:44] pain-free Patriots. The AG
alleged that Payne 3 Patriots violated Minnesota law with its
leadership directed that its
[25:52] charitable get grantees, see
pain relief. Only at insider own businesses may grants of
more than 2 million to those
[26:00] inside are owned businesses and
turned a blind eye to hundreds 4 of thousands of dollars in
debt amassed under the
[26:08] direction of its founder. They agreed to replace the
board, determined it and determine any potential claims
and remedies against wrongdoers
[26:17] and conduct governance reviews
and implement substantial changes to prevent future
abuses
[26:24] in 2024, the Minnesota Attorney General
investigated Eagle's Healing Nest and nonprofit providing
veterans and their families
[26:32] with housing and services.
After reports that the founder was misusing nonprofit funds.
The investigation uncovered
[26:39] evidence that the founder was
using nonprofit funds for personal expenses

[26:44] after the organization from the
new board and hired experience nonprofit council to improve
compliance. The Minnesota
[26:51] attorney general's office
entered into an assurance of discontinuance with the
nonprofit and founder in March
[26:57] 2024. Requiring the founders
termination continue. Compliance efforts include
reinstating its registration to
[27:05] solicit donations and the
founders repayment of $10,000
[27:10] to the nonprofit over 3 years.
The Charities division has voluntarily has skews me. The charities
division is in voluntarily is
[27:19] over 30 fraudulent charities
since 2019, the folks in the Division and the Charities
Division and up dozens of
[27:26] additional investigations every
year into potentially concerning conduct to help
detect and correct potential
[27:33] concerns. Their registration
team also collects financial filings from tens of thousands
of charities which help prevent
[27:41] fraud by making their
operations public and making red flags. It's sensible to our
office

[27:49] financial impact. As I say, whenever I get a
chance office sees our work as
[27:57] helping Minnesotans of for
their lives and live with dignity, safety and respect.
A big part of that work is to
[28:03] take on issues of fraud, abuse,
scams and exploitation issues that can cause real
damage to the state's bottom
[28:10] line and the people's
pocketbooks. This part of our story is best
told by the numbers over the
[28:18] past 6 years we've protected
the state of Minnesota and its residents from our in that time we've contributed
2.1 billion dollars to the
[28:27] bottom line of both the state
of Minnesota and Minnesota House holes. That number far
exceeds the legislature's total
[28:34] appropriation to the Minnesota
attorneys general's office over the same period
[28:40] since 2021. The officers
returned over 40 million to the state's general fund in the
form of revenue and deposits of
[28:48] and dispersed restitution
funds. The offices for the consumer didn't significant
amounts to dedicated funds like
[28:56] the tobacco or opioid funds. For example, we've reached a

total of 565 million

[29:05] in settlements with opioid

companies. 183 million of that amount has already been

received at the office is also

[29:13] want an additional 81 million for the state's tobacco fund

and a recent judgment of

[29:19] Minnesota, maybe up to

58 million more plus interest

[29:24] by successfully litigating

against tobacco companies for not paying the state the full

amount they agreed to under

[29:31] Minnesota's historic 1999 Tobacco Settlement, which the

attorney general's office

[29:37] continues to enforce. He also won more than

60 million for the state in a

[29:42] settlement with Juul and Altria

over their deceptive marketing of e-cigarettes and which was

the largest per capita state

[29:50] settlement in the country.

With those defendants, the set of the legislature also

designated these funds to go

[29:56] directly. Tobacco related

prevention efforts were turned over 85 million in

restitution and debt relief

[30:05] that the office has won for

Minnesotans victimized by student loan scams. I'm

Consumer Action. Division has
[30:12] returned 51 million directly to
miss those pockets over the last 6 years by helping
consumers informally mediate
[30:21] and resolve thousands of
complaints with businesses and other organizations and much
more.
[30:28] This group answers over 50,000
calls a year and helps resolve the complaints we received from
people, businesses and other
[30:35] organizations who contact us
for assistance. We've won 9 million in
restitution for consumers.
[30:42] A century link and 4 million in
restitution and relief for consumers of Comcast for
fraudulent and deceptive
[30:49] overbilling. More than
4 million in restitution relief for tenants were victims of
illegal and uninhabitable
[30:55] living living conditions and
2 million in properly with wages
[31:01] that the office's waste Theft
Division has returned to the pockets of Minnesota workers
and much more.
[31:09] This work is ongoing, whether
it means monitoring accurate payment from the tobacco

companies for the for nearly 30

[31:15] years ago or current

investigations into any trust deception affecting our state

and the nation's farmers and so

[31:23] much more in closing. Those are

the numbers behind. Every single dollar is a real human

person and their story.

[31:32] We're driven by those stories. We work hard every day to help

give people money back to the

[31:38] state and the people. We were

just as hard to protect Minnesotans from scams to fight

Medicaid fraud. The victimizes

[31:46] the vulnerable to make sure

your donation dollars and are working as they should

[31:52] to assist in the criminal

prosecutions when called upon and to defend the agencies that

do so much more for people of

[32:00] the state. That's the job that we take it

seriously. And let me conclude by saying

[32:06] that I have some staff members

who are here to help me answer questions that I mean, I have

all the information. One of

[32:13] them is Kerry Washington in the

other one is Nick Wonka. Kerry runs our charities

division, Nick runs or Medicaid

[32:20] fraud division. And they're

prepared to answer. Help me answer any questions. I mean,
that have the answers to.
[32:26] So with that, Madam Chair,
prepared for questions. >> Thank you. I really
appreciate your testimony and
[32:33] coming before us. I do want to
start with a couple questions of my own. And so I'm
particularly interested in that
[32:39] charities oversight. He's and
and I appreciate
[32:46] the work you have done and
shutting down some of the charities related to feeding
our future. But I do have a
[32:53] couple questions about that. So first of all, I
[32:59] many of the charities involved,
including feeding our future, would be under the jurisdiction
of the attorney general's
[33:05] office and in you did initiate
proceedings to close that down.
[33:12] But there are many ancillary
charities that run the sites that have not been addressed.
But in May of 2023, I believe I
[33:22] did reach out October of 2023, you
filed lawsuits to shut down 23
[33:31] and then in May of 2024, 17
were shut down, which, you

[33:37] know, we appreciate very much
that you're minding the store on that. But one of my concerns is that
[33:43] of the 17 that were shut down,
none of them were active on
[33:49] your Web site. Prior to that, they had all not be filed as charity.
So they were operating
[33:57] without having filed their
charitable filings in the state. So
[34:03] they were already sort of
involuntarily terminated. But then you claim you set them
down and then also thing all 17
[34:12] didn't respond to filing.
[34:17] And so that is the basis on
which they were shut down because they didn't respond.
But it's unclear if they're
[34:24] still active, what happened to
them and then of the 6 that you settled west.
[34:30] And it doesn't look from what I can tell. And it's
very difficult to tell honestly
[34:37] what happened to them. In some cases, they were
[34:43] allowed turn their assets over. I
believe 2 other nonprofit
[34:48] organizations. So they may be we don't know, just
reconstituted themselves.
[34:56] And that is the case for
several of them. So I just wondered if you could speak to

those cases and you put out

[35:04] press releases touting that you

shut down 17 nonprofits. But in fact, they were already

sort of shut down. And of those

[35:10] 6 you settled. They also don't it's hard to see what happened

to them. So if you could just

[35:16] address that, I would

appreciate it. >> Madam Chair, Kerry

Washington's here. Perfect.

[35:22] She can help me respond to

questions. >> Welcome to the committee.

Please stay tuned in for the record.

[35:28] Thank you, Madam Chair. I'll

try to hit. >> These one at a time. So I

believe that one of your

[35:37] questions, where was that many of the time said could use

to tune in for the record

[35:42] again. Yeah, sorry and new to

this. So, Carol, Washington,

[35:48] I'm the manager of the

charity's division. Thank you.

[35:54] So I believe that one of your

questions is many of these charities appear to be

[36:00] dissolved or shut down already.

Yes. And one thing that I want to make a clear distinction

have is the difference between

[36:09] a charity being inactive, for
example, and then it may get automatically dissolved on the
Minnesota Secretary of state's
[36:18] website and that is very easy for
charities to cracked. It also happens all the time, including
to legitimate charities.
[36:26] The only thing they have to do
is pay. 25 bucks filed a piece of paper work and then there
revived again, right? And in
[36:33] fact, that's what many of these
charities said. These were old charities that were revived.
That hadn't been
[36:40] the active for years and many
of these bad actors. But they did is they took these old
incorporated zombie entities
[36:48] and reanimated them. All right.
So the difference between that is and our work is we went
to court to shut them down
[36:57] permanently so that they couldn't be
revived. And that's really an important distinction, because
as you saw here, it's very easy
[37:05] to bring them back to life. So there's there's a
distinction between how they might appear on the secretary
of state's website
[37:12] and and whether or not they're
actually permanently just saw. >> That's that. That's the

first question.

[37:20] >> Thank you. And I appreciate

that. But none of the ones that of the 17 that were shut down,

where zombies, charities that

[37:26] were revived, they were all in

fact, some attorneys when they were shut down. And it's hard

to see

[37:34] now that there's been this

settlement like what, in fact is their status. So can you

address that have have their

[37:42] assets been dispersed? If so,

to whom? I have not been able to figure

that out? Yeah. So the vast

[37:50] majority of the cherries based

upon our investigation had minimal to no assets because of

the fraud.

[37:57] And and so I I'm not sure what

you know, I'm happy to follow up with specific questions

about what you mean about,

[38:04] you know, what happened next?

A court has ordered them to dissolve. They've been

terminated. So

[38:10] they have been issued the death

penalty for charity. And so how do you follow up to ensure that

that has happened that they are

[38:17] indeed dissolved and that still

operating? It is reflected on the secretary of state's
website. Me and the court does
[38:24] a referral to the secretary of
state provides the paperwork in the secretary of state reflects
is dissolved,
[38:31] right? I understand that.
But that's all just paperwork. Does anyone checked to see that
they're still not operating?
[38:39] It's difficult to answer that
question night. You know, it depends on the circumstances
and I don't necessarily want to
[38:45] get into investigative
processes. But a court order is, you know, a significant
resolution of the action that
[38:53] we've got. Okay. Thank you. Move on from
that. But I would if you don't mind, I would like to follow up
with you about that afterwards
[39:00] in a future conversation.
Yes, Mr. Attorney general. >> And then a minute. Are you
asking if we're tracking the
[39:07] individuals who are associated
with those shutdown charities, as is that what you're asking
because
[39:14] though, that they're shut down
their shutdown? >> No, I'm asking if, in fact,
they are shut down because many

[39:20] charities that are not active
on the secretary of state's website, as you noted, continue
to operate. And then they just
[39:26] file a piece of paper and then
they're back having their status. But these that are
ordered shut down also appear
[39:33] inactives but also could
continue to operate if no one's checking on them. So I'm just
wondering
[39:39] once the court orders them to
be shut down, how do you in fact verified there are no
longer operating.
[39:47] >> Madam Chair, could you
identify the organizations that were shut down via court order
the you believe are still
[39:54] operating? >> I don't know if they're
still operating. I'm just wondering if anybody knows.
[39:59] >> If they've been such Madam
Chair, Yes, March a court has ordered them to be shut down.
[40:07] I think that's pretty much the
end of the story for that charity. Now, the individuals,
[40:13] I think it's impossible for
anyone to know if things open up some other
charity and that some of the
[40:18] name or perhaps went to some of
the state or does something else that charity, which a court has

ordered

[40:26] terminated, that charities I would I would

say to you is either not

[40:33] operating or is operating illegally put.

It would be speculating

[40:40] to say that a court-ordered dissolved

institution is still operating.

[40:46] And how do we know they're not?

Well, the court ordered to be shut down. The court order

[40:51] is just it's like would sent

like it is a at the end of a

judicial proceeding.

[40:59] That's what is like the final word in any

case in any case. And so if

[41:04] there's a if there's a if there

is an entity that's operating that has been shut down by via

court order and it's still

[41:12] operating, I love to know who

which institution that is because that would mean that

they violated a court order and

[41:19] could be subjected to content. >> I appreciate that Mister

Attorney general and what I'm

[41:25] what I'm questioning is as the

head of charities like if a person is convicted

of a crime, they go to jail.

[41:33] You can see that happening if a

charity is ordered to be shut down and no one checks to see
if, in fact they stopped
[41:40] operating. And I just don't
know how it's verify that I'm just wondering generally how
it's verified. And then in some
[41:45] of the cases, it was actually
part of the settlement that their assets were transferred,
2 other nonprofits. So even as
[41:54] part of the settlement, it's not like love that entity
was shut down, but a new
[42:00] entity, they were required to
transfer it to another nonprofit. So it's unclear what that new
nonprofit is who is now
[42:08] involved with that. So I'm just
wondering what additional layers of due diligence or
office does to follow that
[42:15] thread. If these charities are
shut down by the court
[42:21] 4, it's in a settlement required
to transfer their assets to
[42:26] another charity. How is that then followed up by
your office to make sure that
[42:33] they are, in fact, still
telling their charitable purposes? Yeah, I can reach.
Thank you.
[42:38] >> I would say this does get

into our investigative process us, but we do take that
compliance with our settlement
[42:47] agreements and court orders
seriously. But it is a sensitive issue to
talk about how we might be
[42:53] looking at these organizations
right now. >> Thank you. And just I know
the people of questions.
[42:59] I have one more just in this
little pain here. So one of the concerns that's been discussed,
a lot of the legislature this
[43:05] year is once a case has been
resolved, how that data is classified.
[43:12] And so in these cases where
these charities are shut down and the investigations are
over, how is that data
[43:20] classified under Chapter 13?
65? It depends if there.
[43:27] >> It depends on on the case
and some situations where especially where there's
ongoing monitoring or
[43:33] enforcement mechanisms in the agreement
with the court order, it may be
[43:38] active and if there is a
complete resolution. And again,
[43:44] it depends on the case. I'm not

speaking of any specific case here, otherwise,

[43:49] but there's a complete

resolution that it would be inactive investigative data.

[43:54] So it'd be publicly available. >> Neither. >> Active Nora inactive

investigative data is publicly

[44:01] available, which is quite concerning.

I think that's one of the reasons we're having trouble

finding some of these threads

[44:07] is because it's not accessible.

So would you support making closed investigative data about

organizations, not individuals

[44:16] public? Madam Chair? Yes. >> We're not going. I'm not

going to opine on what the

[44:22] legislature should or shouldn't

do. If there's a specific proposal

to change the Data Practices

[44:30] Act will respond to that.

But at this time I'm we're going to

[44:35] respect the separation of

powers and allow you to

[44:41] decide what the legislation

should be and will weigh in on it. And if there's ever a

specific legislative proposal.

[44:49] Thank you. I appreciate that. >> Appreciate both. You okay.

Many questions here. So I'm

[44:54] going to turn to Representative

Holt, Walter Hudson.

[45:01] >> Thank you, Madam Chair, and

thank you. Attorney General Ellison and your office staff

members for

[45:06] speaking with us today. It's

very much appreciate appreciate your candor.

[45:12] Just a quick follow-up on what

Chair Robbins had to say regarding

[45:18] entities being shut down and

then to one degree or another being resurrected in a

different form.

[45:23] It may indeed be impossible to

know what individuals who were involved with nonprofits that

were shut down are currently

[45:30] doing. However, I would

certainly hope and presume that as part of the grant management

process with more on that

[45:37] prayer works phase. We're

looking at things like that. So if organization comes along

with a different name, but

[45:43] there are officers involved

with that organization or links in terms of where they got

their financing or assets that

[45:51] connect to a previous

organization that had a problem, that that's something

that the state agency to put the looking and I see you

nodding your head. I appreciate

[45:58] the fact that you're with me on

that. I want to go back to this meeting that took place on

12/11/2021.

[46:05] you mentioned here today and in

your op-ed that at the time you perceive these as business

people with concerns

[46:14] and that they were using,

forget the adjective you used, but egregious claims of racial

discrimination as part of their

[46:23] scammer scheme to try to pull

the wool over people's eyes. But when we

[46:29] in the course of the

conversation, we do have a little bit audio here that I

want to play momentarily.

[46:35] It's clear that they're talking

about state agencies getting in the way of their ability to

conduct business.

[46:42] That seems to be a reference to

grant management. And so what will let's listen

to the audio and then all asked

[46:50] my follow-up question.

[47:08] >> And so this is my attention

and extremely frustrated by.

[47:14] But we are in the middle of a

battle with these agencies. And I can tell you this

[47:22] walls agrees with me that this
really stupid stuff running small people of this is served.
[47:29] But it's a problem of life. This is probably love
[47:35] in ocean plastic problem if he's here
[47:40] and this time here, given these
this is a part-time
[47:46] this guy, these poll somehow
say, hey, they're picking on me, but all
of us do not.
[47:54] And so it's this that or so. Now we've got to make it
clear that this guy is that
[48:01] stopped me right. But it's a
problem. But Uber, he knows that there's a lot of
[48:07] unfair discriminatory stuff when the
second is
[48:12] I do it. The department has might do to
her son and now we know it and
[48:19] she says we're going to stop
doing. But I don't believe it until
you tell me they stop to it.
[48:27] >> So Attorney General, Alice,
in a very much seems to me that the abiding concern there is
keeping these business people
[48:35] in business. But in point of
fact, they work grant recipients who are supposed to
be providing services to people

[48:42] in need. And so of the parties
that are involved here, you've got the and you've got the
state agencies who are managing
[48:50] the grants. You've got the
grant recipients, who would be these business people with
concerns. And then you have the
[48:56] people we're supposed to be
receiving services in that chain of relationships.
[49:03] The role that you play as
you've articulated here today is to represent the state
agencies. And of course,
[49:08] your office was the middle of
representing Mte when they were sued by fo f that happened in
November 2020. This
[49:14] conversation was December of
2021. And so I guess my question is
I'm concerned about
[49:21] the seeming focus and priority
on keeping grant recipients in
[49:26] business as opposed to
defending the state agencies and maintaining the integrity
of taxpayer funds that are
[49:33] going to these recipients for
the purpose of providing services to people. Why was the
focus on the East African
[49:41] community business owners

keeping their businesses open when those businesses were, in
fact, grant recipients
[49:46] entrusted with the public
responsibility. Madam Chair, let's keep in mind
[49:53] in December of 2021. >> The search warrants
[50:00] would not issue for another
month. Indictments wouldn't occur for another 9 months.
[50:06] When I'm sitting in that
meeting, there is no logical way for me
to know
[50:15] what is what these people have
done unless I had some way to know
the future.
[50:22] What I'm hearing and I've heard
many times is that people are trying to
start businesses and they're
[50:28] running into problems with
state agencies. As you might know, I don't
reference the conversations not
[50:35] even about MDE in it. The one that you play it. What I'm hearing as is that
we have people who are coming
[50:45] forward with issues. >> If they have real issues,
[50:51] I'd like to deal with the it's not not
everything is an adversarial
[50:56] relationship. Sometimes if you
have a problem and you can talk to the agency and the and the

vendor and resolve the matter,

[51:05] that's preferable way to do it. But certainly let's ask

ourselves one question what

[51:11] happened after this meeting? I go back to my staff and I'm

like, no, we believe these. Those folks are bad actors.

And then what happens? Well,

[51:19] within a month, these people

are indicted. We're cooperating with the federal authorities to

help convict these people were

[51:28] cooperating. We're using the

authority. We have to get them convicted. So in a community

meeting

[51:34] where people are representing

to me that there, that they have some problems

[51:39] that they like to sort out and I have no facts to support

the idea that these are

[51:44] fraudsters. Of course, I'm going to listen

to them. I'm gonna go back and I'm going to ask some questions

[51:51] when I got the questions

answered. It was clear to me that these people are not good faith

actors.

[51:57] The I did nothing for them. There's no claim that I went

out and advocated our lobby for

[52:04] them. Because when I did my due

diligence, I found that they were not worthy of that. And of course,

[52:11] that's the that's the story.

So I guess in answer to your question is I meet with constituents all
the time
[52:19] I meet with constituents.
It constituents probably I don't know. I
wouldn't be surprised if it's
[52:26] multiple times a week since I
first got into politics in 2003,
[52:34] some of them, most of them overwhelmingly,
most of them are good, decent people who just want to have
one of the listen to some of
[52:42] them. Fraudsters. If I have no way of knowing
that they can tell me whatever
[52:48] they want to tell me when I go
back to do my homework and I find out,
[52:54] then I act accordingly. So I
hope the answer to question the happy to respond to any
follow-ups.
[53:01] Representative Hudson, thank
you, Madam Chair, and thank you, Attorney General. I
listen.
[53:07] I find it. >> Difficult to believe that
you didn't have some suspicion
[53:13] about who these people were and
the potential at least suspicion of them having some
connection to what was going on
[53:20] simply because your office has

already been involved for over a year at that point in the
feeding our future lawsuit in
[53:27] defending the state agency, AMD
E and you know, these are folks
who are coming claiming racial
[53:34] discrimination by the state
agencies, which was the complaint in that very lawsuit.
So certainly the idea of state
[53:43] agencies acting in a
discriminatory manner towards Grant recipients was not a
novel concept on 12/11/2021.
[53:51] and the context and of this
conversation and what we'll hear more about it later.
You're talking about taking the
[53:59] fight to these people in
reference to the state agencies. You're saying you're
with these folks here meeting with you're going to fight on
their behalf. Now,
[54:06] perhaps nothing happened after
that. But that was certainly what was portrayed as your
intention at the time.
[54:12] And again, my concern here is
that rather than the focus being on
[54:18] defending your client, upholding the integrity of
taxpayer dollars, ensuring that
[54:23] services are actually being

provided to the people who need them. The overriding concerns seem to

be grant recipients and keeping

[54:31] people and business. Thank you.

Madam Chair, Madam Chair, the guests, Attorney General

Ellison.

[54:38] So let's just review the

record. So we know

[54:43] that a court >> had been had issued an order

[54:50] finding that the fraudsters

were in the right and that my client

was was not. That's one thing

[54:58] that had already happened. And remember, that happened

[55:03] and the conversation happens

and then the search warrants issued. And then 9 months

later, that's when the

[55:08] indictments issued. So what is

the existing record at the time

[55:15] had found that the the the lies that

these fraudsters have been

[55:20] telling amounted to them being improperly denied the money

they were seeking.

[55:29] So we also.

[55:35] >> I just want to ask. So you

are saying that what the court found in June of 2021

[55:41] in their contempt order was about the stopping payment.

[55:48] Did I hear you say that

correctly? What I'm saying is that? >> What we see is that what?

Here's what I'm saying. It's

[55:54] very simple that there was a dispute

between vendors and the state.

[56:01] The court found that there was

no basis for the for the client

[56:06] to not have the payments flow forward.

That's what I'm saying. >> And I think that's an air

Mr. Attorney general is great

[56:14] respect. I believe the order of

contempt. It's because Mte was not making a decision whether

to approve applications or not.

[56:23] That contempt judgment had

nothing to do with their decision to stop payments. And so I think the record just

needs to be accurate on that

[56:32] point. Madam Chair, yes, Mr. Jones

went out. So. >> I'm not really sure right

now whether to respond to to

[56:39] represent Hudson or to you. I wonder if we could deal with

the question,

[56:46] complete that and then deal

with another question that that way I'm able to. >> We can keep a clear read it.

I think that's a great idea.

[56:54] But I do want to just make sure

we're accurate on the contempt resident about so pleased to

see it in responding to

[56:59] representative had said, Well,

let me just say, Madam Chair.

[57:05] >> Well, so March list Mean

Representative Hudson is suggesting somehow that

[57:13] that I should have known that these fraudsters who were

lying, not just to me but to

[57:19] courts, but to the media, to the agency that I somehow

should have known. As I noted,

[57:26] Nye said on several occasions, I do not handle every single

file personally.

[57:33] I have a staff of 430 people

and at that time maybe around 380, I'm not sure what the

exact number is

[57:42] that helped me do these cases

every day. These lawyers and legal workers who work on this

stuff, they knew the file very

[57:49] well. But we're one law firm. And so no, I don't know.

Every single thing happened on

[57:55] every single file. What I do know is that our team is defense state

agencies all the time that they

[58:03] do a good job. And I and I was well aware that

there was a dispute

[58:08] between vendors and the and the agency.

[58:16] I do know that a court had found against my client. That was

what that was. What had

[58:24] happened up to that point. I still believed in the

position my class were taking.

[58:30] But I wasn't ignoring the fact

that there was at least somebody, including the press,

[58:36] including courts, including the

agency who had been light to buy these by these

fraudsters. So when I meet with

[58:44] the these people on this day, no, I I got to be I mean, it's

just not how it works to

[58:52] believe that I know every

single thing that happened on every single file in my office.

What I knew then

[58:58] is that there was an ongoing

dispute between vendors and the state. What I knew then is that

[59:06] a court had found the client in content. What I knew then

[59:12] is that there had been this

dispute plan out in the press. But still

[59:18] the proof of the pudding is in

the tasting. What did I do for these people? Nothing. I

investigated after the

[59:25] conversation and then what we do. We

cooperated to help

[59:31] get these people found

accountable as they eventually were. So

[59:36] no, I have to tell you that in

all the meetings that I have with people,

[59:42] some of them have disputes with

the state they may or may not. They may
or may not bring them up in the
[59:47] meeting. If they do, I will
listen. And then I'll go back to my office. What's going on
with this
[59:53] now again in September in some in OT in
January of 2022,
[1:00:01] that's when the search warrant
issue. That's when the search warrant
issue.
[1:00:07] This conversation that I didn't
know was being taped happens in December of 2021.
[1:00:14] And so let me just again, quote, the
person who did
[1:00:20] pull the heavy or on
prosecuting these criminals,
[1:00:26] you know, we just find where it
says the when Mister Thompson says in the beginning this
month small.
[1:00:35] And so again, I don't know if
that satisfies or not, but the reality is
[1:00:41] these these things often do
start out somewhat innocuous. And then
when we get into the evidence,
[1:00:49] it's clear that it's much more
than that. I have to listen to people.

I do listen to people

[1:00:56] and look what I do. I

investigated it with my club with my staff, asked the right

questions and those people were

[1:01:03] then search through these of the

search warrants and subsequently indicted and tent.

And since that time, many of

[1:01:11] them were convicted. Thank you, Mr. Chen General

Representative Shoaf.

[1:01:18] >> Thank you, Madam Chair and

Attorney General Ellison. So looking at the picture of this

whole quote that we listen to a

[1:01:23] moment ago. You know, it's one thing to be

concerned with the general tone. And you've addressed a

lot of just the nature of the

[1:01:31] fact that you are in this

instance meeting with constituents. And at the same time, I'm

struck by this this statement

[1:01:39] where and again, if we did play

earlier, but it's and so this has my attention. I'm extremely

frustrated by it.

[1:01:47] >> But we are in a battle.

We are in the middle of a battle. >> With the agencies.

[1:01:52] So Attorney General, Alice, and

can you share for the committee, what do you mean by

a battle with the agencies,

[1:01:58] Madam Chair? All right, Attorney general
also again, we're talking about
[1:02:06] 3 and a half years ago. We're talking about a
conversation with constituents.
[1:02:12] I didn't know who I was talking
to. I was just talking to some constituents who had been
complaining that they felt that
[1:02:19] they had not been treated
fairly by state agencies. This is not the first time I've
heard people say I have a
[1:02:26] dispute with the agency and
when this happens, I don't think it's my job to
presumptively.
[1:02:32] Just ignore what people are
telling me. What do I do? I listen to them.
[1:02:38] I take notes and I go back and
figure out what's really going on.
[1:02:44] That's what happened there. I suppose I don't know any any.
I don't know the elected
[1:02:49] officials who do talk with
constituents who do try to listen to constituents who've
never been lied to by kids to
[1:02:56] to to it by constituent who
then go on to find out that what that constituents said at
the meeting that sounded highly
[1:03:03] sympathetic actually isn't

real. So if I may,

[1:03:09] that's what happens. This is a

this is this is me listening to somebody who's telling me that

they have a problem.

[1:03:16] When I find out what really is

going on. When I go back to my office, I find out that that

person is not credible. So

[1:03:22] that's what you're seeing right

there. Aid elected official

[1:03:28] listening to people demonstrating some sympathy for

the problem that they claim to

[1:03:33] be having and then finding out later that this person is incredible.

That's what's going on.

[1:03:41] >> Thank you, Representative

Saltzman follow-up. Thank you, Madam Chair. So when I'm

looking at this, right, you

[1:03:46] have been at this point in

time. If I'm if I'm gathering this correctly by this point in

time, you have been

[1:03:51] representing MDE for over a

year by this point in time. And and so when I'm looking at

this in this statement here

[1:04:01] that goes on and talks about

discriminatory stuff that the

[1:04:06] at least through the way that

this is written and the way the word the way that your words

were here, it was this this

[1:04:14] attempt at saying that

discriminated the discriminatory actions were

taking place within agencies

[1:04:20] who in this instance in your

quote here, who are you fighting?

[1:04:26] Madam Chair, Attorney General Austin, as you

know, >> the agencies and general who

I'm hearing complaints about,

[1:04:35] I'm trying to solve problems

for people who are telling me that they're having problems,

[1:04:41] which agency? I don't know.

I mean, I don't I don't mention the I don't I don't believe

that I we even talked about

[1:04:48] this specific agency when I'm

Cindy and representative, is that

[1:04:53] in all the meetings that I

would go to and still go to, you'll hear people say I'm

frustrated with how this agency

[1:05:02] is dealing with me. Sometimes these people may have a

legitimate concern about how

[1:05:08] things are going. Sometimes they lie. And then

it's really is the fault of the

[1:05:14] person who's telling me that

it's not their fault. I can't control what people say

to me, but I do try to listen.

[1:05:24] I do try to demonstrate some
sense of I want to try to help you.
[1:05:29] And sometimes those people are
lying. So what we're really talking
about here is
[1:05:36] clip 3 and a half years ago is before the convictions
before the indictments before
[1:05:44] the search warrants where some people are telling
me that they feel they weren't
being treated fairly. And I'm
[1:05:51] saying, yeah, that's that's too
bad. Let's see what's going on there. And then what do I do? Nothing.
Actually, I do the opposite of
[1:05:58] help. The might I have my
office cooperate to convict him. Now you said this
happened. My office have been
[1:06:04] working on this for over a
year. Yeah, true. And let me tell you as it
again, we represent over 100
[1:06:13] boards, commissions and
agencies we represent. I mean, and all of these these
groups, all of these cities
[1:06:20] that we represent, we're my my staff does they
give me reports that it's
[1:06:30] impossible for any individual
to know every single thing about every everything about

every file that every agency
[1:06:37] does. It's simply not how large
organizations work. I highly competent managers
working on this highly
[1:06:44] competent, the deputies working
on these things. And they knew even if I did know every single
detail, what I knew was that
[1:06:52] people in a community meeting
said we feel like we're not being treated fairly. I'm like,
oh, that's really too bad.
[1:06:59] And then I go back to figure
out what's going on. And what I find out is all those people
are the ones who are in the
[1:07:05] wrong. And then what is our
action actually this to cooperate to
help convict these people?
[1:07:12] So you not not you
representative? I mean, this in the most respectful way.
So individual could
[1:07:18] say, oh, you should have known all
these things. Not really possible. Given that the indict
that search search warrants
[1:07:26] didn't come out. And when I walked in that room,
it's not like I had seen the faces of these people or I knew
their names or I knew what they
[1:07:34] were alleged to have done. It just isn't that way. What I knew was people who I

didn't know

[1:07:43] who told me we have a problem

and I think nothing for them. I took nothing from them

[1:07:49] and that's it. Thank you. Attorney General

represent Dawkins.

[1:07:57] Turn that on. >> We're an hour and 10 minutes

into this meeting and this is our first opportunity to ask a

question.

[1:08:04] So Attorney General Ellison, this is a federal crime being

investigated by federal

[1:08:11] authorities. Clearly, the FBI

had been working on this case for some time leading up to the

issuance of this church search

[1:08:18] warrants. But it sounds like

they were playing it really close to the vest. And they

shared any of the information

[1:08:24] that they had collected in the

time leading up to the issuance. Are there for search

warrants with you or your

[1:08:29] staff, the chain General Allison. >> Mr. The represent Madam

Chair.

[1:08:37] The answer to that question is

I was not aware that there was a federal investigation, but my

staff probably didn't know

[1:08:46] and the information was held very close to the

vest. Here's here's the reality of

[1:08:52] cooperating with the federal
investigation. They tell you what you need to
know to not screw up their
[1:08:58] investigation. So obviously they didn't their
communication with my staff,
[1:09:04] which I didn't know when this
meeting happened was, as you conduct your discovery,
[1:09:11] don't do things that are going
to tip them off so that they abscond so that
they wash off other boards so
[1:09:19] that they do things to hide
information. But they don't tell us the
scope. And by the way, if you
[1:09:26] if you believe the quote, the
Joe Thompson shared in these recent interview,
[1:09:32] maybe even the feds didn't know
the scope of the fraud until the search warrants issued.
They knew a lot, but they
[1:09:39] didn't tell us everything.
They certainly we certainly didn't know the names of
individuals involved.
[1:09:46] What we knew is that what we
knew? What I knew at that December meeting was that there
had been a dispute between
[1:09:52] vendors and a dispute between the
state, a state agency.

[1:09:57] And at that meeting, I'm not
even sure which agency
[1:10:03] their information was a very
close to the vest. We cooperated. And the result was that to the
people who are responsible got
[1:10:11] indicted, got got search, then indicted
and convicted. >> Thank you. Any follow-up.
Representative Elkins, Fine.
[1:10:17] Thank you. Okay. Represent
agreement. >> Thank you. Madam Chair
Representative has isn't here.
[1:10:23] Boaters can see sort of back to
this question. But I think we've been asking as a
legislature about this idea of
[1:10:30] fraudsters. So taking one for
going to another. We see the sun wage theft all the time.
There is a lot of work right
[1:10:36] now that we need to do in the
legislature to ensure that we are shutting that down. That's
obviously our work in the
[1:10:42] legislature. And I just since
he's not here and we'll go further on that. I this is but
every really interesting
[1:10:51] conversation, but not because
and I think to the attorney general, also this point,
looking back 3 and a half years

[1:10:59] ago before feeding our future
was a not not only was it not a
[1:11:05] household name. I think most of
us I didn't know or had heard about it before a search
warrants before investing
[1:11:13] investigations at a meeting.
When I was I listened to the entire hour where it was clear
that the attorney general was
[1:11:21] actually sure, you know, I hear
complaints about DEET all the time here. Complaints about the
lie. I'm sure my Republican
[1:11:28] colleagues across the aisle
here about red tape and all sorts of stuff that gets in the
way of people being able to get
[1:11:34] a contract of people, having
able to get a grant. That is pretty normal conversations
that we have. And and certainly
[1:11:42] as as a lawmaker's, we often of
conversations with folks about how we're gonna help folks
solve the problem. The thing
[1:11:50] that I actually think that this
was helpful for is were not 2 months, 3 months into this,
this conversation about fraud.
[1:11:59] And it is the first time we've
actually seen, you know, the business model of fraud as
it operates, like we're not

[1:12:06] talking about. We have not had
investigators come in and talk about how they investigate
these cases. We have not had
[1:12:13] investigators come in boards in
the Medicaid fraud unit or anyone else. Prosecutors come
in and talk about what it looks
[1:12:21] like when fraudsters bill this
together. We have heard in a in a in a closed door meeting from
investigators about how one of
[1:12:29] the ways that fraudsters
actually work is when they go after the whistle blowers, they
got after the enforcers,
[1:12:36] they go after the prosecutor to
whoever strain investigation and they have a strategy and
oftentimes that strategy,
[1:12:43] if it's a closed network rate
might be too go after Harden racism. I have heard it on.
That's why we why you coming
[1:12:51] after questioning bats to go
after folks on religion, whether it's, you know, a this
is Islam, a phobic are
[1:12:59] antisemitic. That is actually
something we've heard over and over again. And we a few of us
actually heard how that works.
[1:13:07] This is actually detailing and
showing in real form how that

[1:13:13] works. We also know that these
folks went to the mayor's office. They probably went to a
set of other elected officials
[1:13:19] and as part of their fraud as
part of the business model and the divide it among the fraud,
they went after the exact
[1:13:29] people who work who are tasked
with and in some cases and as
[1:13:34] things move forward, who did
the prosecution investigation? And so I think that's actually
what this shows and it's really
[1:13:42] helpful to see. It would be
really great to talk about the rest of it to bring in what it
looks like to go into and do
[1:13:51] the forensic accounting.
You would be great to to go into and see how you network
how these organizations are
[1:13:59] related. We haven't done any of
that. I think we've been saying for now 2 or 3 months like
let's do that. And so thank you
[1:14:07] for starting this conversation.
I hope that that's where it goes from here. My question for
for you on your office in that
[1:14:14] context is now looking back 3
and a half years. Not what
[1:14:19] would you have done

differently? And that's one question. But like looking
forward and now with an
[1:14:25] understanding that this is
actually a piece of how they conduct, that's odd, like has
your office is thinking about
[1:14:33] have to public funds? What have you learned? What
would you recommend to us that
[1:14:40] we should be looking at in a
different way now that we've gone through this experience
future future.
[1:14:46] >> Thank you. Attorney General
Ellison, Madam Chair. Thank you for the question.
Representative. One thing I I
[1:14:51] would certainly suggest is that
it's important to be aware that
[1:14:59] fraudsters tend to figure out
what you value and they weaponize it against the entity
that they're trying to
[1:15:05] manipulate. If you say that you really care
about
[1:15:12] financial about saving money, then they're going to represent
their
[1:15:18] their position is all this is
going to save the government. A lot of money. If you
represent your position is
[1:15:24] being sensitive to equal

opportunity. They're going to say, oh, we're victims of
[1:15:29] unfairness in some way. If you
say that you care about women's empowerment was, oh, this is
terrible for when they're going
[1:15:35] to figure out what you what you
care about. And they're going to somehow
say that they're the victims of
[1:15:41] that. And so I think it is important
to Kate, keep in mind that when somebody is banging
on the table
[1:15:49] about how the state agency is
somehow going after fill in the
[1:15:55] blank, it's important to really keep
in mind
[1:16:00] that may be that an entity is using that as a shield
[1:16:08] to not be investigated. What I would say it is
important to
[1:16:15] to not act just on their say so to go back to your to the
people who are working the file
[1:16:21] and see what's going on. So I think that's very don't.
That's a very important thing
[1:16:29] to keep in mind. I'll also add
that,
[1:16:34] you know, it's important to
sort of make sure that communication
[1:16:40] is a robust and that to the degree possible

[1:16:46] we try to communicate and so
that week, so you get a little bit more heads up. Keep in mind
that some possible. Here's the
[1:16:53] here's one thing above
fraudsters, they present that they try to
perfect their craft all the
[1:16:58] time. You know, that's what they're
doing. And if we shut down this
[1:17:04] area, they're going to pop up
in another one. As I said, I happen to know
[1:17:10] then heaven help us after a
massive storm because people who
[1:17:16] have had their roofs blown off
or had there some sort of
structural damage to their
[1:17:23] home. There will be somebody
knocking on the door and it's impossible to know.
But one of them are 2 of them
[1:17:29] are 3 of them. We'll be
somebody who means nobody any good except for themselves.
So it's that we have to be
[1:17:36] hyper vigilant when there's
sort of a crisis because some some will be good faith
actors trying to help try to
[1:17:44] provide a service. Others will
not. >> A quick follow-up. We have

many more people with questions
[1:17:50] here. I understand we waited an
hour and everybody else's as well as the attorney general
have been very verbose. So it's
[1:17:55] not my fault up. Madam
Chairman, I'm sorry. We're going to let my representative
and have a that. I'm going to
[1:18:01] ask a follow-up. Thank you. >> Because I think that what's
important for it, the work of
[1:18:07] this committee is actually
serious and not political. What we should be asking is
what are we learning to ensure
[1:18:14] that we're protecting public
funds and taxpayer dollars so that we can continue to deliver
the services that people rely
[1:18:22] on a need? And so when we think
about we've spent a lot of time talking about future future,
which is an important thing to
[1:18:30] learn from, it was a pandemic
era government, federal government program. So it
doesn't exist the same way now.
[1:18:36] But we do have billions of
dollars that got the door in Medicaid and where we are
spending government. We're
[1:18:43] we're passing through, but we
have private vendors, private providers. And it does seem

like that's an area where when

[1:18:52] we talk about and again, we

have not spend as much time talking about this committee

because I think that there's it

[1:18:57] doesn't align with the

political objectives of of some of my colleagues. But it feels like that's really the

area across the country and

[1:19:05] here that we should be focusing

on. I'm wondering if there are tools that we've learned as we

think about our Medicaid fraud

[1:19:12] unit. I look at this and I

think we asked you to to talk about this, but that we spent

about 5 million dollars.

[1:19:18] I think I heard about I heard

some of this in public safety. We have the Medicaid fraud unit

come in and they haven't yet

[1:19:25] been here. I think we've been

asking to be invited. But and that we've won 53 million

dollars in restitution. I'm

[1:19:31] wondering from the lessons that

we talked about here today. What can we be doing to make

sure that our Medicaid fraud

[1:19:39] and and frankly are consumer

fraud, all fraud, but the fraud that's actually the the ongoing

programs that we're doing a

[1:19:46] better job in that. The

Legislature is making sure that we're empowering the
enforcement that you're doing
[1:19:53] that is happening at the
federal level and and that our agencies are doing to better
protect public dollars and and
[1:20:01] the people who live in
services. >> Thank you, Attorney General.
I would just note that we we
[1:20:06] did indicate in our letter we
do hope to have the medic Cade fraud unit back at another
time. So I'd encourage you to keep your comments brief
because we will have a full
[1:20:14] >> discussion of that at a
future date. Thank you, Madam Chair. And I just like to point
out for the benefit of members
[1:20:19] here that the head of our Medicaid
fraud is present. If people have questions that they like
to direct toward Mr. Nick
[1:20:26] Walker, who does a phenomenal
job are very proud of. Well, I will if I may, Madam,
Madam Chair, representative,
[1:20:33] there's that few things that I
hope we don't do in response to fraud. Then I'll get to some
things that we should do
[1:20:40] as public officials. We should
not mean we should not cut off the public. We should continue to meet with

people

[1:20:47] because it would be said if

because of some fraudsters were like we won't meet with people

anymore because

[1:20:55] some of them might be

fraudsters. I also think it would be unfortunate if

[1:21:02] we sort of suspect the because

of the people are lying to us

[1:21:08] all the time, although some will be, we should keep that in mind.

[1:21:14] But I think we absolutely need

to do is just know what are some of the tip offs

[1:21:19] weaponizing your sympathies or

your values? What statement?

[1:21:25] High communication. And then

also read recognizing this. We feel that Medicaid fraud.

We're confident in about our

[1:21:33] good job that we're doing

because quite honestly, the 40 year-old program we've

learned a lot about how to stop

[1:21:40] fraud over the over the course

of that. One thing we should do and keep

in mind is when that there's a

[1:21:46] crisis and we're trying to

respond to human need within a crisis. We need to be able to remember

that there's going to be

[1:21:53] somebody who's gonna try to

take advantage of that. We've got to be able to maintain
those safeguards
[1:22:00] in that circumstance because
the well worn path of fraudsters.
[1:22:07] We were probably in decent
shape when it comes to those old. Those programs have been
around. But the new things that
[1:22:13] are based on a crisis, that's
where you're going to see really lot of the negative
actors try to get involved.
[1:22:21] So those are some things on his
mind. >> Kelly Kevaney thinking that
I think we're going to move on.
[1:22:26] Representative Anderson, thank
you, Mr. Attorney General. >> Thank you. Miss it. I'm
just, you know, my history.
[1:22:33] I worked with your 2
predecessors as and they were both very get attorney general.
So worked with them either as a
[1:22:42] constitutional officer as a
commissioner. The attorney general's ball, as you've said
in your in the essence to
[1:22:49] represent state agencies said
the chief legal officer of the state, not law
enforcement, the chief legal
[1:22:56] officer and you have a

fiduciary duty to your clients. Your clients are the citizens,

Minnesota, but LCA clients of

[1:23:04] the state agencies here in the

state. And so I I sit on the fraud, the legislative audit

commission to is as you're

[1:23:12] aware and I since coming back

in this role, I have tried to

[1:23:17] figure out how this could

possibly the feeding our future and all the other fraud because

it isn't just that how this

[1:23:24] could not ever happen in the

state. And we've been trying to figure it out and get 10 and

word of the ball drop and and

[1:23:32] and how did it happen? And

there's been a really good. You put a good timeline.

It here. We've looked at the

[1:23:38] timeline, but I have some serious questions because

your office knew as early as

[1:23:48] 2020 your office was involved.

When you enter future was sued

[1:23:53] for the first time your office

was involved, defend the in Mt.

[1:24:00] Who was essentially pulling

payments, not point payments

[1:24:05] because they thought that this was fraudulent. So you are very well aware.

My understanding is the FBI

[1:24:12] started their investigation in
May of 21. I don't know what what point
you yourself personally were
[1:24:19] aware that the FBI was
investigating, but certainly a staff was as early as may have.
21 and I've got to believe that
[1:24:26] you are where unless your
offices partly run, which I don't believe. I think it's
well around. Probably I'm sure
[1:24:33] that you knew at some point
after that that the FBI was sent by have a clip. And I want
to play this because this is
[1:24:40] this is important is our
children.
[1:24:45] >> Yeah, we're talking about
here are all stunned. >> It is. We have suspended
patterns of use ways and from
[1:24:55] yet from the department's
claiming the same from the
[1:25:00] visitors. >> And the theme parks along.
But you're not willing to operate in that area and more
okay here jumping into the
[1:25:07] fight with the serious money,
serious or anything. And we need your insight with us.
[1:25:13] >> And I know you're going to
hit hard, but we are committed so that can you comment to a

little town from where is there

[1:25:23] any part of all time? Yes, does. >> Of course it is. We want to

assure that is different than

[1:25:36] just the last one. A sweet as

we, you know, hundreds more.

[1:25:42] So yeah, it is. And as you get

to meet Kofi our leaders.

[1:25:48] >> The fight for those

communities and not just to grow and develop and bring a

new generation of leaders into

[1:25:54] office and we are ready and

willing to back those efforts all the way. But we need true

and steadfast partner to fight

[1:26:02] for basic justice. And that is

here and now rather than just 2.

[1:26:07] >> Of course, I'm hearing, you

know, I mean that. But I mean, clearly I'm not here because of

these the home every last one

[1:26:14] to health care who it I

voluntarily through my congressional career away my it

anymore morning. So too,

[1:26:24] do this is to do what I do.

And that's what I believe and nothing in this job done.

[1:26:31] I mean, is it that you want?

He said, got my prosecute police officer officer given

life in prison.

[1:26:36] >> Well, right, so we're going
to guess it was just goes. This is still fighting people.
[1:26:42] So the question, of course, is
figuring out exactly how to put
[1:26:48] a stop to it, right? >> Can you play the I have one
other and they related
[1:26:54] because they're all on the
same.
[1:27:01] >> These are children that need
to do it and it's very serious. Something in being able to do
more than one thing at the huge
[1:27:09] department with tons of money
is need to pause while we figure something out.
[1:27:15] >> But as a pass and they're
running people out. Yeah, that's intentional. You under
the law. And so that is what is
[1:27:27] known as a team. Well, it at a
piano that you still got people
[1:27:33] in the U.S.. >> And he said it was like
everyone wears a and here are
[1:27:40] your thing you need is given in
the last week. We're counting on you. Yeah. >> And then there's laying down
on private services.
[1:27:47] >> In the 2020 side of the deal
and he saw that have not received the unrest in June
[1:27:56] and the city can do it. You

know there. >> Since it is. So the 2 of my
government once a key member
[1:28:07] kdhe that and that's in the isolated at
[1:28:12] AG that state by the state and
the U.S. in December, the names
[1:28:20] of all those folks who are just
in my hand on my and varied and probably even survive the sake
of the month so
[1:28:28] >> that I can take that Liz and
start saying and I call Joey Hurst, invest in the first over
it and it is okay. Jean said
[1:28:38] what is going on? Why getting
these complaints? And then it started to call my office and
the Mystics for missions.
[1:28:46] >> Right. Well, I'm one of
them. Those guys don't ever want to be that shut down and
about we will be on BOCES April
[1:28:54] April 30th. It was like the
whole summer and the fall and
[1:28:59] my sense that I temp wasn't it up to testify.
[1:29:05] Syria violence takes place.
5 is by any time. >> So the last it actually
initiated from the restaurant
[1:29:12] specially Safaris if it was the
largest in the obviously being the largest restaurant. They
had that big o.

[1:29:18] >> Wedding hall.

[1:29:24] >> It was clearly the person that is suing your

client,

[1:29:31] a person that sued the

Department of Ed. He's also in the end what she

didn't know. He's been

[1:29:37] convicted of 21 felonies, but he was in this

conversation, you know, said

[1:29:43] that he is the owner a safari

and that he I was one of the lead plaintiffs on the lawsuit

against your client.

[1:29:51] So you said earlier in this

conversation that you didn't know who you are talking about,

that this in this conversation

[1:29:58] told you who you are talking

to. You are talking to the person.

So it that they had sued the

[1:30:04] state of Minnesota and said

your client and you have a duty of

fiduciary duty to protect your

[1:30:12] client who was empty and you knew they said in April

[1:30:19] that they were shut down in

April. And you and you know, in in April, that's when the

department of Ed shot down

[1:30:26] the fraudsters think stopped

payment on people. And in his case it didn't restart in the

summer. Still in December,

[1:30:35] he wasn't getting paid. So is

clear that he was one of the bad guys at the time.

[1:30:41] >> He's cut your question.

And I were running out of sorry. But but

[1:30:47] why do you say now that you

didn't know we was when he clearly told you who he was and

why are you offering help

[1:30:56] to these people to work against your client who

see agency

[1:31:02] Mr? Chen in general. >> We'll hear the hear the

facts. Madam Chair,

[1:31:08] what are the what's the help

that these people got? No help. They got the actually the FBI

and the my my the Attorney

[1:31:15] general's office and the Jet

Department of Justice got help 2 actually

[1:31:21] pursue accountability with

these people. That's the help that they got were talking

about new listening to people

[1:31:28] representing themselves as some

sort of victims in a meeting. The actual help

[1:31:34] was the was the help that my

Office Ltd to the people who convicted these people. So

that's the help that they got.

[1:31:42] No help at all. Actually, they

got convicted, which are appeared with Toomey,

which are asking is why did I

[1:31:50] sit in a meeting and listen to

people? Well, because I don't regard listening to a

constituent as

[1:31:57] a damaging thing to do, because

I'm certainly going to go back and asked my staff what's going

on here and is actually what I

[1:32:05] did. And these people have been

held accountable. Clearly, these people, the tape

that you played shows a view

[1:32:13] does show a few things, one that I listen to people.

But then I investigated

[1:32:19] demanded that they put their

complaint and some support of an email or writing to win

image the election. I clearly

[1:32:26] rejected their overture to help

my campaign somehow. And that's

[1:32:32] right there. You heard that.

I heard that. And then what else do we hear?

We heard,

[1:32:40] you know, these actually didn't

understand that even the agency they were talking about, I

mentioned DHS and yet they were

[1:32:48] talking about in the east.

So it's not cleared. Wasn't clear. It's apparent that in

that conversation it wasn't
[1:32:55] clear to me what agency they
were even discussing. They didn't stop me and say, oh, no,
no, no, we're talking about
[1:33:00] another agency. You're talking
about the commissioner and this agency were talking about this
other AC that. So it's not
[1:33:06] Clinton. So, you know, quite
honestly, I think that the premise of your conference, you
of your question is, is is
[1:33:15] faulty because at the end of
the day, yes, my staff have been working on this for about
a year. What I knew at that
[1:33:22] time is that my very competent staff
was doing a good job representing
[1:33:28] Indy E there was some dispute
between a vendor and the agency that I fully supported my staff
member in that dispute that
[1:33:37] that dispute had gone in a direction we didn't lot.
But then my agency was continuing the fight and me as
the attorney general was
[1:33:45] backing up my staff member in
supporting the agency. And then
[1:33:51] I went back to those people and
said what's going on as clear to me that the right thing to
do is to consider pursue that

[1:33:57] can the that investigation and
ultimate indictment and conviction and to support the
feds to do so. So I guess I
[1:34:05] guess I don't agree that I did anything wrong other
than to listen to people who
[1:34:11] ended up being. >> Liars in dance dance.
You did. You have a quick follow-up. Otherwise have more
people that want to let others
[1:34:18] coach Craig represented.
Eric, but thank you, Madam Chair. So I'm
we don't have that tape for
[1:34:24] this. But I have the transcript
as you do and is public and the entire 50 some minutes of
this is public. It's been out
[1:34:32] there for a long time. But one
of the things that I find repeatedly through the
transcript is mentions of MDE
[1:34:39] and the fraudsters only
literally go through step by step
[1:34:44] the how they do it. The who is
involved
[1:34:50] at the very beginning of the
tape, they spell their names. They say the crime, Mohammed
and she says she spells
[1:34:58] Muhammad. They tell you who they are.
The very first 2 minutes of the tape.

[1:35:06] It should be no surprise that
they're talking about him to eat because it's almost on
every page of my transcript MDE
[1:35:13] MDE MDE and they go through and
talk about specifically the program that was being
defrauded.
[1:35:20] And then you said, hey, tell me
more about that. And they tell you in long explanation
[1:35:26] exactly how they they say they
perpetrated the fraud without saying they were fraudsters.
[1:35:33] So I would push back on your
statement that you didn't know that they're talking about him
to eat because it if we have
[1:35:39] time to play the 15 minutes, we
played 15 minutes, but we don't have a kind of time, but it's
throughout the entire
[1:35:45] and the transcript that's in
front of me. The other thing I would say is
that
[1:35:50] your very own press release
from your agency from the attorney general's
office dated September. 26 of
[1:35:57] 2022, the very first line says
Minnesota Attorney General
[1:36:02] Keith Ellison and his office
have been deeply involved for 2 years holding feeding our

future accountable.

[1:36:11] And yet you're saying a year

later, so that would that would be an

entire year before the tape

[1:36:18] that you weren't aware of

feeding our future. And also, I would say in the tape, it

says multiple times feeding our

[1:36:24] future talks but Safari

restaurant multiple times. In fact, there's one part of

the tape that you said Safari

[1:36:29] Restaurant. I know you by your restaurant. That's what it says. That's

what you said in the tape.

[1:36:35] So I would just push back on a

lot of the things that you said because if you if we have time

to play the whole 50 some

[1:36:40] minutes, it would refute a lot of what

you're saying that Madam Chair, I'll just leave it at that as a

quick statement.

[1:36:47] >> Madam Chairman responded

that Jessie Mei Attorney General.

[1:36:52] Let me first of all, discuss

the September 2022. Presser,

[1:36:58] representative, my office sends out pressers

all the time.

[1:37:04] And in those pressers, they say

Keith Ellison, the attorney general's office did doesn't

sell.

[1:37:10] Just so, you know, I obviously I'm not the primary

lawyer on those files and know

[1:37:16] the details of that. Clearly I'm the leader of the office

ultimately responsible either

[1:37:24] asked the agency to my not

agency. I asked my office to do a job. They know the mission.

They pursue the mission.

[1:37:33] But that doesn't mean that I

know exactly what's happening on every file any more than a

police chief would know every

[1:37:40] ticket that was issued in a

given year. It's just not possible to know.

It's not the responsibility of

[1:37:47] the leader of the office to

know every action on every file

[1:37:53] in my mind clearly explains the

verbiage used in that 2022

[1:37:59] press release. It is what my

office was doing with my office is doing is what I'm doing.

So I think that is pretty clear

[1:38:07] now in addition to that, yeah, I mean, and there was up

up until that point

[1:38:16] that day and in December 2021, no, I I did not know nor would

I know the individual names

[1:38:24] that we're going to be on a

search warrant in a month after that meeting.

[1:38:30] There's a reason why they're

called search warrants. And that is because there's

searching for evidence to use

[1:38:38] in a criminal prosecution that

had not been disclosed to me. The identities of the people

who are doing it had not been

[1:38:44] disclosed to me. What was

disclosed to me was that there was an ongoing dispute between

vendors

[1:38:51] and the agency. We was I totally back my

agency. There's no one who I

[1:38:57] don't know. I don't believe

there's anybody who's going to say else and pulled us back,

asked us not to get after these

[1:39:03] people. I said, yes, get after

these people. Absolutely. And then when the information

became apparent,

[1:39:10] we've we cooperated in the in

the prosecution. So, you know, I didn't know the names of the

individuals. They were not

[1:39:18] disclosed to me. It's not

necessary for the attorney general to know the names of people who were under

investigation.

[1:39:25] >> Thank you. We take your

point, attorney general, but a leap into also wants to

still has something so quickly.

[1:39:31] Representative Rick, your

follow-up and then Le Pen to thank you. >> Just really quickly. So you

keep talking about the vendors

[1:39:37] of enders of enders wasn't

feeding our future, the vendor, and they literally said that

that's where they were.

[1:39:44] You may quickly respond if you want, if otherwise,

we'll go to leap into.

[1:39:52] >> My client, my colleague,

like to please remind ocean in for the record, my

understanding is that they

[1:39:57] administered the sites to the

vendors. I can't speak to specific tent what's being

discussed on the tape, but

[1:40:04] they're not the actual sites

themselves. If I may. Madam chair, the just just answered

the representative question.

[1:40:12] Yes, in December 2021.

[1:40:18] I mean, today, everybody knows

the name feeding future. At that time. They were not a household name.

They simply weren't.

[1:40:25] And the last legal thing that

happened is that a court made a

[1:40:31] finding and first to my client,

I didn't agree with it. We were fighting that.

[1:40:37] But I was back in my client, my
staff to the hilt. But I also simultaneous was listening to
constituents who happened to be
[1:40:46] lying. That's what you hear on that
tape. I'm sorry. >> Thank you. And just to
correct the record from his
[1:40:52] Washington, she said that the
stuff I was not a site, they were actually one of the sites.
No, I'm sorry. That was she
[1:41:00] said, Madam Chair. And yet just need
to clarify my response.
[1:41:05] >> And to represent sorry to
see representative and Nick
[1:41:11] over there that I believe she
mentioned feeding our future. She asked to feeding our future
was a sight. And I was just
[1:41:17] responding to that. Thank you. So just so
everyone's clear, Safire
[1:41:23] restaurant was a site is just
want to make sure that that's clear. And the record, OK, lead
Pinto.
[1:41:30] >> Thank. Thank you, chair.
You know, we've got really limited times just a couple of
comments, probably first
[1:41:36] regarding the the awareness of
what was going on at that time in this recording. And as I

look at the transcript, I

[1:41:43] believe in direct folks

attention, this is the AI generate transfer from he

tried. One of the one of the many areas in here is that is

that a question that the

[1:41:50] attorney general asked is

actually attributed to one of the participants where the

participant talks about the

[1:41:56] child and adult care food

program to prevent occasion and the attorney general

interruption and says, wait a minute, what is that? And he's

clearly very confused of what

[1:42:03] this what they just doesn't

know, because he's overseeing an office of 400 lawyers and

middle of the tax. His attorney

[1:42:09] who's overseeing that area just

asked some basic questions. I did listen to the whole hour

and reviewed everything.

[1:42:15] And I notice that, in fact, the

only named the commissioner, he says the commissioner of the

DHS not commission empty like

[1:42:21] it's like he's overseeing all

sorts of things. I will say that at the time I was

certainly aware of concerns and

[1:42:27] many people in the community.

My my own jurisdiction was and the DHS space is a lot of

concern that DHS, I'm sure the

[1:42:34] attorney general I suspect was

hearing and other meetings as well as concerns. That doesn't

mean they're all well founded, right? These ones were

particularly badly frogs,

[1:42:41] attended their fraudsters, hear

from other people who are honest and concerned and so

trying to sort of sort things

[1:42:46] to provide that that attention.

I'm also I'm just thinking about my own role. The county

attorney's office and Ramsey I

[1:42:52] prosecuted that put together a

sex trafficking case ended up resulting largest center

longest sentence in state

[1:42:58] history for like the 9 months I

built that case. John Choi didn't know what I was working

on, right? Only right at the

[1:43:03] very end that he find out what

ended up being this major case for us. So I'll just say, I

think the transcript and just

[1:43:09] logic would say the attorney

general has a lot going on in the course of things. I

appreciate that. It certainly

[1:43:15] sounds like and it's consistent

then right after the meeting, he looked into things and found

out, oh, my goodness, you know

[1:43:21] what is going on and wants to
make sure that then pursuing things and then and then I'll
note also the transcript that
[1:43:27] what he ends with the action
step. He's walking out with his asking questions, what's going
on. He says he's going to ask
[1:43:32] commissioner harvested from DHS
because, again, that's where kind of where his head is.
He's been asked questions, which is thank goodness he's
doing that. And then final
[1:43:39] point. Just thinking of the
timeline here and so empty. Actually notice a concern and
starts going after what turned
[1:43:47] out to be fraudsters out stuff
to know at the time that for a certainty knows there's
concern. They start trying to cut off payments and the
attorney general and his staff
[1:43:55] is representing them and the
district court sanctions and the and then says and it's true
does not say you have to resume
[1:44:02] payments but says there be a
quote, big problem if you don't. And we kind of know how
to read in court, say that sort
[1:44:08] of thing. And then later on
this, the meeting, et cetera. So I just think we can be very
proud of the actions of Andy,

[1:44:14] proud of the actions were
attorney general in this in this incident. And the other
hand, we've been talking a long time but a recording from 3 and
a half years ago. I'm grateful
[1:44:22] you attorney general for
everything else. You've talked about the beginning of this
presentation. But all the work that you're going to go after
fraudsters, not only about
[1:44:29] public funds, terms of
charities and to protect consumers from the from
business and corporate fraud as
[1:44:35] well. That's how incredibly
important work. I'm grateful to you for it and for clearing up
some of the I hope I hope the folks now had their questions
answered and confusion cleared
[1:44:43] up, but it's recording several
years ago. Thank you, Sir. Mr. Attorney General, any
response.
[1:44:50] >> Madam Chair, thank you,
Representative Pence. So I think I cannot improve on the
statement that you just made.
[1:44:57] I think it's accurate. I just
want to be clear if I am willing to work 100% with
everyone on this committee and
[1:45:04] the entire legislature on
fighting fraud in the fight with you, let's do it.

[1:45:10] One thing that's cleared,
however, is that when offered help in my campaign, I rejected
it on the tape. You can hear
[1:45:18] it. I didn't know what was
being recorded that happened and you will not find any body
in this world to say Ellison
[1:45:26] tried to back us up off of our
investigation. Nobody will say
[1:45:32] I tried to pull my team off the
investigation. I did nothing for these people.
[1:45:37] I did nothing. I accepted
nothing from these people and they were convicted in my
office played a role.
[1:45:45] No, I don't know everything but
every file the comes to the door. But I have a great team
that does I back them 100%.
[1:45:54] And I think they did a valiant
job. So Representative Pinto, thank you
for pointing those things out.
[1:46:00] I hope that we can work
together to fight fraud, waste, fraud and abuse.
[1:46:05] I'm not naive. I know that we
live in a political world, but if we can leave politics
aside
[1:46:12] and try to figure out how to
protect the public dollar, you have a partner in need. >> Thank you for that, Mister

Attorney General and and I
[1:46:19] appreciate your closing
statement. Appreciate that. You came to the committee
today. We do appreciate the work of your office. And we do
look forward to having the
[1:46:26] Medicaid fraud unit here at a
future meeting. The joint last statement I have to say, just
raised the question with me.
[1:46:33] So I'm going to quickly allow
myself a quick follow-up. So in the tape, it said you
asked them to send you an email
[1:46:42] outlining who is being sort of
harassed and that you would follow up with in the tape that
says MDE and Toni Harp said did
[1:46:50] you ever get that email? >> Madam Chair, to my
knowledge, I don't I don't I don't have
any memory. As I said here of
[1:46:59] receiving any such email out,
I'll check my records. I don't
[1:47:05] remember ever receiving any
such follow-up document. And if they didn't send it
certainly didn't remind them
[1:47:12] to. But I'll check, but I don't
think so. >> Thank you. I appreciate
that. And then did you have any follow-up conversation with
commissioner have said or can

[1:47:20] the commissioner of Mte you respond to this meeting
where you said we'll fight them all called them all. Did.
Did those follow-up
[1:47:28] conversations happen? >> No, because when I got back
to the office and said
[1:47:34] what's going on with this, it became clear that this was a suspected fraud
matter,
[1:47:41] not just a routine dispute
between a vendor and agency
[1:47:48] or the but it wasn't but was
something of a very different nature. So right there, I just
said okay and no, I didn't
[1:47:56] didn't reach out to anybody. >> Okay. And UV Utley said you
didn't do anything for them or
[1:48:01] take anything from them.
Did you receive any donations from them?
[1:48:07] >> That from anyone in that
meeting? Okay. There were people who sent me donations
that were ancillary Lee.
[1:48:14] If that's a word connected to
this, I sent the ones I'm aware of elsewhere. I actually sent a
check back to a lawyer
[1:48:22] connected to this. Once it
became clear they were in some way a part of this.
[1:48:27] I said we can't accept your
money and send it back. If it becomes aware if it

becomes clear to me that

[1:48:33] the that happened, I certainly

our our way of handling these is too find an appropriate way,

too.

[1:48:40] Send that money way. But for

the people who were in that meeting, the answer is now okay.

[1:48:46] >> And did you send the money

back to people affiliated with feeding our future that you did

receive all of it was returned?

[1:48:52] >> Again, at this point, it's it's an

inlets. They were indicted or

[1:48:59] convicted. We may or may not know how

closely are are they were

[1:49:05] associated. So what I want to

tell you was that nobody in them that meeting send us campaign donations to

my knowledge. And I have asked,

[1:49:15] I don't know the names of those

people that I have asked. And I've been told no, nobody

in that meeting donated to you.

[1:49:22] And but there was a lull in the

one lawyer who was representing somebody connected to this

situation. And I know that we

[1:49:29] sent that money back because

that particular donor coming up angry about us and the Czech

back. So I know what that I

[1:49:36] know about that one, if we have

others that, you know, will certainly. >> I'm in the right way.

If you could just follow up

[1:49:43] with me and this defendant

number, 36 and defendant number 69, did Max out to you and I

don't see any record of those

[1:49:51] being returned. So if you could

look into that, I would appreciate it. >> We certainly would do that

if we can keep. Let me just

[1:49:58] make note of that. Use it to

get the defendant, 36 and defendants. 69. 36

[1:50:04] 69 yet, Madam Chair, we certainly

will follow with that and say

[1:50:09] with the e-mail if you ever

received the e-mail perfect. But I would say Madam Chair, I

do not believe that defended 36

[1:50:16] in 16. I were in that

particular meeting. >> Right? I don't believe they

were in the meeting either just because there are ancillary Lee

tied to the investigation your

[1:50:24] office was involved in. I I

just would like to see what if anything was done with that

contribution. And I look for it

[1:50:32] also to a separate meeting with

Ms Washington about some of the charities things that I'd like

to follow up. I'm to make you

[1:50:38] very much, Madam Chairman.

Just say in closing, I think see you all having me here.

I hope. >> Some of the things that

members were concerned about

[1:50:45] try to answer the most fulsome

on a straightforward way that I could. That's why did the

op-ed. That's why I'm here

[1:50:50] today. And I also want to just

let you know that. Yeah,

[1:50:55] it is important to me that we work together to stop

waste, fraud and abuse for a

[1:51:01] few reasons. One is kuz is

wrong and number 2 because I

[1:51:07] feel that it erodes the support

for important programming which I care about. I care about

Medicaid. I want people to get

[1:51:15] it. And if there's people

believe it's a fraudulent program, I fear people won't

support the program and same

[1:51:21] way with these emergency food

programs. At the end of the day, I would just say this

stick to to members whenever

[1:51:27] there's a crisis. We also have got to put on our

detective had because

[1:51:34] fraudsters trying to make use

of those tragic incidents to enrich themselves.

[1:51:39] >> We agree and we look forward

to working with you. Attorney general. We are adjourned.

Thank you

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 05-05-2025

[0:03] >> Good morning, everyone.

Welcome to the last meeting of

[0:09] the in the House Fried Waste in

a state agency Oversight Committee

[0:15] Committee for this session.

But we are going to continue to meet during the interim.

So it's not our last meeting

[0:21] for 2025, but it is far this season of the session.

So appreciate everyone's hard

[0:28] work and really look forward to this

meeting diving into Medicaid fraud. But before we do that, I

just wanted to it's spend just

[0:38] a second thinking art, amazing

staff who have worked so hard this session to make the Fried

and state Agency Oversight

[0:47] Committee a reality. So on the

DF outside, we want to thank John Bowler and Anna Burge.

[0:54] >> Darling, word for reading.

I'm sorry for hurting for your

[0:59] team. Borgerding for give me an

A and a Burger King. Thank you.

[1:05] >> And on our side, we have

Aaron, Caitlin, like has now

[1:12] and hey Kennedy, who served

with us for part of the session and now his duties and the Ways

and Means Committee have

[1:18] overtaken. So we appreciate Lee

stepping up and of course, non-partisan Ven Johnson.

You have been amazing. We're so

[1:24] grateful. None of this would

have happened without the tremendous staff that have

served our committee. And we're

[1:29] very, very much appreciative

with that. We do have a quorum. And I would like to ask

[1:37] a representative for Eric to

move approval of the minutes from April 28th, Madam Chair

Summit chair. Yes chair.

[1:47] >> And to thank you, Madam

Chair and I I don't know if if the second presented from the

agent's office if the last name

[1:52] is spelled correctly, we can

just we'll just even if we approve this. Maybe we can just

I get that ISIS has Washington

[1:58] and not sure if this just ug

and they're not preps. People verified that there's not. >> But Mr. Cherney Channel.

Is that correct?

[2:07] Yes, the yeah. With the GOP. Yes.

Thank you for clarifying that.

[2:13] >> Thank you for your ego.

Lighter Pinto and thank you for confirming the record. So with

that clarification,

[2:19] Representative Eric moves the

approval of the April 28th minute. All those in favor say

Aye, aye. All those opposed

[2:25] nay. So those minutes are approved. And now today members we are

going to have an informational

[2:32] hearing on Medicaid fraud, as

we have talked about multiple times throughout this session

that we wanted to get this on

[2:39] the calendar. And so we are

grateful to have the attorney general's office here and the

Department of Human Services.

[2:45] I guess the Department of Human

Services, one unable to send someone because please join us

at the table because they are

[2:52] in negotiations trying to get

us out of here on the budget. So they have sent a slide deck

that's in our packets. But

[3:02] today we're going to hear from

that and Attorney General Keith Ellison and his staff. And we

very much appreciate that.

[3:09] And just say, you know what,

this is the first portion of the hearing and then we are

going to pivot to looking at

[3:16] the 2 bills that we have put

together based on all the testimony we have had this

session. Our committee has to
[3:22] committee bills that we are
also going to talk about and that will be at the end of the
hearing. So just one off like
[3:28] that for every once. And with
that, we welcome you to the committee, Attorney General
Ellison, please state your name
[3:35] for the record and you can
begin your testimony. >> Good morning. Chair Robbins,
vice chair and his son and the
[3:41] FL lead 10 tall and members of
the committee. As you know, my name is Keith Ellison and I
serve the residents. The state
[3:48] of Minnesota as attorney
general, the state of Minnesota. Thank you for inviting my
office to give a presentation
[3:54] on the Medicaid fraud control
unit. I'm always proud to share the
work happening at the Minnesota
[4:00] Attorney General's office and
the work they're doing to help Minnesota us every day.
[4:05] I'll be turning the
presentation over to Nick Waca who sued to my left. He's the
director of the Medicaid
[4:11] control fraud unit into John
Keller chief deputy attorney general. But I want to set the

stage for the presentation they

[4:18] are about to hear as you'll hear multiple times

today. I'm sure that men in Minnesota and

[4:25] and until and unless the

Legislature sees fit to expand their authority, the attorney general's office

says original jurisdiction to

[4:31] bring a criminal case. Again,

someone in only one area of work, Medicaid fraud.

[4:39] Our investigators and

prosecutors are good at what they do. They spend 100% of

their time investigating and

[4:45] prosecuting Medicaid provider,

fraud and the abuse, neglect

[4:50] and financial exploitation of

vulnerable adults residing in certain settings

[4:55] work. This unit is a great

value for Minnesota in terms of the state budget is one of

these units is funded by

[5:01] federal grant from the

Department of Health and Human Services Office of Inspector

General.

[5:08] That grant covers about 75% of

our funding. The state pays remaining 25%.

[5:14] And for the 25% match, this

state gets a great return on investment

[5:19] over the past 5 years minutes

that Minnesota has only spent about 5 million dollars or

non-medical Medicaid control

[5:26] unit in that same time, the

unit one 53 million in restitution and recoveries.

[5:34] But I want to emphasize that

the greatest value of this unit far greater than any budgetary

value is the work they do to

[5:41] protect Minnesotans from being

defrauded from being exploited it and most importantly, holding

those who abuse neglect and its

[5:48] plate vulnerable Minnesotans

accountable. And with that, I'll turn it

over to Nick Walker and John

[5:54] Keller. I do have a schedule this

morning. So I will excuse myself at this time. Madam

Chair, but thank you for having

[6:01] us. Thank you. >> For taking the time to

commit an attorney general, we appreciate it. We appreciate

your work and your team.

[6:07] Thank you. >> We're going to work out an

HDMI issue and I will start

[6:14] shortly. >> Thank you. Is someone from

our tech team helping you Sierra and she available.

[6:21] Just plug it into the other this year. Okay. She'll she'll come to the

rescue. Sees fantastic.

[6:29] Perfect,

[6:47] Mr. I sit there.

[6:56] And while members, I just want

to draw attention to things that Department of Human

Services sent in your packet.

[7:02] So there is and this is

available online for anyone watching. There is a list of

Medicaid

[7:09] medical assistance, eligibility

requirements. And then there's a small slide deck from the

Department of an

[7:15] administration. And I believe

[7:21] there's also the income

affordability guidelines for Ma from the Department of Human

Services. So I think all of

[7:29] those will be helpful in our

discussion.

[7:49] So it's an unsolvable. Just got

your paper copies, right? Y'all have paper copies and

they're also available online.

[7:55] So we'll look forward to your

presentation. Please start by stating Your name for the

record there.

[8:01] Good morning. I'm Nick Wonka. >> And I See K W and K I'm the

director, Minnesota's Medicaid

[8:07] Fraud Control Unit which is

housed in the attorney general's office and before I begin discussing

who we are and what we do.

[8:14] I want to thank you all for

inviting me here today. Medicaid fraud is a critically

important topic and it's great

[8:20] to see you all discussing these

issues and possible solutions in a public setting like this, ensuring that the taxpayer

dollars you dedicated to

[8:28] providing critical health care

services to Minnesota's most vulnerable people actually go

to that purpose

[8:34] and not to lining the pockets.

Fraudsters is among the most important functions of our

state government.

[8:39] And I'm happy to be here today

to talk to all about what we in the Medicaid fraud control unit

due to hold people accountable

[8:46] for stealing those funds that

should be going to caring for people who need it and what can be done to help us

in that shared mission that all

[8:53] of us have. Now before I get into the stats

and details about the things

[8:58] that we do and things that we

don't, I want to highlight some cases

examples for you to help better contextualize

what it is we do on a

[9:05] day-to-day basis. And some of

the cases that we bring some of you already know.
And as I hope all of you know,
[9:13] when we're done today that the
direction the federal government, we in the Medicaid
fraud unit handle 2 categories of cases,
[9:19] provider fraud and what the U.S. Department of
Health and Human Services calls patient abuse, which here in
Minnesota is abuse, neglect and
[9:28] financial exploitation of
vulnerable adults. Our unit does both and we do
both. Well,
[9:34] for instance, let's talk about
some of our provider fraud cases. In one example, we have a home
care nursing agency.
[9:41] They're supposed to be
providing home care, nursing services to residents
throughout Southwest and Southeast Minnesota.
[9:47] In some instances that includes
children under the age of 5 and other instances, it's
elderly adults.
[9:54] But in all cases is people with
serious medical issues, a four-year-old boy with a
feeding tube,
[10:00] vulnerable adults who are not
ambulatory people with serious medical
conditions who desperately need

[10:06] this care. But instead of providing that
care, you have the person who manage the agency stealing from
the Medicaid program
[10:13] to the tune of 1.8 million
dollars when that kid needed 6 hours
and nursing services in a day.
[10:20] The manager built for 24 hours when that vulnerable adult
needed. 24 hours of care from a
[10:25] registered nurse that manager built for over
2000 hours when she sent out an unlicensed home health aide to
do work around the house if
[10:33] anyone showed up at all and when we found out, we
investigated, we prosecuted.
[10:39] We took her to trial and we
convicted her and we held accountable. Then you have the mental health
therapist who provide services
[10:46] to groups of people with every
mental health condition. You could think of
[10:52] these are people from all
backgrounds, some from war torn areas of the
world, some from right around the corner from his office in
Anoka,
[11:00] all of whom are struggling with
their mental health and rather than providing it and giving
them what they need. What did
[11:05] he do? He built for services. He

wasn't providing. It's in the group session with
6 people. Then Bill Medicaid is
[11:13] if he provided individual
services to 8 licensed therapists open a new
clinic where instead of
[11:20] providing mental health
services, they have people stop by to
drink tea, then be transported home after a couple minute.
[11:26] And at the end, his enterprise
defrauded Medicaid of well over a million dollars and he was found guilty and
held accountable for that,
[11:33] too. And as I also mentioned, we do what we called patient
abuse neglect cases. These are
[11:40] some of the most
heart-wrenching that we see cases that we get from county
attorney to ask for help.
[11:46] For example, woman came out of
Chippewa County Montevideo, an elderly woman whose son is
supposed to look after her
[11:52] finances as the conservator. She's in the last few years of
her life living in a nursing home and sitting on hundreds of
thousands of dollars in her
[12:00] account and family farm. What is their son and
daughter-in-law do? But take care of her.
[12:07] Her nursing home bills don't
get paid. She doesn't have personal needs

that money to buy basic things

[12:13] like socks, toiletries,

toothbrushes, her farmland that was worth

hundreds of thousands of

[12:19] dollars gets deeded over by her

son to his wife are less than $500.

[12:24] And when her nursing home bills

go unpaid, she no longer has a place to live. She's a victim.

72,000 $1 in the Hole of

[12:31] nursing home. Meanwhile, the son and

daughter-in-law make away with the money

[12:36] they take or debit card to dog shows. Another states

spend thousands of dollars of places like hot topic in

Walmart.

[12:44] She passes away and score. We took that case in Chippewa

County after the county attorney asked us to

[12:50] we held them accountable just like we've done with other

counties. There's the Representative

Payne who stole over $50,000 in

[12:58] Social Security benefits years.

He was supposed to be taken care of 25 separate people whose funds

he was supposed to safeguard

[13:06] because they were incapable of

handling their own money. People in memory care unit to

kind of him to do that.

[13:12] 25 people who lost their money

so this guy could spend it away. Places like running is

[13:18] we took that case. Mississauga

County attorney asked us to we took it to trial and we held

him accountable as well.

[13:25] And if you pay attention to the

news out of Central Minnesota, you'll hear about another case

for prosecuting later this week.

[13:31] It's about a mom. He's about to

go on trial for some of the most horrific medical child

abuse our state has ever seen.

[13:37] She did. That will also

defrauding the Medicaid program about the care she was

providing to her kit.

[13:42] That case came to us after the

Crow Wing County attorney asked us to and we have 2 great prosecutors

who are about to go on trial

[13:48] and brand new this week to hold

her accountable. And those are just a small

example of the cases we

[13:54] prosecute in the Medicaid fraud

control unit and the work that we do every

day.

[13:59] And now that you have some

examples of the work we've done, here's a little bit about

who we are.

[14:05] Our Medicaid fraud control unit

has existed for over 40 years. We want to 53 in the country.

Every state has one as the DC

[14:11] Puerto Rico and the U.S. Virgin

Islands for Law Enforcement entity in

the sense that we investigate

[14:17] and prosecute our own criminal

and civil cases. We have 32 people on staff that

are comprised of attorneys

[14:23] investigators, analysts,

paralegals and legal support staff. Each one of us is funded by

federal grant from the

[14:30] Department of Health and Human

Services Office of Inspector General. That grant cover. 75 1% of our

funding comes with conditions

[14:37] on what we can and cannot do. It requires us to spend 100% of

our time investigating and

[14:43] prosecuting Medicaid provider,

fraud and the abuse, neglect and

financial exploitation of vulnerable adults residing in

certain settings.

[14:50] The Office of Inspector General

also frequently issues policy guidance to think isn't that

guy says public can posted on

[14:56] Org website what we do and what we're

supposed to be doing

[15:02] and what we can and can't do

with the money the federal government gives us is covered
by federal regulations. We can
[15:07] investigate and prosecute
Medicaid provider fraud. And as you've heard, we have
concurrent jurisdiction under Minnesota law to do that
[15:14] and we can investigate crimes
that arise out of the same set of circumstances, certain ones,
most often of which are other
[15:20] financial crimes like money
laundering and identity theft. So that's how we do those cases
against the home Care nursing
[15:27] agency manager or the mental
health therapist or the PCA Services agency owner whose
federal excluded because of a
[15:33] prior conviction for Medicaid fraud. It then finds strong ours to
run their companies on paper.
[15:39] Does the scheme scheme they did
before and feels millions of dollars
from the taxpayers?
[15:45] We can also be patient the U.S.
and like cases, if the victim either resides in a facility
that receive Medicaid funds
[15:51] like a nursing home or if they're abused by a
provider who is providing services to them in the
victim's own home.
[15:58] And as I mentioned, we do lack

original jurisdiction for these, but we take them on
referral from county attorneys.
[16:03] As you heard, some small
examples of these are some of the saddest most
heart-wrenching case is that we investigate and prosecute.
[16:10] Finally we assist other law
enforcement agencies when they requested. We regularly work with our law
enforcement partners at the
[16:16] U.S. Department of Health and
Human Services Office of Inspector General, the FBI and the Converse Fraud
Bureau, which is now the state
[16:24] Friday and that the BCA, they're all fantastic partners.
And when we work together, we're able to bring great cases
that hold fraudsters
[16:31] accountable, as has been mentioned with the
federal grant federal
[16:36] requirements come certain
prohibitions, too. For instance, there's just
certain cases we can't use federal funds to investigate or
prosecute certain activities
[16:44] that we can't do. We can't do recipient fraud,
for example, fraud in obtaining benefits.
[16:50] We can't do other crimes that
may arise out of the same set of circumstances. For instance,
if we execute a search warrant
[16:55] at a health care company and

find drugs or guns, which you may not think would happen.

But has

[17:01] we send that to local law

enforcement to bring the county attorneys? And last year federal

regulations require us to be

[17:07] entirely separate from the

agency that administers the Medicaid program, which here's

DHS

[17:12] so we can prosecute it but we

can turn off payment on the front end or bar certain

provider from rolling with

[17:18] Medicaid are continuing to

receive payments. We also can't investigate or

prosecute as I mentioned,

[17:23] fraud in obtaining benefits or

through other public programs.

[17:31] There are some examples of

cases in your hand out that we've done on different

provider types.

[17:36] You'll see that big. They cover really anybody who could be a

Medicaid provider from licensed professionals to home care

agencies to other treatment

[17:44] providers. In other words, if someone's a

Medicaid provider there within our and

[17:52] how do we get our cases? Well, they come from different

sources. But the most common is the Department of Human

Services who's Medicaid

[17:59] provider, audits and

investigations division refers them to us after they conduct

their own administrative

[18:05] investigations. We also get a lot of our cases

from managed care organizations

[18:10] and their special

investigations unit. Those apps. I use the acronym

for Special Investigations unit

[18:16] investigate provider Friday

CEOs and may send us referrals that we then investigate and

prosecute.

[18:23] We also get cases from other

law enforcement agencies, other state agencies like the

Department of Health whose team

[18:29] service nursing homes and

assisted living facilities and the temps we get from the

public.

[18:35] Our team is house with

investigators and prosecutors from a number of different

backgrounds. We have former

[18:41] assistant county attorneys and

former law enforcement officers like you probably expect.

[18:46] We also have people from a

number of other disciplines, for instance, for attorneys.

We have skilled so litigators

[18:51] who him are false claims Act
cases and our staff includes multiple
levels of investigators as
[18:57] well. We have a supervising
investigator who manages them and does a fantastic job of it.
[19:03] We have an auditor that
required by our federal regulations. We have lead investigators who
are some of our most
[19:09] experienced people under most
complex cases. Nurse investigators who put a
lot of time into our abuse and
[19:16] neglect cases. We have a lead analyst who does
things in excel that quite frankly, I can explain to you
without bringing them in here
[19:22] myself and our staff comes from a
variety of backgrounds summit. I mentioned you may expect like
former law enforcement officers
[19:31] but other backgrounds as well. Staff who previously
investigated health care fraud, private insurance or other
state agencies.
[19:38] Former military members who
served as military police now investigate crimes for us in
the civilian world,
[19:44] former financial fraud
investigators who can review and follow money. But those are just some
examples of the talented team

[19:50] that we have that like every
other Medicaid fraud unit throughout the country dedicate
all their time and effort to
[19:55] protecting program integrity and vulnerable populations by
holding fraudsters and abusers accountable.
[20:03] Now our size of 32 is set by
the federal government. As I mentioned, they pay 75% of our
cost while the state pays 25%.
[20:10] So it's a pretty good deal for
Minnesota. Each Medicaid fraud unit sizes
based on the size of its state,
[20:15] Medicaid budget. So California
has a much bigger Medicaid budget. They're going to have a
much bigger Medicaid fraud control unit
[20:22] and based on our state Medicaid
budget. Our size is supposed to be 41.
[20:27] It's still 32. It hasn't grown
like our state. Medicaid budget has over the last 5 years.
[20:33] And as you can see from this
from our slides when our state Medicaid budget is expanded,
our Medicaid fraud unit has
[20:38] not. And our state Medicaid fraud
unit has a smaller staff size another Medicaid fraud unit
with similar Medicaid budget.
[20:47] Again, this to hand out shows
with the exception of Missouri other states with a similar

size, Medicaid budget to

[20:52] outpace U.S.. And in some cases

fairly significantly, you can see from Virginia, for example.

[20:59] But even with that, we get

results. We regularly outpace other states, number fraud,

convictions and charges we get

[21:05] and bring this included 2024

when we had 58 provided fraud charges, which is 5th in the

country.

[21:12] When you ask what you can do to

help us all says first step is to pass the Medical Systems

Protection Act

[21:18] that will allow us not only to

grows. We should be in line with the recommendations with

the federal government, but it

[21:23] will also implement the policy

changes. We are asking for more people

just to keep pace right now.

[21:29] The funding attached to that

Bill will get us to 41 people, which is where we should be

based on the federal

[21:35] government's recommendation. And the policy change will be

helpful to our prosecutors.

[21:41] Investigators to right now, the

current version of the medical assistance fraud statute has

gaps and as insufficient

[21:47] penalties when compared to
other financial crimes. For instance, the current fraud
statute, the way that it's run
[21:53] only applies to claim submitted
to the state agency that MCS. Now we still prosecute fraud
again. Some CEOs don't worry
[21:59] about that. We've done that for
years, but we have to use other statutes do it. And those
aren't as articulate or clears
[22:05] the statute. The map Act would
be the statute, as I mentioned, is
drafted by the prosecutors who
[22:11] go into court every day and
fight to hold fraudsters accountable and enacting it
will help them in their efforts
[22:16] to do just that. And finally, there's some other
provisions. Most prominently
[22:21] increased subpoena authority
when the Medicaid fraud unit is conducting provider fraud
investigations.
[22:28] This would give us the same
power the county attorneys have when they conduct welfare fraud
investigations. No more no less
[22:35] investigating. Agency is
conducting provider for investigations. Should have the same power is
those conducting beneficiary

[22:42] fraud investigations and that's
what this would do. She brought me here today to
answer number questions.
[22:48] Like I said, thank you for
doing that. I'm happy to be here. But before I do, I just like to
make a couple things clear as
[22:55] possible. First, I'm not going to be
discussing ongoing are active investigations or in specific
investigative techniques we
[23:01] use. That includes even confirming
whether particular provider is under investigation. And I
don't mean to be disrespectful,
[23:08] but I'm not going to jeopardize
the integrity of any ongoing investigations today because
that is unfair to the investigators and prosecutors
working on the case. And I it's
[23:16] quite frankly, not what any of
you want to happen either. I would imagine you're hearing Republican as
they should be. I want to give
[23:24] any fraudster tuning in any
advantage over our investigators
[23:29] next. I'm more than happy to
talk about fraud indicators and what we see is high-risk
providers.
[23:34] But I will catch the virus
providers with the cabinet as well. I can only talk about the cases

that we see,

[23:40] which is those that are

referred to us by various different sources. We in the Medicaid fraud unit,

as I've said, or the

[23:46] investigators and prosecutors, we don't have access to the

same source data that some of our working partners like DHS

and managed care organizations

[23:53] half we don't have real-time access

to claims data submitted by health care providers.

[23:59] We don't have real-time access

to payment information to the point that we can run queries

on what providers are being paid the most in different

intervals

[24:06] for which providers have seen

the largest jump in their reimbursements in the past 6

months or things like that

[24:13] because where the criminal

prosecutors, we have to get that information either from

our working partners gathered

[24:18] through constitutionally

sufficient means like search warrants. So if you're asking about

high-risk providers, I want to

[24:24] be able to talk to you about

what we've seen and what our view is. But that's going to be

necessarily restricted by the more limited information that

we have as compared to some

[24:31] other people. So with that, I look forward to
your questions. Thank you.
[24:37] Thank you very much for your
testimony. >> I'm sure we have a number of
questions. I'm in a leadoff.
[24:45] First of all, thank you for
that overview of what your agency does. And for the work
of your team, you have had
[24:51] success in prosecuting Kate
Fried. And we're very grateful for that.
[24:56] I appreciate a discussion of
the bill that's currently working its way through the
process and have that would
[25:01] help your team. I think first I I would just
like to talk about this access
[25:07] to real-time data. Is that part
of that proposal? >> No, it is not.
[25:15] There are certain restrictions
that come from federal law on what we can and can't access
through DHS. There is a
[25:23] deliberate scheme that was
enacted by Congress when they set up Medicaid fraud units
that we would be entirely
[25:28] separate from them. That's why we don't have that.
[25:34] >> But if you do get a search
warrant, are you able to get real-time access or is it still

subject to?

[25:40] >> It's going to be very it's

going to be delayed. I mean, we can we can send over

requests the DHS and say,

[25:46] hey, can you give us all the

claims submitted by this provider for the last year and

from that, if we were to set it

[25:52] center today, May 5th, right?

We may say everything up through May 5th and they'll

send us everything up through

[25:57] May 5th, but we won't get it

going forward on an ongoing basis if that makes sense.

[26:02] >> Yes. And so is that

something that you are working with our federal delegation on

or

[26:09] >> is that good? I don't know

that there's an interest in Congress and changing all of

these Medicaid for and

[26:14] regulations right now. You

know, Medicaid, private, a a chainsaw says going affect

all 53 of us. There are

[26:22] provisions that could

theoretically allow it through what's called a data mining

labor

[26:28] that is contained in federal

law. And that's something that we internally

[26:33] have to work with it at the
Office of Inspector General on. And we've had those
conversations with them and other Medicaid fraud units
throughout the country
[26:41] who have obtain that data
mining waiver. There's a lot of initiative that it died
[26:46] not going to do it today, but
but yeah, there's there's a provision in the federal
regulations for something
[26:52] called a data-mining waiver.
It wouldn't give us identical access, particularly if it doesn't
cover payment information that
[26:59] would be held by another
agency. But if we look at real-time data,
[27:05] it wouldn't be a perfect
substitute for it. But what it would allow us to do is go in
and say, hey, this provider of
[27:12] housing, stabilization
services, right? Just picking one that was in the news. Please give us the highest bill
providers of this for the last
[27:20] 2 years. That would be that
would be necessary through a data-mining waiver for our
investigators to go in and look
[27:26] at that themselves. >> Thank you. And just one more
follow-up if I get my
[27:32] colleagues. So it's you can't have access to that

data. Does

[27:40] DHS regularly look for those flags?

[27:47] >> I that's a question for DHS.

I mean, I can't talk about I and I'm not trying to be cage.

I don't know how they conduct

[27:55] their own internal data mining.

What I can tell you is that if we ask them for something like

that,

[28:01] they will get it to us. Okay. >> And if would that be

something where you as you know, both the governor and the

legislature looking at

[28:08] inspector general creating an inspector general

office that might have that oversight and can work between

agencies and among agencies

[28:16] with that the type of authority

you think we could potentially

[28:22] house in an inspector general

officer, would you support something like that? >> I would have to look more at

the federal regulations.

[28:28] I I will tell you that there

are our number of other states as you know, that have

inspector generals. Yeah.

[28:35] What they do with that data

would probably be similar to what we could do under federal

law. I can't speak to say a

[28:40] lot, but I that's something

that I would need to look at the actual regulations and have in front of me to give you that appropriate answer.

[28:46] >> Okay. Well, I appreciate that. And perhaps, you know, the people working and that it bill could follow up because I think the more that we're looking at the whole enterprise

[28:55] and having agencies talk to each other and flag these different anomalies, it's, you know, going to help us. I get

[29:02] ahead of this in different areas. So thank you, Ty Group that. Thank you. Thank you. So with that, Representative Elkins.

[29:08] >> Yes, thank you. Madam Chair, just on on this subject, actually just wanted to make the committee aware of things

[29:14] that are kind of going on in this area and the background. So the Minute Technical Advisory Commission, which the

[29:22] legislature created a few years ago has constituted a data

[29:28] sharing subcommittee. I'm not active member of that subcommittee. And some of these issues are under active

[29:36] exploration in particular is as part of the the breakup of DHS and DC why

[29:45] and direct services. There was

an extensive legal analysis of

[29:51] what are really the the

limitations on data sharing, especially related to a DHS and

its sister organizations.

[30:01] And I can say that the

preliminary investigation indicated that a lot of the

data sharing restrictions are

[30:08] really as severe as that they

were a match. And I mean, we have a a big problem generally with

data silos and in state

[30:16] government. But when those

contracts with the federal government were examined in

more details, it was discovered

[30:23] that most of the contracts are

with the state of Minnesota, not with DHS, for example,

[30:28] we're also in that subcommittee

looking at very closely about, you know, what would it take in

order to make it easier for

[30:35] state government to to share

information of this nature? You know, for me, EU members of

this committee of the Red,

[30:42] lots of Ole reports this year,

the one that was the most eye-opening for me was the one

on the front line worker pay.

[30:49] And that was because it it

required in order to execute that program in about 5 months,

it were required. You know,

[30:57] the idea lie minute and revenue

too very quickly within the

[31:02] course of 5 months stand up.

I'm integration of the data across those sources in order

to execute the program.

[31:11] Actually, I think, you know,

and the big scheme of things considering what they did, I

thought it was pretty remarkable and the level of

fraud that resulted we which we

[31:18] knew there would be some was

relatively modest in terms of, you know, what the the effort

that was required. And I

[31:27] personally went back to a

minute. Commissioner Derrick Thompson said Tara, quiet, this

was an extraordinary effort.

[31:36] Why can't it be ordinary? And so I let some of the

discussions that I've been

[31:42] having with that agency it

staff with with minute. We're now kind of, you know, moving

in a direction of let's say,

[31:50] why, why can't this be

ordinary, you know, well, you know, protecting the

privacy of people's data and,

[31:58] you know, a lot of it in, for

example, the data could rest in place where it is to be

accessible to other agencies,

[32:06] prove through what are called,

you know, data services, what you just make out a call

to say, what is this person's

[32:11] income or is this person dead

or not? Does this person have a Social Security number which

doesn't involve lots of flying

[32:19] of, you know, masses of data

around like is being done by doge right now. So it's limited

its focus to individual cases.

[32:26] But you should be able to make

these kind of Corey's which have a huge impact on on on

fraud in real time

[32:34] just as the as the data is

needed. So I think by the time we get to come back together

early next year, we'll probably

[32:42] have been way down the path to

figuring out a road map, you know, for premium to do

some of this staff. But all

[32:49] note also that time keep

components of that have not been funded by the legislature

so far. So DHS, for example,

[32:57] had a proposal to stand up

what's called a master data management solution, some

master data management for

[33:03] clients into something that DHS

has always struggled with is just keeping track of that.
Who are their clients making
[33:10] sure that they have a single
record in the in their system for each client.
[33:15] They requested that money to to
stand up a master data management to get a golden
record of the client 2 years
[33:21] ago. And we didn't find it this
year. I would note that the governor's proposal had and a
fund to funding to pursue
[33:30] artificial intelligence to
scour the D H S databases for fraud. And that that doesn't
look like we're going to fund
[33:37] that this year either. So if we really really want to,
you know, bring the best technology to bear on some of
these problems. We have to be
[33:45] prepared next year when we come
back to step up to the plate and fund some of these things
that we're really going to be serious about fraud, because it
can't just be a whole bunch of
[33:53] arms and legs, you know,
working harder to get this out. This problem under control.
It's going to require some
[34:00] investment in it
infrastructure. >> Thank you, representative
out and Senate and I agree with

[34:06] a lot of your comments. I've
had a bill for 6 years to have an enterprise wide grants
management system put in place
[34:13] and I do hope I know many
agencies are working on this. And my hope is that we actually
get something that does work
[34:20] across the system so agencies
can see providers or people that have had trouble or people
that have, you know, failed in
[34:29] different aspects of grants,
management and gets flagged for other agencies. So I know a lot
of agencies are looking at
[34:35] different aspects of data, but
we need to make sure who has ever is working on it. And your
task force and other groups
[34:41] that we're looking at some
things that we are putting money into that will work
across the enterprise. So I I
[34:48] look forward to seeing more of
your work and appreciate your hard work on that. And also
you're concerned about data protection which I know we all
share.
[34:55] Thank you, Representative
agreement. >> Thank you, Madam Chair.
And I really appreciate being
[35:01] here as the chair would tell

you, I've been saying for 2 or 3 months, be great to hear
from, you know, and got to hear
[35:08] the presentation of your bill
in public safety and other places are one of the pieces I
want to just wanted to clarify
[35:17] something and then. >> And to get to the then heart of the issue that I think
we're looking at, which is
[35:24] like. >> How do we study the system
of fraud? I think we're thinking about when we think
about recommendations,
[35:30] obviously not just asking you
all asking the agencies asking investigators have to as
[35:35] >> asking both at the federal
and the county level. But we're trying to get to, you know,
there's tools we have that can
[35:41] deter and and disrupt. And then
there's tools that we have the
[35:47] kit prosecutors and
investigators the ability to find and hopefully and punish
as both a deterrence, but also
[35:56] to deal with folks with that
act or so. But those are we know that there's a broad range
of tools. I think oftentimes in
[36:02] this conversation we have had
conversations about the policy without connecting it to
what folks like you're actually

[36:11] seeing on the ground. And
that's one of the reasons I'm really excited to have you
here. One thing I just want to
[36:16] clarify, though, because they
heard it. I think we oftentimes conflates a lot of different
things and I'm wondering,
[36:22] are you mostly looking at
grants and grants to nonprofits? Is that something
that you do?
[36:30] >> Sorry. I know that
scientists want to please proceed.
[36:36] >> No, we do. Medicaid provider
fraud that not not profit Grant.
[36:43] >> Representative King, thank
you, Madam Chair. And I really appreciate that because I think
when I talk about private
[36:48] providers and when we talk
about Medicaid providers, >> there is a set of tools that
are not about nonprofit grants,
[36:57] that that is a whole different
thing. I think oftentimes in this committee we complete
them. But we need to actually
[37:03] look at the problem of trying
to solve. So it feels like we hear a lot about overbilling
about strong owners. I want to
[37:13] sort of push to aside the

really personal but individual cases. I think when you talk

about the neglect, but looking

[37:20] at was it our our farmers?

Yes. Attorneys to the talked

[37:25] about us 3 different types of fraud.

He talked about to the small,

[37:31] bought some screws up the

extent we get something and then they continue to get it.

He talked about sort of small,

[37:38] low level systems fraud and

then he talked about and I think this is where most of our

folks have been. It's like

[37:45] folks who see a system and

figure out how to create yeah,

[37:51] Exploited Creek government of

the profit center using illegal tools. And so that's the

business model of fraud that

[37:59] we're really looking at.

And I'm wondering if you have thoughts both on where we are

tend to see that over and over

[38:08] again. But more importantly, I

think is we want to be able to understand the business model

so we can look at those tools

[38:15] of how do we actually detected

earlier? How do we close the

[38:21] places that can be exploited

and more generally like, how are we looking at folks who
have built, you know, systems,
[38:28] whether it's straw purchasers
and other things, too, actually create a bigger
[38:35] system of fraud. >> I know that's a big question
for waiting 3 months for you to be here. But if I'm happy to
make those into smaller chunks,
[38:43] but that's sort of where at
where we've been thinking about. I've been just so okay.
[38:48] >> Sure, I'm trying to figure
out where to start with that. I mean, I think as a general
matter, you know, anytime you
[38:55] have a new program come on
mine, particularly if it's an unlicensed program with low
barriers to entry,
[39:04] that's going to be ripe for bad
actors to look into. You know, you whenever a new program
comes online,
[39:13] number one, it's probably
coming online because there's been a demand for services or
you're going to see a lot of
[39:18] people who want to get those
services. Number 2, if it's not a license program, it's a lot
easier to sign up and start
[39:24] getting reimbursements sooner.
And number 3, sometimes there's not as much oversight of new

programs initially when it

[39:31] comes on line is there should

be and part of that can be, you

know, related to how the

[39:36] regulations are written.

If their broad regulations in the focus is primarily at least

at first time getting people

[39:42] services, then that's going to

be easier to justify both the reimbursements for and it's

going to be more difficult to

[39:48] prosecute later or to

investigate, because essentially, if you have a

program where essentially like,

[39:54] look, if any type of services

being provided of someone's present with you, we're going to reimburse it.

I mean, that makes it hard for

[40:01] us right for us to prosecute a

case. We have to have a very from statement that can

hold up in court and that we

[40:09] can present a witness to in

front of a jury who will say we would not pay for the service

was delivered. Right. Like,

[40:15] for instance, I brought up the

home care nursing agency case. If you have someone who's

supposed to get services from a

[40:20] registered nurse and you sent

out an unlicensed home health aide to do it, that's not going to be reimbursed. That's clear
[40:25] fraud, right? But you need a witness who's going to come in and say that where is if you have a more murky here
[40:31] type of regulatory structure where, you know, that's going to be more difficult case to both withhold payment on and 2
[40:38] later prosecute. So I think when you have those new programs come online, that is one area,
[40:46] you know, for years we've had I mean, we've had cases with all sorts of home care fraud and within them, that's going to be
[40:53] another area that's going to just be ripe for abuse because it occurs in someone's home outside of the view of, you
[40:59] know, the general public or any licensed professionals. So those are other areas in, you know,
[41:05] one thing with respect to the home care services is >> particularly, you know, PCA services a number of years ago.
[41:12] You all put additional regulations in place on an additional statutes. One being that, you know, all PC A's have

[41:20] to enroll as Medicaid
providers, which means that the companies have to identify the
provider when they submit a
[41:28] claim for reimbursement. That is 8 good fraud mechanism
in place because then if you
[41:34] have DHS, they can say, hey,
look, this person is providing
services to this climate the
[41:39] specific time and they can't be billed also
by another agency for providing services to another client.
On the same day,
[41:47] those typo, that type of oversight is
not present with most home care services you don't require,
[41:55] for instance, providers of home
and community-based services which are waiver services to
enroll as providers. And I
[42:02] mean, from our perspective,
there's not a good reason for that because home and
community-based services reimbursed at a higher rate
than PCA services, but they're
[42:09] less of a similar nature and
that they're provided in someone's home and can be
provided for up to 24 hours a
[42:15] day. And when you don't have
that type of enrollment structure, it is more ripe for
fraud. The same is true of

[42:22] other home care services.
Adult rehabilitate a mental health services are another one
where you don't require people
[42:27] to enroll as providers. That's
another area that we have seen quite a bit of fraud in over
the years. And so that's just
[42:34] one example are a couple examples of areas
where we see that the home Care
[42:40] nursing agency case. Nurses
aren't billed in the same way that PC Azar and they're not
enroll in the same. So, you
[42:46] know, and I don't want to take
up, you know, the entire time talking about this minutiae.
But that's just one example
[42:53] that we see as prosecutors and
investigators is an area that, you know, could really be
addressed by you is to look at
[43:00] the enrollment requirements
that you have for personal care assistant and place them on all
home care providers, because
[43:06] that's going to go a long way
to eliminating some of those things on the front end and
making it easier to investigate
[43:12] and prosecute when there are
still fraudsters who are trying to steal money. >> Thank you. That is an
excellent suggestion and we

[43:18] look forward to all of your
suggestions in that vein or other veins for you have
specific things like that where
[43:24] we could take action. That's
that kind of roll that we're trying to play
to fill gaps in statute that
[43:30] would provide the tools for
better oversight and prosecution. So thank you for
that, Representative Rudman.
[43:35] >> Thank you, Madam Chair.
And thank you. And that and I agree with that chair. I have
another question sort of in
[43:41] that can end, you know, not all
of these services, right? We're talking about potentially
health care, whoever else,
[43:48] some of those services can be
provided by by public by government. But some of that
can leak when we're talking
[43:54] about some of these their
counseling, they sound a lot like social workers that the
counties of the in some cases
[44:00] the state have Representative
Anderson and I have been talking have had a conversation
about in some cases bringing
[44:08] the transparency of government
of government provided services

[44:14] may be an option. I'm wondering
if in the Medicaid fraud space, if you actually have seen fraud
when it comes to the kinds of
[44:25] things for the Medicaid system,
even at the social work level that exist that are provided by
public infrastructure as
[44:33] opposed to private
infrastructure, Mr. Want to
[44:39] we. >> Investigated and prosecuted
public employees before.
[44:48] Does that into question? >> Representative Goodman,
thank you. I guess I'm asking and that that is I think you
should investigate prosecute
[44:55] wherever it comes. I think what
we're thinking about from a systems level is to your point
about, you know, whether it's
[45:02] one of the things that
licensing does as you talked about or that putting providers
is it just provides a level of
[45:08] transparency that we may not
have into whether it's a for-profit provider, nonprofit
provider when they're not when
[45:14] they're one or 2 steps removed
from us. We don't seem to that business so we don't see into
that business model. So I guess
[45:20] I'm asking in terms of as we

think about tools, one of the things that I feel like when we see these big numbers in these
[45:28] big business model, the fraud I just looking at whether you
[45:33] look at what we see in the news, what has come across or our desk in the L a it seems like most of what we're talking
[45:41] about, his private providers. And I'm wondering if that if there's a structural piece there are, if it's just
[45:47] something different, I mean this to want to. >> I think that that's just the way that the Medicaid program
[45:54] is set up in Minnesota. You know, most of the providers are private providers. I mean,
[46:00] >> we there is a public peace in the way that the services may be authorized by public health nurse or something like that.
[46:09] And I mean, we've seen issues there, but it hasn't been as common, at least that's been told to us
[46:16] that like we have a public health nurse whose aiding and abetting, you know, a large home care provider and
[46:21] defrauding the government. That's not something that we frequently see. I can say we've

never seen it

[46:28] the way that it, you know, the

Medicaid program works here is that most of the time, I mean,

you have a private company that

[46:34] enrolls Medicaid provider and

that is receiving funds in reimbursements from the

government to provide those

[46:40] services. And that's just the

way that it's structured here. So there, you know, by the way that it structured

work, most of the people that

[46:48] we investigate and prosecute

are going to be those private providers.

[46:53] >> Thank you. So turning to

Representative Eric. Thank you, Madam Chair.

[47:00] >> So I'm really interested in

the consequences. The penalties

[47:05] on one of your last slides.

You talked about only 2 and a half years in

prison is the maximum for that

[47:12] sea. Medicaid fraud. I believe in.

You can't do an aggregation of

[47:18] the value. It's on. It's the

second to the last slide. And I know when we've had

discussions and hear about

[47:26] feeding your future, you know,

those convictions were like 16 years, 17 years in federal

prison, which of course,

[47:33] federal prisons completely

different. The Minnesota State prison because you serve the

vast majority 80 to 85, maybe

[47:40] 90% betting on your behavior in

prison in Minnesota. We even have now you can serve 50%.

We've got that

[47:49] new wonderful thing. So can you just talk to us a

little bit about this because

[47:55] you have this on the slide.

You didn't say it was only 2 and a half years, but I read

this high nose like a pretty

[48:00] shot that that's the maximum is

2 and a half years for defrauding, you know, the

taxpayer and the poor people

[48:06] that are trying to get services

because we've had massive fraud in Minnesota, someone if you could speak to

that just a little bit. And

[48:13] also the part about it, it

doesn't contain aggregation. So looks like you got a little

pocket money here and then you

[48:19] got a penalty there and get a

little pocket of here. We can put them together. I'm assuming

is what you're referring to. Can you just speak to that?

Just pulled up?

[48:26] >> Yes, I'm speaking of Minnesota

statute, 6 on 9, 4, 6, 6, S the medical assistance fraud
statute that was enacted 40
[48:34] years ago and hasn't been
updated since even though we've updated a lot of our statutes
[48:41] to be more in tune with the
modern day that statute is and the way it's written. It says
anyone who commits medical
[48:49] assistance fraud is guilty of
an attempted theft of public funds.
[48:54] Public funds stealing public
funds is punishable in the theft statute under 6, 0, 9, 5,
2, subdivision, 3 paren 5
[49:03] as up to 5 years in prison in attempt to crime attempt.
Crimes in Minnesota are always
[49:09] one half of a completed crime.
So it's punishable by up to 2 and a half years in prison,
[49:15] which is not sufficient when compared to
other theft crimes, you know,
[49:21] and so quite frankly, we mean
mad frog. You know, all of the cases that I mentioned, you
wouldn't prosecute a medical
[49:26] assistant right after we
prosecuted under that statute because the medical assistance,
fraud statute, Kerry's these
[49:33] low penalties. And quite
frankly, I mean, if you still 1.8 million dollars, you

shouldn't be getting a maximum

[49:38] sentence of 2 and a half years

in prison, right? Like that person who I mentioned got a

prison 10's of 93 months.

[49:45] So, you know, we use other

statutes to accomplish those goals right now. But the

medical assistance statute that

[49:51] were, you know, asking to be

enacted into law, would carry the same penalties

as other theft offenses,

[49:58] but would have much better

charging language as well with

[50:03] an aunt. And so that's why that's the reason we're asking

for.

[50:08] >> Get any follow-up.

Representative Eric just sent us different question. When

Attorney general some was here,

[50:14] I believe you said you had

153 million dollars of funds recovered and may maybe not

sure. Maybe that wasn't the

[50:21] right number. But do you have a

sense as to say in the last 2 years, 4 years, whatever number

you might have, how much money

[50:26] been able to recover? >> I would need a bit sorry.

I believe that it was

[50:33] 53 million in the last 5 years

is what he said. As far as in the last one or 2. I could get
that information for you.
[50:40] I do not have that off the top. >> Representative Eric, thank.
You know, that's always so I I
[50:46] misheard and then to 53 million
over the last 5 years. So approximately 10 million years.
What is recovered? And
[50:54] I'm wondering if you have a
sense as to what you think. Well, lets just say what you
prosecutor like the amount in
[51:01] that same period of time.
I mean, that's just what you've recovered. But you have a sense
that's what was stolen.
[51:10] >> Before me today, in part of
the reason is because some of our larger dollar cases are
still going to the court
[51:17] system. You know, if we could,
I mean, we could try to look up exactly the amount that we've
charged as fraud over last
[51:23] year's and include that.
But I just I don't have that information for you today, but
that's something that we could
[51:29] gather the way that we we report our
information to the Office of
[51:34] Inspector General. We're
required to do a statistical report every single year.

It's all publicly available.

[51:41] And so we can certainly pull

information from there if you'd like

[51:47] Representative Hudson. >> Thank you, Madam Chair, you

had mentioned

[51:54] due to federal law. There are

certain restrictions on what you can do. One of those is

that you can't basically order

[51:59] an agency to take

administrative action. I'm wondering, though, if you're

able to keep lines of

[52:05] communication open and advise

them of what you believe would be appropriate in a given

situation,

[52:12] Mr. Duncan. >> There's no prohibition on us

talking to them. And, you know,

[52:18] we do tell them, for instance, whenever we

execute a search warrant on an

[52:23] agency, we send that to them so

that they can review it and determine whether there is a

credible allegation of fraud

[52:30] that would allow them to

withhold payments to that provider. And that's if they

don't already know that we're

[52:35] investigating. You know, a lot

of times we will let them know. Hey, we are investigating these

people. There's certain
[52:43] information that we're going to
share and that certain information I'm gonna not in an
active investigation, but once
[52:49] they're a publicly available
documents like search warrants were just going to send it over
to them so that they know this is what we found. This is what
a judge has found probable
[52:56] cause for and then they can
take the action that is appropriate and by state
agencies here. I mean, the
[53:02] Department of Human Services
and so the one to administer Medicaid. >> Representive Hudson, thank
you, Madam Chair, thank you for
[53:09] that answer side. That
definitely gives me some follow-up questions for the
next time. We talk to the HS. So I appreciate it.
[53:16] Just before I go to Chair
Pinto, I just want to ask in following up to Representative
Hudson. So every time you
[53:22] execute a search warrant, you
let the agency now so that they know that there
may be probable cause for fraud
[53:31] so that they could, in fact,
stop payment. Do you know how often they act on that
information?

[53:38] >> I do. I do not what our
process is. If we execute what we call a premise, a search
warrant, right? So that search
[53:44] warrant it an agency we send a
signed copy of the search
[53:50] warrant after it is publicly
filed and has been executed to the Department of Human
Services for them to take the
[53:57] action that they believe is
appropriate. Ultimately the determination of
whether to stop payments are
[54:04] not rest with the state agency. We again, we can't
[54:10] ordered them to do that.
We can tell them not. You know, there's a separate structure
between us, but we send it over
[54:17] to them and then they can take
what action they see fit. >> And we do have data on how
many of those search warrants
[54:23] you've sent to the agency over
the past say 5 years. >> That is not one of the
categories of information that
[54:31] we track. I mean, what I could
say is that would take us a bit of time to pull together
because it's just not within
[54:38] our natural Cisco reporting
system. But I mean, we keep copies of search warrant so it

would take some time, but we

[54:46] could probably pull together. >> Thank you. If if someone

would have time over, you know, the next few months to look

into that, I think that would

[54:52] be helpful because that's the

way we can follow the thread. You're doing the work. And then

we're wondering what's the

[54:59] agency responses. And it's been

hard for us to necessarily always find that. So that would

be helpful.

[55:04] And also, you mentioned in IG

report that you file yearly to Representative Rex question

with a bunch of statistics.

[55:14] And I don't know if you make it

available to 2 the inspector general at the federal level,

if you could also make that

[55:20] available to us or show us how

to find it. >> Yeah, it's posted on the

Office of Inspector General's

[55:27] website. They posted this go

information for every Medicaid fraud unit in the country on an

annual basis. Great

[55:35] on the Department of Health and

Human Services Office of Inspector General website that

a lot of information about

[55:41] the work that all of the

Medicaid fraud control unit, Stu and

[55:47] >> perfect. We look forward to

looking that up as well. Chair Pinto. >> Thank you, Madam Chair.

And I know I think represent

[55:53] Anderson was going to follow

for some green. I don't mind to defer to her and go after that

was just to sort of keep vice-chair. Anderson, thank

you.

[56:01] >> I want to follow up for the

comets are represented. May have.

[56:08] Are you seeing more? The problem is unlicensed

providers. So when we talk

[56:14] about public versus private,

private is also could mean

[56:20] nonprofit. But public is sentia

least 8 run to me. State run

[56:25] services government in place,

whether they're at the state level of the county or whatever

[56:30] and the fraud that I have seen

[56:36] in within the private or nonprofit sectors that are

billing generally, I think

[56:43] licenses. So that my question

is, are, is it generally unlicensed

[56:49] providers, Mr, Duncan, that you've seen

the majority of the fraud?

[56:55] >> I would say more so then

licensed professionals.

[57:01] Yeah, I would say more. So

would be my sense. I mean, I I'm the reason I'm hesitating

is because if you want me to

[57:08] give a complete answer, I want

to run all of our stats in our system, Bob. But my sense today

would be that it would be more

[57:16] on licensed and licensed. >> Representative Anderson,

thank you. And unlicensed meeting, even the business and

my son it. Maybe they hire.

[57:25] >> Nurses or something, but

it's the business or nonprofit. That's correct. There's a

number

[57:31] of provider types that are

required to have, for instance, licensed professionals on

staff. I'm with, you know,

[57:39] for a lot of the home care

agencies front and still have a nurse who is required to

supervise the home care workers

[57:46] in certain statutorily required

our calls, so have a license person on staff. But the

business itself will enroll as

[57:53] a Medicaid provider. But like wall get friends since

[57:58] you know what to 45 D license

from the Department of Health like some like some providers

have to

[58:04] or from the Department of Human
Services. They won't get a specific license. All they will
do is submit
[58:10] provider enrollment document
still sign provider agreement. So this close ownership, the
outside designate a bill for
[58:16] the agency and then when all
that happens, they'll get a provider ID number that allows
them to bill the Medicaid
[58:22] program, got to pass background
checks and disclose everybody. And you know, everybody they
disclose we'll have to do that,
[58:28] too. But there isn't a dedicated in specific license
that they either need to
[58:36] provide the services, right.
Like if you own a business, that doesn't necessarily mean
[58:42] you have to have a particular
medical background or particular license to do that
in most provider types.
[58:48] >> Does that make sense?
Yeah. Yeah. Thank you. Thank you, Chair Center. >> Thank you, chair. Just a
quick couple quick items.
[58:56] Some look at the 2 sides with
the policy change requesting just want to make sure the nail
down. It's so a number of these,
including I think the changes

[59:03] represent Wyrick was asking
about about aggregating, et cetera, contained in my bill
age of 26. 0, 3, that was
[59:10] proposed by the administration.
And I think I think that everything on these 2 sides is
being carried in the House state government bill enough
that s fires or where this or
[59:18] if anybody else is it kind of
want to make sure nail down that these things that are
being suggested to us are in
[59:23] fact, currently moving in the
house. I think the answer is yes. I know if anybody has
knowledge of that looks like
[59:28] maybe just a killer. >> Jon Keller, the chief deputy
and I heard are alleged
[59:34] director say yes from the
shares of their could. I will
[59:39] realized her. Okay. Thank them. >> Representative, thank you.
Chair OKC phoned a friend.
[59:44] We got. That's a good. So those
there's a cover. And then I to really appreciate the
additional suggestions that
[59:49] remain, I guess just to request
is to continue to please send those to us to have the depth
of expertise that you all have.
[59:56] It's really useful to us.

And so please continue to to share the suggestions. I guess
I just want to make sure it
[1:00:02] didn't pass and commented the
son going back a couple more slides. The NFC results and the
fact that our state had the
[1:00:10] most provider fraud convictions
compared to other similar size states. Interestingly, not even
we're actually right in the
[1:00:15] middle of the so the size.
They're not near the top and yet the most by to fraud
conviction. So we're really
[1:00:21] fortunate to have you all doing
your work and the expertise to bring in a guest. Just want to
suggest in addition to those 2
[1:00:26] slides, sounds like there may
be some other ideas and please keep them coming to us because
it's really, really useful to us. Thank you, Chair. Thank
you, Representative Schultz.
[1:00:35] >> Thank you. Madam Chair.
I think you missed Wonka for your presentation today.
So Minnesota
[1:00:42] between federal and state
dollars to about 18 0.1 billion dollars in Medicaid. My
understanding is that's every
[1:00:49] year I have that correctly or
at least every biennium. And so when I visit by year by

your and so when I'm

[1:00:58] considering the amount of

Medicaid and fraud that has

[1:01:03] been recovered and your number

being around, 53 million dollars

[1:01:08] personally feels a little bit

small. Makes me believe from the stories that we've heard,

that that number is probably

[1:01:14] larger. And I know you've

referenced a lot of other cases that are still pending. So I

know that there's plenty of

[1:01:20] work there. But I just want to

just frame up for this that especially with where where

we've seen fault lines in other

[1:01:29] areas of, you know, our state

agencies and the oversight that we seek to bring. I'm just I'm

I'm really curious if there is

[1:01:37] more than what we're currently

going after. But to that,

[1:01:42] and I really wanted to just

kind of see if you could provide for us a little bit of

understanding as to what are

[1:01:49] some of the the methods that

you used to detect fraud and

[1:01:55] teen or those audits. That

whistleblower reports data analytic analytics. Do you rely

upon the public to share a
[1:02:04] certain? And I guess that would
kind of fit within a whistleblower. But can you kind
of share what methods of
[1:02:09] detection and that your agency
huge uses Mr. Duncan?
[1:02:15] >> Yeah, I think like I mean,
number one, you know, like any law enforcement entity, we rely
on the trust of the public and
[1:02:22] the public reporting things to
us. And if you know the public, see something that looks a
mess, right, like if you see,
[1:02:28] you know, some company that you
looks like it shuttered and, you know, nobody's going in
there, whatever. And then
[1:02:34] suddenly, you know, you see 30
people show up one day for a very short period of time to
get paychecks. And then they
[1:02:40] walk away and nobody there's no
action for another week. I mean, that, you know, if
someone sees that and they
[1:02:45] working across the street every
day, that seems like a red flag, right? And so we rely on
the community and the public to
[1:02:52] report things like that to us.
But the majority of the cases that we get come on referrals

from the Department of Human

[1:02:59] Services or from managed care

organizations, you know, managed care organizations or

SAR another thing that, you

[1:03:06] know, I don't know how much

that's come up, but they just so you all know they investigate

[1:03:13] the providers who are providing

services through them just as the Department of Human

Services doesn't defeat for

[1:03:19] service model. So we had a lot

of referrals them to when they see providers who are

defrauding the program.

[1:03:26] We do do some data analytics

with the restrictions. I mentioned earlier, we May ask

the Department of Human

[1:03:32] Services to send us hate. Send us, you know, the top 20

providers build providers for

[1:03:39] this provider type. And then

what we can do then is we can dig down into all right.

You know,

[1:03:45] water, what's this provider

billed for the last few years? Are we seeing dramatic jumps

who owns this company?

[1:03:53] Who are some of their clients?

Are they receiving services from other agencies to are they

receiving, you know, and amount

[1:03:58] of services in a day that seems
unreasonable. But really what we rely on with that data
analytics work is just to give
[1:04:04] us an idea of who to look at,
right who may be an outlier and then we can do it bigger debt,
a deeper dive into that
[1:04:11] information. And outside of those 2 referral
sources, you know, we have local law enforcement agencies
who may say may get a Medicaid
[1:04:19] Cason. You know, they may not
have the resources to investigated or they may call,
you know, in the past the
[1:04:25] Commerce Fraud bureau and then
we connect with them and we do a Medicaid fraud case together.
We may, you know, we work with
[1:04:32] our federal law enforcement
partners at the FBI and the U.S. Department of Health and
Human Services Office of
[1:04:37] Inspector General on health
care fraud cases, too. And so really, we you know,
they come from I mean, they
[1:04:44] come from all over and you
know, whoever wants to report to us. We're always happy to
listen.
[1:04:49] Representative Shoaf. >> Thank you, Madam Chair.
Thank you, Mr. Walk for that answer. You know, since this

this committee was established

[1:04:57] and for my colleagues across

the aisle who wish that this presentation would happen

sooner, we missed 3

[1:05:02] opportunities when you weren't

here. The beginning of session to have this hearing earlier in

session saw just mentioned that

[1:05:09] for the record. And and so 3

opportunities that we could have this in front of us.

And so for our purposes here,

[1:05:18] when I talk about when this

committee was established and getting up and running ever since that time, our

committee members have heard

[1:05:25] not just whistleblowers that

come from within state agencies, but we've heard from

the public like there are

[1:05:31] people who are shining a light

and they see us in part because we're the elected

representatives that sit on a

[1:05:38] community committee like this

that are sharing these types of concerns. So my my question

back to you, especially as an

[1:05:45] office that is, you know,

elected is is how accessible is is your

and Ys office and is your

[1:05:55] reporting process to people who

have or do suspect Medicaid
[1:06:01] fraud? And how accessible is
that to the public to be able to share those stories with you
so that you can further
[1:06:06] investigate, Mr. Biden. >> So what I would say with
that is we have a dedicated
[1:06:12] consumer complaint department
that when they receive report a potential Medicaid
fraud, they forwarded to the
[1:06:20] Medicaid fraud Division.
There's a lot of information available on our website and
Mr. Keller will detail how the
[1:06:26] consumer reporting process
works further. But what I can tell you is that when one comes
in, it gets sent to us. And
[1:06:32] then one of our investigators
well, typically contact directly the person who
reported it to us if they get
[1:06:40] contact information with that,
that Mr. Color go through that Mr. Kelly. >> You're not allowed to add.
Thank you, chair and
[1:06:47] Representative Schultz. But
we've previously reported on the volume. That's a very high
volume of consumer complaints
[1:06:54] that we get. I believe it's
around 50,000 complaints per year. One of the first things

that we did as a new
[1:07:00] administration was to update
the ways in which people can submit complaints used to be
completely over the phone when
[1:07:08] we took over. And we've
subsequently added an online, a written
submission e-mails. So really
[1:07:17] any way in which the public
wants to contact us, they all add up to those roughly 50,000
complaints per year. It's so
[1:07:25] large a group of individuals
who really are our first line
[1:07:30] of hearing about really
anything that's happening in the public and it's extremely
valuable to U.S..
[1:07:37] Representative shelter. >> Thank you, Madam Chair.
So that's a lot of complaints.
[1:07:42] And when you have 32 staff,
according to your presentation,
[1:07:48] are each of those complaints
being given their day in the sun with the proper look into
those things are what tools you
[1:07:57] use to at least send some level
of follow-up to that level of
[1:08:02] complaint that is coming from
the public. You know, I think that that's probably why

legislators hear about these

[1:08:11] things back home is because

we're the ones most accessible to them, that they know of

something that is happening.

[1:08:18] And yet they feel as though

even if they do report, even if

[1:08:23] they bring it to their

superior, if they happen to work with in some agency of

government that somehow that that's not

being heard or but no action is

[1:08:32] being taken up on it. I think

that that's one of the Crocs is of the issues that we hope to

address as a legislature is

[1:08:40] that we're stopping fraudulent payments that were

stopping the theft of public

[1:08:47] dollars so that it's helping and

supporting the people who need it most,

[1:08:52] but or so and or I should say as much so

that we don't have to take from

[1:08:57] the people more in the form of taxes to

pay for government services.

[1:09:03] I mean, that's that's one of

the big issues that is before us with such a rising

cost of living.

[1:09:10] >> Mr. Cameron, if I could

maybe clarify the 50,000 complaints are not on Medicaid

fraud complaints. They are

[1:09:16] across the board. Really

anything that's happening and troubling people. We do have a dated systems that

allow us to quantify the the

[1:09:26] types. So all of our analysts

will categorize, you know what our what are the areas that

people are complaining about

[1:09:33] and weekly. We get a report.

And as long as I can remember since we got the new software,

the top complaints are almost

[1:09:41] always landlord tenant issues. Thank you. But we do out if I

could just a follow-up. One of

[1:09:49] the things that we are extremely proud of in

that unit is that

[1:09:57] to your point, I think about

some of the frustrations the public has is that we do follow

up and provide referrals.

[1:10:04] If we can't help people, we

make sure that everybody hears back from our analysts. If

there is something that we can

[1:10:11] do and we often get positive

feedback about, you know, this is one of the only areas

where people still answer the

[1:10:18] phone so we can always do

better. But I will say we'd love to have our consumer

analysts and manager come in

[1:10:25] and talk about the success that
they have in providing those really critical services to the
public.
[1:10:31] Quickly represent Schultz. >> Yes. Is there any way that
you're able to quantify of the number of complaints? What
amount is related to Medicaid
[1:10:39] fraud? Representative Michele this?
I don't know. I can look into
[1:10:45] that and get back to you. Thank you. That would be
helpful for the entire committee. Representative
Elkins.
[1:10:51] >> Thank you. Madam Chair.
First question I had was answered in response to
Representative Pintos question.
[1:10:57] Yes, we do have legislation
moving. Second was we received in our pronounce this morning.
A bunch of good staff that I
[1:11:05] wasn't received in time to post
was wondering if staff could could pose the presentation.
Anything that was news site as
[1:11:11] I love to grab soft copies. >> Yes, that's already been
posted. Thank you case.
[1:11:18] And if you wouldn't mind, I
have a couple more questions. So I just want to kind of level
set
[1:11:24] in our work as a committee as

representative agreement had said, we have tried to investigate the business model of fraud,
[1:11:32] not just the small pieces and you've highlighted a few of those areas,
[1:11:38] but especially in the Medicaid space. It seems to be
[1:11:44] enormous. We have seen reports of 610, you know, million dollar fraud over the last 5 years. And it's
[1:11:51] great. You've recovered 53 million, but that's a small amount compared to that depth of the cases that are out
[1:12:00] there. And I realize some of them are still working through the process. So there may be more, but we have seen it in sober homes. Autism Center's
[1:12:08] non-emergency medical transportation. We saw any situation this week with Minneapolis. Public Schools had
[1:12:15] overpaid 4 million dollars for transportation services. We've had, you know, housing, stabilization. You mentioned,
[1:12:22] you know, a lot of areas in the housing, stabilization peace. And I appreciate that. You know, it's peer recovery its
[1:12:31] new way. It's evergreen all

those type of support services for addiction treatment.

[1:12:37] As you look out at the

landscape, how can

[1:12:43] it seems like something's

popping every day? I don't want it and I'm sure

you don't want to do at the

[1:12:50] mall where it's like, oh,

that's now we'll focus here. Now will focus here. There has

to be a better,

[1:12:56] more systemic way. We can look

at that. And I think some of it is the real time data issue.

One of the issues, when then

[1:13:03] non-emergency medical

transportation came to our attention and believe me, I

have heard all the

[1:13:08] people out there who have was a

blow to me on this issue. We're look, we're also looking

at it.

[1:13:14] But when I called the

Department of Transportation for their list of people who

provide that service and then

[1:13:19] like you, they send something

over to DHS when people are no longer eligible,

[1:13:24] but then they don't know what

happens. So it seems like part of the problem is in the

translation. I appreciate that

[1:13:30] teaches isn't here. But you are
sending reports to DHS DOT is sending reports to DHS and then
the follow-up doesn't scene
[1:13:40] to be taking place at least in
time to stop the fraud. So what can we as a legislature do
better or how can we improve
[1:13:50] the follow-up? So you send a
warrant and then it's just in their hands. Is there any other
follow-up
[1:13:56] from your office? I had that
discussion with dot the other day. They send real-time
updates and it doesn't seem to
[1:14:04] translate into their system.
So partly to be a technology issue.
[1:14:09] But I'm looking for ways. You know, we're an oversight
committee from a management
[1:14:18] perspective. We can help connect the dots to
the people who are seeing these flags and then reporting back
into DHS. And it seems to not
[1:14:27] be having an effect. Could you
comment on what you would like
[1:14:32] to see different? >> Well, I think if you're
looking at this systemically from all public programs as a
state,
[1:14:41] one thing that, you know,
always we have questions about

[1:14:48] is if someone is an enrolled,
Medicaid provider was defrauding the system
[1:14:54] and were investigating them. Do they have
[1:15:00] contracts with other state
agencies? Are they billing other state agencies? We only know as we've talked
about, we can Medicaid fraud.
[1:15:08] We can't do other things.
But there are other law enforcement agencies that can
do other things. However,
[1:15:14] I'm you know, a centralized
some kind of centralized database where you can punch in
a person's name
[1:15:22] and we've done a search warrant
it, you know, their health care agency. We have probable cause
to believe a crime is being
[1:15:28] committed. Well, if we can go into a database
and put in that person's name or that person's taxpayer ID,
something like that and to
[1:15:36] they're also building these
other state agencies, we should let them know to. We would be
happy to do that.
[1:15:42] We would be happy to let the state fraud unit at the BCA
know about that as well.
[1:15:49] If they're not jointly working
the case with us, we don't have access that.
[1:15:54] I'm not aware of a database,

something like that existing. And I think if you're looking
at this systemically and you
[1:16:01] want to take in take a view,
you know, for all state agencies, I think something
like that where there's a
[1:16:09] central point where someone like us who only
investigates Medicaid fraud can
[1:16:15] talk to a person who can tell you're
investigating them for Medicaid
[1:16:20] fraud. Will they have state
contracts with these other agencies to please let them
know what you're investigating.
[1:16:26] We can talk to them in like
that's not going to get us in trouble with, you know, our
federal grant or anything.
[1:16:32] And we can tell those agencies,
hey, you should be looking into this person. Maybe you want to
do with the administrative audit of them because we're
investigating them for Medicaid
[1:16:39] fraud. I think if you can look
at something like that, that would be a very, very good
first step.
[1:16:46] >> Excellent. I appreciate that
because that's one of the components of age of 28 91.
We will be talking about in the
[1:16:52] next section of this hearing

where we would create as sort of a D bar list or a a
suspension last where where
[1:17:00] people across the agencies are
all reporting into the GM and then that can be accessible to
everyone. And if your fraud
[1:17:09] control unit put also right
now, we don't have an incorporated in the language,
but that you would be willing
[1:17:15] to put into that system if we
get it created where you've executed search warrants so
that people are also aware of
[1:17:22] what your finding. I think that
would help strengthen the system.
[1:17:28] >> Thank you. Yeah, I I will say we would want for
any time there's a pending
[1:17:34] investigation. We would want
some sort of private reporting structure. So we know that if
we report into it, it's not
[1:17:40] going to be publicly shared
with, you know, generally like other state agencies so they
can take whatever action to cut
[1:17:47] off payments. Great. That's
what we want. But
[1:17:52] we don't want to be airing
every detail of our investigation in public Walt
occurring. >> Yes, of course, we

understand that. And we would

[1:17:57] work closely to make sure the

language see to needs. But I do think that's a huge part of the

problem we're seeing where

[1:18:04] people are reporting and it and

it seems too good, too, hit a wall in different agencies and

I think that's a role that our

[1:18:12] group can play. So Chair Pinto. >> Thank you. Thank you, chair.

If I were a couple things I I I

[1:18:22] want to correct a misstatement

that I heard earlier about the committee having heard from

whistleblowers members of the public. I think that may be

true for individual numbers.

[1:18:29] The committee, the committee

itself has not heard from anybody. I know that the chair

chair and I've had conversations, folks in contact

with a chair and she's doing a

[1:18:36] lot of vetting and examine

things. But so far nothing has risen to the level of sort of

being ready to be shared.

[1:18:42] So when they hear from the

testifiers that you're receiving, even to the extent

that there are Medicaid complaints and a portion of

those 50,000 men, assuming that

[1:18:50] what you're doing is the same

thing the chair is doing, which is you are evaluators

complaints come in and you're examining them for credibility
in for action ability, et
[1:18:58] cetera. But this committee has
not actually heard anything itself. We've had a series of
presentations, which is which
[1:19:03] is good. That's been helpful.
This has been especially helpful. And I guess I'm also
just trying to get my head
[1:19:09] around chair. You made a
comment about this. This work
[1:19:14] doesn't seem to be having an
effect. And I think we do want to be careful about making
conclusive restatements that
[1:19:21] are not necessarily backed up
by specifics. We want to make sure that we are getting
specific and concrete. So for
[1:19:27] example, we have the G S office
has said that they send all search warrant information to
DHS. I think we don't want to
[1:19:36] make an assumption about what
happens because, in fact, from the looking into this that
I've done DHS withholds
[1:19:41] payments and we should ask
this, of course, when you're in front of us, but withholds
payments stops making payments
[1:19:47] when, in fact, it's been a

search warrant that's been issued. So I I think it's it's
easy in this space to sort of
[1:19:53] say there's a lot going on and
things don't seem to having an effect. In fact, they've been
multiple years of work done to
[1:20:01] do. The kind of if somebody is
is found to have committed wrongdoing in one space to
prevent them from receiving
[1:20:07] funds and other spaces. And I
just I'm concerned, I guess about saying making these broad
statements when, in fact,
[1:20:16] we don't have the concrete
information presented to Malta months. It's true, right where
they were several weeks where
[1:20:23] of folks were denying quorum
for a number of reasons trying
[1:20:28] to protect the integrity of
elections. It's true. The state constitution, there was a I
only bring this provincial is because it brought up but you
state Constitution was
[1:20:35] violated. We're now back
together. We're trying to work together. We've had multiple
months of this committee and
[1:20:40] what I want to make sure we do
is get concrete. And today has been a great example of doing
that. So thank you, chair and thank you to the east after

your fabulous work. I want to
[1:20:47] make sure that we're really
looking right in simply saying, well, this front out there,
things are not having an effect. Actually, there's
incredible public servants
[1:20:53] doing a lot of powerful work.
And we are then called on as a legislature to give you the
tools to help you do more and
[1:20:59] more of that work we've done
over the last few years and our state government bill contains
more to do that. And let's keep on looking at it together.
[1:21:05] >> Thank you. Thank you.
Chair Pinto. And I would note for the record, we've talked a
lot about the work of this committee and I just want the
public to understand, yes,
[1:21:13] we missed the first 3 weeks of
session. We are committee, the only committee in the state
in the legislature that meets
[1:21:19] only once a week of the months. We have been
meeting once that our colleagues came
back to the legislature,
[1:21:29] 3 of those Monday's, which our
committee days where holidays. So we've had very limited
opportunity to meet. And we
[1:21:37] have been vetting the
whistleblowers to come forward to us. But I have to say, as

you well know, it's very

[1:21:45] challenging to bring

whistleblowers forward to the public. And in some cases when

we've met with whistleblowers,

[1:21:52] we have immediately turned it

over to the U.S. attorney or the FBI. And once we've done

that, we are not able for

[1:21:59] investigative reasons that we

all want to protect to find out what's going on with those

cases. But the most egregious

[1:22:05] cases, we have taken

significant action on and passed on to law enforcement

partners. And then we're

[1:22:11] continuing to meet with others

and we hope to be able to bring them to the committee in the

interim and have those

[1:22:16] discussions because it is very

illuminating to understand what they see. And to your point,

some of them are the managed

[1:22:23] care organizations who see this

fraud in real time. And they have reported up the

chain in their best way.

[1:22:31] But it has not always then they haven't heard back

necessarily, not necessarily to

[1:22:38] you, but to others. And and so

we've become a portal where people can come. And I

appreciate that role that the
[1:22:43] committee is playing. And to
the chairs point, we're also working h*** o* various strands
of legislation that through all
[1:22:50] these hearings, we have brought
forward to the public and learned for ourselves the gaps
in statute that we're
[1:22:55] continuing to work on. And I
hope that we get a lot of that over the finish line. But the
work of this committee will
[1:23:01] continue in the interim.
With that. We do have another question from representative
rare
[1:23:07] and then at to see, you know,
we are going to pivot to the bill presentation at 10
o'clock. Just so everyone
[1:23:12] knows. Thank you, Madam Chair. So then
I'll just be very, very brief. So.
[1:23:18] >> Just a couple quick things I
was looking at what your size and says you it's a 20 billion
dollar annual budget which my
[1:23:25] colleague referenced an we had
unemployment insurance and your firm deed. And it was
interesting that presentation
[1:23:32] they talked about a very, very
low rate of fraud, which is 1.4%. So if you only think

there's a I mean, I don't know

[1:23:40] what you think, but I'm just

saying if there's only one percent fraud in a 20 billion

dollar budget, that's 200 million dollars.

[1:23:47] I just want to emphasize how

important it is to catch it on the front end, not the back and

write. And so we've talked

[1:23:52] about this and that's something

that U.S. attorney, former U.S. attorney Lugar, talk to us.

We had a very long meeting with

[1:23:58] him off, not here, but

personally talked about how important it

is to catch it before it's

[1:24:05] happening or as it's happening

to stop it. Right. And so just those numbers alone, that's a

[1:24:11] potentially 200 million dollars annually of fraud at a Medicare

if that's a really, really low

[1:24:17] number. So unemployment

insurance, which of course, has got incredible levels of

administration. And so they

[1:24:24] catch a lot of things. I don't

know if you're familiar with how that operates, but it it's very hard to to take money

out of unemployment insurance,

[1:24:32] fraudulent. It's a very

difficult way to to get money so anyway. So if it's only one

percent, that's 200 million,

[1:24:40] you are able to recover
approximately 10 Million. So that's 5% of that. So the
recovery is incredibly
[1:24:47] difficult, incredibly
expensive. And so my my question, though,
is you talked a little bit more
[1:24:52] about the penalties and we do in
Europe proposal. You asked for
[1:24:58] an increase of 1.5, you are
says me, 2.5 years. What are you using the theft statutes
now? So what exactly have been
[1:25:06] the penalties and the
sentencing? Because you haven't really talked of the
sentencing. So is that it's probably more than 5 years on
the Syrian. But can you just
[1:25:15] talk about that just lit, Mr.
Monica? >> Are you asking for generally
what the sentencing guidelines
[1:25:21] for scrap so that statutes provide that if
more than $35,000 is stolen
[1:25:30] within 6 month period of time,
there's a maximum penalty of 20 years or $100,000 fine or both.
That's the maximum. As you all
[1:25:38] know, Minnesota sentencing
guidelines state under the Minnesota sentencing
guidelines. If someone has no

[1:25:44] criminal history and they are
convicted of one count of theft of over $35,000, the penalty is
a stayed 21 month prison
[1:25:53] sentence as you get more criminal
history that goes up. But that
[1:25:58] is the maximum penalty for
someone who has no criminal history. It's a severity level
sex offense under the
[1:26:05] guidelines. The next increment goes down.
35,000 $1 is the maximum is the
[1:26:13] highest threshold. So if you
sell $35,001 for you steal 3.5 million dollars. I mean,
there's aggravated sending
[1:26:20] provisions that prosecutors can
use and we use those 2, but by statute that
[1:26:26] it's the same charge. The next defense is a theft
over $5,000. That's a maximum
[1:26:32] penalty of 10 years in prison.
I the fine. I would have to look
up. But that is a severity
[1:26:39] level. 3 offense that is stayed
prison sentence of one year and one day. And then after that,
it is 8
[1:26:47] that over $1000 that is also
that it's a maximum penalty of 5 years in prison and that is
ace State prison sentence of a

[1:26:55] year and a day. It is the
severity level to offense under the second thing I'd want
[1:27:00] Representative Rick. >> Thank you, Madam Chair.
So again, to the point where we had the feeding our future
folks announced why I believe
[1:27:07] they took a federally because one of them a sentence, a 17, I
think other was sentenced to 16
[1:27:12] years. And you just heard that,
you know, Minnesota, we just don't not that serious about
punishment. And so
[1:27:22] so if you've got somebody that
hasn't been caught before, they have state sentence
[1:27:27] federally 16 years, 17 years in
prison, huge difference. So our our statutes really need
work.
[1:27:34] >> Thank you. And I'm sure you
will work on that with your colleagues on the Judiciary
Committee next year.
[1:27:41] So I would like to give the
testifier just said closing comment, but
[1:27:48] I'm sorry, Representative
Anderson, real quick. >> I'll be quick to things.
Not a question. The OIG bill,
[1:27:57] both the House and Senate
version, the House, which is fun, held hostage and Gov for a
month. But hopefully we'll get

[1:28:05] moving out of there actually
has enough provisions that
[1:28:11] they'll act as an aggregator on
these things. So both versions, too. So I think we're going to
get to that. But I would like
[1:28:19] us to ask for a list of from
DHS of providers that are unlicensed that art, not
individual providers, but but
[1:28:29] types because I think a lot of
this is Medicaid expansion dollars. And what programs do
we have in the state that are
[1:28:36] essentially being run by
unlicensed providers or non-government ISIS to us
entities? Because I think
[1:28:44] that's where the fraud is.
And I think it's good for us to understand what that is and how
large those programs are.
[1:28:50] So that's it. >> Thank you. Yes, thank you.
Representative Anderson and I did send an e-mail request and
and they sent a reply. But I
[1:28:59] think there's more we're going
to get on that to make sure the committee gets everything.
Dhs has already set me on that because I do think from
previous hearings we've had
[1:29:07] that areas of Medicaid
expansion seem to be where a lot of this fraud is occurring.

So that's something we need to

[1:29:12] take a look at with that Representative

Hawkins very quickly.

[1:29:20] >> The move today is that it's

all about the data, but it's not really a

stand-alone. It's the people

[1:29:27] important to think that it's

all problem. The problem is that we have today that it's

out there. The thing that we

[1:29:36] have to figure out to work is

going on as we take the data

[1:29:42] that we have this all over the

place in the assembly meeting in there.

[1:29:49] >> So we appreciate your

testimony. We appreciate the work of the Medicaid fraud unit

at the attorney general's

[1:29:55] office. And we just encourage

you to continue to support the

[1:30:00] legislative changes you've

asked for. We need to get those over the finish line this year.

And also, you know what?

[1:30:07] I'll do some follow-up with you

on some of the specific things we talked about pursuing.

[1:30:12] And we also may have some

specific questions about one of my specific questions. As I I

went on your Web site, did a

[1:30:19] deep dive this weekend and all
that different charges that you brought in Medicaid fraud.
And there are a lot, but it's
[1:30:26] it's hard for us to, you know,
it's all these charges. It's great. And sometimes they're a
conviction announced. But it's
[1:30:32] hard to see this has been
charged. This was convicted or this wasn't convicted. So to
see the disposition of
[1:30:39] everything. So if you could
help either educate us and how to
better track that, or if you could consolidate that. So it's
easier for legislators and the
[1:30:48] public to track because there's all these announcements
all the time about charges,
[1:30:54] but then following the threat
and seeing what actually has happened. And to representative
Rick's POINT, if everyone's
[1:31:01] getting his state sentence, how
many repeat people are and they're in that would be really
helpful for us to now. You
[1:31:08] know, if someone was it,
they've never had a conviction before. Then they get the state
sentence, but then they go back
[1:31:14] to the same business model, a
fraud under a different name. How often are you seeing that?

Because that's a of a concern

[1:31:20] of this committee. So we

appreciate your time. If you have any last thoughts for us,

we'd love to hear.

[1:31:26] >> Now I want to thank you all

again for bringing me here and for your interest in the topic.

It's it's really good to have these conversations and the

public and out in the open top,

[1:31:34] how we can all work together to

prevent Medicaid fraud and to hold the people who do to prod

the system accountable in the

[1:31:41] way that they should be.

So thank you for having me. Thank you for your time and

your interest. Thank you.

[1:31:47] >> With that, I'll turn it over

to Representative Anderson. Like to the test fired.

[1:32:02] Do I mean by that and even bring this up or maybe

you just mentioned?

[1:32:10] >> And you know, which area if

any of that

[1:32:15] and 2.

[1:32:26] >> Thank you. We have 2 bills up next and I

think we'll start with the

[1:32:32] House file 30 43 Chair Robbins. >> Thank you, Madam Chair.

And thank you members. As you

[1:32:39] know, this committee has heard

from a number of agencies over the last several months where we've learned things about how

[1:32:48] we can strengthen statute and close up some gaps that would make the agencies more accountable and we are to

[1:32:56] Minnesota fraud and state over agency Oversight Committee. So part of our our role is to hear from all the agencies and

[1:33:03] then provide that statutory changes that they are requesting to be able to do a better job of managing that

[1:33:11] grants and that federal programs that the state of ministers. So H f 30 43 comes out of that work and I'm sure

[1:33:19] you all remember cause. I think we were all stunned when the Testifiers said that because there's no state

[1:33:28] crime for kickbacks and that that's something they won't.

[1:33:33] Even though to be clear agencies can step payment. When there's credible allegations of fraud,

[1:33:39] they didn't see kickbacks to rise to the level of credible allegations of fraud that would require them to stop payment.

[1:33:47] And they requested that we get

a state crime and for kickbacks or it as
we're saying in the bill
[1:33:54] illegal be mean or shuns. So our
committee bill, which I hope we
[1:34:00] will get bipartisan support for
is 30 43 and it is moving in different
pieces. The governor had a
[1:34:08] similar bill are a similar
kickback provision. And I and there is language moving in the
HHS bill right now, which I'm
[1:34:16] grateful for. But I wanted us
to discuss this as a committee and hopefully as it moves
forward in the HHS bill.
[1:34:24] I'm hoping that we can
strengthen it because the HHS bill does not contain a portion
of our bill that would deal
[1:34:32] with kickbacks for grants. So they have stepped to the
federal programs. And I
[1:34:38] appreciate that. But as we have
seen in testimony and in many
[1:34:44] of the things that that if you
look at the office of Attorney general, a
lot of the Medicaid things are
[1:34:52] kickbacks that are run by small
businesses or nonprofits that are providers. And so that's an
area I gaping hole in the

[1:35:00] current language that's moving
forward. So with that, I would just stand for any questions
about the bill or we can move
[1:35:07] on to the next one. Thank you. Is there anyone here
from the audience would like to testify?
[1:35:13] Okay, seeing none other any
questions for Representative Pinto. >> Chair Pinto, thank you.
Thank you. Thank you, Madam
[1:35:20] Chair and thank you chair.
So I just confirming so the subdivision to yeah, I think is
in the Human Services budget
[1:35:27] bill in a slightly different
version. It was originally the administration propose it sits
in the larger administration
[1:35:34] package that I'm the author of
age of 2.26. 0, 3, And I think represent current actually is
that was then the author,
[1:35:40] the bill. So maybe just
confirming that a vision to. >> Generally matches what is
currently moving and Human
[1:35:45] services budget. Is that right?
Yes, it is. I took out the weekend. I'm sorry, Vice Chair
Anderson, I checked over the
[1:35:52] weekend and I got copies of
what's moving in that language in the human services bill.
And I appreciated and I want to

[1:35:58] make sure that stays on track.
But I think because it's missing the piece about grants
that sew up a place where we
[1:36:04] could strengthen it and I'm
certainly prepared to have that conversation on floor and would
love to have your support for
[1:36:10] that. Okay. Here at the
Pentagon. Thank you, Madam Chair. >> So chair. But he adds that.
That's the thing. I guess I'm
[1:36:16] trying to think through the
subdivision, 3 them, which is the new peace. And as I stated,
there's nothing like this
[1:36:22] and federal law does. The
federal government has a lot of has a lot of grants and they do
confirm that Mr. Johnson to
[1:36:30] fight with House research.
If I can, there's no kind of analog otherwise. And in
federal law to this.
[1:36:36] >> Chair happens. Yes, I would
love to hear from Mr. Johnson, but that is my understanding.
Okay, Mr. Johnson.
[1:36:43] >> Madam Chair members. That is
essentially correct. Obviously any theft of government funds
is different. The issue often
[1:36:49] with what what people refer to
as a kickback is it is not always easy and clear to tie

the specific action or the

[1:36:57] specific benefit to an actual

theft or use or misuse of public funds. To my knowledge,

there's nothing specifically

[1:37:05] like this in federal law. >> Thank you, Allan. Yeah, I

do. Thank you chair. So and I

[1:37:11] maybe should just clarifies my

understanding from earlier. So kickbacks can be charged

under state law and they

[1:37:17] currently are. It's just that

they have to be done under the theft statute, which makes it

very khaki for lack of a better

[1:37:23] word, which is why the

administration proposed in the first place to have the so the

nation to which again, is is

[1:37:28] great. I'm I'm so sufficient.

The eager to I know this bill is in the possession of public

Safety Committee of eager to

[1:37:34] have it give the bill I review

and hearing because I'm just concerned, I guess about about

the the the Phrasing in

[1:37:42] subdivision 3 and how kind of

vague it is. I guess so. I'm looking. So if somebody is

employed

[1:37:50] and isn't involved in grant

work as part of their job,

[1:37:56] I guess I get worried that
they'd that their conduct would, in fact, be captured
under this. If you kind of
[1:38:01] comparison vision, 3, it's a
vision to you'll see, it's it's just much more sort of general
and fake. It would give
[1:38:08] prosecutors a really massive
amount of discretion. So person who who receives an appointment
[1:38:14] in return for awarding a grant, even just freezing it that way.
I'm I mean, I'm I receive
[1:38:22] employment and in return for
warning Grant or I'm I recommend that any agency
awarded grants of if someone is
[1:38:28] writing a recommendation letter
and I know this is kind of stretching things with is how
we have to think in the public safety world. I worry that the
phrasing of this is quite
[1:38:36] broad. So again, I'll bet I do
think this will need review by the Public Safety Committee,
which has the official position of that. Obviously, our
committee doesn't just to
[1:38:42] really tighten the language in
reviewing that way and make sure that really works. Tell
you, I'm just worried about how
[1:38:47] broadly this is written, that
we capture some folks who actually not not that there's

no, you know, the word there's
[1:38:55] false information in class 3,
there's not sort of a wrongfully or that sort of
thing, which often there is. I just want to tighten the
language quite a bit examine
[1:39:02] that happens. Thank you, Chair
Pinto. I appreciate that. And I look forward to working
with you on the language.
[1:39:08] >> And just so the members and
the public now we drafted these bills after this. The many
first hearings we had with
[1:39:15] various agencies, we sort of
collected all the suggestions the agencies gave us and I
didn't get the bills back from
[1:39:22] the revise or until April 2nd.
And then they were posted on April 7th, which was deadline
day. So that is why we're
[1:39:30] having an informational
hearing. But some pieces of the language are moving in other
bills. And I do look forward to
[1:39:35] working on that on that
specific question, just, you know, about why the
awarding a grant is in there.
[1:39:40] So there are specific examples
I could cite and that have been in the news where someone who
had grants management authority

[1:39:48] and awarded contracts and then later became an
employee of a particular
[1:39:56] company. They had awarded a
grant to. And so I agree we need to prep state in the
language. But when someone has
[1:40:03] direct ability to award a grant and
then quickly becomes an
[1:40:08] employee of that operation, I
think that's something we all
[1:40:14] want to be sure being careful
about. So that is why, you know, that's the situation we
were trying to get in where
[1:40:21] where people were leveraging
their authority over grant awarding for their own personal
gain.
[1:40:27] >> And the fight to give
chairman and thank you, Madam Chair and read the Terrapins
it. That's a I could imagine
[1:40:34] that situation might be
especially well covered. I think it may be in fact
currently if it's not, we should make sure that is in a
typical guidelines in policy.
[1:40:42] It sounds like that may have
been a state employee. You're describing it. So, you know,
that's something where we want to make sure that there are
those certain guidelines,

[1:40:49] I guess, as a prosecuting it
worried when we bring in I mean, these are all felonies.
When we turn into a criminal
[1:40:55] law, we just want to make sure
we have very specific language to sort of capture because it
and not all concerning conduct
[1:41:03] is criminal conduct rate.
We still want to make sure even concerning conduct doesn't
happen. But it may be that there should have a better way
to get out and see. All look
[1:41:09] forward to continue
conversations with you about this. I know has been
challenging the session, bringing bills together, pieces
together, their visors and very
[1:41:17] busy, et cetera. But I'm glad
at least there's a consensus on television to and is moving in
the bill and then look forward to to continue reviewing
supervision. 3, thank you.
[1:41:24] Thank you, chair. >> Thank you there. Any further
questions many members
[1:41:29] chair Robin Stuart, you thank
you. Well know I'd like to turn to H f 28 91 also for
informational purposes and
[1:41:37] members. This bill comes out of
all the other hearings we had particularly early in session
where we heard from the office

[1:41:45] of Legislative Auditor. We
heard from the Office of Grants Management on ways that we
could do some of the things
[1:41:52] that we actually just heard
about from the Medicaid fraud control unit director, Mr.
Wonka about the need for a
[1:41:59] centralized place. 2 have people report. Businesses
are grantees that are not
[1:42:08] fulfilling their responsibility
or are alleged to be committing fraud so that that's flag
across the state wide
[1:42:15] enterprise. So other people
don't give grants or contracts to them. So that's one of the
pieces of this bill.
[1:42:21] The other significant piece of
this bill is that we are providing a very detailed
definition of what grants
[1:42:28] management responsibilities
are. Again, this varies widely
across agencies and it's not
[1:42:35] currently embedded in people's
job description. And if Bill,
[1:42:40] an earlier version of this bill
that I had for 6 years that I worked on for many years with
the Office of Legislative
[1:42:46] Auditor, that was one of the

big concerns is that if peoples a job description or
responsibilities isn't spelled
[1:42:55] out for grants management, then
it becomes a game of hot potato. Well, that wasn't my
job. That wasn't my job.
[1:43:01] That was someone else signed
off on this. And so that's why it's been hard to have
accountability. So that's the
[1:43:08] first piece end there. And then
the other piece we heard from the from both agencies and the
Office of Grants Management is
[1:43:15] that the Office of Grants
Management provides 13 training modules, but they are
recommended to agency employees
[1:43:23] who have grants management
responsibilities, but they are not required. And I know I was stunned to
realize that and I think others
[1:43:31] of the committee was well, so
we were not going to be requiring grants management
[1:43:36] people with grants, management
responsibilities to actually go through the training and also
to be certified that they
[1:43:42] successfully completed it
because it's one thing to sit there and watch a webinar and
check the box saying you took the training, but it's another
thing to demonstrate capability

[1:43:51] and success at up up, take up the knowledge. And then the other piece of that

[1:43:59] is this this issue of being D

BART and and or suspended and

[1:44:05] having the uniform reporting

place where everyone I can understand that there's a

problem with this grant here,

[1:44:13] this business and it should be

flag. So those are the pieces of the bill. I know I heard

from one of the agencies that

[1:44:20] had concern the way it's

currently drafted each agency, candy bar and that preference

by DHS was that we say no.

[1:44:30] Everyone reports in 2 and GM and GM makes the final

determination of who is to

[1:44:38] fired. So it an agency like DHS

could flag and instance of fraud or alleged fraud and say

I recommend that this grant TBD

[1:44:47] barred that the actual decision

to depar or suspend would be

[1:44:52] from GM. And honestly, one of

the concerns that people have different thresholds. But the

second concern was for the

[1:45:00] fiscal note, if we left it up

to each agency, they were going to be requesting a lot more

staff. Whereas if we keep it

[1:45:08] housed and the central location
of GM, they felt there would be more consistency and it would
be less costly. So and so there
[1:45:16] is an amendment that I've
submitted for the committee's consideration on that point.
[1:45:22] And I just want to like for you
what that means. So with that, I believe I'm a
testifier the office of
[1:45:28] Legislative Auditor and also
know please come forward in
[1:45:34] someone from the Department of Admin from
the Office of Grants
[1:45:39] Management. >> Thank you. Thank you.
Can you please state your name
[1:45:44] for the record? >> Thank you. And good morning.
Vice Chair Anderson and members
[1:45:50] of the committee. My name is
Betsy. He's an assistant commissioner with the
Department of Administration,
[1:45:55] our admin. I appreciate the opportunity to
testify on House file. 28 91
[1:46:00] today. A significant portion of the
bill is focused on creating a new certification program that
would serve to verify
[1:46:07] proficiency in many areas of
grants, administration and then supports this idea.

And in fact, although on a
[1:46:14] smaller scale, admin and
ministers, similar non-statutory certification
programs in the procurement
[1:46:20] area in 2023, the legislature
provided additional resources
[1:46:25] to Edmunds opposite grants
management, which is allowed us to expand our training
offerings considerably.
[1:46:31] Since that time we've been
rolling out courses and platforms to get state staff
trained since July one of 2024.
[1:46:39] Over 300 state staff of
attended one or more of the 15 virtual and in-person 2 and a
half hour training sessions
[1:46:46] that the office has delivered these enterprise wide training,
trainings build essential
[1:46:52] skills and areas of knowledge.
Critical to grant oversight and accountability. Examples of available classes
include an overview of grants,
[1:47:00] administration, financial
reconciliation and grants management grant monitoring and
grant he evaluation
[1:47:07] online training videos,
template checklist, sample communication, tip sheets, flow
charts. Enough cues are all

[1:47:14] available in comprehensive tool
in a comprehensive tool kit related to conducting Korea
word risk assessments.
[1:47:21] Further GM is currently working
with Mnd to launch a 3 course says training series that will
be available on the state's
[1:47:29] enterprise learning system by
the end of the fiscal year. There are also dozens of
trainings and templates and
[1:47:34] checklists and other materials
on the division's website. So adding a certification
element to this would bolster
[1:47:41] this already strength
strengthen training regimen. So again, we really support the
idea, but would like to point
[1:47:47] out some ways we think that the
bill could be improved first and most critical.
The development of additional
[1:47:53] training content testing and
building the certification program will require additional
resources to supplement GM
[1:48:01] small team. Those details are reflected in
our fiscal note that we have prepared
[1:48:06] and second and also critical.
The bill needs to identify an effective date that reflects a
reasonable amount of time to

[1:48:12] design and develop and
implement certification program of this size and importance
which we estimate to be about
[1:48:19] 18 months. This would allow time to
onboard the additional staff to design and develop the
certification program and then
[1:48:26] allow the remaining time for
agencies to complete their certifications. Moving on to section 2 of the
bill. This section includes a
[1:48:34] list of items that admin would
be required to maintain. One of the items to be
maintained is a list of
[1:48:40] grantees that have been
convicted of a crime involving the misuse of government funds.
[1:48:46] While we understand the
usefulness of such a list, being able to identify and
ascertain this list is not
[1:48:52] feasible, especially without
any limits on jurisdiction as written admin would be required
to research and locate every
[1:48:59] criminal conviction and also
review the content of the crime to ensure the conviction
related to misuse of government
[1:49:05] funds. Finally and moving on to
section for the bill and provisions related to grants
administration. And as we

[1:49:12] previously testified in the
state government committee, we understand the intent behind
unannounced visits. We think
[1:49:18] the bill would be improved if
the lies that site visits as opposed to a monitoring visit.
[1:49:24] A monitoring visit is an
extensive review that requires planning and coordination with
the grantee monitoring visits
[1:49:30] require certain personnel to be
available. Documents ready and attendees prepared for a
discussion. We believe what
[1:49:37] you're intending in this bill
is more of a site visit for an agency would stop in announced
fresh or check in for the
[1:49:45] purpose of verifying that the
operations are proceeding as they should be. We think these types of sight
visits, mate
[1:49:52] not always be necessary or
reasonable for all types of grants. But we agree that it is
appropriate and useful for some
[1:50:01] concerns from agencies
regarding the unannounced site visits about their capacity to
meet this requirement as well
[1:50:08] as other concerns. This provision would require
further discussion with other grant making agencies to ensure
their needs and concerns are

[1:50:15] addressed. Agencies will need adequate
funding to accommodate additional grants management
requirements
[1:50:21] and the exceptions that were
detailed in Representative Davis is House file 2 should
also be considered such as for
[1:50:28] grantees that do not operate
from a fixed physical address. This concludes my remarks, I
thank you for the opportunity
[1:50:35] to testify and thank you for
the work in goals behind this bill and I'm happy to stand for
any questions.
[1:50:41] Thank you either. Any questions
of the testifier? >> The specific question.
Okay. Thank you. And we'll
[1:50:48] bring it back to the committee
had questions for >> the officer. But we have
another test fire. But a bit if
[1:50:55] you would mind, Madam Chair, I
would just like to comment. I appreciate that partnership
we've had with admin and I do
[1:51:01] especially I'm interested if we
do move forward with this language next session
that I would concur about the
[1:51:09] need for changing it from a
monitoring visit to a site visit. And we are still trying to get

a fiscal note on this bill that

[1:51:16] I saw an early copy this

morning. That's not for distribution. And currently

it's about 7 million per

[1:51:24] biennium. So 7 million in that

for 26, 27 and then 7 million

[1:51:29] and the tales. So we would have

to invest in this members, but 7 million to stop hundreds

of million then fraud, I think

[1:51:38] would be well worth the

investment. And I hope we can continue to work on this as a

committee. Thank you, rep somehow son.

[1:51:45] >> Thank you. Madam Chair.

I did have a question for the testifier. You'd mention that

[1:51:50] it was in your view on feasible

to maintain that list of 5 folks who have had criminal

charges. Is that analysis based

[1:51:58] upon applying this

retroactively or would there be a possibility of setting

something up that going forward

[1:52:04] from a certain date he would be

able to at least a line or or create a list based upon

[1:52:12] things that are discovered

moving forward. >> Thank you. Assistant

Commissioner Hayes, Madam Vice Chair representative, it wasn't

so much about the timing or

[1:52:22] whether it's retroactive or
not. It's more just the depth and the scope. >> Of the of the requirement.
It doesn't limit jurisdictions.
[1:52:32] So there were a conviction in a
different state. It would require staff, which now is
currently 8 individuals to
[1:52:40] really be proactively
researching every jurisdiction at every level. And then
further, it specifies what type
[1:52:49] of crime. And so it may even
require research into the content of the case to
understand what the conviction
[1:52:57] was for and whether it involves
misuse of government funds. So it's really just, I think,
working meeting to work on the
[1:53:02] language to limit the scope of
what would be feasible or are practicable for an office to to
reasonably maintain.
[1:53:12] >> Represent Hudson all up.
Okay. Any other questions? Okay. We do have a second
testified. Yes. The opposite to
[1:53:19] the mantle. Thank you. Thank
you for coming. Oh, I okay on my list.
[1:53:30] Thank you, please. State your
name for the record. >> Thank you, Madam Chair
members for the record. My name

[1:53:36] is Judy Randall Legislative
Auditor. Thanks for taking the time to it. Cites the to hear my brief
comments. Most of the comments
[1:53:46] I have are related to a program
of all, uh, an overlay released in 2023. I believe we spoke
about earlier this session
[1:53:53] regarding oversight of state
funded grants to nonprofit organizations. And I'm just
gonna put the bill on my phone.
[1:53:59] Us got these were gone by the
time we got here. I wanted to just say that section 3
regarding requiring training
[1:54:08] for it employs agency employees
who are responsible for grants management is the key is
consistent with our
[1:54:15] recommendation. We made several
recommendations in that report. One was too for the legislature
to require admin to develop
[1:54:24] robust training for employees
in agencies for managing grants. And as you already
heard, the agency has already
[1:54:31] done that really without the
direction for the legislature. And I was on their website last
week and they have a whole
[1:54:37] range of topics and template
and webinars and and really a whole host of training

materials which is great when

[1:54:44] we did our work. We did surveys

of agency staff manage grants.

[1:54:49] We did surveys of Grant

Management Committee. We have some focus groups. And what we

heard was a lot of a large

[1:54:58] percentage. Almost 75% of the

employees we surveyed did not were not aware of all the

training that was available to

[1:55:05] them did not know whether they

had taken training. And and these are the folks on the

front line who were expecting

[1:55:12] to uphold the policies that are

already in place. I think one thing that's really important

for the legislature to hear is

[1:55:19] that a lot of the rules and

requirements that you are looking for are already in

place. Officer grants

[1:55:26] management has a robust set of

policies. The legislature put into place a whole bunch of

requirements. And 23, the real

[1:55:32] issue, one of the real issues

we see is that state employees don't necessarily know all of

them haven't necessarily been

[1:55:40] trained on all of them. There

is a lot of turnover in agency staff, a lot of staff conduct

grants, management functions

[1:55:48] and so requiring training for

those folks in some form we think is really important to

make sure the folks who we are

[1:55:55] expecting to do the work

actually know what's expected of them regarding other sections of the

bill. I will just note that in

[1:56:04] this 2023 report we did kind of

a compendium of our work

[1:56:09] related to grants over the past

five-plus years. We have done a lot of work related to grants

over say we have 8 financial

[1:56:16] audit reports into program

evaluation. Reports with the findings in the back of of this

23 report and a consistent

[1:56:24] theme we see as problems

related to monitoring right now, a GM policies do not

require insight this art on

[1:56:32] site visits. And we do think

that's an important piece of accountability. I think the

change the department

[1:56:39] administration is recommending

changing it to site visits or other. The monitoring visits is

a good one. I do think that

[1:56:45] that captures the intent which

is just to look and see. Is this happening? Is there a

program here either they're the

[1:56:52] necessary pieces we would

expect rather than doing everything that's involved in a

a a

[1:56:59] technical monitoring visit,

which would include financial reconciliation and other

things. Finally, there's a

[1:57:05] piece in here related to

reporting and I would just say that there are already

requirements on the books

[1:57:11] related to reporting possible

misuse of state resources reporting to L a that being

said we are doing a lot of work

[1:57:19] this year reminding agencies

and helping agencies understand that responsibility. We do have

some language going through

[1:57:26] both bodies that we're hoping

will clarify that. I don't think there's a problem with

over reporter Heene because

[1:57:33] right now we're not we don't

believe we're getting all the reports we should be. I will

note that when we do receive a

[1:57:40] credible allegation of misuse

with the grantee, we do have access to look at Swift, which

is like this, the state's

[1:57:48] checkbook, if you will. We have

the ability to look at that across all agencies which other
agencies to not have that
[1:57:54] ability and we do run queries.
And if we see that that grant, he has received a contract or
funds from another agency,
[1:58:03] we will get in touch with them
and may be asked to see if they're doing monitoring and
things like that. But we don't
[1:58:09] have the authority to to share
with them. Hey, we're concerned there's a an allegation.
So
[1:58:16] we use our authority carefully
to make sure the agency is doing the oversight. It should
be when we learn of those
[1:58:22] allegations. But but are
authorities limited to that? I think that's everything.
I have all be happy to answer
[1:58:29] questions. Thank you at around
questions for the honor.
[1:58:34] Any questions. Thank you. >> Okay, Sharon once, thank
you. Madam Chair members, I appreciate the opportunity to
present these bills. I think it
[1:58:42] is reflective of the good work.
Our committee has done this session and I want to point out
how salient it is in real time.
[1:58:50] So today we had the office of

the attorney general's Medicaid fraud control unit here.

And to the point about the

[1:58:57] site, this it's that's why this

is so in incredibly important. So I'm quoting from and

6/19/2024 announcement by the

[1:59:07] Friday unit that they had announced charges for stealing

more than 10 million dollars in

[1:59:15] 2 different Medicaid

prosecutions. And this was an example of a

home base communities service

[1:59:22] and they lacked it says one of

the tip ups for them was it lacked any office building and

they had operated for years out

[1:59:31] of a mailbox. If they're going

to site visit that would have been discovered

years ago and we went and got

[1:59:38] into 10 million dollars in

fraud. Here's one from January 8 of

this year 2025 they charged.

[1:59:47] One person was 7.3 million in

Medicaid fraud. And the situation here is that

the owner of the business,

[1:59:54] as we heard in the earlier

testimony was legally barred from owning it because he had

previously been convicted of

[2:00:02] aiding and abetting

second-degree murder and so was barred from owning managing or
operating any Medicaid fraud
[2:00:08] business. But in addition, the person who
he had running his billing
[2:00:13] operation was also barred
because of previous identity theft. And she at one point in
this press in in this scandal
[2:00:24] was billing from jail members. If we were doing any
sort of site visit,
[2:00:31] these things would have been
caught much earlier here. We are going years later to get
to the final stage of
[2:00:38] prosecution by the attorney
general's office. And they're doing good work, but we need to
tighten up the front end of
[2:00:45] agency oversight by having site
visits. So we catch this earlier. This is exactly the
kind of work this bill is
[2:00:52] intended to do. And I hope we
can get it over the finish line next session. But any of the
pieces that are moving this
[2:00:59] session, I hope we all commit
to working with our colleagues to getting him through. So
thank you very much. Thank you,
[2:01:05] Representative Freeman. >> Thank you, Madam Chair and
thank you. Representative

[2:01:10] Robinson picking up and where
you ended, which is my understanding and have incurred
both in this committee as well
[2:01:17] as hearing, including the
Medicaid fraud control units, proposal that that most of that
is focused on this issue.
[2:01:26] And and some of the issues
we've heard about Medicaid fraud in the systems we we use
when they look at 2.80, 2.90,
[2:01:34] heard to 89.1 per one. I just
want to be clear because there's been a lot of confusion
is committee. There is a
[2:01:42] different process. There are
different set of rules and to a certain degree there's
differences. Statutes that deal
[2:01:47] with nonprofit grants then deal with Medicaid
provider reimbursements.
[2:01:53] And this bill is about
nonprofit grants. And I know we spent
[2:02:00] 2 and a half months before we
got to the Medicaid fraud control unit talking about
grants. That's actually not
[2:02:08] where we are seeing one, even
if you look at the disputed and I would say inaccurate fraud
tracker. But certainly when you
[2:02:17] look at what both the

government's tracking, the main issue we're talking
about and I think I heard from
[2:02:23] this committee is Medicaid
provider fraud. Those are private providers.
[2:02:29] This bill to 89 1 doesn't.
And unless like, I think I'm
[2:02:36] reading your eyes, it covers
government grants. And so when we look at the list that we
heard think director want to
[2:02:43] talk about it, be held of
information sharing. A lot of that information sharing is
ready, isn't Representative
[2:02:49] Pinto's Bell? I think that
there's some in the the A G the Jews bell, but this wouldn't
actually do that because this
[2:02:57] just says a list of grant
tease. And when we talk about
providers, they're not grant to
[2:03:03] use their private providers.
And so one, I think it really matters because I want to make
sure that we have the tools
[2:03:10] that we're saying we want which
I agree with, which is I want the tools to say won, I think
thinking about licensing to
[2:03:18] thinking about the tools we
need to ensure that Medicaid providers are. We are actually

looking at the business model

[2:03:25] and we are preventing them from

doing what we see in, you know, in misclassification other

places which is dissolve when

[2:03:33] they get caught and then re

pop-up, nothing in 2, 89, 1 would do

that because we're talking

[2:03:39] about nonprofit grants, which

is a different model. So we do need to be really clear that

we're talking about attacking

[2:03:46] the business model fraud.

We are actually looking at the right business model. And I

don't think it is useful to our

[2:03:52] work to complete those to which

I think we have. What I will say is I

do think that looking at the

[2:03:59] bills that are moving forward

through the process, looking the bills that I think given

where they're at in the House

[2:04:05] and Senate will become law.

They do get to this point that we heard

Director walk and I think

[2:04:11] there's more work to do.

I'm really interested in looking at when we talk about

home health care about

[2:04:17] licensing. I'm really

interested in looking at where we're doing it well with PCA is
and applying it to the rest of
[2:04:24] the model. But I think that the
to a certain degree, the focus on Grant's, particularly
grants, nonprofits, although
[2:04:32] their grants that go to
for-profit providers to that has
[2:04:38] actually taking us away from
the work of looking at Medicaid provider fraud, which we're now
getting to late in the game.
[2:04:46] But and I'm glad we are.
But so I would say especially to 89 1. I just wanted to make
sure we're not expecting it to
[2:04:52] do things that it can't do
because it's focused on the wrong set of actors on the
wrong problem. >> So that's what I'm saying.
Thank you. And I think it's
[2:05:00] important that we know this. I agree with rep an angry man
in generally that there are
[2:05:08] nonprofit grants generally go
to nonprofits for some time to go to profits. The difference
there is a we don't actually
[2:05:16] have thanks to judge them by
whether what they did was fraudulent or not or whether
they did anything for the
[2:05:22] dollars that they got from the

grants in regards to Medicaid, the dollars this post beefy for
[2:05:29] for service. And the question
is where the services even provided. And so they are 2
very different things. The
[2:05:36] grants, I think and and
Medicaid, which is that generally grants, but both have
product and private entities
[2:05:45] involved. So thank you, rep
some Greens. >> Thank you, representative
urge tear Anderson. I will see
[2:05:53] that we actually do. And a lot
of the language that that the auditor mention that we added
in 2023 2024 actually does give
[2:06:03] us the tools to say both on the
front end. Do you have and are
[2:06:08] you going to do what you say
you do, but also to withhold payment if they're not doing
what the grants. So there is
[2:06:16] this conversation that I think
all of us share about what it means to direct directly
appropriate grants, what the
[2:06:23] legislature's setting those up.
But when you look at competitive grants, there are
set of metrics and we do
[2:06:29] actually now have the tools to
hold them accountable. So I just wanted to just get a

little bit the idea that when

[2:06:35] we make on private brands, we

somehow they go into the ether. We now have much better tools

in some cases for nonprofit

[2:06:43] grants than we do for contracts

that were vending. Now that are

[2:06:48] that our agencies are running

out to just businesses. They want better tools with

nonprofit grants than we do for

[2:06:55] tax expenditures that are in

some cases going hundreds of millions of dollars that are

going out the door. Look at the

[2:07:01] research and development tax

credit that the auditor is actually said. We don't know

what we're getting forward.

[2:07:07] We have better tools than we

do. I think in some cases for this Medicaid provider fraud.

So I just I we have actually

[2:07:13] spent a lot of time, I think

looking at the nonprofit grants face and put a lot of stuff

into play. I think the rest of

[2:07:19] this piece, whether it's

checked expenditures, whether it's Medicaid fraud, we are now

getting to this place of how do

[2:07:27] we make sure that we're holding

at 2 accountable to the goals that we set. >> Thank you. And May I

respond, madam, to get

[2:07:35] interesting now that R D tax

credits, not a tax bill that's coming out tomorrow. So just

enough chair Robbins S thank

[2:07:43] you, Representative Greenman

for those points. And I agree. I think we have to

[2:07:49] continue to look at all the

buckets of fraud. Medicaid is a huge piece of it. But there are

[2:07:56] areas of grant where there's

nonprofit fried that we have seen and the grants management

has not been sufficient as we

[2:08:04] have seen throughout the

testimony and then there's the unlicensed, a generally

business fried that we've

[2:08:11] identified often in the

Medicaid expansion area where we need to tighten that down.

But in all those cases site

[2:08:19] visits are important. And I

agree this bill is dealing with the grants peace, but we need

to be sure that there are

[2:08:26] billions of dollars, state

dollars going out in grants. And we need to make sure as

part of our charge as the state

[2:08:34] agency Oversight Committee that

the people managing these grants on behalf of taxpayers

take the training that's

[2:08:41] offered and that they
understand their job and are doing it well, and many of them
are. But as the LA said,
[2:08:49] many people who manage grants,
there's a lot of turnover. They haven't there and even
aware the trainings available.
[2:08:55] So that's on us to make sure
that as this state legislature
[2:09:01] appropriating funds, where it's
granted out, that we're ensuring that the agency staff
are well trained and managing
[2:09:09] that grant money. Well, so it
is very important. And then there's overlap members.
We saw this in feeding our
[2:09:15] future. And we are continuing
to see it in real time with warrants that worst executed in
December of last year where
[2:09:23] there is an autism center,
which is a business that was also tied to a nonprofit that
is a feeding our future site.
[2:09:31] That also has non emergency
transportation that also has interpretive services. So
there's overlap between the
[2:09:38] nonprofits and the businesses
that are in fall in the business model of fraud.
We are all trying to

[2:09:46] define and limits. So I just think that we
have to acknowledge that all
[2:09:53] these buckets of potential
fraud exist and that we have a responsibility to be working in
all these lanes, Medicaid,
[2:10:01] unlicensed or a business area,
including some of the managed
[2:10:06] care organizations, not just
the individual businesses and the grand. So I think we can do
all and I think we shouldn't
[2:10:14] limit our focus. We should
instead be working in all 3 buckets. And I appreciate the
work of this committee this
[2:10:19] session. Thank you,
representative or quickly. >> Since really quick place to
just to the point of the
[2:10:26] tracker that we keep are
feuding. So so it's 610 million and it's across all kinds of
things. If we just did the
[2:10:33] simple math, again, 20 billion
dollars annually coming in for Medicaid.
[2:10:39] If we had an exceptionally low
fraud rate, one percent, that's 200 million
[2:10:46] representative Graham and
200 Million. That's just Medicaid. If that was an
exceptionally low for Audrey.

[2:10:53] So I don't know why we keep
pushing back on this trackers. Probably incredibly low,
610 Million. And that again,
[2:10:59] that's one year's worth of
fraud. So 220 Susan, 20 billion
dollars, one percent fraud
[2:11:07] rate, which is incredibly low
nets. You 200 million dollars. Just simple math, a year of
Medicaid fraud
[2:11:15] and maybe a top of that, OK?
So 100 million a year.
[2:11:20] It's still an incredible amount
of money going out. And as we've been working
through this, these bills,
[2:11:28] this committee talking to
whistleblowers as the chair just said, we have heard
complexity and an industry
[2:11:36] fraud in Minnesota. That is
like nowhere else in the nation that would. That's actually
what
[2:11:43] to now attorney U.S. attorney
generals have said I think we have a huge problem.
I don't know why we keep
[2:11:49] pushing back on the fraud
tracker cause. It's incredibly low but just do the simple math.
Thank you. Thank you. If 2

[2:11:56] minutes anyone else okay. Up up represent Hudson.

[2:12:02] >> Thank you, Madam Chair.

I I just want to point out that as kind of a closing comment on the experience of the session,

[2:12:07] it's been interesting being in this committee will also be an education finance. And the contrast that I've observed

[2:12:13] between the commitment to scrutinize literally everything that our

[2:12:18] school districts do and to micromanage it down to the dollar versus the seeming just everything's OK when it comes

[2:12:26] to these nonprofit grants would just give the money interest that they're doing what they're doing. It will be fascinating

[2:12:31] to live in a world where we flip that script, where we had the type of micromanagement and scrutiny applied to our school

[2:12:38] districts apply to these nonprofits that are receiving grants and obviously getting away with hundreds of millions of dollars where the fraud and we actually trusted art

[2:12:46] government entities that have elected officials in place at the school board level. There's there seems to be this odd

[2:12:54] disparity in our treatment of

our local communities that aren't government entities and
these nonprofits that we just
[2:13:01] have money to address, that
they're going to do what they say. >> Thank up some Hudson.
And I hope that we work on some
[2:13:08] of that. Those issues over the
interim. >> Represent penalty will be
very quick, Madam Chair.
[2:13:14] And I guess just just to
confirm yet, nobody saying that things are out the door at all.
We just want to make sure that
[2:13:20] we have that if we're going to
be driving toward solutions, that we make sure that we truly
truly understand the problem.
[2:13:26] And when I look at the age of
28 91, it relates to watch a
[2:13:32] nonprofit grant management.
But in fact, as we've just we're hearing today, so much is
about Medicaid fraud in effect.
[2:13:39] Even when I look at the the oft
refuted tracker reference by represents a rare Rick, so many
of the items on the list,
[2:13:46] in fact, would not age of 28 91
would not apply to. So I appreciate that. Over the
course of the these hearings,
[2:13:53] we've heard a lot about grants

management policies. We've had a lot of discussion about
stating she's actions in
[2:14:00] various ways appreciated today,
especially we got into a really credible way, some the details
of how front programs of how
[2:14:07] Friday's occurring not at all,
pushing back on the idea that's occurring. We want to make sure
that we understand it well enough to drive towards
solutions. Appreciate Chair
[2:14:14] Robbins reference that age of
2029, 1 is one that she sees as the bill passed, the being
something that we come up next
[2:14:19] session. But there there are
other things I think, especially from the governor's
package and that are moving
[2:14:25] bills this session and up and
building, I should say, and the work that we've all done over
the last number of Sessions. Let's continue to take to work
based on credible specific
[2:14:33] information. It's easy to make
broad conclusion. Restatements want to make sure that we're
looking at concrete information
[2:14:39] that taking action based on
that and we can be proud a lot of the things that are moving
in bills this session that are
[2:14:44] doing just that and that's

something we'll look forward to discussing next session is the
cause that your it's set to? Thank you. Chair Robinson,
thank you, Chair Anderson.
[2:14:49] >> Thank you. Chair Robbins,
thank you in closing. I appreciate that representative
can do. But I want to remind
[2:14:55] the committee that these
suggestions and 28 91 came from the agencies and from the L a
there have been only report
[2:15:03] after LA report about fraud in
grants management. And we have
[2:15:09] made steps towards addressing
some of that. But these are recommendations they requested
that we tighten up, that we
[2:15:17] require the training that we
ensure that state agencies have
[2:15:23] whose staff I have grant
oversight actually know how to perform the functions that we
have a list of required
[2:15:31] functions like closing out the
grant before final payment is made numbers. These are simple
things that honestly I think we
[2:15:39] took for granted were happening
but they have not been happening and I'm not a fan of
micromanaging in statue down to
[2:15:45] this level, but that is what

they are asking for because it is not happening across all the agencies and we are going to

[2:15:53] clean up this mass of fraud, whether it's Medicaid, whether it's with the providers or whether it's in nonprofit

[2:16:01] grants management, we should be responsive to the things they have asked for in these recommendations came out of our

[2:16:08] hearings. So I look forward to continuing this work with all of you. And I do well, we'll advise you and schedules over

[2:16:15] the summer, but we do hope to meet in the interim to continue this work. Thank you, members. Thank you. We're adjourned

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 07-08-2025

[0:11] >> Stab list. And today we're going to have
an informational hearing regarding the interplay between
the Office of Inspector General
[0:20] and a DHS commissioner. And we
are going to be hearing particularly going to questions
we've had for a few months now
[0:27] in Medicaid. Eligibility rules
and how you're managing a verification of eligibility for
enrollees and providers and
[0:37] some of the payment issues.
We've seen a Medicaid. So that's the scope of today's
hearing. We do have minutes
[0:43] from our May 5th meeting, but
we are not going to approve them today. Committee members,
there's been some discussion
[0:50] with staff of weather when
we're out of session. That's the right approach. So we will
[0:56] take that up with counsel and
decide at the next hearing, whether it we're going to
approve minutes. So we'll just
[1:02] have for today. So before we
get started members, I just
[1:07] wanted to take a moment.
I know this is the first official meeting of anybody

sense that

[1:14] horrific assassination, some

Speaker Hartman and her husband Mark and the release of the

attempted assassinations of

[1:21] senator happen and his wife. And we just want to acknowledge

that that is still a process

[1:27] where all dealing with and

grieving. And we continue to pray for the Hartman family and senator half and delighted

to see that he was released to

[1:36] re have yesterday. And, you

know, we just start failed about that and we will continue

to pray for he and that's

[1:43] complete recovery back. Certainly it's important for us

as a body to show the public

[1:49] that the work of the

legislature continues. And I do think and Speaker Hartman was

very practical percent focused

[1:57] on the institution of the

legislature. And I think that we are honoring her by

continuing our work. And I know

[2:04] chair Pinto would like to say a

few words as well. >> Yes, thank you, chair.

Thanks so much for those for those remarks. And one thing I

want to make sure to say

[2:11] publicly is a big thanks to the

people of Minnesota for their support and messages of just of

love to so many of us seeing

[2:21] people at the vigil on that

Wednesday after the assassinations. And then when

they were lying in state on

[2:28] that that following Friday that

provided a measure of healing and support. And I mean, I

think a lot of leaping over

[2:36] those couple weeks and those

events in particular, this just really powerful and so really

want to say thank you to folks

[2:43] that support for for all of us

were thinking about. Listen, Mark, and I'm just so grateful

for for the leadership. He

[2:52] provided the spotty. I'm

thinking, especially today about for her to get this from

my colleague represent 3 men

[3:00] that the work that we do here

is is really about people and the impact on people. And I

feel like she pushed us so

[3:06] often to be thinking in those

terms, it actually feels appropriate to me that we're

having this this hearing at this time. The Medicaid, which

is a focus on the going to be

[3:14] talking about today is is so

much about the impact on people, making sure that they

have on the health care that

[3:19] they need to to lead successful
lives and so and really grateful to the public servants
who work to make sure that
[3:26] program is available for those
who need it. It's a program that is in a lot of our minds
right now. I'm not I'm sure we'll talk about this
throughout the hearing. But the
[3:33] they've been recent action in
Congress on that. We know it can take a lot of people off
the program. Eligibility
[3:39] determinations are going to be
especially important. Want to make sure they would in any way
prevent people from being able to access the services as a
safe that impact on people.
[3:47] I guess I'm going to have that
continued uppermost in my mind, both this hearing and and this
upcoming session. And I hope
[3:53] and would imagine that all of
us will have that as well. So thank you, chair for this
opportunity. Thanks. Thank you.
[4:00] >> And before we get started, I
just want to kind of remind the public how we got here today.
Sweida originally scheduled and
[4:07] May 5th hearing with DHS to
talk about Medicaid eligibility and just due to end of session
budget negotiations. They

[4:15] requested a delay which we were

happy to accommodate. And then we rescheduled for June 24th

[4:20] because that intention of this

committee is to meet monthly during the interim. But then

during due to the horrific

[4:26] assassinations, we again

delayed. And now we are back. So this hearing has been months

in the making. We have been

[4:34] trying to get a handle on just

sort of a level set for us as

[4:39] committee members and the

public about the work of the Office of Inspector General and the work of DHS and how we verify Medicaid eligibility.

[4:48] So with that, I'll turn it over

to acting commissioner sharing Gandhi and her team. And I

think I know you've outlined 2

[4:57] different presentations.

Let's just tried a run through both of them and then we'll

have more of a wry wide-ranging

[5:03] discussion at the end. >> Thank you. Thank you.

Chair Rob and sleet, Pinto and

[5:08] members of the committee.

For the record. My name is sharing Gandhi and I'm serving

as temporary commissioner for

[5:14] the Minnesota Department of

Human Services. Before we begin today, I just

want to also share my

[5:21] condolences with all of you and

your staff for the political violence that unfolded just 3

weeks ago. It's hard to believe

[5:31] the assassination of Speaker

Mr. It to court men and her husband Mark and Senator, the

attempted assassination of

[5:40] Senator Hofmann and of that are just heartbreaking where

we're heartbroken over it.

[5:47] We're angry and we just want to

acknowledge that many of us are still reeling from those events

as well.

[6:00] So getting as you said, Chair

Robbins getting at the task at hand today.

[6:06] I want to start off by thanking

you. We are grateful for the legislature's focus on

preventing and detecting fraud

[6:15] last session. Most of the provisions that

were in the governor's budget

[6:21] in the fraud package were

supported by the legislation by the legislature, including many

of you.

[6:28] We also enjoyed collaborating

on program integrity, measures that were not included in the

governor's budget but also

[6:35] support program integrity in particular. We worked

closely with Chair Robbins Le

[6:41] Pen tell chairs Schumacher in or chairs, backer and Biermann

[6:48] Representatives, Norris and

Anderson and Judiciary and public safety

chairs and members on those

[6:55] committees R Minnesota. Medicaid programs

help more than 1 million people

[7:01] access the care they need

medical care, therapy, treatment, housing and other

services that allow people to

[7:10] stay healthy and to contribute

to the economy. We know that fraud hurts the

people who need the services

[7:19] program. Integrity work is a

high priority for DHS and the Walls. Flanagan administration.

So I thank you for your

[7:27] partnership on this. The committee's focus on fraud

oversight led to many important

[7:36] reforms in the governor's

budget being enacted this last session. This isn't an exhaustive list,

but I'll name a few reforms to

[7:45] celebrate and recognize our

collective efforts prohibition on illegal

remuneration. Ys also known as

[7:53] kickbacks for medical

assistance, which is Medicaid. What we call Medicaid in

Minnesota and child care

[8:00] assistance programs, prohibition on duplicative

billing

[8:05] provider, compliance training

required prior to enrollment for unlicensed services.

[8:13] The authority to share data

including claims data with state and federal agencies to

investigates suspected fraud.

[8:22] The authority for DHS to

disclose payment withholds

[8:27] the authority for DHS to Bill

Nye Licensure applications or temporarily suspend the license

for individuals that are the

[8:35] current subject of a pending CE

administrative civil or criminal investigation.

[8:43] And then more specifically for

autism services, which are known as early intensive

developmental and behavioral

[8:51] intervention. A new provisional license was

enacted for the IDB. I it's a

[8:59] short-term staff. That bridge

is us to allows us to increase oversight until robust

licensing standards are

[9:08] developed with community input. The ID providers will be

required to be valid. 8 their

[9:14] Medicaid enrollment every 3

years. Instead of every 5 years, DHS will have the authority to
investigate maltreatment
[9:23] allegations in the IDB. I we will have tightened
standards for the IDB. I to
[9:31] ensure a background study is
completed before an individual is allowed to start work.
[9:38] It's added staff to DHS to
manage the additional eligibility and compliance
checks that will be coming
[9:47] allowing for a higher volume of
on-site screenings and background studies
[9:53] and improved oversight of
clinical requirements to ensure high quality service provider,
retention and better outcomes
[10:01] for children and families for the Housing Stabilization
Services program. Legislative
[10:10] changes enacted include billing
unit limits, capping billing at
[10:15] 100 hours annually per client limits on remote support to no
more than 20% of all housing
[10:24] transition services required compliance training
[10:30] before enrolling in rollers and
managers involved in day-to-day operations are required to
complete training on a number
[10:38] of items including state and
federal feeling documentation and service delivery

requirements. Enrollment

[10:46] requirements program integrity,

including fraud, prevention detection and penalties.

The fair labor standards work

[10:54] safe, workplace safety

requirements and recent changes in service requirements.

[11:02] It also added additional

funding for more site visits. Providers will get a

pre-enrollment this

[11:08] pre-enrollment visit as well as

unannounced site visits.

[11:14] We are also conducting pre

enrollment risk assessments for

[11:19] all new and renewing providers

as part of confirming provider eligibility. That was effective

July 1st

[11:28] and our pre enrollment risk

assessment which we call para

[11:33] for short in case I use that

acronym will a covered the providers

history of performing similar

[11:42] services. Whether enrollment

would require the provider to

[11:47] perform at a significantly

increased scale. And if so that they have the capacity to do

that

[11:55] for the providers, financial
information and internal controls compliance with other state and
federal requirements, including
[12:04] the barman and suspension
status. And they're standing with the secretary of state
[12:10] increased documentation
requirements. Recipients of the services must sign that they
received the hours that were
[12:17] billed. And lastly, surety bonds
providers must show proof of
[12:23] surety bond, which helps
guarantee performance by the provider or the state will be
compensated and the Surety
[12:31] seeks repayment from the
provider.
[12:38] So with me today is DHS is
Inspector General James Clark.
[12:45] He joined DHS at the end of
March and brings a wealth of experience prosecuting fraud in
human services programs.
[12:53] I feel fortunate that we found
somebody that knows both DHS and the Medicaid program.
[13:01] He comes to us from the
attorney general's Medicaid fraud Division.
[13:07] James not only knows DHS
programs. He has taken down fraudsters and has strong

partnerships with law

[13:15] enforcement as an assistant attorney

general. He investigated and

[13:21] prosecuted CE criminal and

civil cases involving the theft of Medicaid funds.

[13:26] The False claims Act violations

and the abuse neglect and financial exploitation of

vulnerable adults.

[13:35] He has white experience

managing complex financial investigations of nearly every

type of Medicaid fraud.

[13:44] As assistant Attorney General

James also represented DHS in state and federal courts

[13:51] and for administrative hearings

giving him a broad understanding of DHS

[13:56] and beyond. This Inspector

General Clark understands hope critical human services are to

the people of Minnesota having

[14:04] worked for legal aid after

graduating law school. I am grateful that Inspector

General Clark's professional

[14:12] path brought him to DHS and he

is immediately put his considerable talents to work

for our Office of Inspector

[14:19] General Chair. Robin said like to have

Inspector General Clark introduce himself and provide

more information on DHS is

[14:28] Inspector General office. >> Thank you. Welcome to the

committee Inspector General Clark pleased to start with

saying saying your name for the

[14:35] record. >> Good morning. Madam Chair

members, James Clark

[14:41] and the suspect knew inspector

general at the Department of Human Services. So I first want to thank the

committee for having me this

[14:47] morning. As you know, and I just introduce myself, James

Clarke, the new inspector

[14:54] general and DHS as of March

prior to this role, as the commissioner said, I worked at

the attorney General's Office

[15:00] for close to a decade. I've investigated and

prosecuted doctors, nurses, dentists, therapists, business

owners, killers, all for

[15:09] Medicaid fraud from all

different and business owners of all different Medicaid

provider types sent people to

[15:16] prison for stealing Medicaid

dollars. I've helped to secure several millions of dollars in

monetary recovery for our

[15:21] state. I take this work extremely

seriously. And I also care deeply about

the people that Medicaid and

[15:28] other public benefit programs
are designed to help. As the commissioner said after
law school, I worked for
[15:33] several years at legal aid in
Minneapolis where representative people who
depended on Medicaid and other public benefit programs for the
family's health and safety.
[15:41] I have many clients that
remember vividly crying in my office at the prospect of
losing their public benefits.
[15:47] This work is critically
important to the people of our state and that's why I'm
passionate about it.
[15:52] The fact that people decide to
steal from taxpayer funded programs that are designed to
help people in need is
[15:58] reprehensible. Personally, I
find it disgusting. It's also illegal. But I think most importantly,
it's also immoral.
[16:05] It harms taxpayers but also
harms the very people that these programs are designed to
help.
[16:11] I know the schemes that
providers are engaging in because I spent years
investigating investigating and prosecuting them.
[16:17] Part of why came to BHS from

the Attorney General's office. Medicaid fraud division was to
share my knowledge of Medicaid
[16:23] fraud schemes and help
strengthen the ongoing work. The DHS is doing an
administrative oversight on the
[16:29] front end. Unfortunately, we all know
Medicaid is on the chopping block. People in Minnesota
around the country are at risk
[16:36] of losing their health care.
I think right now we need to be more vigilant than ever to
ensure that we are safeguarding
[16:42] Medicaid dollars and they are
not being stolen from us. I will do everything I can in
this role to detect and prevent
[16:48] fraud and hold bad actors
accountable. Continuing the work that I did at the Medicaid
fraud division at the attorney general's office. And I look
forward to working with all of
[16:56] you on these important issues. So I do have a few slides that
have some high level
[17:05] information about how it
functions. So I want to start by giving
some background about the work
[17:10] the inspector general's office.
So the inspector general's office has 3 core program,
integrity functions as the

[17:16] slide shows background studies. We call them background studies. Most people refer to them as background checks, licensing of providers and then
[17:24] provider investigations.
So our fight against fraud and overbilling starts at the front end with vetting and educating
[17:31] providers. Background studies prevent bad actors from gaining access to children, vulnerable adults and Medicaid dollars.
[17:38] The background studies division at the Office of Inspector General conducted over half a million background studies on
[17:44] entities and individuals each year and determines whether there's criminal conduct or other disqualifying information
[17:52] that would that prohibit someone from gaining access to Medicaid recipients are Medicaid dollars. So that's
[17:58] where we start on the on the front end that in providers making sure they don't have disqualifying criminal conduct.
[18:04] Moving on to the licensing division, the Licensing Division vets provider applications and conduct
[18:10] inspections to ensure that license programs such as substance use disorder

providers and home and community-based service
providers comply with required
[18:18] statutes and rule rules that
that often involve site visits to providers, reviewing
records, interviewing
[18:25] recipients that receive
services at those programs to make sure that no treatment is
not occurring and make sure
[18:30] that the laws being followed
that license programs. Finally, a core function of the
Office of Inspector General is
[18:37] providing investigations. The Office of Inspector General
is responsible for overseeing
[18:42] close to 300,000 Medicaid
providers in the state of Minnesota. We currently have 988 so close
to 1000 open cases that we're
[18:53] investigating. Important to
note that not all cases and investigations resulting
findings of fraud. Wright.
[18:59] Oftentimes there's
administrative errors that we're investigating. There's
over billing issues that may
[19:04] not have been the result of
fraud, so mistakes. But nevertheless, we're
investigating all of those
[19:10] cases nearly 1000 to make sure

that we are identifying any any

[19:15] problematic billing practices

and recovering any money that the state is entitled to.

[19:20] It is important to note that

DHS is not responsible for investigating Medicaid

recipient fraud.

[19:26] Each of the 87 counties in

Minnesota is responsible for enrolling in detecting

potential recipient fraud.

[19:33] Right? So we're thinking about

investigations at the Department of Human Services.

We are

[19:38] so we investigating Medicaid

providers. Well, we do some

[19:44] Minnesota care investigations

but not Medicaid recipient investigations.

[19:50] I also want to stress the DHS

OIG is not a law enforcement are prosecuting agency.

[19:55] Our role is providing

administrative oversight. However, we work closely with

law enforcement partners at the

[20:01] local state and federal levels

to develop strong cases they can take the court. One of the reasons I came over

to the Department of Human

[20:08] Services is to further

strengthen the partnerships between OIG and the Attorney

General's office. Also our
[20:16] partners with HHS OIG, the FBI
and the U.S. Attorney's Office. In my short time here, I've had
several meetings and briefings
[20:24] with our federal law
enforcement partners on on fraud schemes and providers
that that we are looking at.
[20:31] I G I think it's also important to
note that the vast majority of cases prosecuted in our state
originated as referrals from
[20:39] the Department of Human
Services. But referring the case to law
enforcement does not. And the
[20:44] Department of Human Services
work after a referral is made.
Dhs also plays a critical role
[20:50] throughout the wife of a
prosecution speaking from experience and
trials and hearings at the
[20:56] attorney general's office.
Really our work depended on the data. The documents in the
witnesses at trial from the
[21:02] Department of Human Services
know Medicaid fraud investigation or prosecution
can be successful in the state
[21:08] without the work of Department

of Human Services employees.

[21:14] Next want to talk about Office

of Inspector General collaboration. As I said earlier, we currently

oversees close to 300,000

[21:21] Medicaid providers. And my

short time at DHS I've seen

[21:26] it's very important to be able

to collaborate closely with DHS, Polly's policy areas,

Medicaid rules and statutes,

[21:35] as you all know, can be

complicated. They are lengthy. So when OIG staff investigates

providers, we rely on the

[21:44] administrative expertise of DHS

policy staff who know the rules and requirements of these

programs, most intimately

[21:52] working closely with the adjust

policy staff also gives the Office of Inspector general the

ability to share our hands-on

[21:59] knowledge about fraud schemes

and over billing schemes were saying to work with the policy,

the policy teams to develop

[22:07] policy in statutory revisions

that can strengthen compliance, accountability and enforcement.

[22:13] This collaborative approach helps ensure that the Office of

Inspector general in policy areas maintain a unified

strategy for protecting

[22:21] taxpayer dollars. So my 3
months here we are frequently I've seen. We are frequently in
communication with DHS policy
[22:27] areas thinking about ways that
we can strengthen program integrity across the chest
programs.
[22:38] Next want to highlight the fact
that the Office of Inspector General uses data to
proactively detect and prevent
[22:43] fraud, waste and abuse. We have our own in-house data
team, our Data Analytics
[22:49] Division that monitors Medicaid
billing data to identify problematic,
[22:54] billing patterns and billing
outliers that we can then review that data to identify
investigative targets. So we
[23:01] have our own in-house data team
that's proactively monitoring or billing information
informing our next
[23:08] investigative steps. It's also important to point
out that the Office of Inspector General Partners with
private sector vendors to
[23:15] detect and prevent fraud, waste
and abuse. We work with the CMS. So the
Center for Medicaid and
[23:22] Medicaid Studies or services

mandated federal contractor. We work with that contractor
called the U-PICK is the
[23:29] acronym, the UNIFY Program,
Integrity, Contractors. So each state Medicaid agency is
required to have a CMS
[23:35] contractor working with them so
that contractor proactively reviews are billing data to
detect fraud, waste and abuse,
[23:43] prevent fraud, waste and abuse
and also identify program formal former abilities in room
for improvements. We also work
[23:51] with the private sector
contractor to conduct audits of providers and recover
overpayments. So DHS is doing
[23:59] that work in house, but we also
leverage the experience of the private sector to help us with
reviewing billing data and
[24:07] conducting audits of of
providers and recovering over payments. The last thing I know is that
Minnesota is a 90% managed care
[24:15] state. So we have Ali rely on the
proactive investigative work of our managed care partners such
as you care, Medica Blue Cross
[24:23] and health partners who are
responsible for fraud detection and prevention in the 90% of
Medicaid dollars that funneled

[24:31] to them. So each of the mco is
that we contract with they all have investigative units that
column special investigative
[24:39] units who are responsible for
detecting and preventing fraud. Right. So internally, DHS is
doing a lot of work. We also
[24:47] work with private contractors
and we also rely on the private sectors are private health care
companies here in Minnesota to
[24:52] prevent and detect fraud of the
Medicaid dollars that they work that they receive.
[25:00] Next. Call briefly walk through
this flow chart. Slides to the slide, contains a flow chart
outlining the process for
[25:07] handling provider complaints at
the Office of Inspector General. Again, we're well. We review
all complaints, tips or
[25:14] information shared with us tips
can be submitted online through
[25:19] the DHS website by phone by
e-mail in-person. We will take tips from any source who wants
to come forward with complaints
[25:27] about Medicaid providers. We have a 0 tolerance policy
for fraud, waste and abuse and
[25:33] we take every complaint
seriously and track. All of them are centralized computer

system.

[25:39] So first intake staff will

review the complaint. The complaint is not regarding a

provider who bills DHS

[25:44] programs. We will reroute the

complaint to the appropriate area. Maybe it's a county

issue. Maybe it's a different

[25:50] state agency issue. For

example, we get complaints about health care providers who

don't participate in the

[25:56] Medicaid program, but they

might be licensed by the Department of Health. So we

refer those complaints to the Department of Health.

[26:03] Sometimes our office will need

to reach out to the reporter to gather additional information

or clarification.

[26:10] So, for instance, names

addresses more information about the provider dates and

times.

[26:16] So we'll do that. Will gather

information to get clarification when all

necessary information is

[26:21] gathered. A preliminary

investigation will occur. A preliminary investigation is

really just a very high level

[26:28] overview of the information we

can gather from the complaint. So really is the provider are looking to provide are actively
[26:35] building us and is the recipient who maybe made the complaint are the recipient that's involved with the
[26:41] complaint? Are they actively receiving services from that provider? So if a complaint concerns a Medicaid provider that is
[26:48] actively billing U.S. and there are allegations of improper improper billing, we will open up a full investigation.
[26:54] Our investigations involve reviewing documents, doing on-site visits, doing interviews, looking at bank
[27:00] records, looking at billing records, really looking at all of the information we can get our hands on.
[27:05] And the finding of that full investigation will determine the office of Inspector generals next steps. Those
[27:12] steps can include in cases of where we see evidence of fraud referrals to the attorney general's office or the FBI or
[27:19] other federal law enforcement partners. Again, you know, if we don't see allegations that rise to

[27:27] the level of fraud, we could
take administrative action such as a termination of a provider.
We can suspend the provider
[27:34] from participating in the
Medicaid program. We can suspend their pick them from
receiving payments during an
[27:41] investigation. When we see
fraud and at the end of investigations, we can take
them to the court at the office
[27:47] of administrative hearings to
recover overpayments. Just like to point out that the
the case that I last charge
[27:55] before coming over here at the
attorney general's office was a pretty large racketeering
case involving a Medicaid
[28:01] provider, personal care agency.
And that case, right that I that I charge worked its way
through this process, right?
[28:09] So it started as a complaint, a
Medicaid recipient calling the just saying, hey, look, I'm not
getting the care that I'm
[28:16] supposed to. I think
something's wrong with this company. Dhs investigated that complaint
through this process here.
[28:23] The just stop payments to the
providers. Do you just referred to the attorney general's

office? The attorney general's
[28:29] office expanded the scope of
that investigation and ultimately charged a very large
racketeering case for that
[28:36] provider. So that's all I have in terms
of slides. Again, that's a very high level overview of the
work. We do not give it back to
[28:42] the commissioner. Thank you very much,
Commissioner County. >> Thank you. Chair Robbins
members of the committee.
[28:50] The committee also asked us to
provide information on Medicaid eligibility and oversight of
the program. So our remaining
[28:57] slides will cover this request. Federal law establishes the
minimum eligibility
[29:03] requirements for individuals to
qualify for Medicaid. There are many factors that impact
Medicaid eligibility including
[29:12] citizenship, immigration
status, state residency in come in
[29:18] assets for some in Minnesota counties make
individual medical assistance.
[29:25] Eligibility determinations as
inspector General Clark noted and oversee alleged recipient
fraud
[29:35] to be eligible for medical

assistance. Applicants must be a citizen, be a U.S. citizen or have a Medicaid qualified
[29:44] immigration status reside in Minnesota, Minnesota, their home
[29:50] provide their Social Security number as a condition of eligibility unless they meet certain exceptions.
[29:59] Generally, a person's income must be less than or equal to the appropriate income limit. Income limits vary based on a
[30:08] person's basis of eligibility. So, for example, a child a pregnant woman, apparent adult
[30:16] without children, seniors or people with disabilities, income limits are based on federal poverty guidelines and
[30:24] are updated annually. There is an asset limit for people who are 65 or older and
[30:31] people who are disabled assets are counted, including checking account savings accounts, money market accounts, certificates
[30:40] of deposit, certain truss non homestead, real property, certain vehicles and other items of value.
[30:48] The asset limits are 3,000 for a household of 1 6,000 for a
[30:54] household of 2 and $200 for each additional

households member.

[31:01] There are no asset limits for

children, pregnant women, parents or adults without

children as specified by

[31:07] federal law. There are other program rules.

So for example, to qualify for

[31:16] MA as a parent, you must live

with your child who is under age 19.

[31:22] Eligibility determinations are

made by the counties and tribal workers with system support

from DHS.

[31:37] A renewal is a review of income

and other information to see if

[31:42] individuals and other family

members are still eligible for medical assistance. Generally,

this happens once every year

[31:50] at renewal, Medicaid agencies

are required to first check electronic data sources to see

if they can automatically renew

[31:57] an individual's eligibility

before requesting additional documentation. Use of these

electronic data sources helps

[32:06] improve the accuracy of

eligibility determination, reduces the workload for county

and tribal eligibility staff

[32:15] and reduces the reporting

burden for MA enrollees. If eligibility is confirmed
using these trusted data
[32:23] sources, the individual is
mailed a notice and information summary to review for accuracy.
[32:30] If the information is accurate,
the individual does not need to do anything.
[32:36] If the information is not
accurate, they must report any changes or corrections to their
county or tribal processing
[32:44] agency. If eligibility cannot be
confirmed, a renewal for is
[32:50] mailed to the individual to
complete sign and return with the required proofs, for
example, incoming assets.
[32:59] If the individual is subject to
an asset limit, if they failed to return the
form, then that will result in
[33:08] the loss of eligibility and
their case is closed and they are mailed a 10 day
advance closing notice.
[33:18] In addition between the annual
eligibility renewals, there is data matching with trusted data
sources to identify individuals
[33:26] who may no longer qualify due
to income or death. These individuals are sent a
discrepancy notice and must

[33:34] respond by completing and
returning the form or contacting their processing
agency. If they fail to respond
[33:41] their eligibility closes.
If they respond, their eligibility is re determined to
see if they remain eligible.
[33:51] Want to share the data sources
that we use Medicaid. Eligibility determinations
involved the use of a number of
[33:59] trusted federal and state data
sources. You can see many of them listed here on the slide.
They corroborate the
[34:07] information provided by the
individual at application and annual renewal.
[34:14] The data that we use includes
data from the Social Security Administration to verify Social
Security numbers,
[34:23] SSA benefits and U.S.
citizenship and identify deaths. The U.S.
Department of Homeland Security
[34:31] is used to verify immigration
status. The Internal Revenue Service is
used to verify income and self
[34:38] employment. Equifax also known as the work
number is used to verify wages.
[34:46] The Minnesota Department of

Employment and Economic Development is used to verify
wages and unemployment
[34:53] benefits. The asset verification services
used to verify certain
[34:58] financial accounts, such as
checking savings and CDs and identify an reported financial
accounts for those that are
[35:07] subject to an asset limit. And the Minnesota Department of
Health State death records are
[35:13] used to identify enrollees who
have passed away and their eligibility.
[35:21] So the committee also asked us
about the COVID-19 pandemic. At that time. All states were
required to maintain health
[35:29] care coverage for Medicaid
enrollees. This pause regular eligibility
checks and renewals.
[35:37] Minnesotans newly gained
eligibility are already had. Eligibility for medical
assistance for Minnesota care
[35:45] remained enrolled in the
coverage regardless of most changes in their lives. That
previously would have affected
[35:52] their coverage. Continuous coverage help
Minnesotans access care during
[35:57] the global pandemic and

maintained high insurance coverage rates in the state
[36:04] in the spring of 2023. Congress
pass legislation requiring states to return to standard
medical Medicaid eligibility
[36:13] procedures which included an
annual eligibility review.
[36:18] This meant as of March 31st.
2023, the continuous enrollment
[36:24] provision ended the process of
renewing all recipients was completed in June of 2024,
which was a very heavy lift for
[36:33] the counties in the state. And for the past year, regular
annual renewals have been
[36:38] taking place. Turning back to program
integrity. Dhs is currently in
[36:47] the process of implementing
laws enacted by the 2025 legislature.
[36:52] Paramount to this work is
ensuring that the laws are implemented. According to the
letter of the law and as
[36:58] intended DHS looks forward to ongoing
collaboration with partners to
[37:04] implement what was passed.
There are many steps to implementation.
[37:09] We have to communicate. Some of
you may have seen the emails from DHS, a new laws or heard

about or pardon end of session
[37:17] presentation. It's important
that DHS communicates new requirements with providers,
community update fact sheets
[37:28] provider manuals hold meetings
with various partners and constituents including counties
provider associations, tribal
[37:37] nations advocates and health
care systems. We also have to clobber
collaborate across DHS program
[37:44] areas to implement Medicaid
changes. This requires updates to the Federal Register member
notices provider notices
[37:53] managed care, contract,
amendments and federal approval. In some cases, DHS needs to
submit amendments or waivers to
[38:02] the Centers for Medicare and
Medicaid Services seeking federal approval.
[38:07] As part of this process, DHS
must post changes for public comment and work over the
course of approximately 3 to 6
[38:15] months to get approval. We also have to update systems
as we've talked about in this
[38:21] committee previously, which is
critical component of implementation. We partner with
minute on that work as well as

[38:29] expected external vendors.

[38:36] While we are next slide in the

midst of managing this important work of implementing

state changes, the federal

[38:45] budget reconciliation bill was

just signed into law on July 4th,

[38:50] DHS is still assessing the

fiscal and enrollment impact of the bill on Minnesota health

care programs.

[38:58] But estimates are that it cuts

roughly 500 million in annual funding to Minnesota

[39:04] while increasing costs and red

tape for county's hospitals and

[39:09] enroll. These the Association for Minnesota

counties estimates that the

[39:15] requirements in this bill will

double and possibly triple the administrative workload to

counties

[39:22] counties of share that even

with the recent funding Minnesota's outdated systems.

[39:29] Some of those are ones that

we've talked about in various committees. S S I S M access

mats will make it very

[39:37] challenging to implement this

bill. They are assessing the specific

cost to the state for systems

[39:43] upgrades as they plan for the
2026 legislative session.
[39:49] And the most recent projection
from the Kaiser Family Foundation for the
reconciliation Bill estimates
[39:55] that between 150,250 1000
Medicaid enrollees in
[40:01] Minnesota, we'll lose coverage
because of the bill people with disabilities, older
adults, people with mental
[40:09] health conditions, rural
hospitals and nursing homes are likely to be the hardest hit by
a weakened state Medicaid
[40:18] program. It's important to keep in mind
that impacts and Minnesotans
[40:23] who rely on Medicaid. Minnesota
providers and Minnesota's taxpayers are cumulative an
interactive
[40:32] among the many provisions the
bill implements work reporting
requirements, six-month
[40:38] eligibility checks and cost
sharing for adults in the expansion group
[40:43] reduces retroactive coverage
which means Emmy applications need to be submitted quickly to
ensure people have the coverage

[40:52] they need for their bills to be
paid to providers. This puts additional pressures
on navigators hospitals and
[41:00] counties and others who assist
people in filing their applications for MA.
[41:07] It prohibits federal Medicaid
funding for some family planning clinics, eliminating a
critical access point for
[41:14] reproductive health care
services and implements tough, tougher
restrictions on state directed
[41:20] payments and provider taxes
which present an obstacle to implementing hundreds of
millions of dollars in rate
[41:28] increases for hospitals, basic
care providers and behavioral health providers throughout the
state.
[41:35] So in short, while we are
working to implement the strong program, integrity measures
that this legislature past,
[41:42] we are also juggling the
significant changes, federal changes that are costly to
Minnesota.
[41:53] >> Great. Thank you very much.
And I just was checking. We had to testify or sign up to
testify virtually, but she here

[42:01] yet. So I think we'll move on
to member questions and then interrupt ourselves if
[42:06] she does join us. And also
following up on that, we did
[42:11] during the discussion, learned
that we can approve minutes during the interim. And so with
that of Vice Chair Anderson,
[42:19] I wonder if you would be
willing to move the minutes from May 5th. And with the
minute
[42:24] move, the Mets May 5th. Thank
you. Great. And the minutes are in your packets. Does anyone
have any questions?
[42:32] All those in favor of approving
the minutes from a 5th. Please signify by saying Aye. I
opposed
[42:38] minutes are excepted. All
right. Now we will go on to member questions. I have a list
and there will be a lot.
[42:45] So we look forward to this
discussion with you all. Thank you for your testimony.
[42:50] >> I think. >> And well, let's start a chair,
Eric. I have so many. I need to
[42:56] get my own thoughts together.
Terror. Thank you, Madam Chair. Thank
you all for being here and

[43:02] being back so many times.
Commissioner Gandhi, appreciate that. And it's great to have
the new inspector general.
[43:09] It's fantastic. So I just want
to get a better understanding of the inspector general's
office within DHS. It's
[43:16] interesting that you would work
for the attorney general because we had key 1000
attorney general and and when
[43:22] we were talking with the
Attorney General Ellison, he had mentioned that they
oversee 20 billion dollars a
[43:30] year and Medicaid money.
And I'm just wondering if you I got a few questions around that
and maybe you can verify that
[43:37] if that's accurate with money,
that kind of flows or DHS and some things that they're
responsible for in,
[43:44] you know, because they're all
the fraud they're responsible for in Medicaid, the Medicaid
area. So
[43:50] the question is, is a
20 billion dollars annually of money that flows through for
Medicaid. And secondly, I also
[43:59] at that time when he was here,
we talked about the this

[44:04] appropriations or incorrect
payments or fraud or whatever category want to put it in.
[44:11] And we talked about that
briefly. But at that time, I had kind of thought about the
number of one point 5% because
[44:19] that was a really, really low
misappropriation rate from Devon. We had all of the money
going through from a COVID
[44:26] money. But since then, a
federal number has come out with this big bill that was
just passed and it was 5.0 6%
[44:36] of an inappropriate payment
rate. And want to do, though that number instead of it being
say 200 million a year of fraud
[44:45] or mis appropriations, it's
1 Billion. So I'm wondering because you
didn't give us any of that
[44:51] high-level information. Can you
first tell us how much flows through DHS for Medicaid?
Secondly, what is your fried
[45:00] rate is at one percent? Is it
too? Is a 3. Is a 45 isn't higher than that possessions of
federal average for Medicaid.
[45:08] Thirdly, I want to know you said you had a about 1000 cases right now
approximately 1000 cases.
[45:18] And if I recall in previous

testimony, you had 490 ones are
[45:23] too shy of 500 employees at the
suspect Inspector General office. So for can you tell us
how many employees that you
[45:31] have and how many of those
employees are working on the cases? Because if you had say
almost 500 employees and only
[45:37] 1000 cases, that's only 2 cases
per investigator, which seems
[45:42] kind of low. But I'm assuming
that you have other folks doing other things. But can you kind
of do a breakdown? So I hope
[45:49] you got all that all those
questions. And I did it that way so that we can move
quickly. Thank you, Madam Chair. >> Yes.
[45:56] >> Commissioner County, our
Inspector General Clark stunt.
[46:02] >> Thank you, Madam Chair.
Thank you, Representative Eric. So there was a lot lot to
unpack there. So I will try my
[46:08] best. So I believe that figure
20 billion dollars. I believe that's the total
amount of Medicaid spending in
[46:16] the state of Minnesota. Right?
So when the attorney general's office is saying our Medicaid
fraud division is responsible

[46:22] for overseeing 20 billion
dollars, I think that's what he's saying. Right? And we know
that not all 20 billion dollars
[46:28] is is being stolen to fraud.
But there is a percentage that is hence we have prosecutors
that prosecute those cases
[46:36] where there is fraud. So I
think that 20 billion dollars is is correct or close to
correct. I think it varies from
[46:41] year to year. Looks like the
commissioner shaking your head, right? So 20 billion dollars.
The attorney general's Medicaid
[46:46] fraud division is responsible
for overseeing scary thing is they only have about 6 or 7
prosecutors, right. When you
[46:54] think about the amount of
resources that would be needed right to really oversee a
20 billion dollar program.
[47:02] We have to think about whether
or not the attorney general's office says the amount of
resources it needs and also whether DHS OIG has the amount
of resources it needs.
[47:09] 20 billion dollars is a lot for
us to to be in charge of unsafe car. This second part of your
question is was about improper
[47:17] payment rates. I've seen that

figure where CMS is estimating nationwide. It's about a 5%
improper payment rate. The most
[47:28] recent figure I saw it. I kind
of anticipated this question because I saw posed of my
former boss Nick Walker from
[47:35] the Medicaid fraud division
when he was here to testify. So did some digging,
thankfully, some of our folks
[47:40] at DHS. And so the most recent
statistic I was able to find to CMS study from 2022, which says
that Minnesota's improper
[47:49] payment rates are actually less
than the national average rising to 2.2% rate of improper
payments in Minnesota. So this
[47:56] was in 2022. With I was preparing on the fly
here, going at DHS been here about 3 months, but at least
CMS said as of 3 years ago,
[48:06] we were better than the
national average in improper payment rates. And also it's
important to note improper
[48:12] payments is not being fraught,
right. There's a lot of administrative error. Lot of,
you know, documentation issues,
[48:20] not everything that we
investigate. So getting to the 1000 cases, right? I think I
wish I had the percentage.

[48:27] I don't get a new here. I can
get that information for you. But it's it's a small
percentage of that 1000 that
[48:34] then gets referred to the
attorney general's office for suspected fraud. I think so far
in
[48:40] 2025 and I wish that these
figures in front of me it's around 30 or 40
[48:46] cases are referrals for
suspected fraud. That OIG is made to the attorney general's
office so someone can do the
[48:54] bath Matthews better than me.
Right at the 1000 or so cases. We have that we're looking at
any given time. We're on
[49:02] average refund, suspected fraud close to 100 cases a year.
So
[49:10] Senate, hopefully that answers
your question.
[49:15] >> Thank you. Just a quick
follow-up. So I also like to know how many employees who had
have it at the inspector
[49:22] general within DHS, how many of
those employees are actually working on those 1000 cases
that are open right now.
[49:28] And then I would just follow
that up with if you which is great that we have a lower the

national average of fraud or

[49:35] improper payments, you know,

whichever category lands and that's still 440 million

dollars annually. And while we

[49:43] had the attorney general here

to that point, they were very excited to have recovered of

its approximately 10 million a

[49:52] year. So if we've got improper

payments of 440 million a year,

[49:59] your number, that's your number and are

recovering 10 on average.

[50:04] That's a pretty low recovery.

So I'm wondering if you could again, tell me how many

employees that you have and how

[50:10] many those employees are

working on these 1000 cases. Thank you, Matt.

[50:15] >> Inspector General Clark,

thank you. Madam Chair, representative or search.

[50:20] I want to be very clear, right?

Improper payments does not mean frog. Right? Fraud is a crime.

That's means that someone

[50:27] intentionally tried to deceive

us to get money that they were not entitled to. So that for

that to point to improper

[50:33] payment rate, right eye, the

fraud rate would be less less than that. So I think that

might have been what the
[50:40] attorney general was getting
at. We have other ways to recover improper payments,
right? We go through the
[50:45] administrative appeals process,
right? So there's a criminal
[50:51] prosecutions in recovery for
the restitution recovery through False Claims Act
lawsuits. That's one way to
[50:56] recover criminal or intentional
fraud for the unintentional kind of errors
[51:02] or, you know, we think of
fraud, waste and abuse abusive practices. Wright billing us
without having proper
[51:09] documentation, filling us in a
very sloppy manner. We recover money through the
administrative process. So when
[51:17] the AGS office is saying
they're only recovering, I don't know what the figure
is. A certain amount of millions of dollars for fraud
were recovering more through
[51:24] the administrative process than
the attorney general's office is recovering just through
fraud prosecutions. The other
[51:29] party question was how many
employees we have doing provider investigations.

I think that number is around

[51:37] 30. I could get back to you

with actual more specifically. I think it's

31 in terms of total employees

[51:46] at the Office of Inspector

General. I think that number is around

[51:53] the high 3, 100's, maybe so. I know it was 500 we split

offer. Inspector general's

[51:59] office split off some. A lot of

our employees went over to the Department of Children, Youth

and families. So whatever

[52:07] staffing statistics that you

previously had, those have been reduced now because a lot of

our staff has moved to DC why

[52:13] off? So? >> Yes, chair Eric last last

question. Thank you, Madam Chair. So to that point then so

if you have 30 working on these

[52:21] cases but you have just shy of

400 employees, what are the other employees doing?

[52:28] >> Right sites. Explain the

core functions of the Office of Inspector General. Right?

So we have background studies

[52:34] so significant. We do in half a

million background checks a year. So a significant amount

of her employees are doing

[52:40] background checks, right?

That's an important part. Part of program integrity,
making sure that criminals and
[52:45] other people with disqualifying
conduct do not get employment and Medicaid programs do not
get access to Medicaid funds.
[52:52] So that's very important
background checks. We're also have a significant licensing
oversight function, right?
[52:59] So we're responsible for
ensuring that license programs in the state of Minnesota.
They're following the laws.
[53:04] They're not committing
maltreatment as you think of the core functions of the
Office of Inspector General background Studies licensing
and provider investigations.
[53:13] So that's what the other
employees are doing. >> Thank you very much. Before
we move on to my colleagues,
[53:20] I have a couple questions.
I just want to jump in on a following up on some of Chair
Eric's questions.
[53:26] First, you talked about
improper payments and I appreciate that. But I'm I'm
sure you're aware that just
[53:33] last month there was a GA study
talking about how there's a low rate of audited findings of

improper payments with managed
[53:41] care organizations, but that
nobody seems to be checking up on how the managed care
organizations provide payments
[53:49] to providers. And that seems to be where the
bulk of the Friday is and at the state level and at the
federal level that doesn't seem
[53:57] to be happening. So could you
comment on what procedures you currently have or will put in
place to ensure that we're
[54:05] monitoring that payments
between that CM owes and their
[54:11] providers. >> Thank you, Chair Robinson.
That's a very important
[54:18] question. And I think this is a very
important point for everybody to understand about the
Minnesota Medicaid program.
[54:24] Right. 90 1% of the Medicaid
dollars in the state are managed by managed care
organizations. Again, the the
[54:30] you cares a blue crosses
medical health partners. There's others, right. So DHS
to a certain extent as a pass
[54:37] through entity, right? The
money comes from taxpayers to DHS. Dhs sends that money to
the managed care organizations

[54:44] are responsible for the care
and the payments for Medicaid
[54:50] recipients, 90% of which get
insurance through those through those entities.
[54:56] So in terms of what we are
currently doing with managed care. So we have a team.
It's a small team at the Office
[55:03] of Inspector General whose job
is to provide oversight to managed care organizations and
their SIU divisions of fact and
[55:11] set a meeting with that team
yesterday to talk about their work again, a fairly new to
DHS. So I'm getting up to speed
[55:19] on what we're doing. But I
think this role of managed care oversight to make sure again
that these entities have 90% of
[55:26] the Medicaid funds going to
them are taking actions to suspend providers to
terminate providers, to make
[55:33] referrals right either to DHS
or to the attorney general's office. That is that is a very
important space that I plan to
[55:42] look into more closely. And
we're currently doing work. We do audit managed care
organizations to make sure that
[55:47] they're taking the actions that

they're supposed to managed care organizations also have reporting requirements are
[55:53] supposed to refer reports to the Department of Human Services on the Fraud detection prevention steps they are
[56:00] taking and instances when they have have detected fraud. So that information is reported to the Department of Human
[56:06] Services by that managed care organizations. But I think it's an area where we can. We can definitely expand.
[56:11] >> Thank you. So I would like to request that you send us whatever the most recent reports are so that we
[56:18] understand I would like to know what is the percentage of fraud in that managed care organizations that either has
[56:25] been self reported or that you have identified or that CMS has identified. My understanding is CMS is doing audits
[56:33] themselves of the managed care organizations on a rotating basis across states. And so I don't know where Minnesota
[56:40] falls in that rotation, but whatever their most recent audit of Minnesota is, I can find it when I was looking over

[56:47] the weekend. But I'd love to
have that information and then I'll move on to my
colleagues. But I had one more
[56:53] quick question. You talked
about how you recover improper
[56:59] payments and the 2 questions
are you said through administrative recovery at DHS,
you recover more than the
[57:05] attorney general's office.
So how much does DHS recover? And then secondly, there was
that report by the LA saying
[57:13] that there's 40 million dollars
in an recovered payments that DHS just chose not to recover.
[57:21] And I would like you to speak
to why you're leaving 40 million dollars out there.
Thank you.
[57:28] >> Thank you. Chair Robbins.
I'm 40. I'm not familiar with that. All they report. So I
have to do homework after this hearing to to make sure you get
a copy.
[57:37] >> And then what was the other
part of your question, Sir? >> I'm sorry. The other
question was, you said you'd
[57:43] done a lot of administrative
recovering over payments just when it wasn't fraud, but just
for heirs or whatever way is a

[57:50] total that DHS, it's recovered. >> And unfortunately, I don't know the answer to that question. I can definitely follow up after this hearing to [57:57] get you dollar figures on administrative recoveries. So I apologize for not having that information on the top of my [58:04] head. So. >> Great. We look forward to that next Step. Representative Hudson. [58:12] >> Thank you. Madam Chair, like many of us and I'm sure I have more questions than we have time to to address all be [58:19] selective. Try to figure out a sensitive way to address this. But we [58:26] have had whistleblowers from within DHS who have approached us and have alleged that efforts to try to bring [58:36] impropriety to the attention of the inspector general for the [58:42] commissioner. Higher-ups within DHS has resulted in to one degree or another discouragement. Even [58:48] retaliation is a word that's been thrown around. And that obviously counters what you've said today in terms of priority [58:56] that you guys place on ensuring that these allegations were taken seriously. So my question

would be what kind of frontline

[59:04] DHS employee expect if and when they report

suspected fraudulent activity

[59:09] or can adequately agency

function that they're observing. And either of you can speak to

that

[59:17] Commissioner County. >> Chair Robbins,

Representative Hudson, thank

[59:23] you for the question. Our front line employees are

recipients are

[59:33] best window into things going

wrong and it is

[59:38] of paramount importance to me

that they feel safe in reporting any concerns that

they have

[59:45] now, I know that people will

not always feel safe. I as as a former chief compliance officer

and working with compliance

[59:53] officers around the country,

they're all wiz concerns of retaliation. That's just part

and parcel of reporting

[1:00:02] concerns. So I think it's

important that we have more than one avenue where people

can report concerns and like

[1:00:10] Inspector General Clark said we

will take the information from

[1:00:15] anywhere. So if an employee has
concerns and they don't feel safe, reporting it internally,
they can share enough specific
[1:00:26] information with the office of
the Legislative auditor. They can share it with a the
BCA which has expanded
[1:00:35] reporting. They can share it with you all. And as
long as we have enough
[1:00:42] information to act on it, we
don't need to know who said it. We just need to have enough
information to act on it.
[1:00:50] Then we will investigate the
matter.
[1:00:56] I think the other thing that I
want to share is that I have had
[1:01:02] since I've stepped into this
role, some very brave staff who have come forward to me and
shared information
[1:01:12] sometimes anonymously and
sometimes not anonymously. And in those instances where
there's been enough credible
[1:01:21] information provided to me, I
will take steps such as hiring an independent investigators.
I don't need to know the name.
[1:01:29] I just need to get the
information so we can take action

[1:01:34] for Senator Hudson. >> Thank you, Madam Chair and thank you, Commissioner County for that answer. The other thing I want to ask you about
[1:01:41] was we received some public testimony with questions regarding your stated opposition to the OIG bill that
[1:01:51] unfortunately from some of our perspectives in Crockett get across the finish line at the end of session despite its
[1:01:57] broad support in the Senate.
And a lot of conversation about that took place throughout the session. You had a letter that
[1:02:03] was offered on March. 11th,
were you expressed some concerns about the impact that and independents
[1:02:11] overriding statewide enterprise
OIG would have on your existing
[1:02:17] operation. And some of those concerns are summarized as potentially that compromised investigations by having
[1:02:24] duplicative investigations going on. At the same time, concerns about your ability to maintain compliance with
[1:02:33] federal guidelines, potential loss of federal funding and a reduced fraud handling capacity.

[1:02:40] I want to if you can expound
upon that because for for the folks who submitted the
testimony and I confess for
[1:02:47] myself as well, I don't quite
see how those concerns mash or
[1:02:54] at least present themselves
plainly in just a basic understanding of how that new
potential agency would.
[1:03:02] >> Commissioner County Chair
Robbins, Representative Hudson, thank you for that question.
I believe I came and testified
[1:03:09] to this committee after that
letter and I am on record sharing that
[1:03:17] I generally support program, integrity,
measures that are going to
[1:03:22] advance integrity in Medicaid's
programs in protecting the
[1:03:27] states taxpayer dollars.
Just as a general statement,
[1:03:33] what matters is how we do it
and how we get there. And so I think if legislation comes
forward again, we would like to
[1:03:41] work closely with you so that
we can make sure that our
[1:03:47] federal requirements work.
We believe I believe that it is very important that DHS

maintains an office of
[1:03:56] Inspector General. You heard
Inspector General Clark talk about the close collaboration
with our program areas and how
[1:04:04] we have to knit together the
program areas and the oversight to have the strongest work.
And so it's important that we
[1:04:13] maintain that and we maintain
our federal obligations. We do the work that's required
to do. And there may be a way
[1:04:21] to also have that work together
with the state by the OIG. But
[1:04:27] the details matter and we need
people that understand them more than I do. Our federal
relations officers, our general
[1:04:35] counsel, legal advisors, a
state advisors, our federal partners to work on that
together to find something that
[1:04:43] works. Thank you, Representative
Anderson.
[1:04:51] >> Thank you out. I'm going to
follow up with that and then have another question that bill
that actually passed the Senate, though. It, though, is
the bill that was agreed to buy
[1:05:01] at least the Republicans in the
House than we thought the Democrats in the House, that

bill would cap the OIG within

[1:05:08] DHS dead. You have a chance to look at the bill that actually

passed. That was the final

[1:05:16] negotiated OIG Bill Commissioner County.

[1:05:21] >> I guess I mean, I our staff

to look at that.

[1:05:27] I just my question is, do have it. >> You know, my understanding

was the DHS was as close to

[1:05:36] they could get because they,

you know, in I actually being

[1:05:41] okay with that, though. Is that correct? Commissioner

Gandhi?

[1:05:47] >> I honestly I I can't recall.

I mean, so we I know that we

[1:05:53] were committed to working at

that was going to move forward, committing to working with the

legislature to get it right.

[1:05:59] How close or not it was like I

would need to go back and check with our general counsel in

federal shuns experts. Okay.

[1:06:07] >> Thank you. I have but I will

get off that. That will be back. That with that issue will

be back. I have a question for

[1:06:14] him for an inspector General, Clark

and welcome. And I hope that you clean up the department in

an A

[1:06:22] do what needs to get to.
So I know that all a lot of the things happened
[1:06:27] before March before your time
there. And there's a lot of work that needs to get data so
that we don't have
[1:06:35] all the fraud that's been
happening within DHS with the Medicaid
[1:06:40] because we're talking about
that dissipate. But those other programs to my questions so
that
[1:06:46] the OIG within DHS is set at
about 100 cases a year,
[1:06:52] according to you to the
attorney general. And we have been told again, by was light
with this lot of people talk to
[1:07:02] us. Obviously, some is act may
be as accurate and maybe some isn't. But we have been told
that there's a lot of cases
[1:07:08] that and up with the attorney
general and office needs more information. They sent it back
to DHS and they just die.
[1:07:15] Dhs in maybe if you can comment and
that what percent of the 100
[1:07:21] cases that per year, a fraud that go to that attorney
general's office of percent are
[1:07:28] actually prosecuted Inspector General Clark.

[1:07:33] >> I don't know that answer.

I mean, I think that answer is better posed to the attorney

general's office

[1:07:40] here at DHS. So I don't know

the exact amount that they're prosecuting each year.

[1:07:48] Want to say no, this is could be speaking out of turn

here. But I want to say

[1:07:54] listening to when the 80's

officer, Nick Walk again, my my choir boss, I think the

number was in the 40 or so

[1:08:01] range of convictions that they

got last calendar year. But again, prosecutorial decisions,

whether or not to prosecute.

[1:08:09] I mean, those are decisions

that are made by the attorney general's office. So numbers

reasons why cases are declined.

[1:08:16] Reason why cases are

prosecuted. I mean, I think those questions are better

posed to the attorney General's

[1:08:22] office. >> Vice chair and thank yous

about 40% are actually get all the way. So that's

[1:08:29] give or take. I'm a lawyer.

I'm not supposed to speculate. I mean, that's due to the best of my

knowledge, right? But I could

[1:08:36] be could be way off to do so.

Okay. I recommend following up with the AGS office. Thank you,

chair and thank you. And then

[1:08:43] that maybe is a better question

for Commissioner Gottlieb. But have those 100 cases

approximately a year that are

[1:08:50] sent to the to be prosecuted.

I looked at what percent are we

[1:08:56] stopping payment time because we have the a G's with

and we've always been able to

[1:09:02] stop payment. So that was always lobby for

legislation this last session.

[1:09:09] But what percent I mean, are we

actually taking action or are we just letting the set for a

year or 2 and maybe gets

[1:09:17] prosecuted if they have enough

evidence? >> Commissioner County Chair

Robbins vice-chair. Anderson,

[1:09:23] thank you for that question.

What I can tell you is since I've been serving as temporary

commissioner, that's the

[1:09:29] that's the information that I

have. And we are taking action

[1:09:35] immediately as soon as we have

enough information to stop a payment unless the law

enforcement entity that we're

[1:09:43] working with asks us not to.

So our default position now is

[1:09:48] to stop payment. >> Vice chair. Just okay.
Thank you. That best one yet last. That's good in. But
[1:09:56] what percent approximately I
mean, is it is that most of them, the kits
sent to the attorney general's
[1:10:03] office were actually stop and
payment or because you said if we you know, if they ask us,
[1:10:10] not too right. Thank thank you. I would just
like to follow up if you could
[1:10:15] give us a number and you can
report back that of in the last year, how many cases that have
risen to the late Heath office
[1:10:24] or to the attorney general's
office? Have you actually stop payment on the great? Sure.
Thank you. Yeah, we we.
[1:10:30] >> Chair Robinson mean I would
the the number is extremely high. We are stopping pain
percentage wise. We're stopping
[1:10:37] payment unless the law
enforcement entity says that they want us to hold off
because they're gathering more
[1:10:45] evidence that we ended, that
you the number perfect. Thank you
[1:10:51] representing. Thank you, Madam Chair, and I
appreciate you all being back.
[1:10:56] And I know this is part of a

continuous conversation. Wanted to get to this question.

But I think you raised that I

[1:11:04] think is important as we talk

about Medicaid and how we are

[1:11:10] effectively providing the

service to the Minnesotans who need it and doing it to protect

those that health insurance,

[1:11:17] that health care provision as

well as public dollars. And you talked a little bit about. >> The difference between the

provider oversight, which the

[1:11:28] state does looking at provider

fraud provider in extra payments and the individual and

oversight of eligibility

[1:11:37] requirements. And you talk

about the state versus the local and I think that that

that's important thinking about

[1:11:44] the provider peas, which which

you talked about in which frankly this committee should

be more concerned about because

[1:11:51] all of the evidence shows

that's really where the concern is that with the Medicaid fraud

control unit does wondering it.

[1:11:59] We've been talking a lot in

this committee, but that is dwarfed by the national

conversation and the

[1:12:07] reconciliation bill that just

got past. And I'm wondering if that bill provides any help,

any re additional resources to

[1:12:15] do the kind of work you're

talking about both the preventative work of by back on

the licensing and all that

[1:12:20] stuff. But more importantly,

the fraud prevention of prosecutions investigations. Is there any

federal help that's coming in

[1:12:30] that bill for that, the work

that the state is doing to know expect a General Clark?

[1:12:36] >> Madam Chair, Representative

Freeman, not that I'm aware.

[1:12:41] And so I think that question is

is better posed to our legislative folks who have

really the following tracking

[1:12:47] that legislation pouring

through the language. I've also reached out to the

AGs office might my former

[1:12:54] colleagues to see whether or

not they were aware of any fund increases or decreases and

they're they're not aware

[1:13:00] either. So whether or not the

federal budget, it's going to give us more resources. I'm

just not aware. I haven't.

[1:13:09] I haven't heard that. That's

the case, though. >> Representative, thank you.

I appreciate that. I've been also doing a lot of reading and
that's also what I've sort of
[1:13:16] determined. So wanted to double
check that. I think that that's what I heard from the ages
office as it relates to their
[1:13:22] piece of this, which is the
Medicaid fraud control peace. And we actually heard lots of
bills about increasing the
[1:13:28] resources for the AGS office.
I think we made them take it out of the base. I think if we
want to talk about that work,
[1:13:34] we should talk about it in the
public Safety committee. We talked a lot about how they
punch above their weight in
[1:13:41] terms of an because credit you
for the prosecutor there. But in terms of the work they
do and how much we invest in,
[1:13:47] which is, I think middle of the
pack and other states. But we should talk about that because
I think we've been talking
[1:13:52] about a lot of the the outcomes
of their work, but we need to make sure that we're investing
in that piece. I did the other
[1:14:00] piece I wanted to ask about and
actually make it more directed to think we have the
association of a set of

[1:14:05] counties. But my understanding
is the lion share of the are the things you talked about,
the checks on eligibility and
[1:14:15] how that is working. That
changes a lot under the new federal law coming into effect
in 2020 6 of 27. And I think a
[1:14:22] lot of that Minnesota press on
the county's summer, right? I'm wondering if we could have
this decision as a county has
[1:14:28] come up and I just have a
question for them. That's probably better suited for them
than for for you all.
[1:14:36] We could have one person from
the Associated Association counties to donate everybody.
You want to keep moving,
[1:14:44] please state a state, a name
for the record and then Representative Freeman. Well,
it's just a question.
[1:14:50] >> Thanks, chair members of the
committee. My name is Matt Freeman on the Human Services
policy analyst for the association, Minnesota counties
and the executive director for
[1:14:58] the Minnesota Association of
Counties, social Service and the traders. >> Thank you, Representative
can thank you and thank you for
[1:15:05] for >> being here. And I know I

promise a lot. I was mostly from sport. You guys have said publicly so I won't try to
[1:15:14] delve too deeply. But my understanding and and as we talked about this, like we're thinking about oversight,
[1:15:19] we're thinking about how to best serve, how we are investing state resources into ensuring that people get access
[1:15:26] to the health care that they need and that these programs are well delivered. It's my understanding that the
[1:15:32] verification checks it at the county with you all think I'm interested in how you pay for that. But let me just wrap all
[1:15:40] this question in 2 to one, which is I think it's undisputed that the issue of Medicaid fraud that we are
[1:15:48] concerned about is not an individual college eligibility issue. It is a provider issue and the and individual ability
[1:15:54] issue which you all handle is is also some work. My understanding and this is I guess the question I have is
[1:16:03] we're all trying to figure out these new changes that are coming down the pike because that's our job to think about the locals to give a sense of

how

[1:16:12] much additional both work and

resources it's going to take to do this individual eligibility

verifications work requirement,

[1:16:22] very kitchens. >> And if you think that that

extra resources is going to be

[1:16:27] made back by the, you know, in

eligible folks who find or the of the fraud as it's defined in

statute that infant.

[1:16:37] >> Yes, Madam Chair and

committee. Yeah, counties roll in. >> The eligibility process is

the individual durability.

[1:16:44] And so we remain committed to

program integrity, both in preventing folks who are not

eligible from accessing

[1:16:52] services, but also the

importance of ensuring those who are eligible are able to

access that, you know, the

[1:16:58] bill, a reconciliation bill

just passed last week. So we're still in the process of

analyzing and looking at what

[1:17:05] that impact will be on counties

locally in our role. Again, Minnesota's one of 10 states

were counties and minister

[1:17:13] Medicaid helping with

enrollment eligibility. And the renewals and one of 25 states

that contribute financially to
[1:17:21] Medicaid, mostly through our
targeted case management contributions were expecting
significant cost impacts and
[1:17:29] workload impacts. I think you
heard earlier from Commissioner Gandhi about some of those
projections. I think we've
[1:17:37] looked back at the 2018 local
fiscal note that was done on a work requirements around
Medicaid bill here at the state
[1:17:44] level that projected about
160 million dollars at that
[1:17:50] point for the local impact cost
of doing that additional a work
[1:17:57] requirement work for counties.
In addition, we do know in the bill includes additional
verifications, particularly for
[1:18:04] Medicaid expansion populations,
which will be more work for counties and additional
[1:18:11] challenges on our existing
technology system between access and mats and other
systems that don't inherently
[1:18:18] or aren't easily adjusted to
incorporate new changes from the federal level. So we're
expecting property tax burdens
[1:18:26] to counties increased workload

for the folks that are currently working on
eligibility were concerned
[1:18:33] about the ability to add that
workforce is long standing challenge. And we do know that
other changes in the bill be on
[1:18:39] Medicaid. There really is
intersectionality with changes to the SNAP program or or food
stamps in access to services
[1:18:48] like a child. So the child care
or cash assistance, many of the
[1:18:53] folks who are needing economic
assistance or are the same folks that are intersecting
with our health care system.
[1:18:59] And so I think there are a lot
of concerns at the county level about that impact. And
additionally looking at
[1:19:07] administrative burden of
changes in complex in our system, we have a very complex
eligibility system and that
[1:19:13] creates more challenges for
disqualification for folks, not because they're not
inherently eligible, but
[1:19:20] because the administrative work
creates a barrier or that there's a an error in that
process. And so making it the
[1:19:28] system more complex with more

steps, doesn't inherently prevent fraud or ensure that
folks who aren't eligible
[1:19:36] access that information and
more often in examples like Arkansas, 11, 15 waiver
disqualifies individuals who
[1:19:44] are eligible but ran into the
administrative barrier. >> Thank you left question.
And I think it would be
[1:19:51] helpful. It would help if you
would focus on the testimony because this is all speculative
the bill just passed. So I'd
[1:19:57] like to make sure that we're
focused on that testimony of the it and the DHS. Thank you.
[1:20:02] >> Thank you. I think that as
we think about our job as as we
[1:20:08] think about oversight is I
think going into next session, I think we have to think about
the law as it will be in Twenty-twenty 6, not the law as
it will be for the next 8
[1:20:17] months. So I think speculative
is one thing. I think that there's been a ton of but
debate and information and it's
[1:20:24] helpful to hear. I don't think
a fiscal note from 2018 is speculative. I think that
that's the way we do our
[1:20:30] legislation. So I guess I will

just and I have lots of questions as we think about
this impact on the county's.
[1:20:37] But I may leave that to to my
colleagues with just a statement because I want to
make sure that we are focused
[1:20:44] here on what our job is, which
is ensuring that the people of Minnesota have access to health
care and health care provision
[1:20:53] and that our local hospitals
are rural hospitals can continue to read that care and
that we are safeguarding those
[1:21:00] resources, the state dollars to
local dollars, the resources of Minnesotans that are going to
pay for that. And the reason we
[1:21:08] all session tried to talk about
what was happening in Congress is the reality is that we get
lots of resources or did
[1:21:18] about this to do this work here
in Minnesota. And if those researchers got away, the
eligibility hasn't changed the
[1:21:26] work requirements have these
some of the eligibility has actually changed, but we still
are on the hook. So the
[1:21:31] question is, how do we pay for
that? And I don't think that we every time we brought up this
reconciliation bill trying to

[1:21:41] this conversation we heard was
speculative. We heard it was who knows what tomorrow will
bring. Now we know what
[1:21:46] tomorrow brings. It is a giant package which has goodies
for government contractors who
[1:21:53] are going to do Equifax and
other things. 20 $1, a check double that it has goodies for
billionaires in all sorts of
[1:22:01] places and the way that it pays
for that is by giving
[1:22:06] garbage to working class
Minnesotans who don't have enough money to pay for private
insurance. That is going up a
[1:22:12] lot of the reasons because we
have outsourced and provided private for-profit companies
access to, you know, our health
[1:22:20] care markets. So when I think about what our job
is here it is a giant bill.
[1:22:26] We are. We're going to have to
deal with the implications of this giant bill. Lots of
goodies for wealthy people.
[1:22:32] It's going it deprive Minnesotans health care
and coverage it's going to and
[1:22:37] that is wrapped in red tape.
That's going to go to our counties. That's not gonna
provide better care, but it

[1:22:42] certainly will increased costs.
And so I think that as we think about our job, right, that is
waste Ngo, describes it as
[1:22:50] inefficiency in and I had
somewhere. >> The moon.
[1:22:59] >> Inefficient processes and
systems. We are adding to the federal government. The
Republicans bill is adding to
[1:23:06] that in order to >> kick eligible people off of
health care and that it seems
[1:23:14] anathema to the work of this
committee and the work of our of us in the legislature.
And so I guess what I would
[1:23:20] just ask as we look at all of
this, right, we have to focus on provider fraud. We have to
focus on how do we ensure that
[1:23:27] the people who are billing the
state for resources to to
[1:23:32] provide these are providing the
services that people need and we have to ensure that people
who are eligible for the
[1:23:38] services, get them, get them in a way that doesn't
require our counties and city
[1:23:43] staff to raise the property
taxes. >> In order to provide useless
and and ineffective. Think so.

[1:23:51] I think that this is a really
helpful. I think as we talk about this going forward, I do
think we're gonna have to think about both what's happening at
the county level and what's
[1:23:58] happening at the state level
and how we as a state are investing in that. But I hope
we think about our systems,
[1:24:04] not just from the perspective
of the myopic view of what we
[1:24:09] have decided because frankly,
we don't have control over what the Republican big terrible
Bill did, but we will have to
[1:24:16] deal with the impact of that as
it relates to Minnesotans working class Minnesotans for
hospitals and and frankly,
[1:24:23] the taxpayer dollars at the
local level that are going to go up so that I will leave my
questions there and leave it to
[1:24:30] other people. But we have our
work cut out in front of us and it is not the.
[1:24:36] >> It is not an assignment that
we asked for. But it certainly is something that we're going
to have to make sure that we
[1:24:42] protect Minnesotans and their
healthcare from and we ensure that people know who is coming
off a health care.

[1:24:51] Thank you, Representative
Schultz. >> Thank. Thank you, Madam
Chair and thank you to the
[1:24:58] commissioner. Thank you to the
counties as well. Appreciated the insight today. And I the
thing that I'm really
[1:25:04] deciphering here amidst all of
the testimony is the impacts that was just discussed by
representative agreement.
[1:25:11] And I appreciate her
perspective. But let's let's level set here a little bit.
[1:25:17] Okay. So we've been talking
about the amount of money that of Medicaid dollars that are
spent in Minnesota. Lets
[1:25:23] compare ourselves to similar
size states. 20 billion dollars is spent on
Medicaid in Minnesota on annual
[1:25:31] basis as those provided by the
people at the desk from the Department of Human Services.
[1:25:36] By comparison to larger states,
Colorado and Wisconsin
[1:25:42] both spend approximately
13 billion dollars in Medicaid spending.
[1:25:48] How is it? And Minnesota provides
7 billion dollars more.
[1:25:56] Then those states that are

larger than us. I think that's an open question
for us.
[1:26:03] Let's also talk about what the
commissioner just said. The bill from Washington
[1:26:08] is going to due to changes in Minnesota.
She said that there's going to
[1:26:15] be 500 million dollars of cost
per year and that 150,000 to 250,000
people will be removed.
[1:26:26] That's still 6 and a half billion dollars
more
[1:26:33] a benefits provided then states of similar size to
us.
[1:26:38] So my question is, who are these people
[1:26:44] that are receiving 7 billion dollars more than
states that are larger than us?
[1:26:50] And let's start there. >> Commissioner County Chair
Robbins, Representative
[1:26:55] Schultz, thank you for that
question. In Minnesota, the majority of
Medicaid spot spending is for
[1:27:04] older adults and people with
disabilities while they make up 14% of the population. The
spending is that spending for
[1:27:14] them is about 60%. So one of the things that we
have been proud of in Minnesota

[1:27:22] is the quality of life for
people with disabilities that we're able to afford. We have
waivers in place that allow
[1:27:31] people to live in community and to thrive. And if you look at
our rankings across the
[1:27:42] country, we are at the top by a far
margin. So in terms of
[1:27:50] spending, that's where the
largest amount of dollars go. Representative Schultz.
[1:27:55] >> Madam Chair, the I find it
really hard to believe in. I believe there's actually
direct data that contradicts
[1:28:01] what you just said, that there
aren't people with disabilities or seniors that live in those
same states, Wisconsin and
[1:28:07] Colorado, larger size states
than we are here in Minnesota. So let's let's night. I
appreciate this. This is it's
[1:28:14] going to be a doll. It's going
to be a question about the state budget. It's going to be
a question of our values, how we talked about supporting
the dignity of work. It's going
[1:28:23] to be having that conversation
about who who is eligible. So
[1:28:29] in Minnesota, how does one qualify for
Medicaid that has been so much more

generous,

[1:28:38] then states around U.S..

[1:28:44] >> Chair Robbins,

Representative Schultz. I went over the eligibility

requirements. I'm not sure

[1:28:53] of the question. Mr. Represent Schultz. >> Thank you. Madam Chair will

certainly I'm expecting that if

[1:29:00] there's such and such a huge

amount more that we're spending in Medicaid,

[1:29:05] that there are Minnesotans that

are qualifying that wouldn't in other states.

[1:29:11] What are those eligibility

requirements to provide more assistance to people who aren't

eligible for the same benefits

[1:29:18] in other states? >> Commissioner County Chair

Robbins, Representative Schultz.

[1:29:23] I don't have a crosswalk

between the 2 states you mentioned and our eligibility

requirements.

[1:29:31] Representative Schultz, thank

you. Well, at at the end of the day here,

[1:29:37] what Republicans are

championing. >> Is this idea that

[1:29:43] there's a dignity of work and if you aren't able-bodied

adult,

[1:29:49] that you should be contributing

to our economy and

[1:29:55] we have huge opportunities for

jobs across the state to make great wages

[1:30:00] to get jobs with employers who

have health insurance. And

[1:30:05] the bill that just passed in

Washington is all about ensuring that able bodied

adults, people who look just

[1:30:11] like me and many of us around this

table that they're contributing to our society.

[1:30:17] So we need to take a look in

Minnesota because somehow

[1:30:22] there's 6 and a half billion

dollars that could be going to help support counties as they administer this

program.

[1:30:29] And and even if we just use your

number commissioner, it would be 500 million dollars

[1:30:37] could go to help support those

counties as they do the work. So it seems like there's plenty

of money for us to discuss

[1:30:43] around this as we seek to make sure

[1:30:48] building a culture of work and so that we aren't having

the same programs and the

[1:30:55] program program issues that

we've seen here in Minnesota with huge fraud, because it was the governor who

said earlier this year that

[1:31:03] it's I think it's a problem.
It's probably a culture of generosity. I think it's a
culture of being a little bit
[1:31:09] too trusting on this. Those were his words. So I guess the question, my
final question for you,
[1:31:15] commissioner, what have you done since the governor ordered
these words to change the
[1:31:21] culture within your agency so that we're not seeing the
levels of fraud that we have seen in Minnesota, Mrs? Gandhi,
[1:31:29] Chair Robbins, Representative
Schultz. >> In the few months that I've
been temporary commissioner,
[1:31:36] I have been working closely
with the members of the office inspector general. I have been
collaborating with the
[1:31:43] Department of Public Safety,
the Bureau of Criminal Affairs and looking to strength them
[1:31:51] wherever possible. So a couple
specific actions would be that
[1:31:57] in March I designated a couple
services the I D Be I and
[1:32:03] housing stabilization services
as high risk in the Medicaid program.
[1:32:09] Agencies have the authority to
do that. That went into effect June 1st and that put into
place additional oversight

[1:32:17] requirements in these
unlicensed programs. We now have background checks of
owners. We have the ability to
[1:32:26] do site visits and re
validation more frequently. In addition, DHS worked very
closely with the Walls,
[1:32:35] Flanagan administration and had
many program integrity measures
[1:32:40] in the governor's bill that we
advocated for. The legislature passed. Many of them and many
of you supported those
[1:32:48] measures. Thank you. All right. And just
[1:32:53] I know we get 2 more questions,
but I had a quick question. So I think part of the question
of how we compare vis-a-vis
[1:32:59] other states is that we have
and what we call the expanse and population, which is adults
between 19 and 64 who are
[1:33:10] able-bodied. We've become an expansion state
to take that on. But we also
[1:33:15] have an expansion of programs
that other states don't have. Those are the optional
benefits.
[1:33:20] >> And so I'm not gonna ask for
you to provide it right now. But what I would like to know,
it's what are the optional

[1:33:26] benefits outside of traditional
Medicaid that Minnesota has signed on to cause. That's
where the fraud seems to be.
[1:33:32] And I want to get back to that.
It seems to be in some of the programs you've already
identified as high risk,
[1:33:37] high housing, stabilization,
sober homes, autism centers, chair, tuck your recovery, 19
emergency medical
[1:33:46] transportation in those things,
which are optional benefits that other states don't have
necessarily. That seems to be
[1:33:53] where the bulk of the fraud is
and a bulk of the costs. So if you could just get back
to me with what are the
[1:33:59] optional benefits, Minnesota
has adopted first is traditional Medicaid acute in
primary care and also the
[1:34:07] expansion population. How how
many more people does that add
[1:34:12] to the rolls when we took that
on my understanding which I have from the Department of
[1:34:20] Medicaid is CMS in DC is that
we have.
[1:34:25] >> 318 people, 318,000 Minnesotans in our
expansion population, which is

[1:34:33] way more than we have in our
other adult, which is caretaker, pregnant, parent,
disabled or elderly.
[1:34:40] So 318 people who are the
able-bodied 19 to 64, who will
[1:34:45] now have work requirements and
that those people get a higher benefit than the national
average. They get $10,713 per
[1:34:54] person. And the national
average, according to CMS is
[1:35:00] 7,569. So that's at least a
place where we are
[1:35:07] over indexing and B, has the
incentive on the expansion population is to enroll people
there because the feds prior to
[1:35:16] this bill, we're picking up 90%
of the tab. We were pushing people into that expansion
population, which is also where
[1:35:24] the higher benefit amount us.
So for please get back to me with
those numbers because that's
[1:35:30] the crux of what we need to be
talking about here. We need to find out where the fried is.
We need to find out where our
[1:35:36] benefits are, more generous,
perhaps than other states. And we need to figure out how

we can makes these programs

[1:35:43] affordable so that the people

who really need it, the disabled, the elderly, pregnant

moms, parents, children under

[1:35:51] age 14, those art that

traditional Medicaid population and our most vulnerable that we

need to continue to serve.

[1:35:57] So that is my request and now

will go on to represent about kids. Thank you.

[1:36:03] >> Thank you. Thank you.

Madam Chair. I've got 2 lines of questioning trying to keep

them brief. But the first one

[1:36:09] we talked earlier about how 90%

of our Medicare patients are covered under managed care

organizations. So I'm not sure

[1:36:18] which of you will want to feel

this. But my understanding is that for the mco manage

patients, we're reimbursing the

[1:36:27] carriers on Iran. A complicated

basis. Certainly not.

[1:36:32] Commissioner County. >> Chair Robbins representative

up comes. That's correct.

[1:36:37] >> So under this arrangement,

it's if there is fraud for

[1:36:43] their fraudulent claims in that

part of the market and the carrier pays them. It comes out

of their pockets. Not that had

[1:36:50] the taxpayers pockets, right? Commissioner County

[1:36:55] represent her Chair Robbins,

Representative Elkins, correct? Yeah. So so on 90% of our

market, the taxpayers are not,

[1:37:04] you know, liable for for any

fraudulent claims that are that are paid, which is consistent

with all of the reading that

[1:37:12] I've done that, that that says

that Friday is much more prevalent in fee for service

programs that India's in

[1:37:19] managed care programs. So that's the one line. The

other line I been thinking as I

[1:37:25] was listening to the earlier

testimony, is that time, you know, clearly one of the

things that's happening here is

[1:37:31] that both the OIG and the

attorney general's Medicaid fraud unit having to choose,

which claims to pursue, given

[1:37:39] limited staffing. And so The

Economist in me tells me that to that you would pursue the

the claims with the biggest

[1:37:48] reward and forgo pursuing the claims

with the smallest reward.

[1:37:53] And again, the economists to

meet says that, okay, that that there should be a framework

here by which, you know,

[1:38:01] the OIG and the attorney

general's office ought to be able to estimate for us what

would be an optimal staff

[1:38:08] staffing level that would down

maximize the NET returns from a

[1:38:14] person and, you know, from, you

know, for and enforcement. And then that on to be the

basis for a supplemental budget

[1:38:21] request from the administration

to staff both of those offices at the optimal level

[1:38:27] and maybe Mister Clark could

could comment on that Inspector General Clark,

[1:38:33] thank you, Madam Chair. Thank

you, Representative Elkins. I mean, I I.

[1:38:41] >> I think the point that I'd

like to make is fighting fraud takes resources.

[1:38:46] You know, it's a daunting task. I thought coming over from the

AGS office to DHS

[1:38:54] thinking that I was going to be

at least partially in charge of integrity of a 20 billion

dollar Medicaid program.

[1:39:01] That's that's a heavy ask.

There's lots of money. We have 300,000 Medicaid providers in

the state. The AGS office only

[1:39:10] has a limited number of

prosecutors. Oig has a limited number of investigators
[1:39:17] detecting preventing fraud,
fighting fraud, takes resources. We're doing what we
can with the resources we have.
[1:39:23] And I think we're doing a good
job. Like I said, we're doing our own data analytics. We're
leveraging the private sector
[1:39:32] on data. Analytics and audits
were doing the same stuff in-house. We're also leveraging
and heavily relying like you
[1:39:40] said on managed care
organizations who are responsible for 90% of Medicaid
dollars in this state to do
[1:39:45] their fair share. Yeah. When you're talking about
an office that is tasked with
[1:39:51] overseeing the integrity of
20 billion dollars, it's difficult. And
[1:39:57] I think we would welcome more
resources. Again, I've been there 3 months, but, you know,
maybe the commissioner has a
[1:40:02] better idea is to kind of
resources resource it is. But whether it's technology,
investments, investigator,
[1:40:10] investments, you know, I I
welcome at all. >> You represent about to just
kind of closing comment that I

[1:40:17] mean, I think it would. It
seems reasonable to me that tie in a fiscal note for requested
additional resources that it
[1:40:25] ought to be possible as part of
the fiscal know, calculations to estimate both the additional
costs in the in additional
[1:40:31] recovered revenues that would
be achieved by increasing the staffing in both of those
offices.
[1:40:38] >> Thank you, representative to
Chair Pinto. Thank you. Thank you. Madam chair of the few
things I'll try to keep things focused is as usual. First
question is, I think for some
[1:40:45] of the teachers regarding work
requirements that's been brought up a number of times.
And just if there's somebody comment on the impact of them,
kind of what the data and
[1:40:54] evidence shows looks like, gentlemen, coming up. And if
you could just
[1:40:59] talk about the impact in terms
of we obviously want to make sure that the folks are working
and that the dignity of work.
[1:41:06] And if you can talk about the
impact of work requirements, please state your name for the
record. >> John Connally, deputy
commissioner and state Medicaid

[1:41:12] director for the Minnesota
Department of Human Services Chair Robbins Chair Pinto.
[1:41:17] So the initial estimates from
the Kaiser Family Foundation are that about 150,000 to
250,000 Minnesotans may lose
[1:41:25] their coverage through
Medicaid. And that is an estimate that we have right now
as a result of work requirements as the
commissioner said.
[1:41:32] >> I think of it as a mentor
and Mr County, if you could, Commissioner Kelly, if you
could just talk about kind of
[1:41:38] what the evidence shows like,
like basically imposing requirements is the impact
generally positive and that,
[1:41:43] in fact, more people are
working and they're not losing coverage. It were sort of it's reducing fraud.
I have a sense, I guess I'll
[1:41:49] say that that often the impact
ends up being negative. The people who are otherwise
eligible are, in fact working
[1:41:54] and getting kicked off health
coverage because of a lot of people working various things
that you just talk about,
[1:42:00] sort of the the impact of
requirements, Markham. >> To Robin Sande Chair Pinto.

So a couple of things about
[1:42:07] that. So first of all, we we
know that based on data nationally and also about
Minnesota that roughly
[1:42:14] two-thirds of people in the
Medicaid program work if they are working age and those that
don't, the vast majority of
[1:42:21] that group have a reason, a
disability, their caretakers, they're in school, chronic
conditions. So they have a
[1:42:27] reason a small share of the
remainder that aren't working would would kind of be
incentivized to to find work.
[1:42:36] But it's a very small share
less than 10%. So the vast majority of people in the
program are presently working
[1:42:42] or have a reason that would
exempt them from from working as a result or rather under the
federal bill that just passed.
[1:42:50] In addition, the vast body of
research about this also in Medicaid demonstrates that
people who lose coverage as a
[1:42:58] result of a work requirement or
read a re determination is more free. Frequent reader,
terminations typically are
[1:43:06] eligible. So there is kind of a

marginal reduction every time you added administrative
requirement or paperwork
[1:43:13] requirement with respect to
eligibility in terms of production enrollment.
[1:43:19] >> And thank you. Yes, turn
into a famine. Just want to note for the record that we are
going to go a little bit longer. Okay. Thank you.
Thank you so much, Madam Chair.
[1:43:26] And so maybe I will when maybe
actually for Commissioner
[1:43:31] Connelly as well. This
difference between Minnesota spending some more than a
minute later standings. At
[1:43:37] least a portion of that is that
we have rates that are closer to private pay rates when think
about our nursing homes.
[1:43:43] We're so dependent on on these
on these funds. And I think the folks who would lose who will
lose coverage as a result of of
[1:43:49] the budget that just passed the
federal budget could just talk about is part of the difference
between our state and other
[1:43:56] states is the is that we pay
somewhat higher rates that are closer to a private individuals
who pay and therefore keep our
[1:44:03] nursing homes and other

organizations afloat, Mr. Calmly. >> To Robinson, Chair Pinto.
So there there are a variety of
[1:44:11] reasons for per capita spending
being. What it is in Minnesota, I think is the commissioner
said the majority of our
[1:44:17] spending is on older adults and
people with disabilities. We do have have a more
comprehensive set of benefits
[1:44:24] either through waivers or more
generally in the program in our state plan, both for seniors
and people with disabilities,
[1:44:29] but also for the expansion
group. So that is just that has been a historic investment
Minnesota has made in its
[1:44:36] Medicaid program and the health
care provided to its people. And that is probably the
largest driver in terms of per
[1:44:42] capita spending being different
than other states. But it's also true that for behavioral
health service providers,
[1:44:48] I think we in Minnesota are
proud that we do pay generally a more competitive rate for
mental health and substance use
[1:44:53] disorders as an example and
nursing homes due to kind of legal structures here in
Minnesota. Also off and,

[1:45:02] you know, nursing homes that
accept Medicaid, receive reimbursement at the same rate
from other pairs. So that's
[1:45:08] that's just another kind of
feature of of the Medicaid program in our statutes here in
Minnesota. But it's a complex
[1:45:14] set of reasons why we have
higher per capita spending. But in general, it's because of
investment and and benefits in
[1:45:20] provider payment. >> Thank you so much. I think.
Thank you, Madam Chair, I think and I don't need any further
debate. Commissioner County,
[1:45:25] but thank you so much for your
for your comments. I appreciate it. And then a chair and this
is a little bit delicate.
[1:45:31] I was going to leap in a lot
earlier in every second. A question from the other side.
And so and this from vice chair
[1:45:38] and or send them, I respect
greatly. But she had she had and made a comment to the
inspector general about about
[1:45:45] the need to, quote, clean up
the department and reference all, quote, all the fraud
within DHS. And I know we all
[1:45:51] have a lot of rhetoric back and
forth. What concerned me was that we had the commissioner

right here. And so I just

[1:45:56] wondered if I am not, I'm

certainly aware that there is that their fraud and there's

pride, frankly, whatever this

[1:46:03] human endeavors, right when

there's one there's funds and were sold. I'm lucky to have

Inspector General Clark and the

[1:46:08] commissioner and others from

doing this work. I'm not aware Fried put within DHS that may

have been vice chairperson may

[1:46:14] not have meant that exactly

that way. But I just want to make sure the commissioner had

a chance because I've been some comments about the agency that

that I see a line for got a lot

[1:46:22] of concern myself with DHS

various times that the years the boy, I see people working

really, really hard to serve

[1:46:28] the people of Minnesota.

I wasn't sure she wanted to say something in response them to

those comments. Madam Chair,

[1:46:33] Commissioner Candy. >> Chair Robbins leave Pinto.

Thank you for that opportunity.

[1:46:38] Yeah, I am not aware of fraud

within DHS recently. I know

[1:46:44] there were situations many

years ago isolated but I am not aware of any fraud

within DHS staff.

[1:46:53] >> Okay. Thank you. Then.

Finally chair for can yes in the final final comment, I'll

just say I really am glad that

[1:47:00] we've had this understanding

of. We've heard from counties about them overseeing

eligibility of individuals and

[1:47:05] Medicaid, which they do and

heard from the agency regarding eligibility for providers are

sure the concerns in that area.

[1:47:11] And I'm also glad the way the

question is gone and raised by number GOP colleagues about

about the him about this

[1:47:17] program, the impact of the of

the budget just just been passed to President Trump and

congressional Republicans and

[1:47:24] the importance of the program

to Minnesotans the fact that 700,000 Minnesotans will lose

coverage. It may be. In fact,

[1:47:30] I sort of got the sense of

these questions that rolling back some of those benefits is

the goal to a certain extent?

[1:47:36] I can. I heard some of the

reasons that folks may have that. I think we do need to

recognize that nice, though, that we are in a situation

where we think about Medicaid

[1:47:43] eligibility. What we're
thinking about is people losing that eligibility in part for
reasons that may be fair,
[1:47:49] but often freeze is unfair and
people who are eligible for Medicaid, but who will, in fact
not receive the health care
[1:47:55] that they need and that does
and that they deserve because of these requirements,
restrictions go into place.
[1:48:00] And that according to our
health care providers in our state, we'll have a rolling out
of costs on all of us. This is
[1:48:05] from Ascension Health, say that
that cost be shifted to the rest of us everybody else in
this room, whether it's
[1:48:10] commercial insurance, people
that are paying for the health care out of pocket, all the
money that used to come for Medicaid to pay for people's
needs because if they don't get
[1:48:17] coverage, health care in
general, they're going to go to the emergency room and causing
our hospitals to go bankrupt
[1:48:23] and those nursing homes as well
to the north. So important to many of us, I'm glad we've had
the chance to talk about this and Medicaid, I think should
continue to be top of mind for

[1:48:31] all of us. And thank you chair
for the opportunity of this conversation. >> Thank you. Chair Pinto last
very short question from
[1:48:37] Representative Eric. >> Thank you, Madam Chair, sir.
I just wanted to talk really quickly to about S S I S and I
know that's been a huge a
[1:48:46] computer program. The database.
It's been a huge problem. And we I went to a presentation
and one of the counties and 70%
[1:48:53] of a worker's time frontline
worker was putting data in 2 S s I S and how cumbersome.
And you know, this is a blue
[1:49:01] screen and its ancient back
from the late 80's. I believe it was or maybe early 90's.
It was developed.
[1:49:08] So come out and how much more
time these frontline workers would have if we didn't.
They didn't spend 70% of their
[1:49:14] time putting in data into an
ancient failing SSI, a state program that we the state
forced them to use.
[1:49:23] So we finally have given some
money to try to get that fixed. We should've done that decades
ago.
[1:49:28] It's absolutely ancient and I'm
surprised represent opens in talk more about that because

he's kind of our our data guy

[1:49:35] over there. But that is

significant. I think we need to talk about how impactful and

cumbersome our state of

[1:49:43] Minnesota outdated programs

are. It put so much burden on the county. So much burden on

the front line workers both at

[1:49:51] the state and at the county.

So it's again, 70% of a front line workers time at the county

is spent putting data into this

[1:49:59] archaic system that doesn't

work and half the time they get the

[1:50:04] the circle of death so that,

you know, they sit there on a wait, wait, wait, wait, wait

for the single load or it fails

[1:50:10] altogether or whatever. So we need to fix that. We finally

put some money towards fixing

[1:50:15] that. So that's one, too. When you talk about the new

adult. So these are not

[1:50:21] disabled. These are not

children. These are not elderly. They are a new expansion group

of 318,000 new people costing

[1:50:33] the state of Minnesota. 3.2 billion dollars.

[1:50:38] 3.2 billion dollars. These are

not disabled. These are not

[1:50:44] children. They are not aged.

They are not elderly. They are able-bodied people that could
work
[1:50:52] again. 3.2 billion dollars more
per year. So we have to talk about that
as well. That is a huge
[1:50:59] expansion to all the action. So yes, set
lasting a minute. The question
[1:51:05] is I've been talking to
whistleblowers nonstop, as I as I talked about in this
committee the entire time
[1:51:14] I represent Hudson touched on
it. But I am incredibly concerned about our frontline
workers. I am incredibly
[1:51:19] concerned about the people that
are trying to cut off fraud. And what they are telling me is
that
[1:51:25] DHS themselves are surveilling through programs and whatever
the employees looking for,
[1:51:34] keywords like they're talking
about fraud or time weighs 3, talking about whatever. That's
what the whistleblowers are
[1:51:40] telling me that they are being
surveilled. And when they reach out and they step out and say,
hey, I I see something wrong
[1:51:46] here, see something wrong.
They're they're retaliated against. There are jobs are

threatened. Their livelihoods

[1:51:52] are threatened. Their families

are threatened. So I am incredibly concerned with what

the whistleblower's continue to

[1:51:59] talk to me about. And it has

been over months and months and months of talking to us blowers

with India. Jesse's are

[1:52:05] frontline workers within DHS.

So Madam Chair, I am so incredibly concerned about

that. I know you heard them say

[1:52:11] that I know of represent Hudson

has heard them say that. I know Representative Anderson

has heard them say that.

[1:52:18] So I am going to leave it with

that. That nothing we'll change doesn't matter what laws we

pass. It doesn't matter how

[1:52:24] much money we invest. If we are

threatening our frontline workers and we're giving them

it antiquated equipment to work

[1:52:31] with the doesn't work. And it's

just, you know, they have spent over 70% of their time working

in a database that doesn't

[1:52:36] work. So those 2 factors alone are inexcusable and should

never happen. And we should

[1:52:42] have fixed a long time ago.

And I hope that with the new commissioner,

we are not going to be
[1:52:47] surveilling our staff or the
DHS workers and front-line workers and we're not going
threatening them anymore
[1:52:53] because that has got to stop.
Thank you, Madam Chair. >> Commissioner Candy, are you
aware of surveilling the workers and you have any other
additional comments?
[1:53:01] >> Chair Robbins Representative
Eric, thank you for those comments and questions
[1:53:06] I D H S does not surveil its
employees. We have
[1:53:15] what I will share with you in
happy to to meet with you in your office separately. But
when we get complaints,
[1:53:24] employee complaints of
wrongdoing, if our investigation requires
us to look at employee e-mails
[1:53:34] to understand what's happening,
we have a process in place whereby that has to be
requested. That information is
[1:53:43] kept. And so there is a record
of any time that we do that
[1:53:49] and the words we were looking
for we are not looking for whistleblowers. Retaliation is
not acceptable in any form.

[1:53:59] I will stand by that every
single day. And I would be happy to share with you the
types of things that we're
[1:54:06] looking for in employee
investigations. When we do look at emails,
[1:54:11] emails, phone calls, text
messages on government property,
[1:54:18] government data. It is not the
personal property of the staff. That's true of most businesses
where you work.
[1:54:26] So we are not surveilling our
employees too. Do what you suggest. And again,
like I shared earlier, if
[1:54:36] people are concerned, I will
take the specific information with out the name of the
individual. I don't need the
[1:54:42] name of the individual to act. So we will take action on any
information that we're in
[1:54:49] receive, whether it comes from
an employee or not with a name or not.
[1:54:55] Secondly, I want to just thank
you for your comments about the SSI system. When the children,
youth and family was part of
[1:55:05] DHS and I toured the state and
visited counties and tribal nations.
[1:55:11] I got to see the very same

green screens that you're talking about. I heard about
the amount of minutes county
[1:55:18] workers spend with the down time. It is a
system that the state should
[1:55:24] have invested in upgrading a
long time ago. I couldn't agree with you more. I'm very
thankful that the legislature
[1:55:31] put money forward and and that
now DC why off and minute are
[1:55:37] working on a together with the
county's on addressing the systems. And I also agree with
what the Association of mimic
[1:55:45] Minnesota counties and Max has
told us in terms of our other aging systems that need
investments to make the worker
[1:55:54] workers lives easier and more
efficient and effective and that will also help DHS to
implement policy changes that
[1:56:03] happen all the time at the
state and federal level more nimbly and quickly. Right now,
it's very cumbersome and
[1:56:10] time-consuming and staff
intensive to make systems changes. So I agree with you on
that and look forward to
[1:56:17] further investments there. >> So I just was reminded of
one question I had from

[1:56:23] actually my freshman year when
I served and that HHS committee, I have not served on
it since my freshman term,
[1:56:30] but there was a controversy or
at all right issue. I'd say an issue, not a controversy about
making sure that there were
[1:56:37] data matching reports provided
to the legislature and that was paused during COVID. But my
understanding is that has not
[1:56:45] picked back up. So could you
give me sort of a status report on providing data matching
reports to the legislature and
[1:56:52] when we can expect Chair Robbins, I I do you have
that answer? Okay. I don't have
[1:57:00] that. And thank you, Mister
Conley does. >> Yes, so we can look into
providing the specific data to
[1:57:06] you and the committee. However,
periodic data matching has resumed and I believe it or
presumed at the end of the
[1:57:12] unwinding and 2024. >> And have those reports been
have you then reported on that
[1:57:18] status of that, the legislature
to that say the committees of jurisdiction? I'd have to
verify that, but we can provide
[1:57:24] that information. Great.

Thank you. Because that was a big concern, you know, back in 2019. And I just want to make

[1:57:30] sure that we're continuing to follow that because that's part of the thread of understanding eligibility. So thank you

[1:57:36] members. It has been a robust hearing. Commissioner Inspector General, Mister Conley, other members of the public. Thank

[1:57:42] you for being here. We are adjourned

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 09-17-2025

[0:01] >> Good morning. It is 10

o'clock

[0:08] how state Agency. >> And Fried Oversight

Committee to order. Sorry,

[0:13] I got the wrong thing. I am

delighted to welcome you all here. And before we get into

the substance of the day,

[0:23] we are going to approve the

minutes from our last meeting Vice Chair Anderson, have you

had a chance to review the

[0:29] minutes? >> I have Madam Chair. I make a

motion to approve the minutes as is this as I could.

[0:36] We don't need to get all those

in favor. Say Aye, aye. Aye. Any opposed

[0:42] minutes are approved. All right. And our first the

order of business today is that

[0:48] we are hearing from the

Department of >> Human Services on the

Housing Stabilization Services

[0:55] Program, and then the

Integrated community supports program.

[1:00] Then we move to public

testimony and member questions,

[1:07] Chair Pinto. >> Thank you, Madam Chair.

I did want to raise a it was just a concern. I want to raising a question to ask as we [1:15] get started. So when the hearing was noticed up our since there was noticed, there's been a couple of [1:21] significant announcements have been made. You're running for governor. Congratulations to you. Governor was running for [1:27] re-election. He's announced that and I have a concern this incredibly serious issue of integrity of our public [1:34] programs. And obviously we've had legislators run for office. That's a regular thing. This committee, though, is is [1:41] different in that. It's not a committee that has a substantive policy jurisdiction. And what we've done is is we haven't had bills referred to us or voting bills [1:48] out. What we've had is testimony from executive branch folks and questioning of them and then testimony and [1:54] questioning from folks who have criticisms of the executive branch, which raises concerns for me about just sort of [2:01] inherent conflict of of having that happening in this in this committee. And I guess is a

particular example, just a
[2:06] minor one. I know that the the
agency was asked to present on these 2 really complicated
programs that we don't. Human
[2:13] Service expertise in the
committee and a dash for 45 minutes. They were told to keep
it to 10 minutes. That's
[2:18] obviously as chair. Madam sure,
you have the authority to to control the committee hearing
and also as a candidate for
[2:25] office. There's an inherent
conflict there. And so I guess my question is the plan for it.
Will there be someone else
[2:32] taking over the committee are
set of what will be done to avoid that conflict in terms of
how the committee works and
[2:38] question the bank you Chair
Pinto. >> Thank you. I don't see a
conflict. I am an elected
[2:44] representative of my district
chairing this committee. The governor is elected
[2:49] governor of this state. He does
not plan to curtail his governor activities. And I do
not plan to curtail I elected
[2:57] representative activities and
we have conducted this committee in that completely

[3:03] respectful and tried to be
bipartisan way allowing lots of time for both sides. A lot of
questioning. The problem has
[3:11] been when agency personnel come
in here and filibuster and we can't get to members questions.
So I reject that. And I
[3:19] appreciate you raising that
concern. But I think you will be gratified by how we continue to
contest the conduct, the
[3:28] business of the committee.
Now, I'd like to know for the record that this hearing has
been noticed since last June
[3:35] and today happened to be the
day when I get a call at 7.30, and the department announces
they fired the person
[3:42] responsible for housing,
stabilization services and homelessness. And that person
is not available to testify
[3:48] this morning. And then I get a call from the
governor's office announcing their fraud package. Revisions
are announced today. Well,
[3:55] we're having our hearing.
So if there's any grandstanding going on or trying to hide the
ball, it is not by this
[4:01] committee. Thank you. >> Chair Robbins before before
we began and correct the record

[4:09] you may once we receive it your
testimony, you are not recognized.
[4:15] >> So members, as I was saying,
we are going to have a committee hearing today with
DHS about the Housing
[4:21] Stabilization Services Program
and the Integrated Community Services probe.
[4:29] I'm sorry, I'm going to finish
my statement. And so we welcome the
commissioner and her staff with
[4:34] us today. Thank you very much.
And we welcome our public testifiers. We are going to
proceed immediately after I
[4:42] hear from chair back. >> That's why I just want to
correct the record from not
[4:48] Chair Pinto, but lead Pinto.
Also the fact that we did hear bills in here related to fraud.
So I believe we heard I believe
[4:55] you presented bills in here.
So we did hear bills here. Madam Chair.
[5:01] >> Yes, we heard bills. We will
precede commissioner Guy de welcome to the committee.
We look forward to your
[5:08] testimony. This is an ongoing,
difficult topic. We really need
[5:13] to dig in and find out all the

problems in the Housing Stabilization Program and the
Integrated Community supports
[5:19] program. And we look forward to
your test. Funny. You may begin. Thank you, Chair Robbins.
[5:26] >> Madam chair and members of
the committee. For the record, I am sure in Gandhi and I was
point appointed as temporary
[5:33] commissioner of the Minnesota
Department of Human Services in February 2025,
[5:39] I just want to first begin by
correcting the record in that
[5:45] as a courtesy, I have been
making calls to our committees
[5:50] of jurisdiction and as well as
you Chair Robbins as chair of the fraud committee since we
were appearing today to let you
[5:59] know that the appointment of
our assistant commissioner has ended.
[6:05] And so that is the proper
terminology for appointed official and the status of
employment with DHS. It ended
[6:17] as as of yesterday. Thank you again for the
invitation to appear in front
[6:24] of this committee. I believe it
is the 4th time DHS has been asked to come in front of this
committee since its inception

[6:32] in the last legislative
session. The agents, the agency has been
an active partner in the
[6:40] committee's work during the
legislative session and over the summer, we've made our staff available
to you, Madam Chair, as well as
[6:48] to your committee staff.
And we have done and continue to respond to requests and
we'll continue to do so.
[6:57] And I am appearing today to continue to collaborate with
you on this really important
[7:02] topic. I know that there are 3 things
at least we can agree on today.
[7:09] Minnesota hates fraud. You hate
fraud and DHS hates fraud.
[7:15] I want to remind everybody that
DHS is taking a 0 tolerance
[7:20] approach to fraud. We are
committed to program integrity and we are committed to
fighting fraud. And people who
[7:28] are stealing from public
programs are really harming the people who are most in need of
those programs.
[7:37] And we are committed to
continuing. Our enhanced investigations are enhanced
data analytics are quick

[7:46] investigations and quick and
thorough and engaging law enforcement pot prosecutor law
enforcement partners to
[7:54] prosecute these criminals because that is the separation
of our duties. We are an
[8:00] investigative arm and then the
law enforcement does the final
[8:05] investigation and prosecution criminals and the various
schemes they've concocted have
[8:11] become more coordinated and
sophisticated. And it's time for us to catch up
[8:17] while single actors and
individuals used to be more of the norm. Now, what Inspector
General Clark is sharing with
[8:26] me and and our law enforcement
partners are sharing with us is we're seeing more organized
bans of providers, gaming the
[8:35] system in concert. Since I took the helm at DHS 7
months ago, every lead level of
[8:42] our agency has been engaged in
the investigative work to fight fraud.
[8:48] Our old processes that were
based on the type of fraud we used to see are not sufficient
for these coordinated schemes.
[8:56] In the 7 months that I've been
in this role, I have been engaging teams from across the

agency in this intensive work

[9:03] to fight and prevent fraud to

strengthen our internal controls. We've done a lot of work, but

there is a lot more to do

[9:13] and we will continue to be

transparent about what we're finding and what more we have

to do

[9:19] after the past few months.

We've also been working across the enterprise with other

agencies and the governor's

[9:26] office to identify additional

tools and steps that we can take to prevent criminals from

trying to exploit our programs

[9:34] that serve vulnerable adults

and children. In Minnesota. The executive order issued by

the governor today gives DHS

[9:43] additional authority to move

forward with this in rolling inactive providers

[9:49] putting a temporary moratorium

in place for new provider enrollment. Creating unique identifiers for

providers to track across

[9:58] programs, referring bad actors to the

Department of Revenue to investigate tax fraud and

creating a statewide OIG work

[10:07] group using our new data

sharing capabilities and more

[10:13] in terms of your request for
information on our 2 programs,
[10:20] Housing Stabilization Services
is a Medicaid service. It is distinct separate from the
state funded housing support
[10:30] program that provides rent
assistance. The Medicaid service helps
people with disabilities find
[10:37] and keep housing with. They're
using various methods. It is 4 Minnesotans who are 18
years of age or older with
[10:47] incomes at or below 150% of the
federal poverty level.
[10:52] We have approximately 21,000
individuals and 18 100
[10:58] providers roughly that are
enrolled. There is a handout on this
program and with the short time
[11:06] frame, I'm gonna leave it at
that. For Housing, Stabilization Services
[11:13] for integrated community
supports or ICS. This is also a Medicaid
service enacted by the
[11:21] Legislature in 2019 providing
supports to adults 18 or older
[11:26] living with disabilities. Ics allows people to live

independently in the community

[11:34] through residential provider

controlled apartment settings.

[11:39] As of late August, there were

160 ICS providers and 487

[11:46] approved ICS, 7 settings

covering about 2800 individual

[11:51] ICS units. Ics fills the gap in the

service, continue between a

[11:57] person living in their own home and more restrictive settings,

such as group Homes and

[12:04] Assisted Living, which the

state has been moving away from, has assisted living

models geared for older adult

[12:11] populations don't offer as much

client choice and how or if the

[12:17] clients receive services. So that briefly, an overview of

those 2 services. And I would

[12:25] like to ask Inspector General

Todd Clark to talk about the fraud schemes that we're

seeing.

[12:32] Thank you. Welcome to the

committee Inspector General Clark. >> Good Morning. Madam Chair

and committee members a little

[12:38] under the weather this morning.

Severe bear with me. If I'm coughing, I'm James Clark and

I'm inspector general at the

[12:45] Department of Human Services.

I came to DHS in late March but I'm no stranger to Medicaid

fraud. Before coming to DHS,

[12:51] I spent nearly a decade at the

Attorney general's office were investigated and prosecuted civil administrative and

criminal Medicaid fraud

[13:00] actions. The past 6 months, the DHS has

increased my passion

[13:06] for fraud prevention work like

the commissioner. I take a 0 tolerance approach

[13:11] to fraud in these programs.

I want to be very clear on this point. I will not tolerate any

fraud in our programs. I will

[13:17] do everything in my power to

detect and prevent fraud payments will be shut off

immediately at the first signs

[13:23] of fraud. All credible

allegations of fraud will be referred to law enforcement and

I will do everything in my

[13:28] power to kick fraudsters out of

our programs. I also want to be very clear on another point,

[13:34] greedy people in businesses

have learned how to exploit our programs. It's an unfortunate

reality, but this work is

[13:41] serious and challenging and I

sincerely want to partner with you all and everyone else
responsible for Medicaid
[13:48] oversight. We have a shared
responsibility. The legislature managed care organizations, law
enforcement and quality
[13:55] providers that are doing good
work. I want to work with everybody on the serious, the
challenging issues to find the
[14:01] real solutions to these
problems. I also want everybody to know
that fraud is getting more
[14:07] complex and sophisticated at the Medicaid fraud unit AGS
office. And here at DHS we're
[14:14] seeing webs or rings of
connected providers that are working together to commit
fraud. I've seen indications of
fraudulent ai-generated health
[14:22] care records. There are entire agencies as
opposed to individual employees
[14:27] committing from. That means
that fraud is the business model. It's not a rogue or
one-off employee that is
[14:34] committing the fraud. I've also seen businesses
committing fraud to have tentacles throughout the
Medicaid program. Right.
[14:41] When you see a hss provider

committing fraud, they may also share ownership with an autism provider in adult Day Care

[14:48] center and arms provider.

Right? So you can see tentacles of fraud throughout the department. It's complicated

[14:55] and it's a difficult problem to solve. As for housing, stabilization services, fraud schemes.

[15:01] I have not seen any seen any unified hss fraud scheme.

[15:07] What I've seen our schemes are varied. I've seen billing for services when the recipient has never heard of the business.

[15:13] I've seen overbilling, for example, killing us for 2 hours for a short phone call. I've seen providers not having any

[15:21] documentation to support services that were provided. I've seen also building for non reimbursable services such as

[15:27] billing us for employee travel time, which was not reimbursable under the program. Also, I've seen up coating right billing for a more

[15:34] expensive service. So saying he provided a consultation and doing for a consultation when actually you provided a less

[15:41] expensive service like a

transit transition service.

[15:47] I would just like to know

before you go the next slide. As for Hss, we have 120 open

HSS investigations. We've

[15:54] suspended payments 215

providers. These providers have been sent to law enforcement,

law enforcement and notified

[16:01] about these providers as part

of our investigations into the program that start federal

contractor to do a top to

[16:09] bottom review of hss billing

data to detect any anomalies that signal fraud, waste or

abuse. And I expect preliminary

[16:16] results next month from that

top to bottom review of a justice. But what data these

investigations are complicated

[16:22] and there are time consuming.

We have to go line by line through billing records.

We have to review treatment records and we have to contact

recipients to see whether or

[16:30] not services were provided.

It's complicated takes a lot of manpower and ours. We are

working as hard as we can and

[16:37] as fast as we can to shut off

payments everywhere that we see fraud.

[16:44] >> I'm sorry. Just to quickly

for how many have you stopped payments on today? 115

providers

[16:59] chair Rob and I know I would

kick it back to the commissioner. Okay.

Commissioner County.

[17:05] >> Thank you. Chair Robbins.

This slide provides a high-level overview as

Inspector General Clark shared.

[17:14] He and I have both been working

to understand the timeline of what has transpired with hss so

that we can make changes to DHS

[17:24] is internal controls and

processes as well as to continue to keep

taking quick action to identify

[17:32] and investigate fraud, stop

payments as fast as possible and make

[17:38] referrals to law enforcement to

prosecute these criminals to the fullest extent of the law.

[17:44] So this timeline provides

high-level information on HHS actions, reforms and new

processes.

[17:53] There's a lot more items behind

this. And if we want to get into that during questions we

can. But

[18:00] >> at a high level, I want to

flag on this slide that we

[18:07] began investigations in the
fall of 23. We began engaging.
[18:13] Mc owes a and CMS to
investigate this in the spring
[18:18] of 24 patterns began to emerge
throughout 24. But again,
[18:28] it still was not what we
learned by employing enhanced
[18:34] data analytics. So then in 2025
during legislative session.
[18:42] >> As I began to see the, >> the numbers, the amount of
[18:50] spending that was happening at
housing stabilization Services and how that compared to the
forecast that we had expected.
[19:00] I asked our teams to begin
doing data analytics and 2.
[19:06] And we had also received some
vague, credible allegations of fraud, but no, not specific to
provide. And we had the regular
[19:13] community tips that were coming
in. But we were told that there was widespread fraud, but not
who it was. And that was in the
[19:22] spring of 2025. This year after
I became temporary commissioner. So that's when we
went to our data analytics
[19:31] team. As I've discussed with

you before in the inspector general's office and said,
let's start doing
[19:38] the types of analysis that
credit card companies would do. Let's look for trends. Let's
look for outliers. We don't
[19:45] have all the tools for bid
predictive analytics, but that's what were you know,
that's where we would like to
[19:51] get to. And so that's where that
information provided Inspector
[19:56] General Clark and his team
information priority list
[20:02] to look into because this is
very time intensive and takes many hours and a lot of
work with our old outdated
[20:12] systems and lack of robust
fraud fighting tools.
[20:19] When I saw that in April, I
decided that both hss any ID be
[20:26] I need to be designated as
high-risk Medicaid programs that gave us additional
administrative tools to act on
[20:34] those programs. We are required to give 30 days
notice. So in early May we gave
[20:42] notice to providers that those
programs we're going to be high-risk programs effective

June one

[20:50] as we continue to look into

what we were finding and housing stabilization and

hearing from Inspector General

[20:59] Clark as well as the U.S.

Attorney's Office, the it well,

[21:04] maybe it's more the age

attorney general's office. I'm not sure if the attorney

U.S. attorney provided this

[21:10] feedback to us, but both the

Attorney General's office and our inspector general's office

felt overwhelmed by the amount

[21:18] of fraud that we were seeing in

the Human Services, Housing Stabilization Services program.

And so at that time, I made the

[21:28] unprecedented and very

difficult decision to ask CMS to terminate that

program.

[21:38] >> And thank you, commissioner,

give I could just ask where we add on that. I know when you

requested the termination,

[21:43] that was a 30 day period and

people could provide comment. And then there was another

period where they got to review

[21:50] the comments when, in fact,

will the program be terminated? Yeah, I can tell you that at

the earliest it will be

[21:56] terminated in October. 20th, we have to let. >> The the 30 day comment

period. And and then as quickly

[22:06] as possible, we have been

looking at comments that are coming in and reviewing them.

But as quickly as possible,

[22:12] we have to take the next steps

with CMS to provide them with

[22:17] what we heard and CMS

ultimately will work with us to

[22:23] determine what the final date

this. Thank you. Please just keep us informed on that.

Thank you. Yes, we will

[22:29] Representative Anderson. >> Thank you. I I you have a

question. You said that you

[22:35] first looked at numbers in the

spring of 25 and yet

[22:40] actual numbers about the growth

of the services. And yet the gross started years before that

it was 42 million 21 and it was

[22:49] 74 Million. 23. And it was, you

know, over 100 Million. And 24

[22:55] so and and there were concerns from

counties have a county. So did

[23:01] no one at DHS. Look at this

than until the spring of 25.

[23:07] That's what you said earlier.

Yeah, Eisner County, thank you, chair funds and thank you

vice-chair Anderson.

[23:16] >> Yeah, I was speaking to my

role as temporary commissioner stepping into this role and

having ultimate final authority

[23:24] for these programs and them

being properly run. So that's that's what I was talking

about.

[23:32] >> I know I know. >> The program areas, the

community, others were coming

[23:41] out of the pandemic. We're

seeing such a great need for homelessness supporting people

who are experiencing

[23:48] homelessness to become house.

I know there was a lot of attention being paid and a DHS

being asked to process

[23:57] applications for providers

faster. And we James and I are

[24:04] still, you know, looking into

what happened before more specifically our appointments

in this role and that I mean it

[24:14] began. >> Thank the irate Cook

followed. Know. I think. Okay. Okay.

[24:21] Thank you, Chair Robbins to stay here.

[24:27] No, maybe we'll skip so that

you I mean, that's basically what I said on the other side.

[24:33] I want to make sure that we

keep to the timeline here. So for the past 7 months, we

have continued to take bold

[24:42] action. And here is how we're doing

things differently. At a high level. In March, I brought in a

new inspector general James

[24:51] Clark, who has a decade long

record as he shared with you in the classic aiding prosecuting

Medicaid fraud in the Attorney

[24:59] General's office. In April, I

designated both EI Dbi and

[25:04] Housing Stabilization Services

as high risk that was able to take effect June 1st

[25:10] that tightened requirements on

owners increased on site visits and allowed us to make

unannounced visits.

[25:17] We are staffed better. We are

more strategic and effective and data analytics as a result

of both

[25:26] 3 prioritizing work of our

internal staff and allowing our staff and

working on staff Cooper

[25:36] capacity, search strategies,

also that the enterprise has

[25:41] come to our assistance. And in

September, we were able to bring in 5 additional data
analysts from Minnesota
[25:48] management and budget results there results,
management team
[25:54] and these individuals are
trained to look for new patterns and anomalies and
billing and payments for state
[26:00] services and are using AI to
supplement their review and find outliers
[26:06] worst. We started looking at
programs in new ways to identify outliers so that we
could be strategic with the
[26:14] limited resources we have and focus on where we're most
likely to find fraud.
[26:20] We started acting much faster
and much more aggressively him
[26:28] looking at the data so that we
could rise to the level of finding credible allegations of
fraud and stopping payments
[26:36] immediately. As we've discussed in May, we
had one housing, stabilization
[26:43] services, stop payment. And by
August, we had 115 that large
[26:50] change came about because on
May 9th, we had a meeting with the attorney general's office
and the

[26:58] the CA to talk about fraud and
what we could do to act faster
[27:03] with what we were seeing.
We had a past practice of waiting to stop payments until
investigations that concluded
[27:12] and investigations are time
intensive and we're taking too long. So we flipped that. We flipped
that and decided we were going
[27:21] to stop payments as soon as
there was a credible allegation of fraud, not wait for the
investigation to conclude
[27:30] unless our law enforcement
partners asked us to not do
[27:37] that because that would
jeopardize their investigation. So all of us agreed that that
was the right change to make
[27:43] given what we were seeing. And then on August 1st, I
stopped the at asked CMS to
[27:55] terminate housing stabilization
services. That process is under way as we discussed.
[28:02] I do want to say before before I close on that, that
there is a need for housing,
[28:08] stabilization services. And we
recognize that we do. We will be working to
provide providers and counties
[28:20] and our partners with resources

that people can be referred to when this service is terminated. And we very much [28:28] would like to work with the Legislature. And as James said, [28:33] with providers with the community and others to redesign and relaunch the benefit with the proper [28:41] controls in place, in the end, it's going to take all of us working together to [28:48] build the program with the right controls on the front and the right outcomes on the back end [28:55] and internal controls and program integrity throughout. We have to get it right for the taxpayers for the people we're [29:04] serving and for the providers. That's when it's going to take all of [29:10] us doing that together. So now I would like to turn it over to Inspector General Clark [29:17] to talk a bit more about what he's seeing and what the inspector, how the inspector general's office is changing. [29:25] Thank you, Inspector General Clark, thank you. Madam Chair. As the commissioner mentioned [29:31] since I came aboard. >> In March and at her direction, we're doing things differently and prioritizing

our work differently

[29:37] differently. One tool that I'm leaning into

that's essential that the department leans into in order

to do our work faster and

[29:45] better is data analysis.

Since I've become come on board, we are taking a more

thorough review of billing data

[29:52] to identify red flags. We're

also looking at our provider networks and data related to

our provider networks to ensure

[29:58] that we are only doing business

with quality providers. We want to work with good providers,

but if you're inactive or

[30:04] there's no need for your

services or your greedy or you're not providing quality

quality services, we don't want

[30:10] to work with you. We need to be proactive in the

fight against fraud.

[30:17] We when I came on board DHS and

we still are primarily a tip

[30:22] based investigation system

responding to tips is important and we need to react to tips.

But we can't just take a

[30:30] reactive approach in our fight

against fraud. We need to be proactive.

[30:35] We do not have the resources to

have investigators looking over the shoulder of the 300,000 providers in Minnesota to make
[30:43] sure that there killing us correctly. We need advanced data analysis to detect a red flags and anomalies. And that's
[30:50] the direction that we are moving towards. As I mentioned earlier, I asked our federal contractor to do a top to
[30:57] bottom review of hss billing data for red flags. So we will
[31:02] need to lean into data and business technology solutions even more to keep up with the pace of the work that we are
[31:09] being asked to do. So this slide contains information about the shared responsibility for Medicaid data analysis, right,
[31:17] DHS, we do our own data analysis in House. We also partner with external vendors, federal federal federally
[31:24] mandated contractors like the Unified Program, Integrity contractor in the recovery audit contractor, which we
[31:32] engage with on data analysis projects. And we also rely on the investigative and data analysis
[31:39] capacities of art and Medicaid

managed care partners.

[31:47] The commissioner touched on

this briefly, but I want to highlight

[31:52] that since I started since the

commissioner brought me on board since I've gotten

direction here we are more

[31:59] aggressively than ever

suspending payments to providers. Now being aggressive

comes with risk and it can

[32:04] jeopardize investigations under

Minnesota law. We have to notify providers if we suspend

payments due to fraud

[32:11] allegations. I've seen it before. If

providers catch when that they are being watched, they can

destroy records. They can

[32:19] delete emails. They can delete

text messages and they can tamper with witnesses. So there

is a risk to acting fast,

[32:27] right? You have to weigh the need to proactively shut

off money as fast as possible

[32:32] with the risk that you're also

gonna have to notify providers and then they can start whether

it's using AI tampering with

[32:39] witnesses. They can start and

inventing a whole world of of services that they provide.

[32:45] But since May, and I I fully

understand those risks. But since May, our processes now to
suspend payments immediately
[32:52] once fraud is seen previously,
we were waiting to suspend payments until investigations
were completed or until law
[32:59] enforcement accepted a referral
that process. Like I said, the investigation process and
the Medicaid takes a long time,
[33:06] right? We're looking at billing
data on line by line. Looking at provider records were going
on site were doing interviews
[33:13] that can take a long time.
So we have changed that approach. We are proactively
suspending payments at the
[33:18] first sign of fraud. Nevertheless, we're continuing
to collaborate with law enforcement.
[33:24] I'm leaning into the strong
connections that I have in law enforcement here at the AGS
office and the federal level.
[33:31] And I've taken an open book
approach with law enforcement and law enforcement. Anything
you need from me, anything you
[33:37] need from the OIG Inspector
General. I'm an open book. Data documents. Experts.
I will get it to you as fast as
[33:44] possible to assist law

enforcement investigations before the priority was to
protect criminal
[33:51] investigations. Now the
priority is to immediately stop potentially fraudulent money
from going out the door.
[33:58] There's risk there. But I think
it is the right approach to immediately stop money
[34:04] and not have these
investigations play out over several years. Go the next slide.
[34:11] So what is still needed to
address provider from a lot?
[34:16] We need to have closer
relationships and more oversight with managed
care organizations. I want to
[34:22] make sure that they are doing
everything they can to prevent and detect fraud to that.
And I met with recently with
[34:29] compliance investigative staff
at Blue Cross earlier this week. And I look forward to
strengthening our relationships
[34:36] with all and CEOs to make sure
we're on the same page, breaking down silos of
communication, sharing
[34:42] information where we can to
ensure their strong oversight over the Medicaid program. This might be the 5th time.
I've said this, but we need

[34:49] better business technology
solutions and upgrade. We really need to modernize our
program, integrity, technology,
[34:56] giving this given the
seriousness of our responsibilities. Ideally, we
would have the same technology capabilities as the private
sector does to prevent and
[35:04] detect fraud. That's just
simply not the case right now. I also think the legislature
should look into strengthening
[35:10] our payment withhold authority.
It is a tool like I said that I am leaning into to shut off
money at the soonest sign of
[35:16] fraud. I think we also need to
look at expanding our authority to potentially suspend payments
to businesses that have their
[35:25] licenses revoked or suspended.
If we are revoking your license due to noncompliance with the
law,
[35:32] find it funny that we're in a
situation where we still have to pay you money, even though
we we we are going to revoke your license and kick you out
of her programs.
[35:42] It's also can go back. It's
also just true that we need to have enhanced internal controls
[35:48] such as we need to have the

ability to do prepayment review, right? We can no longer
just solely rely on the trust
[35:55] of a system for Medicaid
payment there. Some providers who we could just not trust.
So we need to be in a position
[36:00] to say you actually proved to us that
the services were provided proved proved to us with
documents records. And, you
[36:08] know, the recipient that these
services were provided before we pay, we paid you. We also
just need to do more auditing
[36:16] and data mining and closely
reviewing data to enhance or internal controls.
[36:22] I think it's also a good idea
to have an outside consultant or an audit on the slide.
It says an external gaps
[36:28] analysis to identify where gaps
exist in our anti fraud, ex efforts and how our
organizational structure can be
[36:38] better aligned with program
integrity efforts last. And I think this is most important.
We have a provider vetting
[36:45] problem. We need to make it
much, much harder for fly by night qualified providers to
gain access to our programs.
[36:54] We need to increase spending on

the front end. Whether that's statutory changes, that makes
it easier for the department to
[37:00] say, hey, you are too risky.
We do not want to do business with you or hey, you're too
risky. We're going to put these
[37:06] specific controls or oversights
in place. One example of that
[37:12] was what got passed last
session. What which was a pretty enrollment risk
assessment for the Housing Stabilization Services program.
[37:19] To the extent we can do that, I
would like to see some sort of risk assessment, you know, capability across
these programs and statute like
[37:28] the department just should have
the authority to assess risk, say you have no history of
providing the services. We
[37:34] don't think you have the
financial capability to do this. You have no financial literacy.
You're just too risky to
[37:42] provide to have access to all
this money that you can protect you. But that was for so
[37:47] that's all I have for that
slide. >> Thank you very much. I
appreciate your presentation.
[37:55] I appreciate very much. The new
commitments to stopping payment

[38:00] earlier, not waiting for the
end of the investigations. I understand the risk that that
may pose to certain
[38:07] investigations. And if you need
statutory language so you can do it without notifying them,
that it's per se a fraud
[38:14] investigation. I would be happy
to work with you on that next session. I and that's a million
with that language. So so I'm
[38:23] happy to work with you directly
and taking that up. I do have a couple questions to
start us off here. First of
[38:31] all, when you're most recent
things I chair a general Clark
[38:38] was that you want enhanced
internal controls and internal
[38:44] controls is what I want to
focus on this hearing so that you can do prepayment
reviews. I've had multiple
[38:50] conversations with CMS at the
federal level in the last month. And they tell me you
already have that authority.
[38:57] You can impose a prepayment
review. So I don't know if there's some
sort of miscommunication
[39:03] between you in the feds, but

they have told me on multiple occasions you have that
authority and you're not using
[39:11] that. So I think we should
maybe get on a conference call or something. But my
understanding is you can and
[39:19] should be doing more of that. And then secondly, with the pre
enrollment risk analysis again,
[39:27] my understanding is you could
do that already. So could you speak to why you
think you can't do that?
[39:38] >> He wanted to start. I can.
So I mean, to answer your question, it's my
understanding. We got funding
[39:43] last session to start
prepayment review. So we're in the process of contracting with
an external vendor to start.
[39:50] I mean, it's it's his work
we've never done before. So we need to figure out how
we're going to do and how we're going to implement.
[39:56] >> But you've always had the
authority. In your statement, you said you didn't have the
authority. >> With enough, I did. I miss I
misspoke. I think we can
[40:02] implement it. I mean, I don't
think we need like legislative approval to do that. So want to
talk about internal controls and talk about things that we

can fix internally, right?

[40:10] That would better helpless in

our anti fraud efforts. So if I misspoke, sorry.

[40:17] >> And my last question for

this little bit here is you also talked about

[40:24] and so many questions this this I found curious, you

said that you did not have

[40:33] specific providers. This might

be 2 more you at Commissioner Gandhi. You said that you are

hearing reports of fraud with

[40:41] the housing stabilization, but

that you didn't have specific providers and we have I have a

file folder here of

[40:49] e-mails to your department

identifying specific providers from 2020 for that at Mco was

flagging very specific. And so

[41:02] can you square that circle for

me? You say you didn't have specific providers names but yet we have

it. You know, document after

[41:11] document saying they were

trying to alert you. Could you speak to that Chair Robbins? Thank you.

[41:19] >> I tried to be clear. I think

I wasn't clear since you're asking this question. So

[41:26] what I was saying is we had we started with a few

[41:32] to what we call community

Inspector General Clark calls Unity Tipsaw its. It's this

information being provided to

[41:40] us that there's potentially

fraud and it's coming to us and somebody is giving us specific

information and those started

[41:48] to come in around fall of 23.

We had more in 24 what I was

[41:54] speaking to him a spring of 25

[42:00] is that we also received a

community tip,

[42:06] but it had no providers

attached to that community tip. And that community tip was

telling us that there was more

[42:15] widespread fraud then coming in through the community

tips, the individuals where

[42:22] people were giving us provider

names to check into. And and so that frustration

that knowing that there was

[42:31] more. But we didn't know who

was part of that impetus to say

[42:37] there's got to be a better way.

And let's start doing data analytics. Let's enhance our

data analytics to find the

[42:45] trends an outlier so we can get

to the who

[42:51] thank you all. Move on to

Representative Hawkins. Thank you.

[43:00] >> Thank you. A quick question
for IG Clark. Real quick to do.
[43:05] If you at this point, Dan, been
able to come up with any kind of a net rough estimate of the
dollar value of the fraud,
[43:12] the gist of what you've caught
so far. So what I could commissioner
our General Clark sorry.
[43:23] >> What I can say is that for
the 115 providers that we suspended payments to
[43:29] those providers in total have
killed us about 100 million dollars in for 100 million
dollars
[43:38] over 6 years. So that's like the universe of
money we're dealing with now.
[43:44] The exact amount of that
universe which is actually attributable from fry. We're
seeing mixed mixed bag in our
[43:52] investigations, right? You have
to provide or maybe they're doing some legitimate work.
Maybe they're not doing some
[43:58] legitimate work. It's it's a
mixed bag, right? So that's that's the universe. But I
would anticipate as investigations, administrative
and criminal to play out in
[44:06] ultimately prosecutors in a

court of law will determine exactly that exactly from that
universe. How much of it
[44:13] actually from. >> Okay. And then forward.
Yes, one Marcella. Thank you. So I think the the theme of
this presentation is really
[44:23] stressing that the fact that
that we have been working in the dark ages with the
technology, I think everybody
[44:29] at this table knows pretty much how bad that the
the data systems that I DHS
[44:36] uses. I I did a tour well put
in the backs. So the last presentation we had
Commissioner Ghani presented a
[44:43] list of like a different data
sources that Frontline County worker would need in order to
evaluate Medicaid application.
[44:53] So I went out to the Dakota
County Service Center. I and sat with the trainers who used
to teach the front line workers
[45:01] how how these, how to use that
the existing systems. And my
[45:06] goal was to go out to to figure
out if there were at insights into ways that we might be able
to streamline that collection
[45:13] of that data is that would come
in more accurately in a way that we can process

applications more efficiently.

[45:21] And I never got that far

because when I sat down with them, the first thing they

showed me is that time the vast

[45:28] majority of their applications

are being processed through a system called access, which is

the 1980's era DAs application

[45:36] instead of taking yeah, like

payroll information from from Deep which collects it on a

quarterly basis from every

[45:43] employer in the state, they had

to keys information off of payrolls stabs.

[45:49] And if they, you know, fat

fingered something they'd have to start over. They had to

enter it separately for each

[45:56] program that the person was was

applying for. And I was just just appalled.

[46:02] And you look at the technology

that just generally that we're using and one of the the the

things that strikes me as

[46:10] someone who worked as a day to

professional doing business intelligence work for the lot,

that largest part of my career

[46:17] is that there's no way that

we're getting the data that we need to, you know, identify and

shortstop fraud. I am the way

[46:26] Mr. Clarke is describing what
we need to do today. The and we have not been making the
investments that we need to do
[46:33] that. The you know, where we're
dealing here with a program that was instituted under the
previous administration with a
[46:42] Republican legislature. We did
do some tightening up with the rules of this this year.
We did not find, however,
[46:49] and the improvements to the
analytics. And so these guys are coughing
together, you know, from and
[46:55] then the internal sources, the
ability to do a better job. I know Eric McCool who's in
charge of that program, really
[47:03] sharp guy knows what he needs
to do that. You know, if we want to see substitute process
on on tightening this stuff the
[47:11] way Mr. Clarke describes it.
We're going to have to step up to the plate, make some
investments is as well. You
[47:18] know, we've spent a lot of time
on this committee, you know, talking about what's wrong.
But we really haven't spent any
[47:23] time talking about what is it
that we're going to need to do as a legislature in order to

give these guys the tools to

[47:31] get around around that this is

arms around this problem? Obviously, the the fraudsters

themselves are becoming much

[47:38] more sophisticated. That's a

huge theme that we're hearing today. We have to keep up.

[47:45] You know, we need to be, you

know, if they're if the fraudsters are you, is he going

to use AI, then we need to be

[47:52] able to use advanced analytics

is as well. And we need to step up and give these guys the

tools that they need to do

[47:58] their job. So we've got on all

new. You know, the U.S. temporary commissioner is new.

The IG is new. The guy in

[48:06] charge of Erica in charge of

analytics problem Project is new. We've got a good team

here. They're smart people.

[48:13] They know what needs to be

done. We need to give them tools the tools to do it.

[48:18] >> Before we continue, I think

the question was does going we're going to move to our

testifiers. So I would like to

[48:24] invite Rachel Lean up and then

Cain Hens will be second.

[48:30] Thank you all for your

testimony. Hope you'll stay around in case we have
questions after the public testimony. Thank you. Thank
you.
[48:44] >> What?
[49:06] >> Welcome to the committee.
Ms Lien, please state your name for the record men perceive it.
Your testimony, Rachel Lean.
[49:15] >> Good morning, everyone.
I first want to thank this committee for having me
attendance oversight hearing today. My hope is that
providing the statement others
[49:21] will feel empowered to use
their voice and Speaker church. My name is Rachel mean and I'm
a woman in long-term recovery.
[49:27] I'm a mother, a daughter, a
friend, a sibling, any leader in the recovery community and
have done a lot to change
[49:33] completely the life that I once
lived. Most importantly, I'm a human being. I came in contact with the
housing stabilization provider,
[49:41] brilliant minds. When I was
graduating from treatment, I had already found housing
signed the lease and needed
[49:46] help with moving and obtaining
household items and getting an electric bill taken care of all things that I thought an
HSA provider was supposed to

[49:54] help me with it exit the number
and was immediately met with the response from someone that
so they could help me.
[49:59] The fact that someone was so
eager to help me seemed authentic because that is the
heart I have for helping others, too.
[50:05] Unfortunately trusting this
organization was a mistake. I never met with anyone from
this organization. Never spoke
[50:11] to anyone on the phone. Only
text messages when I questioned the organization about why they
were helping. They showed up at
[50:17] my doorstep with a vacuum
cleaner and I never heard from them again in July of 2024, I began
working as a recovery navigator
[50:25] at the Minnesota recovery
connection. During this time I began to encounter many
participants were similar
[50:30] stories when it came to Hss,
most had signed up when leaving treatment in hopes of finding
permanent housing and had
[50:37] essentially been ghosted by the
organizations. This motivated me to get a hold
of my own insurance claims
[50:42] through you care to see what I
had been don't far. I went through those records

and found that not only had

[50:48] brilliant minds build me for

over $2000 and only provided me with the vacuum cleaner, I

discovered at another housing

[50:54] stabilization provider named

Leo Human Services. Llc was billing me for the entire 10

months that I was in treatment

[51:01] every week for 10 months.

Leo Human Services was lying and saying that they were

meeting with me. This amounted

[51:06] to over $14,000. I had never

heard of them, never spoken to them. Nor did I ever meet with

them

[51:13] finding this out. Angered I

saw. I know what I went through to find permanent housing and I

know because I did it on my own

[51:19] once finding out this

information. I contacted my insurance company and DHS.

I left a voicemail on the front

[51:25] line. I received a phone call

back from DHS on 11/20/2024. DHS asked me a few questions.

Let me know that they needed

[51:33] any additional information, but

a senior investigator, we're coming back in February of 2025. I

contacted AJ from Carolyn and

[51:41] he began investigating based

upon the information I provided to him. Within days of my story airing in May, a senior
[51:48] investigator finally called me back. I can't help but think that if I had not contacted Care 11, would we even be here
[51:54] today discussing this? I want all of you to know today that I am one of the lucky ones
[51:59] when it comes to victim and victim is Asian and the predatory behavior of housing, stabilization services. I am
[52:05] someone who was able to access the appropriate resources in order to catch and confirm that there was something very wrong.
[52:11] That is exactly what I did. But what about the thousands upon thousands of other Minnesotans who may not have
[52:16] this access? This is precisely how just as providers have preyed upon people for years now, I promise you there are no
[52:23] limits when it came to who they were praying on. It could have been someone like me, your neighbor or any community
[52:28] member you see outside without homes to this day. I think I speak for everyone in the recovery community. When I say
[52:34] that we are sick and tired of

the rampant fraud and people getting rich off the backs of
our addiction, even as someone
[52:40] who access to proper resources
compiled all of the evidence of fraud through my medical
insurance and sent it to DHS,
[52:47] it was still not enough to be
heard. My question to DHS is us by your standards and policies.
What is a credible allegation
[52:54] of fraud? Why was I not someone
who is credible enough to be listened to the first time even
with all of the evidence that I
[53:00] had provided, this is not the
first time in a fraud case of DHS has done something like
this. I implore you all today
[53:06] to please think about that when all this first came to
light for me as a victim of this program, I was angry for
myself and how I got taken
[53:13] advantage of like I said
before, I am one of the lucky ones. I have a home. I have a
place to eat meals. I have a
[53:19] job now. I have the things that
I need to live my daily life. There are people who are not as
lucky as me when it comes to
[53:25] stuff like this. That is why I
am now even more angry for all the ones that are still
suffering, the repercussions

[53:31] that they didn't ask for once
they decided to trust an HSA provider with this anger comes
real motivation to make a
[53:37] change and be a voice for those
who don't have it. That is why I said yes to
coming in. Speaking in front of
[53:42] all you today. My hope is that
by doing this, others will tell their stories and real change
we made so something like this
[53:48] never happens again. >> Thank you, Miss Lane.
Thank you. You're raising your voice and speaking out is
making huge changes throughout
[53:57] state government and we really
appreciate it. So on behalf of the committee, we appreciate
you standing up and speaking
[54:04] out. Thank you. Thank you, Mr.
Pence, please join us at the Testifier table.
[54:17] Let's turn this honor. It's
already on. So please state your name for the record and
then begin your testimony.
[54:23] And just as a reminder that
committee staff had recommended 2 minutes for Testifiers.
So China keep it short that we
[54:29] want to hear from you. So
brevity is the soul of wit. >> So thank you, Madam Chair.
When I was young man, I'm

[54:36] sorry. Could you state your
name? See AI and PNC when I was younger. Healthier man. I was
actually a political theory
[54:43] major in Washington, D.C., and
when I used to go for long walks ago by the National
Archives and outside there was
[54:51] written. Eternal vigilance is
the price of liberty. So thank you. This is what is needed.
There needs to be people who
[54:58] are eternally vigilant and I
100% agree with that. Last lady. What she said about the
media channel 5 did a story on
[55:08] me and after a year of trying
to contact DHS and explained to him the massive fraud that is
going on and I C S the next day
[55:17] they happened to call me.
I find that to be more than just a coincidence. I ended up
by a strange series of events
[55:25] in ICs. And I'm just telling
you right now, a couple years from now you're going to be
having a committee hearing for
[55:31] the same thing that happened
was hss happened with autism, happened with feeding our
future. There are people who
[55:38] don't have housing, including
myself. So they come into one of these I C S that gives him a

rebate on housing and promises
[55:46] service. So it's really a
housing program masquerading as a service program. And what
they do is they charge this
[55:55] unbelievable daily rate.
I brought all the billing records. If anybody wants to
meet MS be afterwards, $276 a
[56:03] day in my case and they don't
do Jeff. They do nothing. So they give you a rebate.
The rent. In my case, it was in
[56:11] $1800 apartment. I was getting
for $600 and within 5 days they
[56:16] make up for it by charging for
all the services that they don't give. And there's a lot
of people in the program who
[56:23] need things who don't say
anything because they're scared of the providers. They threaten
you. They intimidate you.
[56:29] They tell you you're not going
to have housing. And what I come from, a group of men who
fought for America, my father
[56:37] actually went to prison over
Vietnam. My great grandfather was a decorated Marine. My
great great grandfather fought
[56:43] in World War One. And I said
you're not doing this to me. I'm not a whim. And I fought

back. Of course, that was

[56:49] called a racist. I was called a

fascist. I was called all these names. Why? Because I want it

girl trees because I wanted my

[56:56] place cleaned and how many

times I call DHS they didn't do a d*** thing.

[57:02] >> Nothing until there was the

news report. So I hear all this fancy stuff up here and you

guys don't do anything. How

[57:09] many times does somebody have

to call them 10, 15, 20? It's ridiculous. So

[57:16] my 2 minutes I just want to say

what Thomas Jefferson sat. Eternal vigilance is the price

a liberty. Thank you for the

[57:24] committee and I really hope

something happens. >> To thank you, Mr. Pence next

step we have Josh Berg.

[57:43] Welcome to the committee.

Please state your name for the record. >> Thank you. Madam Chair and

members of the committee might.

[57:51] My name is Josh Berg. I'm grateful for the

opportunity to be here today,

[57:56] not in spite of the difficult

theme of this hearing, but because of it the issues before U.S. matter,

profoundly to the people that

[58:03] we serve and I'm committed to helping

build a system that earns their trust in meets their needs.

[58:09] The recent revelations of

large-scale Medicaid fraud are deeply troubling. Medicaid fraud is staffed.

[58:16] It steals from taxpayers from

vulnerable Minnesotans who rely on a special services and from

a system already under

[58:23] tremendous strain. As someone who works at one of

the largest ICs organizations

[58:28] in the state serving low-income

Minnesotans with physical disabilities and brain

injuries, I believe in the

[58:34] highest ethical and

professional standards. I support rigorous enforcement

of Medicaid laws in full

[58:40] prosecution of those who abuse

the system for personal gain. We didn't arrive here

overnight.

[58:47] These challenges are a product

of decades of evolving programs, shifting priorities

and reactive decisions. Not the

[58:54] actions of a single

administration or legislature now is not the time for blame

or partisan rhetoric.

[59:02] We all share responsibility for

the system as it stands and we share that duty to fix it

[59:07] too often. We are stuck in a

reactive cycle chasing the next scandal trying to get ahead of
the next feeding our future
[59:13] headline in doing so we lose. We risk
losing sight of the why and the
[59:18] who behind every program, every
policy, every audit. There is a
[59:24] person, a Minnesotan, a child with autism. The young adult with cerebal
palsy,
[59:31] apparent recovering from brain
injury. We need to plan according to Todd full plan
that strengthens programs with
[59:39] integrity in clarity rather
than shutting them down provides clear consistent
definitions of fraud and waste
[59:46] without vague interpretations
or moving targets establishes continuity of care
protocols when a fraudulent
[59:53] provider is shut down. So
housing and services aren't abruptly lost.
[59:58] These are not theoretical
concerns. They're happening now without a plan.
[1:00:03] This moment demands seriousness
and accountability, but also nuance, not everything reported this
fraud, not everything is waste.
[1:00:12] I can connect with providers
doing excellent work within the constraints of a complex, often

contradictory

[1:00:18] system. Get many live in live

and work in fear. Fear that shifting definitions

are one disgruntled staff or

[1:00:27] escort client could put them in

the headlines facing investigations or payment

withhold without any due

[1:00:34] process. This must stop. Let's take a breath. Let's do this work humbly

[1:00:41] and has a friend in one of my

favorite senators often says, let's leave our egos at the

door. Let's be bold. Let's be

[1:00:48] brave. This will be difficult

work, but we are ready. Let's make this system worthy of the

people. It is built to serve.

[1:00:56] Thank you. Thank you, Mr. Bird. >> Thank you to all of our

testifiers and 2 people

[1:01:03] watching. I just want to thank

you for all the people who have reached out to us. Mister Pence

reached out to us. Other people

[1:01:10] have sent us e-mails to the

portals and Mr. Burke's Point, not everything

[1:01:15] is fried, but it takes time to

figure that out. But we are doing the work of trying to

respond to all of that reports

[1:01:22] we receive. And we appreciate

all of you. Thank you. All right. With that, we're

going to start with member

[1:01:28] questions. First on the list is

Representative Shots.

[1:01:33] >> Thank you, Madam Chair.

And I think I'll be asking the the acting commissioner and the

inspector general to join us

[1:01:39] back at the the desk. I was

listening to their testimony, especially preparing for the

hearing. And I have a really

[1:01:47] quick and simple question begin

to begin with today. Inspector general, what what date did you

start with DHS?

[1:01:57] Thank you. Was March. >> 26 of 2025.

[1:02:02] Thank you. And so just to help

color a little bit more of the picture that DHS tried to paint

for us today

[1:02:11] for frame of reference. They

mentioned that they had a meeting with the attorney

general's office to look into

[1:02:18] these concerns over H S S. But that came on the heels of

reporting by Carolyn

[1:02:26] based upon what we've heard so

far from the testimony given by

Minnesotans in attendance

[1:02:33] today. My question for you, either one

of you is how long does it take

[1:02:38] from Minnesota to get a
response from your agency when they have credible
[1:02:44] complaints? Commissioner Gandhi? >> Thank you. Chair Robinson,
Representative Schultz.
[1:02:52] I think part of this will be
important for Inspector General Clark, too
[1:02:58] answer as well. But I would
like to say that I stepped into this role in February.
[1:03:05] >> I. >> I think that the reporting
that a J logo has been very
[1:03:12] helpful to us. It was very
helpful to see the work that he did and what he uncovered.
And that was part of as I
[1:03:21] stepped into this role. And I was seeing the data and
having new information coming
[1:03:29] to me as temporary commissioner having that story was, you know, all part of the
ingredients that went in to us
[1:03:38] along with that vague,
credible, credible allegation of fraud, part of the
ingredients that went into
[1:03:44] economy chair or a different
approach to the then I'm sure. >> Asked a very simple
question. How long does it take
[1:03:51] DHS to respond to a complaint,
a credible complaint from a Minnesotan or in the cases of
the instances in the data that

[1:03:57] we have county entities that
administer this program. How long does it take the chest
to respond?
[1:04:02] >> Commissioner, can you please
try to actually answer the question and we're not going to
allow filibusters. So if you're
[1:04:09] if you are filibustering, we're
going to just move on to another question. Thank you, Chair Robbins. I'm sorry.
You're perceiving that.
[1:04:18] Representative Schultz asked
about AJ Legos reporting and about
[1:04:23] and about how long it takes.
I would like Inspector General Clark to talk about that
because he has been working
[1:04:29] with the inspector general's
office on past practice and the changes that he's making.
[1:04:36] Thank you, General Clark. >> To your question directly, I
don't know the exact time. All right. We have to triage.
We have to assess risk. We have
[1:04:44] to prioritize. My staff tells me that in 2024
got 1300 reports or complaints
[1:04:50] to us. We currently have 1000
open investigations. We just cannot
[1:04:56] actively drop everything we're
doing in immediately respond to all the complaints that are
coming in. We are doing our

[1:05:02] best. We have to triage.
We have to sign risk. We have to prioritize. The also refer
matters to and CEOs, for
[1:05:08] instance, if the NCO recipient
calls us and says, I mean, you care recipient front is
going on. We refer that to you
[1:05:15] care who is responsible for
detecting and preventing fraud and taking action against that
provider. So it's complicated.
[1:05:21] Unfortunate can't you can't
give you an exact timeline of how long it takes to respond to
a complaint it Bears.
[1:05:28] >> Representative Schultz,
thank you, Madam Chair. I would just note for the record that
Hennepin House, you know,
[1:05:33] is on record as having made
formal complaints, not even just a, you know, individual
Minnesota, concerned with
[1:05:40] fraud, but government entities,
counties concerned with this. And that was in March of 2024.
And yet it took until May and
[1:05:49] reporting by Carolyn in order
to see any sort of action from
[1:05:55] the 2 of you who are both in
positions of power to look into this for at least 2 months
prior. And then concerning to

[1:06:03] me is the picture that you
paint it today that you no
[1:06:09] inspector General Clark, that
there are providers to provide services, not just for housing,
stabilization services, but
[1:06:16] they're interwoven through a
whole number of hcbs services.
[1:06:21] And I didn't hear from you
today, nor do I have any level of confidence based upon the
reporting from the media
[1:06:28] that you are tracking the
individuals who are involved in providing those services to
those other programs.
[1:06:36] You talk about data analytic
analytics, but there's no evidence that you're applying
the same principles that are
[1:06:44] happening with with hss into
other Medicaid funded programs.
And I'm really concerned with
[1:06:51] that, especially when earlier
today you said straight into the camera inspector general,
you said payments will be
[1:06:58] stopped for those suspected of fraud.
And then later in your remarks came back and
said
[1:07:06] I don't have the payment

withhold authority. You said that. That's my concern today.

[1:07:13] >> Thank you, Representative

Celts, representative or

[1:07:19] thank you, Madam Chair. I have so many that so

[1:07:24] I appreciate that. We've had 2

members of the public that have had really bad service come

forward and and on on the a**

[1:07:30] to. So I apologize to you.

And I know I I happened to walk in with one of our test fires

because he was trying to find

[1:07:36] how to get to this room.

And thank you for all you went through to even get here today.

Thank you. Appreciate you. Appreciate that.

[1:07:43] I want to talk just a little

bit about what happened just on Monday at the homeless

encampment. So this is what

[1:07:49] happens when we don't serve

people. We just heard 2 amazing human beings, one that has

found recovery and God bless

[1:07:56] you for finding recovery.

I worked at teen challenge for a couple years and I

[1:08:02] I feel for you what you've been

through and its. It's really unfortunate that

the state of Minnesota in the

[1:08:09] Health and Human Services

Department you down. But just on Monday at the homeless

encampment, there was a mass
[1:08:14] shooting and that's because
he's homeless. People don't have a place to go. We have all
of these
[1:08:21] services everywhere in state
government just in this alone, the housing stabilization
service
[1:08:28] since its inception doled out 302 million dollars
when it was ice expected to
[1:08:36] have 12 million dollars of
expenditures and very little of it. In fact,
according to Joe Thompson,
[1:08:44] Medicare, 11 interview said the
vast majority of this spending of that 302 million is fraud.
[1:08:52] I don't know exactly where that
number lies he might. He's doing a deep dive. Thank
God for Joe Thompson
[1:09:00] because he is investigating.
He is going actually do to the sites. I still haven't heard a
ton of a site visits
[1:09:08] looking at the records as they
exist and doing his due diligence and hopefully he will
be and the feds will actually
[1:09:17] take action with what's
happening because we're sorely lacking, madam chair here in
Minnesota. So that is that

[1:09:25] that's one thing. I would also say that as I
looked at the Curragh Levin
[1:09:30] report just from September,
11th, even in that report,
[1:09:36] AJ Legault said that the agency, the inspector general was flat
flying blind.
[1:09:44] This is just days ago. The information that they
discovered was that the
[1:09:49] information that's coming from
the public from Hennepin Health from multiple sources
[1:09:56] are not getting to where they
need to go and the quote was they are literally flying
blind. They saw
[1:10:03] payment 2 dead people. >> Fake meetings for
signatures, brides phantom
[1:10:08] services, kickbacks fly by
night companies.
[1:10:14] >> Not difficult things to see.
All you do is show up at their door and realized that in one
building alone
[1:10:21] there were. 22. Well, Colin ghost providers.
22 providers in one building
[1:10:27] alone. I have a document in front of
me that said that's not unique in another building in
Minneapolis, there are 20
[1:10:34] providers and another building,

15, another building. 14, 2

buildings have 14.

[1:10:41] There are multiple front

providers in the exact same location.

[1:10:46] This isn't difficult fraud.

This is not rocket science. This is not complicated.

This is easy stuff.

[1:10:53] I don't know why we can't.

I don't how many hearings we've had and ask questions of the

stuff of the agency.

[1:11:00] What are you doing? And it

seems like not much. >> Sorry, Representative,

active question.

[1:11:07] Do I have a question? I did

have a question.

[1:11:14] >> So the question I'm going to

go do a different direction. As you said that the director

for housing, stabilization

[1:11:22] Services resigned or his term ended or

whatever term are using. Somebody set fire to said he

wasn't fired south.

[1:11:31] Explain more about that because

we're in the middle of this governor's term, even though

the city Centre run again.

[1:11:38] So how is it? A deputy

commissioner and the director of the housing stabilization

Services just suddenly was no

[1:11:45] longer employed as of

yesterday. When hearing is today, Commissioner County

[1:11:50] Chair Robbins Representative

Eric Government Data Practices Act

allows me to share the dates of

[1:11:59] employment. And as you know,

the legislature has put parameters around personnel

data.

[1:12:07] So I'm able to tell you that as

an appointed official, his appointment ended yesterday.

[1:12:16] It's over, right? So his appointment

ended, interestingly the day

[1:12:24] before the fraud committee over

the department that he was running.

That has according to Joe

[1:12:30] Thomas Graham fraud. How

convenient. Thank you, Madam. Thank U next Representative

agreement.

[1:12:38] >> Thank you, Madam Chair.

And I just want to start by thinking misleading and Mr.

Pens for telling your story

[1:12:47] coming forward and helping us

deal with this problem of

[1:12:53] corporate provider fraud. Nothing makes me angrier than

the fact that we have these

[1:12:59] corporate private providers who
have made vulnerable people a profit center. They have
targeted the programs that help
[1:13:07] people. And as I think
Representative Eric said, we are seeing an overwhelming
need, which is why we have
[1:13:14] heard the agency say that they,
you know, and legislators, frankly, prioritizing access
and speed because of this
[1:13:21] overwhelming meet. But we have
decided to do this with private
[1:13:27] providers who in many cases
have made government a profit center. And I think I heard you
say that because of her Drew
[1:13:33] Evans say this in
Superintendent Evans say this in public safety. I believe
we're talking about the
[1:13:40] expanded resources for the
attorney general's Medicaid
[1:13:46] fraud control unit is fraud has
become a has targeted the
[1:13:51] entire economy. Private sector
public sector is targeted seniors and veterans and
consumers. And in this case,
[1:13:59] government programs, you
Inspector General Clark said something about like

[1:14:04] we need the same tools and
technology as the private sector and wondering
[1:14:09] as you think about the design
questions about where we started and where we're going. What
about the design pieces have
[1:14:19] made us Lake Mead Center of
government, owner of all as a mark for fraud and what are the
pieces that you think we need
[1:14:26] to go? I remember the other
thing. I just remember Superintendent Evans. I think
he'd be helpful to bring him in here and have that
conversation, too. He said the
[1:14:33] suspense over 5 years, 12.5
billion dollars in updating their systems for fraud.
So it's certainly not just
[1:14:40] government, but I do think that
we have a particular vulnerability because we are
looking to serve people and
[1:14:47] solve these problems in a way
that that make us vulnerable. Some wondering what you think
about as you think about the
[1:14:53] same technologies and tools is
the private sector where you think we can go there. >> General Clark, thank you,
rep cream and you know,
[1:15:03] we need business technology
solutions and upgrades. Right when we are being asked to do

data analysis to get ahead of

[1:15:11] this front problem. My staff is

operating out of Excel spreadsheets that we're sharing

through outlook email systems.

[1:15:18] We have antiquated systems that

are not able to do predictive analytics to predict where to

see where trends are going.

[1:15:25] Right. Oftentimes we're looking

at data after the fact after billing has gone out. We need

data that can

[1:15:31] predict or see spike see trends

and we need to automate right. We're having staff having to

pull the data and look at it.

[1:15:40] We need systems to automate.

That means staff time and resources are limited. Right?

We have a limited amount of

[1:15:45] people working on this. To the

extent we can automate our systems and modernize or

technology, that's where we

[1:15:51] need to go. Technology is one thing.

I think we also need to look at

[1:15:57] strengthening programs on the

front end, right. I said greedy people who said greedy

businesses have learned how to

[1:16:04] exploit our systems. I'm sick

of we need to think about what we can do on the front and to

prevent these greedy people

[1:16:11] with businesses from gaining

access to our programs. We need to look at mandatory

trainings for all providers,

[1:16:19] anti fraud, trainings. I

ideally would like them to be in person, come in person and

hear about fraud and how we're

[1:16:25] going to watch. You are going

to be held accountable. I would like to require all

staff to that role to get a

[1:16:32] billing ID number, right, so

that we can track them through data track individuals through

claims. Right? If you don't

[1:16:39] have a unique identifier, we

can't see maybe your billing over here fraudulently your

billing over it. We need to

[1:16:45] connect our systems. One way to

do that would be to give everybody a unique doing it.

I think we need to look at all

[1:16:51] of our all of our human

services statutes to put clear language about billing caps in

our statute so that everybody

[1:16:58] is on notice about what is

acceptable for billing and what is not. I also think it's important to

think about the idea of what

[1:17:05] inks signatures on treatment

records, right? We want recipients to have to verify
and sign off that services are
[1:17:12] actually being provided.
We do that and some statutes like the Pete, the personal
care assistant statute. We
[1:17:18] require the individual
recipient to sign off and verify that services were
provided. We don't do that and
[1:17:25] some other programs, right?
So like I C S there's no requirement that the recipient
actually sign off and say,
[1:17:31] yeah, your billing this. This is true and correct.
So I think right technology is
[1:17:36] one thing, right? But then
you're still talking about working after the fact, right
after money has gone out pay
[1:17:42] and chase, right. We need to be looking at how to
make our program stronger so that these people don't gain
access in the first place.
[1:17:49] And I talked a lot about
technology, but our really like to partner with you on the
legislature to think about fixes that we can do to prevent
people from gaining access to
[1:17:58] these programs. Some of those
are legislative fixes. Like I said, what in signature is on
treatment records that could be

[1:18:04] as a start. >> Representative Goodman,
thank you, Madam Chair. And I really appreciate that. That
was actually my second question
[1:18:12] was going is I actually really
appreciate. And I actually see new leadership not as a
liability, but as an asset.
[1:18:20] I think what we're seeing is
leadership, whether to temper commissioner, whether it's an
inspector General Clark,
[1:18:25] I hope we have a new assistant
commissioner who is as committed to both doing the
things that we have been doing,
[1:18:33] which is trying to us to a
certain degree harden the target of government to this to
think about how do we actually
[1:18:41] change the business model?
Because what we shouldn't have to
[1:18:47] improve the time it takes for
someone to complain, we should make it so people don't have to
complain.
[1:18:54] And what I see is as we look at
this and this is the question for what we should be doing on
this committee is we have seen
[1:19:02] because we have outsourced
services and 300,000 providers
[1:19:07] because we have outsourced all

these services. We have turned one. We have left ourselves very, very vulnerable in the

[1:19:14] same way that we look across the economy. But we also have not been able to do that. The redesign because we have

[1:19:22] Nate, frankly been focus all our time and how you can more manage all of those contracts and all of that preventing what

[1:19:29] would it look like if we did this differently? And I know this, it to me is the work of this committee to that, too.

[1:19:36] If we are looking at best practices from other states, maybe even other countries, if we're looking at different

[1:19:42] models of service that takes the profit motive, the profit center out of the provision of services that we could be doing

[1:19:50] the job. And I know that that doesn't make for great sound bites and it doesn't make for great fundraising emails and

[1:19:56] it's not a good platform to run for office, but it is our work here. And so I'm wondering like how we could use this committee

[1:20:03] because we don't park up bills like so far. Mostly what we have done is just as angry

[1:20:08] questions and I think tried to

get press. But what I want to see us do is think about how do
we take on that business model
[1:20:17] and and think about how
government could be doing this differently, that the public
could be doing this differently
[1:20:22] so that publicly provided
services are publicly accountable and
potentially probably provided
[1:20:27] me to talk about this over and
over and over again. But I think this really puts a fine
point on it because
[1:20:34] we have to be able to to to
meet the needs of our communities. And we have to do
it in a way that doesn't create
[1:20:40] a vector for private sector
fraud, whether it's United Healthcare or it is a, you
know, an individual provider
[1:20:49] with 15 offices. We have seen fraud and all
those 2 says now that health is being investigated for Medicaid
fraud. And so there's one
[1:20:56] through line here, very diverse
set of entities, very diverse set of people tap and all of
the country. The through line
[1:21:03] is they have made government a
profit center and that we I think we should say is
unacceptable. So I'm wondering

[1:21:11] what you think we should be thinking about
doing as policymakers and its people can actually say the
system isn't working as it is
[1:21:18] what we should change, which we
looking at what model should be looking at, which would be
exploring in that thing.
[1:21:26] Commissioner Gandhi, thank you, Chair Robbins. >> I would like to quickly just
think is lean and Mister Pence
[1:21:36] for coming forward with their
just very quickly. Thank them for coming forward. I think
that we are looking at changes
[1:21:45] that DHS to how to respond more
quickly and close the loop. I want them to know that what
they did share with AJ logo and
[1:21:53] asked did make a difference and
that also it and I'd like
[1:21:59] inspector general to share what
he can in terms of the results.
[1:22:07] And we are looking at the way that we've approached
housing, stabilization
[1:22:13] services. We are also looking
at other Medicaid program. So we are using the same
Playbook.
[1:22:21] >> General Clark, thank you.
Rep remind, you know, I sincerely I sincerely want to
work on solutions to these

[1:22:29] problems, right? This Medicaid
fraud seeing these people get
[1:22:34] rich off the backs of taxpayers
off the backs of former Minnesota. It makes me just as
mad as all of you. I want to
[1:22:41] work with you on solutions.
So we're thinking about solutions to the problem and
rep really thinking about
[1:22:47] whether or not it makes sense
to open these programs to the private sector. Think Hss.
This is my personal opinion.
[1:22:55] Hss is a perfect example.
Why did we let these private companies provide these
services which are traditional
[1:23:02] county social worker case
management services. Why didn't we fund counties to provide
these services to have more
[1:23:10] trained, licensed social
workers, provide services to help people transition from
homelessness to new housing,
[1:23:17] to help people when they get
housing stay in their housing instead of funding providers
who actually
[1:23:25] you do have compassion have
been doing this work, have a license, you know, capability,
social workers. We open it up

[1:23:31] to and that private businesses.

And so that I think that's a design flaw. Those are issues.

I want to work with you all

[1:23:38] about identifying those design

flaws in how we can how we can fix these programs.

[1:23:44] >> Thank you, Representative

Hudson.

[1:23:49] >> Thank you, Madam Chair.

I think I think first, I just have to speak in defense of

[1:23:55] our committees existence

because we've repeatedly heard during these hearings comments

from our colleagues on the

[1:24:02] other side of the table,

undermining the integrity and necessity to have this

committee and continually

[1:24:09] pivoting to the idea that the

only thing legislative committee effort, dozens market

bills, we have presentations.

[1:24:15] We have informational discussions. We talk as members

and we're talking about important things become a

menace to public policy.

[1:24:21] This is how the public has its

conversation and they know that. So that's step one. Step 2

[1:24:30] profit motive. We need to get

rid of profit motive. Profit motive is what makes

this not happened in the

[1:24:36] private sector. If I don't get what I expect
from a business, they don't get
[1:24:44] paid. That's why they have the
incentive to give me what I expect.
[1:24:50] What we've done with this
program from top to bottom is completely remove that
[1:24:56] we've created an incentive
structure that invites 115 providers
[1:25:05] to engage in bad action.
100 million dollars to go out the door currently 1000 open
investigations, 1300 reports.
[1:25:15] That's an indication of
incentive structure to do what we're hearing about
today
[1:25:23] and that that structure wasn't
isn't an accident. It didn't spread out of the ground.
It was created. It was designed
[1:25:31] this body and this administration
constructed it.
[1:25:36] And it's it's very fascinating
to me this this point that keep getting
brought up about private
[1:25:42] businesses and this kind of
like an undercurrent of disparagement of if you're in
private business, you're inherently untrustworthy.
[1:25:50] Let's be specific about who's

doing this. This isn't just the categorically business is your
specific people,
[1:25:58] specific people who are using
the the mechanisms of business
[1:26:04] in order to take public dollars
in a way that's very obvious to them. We have a running car
with the keys in it on attended
[1:26:12] and were surprised when I get
stolen. And you ask a very good
question. General Clark,
[1:26:18] why are we doing it this way? Why are we doing it this way?
Why? Why are we engaging with
[1:26:27] private businesses, private
entities, non-governmental people to provide these services when
there's probably a better way?
[1:26:34] And that's a really, really
important question to focus on because what has the response
been
[1:26:41] from your 4 paws in particular,
Keith Ellison? The response has been in conversations that we
have on audio with people who
[1:26:51] are later convicted of engaging in these
activities and abiding concern
[1:26:57] for them remaining in business almost as if the program itself
was constructed to put them in
[1:27:05] business apparently wasn't constructed

to help people

[1:27:11] because that has not been the

abiding concern. If it was you would have to testifiers coming

here today saying help me help

[1:27:18] me. Why don't you help me? I simply refuse to believe

[1:27:25] that these outcomes are

accident. And the accusation of all of

this is this is just a show.

[1:27:34] This is all about campaign

politics. This is about people's lives,

[1:27:40] including the taxpayer to them. This cost a great deal

of money. So maybe he's worked a little

[1:27:48] performance of anger, quote, unquote, to address properly. Thank you.

[1:27:57] >> Thank you. I have a few

additional questions we make over 11 30 times. So just

giving you a little warning.

[1:28:05] I want to drill down on the

internal controls time and time again.

[1:28:11] The problem is that the money

goes out the door and as you said, we can prosecute them on

that

[1:28:17] outside law enforcement.

They're doing a fantastic job. But if we're paying and

chasing, we're not getting the

[1:28:22] money back. And so there's been some

discussion about some areas of

[1:28:29] failure of internal controls.

But I wondered, do you have a list of specific places where

we haven't checked provider

[1:28:37] eligibility? Who's responsible

for that? Why isn't it happening properly?

[1:28:43] A recipient eligibility?

We have numerous reports of people being big getting

services paid for on their

[1:28:52] behalf when they were dead when

they were incarcerated when they were in treatment. So who

is responsible for checking

[1:28:59] provider? Eligibility recipient

eligibility? And I'm also I get that we need

tech solutions. I'm on board

[1:29:08] and I will be a partner with

you in that. We did spend 40 million dollars in the last

biennium towards addressing

[1:29:14] that. And I know that work is

going on right now to identify providers to help with that

[1:29:20] with the new upgrades. But nevertheless,

[1:29:26] the recipients have found this

getting their own billing records. The reporters have found it by

showing up at different

[1:29:35] locations. Are staff put

together this handout that all of you can read where just

looking at Hennepin County,

[1:29:43] they found that HS hcbs
licenses and they identified 22
[1:29:52] at one single address 20 at one
address. And I'm making this available to you and I will
send do that. Unredacted copy
[1:29:59] with the names of the providers
like Des took our staff a half an hour just to do that data
research.
[1:30:06] Not a half an hour, half a day.
I'm sorry. So so this is doable right now.
[1:30:15] And so I appreciate that. But but I but I if we
can't get to it in this
[1:30:20] hearing, but I would like to
have from you in a follow-up meeting is a list of all the
places of internal controls
[1:30:26] provider eligibility whose
death doing recipient element eligible Bility who is doing?
[1:30:31] Who is managing the flow?
We we side just in the spreadsheet of how much that
increase was over time in
[1:30:39] Billings. Our staff has put
that together for you here for those in Hennepin County.
You see dramatic increases in
[1:30:46] billing in 23. And 24, I think that's know about right
now.
[1:30:53] So based on this, I would like a general answer

about the layers of internal controls you're looking at, but
I would like a specific answer
[1:31:02] and that I have a follow-up
after that. Think Commissioner County.
[1:31:08] >> Terry Robbins, thank you for
that. Would be happy to work with you on that. This is part
of the work that we've been
[1:31:14] doing the last 7 months.
We have been like I said, doing the data analysis on the
different services that are in
[1:31:22] Medicaid. And then we also have
a multidisciplinary team looking at program integrity,
which really needs to begin at
[1:31:32] the conception of legislation
and go all the way through post payment review and outcomes and
have internal controls
[1:31:40] throughout. I will tell you
that we have some internal controls, but it is not
sufficient. We need more.
[1:31:47] And so our team is developing a
program, integrity playbook
[1:31:52] where we will continue to
improve and and coming from the private sector. I think we also
need a private sector review
[1:32:02] and as is in the executive
order, looking at the gaps analysis and what we could do

better because it always her

[1:32:09] hard to evaluate your own work. >> Thank you, Commissioner.

Candy, you keep referring to that. You've only been in the

job 7 months that you're taking

[1:32:16] on this review. What was your

job previous to being acting commissioner previous to being acting

commissioner? I was deputy

[1:32:23] commissioner foreign before

that I was assistant commissioner and before that

chief compliance officer.

[1:32:30] And so you have been in these

roles of having a compliance oversight role for how many

years

[1:32:38] I was compliance officer from

2017 to 2021

[1:32:43] and the compliance officer role

is distinct from program

[1:32:49] integrity and the fraud work

that's done. One of the things

[1:32:55] that we're looking at in our

new work and my ability to

[1:33:01] reorganize the department is to

integrate that. So it's not siloed.

[1:33:06] I'm glad to hear that we need

to step that up like today. We have all these theories and

plans and working groups now

[1:33:15] that governor and that's to the
working group today, like we just need to stop the fraud on
the front end. And we need to
[1:33:22] know people are doing the due
diligence that our staff was able to do that. Reporters have
been able to do that. Citizens
[1:33:29] have been able to do that.
The department doesn't seem able to do so. To your point, inspector
general on I really like your
[1:33:38] ideas about add those wet ink
signatures and some of the very
[1:33:44] specific things you gave us.
I would like to follow up with you on that for legislation.
But I would like to understand
[1:33:51] why can't you do that now? >> In like what think so each?
So if you look at to chapter
[1:33:59] 2.56, be right. The Medicaid statute like each of the
services has a subdivision of
[1:34:05] that statute would talk which
talks about like documentation requirements. Enrollment
requirements for providers.
[1:34:13] Eligibility requirements,
right? So like the the personal care assistance, for
example, it talks about the
[1:34:20] requirement that providers need
to have specific records, specific requirements. Time and

time out. Dates of services

[1:34:26] signed off by recipients signed

off by the staff member under penalty of perjury. That fraud

has not been committed on the

[1:34:33] street near record. Right.

That same language does not exist for documentation

requirements across chapter

[1:34:39] 2.56, the. >> Does it have to be in

statute or could you just do

[1:34:44] that? You could put that

requirement on all programs? Am I not correct?

[1:34:52] >> I don't I don't have a

definitive answer to that. I don't believe so. I don't

think that just like the

[1:34:58] statutes require what

documentation requirements or so from like Hss, right.

It had the provider enrollment

[1:35:05] requirements and have the

documentation requirements in this last legislative session.

We saw much sought fix right to

[1:35:11] change the documentation

requirements and to change the provider enrollment

requirements. So I think there

[1:35:16] does need to be do need to be

legislative fixes to those statutes that outline what

documents

[1:35:23] providers are supposed to keep
when they're providing services. So I'm going to
partner with you on that.
[1:35:29] Hap happy to try to get you a
definitive answer. But I do think that there are
legislative changes that would
[1:35:35] help strengthen these programs. >> Terrific. I would love to do
a follow-up meeting because my
[1:35:40] understanding from talking to
the feds that you have more authority, even if the statute
doesn't require that, you are
[1:35:45] still able to do that, perhaps that's not true.
So let's let's get together and
[1:35:51] look at those requirements and
find ways to draft a bill to strengthen that for next
session. I sincerely want to
[1:35:56] partner with you on these
issues. Terrific. And then my last question
[1:36:02] is sorry. So you talked about how you are
stuck. You change the model and
[1:36:08] in housing stabilization
services. You are stopping payment before
[1:36:14] the investigation is complete.
When there are credible allegations of fraud to miss leans question. She
asked us to ask it what defines
[1:36:22] in your mind, the credible

allegation of fraud. And then secondly,

[1:36:28] are you applying that standard

to integrated community services and other programs?

I I see this up as as the

[1:36:37] general said, their their

tenant tentacles into lots of programs where the same

business model a fraud is

[1:36:44] happening. So are you applying

that only in to housing stabilization services? Are you

playing it

[1:36:50] across all the programs

Commission? >> Chair Robbins, thank you for

asking that because I know we

[1:36:56] talked about that earlier.

Yes, that is being applied across all program areas.

Credible allegation of fraud is

[1:37:05] defined in statute. I believe

and I don't know. Inspector General Clark, if there's

anything you want to add,

[1:37:12] we we are applying it. The

other piece I wanted to add is that as he mentioned, we are

looking when there is a

[1:37:18] provider, for example, that's

in Hss and we know that they are linked to their. They are

also a provider for another

[1:37:26] type of service. Our team is

looking across all of those and taking action because

[1:37:33] if you or provide if you are

committing fraud in one program,

[1:37:38] most likely we have enough

information to determine credible allegation of fraud in

other areas as well.

[1:37:45] >> General Clark, so to answer

your question, the standard for what is a credible allegation

of fraud is laid out in

[1:37:51] statute, right? I don't have

this specific some part but it's in to chapter 2.56.

Be

[1:37:57] we're looking thing about

frogger thing about unintentional, right? These

aren't mistakes. Right? And intentional wrongdoing.

Intentional fraud is a front to

[1:38:04] cry, right? It's our job when

there's allegations of fraud, right to stop payments, refer

to law enforcement as law

[1:38:11] enforcement's job to prosecute

ultimately in a court of law, whether or not that fraud

actually occurred. But to

[1:38:18] answer your question, we're

applying the same standards across the board. I that work the work we're

doing with Hss in the past

[1:38:25] several weeks. Fraud

allegations have been brought to my attention with certain
ICs providers and we are suspending payments to those
providers. So
[1:38:33] >> in addition to the 115 nhhs,
how many other providers have EU suspended payments on?
[1:38:39] >> I would have to follow up in
and give you up. I don't. I don't know off the
top of my head. I think since
[1:38:45] I've been there, it's more than
just hss providers. >> Okay, please, please tick up
to the entire committee and
[1:38:51] that and maybe you could give
us a monthly updates so that we stay in the loop over out of
session.
[1:38:56] >> And I I think that is very
important. I mean, I understand there's data practices
limitations, but I think it's
[1:39:03] important for us to be
transparent with the public about the work that we're doing
to instill confidence in the
[1:39:08] work that we're doing, that
we're actually taking aggressive action against
providers and shutting off
[1:39:13] money where we see signs of
fraud. So happy too happy to work with you. Get you the
information you think. >> Thank you. And I know you

want to go leap into but Mr.
[1:39:20] Johnson has the actual
definition from statute. I'm turning to Mr. Johnson.
[1:39:27] >> Madam Chair members, it's to
56. Be point. 0, 6, for its in subdivision. 2 paragraph to
cause too and says the
[1:39:35] allegations are considered
credible when they have been in to come of reliability. And the
state agency has reviewed all
[1:39:42] allegations facts and evidence
carefully in acts judiciously on a case-by-case basis.
Credible allegation of fraud is
[1:39:49] an allegation which has been
verified by the state from any source, including but not
limited to fraud. Hotline
[1:39:55] complaints claims data mining
patterns of identified 2 new patterns identified through
provider audits, civil false
[1:40:03] claims cases and law
enforcement investigations. >> Thank you, Mr. Johnson was
at the ready with answers.
[1:40:12] We've been told. >> Thank you, Madam Chair.
Yeah, actually have that pulled up to was connected to
researcher. But we had our actual research or provide it
and they know this note and
[1:40:20] reference to that. So that's

actually a pretty high standard. So and I really do
also think the 2 testifiers for
[1:40:26] what they shared. I think the
way the statute is written, what Ms Lien, if she simply
went up, he called then that
[1:40:33] that maybe wouldn't qualify
under the law that we passed. That might be something we
actually want to just in the
[1:40:39] sense that it says that the
agency, it's only after the agency reviews everything and
has various corroboration like
[1:40:45] it's not just the person who
calls and at least as I as I read this, that may be
something to explore and make
[1:40:51] changes to. That's obviously up
to the legislature to decide what qualifies side. I want to
make sure and a low note that
[1:40:57] part of the reason that that's
may have been said it's somewhat high is the tension.
The Representative, Eric's
[1:41:02] question or comment alluded to
of providing services to people who are extremely vulnerable
and that want to cut off
[1:41:08] funding to quickly to that.
We want to make sure that folks, in fact get helped out
of homelessness while the same

[1:41:14] time, of course, making sure to
act to prevent fraud and prevent money going out
wrongly. I have a question and
[1:41:20] then and then a comment.
And the question is, I guess I have the sense
[1:41:25] there really were flaws in the
design of the program from the beginning. As we look back
retrospectively in terms of how
[1:41:33] the legislature passed the
program that were weaknesses compared other programs.
And I'm just wondering if the
[1:41:38] the Specter general could
comment on that, sir, what sort of weaknesses that were in
fact, I'm correct in asking
[1:41:43] that question. Thank you, General Clark, my
assessment right after being at
[1:41:51] DHS for a few months now said it was
just simply too easy
[1:41:57] for providers to enroll in in
that Housing Stabilization Services program.
[1:42:02] The vetting in statute was you
fill out some forms, pass a background check and
essentially you can become
[1:42:11] housing stabilization service
providers. >> I think that's an important
point to note, right? We are doing criminal background

checks on all of these

[1:42:18] providers, all of the owners.

So these are people without a criminal history that can get

into our programs and then are

[1:42:27] deciding to steal from us.

So the just if you again, if you look at the requirements

for provider eligibility and

[1:42:34] enrollment right in the

original hss statute and then compare that to some of the

other Medicaid programs,

[1:42:41] I think you'll see right again

going at a personal care assistance, a lengthy list of

specific qualifications

[1:42:49] requirements that are needed to

enroll. All right. For PCA. We require people to be bonded.

We require mandatory training

[1:42:55] in statute. You know, we required a

qualified professional either qualified through education or

some type of professional

[1:43:02] licensure to be, you know, on

the staff of a personal care systems. Agencies know same

like barriers to entry. We're

[1:43:09] just not there and housing

stabilization services. I think we need to look at barriers to

entry

[1:43:16] to keep fly by night providers

out of our programs.

[1:43:21] >> Even Tampa Bay manager.

Yeah. And then just a just a comment in part in response to comments made by others and also that was very helpful information and inspector

[1:43:28] general. There's a question of when why the program was designed in that way. Then why have have these private

[1:43:36] providers coming in? And I just know the program was passed by

[1:43:41] the Republican House Republican Senate. It was actually a member of the of the current House GOP was the House author

[1:43:48] and and I believe the proposed by the Dayton administration. So so recognizing the number folks at that at that point,

[1:43:54] I assume part of the thinking of that was exactly the point that represent American made was making sure the folks in

[1:44:00] vulnerable positions are being supporters much as possible. I think we can look back and say that was a flawed design.

[1:44:06] That was not a good way to design the program. We understand the reasons for the even brought up in the course of this hearing and that is something that we need to make

[1:44:12] sure. And I'm really glad that
we've that they've been even the tightening for the Human
Services Committee this
[1:44:18] session. But there's a tension
there. There's also tension on members as the inspector
general reference early on
[1:44:23] about acting very quickly to
stop payment but potentially alerting fraudsters. And Madam
chair, you made the reference
[1:44:30] to maybe there's a way to get
around that. But for now, that's something I think also
explains one of the challenges of work outside the
Legislature's a prosecutor.
[1:44:36] I absolutely understand the
concern that you're going to alert somebody really glad to
stop the payment. I want to
[1:44:42] hold them accountable and
potentially send the jail, have a criminal conviction.
And that's going require as the inspector general knows a lot
of a lot of fun, a higher
[1:44:50] standard. Lot of them. And so
there's a tension there. There was a comment that that
the profit motive, this my this
[1:44:56] doesn't happen. The private
sector and I will direct members attention. Tudor Evans
testimony a number of hearings

[1:45:01] ago talking about I think you
said that the visas identified a 3rd of a trillion dollars to
50 billion dollars worth of
[1:45:08] private sector fraud. These
sees this. This is a growing concern for corporations for
individuals. This is happening,
[1:45:16] in fact, in the private sector.
And we know this is a case for the program, had this at this
design, tension built within
[1:45:22] it. And the final tension that
I see in and that's referenced is referencing the committee.
No doubt at all that we need to
[1:45:29] be focusing on the program,
integrity and from their public programs. I found a challenge
for that in this seat that is
[1:45:37] we're diving deep and human
services programs. All right. Our colleagues who have the
expertise and actually can what
[1:45:43] I want to do is be able to say
to them, hey, these are changes that usually making in this in
your programs. And that's the
[1:45:48] piece that I found very
challenging in this committee. I would say that while it's
true, we've heard a couple
[1:45:54] bills information that we have
not had bills referred to us. That's what I said. The

beginning nor be voted on

[1:45:59] bills. And it is it's there's a

real challenge of having an insight into what is happening.

I mean, this area. So that's

[1:46:05] the tension that I'm seeing as

well that there's tensions throughout this. No doubt at

all. The programming, Tyrese,

[1:46:10] incredibly important topic.

That's exactly the reason we want to make sure that we're

doing. So it's effectively as possible and members I'm sorry

that I don't see that

[1:46:17] happening. So I appreciate that

the testifiers on and I think that we just need to continue

pushing. Thank you, Madam

[1:46:23] Chair, thank you. So members,

we have 2 people left on. The question must. >> One from the fence and the

DFL and one from the Republican

[1:46:31] side. Is there consensus that

we allow those last 2 questions?

Because I know I'm holding a

[1:46:37] silver. Is that okay? All right there for

Representative Hawkins.

[1:46:43] >> Thank you, Madam Chair.

I just wanted to respond to that. One of the comments that

time Representative Hudson made

[1:46:51] about, you know, the private

sector. I I spent the last 25 years of my career doing
information, technology design
[1:46:59] and development work for a wide
variety of private sector firms. And what I would say is
that if any of these employers
[1:47:07] or clients, it allowed their it
systems to deteriorate to the degree to which we have allowed
DHS systems to deteriorate,
[1:47:15] none of them would be in
business today. You made the point about how
can that Hennepin County
[1:47:22] Produce this chart and DHS
can't. I've met with the it people at the Hennepin County
and aside from the crummy DHS
[1:47:30] systems, they're required to
use to administer these programs. Hennepin County as
much better analytical
[1:47:37] capabilities, then DHS, his
head. You posed the question about
why why can't we figure out why
[1:47:43] when people are that are dead?
Why are we paying benefits to dead people? I have met with
the it staff at the Department
[1:47:51] of Health. So the registrar of
records at the Department of Health says the source of truth
perverse and deaths in the

[1:47:57] state and then it people it at Mvh
think it's completely appropriate for them to stand
up what's called data service
[1:48:04] that would allow DHS or another
agency to just query system and
[1:48:10] get back in answer to the
question. Is this person still a life? I've had the same
conversation with the people.
[1:48:16] It staff it deed, you know, and
and they think that it's perfectly appropriate that
instead of a DHS workers having
[1:48:25] to a key employment and income
information off of paychecks tab, that they ought to be able
to send a query to ID system
[1:48:34] and get the current employment
and income information for a point person in real time is as
well.
[1:48:42] But we don't allow that.
We are requiring people to key information into a 19 area 80's
arid system that doesn't,
[1:48:52] you know, you put the
information into a form that, you know, Mr. Clarke and his
team can use to ferret out
[1:49:00] these issues. So I just I
cannot emphasize enough the need the fact that we need to
come up with a plan and make

[1:49:07] the investments that are
required in our IT infrastructure to enable what
we want to happen to happen.
[1:49:15] >> Thank you, Representative
Hawkins representative and thank you and reps about this.
I completely agree with.
[1:49:21] Yeah, I'm that. So I don't know
the history of, you know, this proposes. I don't know.
But, you know, we have to
[1:49:29] function much better because
clearly we're not. And I would encourage, you know, the with
the legislative branch, your
[1:49:36] the administrative branch, and
you, you know, role is to carry out all these programs and to to
several make in makes is a
[1:49:45] fraud and said and to to do
what needs to be done. So
[1:49:51] things are property
administered. And if that means it systems that that means
[1:49:57] actually creating rules so that you can
stop this of that means when
[1:50:04] you have a credible allegation
of fraud, which I would argue Ms Lien had the data and sent
the data in or attempted to
[1:50:11] send the data. And that is a
crowd along alligator s**** wrought with the data which was

not acted on until there was a

[1:50:17] TV's a news story on it.

But things like connecting agencies. If there is a

credible allegation of fraud on

[1:50:25] a provider within DHS program

acts, they should be cut off of every other program in every

agency.

[1:50:34] Let the county's now if they're

trying to get dollars, that's how you stop some of

this. But when you're allowing

[1:50:40] them to then just bill

somewhere else, I mean, that's crazy. That would never happen

in what I would call the real

[1:50:47] world in the end and we have to

function in the world. So I at

[1:50:54] the other thing I want to bring

up we talked about we've only had a few bills. So here we

should have more. I believe I

[1:51:01] believe that this committee

should be looking at any bills that that deal with fraud in

the future. And I would hope

[1:51:08] that that changes next year.

So thank you for coming in. And I said last time in a lot

of work ahead of you and I hope

[1:51:18] he's successful at it. So thank

you. Asked me to thank you.

[1:51:23] >> Thank you. Members and the
public for indulging has been going over. I appreciate
everyone's contributions to
[1:51:28] this discussion and I look
forward to following up as we discussed in the hearing, we
are adjourned

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 10-14-2025

[0:02] >> Good morning, everyone.

Thank you for coming. I called the House Prevent Fraud

Prevention and State Agency

[0:08] Oversight Committee to order we have a quorum. And today the purpose of the

hearing is to talk with the

[0:16] secretary of state and his team

about how we can understand and

[0:22] prevent election fraud. There was a case this summer

that we will get into where

[0:28] there were convictions for

fraudulent voter registration. But first, before we do that,

we are going to approve the

[0:35] minutes of September. 17th representative vice-chair

Anderson, have you had a chance

[0:41] to review the minutes? Thank

you, Madam Chair. I have and I move approval.

[0:46] Vice Chair Anderson moves

approval. Any discussion all in favor say aye.

[0:51] >> I those opposed minutes are approved. All right. So for the order of

business for going to share

[0:59] from Bill Gallant from center

of the American experiment

[1:04] about the 2 cases and then the

secretary is due to arrive at 10, 45.

[1:11] >> And then he and his team

will be invited to join us at the witness table. So with that, Mr. Khan, welcome to

the committee. Please state

[1:19] your name for the record. Madam Chair, can you hear me?

Guess we can. Thank you.

[1:25] He's on zoom for anyone

wondering what's going on here. >> Build line with the policy

fellow with.

[1:33] >> Center of the American

experiment in Minnetonka, Minnesota.

[1:42] >> So I think Mark, I would

like you to go over. You attended the hearings regarding

the convictions for that voter

[1:52] registration fraud. And could

you just go through brief explanation of that for

the public and then we'll

[1:59] probably have questions for

you. >> Okay, as briefly as

possible. So I it ended as a

[2:04] observer as a reporter, if you

will, to court hearings over the summer.

[2:09] >> One, each for 2 people who

pled guilty to one count each of conspiracy to commit voter

registration fraud.

[2:19] And in general, these 2

individuals, I believe at the time were a romantic partners

living out of West Saint Paul

[2:28] and the were employed by a

foundation as independent contractors.

This foundation is named Annika

[2:35] Foundation. And to my

knowledge, they have never been accused of any wrongdoing or no

direct employee has ever been

[2:43] accused of any wrongdoing

related to voter fraud. But these to see these 2

contractors, one was named

[2:50] Ronnie Williams. He's also

known as Michael Gibson. And then he's a partner in this

conspiracy as name Lorraine

[2:59] Combs. And they were found guilty. You through

guilty pleas of this conspiracy

[3:06] to commit voter registration

fraud. And we don't have so many details about exactly what

the fraud was. But apparently

[3:13] they threw the Annika

Foundation submitted hundreds of falsified voter registration

forms that were submitted to 10

[3:23] counties around the state.

We don't have a list of which counties received the fake

voter registration forms other

[3:31] than the Carver County was

mentioned by name in the course of these proceedings

[3:36] and Lorraine Combs. For her
part, she seems to be the junior partner in this
conspiracy. She admitted to
[3:43] preparing more than 500 fake
voter registration forms. And Ronnie Williams, who
appears to be the senior
[3:50] partner in this, also prepared
voter registration forms of self that were submitted to
these counties. The incentive
[4:00] names identifying information
so says the sub or Social Security numbers addresses.
They were paid by the
[4:08] foundation for these voter
registration forms. It's not known how much they were paid
by the foundation to prepare
[4:15] these, but it is believed that
they were all fate. The information contained in the
forms were did not correspond
[4:22] to any real person, real voter
they were submitted to, as I said, some 10 or more county
election offices. And this was
[4:32] in the 2021 2020, 2 elections
cycle. So not this past cycle,
[4:38] but the cycle before. And apparently this came to the
attention of authorities and
[4:43] eventually FBI conducted an

investigation and then sometime in late 2020 for these 2
individuals that needed to
[4:51] authorities that they had, in
fact committed this crime that they had, in fact engaged in
this rather large voter fraud
[4:59] effort. And then over the
summer, they came in individually, they were
indicted. Individual that
[5:05] indicted are charged
individually and they had there own individual hearings where
they pled guilty.
[5:11] >> Neither has been sentenced
yet. Ms Combs is a scheduled to be sentenced at the end of this
month and
[5:20] the sentencing guidelines for
her because she doesn't have a past criminal history. Rain
from as low as 0 prison time to
[5:27] 6 months in prison, Mr.
Williams, criminal histories much more complicated. Lawyers
are still arguing over what the
[5:35] appropriate punishment for his
guilty plea would be the range being from 6 months all the way
up to to 30 months, 3, 0,
[5:44] months. A maximum penalty for
this crime is up to 5 years in
[5:49] prison and Mr. Williams

sentencing has not been scheduled yet, but it's
believed the will take place
[5:57] sometime next month. >> Thank you, Mr. Glenn, so I
just had a couple of questions
[6:06] that I'm sure if my colleagues
to they will join us. So in the indictment are in the
charging documents that 10
[6:15] counties were never identified.
And we will also be checking with the secretary when he
comes forward. But
[6:23] do you have any knowledge other
than the sighting of Carver County and one of the
documents? What, 10, 10 I've
[6:29] read in other news reports, 15
counties. So is there any clarity on that that you have
found?
[6:34] >> Nothing more than what you
just stated. It was stated at least 10, 10 being the minimum
and then cover County was
[6:42] mentioned in the context that
the U.S. Attorney office went out of the way to think Carver
County law enforcement
[6:50] authorities for this effort for
their efforts in a supporting these prosecutions by inference
you would imagine Carver County
[6:57] was one of the 10 or more

counties involved. >> Thank you. And my

understanding is that this

[7:04] group had. >> Multiple.

[7:10] >> Independent contractors but

2 were charged. Is that correct?

[7:15] >> Corrected. The 2 were

charged. If you read the documents carefully and I was

in the back of the courtroom

[7:20] and and her the back and 4th

between the prosecution and the fence, there were unnamed

others who served as

[7:28] intermediaries. >> Or >> other roles between Mr.

Williams and Ms Combs and the

[7:36] Foundation itself. So there are

other individuals who you would infer from the contacts were

not employees of Anakin

[7:43] Foundation somehow played a

role in the conspiracy. But these individuals are never

named our chalk.

[7:52] >> Thank you. And that was one

of my questions because it says that that the 2 people that

were indicted or charged word

[8:00] where then giving the

fraudulent voter registrations

[8:05] to people at the foundation and

then it was the foundation themselves that submitted them

to the different counties.

[8:13] Is that your understanding? >> I would just make a very

slight to add a little bit a new one so that it sounded like

there were registration forms

[8:21] that were submitted directly by

the conspirators to the foundation and perhaps other is

a little more that were

[8:28] submitted indirectly through of

these intermediaries to the foundation, right reading from it. And it's

been made clear that the

[8:36] foundation itself was the the

entity or people working for

[8:41] the foundation submitted to the

county's. So the conspirators

[8:46] never do that. Don't directly

with the companies. >> Right. So my understanding

just to clarify the chain and

[8:54] obviously I'll ask the

secretary staff this to see guys can be ready. But in the

document, it says that that

[9:02] charged individual would

provide the completed forms to the foundation through its

agents and then the foundation

[9:10] through its agents would submit

these false voter registration applications to county election

officials across the state.

[9:17] So the foundation was never
charged. We don't know who these agents were, but this
group
[9:28] clearly was defrauded by the
individual submitting the the false applications. But then
there doesn't seem to be a
[9:36] check, which is our role as the
committee to find how we can provide better oversight.
There doesn't seem to be a
[9:42] check when this group submitted the fraudulent
applications. So I don't know
[9:51] where that breakdown comes in,
but clearly the foundation received the fraudulent
applications, hundreds up to
[9:58] 500 or more. And then they were submitted to the foundation and then the
foundation's submitted it to
[10:06] the county election offices. So so there's more to
understand in this case that I
[10:12] think is in the charging
documents. And certainly we look forward
to having more of that
[10:18] conversation of how this
happened. So that's in my questions. Members. Anybody
else have a question as we move
[10:23] on to the secretary represent
of Hudson. >> Thank you, Madam Chair, Mr.

Go on

[10:30] in your observation of the

hearing. Was there did you witness any discussion

regarding why this prosecution

[10:38] was coming from the federal

level as opposed to being pursued locally by county

attorneys?

[10:44] >> I BET Chair Representative

Hudson. I'd have to say no again.

[10:50] >> It's a interesting as an

observer to many, many of these sort of hearings where some of

these injured a guilty plea.

[10:55] It tends to be the case that

prosecutors and the defense introduced just

enough information to convince

[11:04] the judge that the defendant is

in fact guilty of the crime. They're pleading guilty to.

They don't get it to a lot of

[11:10] back story or a lot of

extraneous information is very narrowly tailored to a very

specific purpose. So it's not

[11:19] clear why the FBI got involved.

It is clear they were involved because stated in open court

that each of these 2

[11:26] individuals who were convicted

had had admitted their culpability to the FBI. But how

the FBI got involved as opposed
[11:34] to the attorney general or the
secretary of state's office or some state or county authority
isn't clear. Again, there were
[11:45] I'm sure through Congress or the U.S.
Senate. I can't recall recall quite the batting order of the
2022 cycle. But there was a
[11:54] federal election in the fall of
2022, there were state local elections to select. I imagine
there were any number of other
[12:02] ordinances and state laws that
were also broken. But the this was taken up by the feds.
[12:11] >> Yes, Chair Pinto. >> Thank you. Madam Chair, the
leap into for this committee. I appreciate it. And just a
small thing for Mr Gone.
[12:20] I notice the thanks from the
U.S. Attorney's Office for the Carter County Sheriff's Office,
which is terrific. I also noted
[12:26] that the U.S. Attorney's Office
specifically thank the office of the secretary of state as
well. And just, I guess,
[12:32] want to see if you have
comment. I just want to make sure to note that that not only
cover County Sheriff's office, but actually our secretary of
state receive specific. Thanks
[12:39] from the U.S. Attorney's Office

for for the office's work regarding this.

[12:45] >> I'm just a Glenn represent

into all. That's correct. I just didn't bring that up

because I understood I would be

[12:50] followed by the secretary of

state's office who can better speak to their own role in the

process.

[12:58] >> Thank you. All right.

Thank you, Mr. Klein, we appreciate your testimony.

Now. We would like to hear from

[13:04] Secretary of State Simon and

his team. Welcome to the Committee.

[13:24] Good Morning. Secretary Simon,

please state your name for the record. We appreciate you

joining us today. >> Thank you, Steve Simon,

Minnesota, Secretary of State.

[13:31] Good Morning, Madam chair and

members. It's an honor to be with you. Thank you for the

opportunity.

[13:37] The invitation to appear here

today was request to talk about a particular episode that made

headlines last June. It's a

[13:43] story really with 2 parts. The first part is how

Minnesota's election system

[13:48] featuring dedicated election

officials in just over a dozen counties in Minnesota. Plus,

staff from our office worked

[13:55] successfully to prevent

would-be fraudsters from harming Minnesota's election

system with false voter

[14:00] registrations. The second part is how our

office worked with state and federal law enforcement to

ensure that the individual

[14:07] submitting these false voter

registrations were brought to justice. I just want to be

clear here that, as you know,

[14:13] this is a case about

individuals who conspired to submit false voter registration

applications.

[14:19] This is not a case about

fraudulent votes. And this is ultimately a case of the system

working to detect these

[14:26] applications so they could be

appropriately challenged and referred to law enforcement for

prosecution and conviction.

[14:34] I'm here with Minnesota State

elections director Paula now as well as with government

relations director Nicole

[14:40] Freeman and deputy secretary of

state to least rather I'm gonna turn the microphone

over to Mr. Le Now in just a

[14:45] minute to give an overview of

how the system worked to detect these fake applications, how
our office and county partners
[14:52] responded and how county and
state election officials healthy FBI in their
investigation over a period of
[14:58] more than 2 years. But before I do that, I just
want to make sure that members of this committee know that I
personally and the staff from
[15:07] our office are always available
to meet with you and your staff to answer any questions that
you have about our election
[15:14] system. This is an offer us
know that I make regularly to members of the elections
committee and their staff.
[15:20] But I want to make sure to
extend the offer to this committee and staff as well.
So if members and staff don't
[15:25] already have my personal cell
phone number, I will make sure that you get it. You can call
me or text me anytime
[15:31] and the follow-up, by the way,
it doesn't just have to be in your offices as
Representatives, Hudson and Green men and others know I'm
happy to mean your community
[15:39] and do voter education events
as well. So if there are questions or concerns after

this presentation this

[15:44] afternoon, tomorrow, next week,

whenever or if you want to know more

about an unrelated election

[15:49] issue, please don't hesitate to

reach out to me personally or to our office. Now I'm going to

hand the microphone over to Mr.

[15:56] Le now because to appreciate

how these registrations were caught does require and

understanding of the various

[16:02] safeguards in Minnesota's voter

registration system. Now, there are some members of this

committee who now serve or have

[16:08] served on the elections

committee. But many have not so ask Mr. Lynell to give just a

brief overview of how the

[16:14] state's voter registration

works, basically along with the checks contained within the

system, Mr. 1, 0, well, that

[16:19] explained how the false voter

registrations in this particular case we're flag and

how staff from the office of

[16:25] Secretary of state and county

election officials responded and coordinated with law

enforcement to ensure that the

[16:30] individuals attempting to

perpetrate this fraud were caught and charged. Thank you,

Madam Chair, I guess I'll yield

[16:36] with your permission to Mr.

Lindo. >> Thank you. Secretary Simon.

We hope you'll stay is about to

[16:42] answer some questions and

welcome to the committee, Mr. Le Now, please State your

name for the record.

[17:01] >> Thank you, Madam Chair.

Good Morning. My name is Paula Now and I am the director of

elections with the Office of

[17:07] the secretary of state. I've been with the office since

2022 and in my current role

[17:12] going back to July of last year before coming to the office, I

served as the elections lead in

[17:18] Anoka County. So for my presentation this

morning, I'd like to start by providing an overview

[17:26] of how the voter registration

and verification process works in Minnesota. Then I will cover how election

officials in Minnesota work

[17:33] throughout the year to ensure

that our voter rolls are accurate and up-to-date

[17:38] as requested by the committee.

Also include details about the Electronic Registration

Information Center or Eric,

[17:44] a multi state member lead

organization that assists with voter list maintenance.

[17:49] Then I'll briefly talk through

what happens after Election Day to process Election Day

registrations and enter voting

[17:55] history and finally all spend some time

walking through the series of events that led to 2

individuals pleading guilty to

[18:01] charges of conspiracy to commit

voter registration fraud earlier this year

[18:09] to start all provide a brief

summary of the roles and responsibilities for

administering voter registration. In Minnesota,

[18:15] the secretary of state serves

as Minnesota's chief election official among the duties for

the office of the Secretary of

[18:21] State is the responsibility for

defining maintaining and administering the statewide

voter registration system or

[18:28] STRs. The elections division of the

office include the team, a state program, administrators

and it staff that support the

[18:35] voter registration system and

several other related tools, including public-facing voter

tools like online voter

[18:41] Registration and the Polling

Place Finder. The office is also responsible

for developing forms for use in
[18:47] elections, including the voter
registration application and preparing and publishing
information about elections.
[18:54] The office also has
responsibility for training and certifying county elections
officials.
[19:00] It is the county auditor that
serves as the chief registrar of voters and the custodian of
official voter registration
[19:07] records in each county. This is an elected position in
some counties and appointed in
[19:12] others in some counties, especially
those with large numbers of registered voters. Elections
responsibilities are delegated
[19:21] to elections, director or
manager in the vast majority of
counties. Elections and voter
[19:27] registration is just one of the
many responsibilities for the county auditor. Other duties may include
property records, taxation,
[19:34] licensing finance and more county elections. Officials are
responsible for carrying out
[19:39] most functions related to voter
registration, including the entry of new voter registration
applications or updating

[19:45] existing records in the
statewide voter registration system. The county auditor is then
responsible for training and
[19:52] certifying municipal clerks on
their election administration responsibilities and also
training election judges,
[19:59] municipal clerk's elections,
responsibilities largely revolve around serving as the
filing officer for their jurisdictions offices,
[20:06] creating precinct boundaries
and is designating Election Day polling places and recruiting
and employing election judges.
[20:13] Several municipalities
primarily larger cities also administer absentee voting,
including facilitating Election
[20:19] Day registration for in-person
absentee voters at the polling place on
election Day. Election judges
[20:26] are responsible for managing
the polling place rosters and administer administering the
election, a registration
[20:31] process for voters that are not
yet registered or need to update their information on
Election Day.
[20:37] All of the actual entry and
processing of voter registration applications is

managed. At the county level.

[20:45] Voter registration in Minnesota

is limited to only those who meet the eligibility criteria

to register and vote.

[20:53] One must be a U.S. citizen and

must be at least 16 years old to submit a voter registration

application.

[20:59] Those who are not yet 18 are

set to a pending status until their 18th birthday when their

voter record becomes active.

[21:06] Registrants must have been a

resident of Minnesota for at least 20 days prior to

registering

[21:12] those who are incarcerated for

a felony conviction cannot register to vote while they're

incarcerated

[21:17] and individuals are not

eligible to register. If a court is taking away their

right to vote as part of a

[21:22] guardianship or if they've been

found legally incompetent at the time of registration

voters from their eligibility

[21:29] to vote through the signing of

a certification statement detailing all of these

eligibility requirements and a

[21:35] statement that defines the

penalties for falsifying information on a voter
registration form.
[21:44] All voter registration
applications must undergo a 2 step verification process.
[21:49] The first part of this process
is to confirm that the voter is who they say they are. This is done by matching data
provided on their application
[21:57] to a government database. Most matching takes place
behind the scenes when the record is checked against the
Department of Public Safety
[22:05] Database for voter registrations that
come from driver and vehicle services. Those records have
already been verified as a
[22:11] match since the records on file
with DPS. Similarly, any registration
applications that are submitted
[22:18] through the online voter
registration application are only passed along for
registration. If the
[22:24] information provided on that
application form can be matched matched against data in the DPS
or Social Security
[22:31] Administration database for voters that are registering
using a paper application data
[22:37] that's provided on that form is
entered into STRs by the county and then sent to DPS to be

verified.

[22:45] If there's a match and the

voter status in the system will change from to be verified to

verified

[22:52] if there's not an exact match

to one in the DPS database, but their potential matches.

Those potential matches are

[22:59] cued for the county to review

and determine whether the voter record and the DPS records are

the same person.

[23:06] A common example of a situation

where there is an exact match or that where it's getting

where there's not an exact

[23:11] match is when someone has a

hyphenated last name and does not exactly match between the 2

data bases, this would require

[23:19] a manual review to determine

that the record corresponds to the same person. There also may be cases of data

entry errors or instances where

[23:26] the information provided on the

voter registration application may not have been clearly

written. Some common data entry issues

may include trance posing ID

[23:34] numbers or handwriting, where 9

may look like a 4 when the record is return for

further review. It provides the

[23:41] county election official an
opportunity to review that data confirm whether at anything may
have been entered incorrectly
[23:47] if the record cannot be
verified through DPS and the applicant has provided the last
4 digits of their Social
[23:53] Security number, then their
information is sent to the SSA database for verification.
[23:59] If there's not a match, the
county election official must use other methods to attempt to
verify the voters identity.
[24:05] This may include record
searches contact by mail, phone or email. There's a 10 day window for
counties to review those
[24:12] records that cannot be matched
and for any records that cannot be verified. The registration
is flagged as incomplete.
[24:20] Here's a diagram that shows the
workflow. What I just described for any new record for an
update to an existing voter
[24:26] record. As noted on the previous slide,
all voters start with sending their data through the DPS
database to determine if
[24:32] there's a match with an
existing record. Additional review then takes
place for cases where there's not an exact match, but

potential matches are

[24:39] identified if there's not a match with the

DPS record. And we've have the last 4 of the Social Security

number, its center, that SSA

[24:47] Database for review SSA only returns the record as

a match. If there's an exact

[24:53] match with the data that has

provided. So again, for that voter with the hyphenated name,

it would not be returned as a

[24:59] match. If there are

discrepancies between how the name is listed,

[25:04] if a record cannot be verified

through DPS or the SSA, it is reviewed by the county auditor

if it cannot be verified its

[25:11] mark in the system as

incomplete

[25:16] for any records that are marked

as incomplete notice is cute. In the statewide voter

registration system for the

[25:22] county to mail to the

registrant. The content of that notice will

vary depending on how the voter

[25:28] applied to be registered and

whether they are a first-time voter as required by federal law,

incomplete registrations for

[25:35] first time, voters that are

registering by mail and have not voted in a federal election
must either complete the
[25:41] registration with the county
auditor before the election or provide an acceptable
identification document when
[25:47] arriving to vote on Election
Day, these registrants will be
marked with a C ID designation
[25:54] on the polling place roster and
must provide ID to the election judge before they are allowed
to vote.
[26:00] A voucher cannot be used to
clear the see ID requirement for these voters. It must be an
acceptable photo ID.
[26:07] All other incomplete
registrations are marked as challenged an verifiable and
they must clear the challenge
[26:13] to affirm their eligibility
before being permitted to vote. If there's any evidence that a
voter is not eligible to vote,
[26:20] that must be referred to the
county attorney for investigation. >> I may Mister Vanilla catches
ask a question there will I'm
[26:27] thinking of it. So you said that if it did side
SCI D they must provide an
[26:35] acceptable photo ID. So in

these cases, a utility bill is not sufficient.
[26:41] >> Madam chair, in those cases,
it would be the photo ID that's used in combination with
utility bill as an acceptable
[26:49] proof of residence document for
Election Day registration purposes. So that the
distinction is that the
[26:56] vouching process, which is
acceptable for registering to vote on Election Day would not
be applicable for this group of
[27:03] incomplete registrants who are
marked on the roster as C ID.
[27:08] >> Thank you. So just to drill
down one, it must include a photo ID have
some type, correct.
[27:17] >> And that just a second base
or Anderson. And but this is
[27:23] for people who've never voted
in federal elections before.
And we'll talk about the next
[27:29] case where they may have been
an active next. I'm assuming. >> I've been chair. That's
correct. The requirement for
[27:37] marking these records as see it
on the roster would have is a federal requirement that
applies just to first-time

[27:43] voters who have not yet voted
in a federal election. If it's not the first time registry and
if it's an update to a
[27:50] registration or if there's
other ways in which they register to vote, but it still
comes back as not being able to
[27:56] be verified. They are marked as
challenge an verifiable in the system. >> Perfect. Thank you,
vice-chair Anderson.
[28:07] We give drivers licenses to
anyone here. You don't have to be a citizen. You don't have to
[28:13] which is a photo ID. >> So if someone comes in, they
register, they have the
[28:18] driver's license, but they have
an incorrect social or no social or whatever. So they're
then they become incomplete.
[28:25] But if they walk in to vote
with their driver's license, is that
[28:31] make them all of a sudden now, OK, Mr. Avenue.
[28:37] >> Madam Chair. So the
designation on the roster for someone whose registration had
been incomplete, if they
[28:43] present the election judge with
that acceptable identification document, that would clear the
challenge from the roster and
[28:50] they would be permitted to cast

a ballot. >> That's Anderson. Well, okay,
there's your problem
[28:58] potentially. Thank you. So just
to clarify someone who is not a citizen but prevent presents a
driver's license at that point
[29:07] in the process could be
permitted to vote. >> Madam Chair at the time of
registration as well as at the
[29:14] time of submitting a ballot,
every voter is signing the attestation affirming their
eligibility to vote, including
[29:20] that they meet all eligibility
requirements, that they are U.S. citizen. It's determined
then that the voter was not in
[29:27] fact eligible to vote. That
information would be provided to the county attorney for
investigation and potential
[29:33] prosecution. >> Thanks, Anderson, Madam
Chair. But but if they sign and
[29:39] they say they're eligible to
vote and they walk in with that driver's license, even though
they're not because we give
[29:44] drivers licenses to anyone in
the state, they can vote
[29:50] if they sign that they're
eligible, Mr. Le Now. >> Madam Chair, I again, in

this scenario, we're talking
[29:58] about a record that has been
flagged for a the C ID requirement. That is the
requirement that they must
[30:05] clear under federal law in
order to be allowed to vote. It doesn't contemplate
hypothetical where someone is
[30:13] not otherwise eligible to vote
is to affirm their identity as the voter. It's that they are
who they say they are, that
[30:20] it's a match against again, one
of the databases, ideally that's done through the number
matching with the DPS database
[30:28] or with the Social Security
administration. It is the other elements of being eligible to
vote that the voter is
[30:36] attesting to in certifying at
the time that they're registering and when they are
casting a ballot.
[30:41] >> Thank. Thank you. So the
answer to my question is, yes, under that scenario,
[30:47] someone could they get their driver's license
again because we've given anybody here,
[30:53] they register to vote. It doesn't match with the sus
security number. So they're flagged, but they come in as
long as they happen ID, which

[31:00] is that drivers license and
they sign that there, you know, all too well to vote.
They can vote and there and
[31:08] then no longer flag they're on the system. Is that
correct? Mr. The now.
[31:16] >> Madam Chair, if I could add
the it may be stepping back from those that are flagged as
C ID on the roster for anyone
[31:24] that's presenting documentation
to register to vote that is affirmation of their identity.
The driver's license has not
[31:31] been used as proof of
citizenship for the purposes of of registering to vote. It's
it's affirming that they are
[31:37] they they say they are sold in
any of these cases where someone were to cast a ballot
if they were ineligible to
[31:44] vote. There are also reports
that are generated a post election for voters that are
challenged. The counties will
[31:51] run to show status of voters
that have been updated due to the fact that they've now cast
a ballot that can be reviewed
[31:57] and referred to the county
attorney. Okay. So the answer is yes to
my question.

[32:03] >> You haven't said about it.
Is that correct? The answer was. >> Secretary Simon, if I could
intervene here, if I could zoom
[32:09] out a little bit, I just want
to clear that this is not a new issue for Minnesota for over
100 years. People who have had
[32:17] not only drivers license it to
other form of ID you can be used in election. That does not
distinguish between citizen
[32:24] announces. So my mother is a
good example. My mother for over 30 years was a green card
holder. She was driving around
[32:30] Minnesota for decades with a
valid driver's license that could have, I suppose been used
for.
[32:37] Although the ANSA says the the
instances of that are just vanishingly rare. It almost
never ever happens. There's
[32:44] been some recent studies about
that that Minnesota specifics, but I would just draw your
attention to the fact that we have other ideas, not just
drivers licenses that we I
[32:51] guess give to everyone that do
not make a distinction between citizenship and not, for
example, a student it no
[32:58] student. I ate that I've ever

seen from any college or university has a marking that
shows whether someone is a
[33:04] citizen or not or a military
ID. There is no military ID that I've ever seen that shows
a demarcation about whether
[33:12] someone is a citizen or not.
So I just want to put this in perspective. Reasonable people
in this room can have different
[33:17] idea about how we got to do
things. That's perfectly fair. But I just want to give a
little bit of context that this
[33:22] is not new. As with my mother,
this is a decades-old, I would say a century-old issue in
Minnesota.
[33:30] Thank you all up. >> Thank you. All right, Mister
Landau, so sorry to have
[33:35] derailed here. We look forward
to continuing. >> Thank you, Madam Chair.
[33:40] So I. >> Moving ahead to the 2nd half
of that verification process when one registers to vote,
which is to confirm that the
[33:47] voter lives where they say they
want. So after being registered, a postal
verification card or PVC is
[33:53] sent to the voters residential
address as a non for double mailing. If the mailing is delivered,

the address is confirmed and no

[34:00] further action is taken. If the mailing his return to

the county elections office as undeliverable voter record then

must be challenged.

[34:08] A second card is then sent

after 60 days. And if that cart is returned, voter record is

inactivated.

[34:15] There are many reasons why a

PVC maybe return, which included incomplete

information, for example,

[34:20] of the address provided did not

include the apartment unit number for the voter or the

voters temporarily away from

[34:26] their home address. If the cart is returned with a

forwarding address, there are procedures in place for how to

handle that record. Those

[34:33] include updating the address in

the voters record the addresses within the county providing the

card to another Minnesota

[34:39] County to update the record of

the voters moved to another county in the state, triggering

the process to inactivate the

[34:44] voter record data indicates

that the voter has moved out of state. Additional procedures are

required for postal

[34:51] verification cart to return for

individuals registering on Election Day. That will touch
on later.
[34:56] >> I'm sorry. I have one more
question. So I'm curious about this because this happened in
my household. So we received a
[35:06] voter absentee application form for
the previous owners of my home,
[35:14] who I happen to know we turned it. I the homeowner got it and I
did not feel it out. I returned
[35:24] it and said, you know, no
longer here, whatever I put on the envelope and stick it back
in the mailbox.
[35:29] So is it incumbent on the
people living in the residence when they get those things to
return it? If it's not caught
[35:38] in the mail system already? And the example I want to bring
up is there was a case last
[35:45] year where indeed a woman got in
Itasca County ballot
[35:52] for her mother who had died and
she filled it out. So is it incumbent on the
people who get these things in
[36:00] their home to return it or what? What is the process
for making sure that all this
[36:06] postal verification is rock
solid. Thank you. >> Madam Chair, thank you for

the question. There are the
[36:13] technical ways in which the
card is flagged as as non for
[36:19] double. So if the USPS cannot
deliver, it will be returned and they often have the
stickers on it indicating that
[36:24] the the reason why the card was
returned. But certainly if if a card is delivered to residents
and the information does not
[36:31] correspond to who is living
there, we would encourage the homeowner, the resident to
reach out to the county
[36:37] elections office, provide them
with information about the car they received is possible that
it was delivered to the wrong
[36:43] address or to your point, if it
was a previous residents in the information may be out of date
to provide that to the county
[36:49] elections office so they can
take a look at that record and determine if any updates may
need to be made based on that
[36:54] information. I will talk a
little bit about this specific case that you mentioned of how
Minnesota counties to update
[37:01] records based on information
that's received from the Department of Health to Mark

Records as deceased in the system. But there are times
it's not always going to be a
[37:09] real-time update. So if there
is a lag in data, you may find an opportunity like that.
Where in your compost
[37:17] verification card to center,
there's something that sent that's not corresponding to who
currently resides at the
[37:23] address. It's I think as close
as possible based on the list maintenance procedures that
counties are doing on a daily
[37:28] basis, but that that would be,
I think, effective use of the system if that information is
provided to the county. So the
[37:35] more they have, the more
accurate up-to-date the records can be. Thank you,
[37:43] which is a great segue into the
next slide. So after a voter is added into the system, the
record is now subject to the
[37:49] constant checks that ensure
their data remains up to date. The USS received data from a
number of agencies to
[37:54] facilitate these updates. The Department of Corrections
shares of filed each month with the names of all individuals
that are currently incarcerated
[38:02] for a felony offense. Names

that match with the registered voter are provided in a report
to the county to be challenged
[38:08] once an individual's release
from incarceration. The records are flagged for the county to
remove the challenge from the record and any instances where
it appears that an individual
[38:15] may have voted while
incarcerated are also referred to the county attorney for
review and investigation.
[38:21] The Department of Health
provides a monthly filed with names of those who have died in
Minnesota. Names from that file that match
with the record in STRs are
[38:29] shared with counties to review
the data and mark the records as deceased counties. Also often review
obituaries and receive and
[38:36] process reports filed with
their offices certifying that a voter has passed away and
update records accordingly.
[38:43] The Department of Public Safety
provides a monthly filed with names of non-citizens in
Minnesota on a temporary visa.
[38:50] If there is a match with a
registered voter, that data is provided to the county to
challenge the record and referred to the county attorney
for investigation.

[38:58] The state court administrator
also regularly provides information on legal name
changes as well as court orders
[39:04] related to guardianship or
incompetence were ones voting rights have been removed or
restored.
[39:10] Minnesota's also a member of
the Electronic Registration Information Center or Eric,
that helps to facilitate voter
[39:16] list maintenance that will talk
a little bit more about shortly. Each January. The office also
conducts an annual list
[39:23] maintenance process as required
by law. Any records that do not have
active voting that have voting
[39:28] activity or an update to the
record over the preceding 4 years are changed to a status
of inactive
[39:35] voters who are inactivated are
required to register before they're eligible to vote in a
future election.
[39:40] This serves as a routine check
to inactivate any dormant records that may not have been
updated through the regular
[39:46] maintenance procedures when a voter records added into
STRs. A search is also

[39:51] conducted against the database
of existing and active and inactive records to ensure
record is not already exist for
[39:57] the voter election, officials can view
any potential matching records and select the existing record
to be updated if there is a
[40:04] match if a new record is being
entered. But there's already one with certain matching
information. The system will
[40:10] flag that is a potential match
and prop the county to undertake additional review
before creating the voter
[40:15] record. In rare instances, a new record
may be added with data that does not match the R t existing
voter record resulting in a
[40:23] duplicate records being created as fear us as a series of
reports that flag these potential duplicate voter
records for review and matches
[40:31] that are confirmed are the
numbers to ensure that there is only one voter record for each
voter.
[40:37] >> Vice Chair Anderson, thank
you. So you do this maintenance
[40:43] yearly. So do so back to the
situation that we're talking about earlier, where you have
someone that has a a driver's

[40:49] license, which they can get
anywhere and I go there in the state and
they go in, they vote or they
[40:56] register. It's it's flag does
needs an ID that won't go when
[41:01] they use their ID this site.
Do you go back and look at the Social Security number and the
reason that that was not
[41:09] matching originally and you go
back and you can you compare that to the Social Security
database,
[41:16] regular, at least for everyone.
But but certainly for people were it didn't match in the
first place.
[41:23] Do do that, Mr. The now. >> Madam Chair. So for any
record that is flagged as
[41:31] failed verification and
specifically to the Social Security Administration
database, I would say that operate somewhat as a black
box. If we get a matching
[41:40] record to confirm that it is
verified against the Social Security database, it comes
back to confirm that there's a
[41:45] match. We don't have a lens
into that database to see what it is that me because in the
record not to match, whether

[41:53] it's transposed number, whether
it's a issue with the last
[41:59] name, not match exactly any
number of reasons where it's a genuine valid voter
registration. But coming back
[42:07] from the SSA showing that it
can't be verified with that that information. But for any
record that submitted at the
[42:13] time that that verification
cannot be confirmed. That's where that additional review by
the county elections office
[42:20] taking place to make sure that
that record then gets flagged and challenge to the system.
And as I touched on briefly,
[42:27] there are a series of reports
that are generated after each election to show any records
that may have been challenged
[42:34] and updated as a result of
voting in that election that are reviewed. And if there's
any discrepancies, there are
[42:40] unverified voter has cast a
ballot that may be referred on to the county attorney for
investigation.
[42:47] >> Vice chair and yes, thank
you. So so no, you don't go. You don't look after the fact
so that in this case you would

[42:53] take that list of people who have
come in who originally the Socials didn't match. They are
now active because they brought
[43:02] their photo id N but you don't go after the fact
and take a look and see if it
[43:08] matches no-deal do anything
with this security database to recheck the U.S.
talks after the fact that it
[43:17] finally did once they voted are their ballots. Let's say nobody challenges
them at the polls once they
[43:25] voted. Are there the bat, the ball counts,
right?
[43:32] Whether or not there, Madam chair, so that.
[43:37] >> So I as I mentioned, I
there's not anything more that we can do to cross reference
against the Social Security
[43:43] database to determine the
reason why there may not have been a match and that record.
But if that record has cast a
[43:49] ballot, those are reports that
county elections offices are running after each election for
voters that have had their
[43:55] status updated from challenge
to active. And if there's a case that needs to be
investigated further, the
[44:03] county attorney would do that

work to determine whether it was an invalid ballot that may
have been cast. Okay. Thank
[44:09] you. >> Thank you. Please proceed. >> So as noted previously,
Minnesota is one of the 25
[44:18] states plus Washington, D.C.,
that are members of the Electronic Registration
Information Center work.
[44:23] Eric Minnesota joined Eric in 2014
following a legislative change that allows for data sharing
with an organization that has
[44:30] governed exclusively by a group
of states to maintain voter registration. Records.
[44:35] As was just outlined, voter
rolls are constantly changing with voters being added and
removed from the rolls.
[44:41] Roughly 10% of Americans move
each year on average. But most of those individuals do not
notify their prior county or
[44:47] state once they've moved. Eric's reports help to identify
those voters who have moved
[44:53] both with in Minnesota and out
of the state as well as those who may have changed their name
or passed away and ensure that
[44:59] their voter registration is
updated as part of the membership
agreement, members are required

[45:04] to submit their state voter
registration data and driver's license and identification data
to Eric at least once every 60
[45:12] days, Minnesota submits the
state on a monthly basis.
[45:17] That data is always sent via
secure encrypted transmission and sensitive personal
identifying information like
[45:24] date of birth driver's license
number or Social Security number. It's converted into a
string of random characters as
[45:31] part of cryptographic hashing
that is applied for data is transmitted. I'll talk a little bit more
about data security with Eric
[45:38] on a subsequent slide. The state data that is provided
to Eric is compared against
[45:43] data from all other member
states along with other sources like the Social Security death
master file to create several
[45:50] list maintenance reports. Erik then returns. These
reports to states to review the
[45:55] identified potential matches once confirmed. These matches
are provided to counties to make the appropriate update to
the identified voter records.
[46:06] So the reports that are listed
on this slide are those that Minnesota received back from

Eric to assist with the voter list maintenance process.

[46:13] Again, Minnesota receives these

reports that the maximum frequency once per month to

keep our registered voter list

[46:19] as up-to-date as possible on an

ongoing basis. First across state movers

report identifies voters who

[46:25] appear to have moved from one

Eric State to another by comparing registered voter data

against Motor vehicle data.

[46:32] Voters name would appear on

this report at the Register to vote in Minnesota, but

subsequently applied for a driver's license or ID card in

another Eric member state,

[46:41] their appearance on this

report, we provide evidence that they've moved to another

state. Another voter record should be updated to reflect

this change

[46:48] once process by the county

postcards mailed to the voters, knew out of state address,

informing them of the pending

[46:54] change and providing notice

that their record in Minnesota will be inactivated. The card includes information

for the voter to contact the

[47:01] county elections office within

21 days to reverse the change if they're retaining the former

address as their address of

[47:07] residents. The in state MOVERS report

provides information about

[47:12] those who have moved within the

state by comparing Minnesota's voter rolls against the

Department of Public Safety's data so function similar to the

out of state or CROSSTIMBERS

[47:20] report. But for those that have

moved within the state, the duplicate report identifies

potential duplicate

[47:27] registrations within the state.

Same state come by comparing voter registration data.

[47:33] This report function similar to

the duplicate voter reports that are available in SB

Arrests and conduct additional

[47:39] data analysis to determine

whether the state's voter registration records identify

more than one registration that

[47:44] appears to be for the same

person. Names that are identified in

this report are provided to the

[47:49] county to review and determine

if they apply to the same person and if confirms the

records are merged so that

[47:55] there is only a single record

on file. The deceased report compares

voter registration data against

[48:01] the Social Security death date

known as the Limited Access Death Master file to identify

any voters who may have passed

[48:08] away. Registered voters who appear to

match a deceased individual are included on the report and the

data is provided to the county

[48:16] to mark the record as deceased. This provides national data on

deaths and helps to identify

[48:22] registered Minnesota voters

whose death may have not been reported through the State

Department of Health.

[48:27] And finally, the National

Change of address report identifies voters who have

moved using change of address data from the U.S. P S

[48:34] this covers those who have

submitted a change of address request for either in state

move or an out of state move.

[48:40] This report then function

similar to the cross stating in state movers report where

records are updated accordingly

[48:46] and post cards are sent to the

voter based on that change

[48:52] to ensure the secure and a wing

of the Eric provides all member states with an application

that's used to apply a

[48:57] cryptographic one-way hash to
sensitive data elements before it's transmitted to Eric
[49:02] private data fields and
including the driver's license or state ID number or any part
of the Social Security number
[49:08] and date of birth or converted
into those random characters which makes the data
significantly more difficult
[49:14] for a potential hack or to
utilize. Eric will only accept data
files have been hashed using
[49:19] this application to ensure that
sensitive data is protected at the source before it is
submitted to Eric.
[49:25] Once that data is hashed it
securely transmitted using multiple rounds and types of
encryption.
[49:32] This hashing process is applied
a second time ones. Eric accepts the data file ensuring
that the half values are
[49:37] different and secure. Erik then utilizes matching
software to compare the common
[49:43] fields across the submitted
data to determine if those records refer to the same
people and then produces the
[49:49] reports that I mentioned to

make available to member states for secure download once that matching is completed.

[49:57] Erik also has a robust member approved information security management plan and regularly under takes independent reviews

[50:03] of its data security practices.

[50:08] And then just briefly before getting to the voter registration investigation, I want to walk through the steps that take place after each election, which I touched on a

[50:16] bit in response to some of the questions raised in the days and weeks after Election Day, counties are

[50:21] responsible for entering voting history data. This process involves scanning barcodes into STRs for each

[50:28] voter record that cast a ballot on the paper rosters or by uploading electronic roster files to ask the arrests for

[50:35] counties that may be using electronic poll books. This data entry and review ensures that voting histories

[50:41] properly applied to every voter who cast a ballot at the election. This data entry must be completed within 42 days after

[50:48] Election Day. And counties must also enter

voter registration applications for anyone that's registered on
Election Day or as part of the
[50:55] absentee voting process. All voters registered on
Election Day are sent through the same verification process
vote as voters who register
[51:03] prior to Election Day. There's some additional
requirements that are specific to Election Day registries
counties are required to a
[51:11] process, a random sampling of
at least 3% of all Election Day Registry Inc within 10 days
after Election Day.
[51:19] Counties have 42 days to enter
all of their election day registration information. And our office is required to
post data on our website
[51:27] detailing the progress for
county data entry of registrations following each
election
[51:32] as additional requirement,
counties must document and report the number of postal
verification cards that are
[51:38] returned for Election Day
registrations and the reasons why those cards were returned.
[51:43] This report also requires
identified the total number of individuals for whom the county
auditor does not receive
[51:48] satisfactory proof of an

individual's eligibility to vote. In those instances, information
must be immediately forwarded
[51:55] on to the county attorney for
review data from the county's reports
are collected by our office and
[52:02] compiled into a single report
that is submitted annually to the legislature.
[52:09] So with that background on
voter registration verification on now, walk through the
details surrounding the voter
[52:15] registration fraud case that
are office was asked to discuss before the committee today
[52:20] in the summer of 2022, a
handful of counties began to identify anomalies with some
paper voter registration
[52:26] applications. One county had reported a
separate earlier batch that was received back in the fall of
2021.
[52:34] among the discrepancies that
were identified were similar looking handwriting on
applications and similar
[52:39] patterns with the manner in
which the data was provided on the form. As the voter registrations were
entered into the statewide
[52:46] voter registration system,
records were not passing that process to identify and verify

excuse me to verify the

[52:53] identity of the applicant. In many instances, the postal

verification card that were

[52:58] mailed to the voter returned as

undeliverable, which resulted in the records being challenged

and subsequently inactivated.

[53:05] When a second postal

verification card was returned. The pattern was noticeable

enough for multiple counties to

[53:11] have referred the voter

registrations for further review and investigation. One of those counties which was

named in the charging documents

[53:19] from the Department of Justice

was Carver County cover county election staff

reported receiving 2 suspicious

[53:26] batches of voter registration

applications in August and September of 2022, which would

have been forwarded to the

[53:32] county from the office of the

secretary of State. This is a regular practice for

our office when we receive

[53:39] voter registrations that are

mailed to us as the voter registration applications

include are mailing address on

[53:45] the back of the reform to be

returned to our office after they received mail staff

at the office or at the
[53:51] applications by county and
saint to counties to be entered into SPR U.S.
[53:57] within the second batch of
applications. Carver County election staff identified
discrepancies with addresses
[54:03] that were submitted as being
non residential properties. This led to further review by
election staff and the
[54:10] identification of similar
patterns with that group of previously submitted
applications.
[54:15] At that time, the Carver County
elections manager reached out to the Carver County Sheriff's
Office to initiate an
[54:21] investigation into the
suspicious applications. After reviewing the available
information from the voter
[54:27] registration applications,
outreach was made from Carver County to the FBI to assist
with the investigation
[54:35] in mid October of 2022, the FBI
special agent made contact with several other counties,
elections offices and began to
[54:42] assess the scope of the issue as part of this outreach, it
was determined that similarly

[54:48] suspicious voter registration
applications have been recently received by other counties and
that at least one local that
[54:54] investigation was also under
way around the same time, the FBI
special agent also reached out
[55:01] to our office to provide
information from their contacts with counties. As soon as our office learned
of this issue, we conducted
[55:09] individual outreach to the
elections lead in all 87 counties.
[55:14] As part of this outreach, we
share that multiple counties had reported receiving
suspicious voter registration
[55:19] applications and inquired as to
whether they're county may have received any applications that
fit the same pattern
[55:27] for any that responded.
Affirmatively guidance was provided to refer the
applications for investigation
[55:32] if that had not already been
done. And to encourage outreach to the FBI
[55:38] reminders were also provided to
counties regarding the appropriate steps to take as
part of the data entry and
[55:43] verification process. Ines

Ferre us through this outreach. We
learned that voter records had
[55:49] not been created for many of
the applicants due to fundamental deficiencies on the
form. Specifically several
[55:56] instances where addresses could
not be identified as part of a valid address. Range
[56:02] counties create narrow address
ranges within STRs which serves to limit data entry to only
valid address us
[56:15] in Mid-October. Ice give me in
mid November of 2022, the office of the Secretary of
State received an additional
[56:21] batch of voter registration
applications with some that included characteristics that
appeared to fit the pattern of
[56:27] anomalous registrations that
had been previously identified by the counties. We immediately notified the FBI
about these applications and
[56:35] were provided with detailed
guidance for SS staff to use gloves and minimize handling
when reviewing and sorting the
[56:43] applications upon review, it was determined
that the applications contained addresses that were spread
across 5 counties.
[56:51] Our office again reached out to

directly to the elections lead in each of these 5 counties to
advise that we had received
[56:57] potentially suspicious voter
registration applications with addresses in their county.
[57:03] On guidance from the FBI, the
voter registration applications were mailed directly to the
election. Lead and instructions
[57:09] were shared to use gloves when
handling the forms and to keep them separated from any other
voter registration applications
[57:16] were other documents. We reiterated that if a voter
registration application included clearly false
information, such as a
[57:23] nonexistent address were
invalid unit number, the registration should be
considered deficient and that a
[57:29] voter record would not be
created and for any records that were
entered but ultimately failed
[57:34] verification to confirm that
those were properly challenging the system and flags to local
and federal law enforcement for
[57:41] further investigation in the weeks that followed the
FBI special agent travel to the
[57:47] counties to interview election
staff and take possession of flag documents and conduct

forensic analysis.

[57:54] Our office also provide

additional data to the FBI regarding the records in

question as well as clarification on applicable

state laws and procedures that

[58:02] would help to inform their

investigation or the following 2 plus years,

our office would have regular

[58:09] engagements with our FBI

contacts as part of the office's overall election

security preparedness and

[58:14] planning with federal and state

partners at these opportunities. We

would inquire as to whether

[58:20] there were any updates or

additional information that we might be able to provide.

We were told that the investigation was ongoing.

[58:28] Then on 6/13/2025, the

Department of Justice announced that 2 individuals have been

charged with conspiracy to

[58:35] engage in voter registration

fraud. According to the court

documents, the individuals

[58:40] provided the fictitious names

and information on Minnesota voter Registration

applications. 2 unnamed

[58:46] foundation that foundation and turned
submitted the applications to be processed by county election
offices across Minnesota
[58:54] in late June and early July.
The 2 defendants both pled guilty to the charges filed
against them
[59:01] from the time that the office
was first contacted by the FBI. We responded quickly and
comprehensively to all requests
[59:07] for information. We also helped to facilitate
coordination between the FBI and county elections offices
across the state.
[59:15] We reached out directly to the
elections leads in all 87 counties. Once the issue was
brought to our attention to
[59:20] ensure that everyone had the
same information and could be on the lookout if they were to
end up receiving any suspicious
[59:25] applications in their county through this outreach, we were
able to identify 13 counties
[59:31] that flight potentially
suspicious voter registration applications and share that
information with the FBI.
[59:38] In turn, this allowed us to
pass along the FBI's guidance for safe handling procedures to
those counties to help with the

[59:44] preservation of evidence. We also conducted a complete
review, an STRs of all of the
[59:49] identified applications through this review. We were
able to confirm that all records have been challenge and
that the flag records would
[59:57] have been required to complete
additional steps in order to cast a ballot in any election.
[1:00:02] No ballots have been cast or
even requested for any of the potentially suspicious records.
[1:00:09] As noted before many of the
records had never been entered into the system due to
deficiencies on the
[1:00:14] applications and others were subsequently
inactivated. Based on return. Postal verification cart.
[1:00:23] All of the counties that were
involved played a pivotal role throughout the investigation, cover County elections and the Carver County Sheriff's Office,
[1:00:30] which was thanked for their
work in the Department of Justice Press release, played a
critical part of being the first county to elevate the
issue so that it could be
[1:00:37] addressed at a statewide level
using the support of state and federal resources.
[1:00:43] Other impacted counties also
acted swiftly in response to identifying these
discrepancies, including

[1:00:48] starting local investigations
within the county county election. Officials
conducted thorough reviews of
[1:00:54] all of the available
information, including reviewing previously submitted
batches of voter registration
[1:01:00] applications. They worked in concert with our
office and federal law enforcement to respond quickly
to all requests for information
[1:01:07] during the investigation. They followed the law and
procedures to ensure that the records were properly reviewed
and challenged
[1:01:15] for the last several election
cycles. Election administration excuse me, election
administrators have all preach
[1:01:21] the mantra of see something,
say something when it comes to election security. As soon as this issue was
identified, the proper
[1:01:28] referrals were made to dig into
the discrepancies. Sounding the alarm early on a
lot for our office to alert
[1:01:34] counties across the state to be
on the lookout for similar activity in their county.
[1:01:41] It goes without saying that it
is unacceptable that these individuals sought to
manipulate Minnesota's voter

[1:01:46] registration system for their
own gain. But thanks to the coordination
and collaboration between law
[1:01:52] enforcement and election
officials at the federal state and county level for their
actions were identified.
[1:01:57] The records were flagged, know
invalid votes were cast and the perpetrators have been brought
to Justice.
[1:02:04] Thank you, Madam Chair. That
concludes my presentation than happy to yield to any
questions.
[1:02:09] >> Thank you. I'm sure we have
many representative came in. >> Thank you, Madam Chair and
thank you both of you,
[1:02:16] Secretary Simon and your whole
team for giving us this comprehensive review of voter
registration and the
[1:02:22] verification system. I think
I'm the only person on the committee who is on the
elections and local government
[1:02:28] committee and have been for the
last 3 terms in office and so appreciate we get much more
into detail in that committee,
[1:02:36] which is really where we spend
our time. And I'm a little I just wanted to make sure that

the public understands because

[1:02:43] there's a little confused, but

would to Robin said the seems to be a place where there are

no checks, but it is actually those checks

which we heard both Mr. Gland

[1:02:54] painstakingly recount the the

what was happening in court as

[1:02:59] well as both of you talk about

what led to the indictments and prosecutions. I would note to

folks that in the that make the

[1:03:09] the the association of County

officers who actually administer our elections in

Minnesota and the last line

[1:03:16] described, I think what is

important and pretty much wraps up this, which has this outcome

demonstrates that the systems

[1:03:22] checks and verifications worked

as designed. So I I appreciate that. And I think that the out

this was that this was a

[1:03:29] helpful and useful place.

What I will say is that what is

[1:03:36] frustrating is that we have an

hour and a half that we have spent a valuable committee

time. It's the only thing

[1:03:43] really happening officially in

the house and we are chasing

[1:03:48] what is the system working?
Which is great. I think it's great when we spend time and
that feels like there's some manufactured the issue of voter
fraud. But we continue here.
[1:03:57] We know and I will say it's to
TSU sticks about seemingly rare. That is. But the thing
that is hard for me is is what
[1:04:06] we're not doing in this
committee for governor a government oversight. I will
say that the reason I was late
[1:04:13] is that I was upstairs in the
House chamber with 3rd graders from Annunciation, which is in
my district and which I think
[1:04:21] you all know suffered a
horrible mass shooting 7 weeks ago. And I was with those folks
thinking our leaders have been
[1:04:30] talking about gun violence
prevention and and it feels like a the committee on
government oversight should
[1:04:38] also be thinking about how do
we oversee the laws that potentially can stop the
shootings and his weapons of
[1:04:45] war on our streets. A say that
in the district court found
[1:04:51] that there were 2 cases of
voter fraud in 45 million ballots cast since 1979 that

was in 2020. There were 2

[1:05:00] children murdered in 4 minutes.

And so when I think about the issues that we should be

focusing on here, it seems to

[1:05:07] me the ones that are actually

having impact in our communities. And let me talk

about one of the couple of

[1:05:12] things we could be talking

about here as we talk about strategies we saw yesterday

last week. The start to be in

[1:05:18] did a report on red flag laws

of extreme risk protection orders and how they are working

but they are not being

[1:05:26] consistently apply.

Representative going to have anything relevant to the fraud

question because we'd like to

[1:05:31] >> get other members to start

asking questions. This is not a hearing on gun control. >> Thank you, Madam Chair.

Actually, my question is for

[1:05:38] you because it isn't a hearing

on banning its weapons of war. It also is not a hearing on

fraud. And so when we talked

[1:05:46] about we talked about 2

prosecutions, we could talk about the fleet farm

prosecution of straw purchasers

[1:05:53] and guns that are illegally

sold in our communities. What I'm asking for you is when
we think about the issues that
[1:05:59] this committee covers, right,
we talk about fraud and government oversight. And this
committee hearing is a good
[1:06:05] example of when we look at
places where government oversight, we want to take a
closer look at. So my question
[1:06:11] for you is 10, we have a
hearing where we talk about the government oversight of our red
flag laws of our straw
[1:06:18] purchasers. Is that something
that we can put on the agenda? Thank you, Madam Chair.
[1:06:23] >> Thank you, Representative
Rudman. I am open to strings on any topic. I would say that
that's more the jurisdiction of
[1:06:30] the Public Safety Committee.
And I really want to get to the questions that hand. So I
appreciate your comments and
[1:06:37] I'm sure they may just one
final. Thank you. Thank you. >> I appreciate that. I think
this is the jurisdiction of the
[1:06:43] elections and local government
committee. So I know this committee has a lot of things
that are the jurisdiction of
[1:06:48] human services of elections.

What I think we're doing here is highlighting the places
where we about where the public
[1:06:54] is asked us to look deeper.
And I will say that I think the issue of gun violence
prevention, which our leaders
[1:07:00] are talking about, which 60% of
innocence want us to cut to cover its something that we
should be doing this committee
[1:07:06] that looks at the jurisdiction
of lots of committees. Thank you. >> So I would like to start off
the questioning with just a
[1:07:13] couple of my own. So first of
all, from the press reports,
[1:07:19] one of the defendants admitted
to getting 500 fake voter registrations.
We don't have a number on the
[1:07:26] second one. This is the first
time I've heard that there were 13 counties involved. I've seen
press reports ranging from,
[1:07:33] you know, 10 to 15. So having
that clarification is helpful. But you talk about how no one
voted
[1:07:40] and I'd like you to develop to
tie to back out of the numbers know is saying 500 is
conservative because we don't
[1:07:46] know what the other person

submits a 500 sake registrations is conservative.

But if that was indeed the

[1:07:53] floor, how do we know how many were

actually created voter records

[1:08:00] in the system? How many were

challenged? How many were inactivated and help me back

out? How you know, no one voted

[1:08:08] if some of them remained in the

system has challenged and then the person went in to vote and

presented the idea as we've

[1:08:14] gone over, they could have

voted. So I want to understand how, you know, none of those

fake registrations court

[1:08:21] actually votes cast. Thank you. >> Madam Chair, I'm happy to

field that question. So as part

[1:08:27] of that outreach to the 87

counties, that's where it was identified that 13 counties had

flagged. They had voter

[1:08:34] registration applications that

fit this profile information was then compiled

so that all of the records,

[1:08:42] whether they were ever entered

into the statewide voter registration system or not,

we're track to determine and

[1:08:48] provided to the FBI so that

they had the full a list of all of those that had been

identified.

[1:08:54] >> And can you tell me the

number wasn't higher than 500 was the number? Yes, it was

higher than 500 but less than

[1:09:01] 600. So it was pretty close to

what was named in the the statement there.

[1:09:08] So with within those records,

then following the election

[1:09:14] review was conducted to

determine whether any of those records had had cast a ballot.

So we went through every single

[1:09:22] record that was identified by

the counties and tracked whether its status and

confirming its status was

[1:09:29] either not entered into the

system or that it had been entered in challenge and

whether or not there had been

[1:09:34] any voting history associated

with that record. So that's that process that I touched on

where after each election,

[1:09:40] the polling place rosters

absentee voting history is applied to every single voter

record. And as part of that

[1:09:47] review, none of the identified

records had either cast or requested a ballot.

[1:09:55] >> Thank you. My understanding

is that this organization had multiple independent
contractors, so too, were
[1:10:04] caught to know what other
ballots were submitted for voter registration from this
organization and how many that
[1:10:12] was. >> Madam Chair, we are office
or the county elections offices
[1:10:19] would not necessarily track
voter registration applications as being received from a
particular organization,
[1:10:25] most commonly those are
submitted by by mail. So if there are voter registration
applications that it's not
[1:10:31] identified as to the source
from where they came from. >> So once this was identified
that this was going on and you
[1:10:37] knew they all came from this
group, you didn't track other submissions of voter
registrations from this group.
[1:10:46] >> Madam Chair. So the
subsequent batch that was identified in November of of
2022 is ultimately what led to
[1:10:55] that referral to the FBI and
that those 5 counties that were identified is what created that
link to those registrations and
[1:11:05] tracing that back to the

organization. So I to the extent that that was being
tracked, that was was in part
[1:11:11] how those were were identified. >> Thank you, Representative
Hudson.
[1:11:19] >> Thank you, Madam Chair.
First, Secretary Simon. I just like to take the opportunity to
publicly. Thank you for what
[1:11:26] you mentioned earlier, which is
coming out to my district and 7 with kids in high school
talking about pre registration
[1:11:32] and the importance of voting.
I think that was a very enriching experience for them.
And it was something that I
[1:11:37] personally enjoy it. So thank
you for that. May sound like an odd way to
start, but
[1:11:45] my house has never been broken
into. It's never happened.
[1:11:51] But I still locked the doors at
night. I still close the windows. I still take many other steps
to minimize vulnerabilities.
[1:12:00] So it strikes me when we have
these conversations about election integrity, that we
tend to reduce it to the
[1:12:06] question of is there fraud and how much is
there? And that's a that's a

fascinating debate that we can

[1:12:14] go back and forth on. But I

think the more important question is where the

vulnerabilities in the system.

[1:12:20] So I'm gonna pay little

hypothetical here and tell me where I'm wrong. It occurs to me that if this

couple have been just a little

[1:12:30] bit smarter, a little less sloppy, they could have taken the same

fabricated information

[1:12:39] and merely gone the day of

rather than trying to submit voter registration applications

[1:12:46] and have people vouch for each

other. Use the fabricated information

[1:12:52] on the same day registration and maybe that gets flagged

down the road.

[1:12:57] But in the meantime, they're

handed a ballot and they cast it. And once it's cast, it counts

[1:13:05] warmer all. >> Mrna Secretary, thank you,

Madam Chair and representative.

[1:13:12] First of all, you're completely

right and drawing the hypothetical that you draw in

terms of another hypothetical.

[1:13:18] But your premise, which is you

got to protect the house every way that you reasonably can,

even if you've never been

[1:13:24] burglarized, even if you've

never been robbed. I completely agree with that. We can't just rest on our laurels regardless

[1:13:29] of what the statistics are. I would say not to get too. We did here and I'll defer to

[1:13:35] Mr. Le Now on the weeds or any other contacts he wishes to provide. But when it comes the same day, I just respectfully

[1:13:40] disagree with the premise here only in the sense when you register to vote, same day or otherwise. You have to

[1:13:47] basically show 2 things. You are who you say you are and you live where you say you left. That's it. Voter

[1:13:52] registration just means those 2 things, not 20 things, not things, not 3 things. Just those 2

[1:13:58] and vouching and again, there are reasonable minds in this room can disagree

[1:14:03] about watching. You can only vouch for 8 people, by the way, under the a Minnesota state law. But vouching only gets at

[1:14:09] the live where you say you love part, not that you are who you say you are part. So even if they had someone who had

[1:14:15] vouched for 7 other people, 8 other people, that would be that limitation. I get what

you're saying, though about I

[1:14:21] do want to get lost too much in

that. We as you're saying, hey, is there some way by which

whether it's the way that you

[1:14:26] describe or some other way,

they were just one or 2 steps on the

cleverness meter away from

[1:14:33] succeeding, whether it was the

way you describe precisely or or not? I guess I would say that, you

know, certainly anything's

[1:14:39] possible in any system in

election system or anything else. I think the track record

in Minnesota is really good.

[1:14:45] And I would say this, too, and

I'll defer to him, Mr. Lynell on the specifics

[1:14:51] view, is this the any one of us

in this room if we were to redesign the Minnesota election

system, let's say we start from

[1:14:57] scratch. We chucked out the

window every single law and regulation and we start over as

to every single detail. I think

[1:15:03] in the back of our minds what

we'd all be thinking about. We might not name it this way. But in the back of our minds,

we be thinking what is the

[1:15:10] perfect intersection of access

and security, right? We all want to access.

I think everyone in this room
[1:15:15] because no one wanted to be an
unnecessary obstacle course. And I think everyone in this
room wants security. You want
[1:15:20] only eligible voters and no one
else voting no to people in Israel elected
or an elected would plot that
[1:15:29] on a graph at the exact same
space. Your version of the perfect sweet spot of
[1:15:34] the intersection few next that
security would be different from Madam Chair as would be
different from Representative
[1:15:40] Pinto's or anyone else in this
room. And so I guess generally speaking, I would say
[1:15:47] you always have to stay one
step ahead of the bad guys. That's for sure. We always want
to do that. I think you this
[1:15:53] case from June as an example of
the county is first and foremost, I want to give them a
credit. Did do that. We have a
[1:15:59] bottom up system in Minnesota,
not a top-down system and they really did the right thing
there. But overall, I would
[1:16:06] say, you know, there are a lot
of hypotheticals, of course, but
[1:16:11] I think over the last 50 or so

years in Minnesota, we've gotten to a really reliable and
effective blend of access and
[1:16:17] security. But you do want to
talk about that hypothetical or an adjacent hypothetical right
now.
[1:16:23] >> Thank you, said Mr.
Lynnette, thank you, Madam Chair. I think what I would add
on on that particular scenario
[1:16:29] in terms of being able to
coordinate that type of operation. But also what it
would require for the persons
[1:16:35] who are vouching is important
to note that that's not just a slip of paper that they're
signing into legally binding
[1:16:40] oath, that they are attesting
to the fact that that individual is a resident of
that precinct and that person
[1:16:47] was vouching does have to be a
registered Minnesota voters. So there's identifying
information for that voucher,
[1:16:52] that spot Biden. And that is
part of that post election data entry process. If there's any
issues with the eligibility of
[1:17:00] a voter fraud verification
process were to fail for someone who would vouch for
that information would be handed over to the county

attorney's office. And I would

[1:17:07] imagine would be facing an

outcome similar to what these 2 are facing on on these charges.

[1:17:15] >> Representative had Centre. Thank you, Madam Chair. So just to review. So

[1:17:22] you're saying that vouching process, you still have to show you

start to prove that you are who

[1:17:29] you say you are, which you

would do with an ID. Yes. And then the vouching is

that you live where you say you

[1:17:35] live. So going back to Patty

Anderson's scenario, Representative Anderson,

Michael Jace attacked.

[1:17:45] You could have somebody who is

not a U.S. citizen who presents

[1:17:50] their driver's license that

they can now receive here in the state of Minnesota,

somebody vouchers that they live where they said they live.

They get to cast a ballot and

[1:17:59] let's say it gets flagged down.

The line gets referred to a county

attorney results in a

[1:18:04] prosecution perjured themselves,

[1:18:10] but the ballot that they cast

still counted.

[1:18:17] >> Madam Chair and

representative has and you know, when when someone is

falsifying that document to be

[1:18:23] able to register and or signed

the roster and vote they're

[1:18:29] provided with about this

presume that the oath that they are signing off, that they are

an eligible voter so they would

[1:18:34] be faced with those penalties

if it's determined that they were not eligible at the time.

But there's no way of going

[1:18:40] backwards to identify that

ballot that was cast. >> The last question,

Representative Woodson Finance,

[1:18:45] thank you. Madam Chair,

different topic. So when you were talking about this Eric

System, you stated if I recall

[1:18:53] correctly that when Eric to tax

a requirement for status change death, people can't whatever

the case may be,

[1:19:01] that the information goes to

the appropriate county so that they record can be updated.

[1:19:08] What does the update? I mean,

are we talking about the leading records? Are we talking

about switching them to an

[1:19:13] inactive status, which then

could potentially the registration once again,

[1:19:18] Mr than him? >> Madam Chair, Representative

Woodson, the action that would be taken after a match is confirmed would be dependent on
[1:19:26] the type of report data that's being provided. So the instance of a match to the Social Security death master file,
[1:19:33] the record would be marked as deceased. So it would be deceased in the system. It would not be on the voter rolls
[1:19:39] if it suggests that they have applied for a driver's license in another state that would trigger that process to
[1:19:44] ultimately inactivate the record would first male out to them on notice and provide them a 21 day window to contact the
[1:19:50] county and say, hey, I'm actually not moving. There was an error here. I maintain my residents in Minnesota. So each
[1:19:57] of the updates that are are a result of the reports that we receive back from Eric Trigger a designated action that the
[1:20:04] county would take up on the review of those records.
[1:20:10] >> Representative Anderson, thank you. Yes, to questions.
[1:20:15] One is a follow-up, sir. So someone has got and whether
[1:20:20] they register in advance so

they go in the same day they have their driver's license,
which again, Minnesota, anybody
[1:20:27] can have a driver's license.
It doesn't say not a citizen on it. If you're not a citizen,
they've all. But if no one
[1:20:34] challenges that do we go back
after the fact and compare it to records of whether you're
actually a citizen of the
[1:20:45] you must mrna? >> Madam Chair, one of the
reports that we we do have,
[1:20:52] which is from the Department of
Public Safety is the list of persons that are here on a
temporary visa. So that report
[1:20:57] that comes through monthly does
help to identify anyone who may not be eligible to vote for
citizenship purposes and flags
[1:21:04] that for the county to review
and referred for investigation. That's probably the primary
tool at our disposal to be able
[1:21:11] to review citizenship
information. There's not a state level or federal level
database to to run against for
[1:21:20] citizenship purposes that that
state law authorizes Matt exists.
[1:21:26] >> Thank you. And they're here
illegally. They won't be on that list them and they won't

be flagged.

[1:21:31] Is that correct? >> Madam Chair, representative

the list that we received a

[1:21:36] specific to those who are here

on a on a temporary visa. That's that's what is outlined

in statute and the data that

[1:21:42] DPS has to provide to us on a

monthly basis. >> Okay. Thank you. I have a

slightly unrelated to this

[1:21:48] line. One final question, what sort of checks to do on

the county? The county's just

[1:21:56] sort of pulled that are

supposed to clean up the voter rolls it to come. What checks

to the we know that when the

[1:22:02] there was that recount in Scott

County, you know, the 10 PC last year and going to the

ball, we know there were a

[1:22:09] bunch of people on that list

said that word they didn't vote, but they were deceased

and some were deceased, you

[1:22:16] know, several years. So they

were obviously not taken off in that six-month schedule that

you,

[1:22:24] you know, talked about that.

You look at health records. So what do we do to make sure

that people that are deceased

[1:22:32] actually, and we do. We do a double check
the work of the county auditors. So thank you, Mr.
The now.
[1:22:40] >> Madam Chair, representative we at the state level, we do
have access to sort of central
[1:22:46] dashboard that shows the number
of reports or applications that are set in the county queues
for processing to ensure that
[1:22:54] those are being handled and
processed in a timely manner. Also note, I guess going back
to the 2018 office of the
[1:23:04] Legislative Auditor report as
well as the current process that the oil is undertaking to
conduct a review of voter
[1:23:11] registration in Minnesota and
how they assessed the work that was being done both at the
state level and the county
[1:23:17] level in that first report and
are evaluating at the current time to ensure that that all of
us are complying with the laws
[1:23:24] and procedures that that keep
our records up to date and to identify any potential issues
there. So I think that will be
[1:23:32] a good insight into that
process. But we maintain regular ongoing communication
with county elections offices.

[1:23:40] I'll reach to ensure that that
especially new county auditors have the information,
resources, tools and training.
[1:23:46] They need to be successful at
their jobs. The last several years have seen an exceptional
rate of turnover in county
[1:23:52] election positions. And so the
need to provide any quip new folks with that information has
been a priority for the office
[1:24:01] and will continue to be moving
into the future.
[1:24:11] >> Thank you, Madam Chair, and
thank you so much, Mr. Secretary and cheer team.
I guess I want to echo the
[1:24:17] thanks of the Department of
Justice. Both your office also should acknowledge the Carter
County Sheriff's Office sounds like they really kick things
off and so good that they were
[1:24:25] paying attention to the things
I guess to 2 things, maybe Mrl,
[1:24:31] perhaps Senator Simon, you
know, the motivation of these people who were who were
participate in the scheme,
[1:24:37] it seems like the motivation
was to make money as easy as possible that they were not
that their motivation in this

[1:24:42] particular case. It doesn't
undermine any other points that were made. But this particular
case, we have a sense of that
[1:24:48] either. Senator Simon was to
Reno. >> Mr. Secretary, thank you,
Madam Chair. And that's the
[1:24:55] certainly the sense that I got.
I think it was publicly reported that that was the
sense of the Justice Department to obviously there's no trial
here. They played out and so
[1:25:04] well, maybe not never know
specificity, but that seems to have any angle
here. Yes, okay. And then.
[1:25:11] >> The pen to thank you, Madam
Chair. And then the other thing is just Michigan. I guess I
want to ask you to to expand a
[1:25:16] little bit. You you talked
about the balance between think use its security and access and
has an elections expert
[1:25:22] yourself. I think those terms
should have there's a lot packed into those 2 terms.
What I think about it, I think
[1:25:27] about, you know, I mean,
balancing this, there's a fundamental point that we want
to ensure that Al Jabal that
[1:25:35] only eligible people are

participating in this fundamental exercise of our
democracy, which I guess I
[1:25:41] would turn to find it on the
security side and that we're not over burning
overburdening. What is a
[1:25:47] fundamental right, which is the
right to to to vote when you are, in fact, eligible voter.
And I guess before I go to to
[1:25:53] say when I think about that,
like the burglary, Manafort, I think it's such a good one.
I'm thinking about like in this
[1:26:00] case these folks got. >> The. >> There was this this false
form and that was submitted.
[1:26:08] It's sort of like, like needing
that again on your lawn. You know, before they got close
to the house is a whole series
[1:26:14] of checks that that that
happened to go into place. And we really are balancing in
so many areas, fundamental
[1:26:20] rights and wanting to protect
them in various ways. We do that with the First Amendment.
We do that with the Second
[1:26:26] Amendment. The reference to
that with loading as well. I spent time happen to spend
some time in Latin America the
[1:26:32] last couple of years and a

couple short trips and notice like they're almost every home,
in fact, has high walls and
[1:26:38] even like pieces like glass
that's actually attach the top of the Walton. Should people do
climb over? We don't do that
[1:26:44] and the U.S.. And yet if you
want to be absolutely certain, right, you have a whole series
of laws and moats and a whole bunch of things. He also wanted
to get in and out of your house
[1:26:51] if you could just Mr. Secretary
just expand on as we try to balance this in our in our
system. She couldn't.
[1:26:58] >> Secretary Simon share will
represent pinch. I'm not sure I could say it any better.
It does come down to that
[1:27:04] balance is access and security.
I think everyone here wants that balance. But the fines,
the perfect sweet spot in a
[1:27:10] different way. And you're
right. We always have to be careful about making something
maybe too accessible or making
[1:27:15] something subject to too many
security features. And we're always looking for that sweet
spot. And again, there is many,
[1:27:22] you know, sweet spot says there
are people know 2 people were plotted on this in the same

place. But I think you're right. And that's what all of
us I think have in the back of
[1:27:29] our mind. What is that sweet
spot? They will vary widely in this room and in the general
public. There's no question.
[1:27:35] But I think we're on the same
page about those 2 things. I to use your analogy borrowing
from Representative Hudson's
[1:27:42] analogy. I would say in this
particular case they didn't really arguably an even really
get to the house.
[1:27:51] I think this is an example of
the counties in the first instance flagging and catching
something with our assist later
[1:27:57] working with the FBI and this
actually had a happy ending. I think so. That's what I say.
Generally about the balance
[1:28:03] Bono Marlin off. You have
anything to add to that. >> I Martin, Mr to create.
Thank you, Madam Chair. I think
[1:28:08] that's exactly right. And I
think some of the advancements that have been made including
membership in Eric, including
[1:28:15] online voter registration, all
of these things help to get that verification step done on
the front end and then make

[1:28:23] sure that we're constantly
updating and maintaining our roles. And I think Minnesota is
out in front on this and does a
[1:28:30] really robust job of ensuring
that our voter rolls are up to date and remain up to date
throughout the calendar year in
[1:28:37] the election cycle. >> Final comment. They can
reach us. Thank you. Lee can say thank you, Madam Chair and
and so and so thank you so
[1:28:45] much. And so when I think about
the statistic of their having been so few incidents in all
these years, I don't view that
[1:28:51] is saying, oh, we leave the
House act and all the windows and doors open. But more just
to say that the system that we
[1:28:56] have, in fact is doing a very
good job that this is this is a success in this in this
instance and that there are so
[1:29:06] few that we can say, hey, this
isn't doing a very good job of preventing people from doing
the wrong thing while as we try
[1:29:13] to balance out as well, being
sure that this fundamental right can be exercise. So we
don't let up at all. But I
[1:29:18] think we can feel good about
the system we have. And to my mind, that's what the the 2

votes and you know, since 1979

[1:29:25] statistic, which reprimand or

there's a requirement, that's that elections officials have

to have to flag if there's

[1:29:33] something concerning county

attorneys have to go after that cetera and people do end up

going to prison. So it's

[1:29:38] working very well. Thank you,

Madam Chair. >> And to do have a comment

because of a couple more

[1:29:44] questions. Okay. I did. Thank

you. Section 7. I just want the flag since you flag it.

[1:29:49] Representative Joe, a lot of

people in the public don't know. We have a statute quite

strict that I support on the

[1:29:55] books that requires that if a

citizen, any citizen makes a,

[1:30:01] you know, flags a particular

allegation of voter misconduct and does so by affidavit.

So it can't just be a phone

[1:30:07] call or an anonymous note.

If by affidavit you say I saw something, I heard something.

[1:30:13] I detected something. >> That >> law enforcement must

investigate it. There is 0

[1:30:19] discretion. That is an extraordinary

statute. I talked about that recently with some people who

had concerns and think they saw

[1:30:25] something or witness something

with respect to one of the municipal elections going on.

I just had these conversations.

[1:30:30] I don't think a lot of people

know about that. So I was take the opportunity. If you see

something and you can swear to it that

you saw something in an

[1:30:37] affidavit, it must be

investigated. That's a standard. We don't even have

for violent crimes

[1:30:42] and I support them. I'm glad we

have that in law. If it selections related and you make that claim by

affidavit, it must be

[1:30:50] investigated by law

enforcement. No ifs ands or buts. No exceptions. >> Thank you, Mr. Secretaries,

I just want to go back to a

[1:30:57] couple things. First of all, >> we determined that there was

between 50600 of these fake

[1:31:05] registrations and that some of

them were never entered as records. But somewhere in the

system is Terrance writes,

[1:31:12] How many were in the system is

challenged and are they still in the system has challenged,

[1:31:18] Mr. The now. >> Madam Chair, we can confirm

that all of the records that were confirmed to have been

fraudulently submitted had been

[1:31:25] inactivated in the system, so

to not appear. >> So they're listed as an

activated. So if someone showed

[1:31:31] up, they could go through the

process of an inactive where they have to show proof of ID

and still vote.

[1:31:39] How many of those are

inactivated in the system right now? Madam Chair, just to make

the distinction between an inactive.

[1:31:46] >> Voter record would not

appear on the voter rolls at all. It is an incomplete

registration. That would be one

[1:31:51] that has been challenging be

required to show ID at the polling place before they were

able to cast a ballot. I do not

[1:31:57] have the numbers before me of

those that might be in that that status at this time.

[1:32:03] >> Great. I would love to know

that if you could follow up with the secondly, as to Pinto

alluded to, we are paying

[1:32:09] people to register voters.

And clearly that was a huge

[1:32:14] incentive for more than 500

fake voter registrations to support

[1:32:20] paying for voter registration, Mr. Secretary.

[1:32:26] >> Thank you, Madam Chair.
I'm glad you flag that because we have a law that you passed a
couple years ago and thank you
[1:32:31] for that. That makes it illegal
to pay by the registration. You can pay someone for their
labor just like any job by the
[1:32:37] hour. But you cannot pay anyone
her voter registration. Now, we don't know yet because the
FBI may have an ongoing
[1:32:45] investigation, whether their
investigation investigating the pay or so far to pay yeas have
gotten in trouble and they pled
[1:32:52] to felony counts and will be
sentenced as you heard but has to the pay or we don't
know the status of the FBI
[1:32:58] investigation. That is illegal.
You clarify that. I think 2
[1:33:03] years ago and we appreciate
that. And I support that. And in fact, I think we either
testified or submitted a letter
[1:33:09] in favor of that. So it is
illegal. I want to make clear to pay by the voter
registration in Minnesota.
[1:33:15] >> Which I appreciate. And we
are still trying to understand if these people as news reports
flag, they admitted in some

[1:33:23] instances that they were paid
by the voter registration. So that brings me to that to
the point of this foundation.
[1:33:30] Clearly they hired people as
independent contractors.
[1:33:35] 2 of them were found guilty. This group arrived at a deep
dive on their 9 90's. 99 1% of
[1:33:43] their budget comes from state
grants. So this is a group that the
state,
[1:33:50] its funding and that then went out and did
these voter registrations.
[1:33:56] >> And has has. >> You know, they participated
at the foundation, didn't
[1:34:03] participate and fraud that they
hired people with state dollars
[1:34:08] who then use that to creeks
fake voter registrations. Does it concern you that 99%
[1:34:18] groups focus is from state dollars and
what should we do
[1:34:24] to provide oversight of
nonprofits that engage in voter
[1:34:31] registration activities if the
bulk of their budget is from the state?
[1:34:36] >> Madam Chair does concern me
and I assume that you or some other body will look into that.

I just want to clarify for the
[1:34:42] record, not from us. We don't
give any grants. We don't get one penny to any for-profit
non-profit. The only grants we
[1:34:48] ever give grants that you tell
us to give to local governments for things like elections,
equipment or accessibility
[1:34:54] grants. But that's it. So just
to clarify for the record, not from us. I don't know where
they got their money from, but sure I think that's worthy
of discussion. Oversight.
[1:35:02] I leave to you. I wouldn't
presume to tell you how to exercise that oversight.
But sure, I think if ifs,
[1:35:08] if any thing that's receiving
state money is doing something that's against the law that
should be looked into whether
[1:35:14] it's 99% or one percent. >> Thank you. My next question
is related to the Eric System.
[1:35:20] So we participate with 25 other
states in the next system sharing all this voter data yet
you continue to not want to
[1:35:28] share the same data with the
federal government could to explain the difference between
sharing it with the feds and
[1:35:34] sharing it with Eric. >> Yes, I can't thank you for

the question. So as you heard, there are elaborate ways that
that information is shielded,
[1:35:43] that it can never be traced to
a person. We share it with air, according to the bylaws and the
rules of Eric blessed by this
[1:35:49] legislature. By the way, as you
heard, that is so called hashed data and I rely on experts to
describe exactly what that
[1:35:56] means, but it can never be
traced to an actual individual. By contrast with the Department
of Justice has asked for is
[1:36:01] very private data on millions
of Minnesotans Social Security numbers, driver's license
information and some cases
[1:36:08] military-related information.
And as the DOJ lawsuit, if I if I may, madam chair, you know,
this is a great example of
[1:36:14] something that belongs in
court. There's no shame or harm. Sometimes we see
headlines about party aces
[1:36:20] party be are excellent. Why?
And there's no need for any shame
or blame attached to that very
[1:36:26] reason we have courts is to
settle a legal dispute. And here we have one. The
Department of Justice has asked

[1:36:32] us and many other states for
that information. Most states including red and blue states
have said the same as us that
[1:36:40] we don't think as a matter of
law, they are legally entitled under these circumstance.
That data. If they were here,
[1:36:46] they would vigorously disagree
with that position. They'd say we were out to lunch and we
were wrong on the law. But
[1:36:51] that's exactly where we have
courts. We don't duke it out in the streets. We go to a court.
A judge will decide his legal
[1:36:57] position is right. And of
course we will abide by whatever the courts. >> Thank you. And just to be
clear, you do provide the
[1:37:03] Social Security data and the
driver's license data through this past, you know, very
secure system. But you're still
[1:37:10] providing that data and the
Eric System, correct? >> Yeah. In a in a in a way
that's untraceable to any
[1:37:15] individual. >> And so we couldn't use a
similar system to provide that to the feds. >> No became Madam chair know,
because they don't want that.
[1:37:22] They want to tied to
individuals. They want to produce in its native form

where, you know, the person's Social Security number, you know, the person's driver's
[1:37:29] license information. >> Thank you. So I just want to go on to another question about the challenge status in the L a report in 2018, she identified
[1:37:38] that there have been 20 6,000 ballots that were of the challenge status. And I went back in the half a list
[1:37:49] that's available online to anyone who wants to look at it. And in 20,
[1:37:56] 24, we had 6,000 that were 9 matches. The 6800,
[1:38:03] 1320 20 to 3,020. 21 1, 8,020. 21, I'm sorry.
[1:38:10] 23,020
[1:38:15] 16,000 in 2018. So I have the list and all of these go as 9
[1:38:21] matches, which I assume then become challenged. And so are they still in the system has challenged.
[1:38:30] And if so, I know after 4 years they going active. But otherwise, they
[1:38:36] just all these things that matched by DPS or Social Security. They just live in the system as challenge. Then
[1:38:43] anyone can still vote as long as they

provide the ID or the vouching,
[1:38:48] et cetera. That correct? >> Madam Chair, take a step
back. I think so with the data
[1:38:55] that you're sighting from the
high of matching process, I think it's important to point
out that that does not in and
[1:39:02] of itself mean that there's not
it's not a verified individual who submitting that
application. That number's
[1:39:08] actually point to that SSA
matching process being a really rigid exact matching
requirements to the hyphenated
[1:39:15] names to the data entry issues.
Those are really what kick out. A lot of those flag returns as
not match with Dayton, the SSA
[1:39:24] Data base once that date is
returned. If there's an opportunity for the county to
review that record, so will
[1:39:30] provide a unique you with a 10
day time frame to go back. Look at the voter registration
application, determine whether
[1:39:37] or not there may have been
something that was, you know, not clear on the form that was
entered incorrectly to follow
[1:39:43] up with the voters. So those
are those contacts with the voter phone call email mail to

get additional information and

[1:39:49] ultimately get the majority of

those cases to be verified through that process, whether

it's updating the voter

[1:39:55] registration with the correct

number, it's clarifying whether they may have a different name

to be able to match against the

[1:40:02] Social Security Administration

database or for the auditor to verify that. Yes, this is a

person for whom I've been able

[1:40:10] to confirm their identity.

So that impacts I think it reflects a how the process

works for a majority of those

[1:40:18] records. That comeback returned

from the SSA matching process. But that to the number of

challenge voters that are cited

[1:40:25] in the the LA report, I think

in most of those cases, those challenges would relate to the

2nd half of the matching

[1:40:33] process that you live where you

say you live and challenge for returned postal verification

cart. And there are a number of

[1:40:40] reasons for why those those

cards may be returned. And I think the legislative report

that's submitted each year

[1:40:46] helps to eliminate why some of

those cards may come back for perfectly innocuous reasons.
Weather someone may be
[1:40:53] temporarily away or they don't
have their mailbox up at the time. So those are things that
the county would then look
[1:40:59] into. If it shows that that
voter who is challenge for an address issue had been voted at
the election to determine
[1:41:06] whether or not they were, in
fact eligible to vote. >> Great. Thank you. And I I
had one more follow-up. So we
[1:41:14] talked a lot about the
citizenship issue and now that Minnesota provides drivers
licenses to anyone.
[1:41:21] How do you verify that people who are
not citizens and not sure on a
[1:41:28] visa don't get into the system.
So is there a back and communication with DPS about
who is not a citizen but also
[1:41:37] not on a visa? Alright, those just allowed
through.
[1:41:43] >> Madam Chair, I can speak to
the process through those who are applying for a driver's
license at DPS in 2023. The
[1:41:52] legislature did pass automatic
voter registration that's now in effect, which requires that

an individual applying for
[1:41:58] their driver's license must
provide citizenship, affirming documentation in order to be
sent over to our office for
[1:42:05] review and registration
purposes. So that the the timing for that has meant that
the records that are provided
[1:42:13] are only those who have
proactively provided to DPS that citizenship affirming
documentation. I think we
[1:42:20] talked through some of the
other hypothetical scenarios. If someone is registering to
vote on Election Day and is
[1:42:25] filling out a paper voter
registration and testing that they're eligible to vote,
whether they have a driver's
[1:42:31] license or not, if they're not,
in fact eligible, those are cases where it's then incumbent
on the review process to
[1:42:39] identify if that person may not
be eligible to vote. I know one example from a county that we
were just in touch with cited
[1:42:47] media reports the referencing
someone who had been who was
[1:42:53] not an American citizen and
flagged for them to look into that voter record that had just

come through their office from

[1:42:59] the time the media report to

the time that they got that application, that naturalized

in becoming U.S. citizens.

[1:43:05] So there are triggers for that.

That might cause the county to take a look and review and

investigate whether there may

[1:43:11] be I'm issue of someone's

eligibility, Weatherby citizenship or for any other

reason why they may not be

[1:43:17] eligible to vote. >> So you're saying just to be

clear that if they get a

[1:43:23] driver's license and to not

prot provide proof of citizenship,

[1:43:29] it doesn't actually go to your

office. >> Madam Chair? That's correct.

Yet since automatic voter

[1:43:35] registration was established in

2023 and then certified and

[1:43:40] started last year, the only

records that come through for voter registration purposes are

those who have provided

[1:43:46] citizenship, affirming

documentation such as a passport or us birth

certificate to the driver and

[1:43:51] vehicle services at the time of

that transactions. >> And if they have citizenship
affirming documentation,
[1:43:58] passport, a dry, a birth
certificate you said is is there a way they can from
citizenship just based on
[1:44:05] Attestation? I'm sorry. I'm so so good.
Someone provide like base.
[1:44:12] They submit these documents. They say, you know, here's my
birth certificate. I was born
[1:44:17] in, you know, Saint Paul, blah,
blah, blah. Are those verify before the
system kicks them to you?
[1:44:25] >> Madam Chair? Yes, that is
how the process is designed to section 2 step verification
process both at the time,
[1:44:30] a transaction and then a
secondary review by Department of Public Safety staff to
affirm that this document that
[1:44:37] was provided is in fact
citizenship affirming dot. And so it is therefore a visual
review. It's not an attestation
[1:44:43] that takes place as part of
that driver's license or ID application.
[1:44:48] >> Great. Thank you very much.
And Mr. Secretary was about to enter up to 2 to up that she
wanted to share.

[1:44:56] >> I think you covered. >> Okay. Great. And then just
do one last thing for me.
[1:45:02] So you talked about how when we
register to vote, you have to prove who you are and prove
where you live. I think those
[1:45:08] are very good, common sense. But you do not have to prove
citizenship. That part is
[1:45:14] Attestation. Would you support having proof of citizenship
[1:45:20] as part of the way we verify
eligibility in Minnesota versus
[1:45:25] just attestation? >> Well, answer that. Thank
you, Madam Chair. In a couple
[1:45:31] ways this has been proposed by
the president proposed by Congress and it's called the
Save Act and Congress which
[1:45:38] would provide provide
documentary proof us is if you have to attest to it right now,
but documentary proof of citizenship
[1:45:44] and going back to the earlier
analogy that we all want the perfect intersection of access
and security from where I sit.
[1:45:51] There are real problems with
that requirement. For example, we have 69 million American
women
[1:45:56] who have a different last name
now than when they were born. So in order to show documents,

documentary proof of

[1:46:01] citizenship, a woman with a

last name. Now that's different from birth would have to if

they didn't have a U.S.

[1:46:07] passport. And that includes

north of 20 million American women, they would have to show

2 documents, birth certificate

[1:46:13] and a marriage record. And

that's only if they've been married, wants its twice.

You'd have to follow the chain and have to marriage records.

Just want everyone understand

[1:46:21] what that means. Practically

speaking, you can't just take someone's word for it

[1:46:26] if we're going away from

attestation and someone says, well, this is my back my birth

certificate. My name is Jones

[1:46:31] now. But it was Smith. If at a

station is no good proof of citizenship to ought

not to be good for that purpose

[1:46:38] either. So I just want to and

urged everyone to understand what the burdens are imposing that kind of system.

Now, there is one state in

[1:46:45] particular that's worth noting,

Kansas is about 15 years ago to the state level, say that where

they require proof of

[1:46:51] citizenship for registration to

vote and before it was struck down

by a federal court,

[1:46:58] 30,000 eligible Kansas voters

eligible as eligible as you are? I am were turned away

because they couldn't produce

[1:47:05] the proper proof. I don't think

we want to be that in Minnesota. So that's why I

oppose that. >> Thank you, Mr. Secretary and

I agree we want to very

[1:47:13] carefully balance access and safeguards. And I think that in

General Minnesota has and does

[1:47:21] do a good job on that. But I think it's concerning to

a lot of citizens

[1:47:27] that people who are not

eligible to vote may in fact, take advantage of that. And as

a married woman, I had you have

[1:47:36] to do the same thing when you

get a driver's license and you get your new name, it's it's

just part of the process. I don't I I've always I've

always thought that was

[1:47:44] interesting as a as an argument for that being a burden.

I think most people who are

[1:47:51] married and change their names

of either sex because the people change their name either

direction and have not found

[1:47:58] that Byrd and some in terms of

getting a driver's license. So I think I'm not sure that

that's

[1:48:05] as relevant. So we appreciate

your time. I have so many more questions, but I'm gonna go to

Representative Green Men

[1:48:13] quickly. >> Thank you, Madam Chair, and

I appreciate this conversation. Just to follow up one, just

housekeeping question. Can you

[1:48:20] provide those 90's? They were

referring to and absolutely thank you. And can you all

share and

[1:48:29] Secretary Simon, what with as

we talk about the federal

[1:48:34] request for that data, did they

share how they're planning on combining it with other data?

That has been a huge concern

[1:48:41] that I've heard from my

constituents as we have heard about Doe's and security data

and a host of other data.

[1:48:48] Do we have information about if

they get the set of what they plan on doing with it?

[1:48:54] >> Secretary Simon, thank you.

Madam Chair, with this gets to our fundamental legal position

in the lawsuit and this starts

[1:49:00] and ends with the law from our

standpoint. So our read of the law, federal and state law is that

in order for us to be authorize

[1:49:08] legally to share this, not just

with the Department of Justice, but with any federal agency,

they have to do at least 2

[1:49:14] things. One they have to show

with particular already why they need the data not

generally, but specifically why

[1:49:21] this particular data. And

number 2, they have to show what they're going to do with

the data. Those are 2 very

[1:49:27] different things they can share

sell it transmitted. How are they going to store it?

That sort of thing and our

[1:49:33] legal position is that they've

been either of those things. And I will point out that our

legal position shared by multiple secretaries of state,

not just the 8 states,

[1:49:40] including Minnesota that have

ensued so far, but by secretaries of state. I

shouldn't name them who of both

[1:49:47] political parties who have not

been set yet. I suspect it will be because they're taking the

same legal position we have.

[1:49:52] So no, the short answer is we don't believe they've met

either of those requirements, including the requirement of

who they're going to give it

[1:49:59] to. There was some independent
reporting about 3 weeks ago, maybe 4 weeks ago now that the
Department of Homeland Security
[1:50:05] wants to get its hands on this
data that the Department of Justice is seeking from the
states for certain alleged
[1:50:12] purposes. We'll see. You know,
we'll hash all this out in court. But again, this is a
perfect dispute that belongs in
[1:50:17] court because we just have a
fundamental different fundamentally different read of
the applicable laws.
[1:50:24] >> Representing think you just
a quick statement. I really appreciate that. The privacy of
voter data, we know that in
[1:50:31] these in your records and in
that the a voter records are people so security numbers and
very private things we have
[1:50:39] heard as it relates to IRS data
as it relates to voting data as it relates to a lot of the
data, there's very there's of
[1:50:46] federal privacy law and there's
a lot of reasons why those laws have not been compiled into a
mess database over the set of
[1:50:53] 50 years. The federal
government having that has been a concern not just on the left

but on the right to so really

[1:50:59] appreciate you standing up for

the privacy and the protections of Minnesota voters. I know

that there's lots of other

[1:51:05] Secretary States are too, but

for Minnesota for the 3 million Minnesota voters. Thank you for

doing that.

[1:51:12] >> Yes, a leap into that.

They matter just request earlier in the hearing you

referenced an organization and

[1:51:17] a 9.90 in certain percentages.

What if you could get a copy to committee members after of what

you are referencing was a

[1:51:23] little confusing. The

appreciate that. Thank you. Have to do that and thank you.

[1:51:31] >> Members, I'm sorry. I just

want to put that in the LA report. The 2018 does that well

recommended that that counties

[1:51:42] use that reports in the STRs and

[1:51:48] I'd like to understand the

status of that. Are you now kicking out those reports and

having requiring it was

[1:51:54] recommended the county's use

them? Is it not require that the county's use them?

[1:52:00] >> Madam chair, in response to

that finding from the oil, a report in 2018 that there are

some recommendations to make

[1:52:06] some updates to certain reports

to make them think more accessible, make the data more

usable in those reports.

[1:52:13] Those changes were made in

short order after the report was issued and then as a

process for guidance that we

[1:52:21] provide to counties both on the

eve of elections as part of the roster generation steps.

And then in the post election

[1:52:27] period when they begin to enter

voter registrations and are voting history, that finding is

cited in our guidance to

[1:52:34] counties every election cycle

to affirm that this is a report that you need to run to follow

up on the data that might show

[1:52:43] someone status is updated,

devoting it to review any discrepancies that might be

found in that rut report does

[1:52:49] provide all of the information

that was recommended by the LA to have that at the county's

disposal to review those

[1:52:57] records. >> So she did say not all

county officials use the STRs report designed to identify

voting by an eligible persons.

[1:53:05] We recommend they use the

report, but clearly it's still not a requirement that they use
the report. Is that what you
[1:53:12] say? >> Madam chair, as far as what
the law may require for them to run, I think it's more broadly
under their role and
[1:53:19] responsibility to investigate
potential issues or voter
[1:53:24] anomalies. And so I think it
would fall under that our guidance. It's not a legal
requirement to say this is a
[1:53:30] specific report. You must run
each election, but it's reflected in our detailed
guidance to counties about the
[1:53:35] steps they need to follow as
part of their post election data, entry and review.
[1:53:42] >> And the last question the
state law requires that county attorney investigate and
prosecute that voter
[1:53:51] registration fraud. 13 counties by testimony today
[1:53:56] were notified of voter
registration fraud yet none prosecuted. Can you
explain to me why the county
[1:54:04] prosecutors as required under statute
didn't take these cases and white went to the fence?
[1:54:12] >> Madam Chair, I'll take a
stab at that one. Not knowing the individual decision making

tree in 13 counties. I do know
[1:54:19] that it's somewhat common for
counties to deferred federal law enforcement. When the feds
get involved. We have a
[1:54:25] prosecutor now. I'm nodding his
head with representative in tow, but but that's not uncommon.
And I think that would be in
[1:54:32] keeping with the Minnesota law.
I would suspect that maybe someone from the county
attorneys association can
[1:54:37] better answer that question.
I know I've seen it quite often. Not just any elections here,
but in other spheres as well.
[1:54:44] Did they declined to prosecute Madam Chair? I have no idea
idea what the county attorneys
[1:54:50] for our thinking or what their
decision process was. But it's not uncommon for them to have
some sort of agreement with the
[1:54:55] federal government that the feds will basically take
the lead in a particular case.
[1:55:01] >> Thank you. I'm going to
defer to my colleague temp into yet Madam Chair. And I do work
as an assistant county
[1:55:07] attorney, a prosecutor. I'm
looking at Minnesota's statue to a 1.2, 7, 5, which is the
one that that is that reference

[1:55:13] here that requires, as the
secretary said, that the investigation occur and that
requires prosecution. It does
[1:55:18] say, quote, he says if there is
probable cause for an student instituting a prosecution, the
county attorney shall proceed,
[1:55:24] according to the generally
applicable standards regarding the prosecutor functions duties
of a county attorney, which
[1:55:30] certainly would include not
pursuing a a prosecution if, in fact, it's going to be a
federal prosecution, somebody
[1:55:38] very often we get a longer
prison sentences, cetera. So I do not read this statute
is saying that the county
[1:55:43] attorney must I must bring
forth what would end up being a wasteful and in fact, possibly
interfere with the federal
[1:55:51] prosecutions. I I suspect
that's the answer. But again, the County Tree Association sic
reason could provide an official comment on it next.
[1:56:00] >> Members, thank you very much
for a robust hearing on all these matters. We appreciate
the work of the secretary and
[1:56:06] your team for making elections
accessible and safe. And we

[1:56:12] want to all continue 2. Also

thank our federal partners for

[1:56:17] their prosecution of these

cases. 500 fake voter registration applications in

Minnesota was discouraging to

[1:56:25] say the least. But we're we're

grateful that that has been prosecuted. Thank you. We are

adjourned. Thank you.

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 11-19-2025

[0:11] >> We will be hearing from the
Department of Employment and Economic Development also known
as D We will be discussing the
[0:17] internal controls policies and
procedures that are in place to prevent and root out any
possible fraudulent behavior in
[0:25] the paid family and medical
Leave Act. That will be taking effect on 1/1/2026.
[0:31] first before we get started, we
will move the minutes. Vice Chair Anderson, would you like
to move in minutes from
[0:36] September 17th? So actually
from October 14th,
[0:43] Strangest question on the
October 14th Minutes,
[0:48] seeing none. All those in favor
say Aye motion carries minutes are
approved
[0:56] first. Just so everyone
understands that order. We will start with Deputy commissioner
role from deed and deputy
[1:05] commissioner for a minute.
And I-10 and then we'll have some public
testimony and then we'll go to

[1:12] member discussion. So Mr. Rowe that you like to join
us. And and your colleague from
[1:20] Minot is welcome to join us as
well.
[1:29] Good morning. Thank you for
coming to the committee. Please state your name for the
record and just begin your
[1:34] testimony. >> Well, thank you, Madam
Chair. My name is Evan wrote, I am Deputy Commissioner for
for Services and transformation
[1:40] at the Department of Employment
and Economic Development Night. Programmatic Responsibility for
Minnesota's paid leave program.
[1:47] Really happy to be here with
you all today and try have Deputy commissioner. I can
state his name for the record at this point to Madam Chair.
[1:55] So the great thank you. Good
morning. >> Good morning. Thank you,
Madam Chair. For the Record, My Name is John Act and I'm the
deputy commissioner for
[2:01] Minnesota. It Services. Thank
you. >> So we are we are have a walk
through today on paid leave in
[2:08] program integrity. Our agenda
here is brief. It's going to just provide some brief
background on the paid leave

[2:15] program to route the discussion
and then we'll have a complete so some discussion program,
integrity and look forward to
[2:21] the discussion. So just to route the committee
in background on the paid leave law paid leave, law was enacted
in 2023 and the program
[2:29] officially begins 1/1/2026.
The law provides job protections and payments from
the state to individuals who
[2:36] need time off to care for
themselves or loved ones. Premiums are made up of
contributions for both
[2:41] employees and employers from
the program and paid leave Wilson benefit payments
directly to Minnesotans on
[2:47] leave. Just a little bit right
matters, right? Minnesota's going to be the 13th state to
implement paid leave. Only 7
[2:53] countries worldwide don't have
some sort of national paid leave program. And 73% of
American workers lack access to
[3:00] paid family leave through their
employers. States that have implemented
paid leave programs have seen stronger employee retention,
better health and development
[3:07] outcomes for children, higher

labor market attachment for women, gender and labor force participation generally and
[3:13] greater economic security for families. You know, in terms of what is covered under the law, you can
[3:20] teach any individual act and the individual component of leave it is they want from one to 12 weeks. There's of the
[3:28] program split. The 2 major buckets medical leave is exactly what it sounds like. It's time to care for oneself in the event of a seared ups. Sorry
[3:35] in the event of a serious health care diagnosis or condition. These are conditions that last at least 7 days.
[3:41] And then as far as family leave goes, there's a few different types of leaders. Parental bonding leave. There's military
[3:47] family leave. There's caring leave to care for a family member with a serious health condition and their safety leaf
[3:52] lease because of domestic abuse, sexual assault or stalking of an individual or individuals, family member,
[3:59] any one type of leave is eligible up to 12 weeks. There is a maximum of 20 weeks

combined in one year someone

[4:05] combines for both types of

leave. I think the most common scenario in that case would be

a complicated pregnancy where

[4:13] the where for berthing parent

would have you might have health conditions and

complications during the

[4:19] pregnancy and then have time to

care for parental leave. And again, I'll just no

qualifying conditions must last

[4:25] more than 7 days. And that must

be certified by health care provider or the other specified

provider under the law.

[4:32] I do just want to touch briefly

on public engagement because this is a program that then

that's going to touch pretty

[4:38] much every Minnesotan. And

we've really tried to prioritize connection and

engagement around the state.

[4:45] You know, we've made over

33,000 individual connections and head over to, you know,

well, over 300 engagement

[4:50] activities. Since since we have

since late 2023 got a bunch of

[4:56] numbers and stats and down

below thought would be helpful for members of the committee.

But I would just emphasize that
[5:01] we really have tried to build
this program with Minnesotans and really have value the
feedback that we have gotten
[5:08] that every stage of the process
from employers from future applicants. And you're from
health care providers and
[5:13] across the state. This is going to find a little
bit just to our overall approach. You know, our
strategy for success in the
[5:21] paid leave for the paid leave
program is to watch incrementally right? Not have
one big thing, go live and all
[5:27] all at once. But 2 to watch
individual pieces of the program as you go to test them
and make sure that they're
[5:34] ready for prime time we launched it was an example.
We watched combined wage detail
[5:39] reporting with unemployment
insurance all the way back in October of 2024. And this is
something that saves employers
[5:44] a lot of time in terms of not
having too submit repetitive duplicative wage detail
records.
[5:51] We have already, as you might
be aware, opened bonding. We've claim submissions with 2

of the state's largest

[5:56] employers 2 and we are already

accepting and processing those claims ahead of the January.

1st implementation date,

[6:05] we aim to open bonding with

claims submissions to all Minnesotans in the next few

weeks. Again, hope ahead of the

[6:10] January. 1st time line. That's

to again, make sure that we're the that Minnesotans are able

to get applications and that

[6:18] employers are plenty of time to

be ready for the wall. It will get into the sun a

little bit. But we are

[6:24] leveraging Minnesota. It

services that are already in operation like logging a man to

support security and program

[6:31] integrity. We've applied service design

best practices to get early insights from real people and

refine the product constantly.

[6:38] We continuously gathered

feedback to improve the system every single day. So you have

this approach. We think it ties

[6:45] into best practices for service

delivery management and high program integrity and that we

can get into some of the

[6:50] details around program

integrity. You know, there's no what I'm
sure members of this committee
[6:57] are aware. There is no one
silver bullet for program integrity. You've got to have a
combination of people process
[7:02] and technology. You know, the
slides that follow are going to outline some of the key
program, integrity components
[7:08] across all 3 fronts. Now, we're
in this hearing in a public hearing. We're not going to go
into all of the, you know,
[7:14] every single piece of secret
sauce because it is a public hearing, obviously happy to
answer follow-up questions as
[7:20] members may have them. But I
hope that this overview will give members a really good
understanding of our overall approach and Howard and how
we're doing it.
[7:28] So people process technology is
one ones you can take the other the other way to think about it
is that the variant that the
[7:35] various elements in it in any
specific paid leave applications. So you have the
applicant, right? How do how
[7:41] are we ensuring program
integrity at a high level? You have ID verification

through talking to men or administrative data. You've got
a modern application to address
[7:49] those eligibility criteria and
you've got and we have a detailed program, integrity
flag on a work process to catch
[7:56] issues and address those before
payments go out on the employer side. You also
have ID verification through
[8:03] their joint U I unpaid leave
the count and you have a dedicated employee or role for
review every application under
[8:09] the paid leave for all I do verification for health
care providers comes through licensure information on this
and the certification that is
[8:17] required on every application and administer administrative
data is a critical port
[8:22] component of all of this as
well. You have integrations across multiple state agencies.
We have very detailed linkages
[8:28] with the unemployment insurance
system and automated financial world, what ability and benefit
calculation processes. And
[8:35] we'll get into that a bit more
detail as we go along off all next handed over to a
deputy commissioner item to
[8:42] talk a little bit more about

walking and then which which is a I think a really key and
exciting component of the paid
[8:48] leave application process. Deputy Commissioner. >> Thank you, Madam chair and
members again for the record,
[8:55] my name is John Act and the
deputy commissioner for Minnesota. It services happy to
be here today to talk about
[9:02] some of the foundational
elements that make up the overall fraud mitigation
strategy for the paid leave
[9:07] program in particular. I'm here
to talk about I knew service. We as minute are rolling out
thanks to funding provided in
[9:14] the 2023 legislative session.
This service relates to how we manage identities and how we
manage access to state systems.
[9:23] When we're engaging with
residents, service delivery partners, County workers were,
of course, those interactions
[9:29] are in increasingly taking
place online. Quote, that's often cited in
the cybersecurity world is that
[9:34] you can have security without
privacy. You can't have privacy without security. The same
could be said of the
[9:41] relationship between fraud,

prevention and cybersecurity. That is we can work to ensure
state technology systems are
[9:47] protected from breaches.
We can harden them. We can prevent unauthorized access.
That alone will not insure that
[9:53] fraudsters are not able to
manipulate our programs. However, if we want to ensure
overall program integrity,
[10:00] that was that is impossible.
If we cannot ensure that the people who are provided access
to state systems, whether their
[10:06] residents and county workers
service providers are in fact, who they say they are and are
only able to access to
[10:13] information and system
capabilities that they need credit score. That's the
function of locking them in
[10:21] in terms of our tangible goals
were looking to provide additional front door to all
public-facing digital services
[10:27] that are offered by state
agencies in particular. Those that require credentials, which
is a username password to
[10:34] log-in in order interact
program online in doing so we can simplify the
user experience. I we can

[10:40] eliminate the need for separate
log-in credentials for different programs, be that
health care programs,
[10:46] unemployment insurance paid
leave and we can implement additional
security and identity an
[10:51] identity proofing capabilities
while spreading the cost of those capabilities across
several programs and state
[10:57] agencies. This includes multi-factor
authentication which I'm sure you're all use to. If you have
a bank account you interact
[11:04] with online. I where users can
select the method. They prefer be that text message, phone
call pass key as well as 3
[11:12] levels of identity proofing to
help ensure that fraudsters are not able to pass through the
state's digital front door
[11:18] using false identities. These identity proofing levels
provide state programs, the
[11:23] ability to set identity
proofing requirements at the appropriate level, given the
risk of fraud in the
[11:29] sensitivity of data available
to particular user rules. Because while we may choose to
require that someone provide

[11:36] identity proofing documentation
like a driver's license or a live photo of themselves for a
service such as paid leave.
[11:43] We may not need to treat a
similar barriers for those looking to purchase saplings
from the DNR nurseries.
[11:53] Of course, this service was
built with an eye toward regulatory compliance. Be that
HIPPA CMS requirements pup tent
[11:59] empty 5 as well as with an eye toward
usability accessibility in customer experience,
recognizing that we will
[12:06] continue to evolve. The service
agency needs and customer needs of all.
[12:12] It was noted on the previous
slide. But we also see an added benefit here in providing
insurance to residents that
[12:17] there, in fact, operating with
a state program and not a scam website that's looking to steal
their money or their personal
[12:23] information. Lastly, I did want to highlight
from a security standpoint,
[12:29] the comprehensive approach
being taken to testing the paid leave application itself from
Day one we had minute, indeed,
[12:37] have been stressing the need

for high standards of quality, not only in terms of hardening
the system from infiltrators,
[12:43] bad actors, but also ensuring
the system's highly usable functional for Minnesota
residents and businesses
[12:49] interacting with system. This means testing each of the
components individually building an automated checks
and cleansing processes into
[12:56] our code development processes
throwing large volumes of traffic at the system to
simulate high volume events,
[13:03] engaging and users to
collaboratively, identify and resolve systemd facts testing
to ensure Minnesotans visual
[13:11] for other disabilities can
interact with the system as well as independents.
Penetration testing to ensure
[13:17] the system is hardened against
a potential targeted and persistent external cyber
attack.
[13:23] Our vendor partner in this
effort, Nava has clearly demonstrated that they share
these commitments. They've been working with us every step of
the way to ensure the system is
[13:31] fully tested and ready for
launch. I want to commend the leadership for heeding the

recommendations of the

[13:36] technology Advisory Council in

their approach to implementing paid leave technology. This

commitment has been

[13:42] demonstrated in many ways

developing policy with implementation in mind from the

get-go involving users in

[13:49] development and testing of the

system and recognizing that this new service is really a

digital product that must be

[13:55] designed and fall with not just

the needs of government in mind, but the needs of the

customers and users at the

[14:02] center 11 HR team member at 03:00AM or

a first time mom. I'm trying to

[14:07] plan their next 6.12, months

with that. Madam Chair, I'm happy to enter answer your

questions. You are the

[14:14] committee may have thank you

for the opportunities.

[14:19] Thank you again. Back for the

remainder of the season. Yes, Mister Rove. >> Women to continue. Thank

you. Thank you very much,

[14:26] Madam Chair. So now we'll the

aunt of thanks to the contracting for going and just

some of the items, some of the

[14:32] it components of the log on and
then component. We'll talk a little bit more generally about
application controls going
[14:37] forward here. And, you know, I
think it's good to start with the application process just to
think about how this whole
[14:43] thing flows. I want to emphasize that the
employee, the employer and Payton, the paid leave division
all payroll in the application
[14:50] process. Very high level.
It's 5 steps. First employee notifies their
employer about their intention
[14:57] to take leave. Then the
employee starts an application for paid leave them. They
submitted the paid leave.
[15:03] Administrator is asked to
review the application. The paid leave division adjudicate
the application with the
[15:09] feedback from the employer is
part of it. And finally, the employee and the people who
have been a straighter are notified of a determination.
[15:16] What are these, what are what?
But what are these controls? How did they actually out of
the actually come together? Right? So below the norm, but I
kind of initially noted 8
[15:25] people, process technology ones

you can take. People are critical. Can part of this. The claims review teams in the paid leave program are fully
[15:32] staff. And as I mentioned earlier, already reviewing applications from a couple early launch partners. Those
[15:38] teams are supported by robust internal processes and integrity tools, including data analytics to spot trends and
[15:44] ensure high program integrity. And we have a really robust training and information sharing program to ensure that
[15:51] that those application reviews are happening with high integrity that supported by business logic, right? Business logic
[15:58] and application design, support, accuracy and integrity and good application design makes it really makes it easy
[16:05] for applicants to do the right thing. Makes it harder for fraudsters to do the wrong thing. So what are some of these process controls look like? Right? And you've got an
[16:13] internal controls, planet risk management policies to provide structure for those teams to do their work. You've got annual
[16:19] risk assessments for business activities to ensure an updated posture and ensure that they

are responding to emerging

[16:26] threats. It is a constantly

evolving trout landscape and we stay and we work very hard to

stay on top of that.

[16:33] We have risk committees and

infirm. It information-sharing to address incipient issues

that may come about hawk.

[16:39] We have a variety of business

processes and controls built into the application. If you

use the paid leave application,

[16:44] you will see that it is a very

structured information gathering process in many ways

similar to the unemployment insurance application and that

is by design. That is meant to

[16:53] ensure that we are getting data

is structured manner. That is that it allows for analytics

and careful analysis of any

[17:00] application. I'll note that there are random

audits theirs and there are administrative and criminal

penalties for malfeasance,

[17:07] both in the statute and every

didn't rule making. We have collaboration with a

variety of interagency

[17:15] partners, the Bureau of

Criminal Apprehension, the state's information security

office walking. And then as the

[17:20] commissioner mentioned, the
Office of Legislative Auditor and other appropriate parties
as necessary to ensure that the
[17:27] law is upheld. We take that
very seriously. I want to talk a little bit
about the employer role as far
[17:34] as the application goes.
This is actually a very this is an important part of employers
are able to review leave
[17:40] application submitted by their
employees. They can confirm the information submitted by
employees is correct. The
[17:46] contract, the status of
applications. They can view past determinations made by the
division and they're going to
[17:51] be able to access benefit
information for tax purposes in this little animation that you
have played on the screen right
[17:56] now. You really just kind of
shows what that experience is going to work like an already
does look like for employers.
[18:03] This is a this is a very useful
component of the application for us because it allows an
employer to raise their hand
[18:09] and say something doesn't work.
Right. And we're going to end the department will review that

information and take appropriate action is needed to
ensure that that that remains
[18:17] with high integrity. And that kind of goes into the
overall reporting point the
[18:22] reporting control as far as the
application goes, right, you have confirmation of faxes
represented. You have multiple
[18:27] points of validation. You have a pickleball records
which allows for a deal for another kind of another.
Yet another control that layers
[18:35] and to the overall process.
And we have a fraud reporting portal online today as well as
anybody can color code because
[18:43] our customer contact center or
send us an e-mail. 2 is to provide tips and feedback that
that may be necessary.
[18:53] One other control. That's that,
you know, that the paid leave program has his provider
certification. So all claims
[18:59] are required to be certified by
the health care provider or the appropriate professional. We will review and validate
provider information and we
[19:07] will conduct analysys on those
data, you know, to to support program Integrity.
[19:13] One other really exciting thing
that I wanted to just a preview for this committee is at an

early 2026. We're going to be
[19:19] watching integrations with
electronic health record system such as epic and as well as
access to ICD 10 codes for
[19:26] providers to help with tuition
estimation. This is groundbreaking Minnesota's
going to be the first state in
[19:32] the country to integrate
directly with Ye charts. And there's a host of process
and integrity benefits that
[19:38] we're really looking forward to
and hope and hope to be a kind of pioneer, a new level of
program integrity with us.
[19:47] Another item that I mention
that I knew that it previously referenced is what that we're
leveraging, our unemployment
[19:53] insurance, an agency data.
I was in front of this committee back in April where
we talked a little bit about
[19:59] some of the unemployment
insurance controls and approaches. You know, again,
Minnesota is a top performing
[20:04] state when it comes to
unemployment insurance program, integrity. You know, I think
this is something that, you
[20:10] know, that we've has been

reviewed by multiple parties, including the Office of Legislative Auditor.

[20:15] And what we're really trying to do is leverage DUI programs, expertise and data to validate requests and enhance paid leave

[20:22] program integrity. You know, like I mentioned earlier, integrating the wage detail records with unemployment

[20:29] insurance. Both pretty it is. It's it's helpful of multiple fronts. It makes it easier for employers to to fulfill their

[20:36] reporting requests. It also provides a very rich administrative data set that the paid leave team can use to

[20:44] ensure or to ensure that wage detail records are accurate, that employer records are accurate and that we are able

[20:51] to ensure that people are indeed who they say they are. And it's not just unemployment insurance. We're in. We have a

[20:56] variety of integrations with other agencies such as the Department of Public Safety to provide additional support.

[21:03] So in summary paid leave has multiple layers of controls in place to ensure high program integrity, these controls and

[21:10] compass people, process and
technology and leverage tools and data from you. I and across
the state.
[21:16] I also want to emphasize that
our work is never done. You know, we're going to continue
to develop and deliver solutions that further
strengthen the program. I
[21:23] think, you know, the one of
them, the most important part of the people all meant of
people process and technology
[21:29] is the brain's right. We'd like
humans that are thinking about how we can ensure really strong
program integrity and real and
[21:37] continuously seek to improve
our efforts in that regard. Because this is really
important. This all works
[21:43] together to ensure that
Minnesotans are going to be able to count on the paid leave
program in those moments that matter and that we're running
this program with high
[21:50] integrity. So Madam Chair, happy to stop
here and answering the questions. I think you also
mention that you might have
[21:56] testified. So whatever special. >> Thank you, Mr. Brown Missed
Mister Act and we are going to
[22:02] move to public testimony.

But if you would just stay close, I'm sure we have many
questions for you when we get to that point. Thank you.
[22:08] First people have Troy reading
the kitchen is set to testify or take them.
[22:29] >> Thank you for joining us.
Please state your name for the record. Thank you, Madam Chair.
Good morning. Members
[22:35] Lending-tree reading My own and
operate La Restaurants which operates homes table here in
Saint Paul and Rocket on Tavern
[22:44] in Plymouth. We currently
employ 105 people to operate or 2 locations and their food
truck.
[22:52] We're extremely proud of the
culture we've built that la restaurants, providing our
employees with a flexible and
[22:59] inclusive work environment and
offering health care, including mental health care that's fully
funded by the U.S. is the
[23:07] employer with a robust PTO program for
salary to back those employees
[23:15] and then not do company
matching for one kid
[23:20] over time. A breeze concerns
with the implement implementation of paid family
leave program specifically.

[23:27] I'm concerned at what
protections are in place to prevent fraud and how deep will
prevent misuse
[23:35] the challenge we have seen with
earned sick and safe time which the Department of Labor's
working to address through
[23:41] rulemaking especially use for example, if we have an
employee utilize he ESS P
[23:48] creating a gap and our staff
for the day their colleagues take on the responsibility
[23:54] well for a stream. This
generally short-lived. However, it impacts the trust
of our team.
[24:03] For example, a team member
takes off for Ian St. But this posting pictures on
social media traveling or not
[24:12] using E a S S P fairly intended
purposes. My concerns with paid family
leave and fraud stems from
[24:20] generally removing employer
firmly process know our employees will work directly
with state agency for extended
[24:27] periods of leave. We are concerned with the
mechanisms they'll be in place
[24:33] at the verify their employees
to properly caring for the designated the individual and

leave.

[24:40] What are the mechanisms in

place to preclude individual from working a second job in

Minnesota or in another state

[24:47] as they're caring for their

loved one. How wise an employer be able to

validate raise abuse issues

[24:54] with the program. We'll hear

the you lie program. Where have the ability to the dying rebut

the claim.

[25:03] Thank you, Madam Chair and

Committee for your time. Appreciate it.

[25:08] >> Thank you for joining us.

Next step. We have lies next step.

[25:30] >> Welcome to the committee.

Please state your name for the record to thank you. Madam

Chair, thank you for the opportunity to testify. A chair

Robbins and committee members.

[25:39] My name is Larson. Next.

Deny service the policy director for Isaiah. No matter where we live or what

we look like. A Minnesotans

[25:46] believe in caring for one

another. Yet the vast majority of Minnesotans don't yet have

access to paid family medical

[25:52] leave benefits. That's why I

say I was so proud to partner with a broad range of

organizations to fight for paid
[25:58] family medical leave. Few programs or policies and
Minnesota have been as thoroughly studied, planned,
researched that'd debated,
[26:08] discussed, deliberated and
voted on as paid family medical leave. In 2015, a study was
commissioned by the legislature
[26:16] in 2016. The Senate passed paid
family leave 2019, 2020 2021.
[26:22] 2022 the House passed paid
family medical leave. Finally it was passed by both chambers
and signed into law in May 2023
[26:31] then in 2024 the House broke
previous records of deliberation on this policy
with an 8 hour plus floor
[26:37] debate on the 52 page. Paid
family and medical leave cleanup bill
[26:43] as hundreds of small business
owners. Medical professionals and personal care givers have
testified and dozens of
[26:49] hearings over the past decade.
The need for this program is urgent and the benefits are
numerous.
[26:56] I was encouraged by your
committee administrator to keep my remarks shorts. I won't list
all those benefits

[27:03] as you can tell. I'm a
passionate advocate for paid leave. Having spent the past 11
years working for it.
[27:09] No one would be more offended
by failures in the program, especially intentional fraud
and misuse of the system than
[27:16] what I I've been in communication with
research partners from several national organizations
supporting paid leave
[27:22] development and implementation.
I've attended multiple National Committee's with state agency,
administrators of paid leave.
[27:29] And I'm confident that
Minnesota paid leave has put together a highly regarded team
that is taking every measure
[27:36] necessary to implement a strong
and successful program. I'd like to draw your attention
to the fact sheet from the
[27:42] National Organization, a better
balance that's provided in your packet as stated in this fact sheet
[27:49] data from both the federal from
LA and the 13 states that have implemented paid family and
medical leave programs provides
[27:57] clear and consistent evidence
because these programs have been thir thoughtfully designed
abuse and fraud are exceedingly

[28:04] rare. Minnesota's paid leave is a
robustly design program
[28:09] intentionally built on our
highly respected you I system that includes annual reporting
requirements. Multiple cross
[28:17] checks, including health care
provider certification, the seven-day qualifying event
requirements and a benefit that
[28:24] only partially replaces wages. The one area where we would
encourage increased vigilance
[28:30] is in the private plan options. Well, examples of individual
fraud are exceedingly rare and
[28:36] small-scale by definition, we
have copious examples of fraud in the for-profit insurance
industry.
[28:43] For example, United Health
Group has been accused of overbilling the federal
government to the tune of
[28:48] 2 billion dollars among many
other misdeeds. The strength of the 13 states
with paved the programs is that
[28:56] they're overwhelmingly
delivered through highly accountable public
administration and the U.S. are
[29:01] less susceptible to corporate
corruption. Thank you for your time. >> Thank you for joining us

next at Melissa High saying if

[29:10] I'm pronouncing that right, I'm

sorry. Forgive me.

[29:16] >> Thank you for coming.

And please stay tuned in for the record and good morning.

Madam chair and members of the committee. Thank you for

allowing me to testify today.

[29:24] My name is Melissa Hazing and I

am legislative director at Minnesota AFL CIO. The State

Labor Federation

[29:31] representing most public

sector, private sector and building trades unions across

the state.

[29:37] We co-chair the Minnesota paid

leave medicines for paid leave

college, saying

[29:42] which advocated for the

creation of this program. So all workers both union and

non-union, I can take the time

[29:49] they need to care for

themselves and their loved ones because we wanted this program

to succeed. We supported policy

[29:56] provisions that reflected

lessons learned and best practices from other states

including guardrails to prevent

[30:02] fide that are reflected in the

paint leaves statute. Among those best practices was
to require certification from a
[30:09] health care provider. Both the
need for and duration of the leave.
[30:14] Another was to ask the state to
administer the program rather than outsourcing it to a 3rd
party. As we have seen, for
[30:21] example, with Medicare
Advantage plans outsource the administration of public
benefits to for-profit
[30:27] corporations can open the door
to the large-scale waste, fraud and abuse while harming
the people who are supposed to
[30:33] be receiving the benefit. And based on the experience of
other states tried committed by
[30:39] workers is very rare in
California. Only 0, 0, 0, 0, 1, 2%, of paid family and
medical leave claims were
[30:48] investigated for fried and in
Massachusetts out of over 32,000 tonight, applications
less than 200 were because the
[30:56] applicant can it the application
contained false statements.
[31:01] Compare those numbers to what
we know and Minnesota about rates of fraud committed by
some employers through worker

[31:07] misclassification. The office of the Legislative
Auditor estimates that 22% of
[31:12] employers subject to an
employment audit misclassified at least one worker in 2018, an
analysis by Northstar Policy
[31:20] action. So that approximately 9.4% of
private sector workers in
[31:26] Minnesota, about 316,000
workers experienced worker misclassification.
[31:32] This means the worker can be
wrongfully denied access not only to paid leave but all of
the rights and benefits
[31:38] associated with employment.
We encourage both did and this committee to also focus on
preventing this type of fried
[31:45] so that all workers who are
eligible have access to this important program. Thank you.
[31:51] Thank you for coming. >> All right. Now it is time
for member discussion. So Mister Rowan distracting, if
you it might be turning to the
[31:58] table. I'm sure we have several
questions for you.
[32:16] Thank you very much. I think
start us off. And as you know, one of the missions of this
committee is not only to find
[32:24] and prevent find fried and

hopefully stop at that. We want to try to prevent it on the
front. And and this is a unique
[32:31] opportunity that we are looking
at a program that has not actually
[32:36] taken effect yet. And so we
feel this is a place where we can hopefully make an impact by
having a hearing on the front
[32:43] end to make sure we understand
the product fact prevention policies and internal controls
you have in place. And I
[32:51] appreciate your testimony
today. I have to say that there's a
lot there, but a lot of it,
[32:58] you know, wasn't very detailed.
So I'm going to have a few specific questions. And if it's
something that you can't stand the record, I would appreciate
up in-person follow-up later.
[33:09] So just briefly, you mentioned that there are
penalties for
[33:18] misuse in statute and in
administrative roles. So could you outline for me what the
penalties are for fraud or
[33:26] misuse? >> Thank you, Madam Chair.
Yes. So the statutory citation
[33:31] would be section 2.68. Be 0.1,
8, 5, 100 benefit overpayments.

[33:37] You know, there's there's
there's 3, I guess you could say that there are 3 tiers of
overpayments contemplated under
[33:43] the law in this war. Julie
mirrors the unemployment insurance statute. There are some over payments
where, you know, with their
[33:49] through, you know, through no
malicious intent, you know, a good faith, a good faith ever
by an applicant's. There may be
[33:56] an overpayment issued. That's,
you know, that's there's no criminal and there's no
criminal penalty. But the
[34:01] individuals expected to repay
the department for those, you know, for any overpayments.
And, you know, with if the if
[34:09] the overpayment is not repaid,
you know, the the department
[34:15] has the ability under the law
to to to collect on the balance. The second level I would call
it is the this is a phrase from
[34:22] you. I was misrepresentation.
So misrepresentation to escort
[34:27] him from the statute is by
making this a case where an applicant makes an intentional
false statement or
[34:33] representation in an effort to

fraudulently collect benefits again, those are not your
unintentional mistakes or your
[34:41] good for your good faith
errors. That's where somebody is attempting to. You know, it
is tempting to game the system.
[34:49] If the law requires us to issue
a penalty, you 15% of the amount overpaid. And then, you
know, then we have a variety of
[34:57] methods that we can use to
court to recover the overpayment and as well as in
as well as the penalty and
[35:04] interest assessed the 3rd. And I would say most
severe weather would be theft.
[35:10] So that subdivision 3 of that
section of the statute. And that's where you I would say
generally that's kind of where
[35:17] you have a more detailed like
it's a deeper level of coordination of actions of
attempts to defraud the state
[35:26] and that and that contemplates
criminal penalties when which where we would, you know, where
we would presumably refer a
[35:32] case to through the BCA or or
to county to county prosecution for criminal prosecution in
that case. You know, I think
[35:40] the weight the weight of the

way to think about it right is, you know, you don't you
probably don't want to
[35:46] prosecute every single example.
Some should be dealt with administratively. But I think
the statute gives us varying
[35:53] levels of tools based on the
level of seriousness of the offense. And the department
will attempt to use that to
[36:00] ensure what high levels of
program integrity. >> Thank you. And when there is
an heir or a actual
[36:07] misrepresentation, how long? How often are you
sort of
[36:15] auditing these payments to so
that it would be flagged either by technology or by someone
reviewing it? And then how
[36:22] would you I mean, it's your intention to
go after every over payment and have it repaid or how are you
going to?
[36:30] >> Seek repayment? Yes, thank
you, Madam Chair. So just in terms, I guess to start with
we, you know, we intend we will
[36:39] you pursue every overkill
anytime that there is any time their payments made that are
not entitled to know that are
[36:46] not that the individuals not

entitled to whether it is through, you know, a good faith
error or whether it is through
[36:54] you, criminal malfeasance, we
will seek to recover those balances. Again. There is that there are,
you know, there are different
[37:00] ways that we can do that.
You can offset again. You can offset against future benefits.
You know, we can seek to go
[37:07] into more detailed collection
collection method. Ala jeez, if that is what is required to
do. So, you know, we have we do
[37:14] have the authority under the
statute to doings levees and other and other types of
collections methodologies that,
[37:20] you know, the latter would
probably be contemplated only in the most serious occasions.
And, you know, I think in the
[37:26] case of the unemployment
insurance program, most things can be you are done kind of
internally to the program
[37:32] rather than having to do it
that way. I guess to the first part of
your question, you know,
[37:38] how are we going to be
analyzing? The answer is constant and both at the point
of application, right to know,

[37:44] to validate the information of
the ways that we spoke to throughout the presentations.
Additionally, as I mentioned,
[37:50] there are going to be random
audits and reviews that we will be, you know, that will be
conducting is part of the program. And should we get
reports from external parties
[38:01] such as you know, such as an
employer or such as a concerned citizen reporting, you know,
providing us with information,
[38:08] we will we will review those
carefully and act upon them as appropriate.
[38:13] >> Thank you. So just to follow
up on that quickly, you mentioned offset against future
benefits. That seems to be a
[38:21] way the state handles over
payments in many other areas. Is that going to be your first
[38:28] way you will address this or
will you lean into collections
[38:33] or cash repayments somehow? >> Madam Chair, I think it was.
I mean, I think it will depend
[38:39] on this. I think it will depend
on the scenario. Again, I would say that for your typical good
faith. You know, there are an
[38:46] offset of benefits. Is the
simplest in cleanest approach for everybody, right, lake?

That is that is a case where an

[38:52] individual may, you know, if

again, may have made an error on the application, there's no

need. You know, there's no need

[38:59] for them to send us a check.

And then we apply that check to their account that can just get

Nestle for everybody involved.

[39:06] So I think you were possible

offsets are are very straightforward approach.

But again, that will be

[39:12] appropriate in every case.

If somebody, you know, if somebody has entirely, you

know, misrepresented the record and

they were indeed not entitled

[39:19] to benefits and there are no

benefits to offset that we would need to seek collection

and other members.

[39:26] Thank you very much. All right. I represent the vice chair and

reason.

[39:32] >> Thank you. I have all

started when I have some technical questions. So I I am

actually an employer and I'm

[39:39] the administrator for several

companies. So I've been watching your webinars and

everything. Thank you actually

[39:45] quite good. But I'd like to

start when I'm not, Chris. I think it's a good that we did
this as a combination with U I
[39:55] the data is there. That's
easier. And then player are you look back to 18 at the are you
looking at the last quarterly
[40:02] when you're when you're looking
at, you know, earnings records say looking at the last
quarterly 9.41, that was filed
[40:10] or how how do you do that? >> Madam Chair to grant cut
could just stick to clarify the
[40:15] question there are you talking
about in terms of calculations for the benefits are U-turn,
talking about the employer
[40:21] records, just which which
element of the calculations are you asking about? >> Thank you. It would be the
calculation of benefits.
[40:27] And I know that people don't need to actually
be employed like they could have been
[40:33] unemployed and still collect
it. So that's not an issue. I guess it
would be calculation.
[40:39] I'm convinced that Medicare but
thank thank thanks for the clarification. So the.
[40:44] >> The look back period is
generally the last 4 and in some cases 5, depending on the
timing of the application

[40:51] quarters of wage of Wade
records. That's what the that's what the statute prescribes for
us and the benefits are
[40:57] generally assessed are
generally attributed to the high quarter of earnings.
Just give them that individuals
[41:03] may have some very level of
variability in their in their overall earnings patterns.
[41:10] >> Any further questions?
I have a bunch, but I'll try to be quick. So these are all
really technical questions.
[41:17] So guidance to health care
providers to I guess that's not
[41:23] technical. But are you
providing the I'm really concerned about the Internet
and leave it at that pregnancy
[41:29] leave is not busy their baby or
not, right. So it's it's the medical leave part in the
Internet. And then how do you
[41:36] how you going to deal with some
of that has to employers through?
[41:41] >> Madam Chair, all let me try
to answer each question sequence. So medics, medical
leave, like I guess I would
[41:47] just you know what I would say.
It's a kind of a back to the presentation, right? So we have

that we've been working really

[41:54] closely with health care

providers just had to just last week, had a really good session

with the Minnesota Hospital

[41:59] Association about just kind of

how this is going to work at it. I think I'm just a very,

very positive and constructive

[42:06] discussion. We've had really deep

engagement from some of the health care providers. You

know, note, Fairview, Mayo

[42:13] Clinic in terms of working to

get the, you know, the UH out, you know, the electronic health

records integration, which is

[42:20] going to really, I think

transform how doctors and other providers are able to provide

some of that information to us

[42:26] provide and again gone the simplify administration in

that regard.

[42:32] You know, and that's also, I

think, were some of the ICD 10 codes will come in. Will that

will be yet another tool that buckle providers are able to

use. As far as intermittent

[42:40] leave goes, you know, the

rules, the rules are, you know, the rules are clear that an

employee needs to stick to the

[42:47] intermittent leave schedule.

You know, it's from they are, you know, with taken in and
leave when they are not here.
[42:55] When that on a schedule that
they have not kind of submitted and gotten approved by the
department, they are not don't
[43:01] you know, they are not eligible
to collect intermittently benefits during direct for that
for those periods and all the
[43:07] guidance, I would say that we
have a subdivision really tries to emphasize the need for
constructive collaborative
[43:13] conversations between the
employer and the employee for intermittently because that's
going to be the best chance of
[43:19] success. That's going to be the
lead to the best outcomes for success. I think you asked
about multiple players as well,
[43:25] right? So we do have, you know,
we have for each detail records for, you know, for all
employees across you all for
[43:33] all employees in the state. You know, we calculate the
benefits based on total
[43:38] earnings, right? It's not.
You're not. You think, you know, huge as as
an applicant, you're choosing
[43:43] where you go, whether you take

we from an individual employer or not, and that you can
imagine what you might need to
[43:49] do that, right? But what if you
have to put if you have 2 part-time jobs, one that you're
working on Mondays and Tuesdays
[43:55] and one that you're working on
Wednesdays Thursdays and Fridays and you have a chemo
appointment every Monday you
[44:01] might not need to take leave
from the Wednesday Thursday Friday job. But you might need
to take leave you on that Monday from the Monday Tuesday.
So I think the law is the law
[44:09] and the benefit administration
is designed to reflect those different pieces together.
[44:14] >> Thank you. I know one quick.
So what your webinar talks about
[44:21] migrants. So it in play has
migrants and because they have migraines
that the doctor says, you know,
[44:29] occasionally they're going to
migrant and they might need to be out intermittently. So
[44:35] how would you pass? How would
you do a schedule for someone who says I have a migraine
today? So I can't work today
[44:42] and I might have one next
Friday and the fog Friday and then and also, how do you deal

with

[44:50] this time? The caregiver is

really concerning to me. So we have, you know, the the

application says that any

[44:57] person that has a migraine and

could have 3 caregivers

[45:03] that also are off than to give psychological care, comfort it

to the person with the migrant.

[45:11] So how do you do that

internally? >> Mr. Rutte, Madam Chair,

Representative. So in the you

[45:18] know, there's a person is

occasionally had migraines. And after a few, if you if you

know anybody who has any to

[45:24] having somebody work under

those certain, you know, that's a pretty tough

circumstance overall. You know,

[45:30] I guess as far as the imminent

leave would go, right? I think it's I think it's it's

something that we you know,

[45:36] we hope you're going to, you

know, it's something that we hope you're going to have been

conversations with the employer

[45:43] about, as you know, as an

employee, right. And I would think that any employer who

sees an employee having a

[45:48] migraine, you know, and and is
traveling real struggles in terms of being able to do the
work, you know, I would hope
[45:54] that that would be a
circumstance where, you know, where folks would be able to
kind of figure out how that how that schedule that schedule can
work.
[46:02] You know, I think when it comes
to could could you just might be the second part of your
question, Sir.
[46:08] >> Vice chair and thank you.
The caregiver. Yes, someone who has a migraine, which is your
webinar step to you says Mike
[46:16] is an excuse or as a for
example, they can have up to 3 people, caregivers
[46:23] who provide psychological
comfort to a person with a migraine.
[46:29] Well, and how do you deal with
it? >> Deputy Commissioner Madam
Chair and represent that.
[46:35] Thanks for their thanks for the
reminder. So I will note is part of the certification
process, right? The health care
[46:41] provider signs off on the
maximum number of absences, the duration for region for the
period of time. And they also

[46:47] are certifying to the need for
care for those specific for those specific caregivers.
Ryan, I think I believe the
[46:53] certification of the
certification for Mitt, you know, kind of notes that so it
is not in here. You know, it's it isn't just a case where
an applicant can just you can
[47:02] just tell the division. I knew,
you know, 7 different people to to care to care for me here.
These are these are medically
[47:09] validated, medically certified
items that are, you know, that are going to be, you know,
that are going to be validated
[47:16] by the care provider. And
again, as I mentioned, we will be reviewing the records that
we got from medical certify ERs
[47:23] and review reviewing those
state and to and to ensure integrity in the process.
[47:30] >> Thank you, Representative
Frank. Thank you, Madam Chair.
[47:35] >> So my concern is in the
validation verification of multiple things. And
[47:41] one of the most glaring things
that I found odd in both applications for both taking
leave and then also providing
[47:47] care for someone who's taking

leave. Is that an actress is optional.

Can you explain why on these

[47:53] applications? You don't.

The person applying for the caregiver doesn't have to

provide their address.

[48:04] >> Madam Chair, or you're a

which just just just for clarity which applications like

which can point to the

[48:11] application or your friend to

hear Representative Act. >> Thank you, Madam Chair.

So in every question where it's

[48:19] an either an individual saying

I need to take leave or I'm going to go take care of

grandma down in Florida,

[48:25] which is an example, you know,

talked about when we're crafting this. And in all of those instances,

[48:33] the address is optional in

every single. So that's what that means. I can't help it.

[48:38] >> It's the medical leave

certification form and the caring LEED certification from

both say addresses are

[48:43] optional. Oh, sure, no. So I so I get it.

I'm sure I guess what I would

[48:50] just say is that is not that is

certainly not the only place where we are going to be

validating and verifying

[48:55] addresses, right, obviously as
part of the applicant. As for the applicant, the comes to the
applicant, you know, in Deputy
[49:03] commissioner, I can can speak a
little bit to the walking among components, but there is going
to be a there is a very robust
[49:10] identity validation proofing
component there for the for some of the
certifications there may there
[49:16] may be scenarios where it's not
safe for an applicant who share an address such as safety.
We write like that isn't that
[49:22] isn't that is an area where it
would not be. We would not want that to be for reasons that
sure you can understand that
[49:30] would not be something that we
want to do. But the medical certification, but medical
certification form, which was
[49:35] modeled on the FMLA
certifications that, you know, I think employers are already
using, you know, is not the I guess is
not the only point of address
[49:45] another attendee verification
far from these. These are data that we are also collecting as
part of the applicant
[49:52] application workflow in those

components as well. >> Representative, thank you,
Madam Chair. So let's go to
[49:58] something little harder.
This service provider that was an easy one service provider
can be in a foreign country.
[50:07] And you talked about you are
going to verify all of these service providers and the list
is very, very broad. Everything
[50:14] from in advance practitioner,
nurse practicing nurse to a mental health professional
without any calls Cajuns us
[50:21] with well, maybe is a statutory
qualification. But my concern is how do you vet and validate
somebody that's in Mozambique.
[50:32] >> Mr. Brown, Madam Chair,
Representative, I can. I would I would just say is we will be
taking a very careful look at
[50:38] any of the end of any cut any
of those types of applications and as appropriate contacting
the relevant authorities.
[50:46] I think we are certainly aware
of the potential for risk there. And obviously we have to
follow the law and and what the
[50:55] law prescribes there. But that
is certainly an element that our program integrity unit will
be carefully monitoring and

[51:02] will will. I would just say, we
will review with all due
[51:08] scrutiny in that regard. >> I'm sure I've 2 more quick
question. All right. Please be quick. Thank you. Great.
So the other 2 verification
[51:17] things that are of great
concern to me is when you have one we've got on here, someone
who has an expectation and a
[51:24] reliance on need to care for
them without compensation. So I'm not seeing anything in
this application has to a
[51:31] supporting document or anything
to verify. What does that even mean? How does one set up with
another person that you're not
[51:39] related to an expectation of
reliance for care? That's one question. And since I'm gonna
do this quickly into the second
[51:46] question, also, as a person has been
[51:53] qualified to go ahead and offer
care, how do you verify that? That care is actually being
provided? And they're not just
[52:01] as we had spoken in, then he
rings you for just going to Florida for a vacation and not
really taking care of any
[52:06] money, Mr. Room. >> So thank you. Thank you.
Madam Chair, to the first to

[52:12] the first part of the question.
You know, I guess all I did. I get it off for a couple
thoughts there. So one that
[52:20] just returned to the previous
answer, the medical provider right is
certifying to the need for care
[52:26] by that specific individual,
right? So that is that is a component of that. You know, what are the
scenarios in which, you know,
[52:33] you might have somebody who is,
you know, who might not be related by blood. But, you
know, you know, I would just
[52:41] say, you know, family and
caregiving relationships as I'm sure you are aware, complex,
right end. You are you know,
[52:47] they're often cases where
individuals are taken care of each other where you might, you
know where, you know where you
[52:53] might have a an uncle or you
might have, you know, you know, a fan or a more distant family
member who because of
[53:01] circumstances and how those
things have evolved over time. Those are the ones who are
given work, providing care for
[53:07] each other. You know, the
families, I think as we all know, are complicated. You know, what I would say is,

you know, we there is that

[53:14] there are data from other.

You know, Washington state is a good example of a state that,

you know, initially watch with

[53:21] a much smaller with and much

more constrained definition and expanded their definition think

in 2021 or 2022, they did an

[53:30] analysis on the number of

individuals that actually, you know, actually not that

we're kind of that broader

[53:36] family definition and from

memory over the course of about 8.18, months, it was like 500

people in the entire state of

[53:42] Washington, which is a state of

7 million people. So it's you know, you're not. You know, I

think the my my sense of the

[53:49] intention of the law was to

provide flexibility for, you know, if complex family

issues. But the overall dynamic

[53:57] here is that, you know, it's

it's it experience in other states has been that it's not a

big part of the law.

[54:06] I would. And then I guess I

would just reiterate, right, the the certifying part, the

certain to the medical, the

[54:12] medical certification

certifying party is the entity that confirms the need for care
and improve and provides
[54:20] information, but it. But once
again, if you are taking leave for
that care, the employer has a
[54:26] role in providing information
to us as well as you know, as as as well as all the other
kinds of the reporting elements
[54:34] that I walked through that can
help ensure program integrity.
[54:39] Thank you. Just a follow-up on
that. If I move to Representative Hawkins, so you
said that the the medical
[54:47] certification for the
caregiver. >> That they would be a check
on this because they would
[54:53] certify that that specific
person is needed to provide the care. In fact, could the person who
is meeting the care just say I
[55:03] want, you know, my cousin, my
and my neighbor down the street
[55:08] and the medical provider which
is go along with the person's suggestion. They are not
actually saying, oh, no,
[55:15] we need this particular person.
Could you clarify what you meant by that? >> And so I could do. Could you

clarify? I apologize. Madam

[55:23] Chair, could you can? Can you

just could you clarify the question there? And just I just

want to make sure answered. Yes. So when you are responding

to terror, Eric, I wrote and

[55:30] that you said that the medical

provider well certifies, that the care is provided by

that specific individual.

[55:39] And I'm just not clear how the

provider will know other than that. It's a name on

the paper. Well, the provider

[55:45] meet that care provider.

What's that threshhold that you're saying that the medical

provider will certify that

[55:53] specific individual is

necessary to be the care provider? Madam Chair, I guess

I think that I think the I

[56:01] think the answer their rate is that.

[56:07] >> The >> to be able to be able to to

be able to certify right like

[56:13] the individual needs to have a

conversation with their medical provider, right, and the

medical and the medical

[56:18] provider. You know, if they're

going to sign their name to say no to such a certification is

going to need to, you know,

[56:26] it's going to ask that
question, right, like why, you know, why are we what is
the nature of this caregiving
[56:33] relationship? And I guess it's
kind of I guess maybe it's helpful to kind of think was
announced written was in the
[56:39] abstract and more like a
specific example, right? Like I think of like somebody
to, you know, somebody was trying
to take of your relative to
[56:47] chemotherapy, right? Like I
think a very you know that. And that person may
[56:52] if the patient may need
somebody to drive them to a chemotherapy appointment, they
might need a couple people
[56:58] might need to certify a couple
different individuals to be able to do that, right. And but as part of as part of
the straw, the
[57:08] we have, the medical provider
would ask the individual who's going to take you to these
appointments. The individual
[57:13] with the I would say that the
patient would presumably say, oh, it might be bison. And it
might be, you know, my daughter
[57:21] who's going to do that. You know, again that I think
the other come together control here is right. We're also

looking at the family were also

[57:28] looking at family leave from

the perspective of the individual with the medical

that right. So that is that is

[57:35] another control. If you get, if

you had, you know, 50 people, you know, trying to do that,

that that will raise alarm

[57:40] bells and we would be would be,

you know, that would not be approved. That's I think that's

the kind of a dynamic we're

[57:46] talking about. Thank you, Representative

Elkins.

[57:53] >> And thank you, Madam Chair.

And at this point, just wanted to perhaps clarify a few things

that I'm hearing from translate

[58:01] from it ease into legislator

ease. So you heard the term icd

[58:08] 10 referenced several times.

So icd 10 is the coding system used to collect information

about a patient's diagnoses.

[58:18] So essentially what they're

doing in order to validate that the person actually has this

condition that they're claiming

[58:25] on their application, they're

going off to the electronic health care system from the

provider and they're reading

[58:32] the ICD code ICD 10 codes to
determine. Yes, this person really has been seen by a
clinician and that formal
[58:40] diagnosis has been provided. So building on that. Typically
the medical services involved
[58:49] the, you know, the patient, the
applicant is probably going to want to be compensated by their
insurance company for the
[58:58] provision of the services
involved. And in order to
[59:05] successfully file a claim for
medical services, the services themselves will have a hit
picks or CPT code. And that
[59:15] code code that describes the
services has to be supported by
[59:20] a diagnosis codes in ICD 10
code that proved that provides evidence of an indication of
medical necessity. So those are
[59:28] are tied together. So the
record that these guys are tapping into well, describe the
services being provided and the
[59:36] diagnoses that are providing
the justification for providing the services. So this is a kind
of revolutionary we haven't
[59:42] seen this before. Government is
going into electronic health records using the standard

interfaces and collecting

[59:50] objective information about a

person's diagnoses and the services that they're

receiving.

[59:57] >> Thank you to to have any

comments, Mr. But they just kind of town. >> So the second part is that

the questions about the address

[1:00:05] validation. So here also are

seeing a fundamental shift about how we manage people's

addresses. So instead of,

[1:00:15] you know, thanking all the

tracking that, you know, Deeded tracks their address and

DHS tracks their address and

[1:00:21] DNR tracks their address.

All of that information will now be managed through log-in

him in which is modeled after

[1:00:29] logging dot Gov with the

federal level. So if I'm logging in to check my federal

Social Security or Medicare or

[1:00:38] my TSA Precheck, I just have

one log in with the federal government through long in dot

Gov. And that's where they

[1:00:46] maintain all of the information

about, you know, where I live, yada yada yada. So it doesn't

have to be collected and

[1:00:53] maintained by the individual

agencies when somebody sets up their log-in am an account,
they'll supply all of that
[1:01:00] information. And so and they
use those credentials to log in
[1:01:05] the agency that's integrated
with log-in. And then we'll just get that information out
of Logan. Amen.
[1:01:12] >> Thank you. And to that
point, to go back to the edges verification since we're having
this discussion,
[1:01:19] I think my concern is that the
address verification is for
[1:01:24] caregivers and it's not
required and it's for the person
receiving the services. And so
[1:01:30] I see your point on the person,
the applicant for the leave, but for the caregivers,
[1:01:36] I think that given the history
of
[1:01:41] what we've seen in the DHS
fraud, but we've had multiple addresses
[1:01:47] with providers who may or may
not exist to not even require and address
for the caregivers is
[1:01:54] problematic. And I think it
should be reversed that if someone has a true domestic

violence or concerned about

[1:02:02] safety, they should be able to

petition and opt out of providing that address. But I

think to just make addresses

[1:02:08] optional on the front end is

probably of an issue of concern that we

should look at.

[1:02:15] >> So Madam Chair, Fine, just

just I don't want to interrupt but surround. But but I would

just note, caregivers in this

[1:02:23] case are the are applying to

the department, right? So they you know, they are today.

They are there. We need to get

[1:02:29] this. The caregiver needs to

provide the certification needs to provide a certification form

that they are. You know,

[1:02:35] that they are providing care

that is medically necessary. But we are validating their

addresses when they're applying

[1:02:42] to the department for benefits

here. I apologize if I was unclear about that. But you

know, if you are applying for

[1:02:49] family, you know you if you are

applying for care, caring leave because you are going to be

providing care to, you know,

[1:02:57] to a family member, you are

giving us that information through argument walking and
then then you are providing us
[1:03:03] that other validated
information. You know, again, the search the of the search
for is the certification forms,
[1:03:09] one component here. But we are
still validating that you are indeed who you say you are and
that you are real entity and
[1:03:15] all those components, Mr. Acted. Thank you, Madam Chair.
[1:03:21] >> Just to put a finer point on
that in terms of what we're actually going to expect, folks
to prove that they are where
[1:03:28] they said they are paid leave
will be the first program at the state that's currently
operating, that it's going to
[1:03:35] be requiring aisle to level
identity validation. So what that means is that
[1:03:41] whether it's a caregiver or
whether it's a person taking leave for their own medical
need,
[1:03:47] they will need to pass through
Bogen am and as that digital front door to validate their
identity, they will be
[1:03:54] running against 2, 2, levels of validation
alive and is checking the
[1:03:59] documentation check. What that

means is they will need to take a picture. If you've ever if you have an IRS dot Gov
[1:04:05] account, you've been through this. You need to take a picture of your driver's license and then you need to
[1:04:11] take a selfie of yourself and Ted needs to be uploaded into logging. Mn selfie is too prevent fraudsters who may try
[1:04:20] to use AI to scam identities. The our service providers, external service provider, then reviews that uses tools on
[1:04:30] there and to ensure that the live news check picture the image on the ID sufficiently match and then
[1:04:37] approves that individual has aisle to compliant that thing carries forth into the paid leave system and any other
[1:04:45] state system that's going to be using locking them in. I currently
[1:04:51] these kind of identity checks in other areas are done. The administrative data center in the health care space
[1:04:58] pinging, the federal data hub dire a state hub for identity checking. This is really the direction that the industry is
[1:05:06] moving. As I said, if you've

been if you create an IRS count, you've been through this
and it it's intended to provide
[1:05:13] essentially the highest level
of identity validation that's available as an industry
offering.
[1:05:20] >> Thank you for clarifying
that. And is that required every time they like in or just
when they create the camp.
[1:05:25] >> So every time they lack the
incredible pass through that same front door, but they don't
need to keep providing the idea
[1:05:33] in the selfie. We have other monitoring capabilities in
place like to your location
[1:05:40] like behavior, telemetry
someone on the site to prevent someone taking over an already
approved account. I think
[1:05:49] that's the scenario you're
going to get your getting at there. But no, we wouldn't
require the person every time
[1:05:55] they log in to check something
in their account. You know, to take another selfie show
their ID again,
[1:06:02] wouldn't be probably wouldn't
be the onerous and not necessary
given the other security layers
[1:06:09] that are in place to make sure

account takeovers are detected and stopped. Thank you represent Schultz.

[1:06:17] Thank you, Madam Chair. >> Assistant Commissioner Row.

You've been for this committee

[1:06:23] before. You know, we place a lot of our attention on

fraud.

[1:06:29] And given that I'm assuming

that you've spent the last couple years thinking about

[1:06:34] what areas of fraud that you

are anticipating to happen. So can you share with the

committee

[1:06:43] what fraud Dede is anticipating?

[1:06:48] >> Mr. Madam Chair,

Representative Schultz, I guess what off? I guess what I would

just first start with right is,

[1:06:54] you know, our, you know, our

objective, you know, in setting up a new program state. And

certainly this program

[1:07:01] get, you know, is too, you know, do everything in our

power to

[1:07:07] intimate to absolutely minimize

those types of incidences. And with that being said, I

think you hopefully what you

[1:07:13] see in our presentation is that

I think we understand that there can be that there are

multiple factors that these kinds of where for fraudsters

can attempt to attack state

[1:07:23] programs certainly would.
And once that operate at scale, right, and we've learned this
and we learned this
[1:07:30] unemployment insurance. I think
we learned this in many different places. I think when we were when we
were when I presented to this
[1:07:37] committee back in April, you
know, there's what you're kind of one vector. I would just
call cyber crime, right?
[1:07:43] Like you have entities that are
attempting to, you know, spoof identification takeover
or individual accounts, right?
[1:07:53] People who are not who they say
they are attempting to use synthetic identities and the
like to, you know, to attempt
[1:08:01] to obtain benefits that are
that are not rightfully theirs. I think that you commissioner,
I can kind of spoke to, you
[1:08:09] know, walking and then is not
the only component to that. But it's very important
validation part because a lot
[1:08:15] of that what a lot of that
comes down to is making sure that an applicant is who they
say they are. Right. So that's
[1:08:21] maybe your front door, I would say than, you know,
than there is just a question of integrity within the program

itself, right? Are people

[1:08:28] telling if you are who you say

you are? Are you telling us the truth? Right? And those are the

that's the next layer of

[1:08:35] controls that I think we've

that we've tried to talk about, right, multiple points of

validation, multiple, you know,

[1:08:41] kind of overlapping ways of of

of ensuring that we are validating that information and

and ensuring accuracy in those

[1:08:50] in those answers, right. So and then it. But so I think

those are kind of the 2 buckets

[1:08:57] that you can think about.

And that's and I would say that that's been

[1:09:02] at the forefront of our of our

planning at the forefront of the way that we have been

trying to set up this program

[1:09:08] at the forefront of the way.

We will run this program to really make sure that

[1:09:14] we're leveraging all the data

that we can that we're asking the right questions that to the

to the extent that we can.

[1:09:22] We are validating the

information in those questions. I think those are the ways that

you that you come doubt you

[1:09:29] combat malicious behavior and

you can insure high levels of program integrity

[1:09:36] represent Schultz. >> Thank you, Madam Chair and

Mister. All when I listen to everything that's been said

today, there's a few key areas

[1:09:44] beyond what you just mentioned

that appear to be

[1:09:50] burdensome for some. I think

that this program based upon what's been outlined in our

conversation, whether it's

[1:09:55] today are the last few years.

It's that there's a heavy burden. >> That actually lives at the

medical provider. And I'm

[1:10:04] almost very curious as to what

that additional feedback is banned from those who are

health care providers or from

[1:10:11] the hospitals. I almost think that your system

doesn't work

[1:10:16] without a heavy level, a heavy

role and and huge amount of time for medical professionals

in order to verify those who

[1:10:25] are going to be providing care

and what sort of care they're going to be providing and how

to say that that

[1:10:31] >> is achieved. And then along that same line,

[1:10:36] no one in this room has

actually heard how your agency or anyone through the process

and program integrity is going

[1:10:45] to confirm what care is being provided by

these care providers.

[1:10:56] >> Thank you, Madam Chair.

Thank you, representative. I guess that I think there's 2

parts to what you are 2 parts

[1:11:01] to what you were saying. You know, the first round of

the conversations that we've

[1:11:06] had with medical providers.

Again, I think we've had really constructive and productive

ones. You know, to just to a

[1:11:13] large extent, this isn't new

for medical providers, right? I would offer a couple points,

right? First medical providers

[1:11:21] already do this under FMLA.

The Family Medical Leave act of 1993, which is a federal probe,

which is a federal paid leave

[1:11:28] program. You know, medical

providers are already providing those types of certifications

for the, you know, for

[1:11:37] for those type of event.

So it's not on for so it is not unfamiliar terrain. And I'd

also just say

[1:11:45] the you know that as I you know, as

I've said, this is Minnesota is not the first state to roll out

a paid family medical leave

[1:11:52] program, you know, where
they're going to be the 13th state in the country that's
doing this. You know, we're
[1:11:57] like the U 180 us in the world,
I suppose. But, you know, 13th state. So you have medical
providers who, you know,
[1:12:04] have heard from there, colleagues, you know,
colleagues around the Country
[1:12:10] Inc. You know, I you know, I'm
certainly not saying it's not a change. That is a change.
But I think we are, you know,
[1:12:16] we've tried to model our
program on the best practices that we've seen around the
country. And I genuinely and I
[1:12:25] and I genuinely think that
[1:12:30] that the dhr integration that we were
kind of previewing here is
[1:12:36] going to reduce administrative
burden, not just for this program in a week and a
nation-leading manner, but it's
[1:12:43] also going to help that and
it's going to help them. It's going to help of medical
providers on ethanol is.
[1:12:51] Well, I like it. So I'm I'm I'm
genuinely hopeful that this is going to be that,
you know, without, you know,

[1:13:00] fully acknowledging that this
is a change, that this is going to be a component there, that
this is going to be a component
[1:13:05] that, you know, really does
work for works across the
[1:13:10] entire spectrum. You can start
your Monday. The second part of the question. >> Mayor Sam still absolutely.
Thank you, Madam Chair. So the
[1:13:17] second part of the question,
which has been a question that's been asked a few times
now and we don't have an answer to it, which is an area of
concern is.
[1:13:26] >> Who and how are we going to verify
that the people who are
[1:13:31] providing care are providing
care. >> Mr. Thank you, Madam Chair.
Thank. Thank. Thank. Thanks,
[1:13:37] Representative Short. So I
guess I would just go back to, you know, to the previous year
to the previous answers,
[1:13:43] which is there are over why I
would say that there are overlapping controls to ensure
that this is that this is
[1:13:48] occurring, right? You know,
first, I wouldn't I would note that, you know, we have it's a
really robust methods for

[1:13:55] people reporting issues that
they see that they see a current right. We know we have
a we have a fraud reporting
[1:14:01] form and other ways that folks
can get in touch with us. And we really strongly
encourage folks to use those. We take those. We're going to
take those reports incredibly
[1:14:09] seriously, as we as we do know,
insurance and it's redoing those other elements. Employers
have the ability to what you
[1:14:16] know to, you know, both through
the application process, as well as through the
administration of the program
[1:14:22] to let us know as well, right?
That is, you know, that is a another. That's another piece
of the controls, the control
[1:14:28] process here. All right.
So I think, though, I mean, when you there's not just one
thing, I think these things fit
[1:14:35] together, overlap and provide,
you know, multiple layers of do provide multiple layers of
ensuring that, you know,
[1:14:42] that people are following the
rules and that people are are are playing on a level playing
field.
[1:14:49] >> Representative Madame Chair

and all seek to be brief here. And this given the amount of
times you've asked the question
[1:14:55] without any substantive answer.
And with great respect to Mister, what you just said and
what you have said today is
[1:15:02] that there can be up to 3 caregivers per
individual patient, that it can
[1:15:10] have some duty to perform care.
But there is no way to verify
[1:15:15] and no one that is the true
entity that is accountable for
[1:15:21] that verification. In essence,
[1:15:26] you are one of these care
providers. You receive the dollars in your
bank account. You don't have to
[1:15:33] work. And there is no duty to provide any sort of
verification or proof or
[1:15:39] evidence that you provided any
ounce of care.
[1:15:46] >> Actually represent 3 minutes
to thank you, Madam Chair. And I'm looking forward to that
conversation about prior
[1:15:54] authorization form. If we want
to talk about how to unburden health care providers in this
economy, I'm a sister is a
[1:16:01] nurse practitioner and she says

she spends 25% of our time responding insurance companies
prior authorization. So to me,
[1:16:08] that's the bigger issue there.
But that more to what we're talking about here today.
You know, I think that there's
[1:16:15] been confess I'm pleading.
Let's go back to what this program. It's rate. This is a
partial wage replacement for
[1:16:21] folks who are taking time off
to care for themselves. >> Their child or a family
member, a member or loved one
[1:16:30] who has a serious health
condition and that is defer. Then when we have talked about
some other kinds of providers.
[1:16:38] So I think calling a mother
caring for their child health care provider provider, it's a
little bit misleading. And I
[1:16:44] think that the turn of phrase
is important because our job here is to do 2 things, right.
We are here to ensure that
[1:16:52] Minnesotans who are eligible
for these programs in this case, paid family medical
leave,
[1:16:57] have access to it. And to that we're protecting
the taxpayer resources for this program that we at the
legislature have have

[1:17:05] allocated. And I think what's
been really useful as we've seen a lot about that second
piece and focusing on claims
[1:17:12] and claims fell foundation and
verification, which is really, really important. And that's
really what we're talking.
[1:17:17] We almost all this conversation
has been about claims people who are eligible or potentially
eligible for this benefit
[1:17:26] submitting a claim for this
partial reach replacement. And how are ensuring that that
that person is eligible and is
[1:17:35] who they say they are doing
what they say they're doing. And we've had that whole robust
conversation, which I think is really, really important.
[1:17:41] But our experience on this
committee has been that the business model of fraud is not
really with the claims issue.
[1:17:47] It's with the private provider
issue. So we haven't seen when we talk to future future.
We not see a lot of issues with
[1:17:55] claims of of families seeking
food for their kids. The issue
[1:18:01] was the providers in the lack
of oversight of those providers we're talking about. It just
says we were not talking that

[1:18:08] the big issue is not an house
folks who are claiming to get services they were ineligible
for. I'm sure that there is
[1:18:14] that. But it seems like we've
been working on it. It is the providers who are sick or
getting taking government
[1:18:20] resources in order to provide a
service. And then that the person coming to us in most
cases saying that they didn't
[1:18:26] get it in this case, it's less about
the mom seeking bonding care
[1:18:31] with their their kid that I'm
worried about because what the
[1:18:36] California and again, part of
the reason that worried about it is because of the 20 minute
you just described of all of
[1:18:42] the checks and verifications of
allegations and my good friend, Representative Elkins, who
really understands the
[1:18:48] technology behind it seems
satisfied with where things are
[1:18:53] at. California's experience that we
heard quoted, I think is in our packet of 0, 0, 1, 2%, of esta
get claims fraught to me tells
[1:19:03] me that that we have a good
handle on it. There is another kind of fraud

that we haven't been talking

[1:19:09] about, which as housing alluded

to, which is a fraud or misrepresentation and

unemployment or excuse me,

[1:19:19] misclassification employee

misclassification fried for folks have not been on the

Labor Committee are really

[1:19:25] focusing on it. What it is is

when it's when an employer is supposed to to treat someone as

an employee but missed

[1:19:31] classifies as a man is as an

independent contractor. The reason it matters to us here is

one it gets. Both of those of

[1:19:38] both means that those Minnesotans

who were ineligible or who skews me, who should have been

eligible for this benefit will

[1:19:44] get it. But more importantly, I

think to this committee is it means that the tax, the

resources that legally these

[1:19:52] employers are required to play

for the simply are not being paid. And we have a report and

we will even we'll soon have a

[1:19:59] official study. But we have a

report the the LA said up to 22% of employers have

misclassified at least one

[1:20:08] worker. We have a study that we

are going to build on that says
[1:20:13] between 501.3 billion dollars a
year, Minnesota loses in tax
[1:20:19] revenue. And that's not just
that. That doesn't actually include paid family medical
leave Texas because we have
[1:20:24] included that unemployment
insurance calendar million dollars, payroll taxes. We're
not getting workers
[1:20:30] compensation workforce
development account. And that is resources that are supposed
to be coming to the government
[1:20:37] that is that are being stolen
because people are being misclassified. And so I'm
interested and they did that
[1:20:45] the role it because I actually
think we should like if what we're concerned about is
resources being stolen from the
[1:20:51] government and people not
getting the benefits they deserve. That is a very serious
issue that causes paid family
[1:20:57] medical leave, crosses
unemployment insurance process, payroll taxes. So I hope we did
more into that on this case.
[1:21:04] I'm interested in what has the
has DEET has been thinking about this and I know he's been

working with other agencies.

[1:21:10] How are you thinking about

adding paid family medical leave and what that means for

work to combat this

[1:21:15] classification and ensure that

employers are paying into the programs and the people get the

benefits they deserve for their

[1:21:24] eligible for Mr. >> Madam Chair, Representative

Greenwood, thank you for the question. You know, I think one

thing, you know, as as I think

[1:21:31] you're aware, a deed has been

working on the working in concert with

[1:21:37] several other agencies on them

in the combat misclassification through the through the

partnership which the

[1:21:44] legislature enacted in the

previous biennium. I think one

[1:21:49] thing that will make it, you

know, even more straightforward for paid leave to start to come

to work, to contribute to

[1:21:55] counteract that behavior is

that is the fact that we have no set up, you know, kind of

many combined process season

[1:22:03] and records with the

unemployment insurance division. So you kind of adding

that lens into the analysis

[1:22:09] will not be particularly
onerous or or challenging for the division. And I think it
will also provide, you know,
[1:22:16] and it's another use, for
example, of the stakes involved, right? The city of
this is, you know, this this
[1:22:22] program is going to really
matter for Minnesotans. And we certainly want that what
Minnesotans who are entitled to
[1:22:29] these benefits under under the
law to be able to access them in accordance with their legal
rights.
[1:22:36] >> Representative Diamond,
thank you. Just to follow up and this might be a parking
lot. But if either this
[1:22:41] committee are the Workforce and
Labor Committee invite you back, I would love to hear
about what additional things we
[1:22:48] can do. We know that this is a
rampant problem, adding paid family medical leave just makes
their another program that I
[1:22:57] think could incentivize and
some of the business model misclassification is folks
don't pay if they're not paying
[1:23:05] the benefits to workers and
then you're competing against the good the high road in

players who are it's another

[1:23:12] sort of incentive for employers

to skirt the law. I would love to if you have if you have

recommendations now or if you

[1:23:20] are up for thinking a little

bit deeper about how what more we can do knowing that this is

a problem that we continue to

[1:23:27] work on. >> Thank you, Representative

Rick. Thank you. Madam Chair, just

really quickly. Cause

[1:23:35] representative shows asked the

question that I had asked earlier. Henry asked it again.

So you're you're talking about

[1:23:41] the upper limit of caregivers

that can take leave and go take care of someone. And on the

application. There's 3 and you

[1:23:50] and said, well, if they had 50

people that apply, that would be rejected. And I appreciate

that because you and I've had

[1:23:56] that conversation previously in

committee where I said, well, what if 50 people wanted to go

take a vacation in Florida and

[1:24:02] they just filled out all this

paperwork and left. So I don't recall that there

was an upper limit in statute.

[1:24:08] But have you establish some

sort of upper limit of how many caregivers can take care of someone? I know it's more than
[1:24:13] 3 minutes, less than 50, as you just said. So where did we land and all of that, Mr. Rowe.
[1:24:21] >> That Madam Chair, thank you, doctor, should have prepped. Appreciate appreciate the question. And maybe just to go
[1:24:27] back to the just to go back briefly to the point around which, you know, I'm kind of a process trucks, right? I think
[1:24:34] there's about there's about a program designed in terms of making sure that each, you know,
[1:24:42] ensuring program combining program and to combine program integrity while also making sure that you've got a
[1:24:48] realistic approach to program the administration, right to say no to again, as I mentioned, right? I think we've
[1:24:54] got over here. We have a variety of overlapping controls. And again, I would not I would not understate the
[1:25:00] value of the employer role or the value of of of integrity
[1:25:06] reports that we get from from

people or, you know, from the employers or just concerned citizens around the come around
[1:25:14] the state kind of providing us with that information. It is. It is information that we absolutely act upon is
[1:25:21] information that is tremendously valuable in terms of providing, you know, in terms of ensuring that the
[1:25:29] program is going to operate in the way that that that we expect it to double just need to good need to confirm just
[1:25:37] the exact rulemaking or administrative site just to just to get that answer back to you. But I guess just from a
[1:25:43] broad perspective, you know, we have program, you know, our program integrity unit is, you know, exists to ensure that we have checks in
[1:25:52] place when there are multiple caregivers in place, right? Again, family situations are complex. But I think that we
[1:26:00] understand to the questionnaire to the question earlier that there are multiple factors here and we are there going to be
[1:26:06] extremely careful about thinking about how those pieces can be can be put in place to ensure that the

[1:26:16] system is being respected.
That and you know, that individuals are, you know, only
getting the benefits that
[1:26:24] they're entitled to think. Commissioner, I don't have a
quick subjective.
[1:26:30] Madam Chair, thank you. I just
wanted to one sure I understand the snare
you're describing and also just
[1:26:37] sort of play out if I'm understanding correctly
what that might look like.
[1:26:44] I think I'm envisioning a group
of people who coordinate with each other to set up that
Florida vacation.
[1:26:52] That would require that all of
them were going a quick listen. Selves caregivers would come to
the paid leave site.
[1:26:59] They would take a picture of
them. They will be forced to take a picture of their face
with their phone. They'll be
[1:27:04] forced to take a picture, their
driver's license. They'll know that
[1:27:10] they will be essentially
testing to condition. That isn't true. They will be engaged in a
[1:27:16] conspiracy in order. >> To get half of their usual
salary for a short period of
[1:27:24] time, they will be putting themselves

in a great deal of

[1:27:32] risk for prosecution for quite a meager benefit.

[1:27:37] I just want to encourage us

that in any state program

[1:27:43] to eliminate the potential for

fraud, 100%, we would either need to not

operate the program or we would

[1:27:50] need to staff the program to

such a degree the cost of running. It could

start to

[1:27:57] get close to the cost of the

benefits being provided. And so is it as we think about

fraud, as we think about the

[1:28:04] technology and the people

involved in combating fraud. We need to look at this from a

bit of an arrow. I perspective

[1:28:12] look at the risk level, have layers of security, Frey, detection fraud,

mitigation in place. But if the

[1:28:19] goal in possibility, I don't think that that is a

realistic idea to have as our

[1:28:28] it is our North star. But the

cost of achieving that would be

[1:28:33] incredibly significant given a risk that I think we

need to put in context here and

[1:28:40] that their legal remedies in

place for and that would be pretty obvious with any kind of data

analytics

[1:28:50] approach that was applied to

the situation. >> His fall to the quick left,

the senator. Thank you, Madam Chair. Just a quick

clarification. This is a

[1:28:56] conversation that deputy

commissioner when I had had early on as we were crafting

this as a legislature and I

[1:29:05] posed the question will if

grandma was in Florida and grandma needed care? I'm not

saying that nobody in Florida

[1:29:11] needs care. My specific

scenario which is I took a shortcut because commissioner

knows what I'm Debby

[1:29:17] commissioner onus on him

talking about. But clearly what I was trying to say was Graham in Florida clearly

needed care and we'd have that

[1:29:26] conversation. Will can 2 people

go care for sure can 10, yes, can 20 can 30 can 40 can

50?

[1:29:33] And when we were crafting this

as the legislature, there really wasn't a good answer to

that. And I'm not saying that

[1:29:40] there is somebody there that

needs care. I'm saying that there is. But I'm saying that

you would have so many

[1:29:45] caregivers come all at the same
time to a very nice place. And maybe it's December
January, February. It's not so
[1:29:52] nice here. I'll go down there at the same
overlapping time. And my question to the commissioner at
that time was actually can you
[1:30:00] see that in the database, which
at that point hadn't even been built. So really, that was that was
more. So the question and we've
[1:30:07] kind of gone back and forth as
to how many caregivers are allowed, because in statute you
can have whatever number that
[1:30:15] you want. So there has to be
something an administrative rule that limits it. The
application has 3, but clearly
[1:30:23] you can have more than 3.
So my question wasn't about everybody just taken off and go
to Florida, although that was a
[1:30:30] scenario that the deputy
commissioner Ni talked about early on in this development of
this bill and now law. But the
[1:30:38] question is, is there now in
rule and upper limit? Because when the commissioner said,
well, 50 wouldn't be approved?
[1:30:47] Probably because I had it had
that conversation early on as this was being crafted. I would

hope 50 wouldn't be approved.

[1:30:53] But I'm wondering if there is a

level at which you go, but I think that's too much. And

that's going to have to be

[1:30:59] because it's not in statute

because legislators and say here is the limit. It has to be

decided by,

[1:31:05] you know, a lovely bureaucrat

in an office to make that decision. So that was the

impetus for the question that I

[1:31:12] had. But it is a real concern,

right? It was a real concern as we are crafting all of this

that

[1:31:18] when I look at how people are

going to misuse and abuse is program, it is an when they say

they are the caregiver and they

[1:31:27] have let you know, they've gone

through this whole process and yet they take off 2 weeks, 3

weeks, 4 weeks, 5 e 6 weeks,

[1:31:33] 10 weeks, whatever it is and they don't actually provide

care. I think that is what all of our great concerns are.

And of course, we want

[1:31:42] mothers and babies to have time

together and have bonding time together. And, you know,

[1:31:48] the concept of the program is

exactly what it should be, but I'm looking at the bad

actors. That's our that is our

[1:31:55] role in the fraud Prevention

and state Agency Oversight Committee is we're trying to

think like a bad actor. So

[1:32:01] we're giving you scenarios say

here is a bad actor. This is what a bad actor could do.

So hopefully that clarifies it.

[1:32:07] Thank you, Madam Chair. >> Thank you. And just to put a

finer point on it, is there any upper limit on the number of

caregivers in administrative

[1:32:15] rule since there isn't one in

statute? I think that's where we need to get an answer. >> Madam Chair and and the

Representative, Rick, thank

[1:32:22] you. Thank you. Thank you.

First, just for kind of clarifying that. That's very

helpful just in terms of that. So again, that's all I'll

answer all answered and few

[1:32:29] parts, right. So the forgive what I would just

say in terms of the approach

[1:32:36] that we're going to be taken

here, right is so I thought, well, it's always onto the

brief part first, which is not

[1:32:42] in there is there is not a

specific number in statute or rule, but let me Everett on

that response because I think

[1:32:48] it's important to think about

this, right. The as you know, as we've kind of
been talking about, there are a
[1:32:56] variety of family. Caregiving
is complex and in some cases you might have a few people
doing more limited parts where
[1:33:03] you might have one person doing
a lot, right. Like an I think the statute was at the statue
rules have been crafted to kind
[1:33:10] of recognize that, you know,
those kinds of scenarios are complex.
[1:33:16] What I would say, though, is we
have to just because you do not, you know, just recognizing
that complexity, we have
[1:33:22] administrative we have
administrative capabilities of ensuring that things are in
line with what is reasonable,
[1:33:30] right? And you know, when you
when we talk about like, if somebody has multiple
caregivers, well, as part of
[1:33:36] that, the application for
caregiving leave, you have to put a schedule of caregiving,
right? And so we will have
[1:33:41] administrative data that will
that will state like how many people are stuck are
approved to take caregiving
[1:33:48] leave at the specific time for

the specific individual right now. Again, you know, you don't
necessarily want to say,
[1:33:55] you know, you don't necessarily
want to pick a specific number because life is complex, but I
would just say
[1:34:02] we have a variety, you know,
again, with those administrative data,
[1:34:08] we know who is going out.
We know who's going to be taking we for that purpose.
We know how many of them are
[1:34:14] going to be taken away for that
purpose. And as Deputy Commissioner directive noted,
if somebody is trying to game
[1:34:19] the system, there are. And as I
discussed earlier as part of this program, there are ample
statutory tools for us, too.
[1:34:27] You know, to what the you know,
to not pay benefits and to begin with or somebody else,
right, misrepresents the record
[1:34:35] to issue administrative or
criminal penalties as may be
[1:34:40] appropriate. Right? I think the other piece that I
didn't mention that I would just note in addition to the
tips and reporting that you can
[1:34:47] have from employers from the
general public is that, you know, there's also going to be

random audit component of this.

[1:34:52] And we are certainly going to

be, you know, I I wouldn't want

[1:34:57] to get into the specifics of

the program audit the approach in public, but I would imagine

that we will be looking at a

[1:35:05] variety of factors as we

contemplate those items. But I do just want to emphasize

right that, you know, through

[1:35:13] the data that we have, and yet

in the collection of the application, we know who's tied

to. We know who's tied to what

[1:35:18] caregivers and that ended with

caregivers are tied to which individuals and, you know, we

will have and we have a well

[1:35:25] resource program, integrity

team that will be reviewing these components as we go

forward.

[1:35:32] Thank you, vice-chair Anderson, very quick. Just a couple

things.

[1:35:38] >> I'm FMLA there. You know,

you talked about the caregivers and approving that it's very

different than this because

[1:35:45] family is on paid. And so

people aren't going to be trying to get up from L a fraudulently. You know, we're

says

[1:35:53] potentially it would with this.
So it's very different. I also want to, you know, as an
employer, this know because
[1:35:59] there's no experience raining
like unemployment. There is no incentive for an employee to
turn someone in because there,
[1:36:06] you know, at a shopping mall
there says taken someone, you know, 2 came off or
whatever. So there is no
[1:36:12] employer incentive to help with the fraud issue. I tell
you that as a player who's
[1:36:18] dealt with us for decades, I represent cream and talked
about this classification and
[1:36:25] we're really just talking about
self employed people, general people who are out, I'm gonna
talk about some from put.
[1:36:32] So we are, you know, they can
opt into this program. And I
[1:36:37] think I think as that happens, that I
would want to watch that because a
self employed person could get
[1:36:45] back to your example of the
migrants, you know, could easily say they have migrants
one day a week, you know,
[1:36:51] their their own employer and,
you know, they could get wages

[1:36:57] for 20% of their their pace.
I actually think there's more potential for abuse or fraud or
whatever in that case,
[1:37:05] something to and I don't know if you've done
anything about that or.
[1:37:12] >> Thank you, Madam Chair and
Representative Anderson, thank thank you. Thank you for
that point. You know, I think it's it's you know, I would say
in the statute there is a
[1:37:19] requirement that if you protect
that, if you are self-employed or independent contractor, you
sign up for the program,
[1:37:25] you are required to participate
in the program and pay premiums for at least 2 years. As part
of that, I would also just say
[1:37:33] that, you know, the the half of
the scenario with this narrow scenario you outlined, there is
not something that that the
[1:37:41] department has not
contemplated. So it I think it is something that we will be
watching carefully.
[1:37:50] >> We're going to go to
Representative Hawkins. But as he's asking his question, I see
that auditor, Randall is in the
[1:37:56] audience and I wondered if she
would consent to coming in. I have a question for you.

She wouldn't mind.

[1:38:03] >> But Representative Hawkins,

you're next. Yeah, thank you. Thank you, Madam Chair. So I

think we're getting a little off track here because this is

a wage replacement program,

[1:38:12] though. No providers are are

being compensated as part of this program. For-profit

provider wants to be

[1:38:18] compensated for the services

that providing we're going to be compensated by an insurance

company.

[1:38:23] And to Representative Schultz's

point, they're not going to have to do anything that they

wouldn't otherwise do in order

[1:38:30] to get paid by an insurance

company. We're talking about going out to from deed to

existing electronic health

[1:38:38] record systems where the doctor

that whatever the kind of provider does is our already

documented that I provided this

[1:38:46] service to this patient for

because of this tie diagnosis. That's all we're going to going

to be drawing from here using

[1:38:54] standard energy industry

interfaces. So there's going to be like 0 incremental burden on

health care providers as part

[1:39:00] of this program. I think we're
kind of get gotten ourselves and incurred on. You know, our
experiences from examining a
[1:39:09] handful of DHS programs were
and tyranny. New classes of providers have gotten invented
without proper proper vetting
[1:39:19] and its coloring the way we're
looking at everything else. And this is really a
revolutionary way for us to
[1:39:26] approach the the creation of a
new benefit program. And in my 7 years here, this is only the
second example. I can think of
[1:39:35] the first one being men drive
where legislation was crafted specifically to make it
implementable.
[1:39:43] We worked. You know, I
personally worked along with the Representative Richardson,
who is the primary author of
[1:39:49] the bill with D to make sure
that the law we were writing could be implemented in the way
that Mr. Rowe is describing it
[1:39:58] today. So to try and, you know,
force parallels between this
[1:40:03] program and some of the fraud
ridden programs received unseen and DHS, the parallels just
aren't there. This is a model

[1:40:11] for the way that we need to be
administering benefit programs going going forward. And that
the stuff that, you know,
[1:40:19] Mister Eitan is describing, you
know, weren't one of the problems we've had
with some of these other
[1:40:26] programs we looked at is that
there they come up out of nowhere and they involve all
kinds of paperwork. This
[1:40:32] specific to particular program.
They're not, you know, drying data from other available
sources to Capri populate the
[1:40:40] application forms. So I think
we're getting lost here because what's being described to us is
so different from everything
[1:40:48] else that we've looked at. If you know, I I been very
close to this program all the
[1:40:54] way through. And if it bombs on
implementation, I'm gonna take it personally,
[1:40:59] because I really do believe
that that we're doing this right in this in this case is
and it's going to pan out the
[1:41:05] way we're describing it. >> I think you've got it to her
rental for coming up.
[1:41:16] And when you start to stage a
name for the record, my question is you have I did a lot of

programs.

[1:41:23] You've heard a lot today and I know you have that actually audited this program. It's not even implemented yet. But when you think about the

[1:41:32] issues you see in other programs for internal controls. And and I see my concern is some of the things we talked

[1:41:38] about about the caregiver side with no upper limit. And I looked at the schedule and Mr. You can speak to this later,

[1:41:44] but I don't see any requirement for caregiver intermittent schedule. I'm looking at the farm. I don't see it. So maybe can

[1:41:51] point that out to me. But back to out of the Randall years, if you could help us,

[1:41:59] this program isn't live yet. If there are things you've heard today or concerns you have that we should be thinking about so that we can make sure

[1:42:07] this program to represent of Elkins Point doesn't have fraud. We we were were rooting for this not to

[1:42:14] have fraud. I don't want to have more fraught hearings, but I'm concerned because I my reading of the statute, it's

[1:42:21] fairly vague and I we've raised a lot of concerns today. So if you could

[1:42:27] just sort of address what
you've heard and talk about what you think sort of the
basic internal controls are
[1:42:34] that are the without which
nothing are needed and any thought to
have for the committee would be
[1:42:41] appreciated. Thank you. >> Thank you. Madam Chair
members for the record to demand a legislative auditor.
Excuse me. Nice to see all of
[1:42:48] you today. So let me just say
as auditors we don't generally
[1:42:55] are we don't ever opine on
something that we have an audit. And we obviously have
not to this program. I'm sure
[1:43:01] I'm sure we will in years to
come. So people aren't just because it's a risky and often
enough money. The you know,
[1:43:09] it will land on our radar
screen. So I can't I can't say anything definitive, of course.
But I I listen to the
[1:43:16] presentation and and honestly,
I was impressed with a lot of that. I love that. You have the
green book. I'm on your slides.
[1:43:23] That's all the internal
controls, which is what o la audits against. You know, I
don't know if you put that in

[1:43:29] for me, but I love that.
And I think that's excellent that that's something that's
that you're thinking about as
[1:43:35] you plan. I mean, I think we
all have talked and I've heard you talk about it. And I know
as a legislature you've all
[1:43:41] talked about how prevention is
the most effective and the cheapest way to handle fraud.
And so putting the controls in
[1:43:49] place up front is by far the
most effective re. It's much better than pay and chase,
which is what we have found
[1:43:55] ourselves doing in some of the
programs. Representative Elkins mentioned. So I think that's
excellent. And I think a lot of
[1:44:03] that ice taking copious notes
during the presentation. And I think a lot of what you
laid out where we're really
[1:44:11] good internal controls and
procedures for for that prevention piece, you know,
that having policies and
[1:44:17] procedures for determining
eligibility for doing the identification verification
through the log-in, that man.
[1:44:26] So what I think there's a lot
of good things here. You know, the proof is in the pudding and

implementation is always what's
[1:44:33] key. And of course, I can't
opine on that. The one thing I didn't hear
mentioned that doesn't mean
[1:44:39] it's not in place, but I would
just raise this is the procedures and plan for the
investigations on the back it.
[1:44:48] So again, I know we just I just
said it's better to prevent yes, and I think it's excellent
to put a lot of energy into
[1:44:54] that. But we also kind of
acknowledge it might be impossible to have, you know, 0
fraud, which Deputy
[1:45:02] Commissioner Dan, I would just
say, that's always the goal. Everyone's goal.
I know. I believe it's
[1:45:07] attainable. But, you know, so
having some policies and procedures. And and my guess is
you have those in place and
[1:45:16] you're limited in what you can
say here. But just to make sure, you know, a lot of the
internal controls are just
[1:45:21] really basic things. Whose
responsibility is it, right? How do we identify which ones
we're going to investigate?
[1:45:28] What what metrics are we using?

You know what flat? What when we do the data analytics?

What are we looking for?

[1:45:34] What's going to raise a red

flag and then what are we doing with that? And again, I know

that all seems obvious, but

[1:45:40] having that documented. So

everybody's on the same page is really important. Another thing

I would I would just encourage

[1:45:47] is for you all to use all the

authority you have in statute. I know there's a lot of

[1:45:54] of desire and interest in

getting these payments out

[1:46:00] quickly, right? I think the law

has a 2 week made it to week

[1:46:05] window, but I think the law

also allows you to extend it if needed. And so

[1:46:12] holla see a procedure for when

is it needed right? What constitutes a reasonable action

for extending beyond those 2

[1:46:20] weeks and then and then using

that ability? If you do see things that raise red flags, I

don't think anything I'm saying

[1:46:26] is rocket science. I don't

think anything I'm saying would be new to him. Deputy

commissioner role and I'm

[1:46:33] encouraged. I'm hopeful, you

know, but will be today. So, yeah, you know.

[1:46:40] >> Thank you out of there.

And and Mister, keep in mind responding uspis specifically

to her issue about how you will

[1:46:46] handle investigations, what

what will trigger an investigation that would be

useful. Thank you, Madam Chair.

[1:46:53] I you know, I. >> I would I don't want to say

that there's a cop like so to

[1:46:58] the credit to the item that are

out there and noted, yes, we have power. You know, we do

have procedures and plans for

[1:47:05] our investigations will be

conducted. You know, I think there, you know, the as far as

when do we when do we conduct

[1:47:12] investigations? I'm not gonna

give you a comprehensive list here. But examples of things

that would trigger investigations would be

[1:47:18] items that are suspicious,

right, that we see that individual level right in an

application. I think we spent a

[1:47:24] lot of time on kind of one

particular scenario today. You know, I think things where

we see, you know, where we get

[1:47:33] incoming reports, obviously,

that is the kind of thing that would trigger an investigation,

right, whether through a fraud reporting, whether through an
important item that an employer
[1:47:41] raises as part of the program,
whether to whether it's something that we see, whether
it's something that doesn't look quite right in the
certification for, right.
[1:47:49] You know, additionally will be
working closely with the Department of Labor and
industry. You know, as far as
[1:47:54] workplace protections go, that
is, you know, that it's also the type of thing that could
raise an integrity question.
[1:47:59] And I'll just without going
into gory detail. All just say that there's a variety of data
and what X and and other kinds
[1:48:08] of internal analysis that we
will be doing to. I identify patterns. And when we see when
we see something suspicious,
[1:48:16] we will investigate it
thoroughly. And I will just say, you know, we you know,
[1:48:23] we will be the certainly our
objective is to not issue any payment. You will be to stop
payments going out if we see if
[1:48:32] we see something amiss. >> Thank you for that. And just
declare so when you see
[1:48:37] something that's a credible

allegation of fraud, you have authority currently for this
program to stop payment.
[1:48:42] Yes. >> Representative, thank you,
Madam Chair. I know we're we're tight on time, but I just got a
question and a comment as the
[1:48:51] overseeing a lot of hearings
about paid leave in my capacity as co-chair of the jobs
committee members. I don't
[1:48:56] quite know the answer to this
question. The certification process we've been talking
about. And this will be just for the folks that nothing on
the EU and Randall, the
[1:49:04] questions of the certification
process we've been talking about, that would be just for
those employers that are choosing to go with the state
system of employer, choose to
[1:49:11] go with a private plan, which
is an employer's options. Lots and lots of options in
this in this program, though,
[1:49:16] those in the other
certification process ease. Is that right? >> Mr. Rutte, Madam Chair,
Representative, that is
[1:49:23] correct. You know, the unit.
So the you know, we expect the to significant majority of
employers will be using the
[1:49:30] state plan, but a significant

minority of of of of employers will be using equivalent plans.
And, yes, they you know,
[1:49:37] those those plans while they
were, you know, they are required to provide benefits
that are at least as good or better than the state plan.
They do. You know, I'd say that
[1:49:46] the process should be
presumably be similar, but they don't know if they pay. Those
insurers will have their own
[1:49:52] processes in place to validate
claims. >> Thank you. And then tip into
that. Thank you, Madam Chair.
[1:49:58] And so then just a comment on
that. And so just emphasizing then that you have an employer
wants a certification process
[1:50:04] that has some other components.
They can find a plan that offers that they can do that.
It wasn't consistent with state
[1:50:09] law. So appreciate that.
And then just stepping back. You know, our program, as it
has been referenced, several
[1:50:15] times has been has drawn from
the experience of other states, incorporating some of the best
Practices Act together. We're
[1:50:21] the first state to actually
have direct integration with electronic health records,

which seems incredibly powerful. One of those lessons
is that the kind of individual
[1:50:28] fraud that's been reference
here is vanishingly rare, which makes sense because and I
think I just want to kind of
[1:50:34] step back and recognize that
unlike some of the other programs are talked about in
terms of individual claims,
[1:50:39] it's something where there's a
preexisting relationship between an employee and
employer. An MRI commissioner
[1:50:45] gonna so much appreciate the
way you describe it. The kinds of things that's been done that
has been referenced here would require somebody to go out of
their way. Again. You have 20
[1:50:54] people looking for 50% wage
replacement exposing themselves to a ton of civil and criminal
penalties and work. As a
[1:51:00] prosecutor, I said the
legislature first mower a look at these penalties. They could
be going after eventually go to prison for a 50% wage
replacement. Then they come
[1:51:08] back and resume what is
presumably a position of trust with an employer because
employers continue to employ
[1:51:14] this person. So I think we just

need to recognize that the set up here. And by the way, if
you're 20 people who are saying
[1:51:21] they're going to provide care,
giving you have to have a medical provider who would risk
their license, Biden certifying 20 people. And I will say that
I found it especially
[1:51:29] disturbing the the hypothetical
that was brought up of. Maybe you've got a family member who
is actually sick and they're
[1:51:37] living in some warm place and
maybe people take advantage of that by going, you know, Graham
is dying. And also we get to
[1:51:44] have a paid vacation of
Florida. And by the way, come back to to to the employer
4 years. Minnesotans have been
[1:51:51] desperate for chances to be
with their baby to take time to to deal with their own cancer
diagnosis, to be with a dying
[1:51:57] family member. And for years,
those efforts were blocked
[1:52:03] by a number of folks who I hear
now just broadly, not necessarily in this hearing,
but more broadly bringing up
[1:52:10] the point saying that that, in
fact, we're going to do is spend a lot of energy blocking
Minnesotans having exit access

[1:52:16] to that as we head through the
years, if we spend as much energy, ensuring that
Minnesotans have the access to the benefits they were so
desperate for, as we're now
[1:52:23] doing focusing on these
individual situations. My goodness, this would have
happened a long, long time ago.
[1:52:28] So I'm very glad that now we're
focusing that in January one Minnesotans will finally of
access the benefits I share
[1:52:34] auditor, Randall's
encouragement and a sense of really appreciating what you
described and let's get out
[1:52:41] there, make sure that people
finally get the time to be with their family members. They've
been so desperate for for so long. Thank you, Madam Chair.
Thank you. So we are almost out
[1:52:49] of time, but I did have a
couple of follow-up questions. First, the use of the
electronic health records.
[1:52:55] >> And that into Gration, I
understand it's novel and that it might be providing some good
data protection and data
[1:53:04] analysis work. >> Where where was that
authorized?
[1:53:10] >> Madam chair, the authorized

in what sense? >> Was it authorized in statute
that you would have access to
[1:53:15] the electronic health record
system? >> Boucher. So I think that I
think this is so this is us
[1:53:23] working with the health care.
This is what's working with the health system's right. So if
your views here may its its
[1:53:28] center to provide a more
straight for, you know, to provide a more straightforward
method of submitting
[1:53:35] certificates of submitting
certification paperwork that, you know, again, otherwise, you
know, and in other states use
[1:53:42] the paper based process and in
that, and that has worked as you've heard. But I think that
this is really about, you know,
[1:53:50] this is primarily about
providing greater convenience and ease of use for these
critical partners. I think we
[1:53:57] you know, we heard committee
members asking questions about what are ways that we can
reduce the burden on medical
[1:54:03] providers. And I I I could look up for
specific statutory site,
[1:54:08] but I but I think that this is

something that that is what's well contemplated. Thank you,
Mr. Acton. Did you have a
[1:54:15] thought on that? >> Just to the Madam Chair.
Thank you. Just to clarify,
[1:54:20] I think if the impression is
that the department could have access to someone's medical
records, that's incorrect or
[1:54:28] that something is incorrect.
We're talking about receiving the I
[1:54:35] it dear. I bet I like trying to
electronic data interchange that the other acronym
[1:54:42] information that is necessary
from the medical providers in order to adjudicate the claim.
The authority for the
[1:54:50] information is what's laid out
already in the up to the statute. It says you must
collect this information from
[1:54:58] the medical provider in order
to adjudicate the claim. There's a lot of ways to do
that. If you think the Department of
Health in some cases, it's the
[1:55:05] facts of the necessary
information that they need for par to program. In other cases,
it's a portal online where
[1:55:12] someone goes in keys and in
both of those are highly manual labor intensive and costly, the

most effective efficient way to

[1:55:20] interchange. 82 in terms of

quality speed and low cost is the electronic data interchange

where these are established

[1:55:30] data exchange protocols that

are in the healthcare industry. The novel piece is the

willingness of the health

[1:55:37] systems in this state to engage

with the state and work start working on a plan to build that

level of automation. And that I

[1:55:45] think will be ultimately more

secure, more efficient and more accurate.

[1:55:50] >> And if I could just add

certainly Miss room, yeah. And I guess to us for specific

statutory citation, I think

[1:55:57] that would be found in the data

practices section of our of Chapter 2.68. Be. So, you know,

I think were authorized to do

[1:56:03] this with health care

providers. I just know a couple other things, right? Like we

are working very careful.

[1:56:10] You know that as deputy

commissioner acting noted, this is a new kind of standard

electronic data interface,

[1:56:16] kind of component that

hospitals have used to build. For other thing for a variety

of other things, we actually think in many ways this also
this this also really
[1:56:23] >> will. >> Improving of this will
improve data sickness, improves data security, even, you know,
even more strongly in the sense
[1:56:31] that because if anybody who's
worked in the medical field knows, you know, physicians and
medical providers, nurse
[1:56:37] practitioners day with an epic
they live in their HR. And this
[1:56:42] is going to be a way to really
smooth to smooth that process for all of them. And again, we
take we're taking, you know,
[1:56:48] in partnership with these
health systems, you know, working very carefully to
ensure that, you know,
[1:56:53] everything that we're doing is
HIPPA compliant that we're not collecting any unnecessary
information. As deputy commissioner actor noted, we're
not going to be accessing the
[1:57:00] medical records, all that we're
what we're enabling is for a medical provider to not after
break out of their workflow
[1:57:06] that you work with with an epic
so they can send some data and then received state in a in a
in a in a in a very useful for

[1:57:14] them. >> Thank you for clarifying
that. I think when we were referencing earlier in the
discussion, electronic health
[1:57:19] records, specifically, that was
how we were referring to it and that honestly raise some red
flags in my former well on the
[1:57:27] Judiciary Committee and a
protege of Representative Scott. I just had to channel
what I was hearing in my head.
[1:57:33] That's what Peggy would be
asking. And so I appreciate that. And I may
actually have a follow-up email
[1:57:40] clarification on that. And then
the last thing we've got 2
[1:57:46] Minutes X, so many questions.
[1:57:52] So we've kind of beat the
number of caregivers to Das, honestly, but I do think it's
it's important. It's been noted
[1:58:00] that the caregiver form is not necessarily by my
understanding, creating a
[1:58:06] schedule and it's not necessary that the
individual who is seeking
[1:58:12] caregiver leave gets that authorized by the
person who's providing care
[1:58:19] like what the one doctor who is
the care of the patient, who's in care of the patient

needs that care. Is that the

[1:58:26] one doctor responsible for

certifying all caregivers, or can they kind of find other

providers to certify that they

[1:58:33] should play the role of

caregiver? >> Madam chair, so to the to

the first, you know, to the to

[1:58:40] the first part. So it's

certification for because the this is actually going to be

the schedule, something that

[1:58:45] would be would be submitted as

part of the application for caregiving leave. So obviously

we've got you know, there's

[1:58:51] that there's the certification

for that's the medical provider saying this is us at this is

this is a central, you know,

[1:58:57] for your for this. But but as

part of the application flow, when they are, when the

individual who is providing the

[1:59:04] caregiving leave is going to be

signed, it is going to be submitting their application.

That's where we collect that

[1:59:10] information around, believe

schedules and those pieces. So that's, you know, to get in

on that form. That's because

[1:59:15] it's part of the application

flow that will be going live. It's one doctor per person
needing wave. So if you so,
[1:59:22] you know, with so the kind of
the the individual who is seeking needs the kid who needs
the care that needs to be tied
[1:59:30] to one physician, and that is
something that department will be monitored. >> And so the person, if I'm
applying for leave to care for
[1:59:38] my grandmother, I have to go to
my grandmother's doctor to get them to certify or I go to my
own doctor and just say,
[1:59:46] hey, can you serve? I need to
go take care, my grandmother. >> I think if I'm understanding
the question, if I'm
[1:59:53] understanding the question,
right, I think the you know, the the grandparent in the
grandmother in this case would
[1:59:59] have gone to her doctor, right?
And what have you know, when the doctor would have to
certify that she has something
[2:00:06] that she has a condition
required requiring caregiving leave, it would be that doctor
that would set that would need
[2:00:12] to sign off on, you know, on
the caregiver caregivers in this case.
[2:00:17] >> So the caregiver also has to

go to the same doctor so they can't be multiple doctors and

often certifying caregiver

[2:00:23] leave. That's correct. Okay,

excellent. Thank you, Mr. Rau, Mister Acton on a tour

and all

[2:00:30] thank you for participating in

this hearing. It is our

[2:00:35] strong hope that the internal controls in

this program I robust

[2:00:42] and followed because we do not

want to be back here a year from now having a Friday

hearing. So I appreciate your

[2:00:48] hard work on this and we look

forward to your success. Thank you. Madam Chair,

Transcript of Minnesota House Fraud and State Agency Oversight Committee Hearing 12-17-2025

[0:02] >> Good morning. >> I call the House Prevention
and State Agency Oversight Committee to order a quorum is
been established. Today we are
[0:10] hearing from the Minnesota
Department of Health and the Minnesota Department of Human
Services to discuss customize
[0:15] living services and assisted living facilities.
In addition, we are going to
[0:20] discuss adult day services that
are licensed by the Department of Human Services.
[0:26] First, we're going to approve
the minutes from November 19 vice-chair. Anderson, have you
had time to review the minutes?
[0:32] I have got a chair and I move
approval. Thank you, sir. And discussion
[0:39] all in favor of the minutes
from 11/19/2025. Please say aye. Any opposed.
[0:45] The minutes are adopted. All right. First, we will move
to the presentation by the Minnesota Department of Health
and the Minnesota Department of
[0:52] Human Services. And I just want
to point out that the commissioner of Health has had
a prior engagement and is going
[1:01] to need to leave early. So

we're going to let him present first her I'm sorry,

[1:08] Cunningham,

[1:15] some members, how how we're

going to do the discussion is when we get to the Department

of Health, if they have,

[1:21] if we have specific questions

for the commissioner of health for going to turn to that first

and then once we finished,

[1:27] the presentations of both

departments will take public testimony at that point.

[1:33] Welcome to the committee,

Doctor, Commissioner Cunningham,

[1:38] thank you. Madam Chair, I think

you representatives for having us here this morning, members

of the committee.

[1:45] >> We appreciate the

opportunity this morning to tell you more about the

facility's license under

[1:50] Chapter one. 44 G also known as

the assistant living license facilities

[1:56] and BH is the agency generally

responsible for ensuring the quality of care provided

[2:02] 2 residents of facilities and 2

persons needing support services and their homes.

[2:09] Now to ground us. Let me define an assisted

living facilities and assisted

[2:15] living facility is a facility
that provides sleeping accommodations and assisted
living facilities. Do one arm
[2:22] or serve one or more adults 18
and older. So assisted living services that they provide
include helping residents with
[2:31] their activities of daily
living. Those things like bathing toy letting a feeding
dressing medication
[2:38] administration as a nursing
test, taking blood pressure or blood glucose. For those who
have diabetes, again,
[2:45] medication management services,
therapies and treatments and preparation of specialized
diets and assistance to
[2:52] residents of complicated eating
problems again. Assisted living facilities are housing plus
health care,
[3:00] and they may include a secured
dementia unit. So we license
[3:05] both assisted living an which
is the standard license and assisted living with dementia
care. So if stuff is facility
[3:13] advertises or provide
specialized dementia care or has a lot memory unit, it must
have that dementia care license

[3:25] on 8/1/2021. Minnesota
assisted-living licensure became effective in a sling
empties to license survey
[3:33] investigate and enforce other
Minnesota's statue. One 44 D requirements.
[3:39] Keep in mind, this was
happening in the midst of the pandemic which place a unique
strain on the state's
[3:45] assisted-living facilities.
But we were able to implement these needed reforms even and
that trying difficult moment.
[3:54] So it feels important for me to
say a couple of things up front around this again under one.
44 G it asked him th we're
[4:03] focusing on the health and
safety of residents. We are certainly careful to notice
potential indicators of fraud
[4:12] where we see them and work
closely with other entities tasked with investigating
potential fraud when we have
[4:18] any of those observations and
prior to this year in DH was not mandated tough to report
fraud or referred other
[4:27] agencies. But we did that as
part of our regular practice, you know, which shifted in
2021, as we noted on the site

[4:34] was when we went to this
licensing tight, we shifted from housing with services to
the assisted living licensure
[4:40] and certainly carry out with
all due diligence that responsibility with those 2021
reforms. Let me run through
[4:49] what a number of those reforms
were. We established a single license
for assisted living facilities,
[4:55] streamlining the regulatory
structure by creating the unified license type. We
increase licensee
[5:01] responsibilities and
accountability, heightening oversight and defying clear
responsibilities. For
[5:07] operators. We implemented physical plant
and fire safety requirements to strengthen our review of
facility, infrastructure and
[5:14] emergency preparedness
standards. We require licensing for the actual providers
themselves and accountability
[5:22] measures for those in
leadership roles. We change the survey from 3 years to 2 years
which increased our regulatory
[5:28] oversight and we enhance the
resident bill of rights and expand it commute consumer

protections. So all of these

[5:36] reforms that allow us to

increase our responsibility and accountability for licensees

and 2 again, ensure the safety

[5:43] of even the physical space, the

facility and these reforms enhance the

resident Bill of rights and

[5:51] expanded consumer protection so

says allowing electronic monitoring devices and

clarifying resident status and

[5:58] are landlord tenant law. The resident Bill of Rights

contains 24 rights and the

[6:04] recourse for residents in all

assisted living facilities and Minnesota. Many of these things will be

implemented this January 1st

[6:13] and with a new edition and

trying the right to a support person physically president at

the at residents choosing at

[6:20] times of the residents using

these bill writes include things as simple as courteous

treatment. 2 refusal of of

[6:27] care, freedom from out

treatment, right to come and go freely individual autonomy

right to fire. Some decorate a

[6:34] whole list of 24 rights that

were outlined and will be implemented this January

[6:40] to give you all a sense when
license or came into effect. And BH initially anticipated
that about 1300 to 1500 of
[6:49] those housing with services
licenses work would convert to assisted living facilities.
But what we've seen is that we
[6:58] have had growth in the space to
respond to the need and the demand. And we have over 2000
licensees and 2025 and and
[7:09] certainly even back then
initially we have higher than anticipated conversion into
assisted living. So when you
[7:16] look at the bar charts there
you see in 2025 there, 2328
[7:21] assisted-living facilities.
They have a variety of capacity, some with 5 or fewer
residents up to 17 or more
[7:29] residents. And so there's a
clear upward trend. And then to the number of total licensees
reflection of about a 45%
[7:39] increase per year. There were
saying in growth in this space,
[7:45] the numbers, of course,
fluctuates facilities open some facilities close. Sometimes
they're called consolidation,
[7:51] interchanges and ownership.

But the main takeaway from from this graph and my comments,
this is a large and growing
[7:58] industry which means the need
for consistent oversight in collaboration with local
partners like fire chiefs more
[8:06] than ever. It is important to
note that smaller system living facilities are often mislabeled
as group homes and are
[8:13] frequently confused with other
state license residential living settings that may
provide similar housing and
[8:19] health care services. A license assisted living
facility is a healthcare facility regardless of the size
of the facility and the number
[8:28] of residents, which is why it
is regulated by the Minnesota Department of Health.
[8:34] Just briefly, I want to discuss
this in detail. This gives you some idea of the overview
across our state and terms of
[8:42] total numbers to ciliving
facilities, Park County and we have a broken down by percent.
And you see a dominance,
[8:48] of course, here in the Metro
with with Hennepin and Ramsey.
[8:53] Now as part of our regulatory
duties, as I mentioned, as part of the licensure, what from a

survey from every 3 years.

[8:58] So every 2 years and surveys

are literally when we reviewed the documentation we go on

site. So when I say a survey,

[9:05] it is not what we might

commonly think of a survey. It is a site visit. It is

making sure folks are complying

[9:12] with with our regulations and

really complying sufficiently to prevent unacceptable health

and safety risk to residents.

[9:21] So staff go through a thorough

process inspecting facility evaluating resident wellbeing.

They review staff training and

[9:30] resident records. They conduct

interviews with staff and residents and family members.

They look at the

[9:37] administration, a medication, a

bathing and feeding of attending to those activities

of daily living. They certainly

[9:43] look at it faction control pain

management. I mentioned the facility, right. We want to

make sure that there's fire

[9:50] safety, that there's an

evacuation plan that these facilities are ready in case

there's an emergency, for

[9:55] example, that they have egress

windows, that their cup, they're kept in good repair and
that smoke alarms and fire
[10:03] extinguishers are in place.
And certainly we also look to make sure that the kitchen and
food code inspections are done
[10:10] properly to prevent foodborne
illness. So again, surveys are the technical term for on-site
in-person inspections taking
[10:19] place every 2 years. Looking at
the requirements of one 44 G we
[10:24] as part of the survey's do not
inspect billing war financial statements as part of those
survey inspections routinely.
[10:34] So while we are on site,
though, we pay attention, right? We are careful to notice
if there might be potential
[10:41] signs are good. Candidates are
fraud and we work. If we see that anything that might raise
our spent suspicion. We work
[10:49] closely with other entities
tasked with investigating potential front to share those
average observations. So
[10:58] let's talk a little bit about
our credentialing verifications. When
[11:03] new facility wants to come on
line. It all starts with a provisional license

application. In DH reviews,

[11:11] a compliance history looks at

DHS exclusion lists looks for any irregularities. They their

verification items such as IRS

[11:20] forms. Background studies the

board of executives for long-term services and

supports. We look at workers

[11:27] comp and liability insurance.

Certainly we verify through the Board of nursing as well.

And again, we review that

[11:33] facility. So there are number

of requirements that a facility must meet to get a new license

for assisted living before they

[11:41] begin to operate. And these

items that I mentioned are just some of these items that are reviewed at the

time of a new license. They are

[11:49] also reviewed during the

renewal and change of ownership.

[11:58] And if a provisional license is

granted, it is effective for up to one year from the date when

the license is issued,

[12:06] licensees must provide notice

and each within 2 days of beginning to provide assisted

living services. And if the

[12:13] provisional license see

actually does not provide services during the provisional

year, the provisional license
[12:18] expires and they would have to
apply for a new license. These are the ways that first
and foremost, we regulate these
[12:27] U.S. health care facilities.
It's the provisional license is an important way for him beach
to verify that an operator is
[12:34] able to safely provide assisted
living services to its residents and to ensure program
integrity.
[12:43] Since the passage of assistant
living Licensor. We've continue to work with a bipartisan group
of legislators, providers and
[12:50] residents, advocates to update the law to
better serve residents and these facilities. And so we
always like to take a a
[13:00] full approach and engage all
the stakeholders intersted in this important space when these
changes happen. Certainly and
[13:07] 2023, the Legislature directed
in DH in DHS to consult with
[13:13] assisted living licensees to
provide customize living and were smaller than 11 residents.
[13:20] This it's very difficult for
smaller providers in health care at any type to to really
meet regulatory requirements.

[13:28] And you all, as a legislature asked
us to to work on small
[13:34] providers and to certainly
provide the chairs and ranking minority members of the
legislative committees with
[13:40] jurisdiction over assisted
living license or custom. I'm living with
recommendations, including draft legislation to reduce the
regulatory burden for small
[13:48] providers. And what happened
after that 2023 direct. It was
[13:54] after months of discussion with
providers, resident advocates, other stakeholders, this led to
bipartisan changes pass in
[14:02] 2024. Allowing for the
relocation of assisted living facility while maintaining the
same license and providers,
[14:10] smaller assisted-living
facilities with more flexibility for their food
service requirements. So this
[14:15] is work that we were happy to
see him participate. And thank you for the ability to help
support our small providers.
[14:27] As I've all ready, shared in
the 8 has worked to license assisted-living facilities
under one. 44 detest us with

[14:34] focusing on the health and
safety is residents as stated before. So protections for
health like medication
[14:41] administration, checking blood
pressure, taken blood glucose protections for safety like
making sure there's the egress
[14:47] window and an evacuation plan. We are careful to note is
potential indicators of fraud.
[14:53] We see them. And as I mentioned
before, work with other entities tasked with
investigating fraud to share
[15:00] those observations. We are also
not currently aware of any credible allegations of
financial fraud within the
[15:08] assistant living space because Mdh is charged with the
health and safety of assisted
[15:14] living facilities. Let me share
with you some examples of how mdh may identify and report any
fraudulent activity.
[15:25] One example is when the
facility receives payment for nursing services.
[15:30] But we go on site and through
observation and interviews and document reviews.
[15:36] Their questions raised at that
show. Unlicensed personnel are actually the ones implementing
that care rather than a nurse,

[15:45] an RN or lpn or we notice that facility is
supposed to be and menacing
[15:51] services to a resident. But we're not seeing that resident
get those services or perhaps
[15:57] we question whether the resin
actually needs those services and those cases and the age
makes referrals for further
[16:03] investigation to the
appropriate agency. This slide shows the who those
appropriate agencies are.
[16:12] And so we meet, of course, with
DHS, we regulate communicate with our partners and the state
enterprise to discuss assisted
[16:20] living regulation. There's
frequent contact between our
[16:25] agencies regarding licensure
status. Any questions concerns any updates, anything that
comes up on a survey that we
[16:32] might be questioning? Certainly
there also referral procedures for pot, possible fraudulent
activities to the
[16:41] Medicaid fraud control unit to
the Bureau of Criminal Apprehension to the office of
the Legislative Auditor and
[16:46] certainly to Deo. I am the
Minnesota attorney general. In addition to DHS Office of

Inspector General

[16:56] in the last quarter, we have communicated with each other on a number of things.

[17:04] Some examples would be change of ownership. Update on renewals license relocations closure capacity. Chaining

[17:11] cook capacity changes in these facilities, communications training opportunities. We make sure we provider. We report

[17:20] each month concerning licensee status is related to or Knowles. And certainly as we look across

[17:27] our complaints, you know, there are complaints around financial exploitation and we certainly push those into the appropriate

[17:35] partners. There are also complaints around drug diversion or theft of personal park property that have come to

[17:42] our contention attention. And again, particularly if there are any signs of

[17:49] potential financial crime are any other sort of criminal investigation. We move those both to be See's, financial

[17:55] crime and fraud section.

And DHS is OIG program

[18:04] and then just so that everyone

here in the public is aware. We want to hear from folk,
right? That's one of the ways
[18:11] in which, you know, complaints
are come to our attention, right?
We want people to be safe.
[18:17] We want people to be healthy.
And so if there's anything that is coming to mind for the
public or or residents in the
[18:25] facilities, certainly there's
the Minnesota don't abuse reporting says center and I've
provided at the phone number
[18:34] and the slide. And then there's
certainly you can report 2 to 2 as general through our general
licensing comes concern.
[18:42] And so we have an office of
health facility points. And that certainly gets complaints
about any sort of violations
[18:49] issues within a quick, rare
violations of licensing standards, issues related to
discharge determination of
[18:55] services for residents and so
and be staffed Riyadh, the complaints and certainly if
it's not in our jurisdiction,
[19:01] has some of the things that
I've just discussed, that we refer them to the appropriate
agency for follow-up

[19:10] regarding the reports of
possible fraudulent activities because and each is tasked with
life and safety and each will
[19:16] get allegations related to care
and services and then identify any other concerns that are
fraud or financial
[19:23] exploitation, refer them to the
appropriate entities.
[19:30] We have some resources and the
debt for you to to click through. But really thank you
for inviting me here today for
[19:37] this relatively brief
presentation you all know them. Mission of the Minnesota
Department of Health is to
[19:43] protect, maintain and improve
the health of all Minnesotans, no matter their background and
certainly no matter where they
[19:50] live. And that includes
protecting the health and safety of Minnesotans who live
in assisted living facility.
[19:55] So so thank you all. Certainly
happy to take any questions and
[20:01] thank you for your interest. Thank you, Doctor Cunningham, I
think because I know she has to leave in 10 minutes, but for
the member questions first for
[20:08] Dr Cunningham and then we'll

move on to DHS. >> I would like to start first

of all, thank you for your

[20:14] presentation. And I think for

those of us who don't serve on the Health and Human Services

or the Health committee's,

[20:20] it was surprising to see that.

But I certainly understand by your focus is on the health and

safety and your licensure

[20:27] procedures that there's nothing

required for you to also look at the financial health and

billing records and the

[20:36] financial piece of these

businesses because clearly if they are mismanaging funds or

if they're not able to continue

[20:43] reading, it will impact the

health and safety of the residents. I think it should be

a component of your

[20:48] work as part of licensure.

So would you want that task? Do you think somehow the

financial review of these of

[20:56] licensure providers is being

handled somewhere else already? Could you just speak to that? >> Thank you. I certainly we

follow what was outlined in

[21:05] terms of state statue for our

responsibility in this space. And certainly, you know, that

is a that is a question that a

[21:12] lot of people have interest in

and asking. I will say for us as the health department who

does not process claims around

[21:18] health care billing, our role

really do focus on what we see on site. When we come in, many

of our members of our

[21:26] regulatory team, our public

health nurses, they are clinically trained that they

are looking at. Are people

[21:34] being taken care of and are

they being taken care of well, and are their activities of

daily living being met? Are

[21:40] they safe in the facilities?

And then we have other folks who are engineers on our teams,

Wright, who aren't really

[21:47] helping us look at the

facilities. So currently with the staff that we have, we meet

all of the regulatory

[21:53] requirements that have been out

late for us in statue. And as I mentioned when something

because we are they are

[22:00] observing. If there's something

that seems concerning, we lifted up and we pass it over

to our partners who do handled

[22:07] the billing for those services

and who do investigate any sort of criminal activity.

[22:17] So one of the >> points on slide 11 is that

there was an effort to allow assisted living facilities to

relocate while retaining the

[22:25] same license. Could you explain more about

why that was important to the

[22:32] either the providers or to the

department like what is driving that change? So so thank you,

Madam Chair.

[22:39] >> Certainly I can't have our

health regulation, divisional follow-up about the process

that came together with him,

[22:45] the workgroup. So certainly

this wasn't a unilateral mdh decision. This was through sort

of bipartisan work in and

[22:53] multiple stakeholders to say

what would reduce the burden of on small facilities. So in the

workgroup, the work group's

[23:01] recommendation at the time was

to focus on giving those facilities at 4 home applying

for licenses. They're small.

[23:11] Apply for licensors, of course,

is always a lot of work for a small facility. But how can we

support them? And what came out

[23:20] of the work group was that

recommendation. And so we move that forward based on the

recommendation from the
[23:25] workgroup. >> Madam Chair, members of the
committee least attenion legislative director for the
Department of Health to settle
[23:32] more contacts. The small
providers are often be and residents is that they didn't
own. So if you don't on the
[23:38] fuss life, you don't on the
residence and your landlord decides that they're not going
to renew your lease or that
[23:46] it's time to move on. This was
just a way to create a process for them to have an orderly
relocation of that service
[23:53] within the county or continuous
area to the location of the previous
facility just so that they
[23:59] didn't have to start exactly
from square one. But of course, it's still have the same
inspection and survey requirements and everything
that still have to be met.
[24:06] It was just to credible clarity
for the small providers if they had to move their location.
[24:12] Thank you. Both of those
answers were helpful. So to further chill down and that
just one more time.
[24:18] >> If they move because their

lease was up do, then they go back to a provisional license
at the new facility or do they
[24:26] retain the same license?
So like, is there an inspection after just one year at the new
facility or or do they have
[24:33] that two-year window? >> Madam Chair, members of the
committee, I would need to look
[24:39] exactly the requirements, but
my understanding is that there would be an inspection before
they can operate in the new facility as well. It's, you
know, someone like provisional,
[24:46] but I can get you more details
about how exactly that inspection process works. >> Thank you. Any other member
questions or aice changes
[24:54] since. Thank you. So you said
in your presentation that this is not group hopes when I think
of assisted-living facilities,
[25:00] I generally think they're
large. They're generally seniors, right? So you said
that these are not group homes.
[25:08] And can you explain what is a
small provider? I assume that that's a group home.
[25:14] So I sat Madam Chair.
Representative, thank you for that question.
[25:20] >> I think the reason that I
lifted it up is there a lot of small facilities that all gets

sort of botched together and

[25:26] called group homes and some are

assisted living and some are not. And so certainly there are

a number of small assisted

[25:34] living facilities. And then

there's one slight that sort of outlines that. But they get

lumped in to a lot of other

[25:41] sort of supervise residential

facilities that we do not regulate because these are

these are healthcare facilities

[25:48] they have getting getting the

public health nursing. And so that is why this is our space

and other types of other

[25:54] facility. Types are regulated

by other agencies such as the Department of Human Services

[26:05] Chairman, Vice Chair Pinto.

Thank you. Thank you, Madam Chair that we've been done.

Thank you, Madam Chair. >> And just a question, I want

to clarify the point earlier

[26:13] that Mdh does not oversee

financial issues, we think center for health and safety.

I want to confirm that

[26:20] regarding when their public

dollars being spent with China is of particular interest of

all of us, there is oversight. I guess that would be with your

partner agency with DHS,

[26:27] but perhaps Commissioner, Mr.
Mean, you could just clarify that. I mean, it's it's not
that is not being looked at. It just is not your agency.
Is your focus on a different
[26:34] thing? >> Madam Chair, Hasner
representative and thank you so much. Yes, that is. That is a
good summary of our space.
[26:46] Thank you for coming to the
committee. We appreciate it. I'm sure we'll have some
follow-up questions and we'll
[26:52] now look forward to hearing
from Wendy Underwood, deputy commissioner of us know HS
site.
[27:02] We've got quite quite a group
coming from to just thank you. I guess
[27:34] she said
[27:50] welcome to the committee.
Please State your name for the record and begin your
presentation. >> Good morning. Chair Robbins
lead Pinto and committee
[27:57] members. My name is Shireen
Gunn. Dna Service, the temporary commissioner for the
Minnesota Department of Human
[28:04] Services. Thank you for inviting DHS here
today to present and for your
[28:10] ongoing support of fraud

prevention activities. Dhs has 0 tolerance for fraud
[28:18] and our state is right to be
proud of the support we provide to children, people with
disabilities and older adults
[28:27] so that they can live healthy
lives in community and to protect the services.
We have to get ahead and keep
[28:35] ahead of the criminals that
have been preying on our system as an administrative agency,
DHS must follow the evidence,
[28:45] stop payments as soon as
possible whenever credible allegations of fraud are
established and refer cases to
[28:53] our law enforcement partners so
that they can prosecute the criminals.
[28:59] I Pierre, I appear before you
today for the 5th time with a commitment on working on
solutions together to address
[29:08] fried in Minnesota. Fraud is not a partisan issue.
[29:13] People of all races,
ethnicities and incomes. I commit fraud.
[29:20] It takes all of us working
together. The bipartisan legislature
[29:26] providers, community members
and agencies to design programs
[29:33] with strong controls to ensure

that we served the people well

[29:38] and protect taxpayer money.

Yes, I hope that we can continue to

work together to meet this

[29:46] goal. When I was here last September,

Governor Walz had just

[29:51] announced executive order 25,

10 under his direction. Dhs has

accelerated and expanded our

[30:00] actions. Since my last visit.

We have disenrolled 800 inactive providers and

high-risk programs.

[30:08] This action reduces the

administrative challenges DHS has in overseeing providers who

are not providing services.

[30:18] Dhs increased the risk level

for 9 additional types of services bringing the high-risk

service. Number 2.14,

[30:28] this action gives us more tools

in these 14 high-risk services

[30:34] to tighten oversight. The new

types of actions that we can do. Our pre enrollment site

visits unannounced site,

[30:42] visits criminal background

checks and fingerprinting of those with an ownership stake.

[30:49] Dhs signed a contract with a

third-party vendor to conduct enhanced prepayment review fee
for service claims for the 14
[30:57] high-risk services to identify
risks before we pay claims.
[31:03] And at the beginning of
December, we announced a two-year pause on licenses for
new home and community-based
[31:10] service providers. The growth in license service
providers has far outpaced the
[31:15] growth in participants, cars
with an exception process to assure Minnesotans can access
the services they need. We'll
[31:24] allow DHS to provide the
necessary monitoring and oversight of his of existing
providers.
[31:34] And just yesterday we announced
that effective February. 1st, we will implement a
temporary two-year pause on
[31:41] adult Day center licenses which
provide adult day services
[31:47] and there will be more program
integrity, actions coming
[31:52] over the past 5 years. We've
seen a 43% increase in licensed capacity for adult day centers.
While the number of
[32:00] participants is only increased

by about 7%

[32:06] with this temporary moratorium,

DHS will work with counties, tribal nations and managed care

organizations on exceptions to

[32:14] the licenses to ensure that

people can access the services they need

[32:20] the Chair. Rob and John and

James are prepared to provide more information on adult day

centers as well as customized

[32:27] living services. Okay. Thank you. Welcome to the

committee. Please stay tuned in for the record.

[32:34] >> Thank you so much. Chair

Robbins, John Connally, deputy commissioner and state Medicaid

director at the Minnesota Department of Human Services.

[32:42] So grateful. So I will start us with

customize living given the

[32:47] order of the slide deck. So this is just a summary slide

here indicating the nature of

[32:53] the service. I'll get into more

detail on the next slide. So I think the first thing to

clarify given Mdh is

[33:01] presentation is that customize

living as a Medicaid benefit really is referred to often as

assisted living. That is really

[33:09] the type of service in the

facility that that people think of commonly and the community.

So customize living is really
[33:16] the name as as a Medicaid
benefit for assisted living. It's a home and community based
service that pays for services
[33:23] that are typically provided in
those assisted living settings. In addition to Medicaid funding
Medicaid is a significant pay
[33:29] or of long-term services and
supports generally. But there are other pairs like veterans
Affairs, private pay and other
[33:36] forms of insurance that do
cover assisted living as well. Though Medicaid is a large pair
and the space.
[33:43] So more specifically what is
customize living. It's again, a home and community-based
waiver service. It's available
[33:50] on several different waivers
within our Medicaid program here in Minnesota, including
the elderly, out skews me
[33:55] elderly waiver, the brain
injury waiver for people with disabilities and the community
access for disability,
[34:01] inclusion, waiver, also known
as catty. The service is delivered
through distinct health related
[34:07] and and supportive components.

And it's based on an individualized service plan,
which is informed by an
[34:13] assessment which could either
be done through the assessment provided as a part of the
elderly waiver or the men
[34:18] choices assessment through the
the disability waivers that I mentioned earlier,
[34:24] some of the different services
that are included as a part of the benefit assistance. As as with that
activities of daily living.
[34:31] As Commissioner Cunningham
mentioned, she described a lot of this. But all, you know,
some of them made their repeating saw just going to a
few details here in addition,
[34:39] assistance with mental health,
cognitive or behavioral concerns. That's another
important piece of this as we
[34:44] look at overall well-being and
health health related assistance, things like, you
know, this instance with a self
[34:51] administration of medication or
connection to other health services that might be helpful.
In addition, home management
[34:56] tasks, this is, again, a home
and community-based service. So if there are kind of
low-level home management items

[35:02] that folks need help with,
that's also part of the benefit or a service that's offered in
addition to non-medical
[35:08] transportation. So since some
of these folks will grapple and members of the program grapple
with isolation, transportation
[35:15] is a part of what's paid for.
And general social socialization having somebody
again to to help with different
[35:23] needs and interaction generally
with people in the community is a benefit to particularly older
adults and folks with
[35:29] disabilities as a part of the
service to be eligible for the service.
Someone needs to be eligible
[35:35] for. One of the waivers that I
mentioned be I caddy or UW and they have to have a necessity
need for one of the regularly
[35:42] scheduled services, either
health related or supportive in nature that I just mentioned.
And there are a variety of
[35:49] different combinations of those
services that could be provided as a part of the event. The
benefit again, based on
[35:54] assessment through the elderly
waiver or the men choices assessment through disability

waiver.

[36:00] I think with that we are moving on to some of the provider requirements. I think

[36:06] Mdh went went into a lot of detail here in terms of the licensing. This is not a DHS licensed provider setting.

[36:13] We are a pair more exclusively in this in this benefit or service, though. I think it's important to mention that we do

[36:21] as as Commissioner Cunningham noted, meet monthly and regularly kind of cadence meetings but also have more

[36:27] frequent meetings. If there are issues with respect to certain provider, behaviors are issues or concerns about licensure

[36:34] payment the 8 years. So those are things that we do process with them th and just talk generally about questions,

[36:40] concerns issues that we need to coordinate on as agencies

[36:45] moving on to the next slide, a few things with respect to program integrity specifically. So the benefit is structured in a in a pretty careful way.

[36:55] There are, of course, the requirements for the men choices assessment and the elderly waiver assessment to

[37:02] inform what exactly the
person's needs are and what services are appropriate that
will inform the service plan or
[37:08] the care plan that informs an
individualized rate. So I'll just lean on this for a second
because what providers get paid
[37:16] for this service varies person
to person. It depends on the clinical need the assessments
and the care plan that's
[37:23] developed that flows from that
assessment. So I case managers within counties
are lead agencies, including
[37:29] managed care plans in the case
of an elderly waiver member would be in charge of approving
that care plan and would also
[37:37] be authorizing the services
provided that are approved as a part of that care plan.
[37:43] So just to know here again,
prior authorizations to come before the billing occurs and
there are strict limits in
[37:51] terms of those authorizations
and what providers can bill for so they would not be permitted
to bill and excess of the
[37:56] services are amounts that are
authorized by the case manager. We also have an assisted-living
report card that measures and

[38:03] reports on the quality of
individual services are service providers rather so that people
can go onto our website and
[38:09] look at quality ratings and be
able to select a program where a provider that meets their
needs. It's a joint effort
[38:16] between the Department of Human
and Human Services, Aging and Adult Services Division and the
Minnesota Board on Aging.
[38:23] So again, we encourage folks to
go to that Web site. Take a look at the ratings. And this
is generally a resource for
[38:29] people to make informed choices
about providers of this particular benefit and
providers in the settings.
[38:35] So I think with that we'll move
on to should we pause questions for questions on this
particular benefit? Sure.
[38:44] >> Thank you. I think we can
finish the presentation. Then we'll take questions.
Thank you.
[38:52] >> All right. Moving on to
adult day services a bit more about the second service kind
of in focus today.
[38:59] So the goals of Adult Day
services are broadly to provide a meaningful set of age

appropriate, asked materials,

[39:05] activities supports in response

and again to a person's individual goals interests and

needs many of the people that

[39:12] received this service or

approved for it are older adults in Minnesota, though,

some people below the age of 65

[39:19] with disabilities to also

receive adult day services. One of the main goals is to

provide community integration

[39:26] opportunities. Again, many

older adults, people disabilities who are at home in

the community really benefit

[39:32] from an need interaction

broadly in the community. It's it's really an alignment.

The service with the vision

[39:38] vision and mission of DHS to

really help people thrive in their in their communities. So their social and physical

interaction at the centers.

[39:47] There are meals and snacks

cover depending on the length of time that people are in the

facilities daily.

[39:53] I would also note that they're

up to 12 hours of service permitted per day in the

service and the service line

[40:01] and at least 2 hours required.

I will note it. I will note that more commonly folks
usually receive 6 to 8 hours of
[40:08] service a day. And if the
service is more than 4 and a half hours a day, adult day
will cover a meal as well.
[40:16] One other component of this, in
addition to the benefit and health and wellness, the person
who receives the service,
[40:21] it's really important as a
source of support and respite for primary caregivers. So I
think for for a lot of us who
[40:28] have older adults in our
households or families, children, people with
disabilities, we understand the benefit of having an
opportunity to take care of
[40:35] household business, to work and
to have a place for a loved one, a member of the household
to go and receive support and
[40:41] service. And that's really a
major goal of adult day services. So it's making a different
difference not only for people
[40:48] who struggle with isolation and
have health related and social needs, but also for their
family and members and loved
[40:54] ones, people in their
households. Some of the health services

that are included as a part of the service are also consulting
with registered nurses to
[41:02] monitor their health again,
assistance with Self administration of medications,
making sure that folks are
[41:08] monitoring and taking meds as
they're supposed to be offering exercised appropriate for the
needs of folks in the setting.
[41:15] That's an important wellness
benefit and an activity that that many members of the
programs who receive the
[41:21] service receive in addition also providing with
connections to services,
[41:26] including L services and
referrals as needed. There are other cultural kind of
enrichment activities. You
[41:33] could have speakers that
provide health coaching different performances or
activities or or movement
[41:40] exercises that help folks again
with life enriching activity again, for for people who spend
a lot of time or are at risk of
[41:47] spending a lot of time in
isolation and need that kind of engagement both physically but
also socially
[41:53] moving on to the next slide. So I mentioned a different

levers with respect to
[41:59] customize living where folks
qualify for the service. With respect to adult day,
there are available on the 4 a
[42:06] disability waivers. So, Candy,
CAC be I the usual that that I mentioned here in addition to
the elderly waiver, which I
[42:13] mentioned and the the
customized living context in addition to alternative care
and the essential community
[42:19] supports program. As I mentioned, the service
itself is individualized based on an assessment in need for
care and service. Both health
[42:27] and social are included in
that. I mentioned the maximum in terms of building for days,
12 hours and a variety of
[42:34] different services in terms of
supervision, care, assistance, training activities included
just as a note in terms of
[42:42] overall number of providers
that are licensed, we have 104 license currently in Minnesota
as of the 12th of this month,
[42:49] December 2025. and 25 pending applications.
So that's just a bit of context
[42:55] about the nature of the
service. And I think with that I'll pause turned over to James

talk a bit more about program integrity.

[43:04] >> Can money, please state your

name for the record. Thank you. Thank you. Madam Chair, James

Clark, inspector general at the Department of Human Services.

[43:11] So DHS conducts licensing

oversight of Adult Day centers to ensure compliance with state

rules and statutes. First we

[43:18] conduct pretty licensing visits

for all centers prior to granting licenses. Pretty licensing side business

licensors review the physical

[43:25] location and safety

requirements and ensure that centers meet all other

applicable legal requirements

[43:31] after a program is licensed.

Licensors provide technical assistance to license holders

and conduct unannounced

[43:36] licensing reviews every 2

years. If noncompliance is found Licensors can issue

licensing sanctions such as a

[43:42] correction order condition, a

conditional license or revocation. Over the past 2 years, DHS has

done site visits to 85% of

[43:50] adult day centers in the state. In addition to licensing

reviews, DHS investigates adult

[43:55] day centers to make sure that

tax dollars are being spent appropriately. Now more than ever. We are

using data to identify billing

[44:01] outliers and conduct

surveillance of adult day centers to monitor activity and

attendance.

[44:06] We have a project in place as

we speak. We're we're doing surveillance and using data to

target providers that need

[44:12] further review at the direction of the

governor's office. In fact, we've pulled in staff from

other states state agencies to

[44:19] increase capacity to help with

surveillance and investigations of adult day providers.

[44:26] Investigations into adult

providers are ongoing. And if we find credible

allegations of fraud, we will

[44:31] suspend payments and refer

people and businesses to law enforcement.

[44:36] It's important to note that

adult day services paid by medical assistance require

prior authorization by case

[44:41] managers and there are limits

on the number of hours that can be billed per day.

[44:47] Counties and county case

managers plan important role in Medicaid oversight.

[44:52] I've said it before, but

Medicaid oversight is a shared responsibility. The role of county case

managers to monitor their
[44:58] clients and make sure that
appropriate services are being delivered. We put to that end. We
prioritize tips that we
[45:04] received from case managers and
I want more care case managers to reach out to DHS with tips
if they are seeing fraud,
[45:13] waste or abuse or maltreatment
in adults with their clients that are receiving adult day
services. Quality tips are
[45:21] crucial component of fraud,
detection and prevention.
[45:29] So DHS is implementing a pause
on new adult Day center licenses. The pause will go
into effect on 2/1/2026 and
[45:38] will be in effect for 2 years. The reason for the pause is
that the capacity for adult day
[45:43] centers far exceeds the current
and inspected it expected need. In other words we checked at
this time. We just don't need
[45:50] additional adult day centers in
the state. We have excess capacity or excess space for
program recipients that would
[45:59] like to access adult day
services. Pausing expansion of new adult
day centers will allow staff to

[46:05] focus on providing oversight of
existing businesses and protecting the health and
safety of recipients. So we're
[46:12] shifting staff from reviewing
new applications and getting new centers up and running,
shifting their focus so that
[46:19] they can squarely focused on
oversight of existing adult 8 businesses.
[46:26] It's important to note that to
ensure that people have access to adult day services and
exceptions process will be
[46:31] available. Counties managed care
organizations and tribes will be able to identify if there is
a need and requests identifying
[46:39] request for additional adult
day centers. If there's a demonstrated need for
additional centers to be opened
[46:46] in our state, I think it's important to know
this is as a slide points out
[46:52] for the service. A moratorium
was already in place and I think it was in 2021 which
prevented a new authorizations
[47:02] for people under 55 that are
receiving coverage to disability waivers. So really
this service we think about
[47:08] adult day services, this is

really a service for older adults and seniors.

[47:15] One thing I would point out

related to the adult, a licensing moratorium.

[47:21] So when I say Medicaid

oversight is a shared responsibility, we share and work with our

federal partners for Medicaid

[47:28] Oversight. So last week CMS

asked U.S. to implement additional enrollment pauses

for additional services.

[47:35] So I anticipate that we will be

implementing additional licensing enrollment pauses in

the near future.

[47:42] These licensing enrollment

pauses or an important tool that we can use to make sure

and prevent a provider

[47:48] oversaturation and the problems

that come along with provider Oversaturation.

[47:54] That's all after that, someone.

[48:00] >> Thank you for your

testimony. I will start the questioning. So you talked

about the growth of Cup Cassidy

[48:08] in the adult day programs and

maybe for meet our colleague from the Department of Health

to join us. I'm not sure but

[48:16] because department of Health licenses,

the assisted-living facilities,

[48:22] but you oversee the payment for
customized living services at DHS. It's sort of a bifurcated
responsibility. And has there
[48:30] been a similar concern about
capacity in assisted living facilities that you see in
adult day services?
[48:41] >> So thank you, chair. What I
would say is certainly I think we're we're broadly looking at
capacity relative utilization
[48:49] and the rise in numbers of
people who are being served. So we're always concerned and
watching the corresponding
[48:55] nature of of those numbers.
I think the the increase over the last several years, both in
terms of the number of people
[49:02] served in the number of
facilities licensed has in terms of the share or the
percentage increase
[49:08] year-over-year. They are
terribly out of out of line. I think the figure that we're
more focused on is really
[49:16] looking at the increase and
payments overall. And as I noted in my presentation, I
think that that's really
[49:21] multifactorial and that every
person has an individualized rate that is based on an

assessment in the care plan

[49:29] that a waiver case manager or a

health plan will approve. And then there's a service

authorization with the service

[49:35] that's that's provided and

that's setting. So that's kind of where I think we're focused in terms of of

the the increase that really is

[49:44] notable, but the service line. >> So to follow up on that, can

you send me the capacity

[49:52] numbers for assisted living

similar to what you've outlined for adult Day Services?

[49:57] >> Yeah, I think we can do

that. Ok to be that's a very good points.

Medicaid, though it is a major

[50:06] pay or within the the

customized living or assisted living space. Other pairs are

involved, too. So there may be

[50:12] interactions with other pairs

that we wouldn't be privy to. >> Yes, I just and I think

understanding the general

[50:18] capacity issue for both

programs is really important.

[50:23] Okay. Representative headset.

[50:31] >> Thank you, Madam Chair.

I think I have a similar question.

[50:37] Just stated more simply untrue,

trying to understand how the adult day services
[50:45] the capacity of providers could exceed that need from
folks. That would think that
[50:52] the providers would be
something that would be generated by the perceived need in the
community as opposed to people
[50:59] setting up themselves as providers and
then looking for
[51:05] somebody to fill those spaces
like how do you get established as a adult day provider in the
first place? If there's nobody
[51:12] that you need to take care of? Sure, I can start search and
you want to add more.
[51:21] >> So depending on the service,
there may not be a requirement to have a general service need
demonstrated for provider to to
[51:30] be approved or to seek a
licensure. So they may set up a
[51:35] facility without demonstrated
community need or without a needs assessment. That said
part of what generated provider
[51:42] enrollment moratorium that we
announced just yesterday as a result of a concern related to
that, that if you you have an
[51:49] excess of providers, a provider
capacity relative to need or utilization, that's that's a

situation where I think program

[51:56] integrity, risk rises. >> Today, you think that maybe

so. Yes, General Clark to

[52:04] Representative Woodson. I mean,

I think this is this is a very important point. And I think

[52:10] as a state we need to look at potential needs assessments

across the board, right for new

[52:19] Medicaid businesses that enter

our programs. I think

[52:24] unfortunately, the adult day

program did have a needs assessment that was required.

But that was removed from

[52:30] statute last session on trying

to figure out why that was the case.

[52:35] And I've talked about, you know, we need additional resources and technology on the

back in to investigate. But we

[52:42] need to keep, you know, on qualified

unserious providers, like you're saying, like, why would

the business open up if there's

[52:48] not the need for their

services? So what can we do as a state to figure out how to

prevent those on Syria's

[52:54] providers from opening up in

the first place? So one thing I thought about and kicked around

is just a general needs

[53:00] assessment for all new Medicaid
businesses in this state. Right. You need to demonstrate
that there's a need for your
[53:06] service is before we allow you
to open up and get licensed. I think that would help with
this access Cup, this excess
[53:13] capacity issue that we're
seeing because when you have a marketplace where there's
excess capacity, there's not a
[53:19] way for you to drum up
legitimate business. Then you're going to try to figure
out if if profit is your
[53:24] motive, you're going to figure
out ways to drum up legitimate businesses. So that's why we've
seen allegations and we're
[53:31] investigating allegations of
kickbacks in the adult day program area because when you
have a flawed or excess of
[53:39] providers in the marketplace
and you can't, you know, make money the legitimate,
we're going to try to think about how to make of it
legitimately and drum up
[53:46] business. So this idea of of
kind of a blanket needs assessment, I think the front
door or something that we
[53:52] should consider as a state for

new Medicaid businesses. >> Thank you, General Clark.
I'd like to just pick it back
[53:59] and that into from minute
because multiple whistleblower reports that I have received
and and some have spoken to
[54:07] directly 2 alleged kickbacks in
this space. So people who have
[54:12] opened, especially these newer
providers, offering kickbacks to get
people from other adult day
[54:19] services to instead come to
their
[54:24] adult day service business.
Have you also seen evidence of that can when you see evidence
of those kickbacks? What do you
[54:31] do? >> Yes, Licensors investigators
have seen what we've seen,
[54:37] alligators of kickbacks and so
we investigate, right. But kickbacks are difficult to
prove and investigate. Right.
[54:44] When you have a business employee in a
recipient kind of in on the scam right there, changing
money between each other,
[54:52] right? It's hard to kind of
peers that bail and figure out like what what's really going
on here, right? Like is one

[54:58] thing to investigate and a
recipient like but never heard of this company what you're
talking about. But if they're receiving a financial incentive
right to access this business,
[55:07] they're probably not going to
be forthcoming about the fact whether or not they're
receiving services. So we do investigate if we establish
credible allegations of fraud
[55:16] that we refer to the attorney
general's office and put a stop payment and and we suspend
payments when we when we see
[55:23] credible allegations of fraud.
Thanks, Commission. >> Thank you. So to be clear,
you I know suspending payments and credible allegations of
fraud. Every time you see them.
[55:31] >> Yes, and I think if you look
at so are we in
[55:38] the answer is yes. And if you
look in the interest of public transparency, we are now
publishing on DHS is public
[55:45] facing website, all of the
numbers of stop payments that we are implementing all the
numbers of monetary recovery
[55:53] that we're you know, we're
taking action on all the number of open investigations. And you
can see

[56:00] there's been a significant
increase in payments suspensions over the past year
as opposed to years past.
[56:07] So, yes, we are aggressively
suspending payments whenever our investigators, the
evidence, a problem.
[56:15] Representative Anderson. >> Thank you. Several
questions. But what is it a
[56:20] crime for someone to take a
kickback? Because we know that's going
on. And you know, for the
[56:28] person that's receiving the dollar, is that a crime? >> I don't know. I can look at
the statute. I know we have in
[56:36] the kickback laws new as of
last year. So I could I mean, we can get your legal opinion
on that. It's a few at 9.
[56:45] We are our counsel for the
committee would like to respond. And Madam Chair members, the
kickback wanted passed last
[56:53] session and it does apply to >> both those who would be
paying the kickback and those
[56:58] who would receive the kickback.
So someone receiving a kickback would be potentially guilty
under that new, correct.
[57:05] >> Thank you, Mr. Jones and 30%
of Andrew, thank you. I think that's publicizing that widely.

[57:12] It's going to help because that's where a big part
of this promise I have. I'm trying to get the numbers.
So I saw something and I think
[57:19] was channel 9 and they said
that the active the growth in and licenses or
the growth in people using the
[57:28] adult daycare is like 25% in
the last 5 years. This is from channel on the growth in active
licenses is 55%. And then the
[57:37] new apps was like 283%. Is that
accurate? So the growth over the last 5 years, an adult
daycare.
[57:44] It's 25% is that I just said that on that
Channel. 9 story,
[57:51] Mr, coming. >> Thank you, chair. So I would
have to confirm that number, but it sounds broadly in line
with the numbers that we have
[57:58] and certainly the number of
what the capacity of adult day services has out paced the
number of people, for example,
[58:06] who are using the service.
So we've seen increases in both of those metrics, but certainly
the license capacity has
[58:12] outpaced the increase in
license capacity as a parent, the utilization of the service,
which led to the action

[58:18] yesterday to that, that is an
accurate characterization. >> Ok, thank you,
representative interest.
[58:23] Thank you. So we have a 25%
more people currently using adult daycare. Then where 4
years ago. That's this is what
[58:31] I saw from the news story. That's a big red flag. I mean
that he uh, huge red flag.
[58:39] And of course, and we see all
these other people trying to get into the space and out.
You know,
[58:45] I guess my question is at what
point did you know, DHS notice this was a before the
last 3, 4, months and it had to
[58:54] have been ongoing over the last
5 or 6 years scene.
[59:00] This is a huge red flag. And so at what point were we
looking at going, hey, this
[59:06] doesn't go up. You know, we
don't have 25% more people that need adult day care in the
state,
[59:15] Mr. County. >> Thank you, Chair Robbins
Representative Anderson. I think that is a really
important point. So I just want
[59:22] to clarify, did come across 2
data points here that I think are helpful. So you are correct

that the license capacity has

[59:30] out paced the need and the last

several years. So we've seen that the number of participants

has grown by about 7% in the

[59:38] last 10 years. Capacity license

capacity has grown by about 43%. So we absolutely share

your concern.

[59:44] What I would say and certainly

others can join me here in response is that we have

included the service is one of

[59:51] the 14 that high risk. We have

been looking at it in the last year very closely along with

others, including billing

[59:57] trends. I think this is this is

in line with some of the conversations we've had with

the committee historically

[1:00:02] about. Certainly we wish that

we had identified any concerning trend, you know,

sooner. But I think we've we've

[1:00:12] kind of communicated that our

tools we're really not up to. I think that the enormity of of

what we were facing. And so

[1:00:19] what we have done this year is

really pivoted from a tip based investigation model to one that

is more proactive in terms of

[1:00:25] how we stop payments, how we

use data analytics to investigate what might be

causing rises in payments and

[1:00:31] looking at the different

variables that could be at work. And certainly one of the

risk factors is licensed

[1:00:37] capacity or provide a capacity

that exceeds community need or demand or utilization of the

service. So absolutely. I think

[1:00:45] it's something we're looking

very closely at. We took action yesterday and are pivoting to

use more advanced tools as the

[1:00:50] different schemes of all and in

front of us. >> They just want their

equipment. What are the

[1:00:58] dollars? You know, you talked

about 7% more people use and but the capacity they're using

it more, the Billings get

[1:01:05] what's been the growth in this

program over the last 5 years. Let's say in

the dollar spent on this

[1:01:13] program, Mr. Khan, what's a dollar?

We can't find it so.

[1:01:19] >> So I don't have that in

front of me, but we can certainly get you that number.

It's a very reasonable data

[1:01:24] point to to request. >> Thank you. I would like to

thank you. Thank you. Thank you. I would like to go to
represent agreement.
[1:01:34] Commissioner Gandhi, did you
want to say something as well? >> Yes, thank you. Chair
Robbins. I I wanted to point
[1:01:41] out just a couple things to add
on to what John said, the the
[1:01:47] growth in to Representative
Anderson's question, the growth in the number of people.
Again, I just want to remind
[1:01:55] everybody that these are people
that have been seen by a case
[1:02:00] manager. The case manager has
identified the need for the service is authorized. The
service is authorized the
[1:02:07] amount of services. So that is happening and we need
to do everything John is
[1:02:15] talking about. And that's what
we've been focused on for the last 10 months is expanding the
use of data analytics to watch
[1:02:22] these trends to look at
outliers and trends and the controls that the services had
in them when they were past
[1:02:32] with the legislature and
whether that sufficient or not for the program. And so that's
why we have these 14 high-risk

[1:02:38] programs and we will continue with our capacity going.
Absolutely as fast as we can
[1:02:45] going through each and every
one taking action to strengthen program, integrity and to
protect people. Because when
[1:02:54] these dollars are being
siphoned off from our system, they're not going to the people
that actually need the services.
[1:03:01] Thank you, Representative
Green. >> Thank you, Madam Chair.
And I appreciate this conversation. And you know, I
am not on and on human services
[1:03:10] in the veteran space. We've had
a lot of conversations about adult day and how it is allowed
folks in a less institutional
[1:03:17] setting to get some care and
and have their caregivers get some support. And so I think
the question, but it be
[1:03:25] interesting to know, I assume
some of the increase is really is the fact that we just have
baby boomers who are now
[1:03:31] entering. We have a demographic
tsunami, whatever that we are facing. And so in the next 10
years and we've been hearing
[1:03:38] about this last, 25 like the
next 10 years, the needs for services of that aging

population are going to

[1:03:45] increase. And so it's a good

conversation we're having now about like how we want to care

for folks in an institutional setting like a nursing home or

assisted-living, how we want to

[1:03:53] transition folks and keep my

understanding is this is one way to keep people in the home

is to provide some services,

[1:04:00] especially relief for those

those caregivers. But I actually had a different

question because I appreciate

[1:04:07] the conversation between

Representative Woodson and

[1:04:12] and Miss Clarke, because this

when I was reading about that, particularly an adult day and

this this idea that there is

[1:04:20] more capacity than supply than

demand, I it does seem to me

[1:04:27] that we in some ways are

treating this like a service that's provided in the market

like not. That's our paying

[1:04:33] forward that we're providing it

that way. And so like the lot, the supply and demand are the

principles we use. And when we

[1:04:41] outsource the provision of a

lot of these services which is different than we do in the

veterans home, right, which is

[1:04:46] paid for and provided by the

Minnesota, the Minneapolis Veterans home in my district.

But it's different here because

[1:04:55] what we've said is we are going

to create we're going to use private providers. And in this

case public pairs the question

[1:05:05] and so nice reading about

kickbacks, which I'm glad we took action on. But some of the

kickback behavior in the

[1:05:12] private sector would just look

like market forces, right, like charging less for your

services in if you are a

[1:05:21] business trying to get

customers who would charge last. And so I think that is

not to say we should change the

[1:05:28] way we do it. But I think the

incentive structure we have set up bites of treating this as a

cause, a private provider with

[1:05:35] public pairs does make does

raise all these questions of and how are we regulating

supply and demand of Howard

[1:05:44] making sure that the supply

meets the demand? What what what you're proposing Clark and

I think what you're saying,

[1:05:50] Representative Hudson is what

we should have that regulated. We should decide as a government, which I agree with.

[1:05:57] But I do think we should just think about how we're looking at these services because to say, well, so the government is

[1:06:03] going to side how many providers we're going to have in this space, which is I think what we probably are getting, too, is not getting

[1:06:13] the benefit of private providers competing against each other so that it's like, well, why are we then using

[1:06:19] private providers may be a lot of good reasons. But I just think to me this comes from some of the conversations comes back to

[1:06:26] the very acute issue we're talking about, which is how do we create more front-end policy? How do we create more

[1:06:34] checks and frankly more bureaucracy? I think that the bigger question we should be asking is the incentive

[1:06:40] structure we built into the systems with a place or a private providers.

No

[1:06:49] public view. We have public providers, I know in the VA system, but what would that look like? Are we having the

[1:06:55] same problem in the public
provider space and how are we looking back? Because I think
if we want to get to the root
[1:07:01] of the problem, we have to look
at the incentive structures of the markets we've set up.
[1:07:07] >> Thank you. To that point, I
just want to make a comment and I was going coming up to your
original comment inspector
[1:07:14] general. But I do think this is
an important conversation that we as a legislature will be
having ongoing. And my concern
[1:07:21] is that when that department
has the ability to
[1:07:27] regulate and and approve these
applications, why on Earth are you improving all these
applications that basically
[1:07:34] fill out a form? Why have you
allowed it to get so out of
[1:07:39] whack? And I think that's
really important because the providers try to enter the
market.
[1:07:47] But if there aren't, if you
know, there isn't demand, my huge is green-lighting all
these providers to start
[1:07:55] billing Medicaid, like I think at the department has
enabled some of this fried by

[1:08:01] approving basically hundreds of
providers that are necessary. And I'm glad to see the pauses
happening. But I think we have
[1:08:09] to look at that's across all
programs because my concern is in assisted living. This is
also going on. And that's why I
[1:08:15] want that capacity demand
number. We clearly, as Commissioner Gandhi said, have
to people in our communities
[1:08:21] who have needs and we want to
make sure they're being addressed. But we should be
putting the cart before the horse and approving hundreds
100's of providers when we
[1:08:30] don't have on that. On that
case, management demand side case managers signaling that we
need those providers.
[1:08:38] So could you address while
those were were approved? Thank you, Chair Robbins.
[1:08:46] >> I agree. We need a system
that is balanced properly.
[1:08:51] Just last year we got the
ability to put temper more moratoriums in place before
that.
[1:08:59] And, you know, we we're given the directive in and
authority to approve providers
[1:09:07] based on what's in statute. And when we are not doing that

or when we have had a glut of
[1:09:15] providers coming into the
market. In fact, DHS faced a lot of pressure from
legislators and the public not
[1:09:24] going fast enough and not
getting enough providers licensed or approved or
enrolled as providers. So I
[1:09:32] think I go back to my opening
comments were I say I really want to work on this together.
I think the legislature in a
[1:09:39] bipartisan way needs to look at
how we set up providers, what tools we give agencies to
approve or deny providers and
[1:09:50] that we are creating the right
incentives and balance it in the marketplace. So who is
pressuring you to approve
[1:09:58] providers? So it would be a whole host of
legislators and providers.
[1:10:05] So when they're people wanting
to enter the market licensure or approval or
certification is seen as a
[1:10:13] barrier to entry and we would
get people saying my application
has been them for X number of
[1:10:20] weeks, X number of months.
You need to, you know, we need you to go faster. People need

services. And so I've been at
[1:10:28] the state long enough that I've
seen sort of the absent flows of this.
[1:10:34] Thank you, Representative
Elkins. >> Thank you, Madam Chair.
So there are a couple of things
[1:10:40] that time are puzzling me a
little bit about all of this.
[1:10:46] You know, as as Representative
Green and pointed out, I'm a believer.
[1:10:51] Boomers are leading edge of the
boomers are are hitting 88 the age at which a we in the
increasingly need care. It it's
[1:11:01] not a linear function. So it
doesn't surprise me at all that were suddenly seeing an
increase in significant
[1:11:07] increase in in demand that
that's going to continue for at least the next decade.
[1:11:14] These are very customized, very
labor intensive services.
[1:11:19] And one of the things that's
kind of puzzling me is that time and I follow this for a
while. Have constituents who
[1:11:26] need these services. I've spent
time with some of the long-standing provider
organizations like Opportunity

[1:11:34] Partners, which I'm is it
located an area used to be in my district. And what I've always been told
by providers is the time it's
[1:11:43] very difficult to find personal
care attendants. The people actually do this work. The
legislature has increased the
[1:11:50] pay of people doing this work significantly, but there isn't
and never been enough people
[1:11:56] available to do all of this
work. The people who need these services will tell me that
though they they wait, you
[1:12:03] know, 3, 4, 5, months just to
get a personal care attendant, a sign to them.
[1:12:09] And so I am having trouble jive
in that reality with that. This, you know, provision of
this, this sudden fluctuation
[1:12:17] in the number of provider
organizations. I'm hearing that there's a lot
of churn in the business that
[1:12:26] longstanding organizations are
dropping out. It's never been a lucrative business and other
ones are coming in.
[1:12:34] And so one of the questions I'm
wondering is if if part of this turn is just new new
organizations coming in to
[1:12:41] backfill for the ones that are

leaving the business. But the biggest thing is that
is that just I I think this is
[1:12:51] a red flag is how are we seeing
is huge increase in the number of organizations that want to
provide these services at the
[1:12:58] same time that time we've never
been able to recruit enough workers to actually do the
work.
[1:13:05] And also in an era where it
historically a high percentage
[1:13:10] of the people who does do this
work have been first generation immigrants and where we're
losing a big part of that
[1:13:18] potential workforce. But have
you guys had a chance to kind of digging into the underlying
dynamics to see,
[1:13:26] you know, how much just churn
there is among the organizations? And it is there
is the employment situation
[1:13:33] improving our they're actually
enough workers to to staff these organizations that are
starting up and provide
[1:13:40] services. >> I'm confused. Thank you.
Would like to take that
[1:13:47] Mr. Conley. >> The chair Robin strep
resented of Elkins. Maybe I'll begin with the fact that

broadly, I think when we talk
[1:13:53] about home and community-based
services, there is a workforce shortage. That is a fact.
And I can understand how that
[1:14:00] doesn't really comport with
some of the comments and concerns about licensed
capacity. So sometimes even if
[1:14:09] you have licensed capacity for
a particular service like adult day, that's outpacing demand or
need for the service, you can
[1:14:17] still have a broader home and
community-based services. Workforce shortage across the
array of services that are
[1:14:23] considered home and
community-based services. So those 2 things Do co exist
right now in Minnesota and nationally. So absolutely
you're making a good point that
[1:14:31] we simultaneously have an issue
with workforce who can care for, you know, the folks in our
communities who need those
[1:14:38] supports and services. And we
also have issues and some services where we have excess
license licensed capacity above
[1:14:46] and beyond what the need for
the services. >> Thank you. Thank you,
Representative Schultz.

[1:14:56] >> Thank you. Madam Chair.
I am struck a little bit by some of the things shared today
boat just following this train
[1:15:03] of thought of the last couple
of questions here from an agency perspective.
As you're looking at the
[1:15:09] licensing of these providers, do you ask for from providers
to prove that they have any
[1:15:17] level of expertise in providing
this care or are there no for
[1:15:22] qualifications that they need
to have? Can they just be some individual right off the street
that starts a new business in
[1:15:30] this space. What additional
background are you seeking that has resulted in this large
increase in number of
[1:15:37] providers? >> Thanks for the question.
Representative Schultz. So
[1:15:43] unfortunately don't have all of
the statutes in front of me but each license service as
statutes and rules which lays
[1:15:50] out the requirements for
obtaining licensure. I don't know if it's across the
board, but some of those
[1:15:57] statues do recall why are in
evaluation of competence, competency to be made by the

department. So to the extent we
[1:16:05] as a state want to look at
that, and I think it's it's we should be looking at
potentially raising the
[1:16:10] qualifications, raising the
competency levels, raising what we expect from providers
[1:16:17] to that. That's my opinion,
might not be the department's opinion. But I think anything
we can do that on the front end
[1:16:24] to make sure that providers
that are getting licenses are competent and qualified to
provide the services. I 100% on
[1:16:31] board for that and examining
where those gaps may exist. But to answer your question,
each of the services have
[1:16:37] different licensing
requirements and different requirements about what
showings need to be made in order to get licensed. So
that's another thing. We have
[1:16:45] an incredibly complicated
system with different rules across these license services.
So think about how we can make
[1:16:51] it more uniform. Also is
something I think we should work on this estate. >> Represent Schultz all.
Thank you, Madam Chair and
[1:16:58] inspector general. And I'm glad

to hear you share a lot of that. And I think that whether it's what we hear from whistleblowers or from

[1:17:06] Minnesotans, I think if we follow the precept that you outlined, we might see a higher level of care for those people to for

[1:17:14] the people who actually need it, right. But inspectors general, I think that that then brings me to

[1:17:20] something you said earlier and something I want to kind of follow down the line of and we talk about following billing

[1:17:28] patterns. You spent a moment of the day talking about the role the county's play and in collecting this information

[1:17:36] that it's a social service individual who ultimately grants this ability for the scare.

[1:17:46] What do you think inspector general do we need to do to mean add the statute so that there's a greater level of

[1:17:53] scrutiny that county employee places over whether or not that

[1:18:01] individual receives care. >> Inspector General Clark,

[1:18:07] I guess so. He would be open right to that, you know, looking at solutions. I mean, I've heard anecdotally

[1:18:14] right that we are seeing
serious troubles with their county case management system. Folks are overworked,
underpaid. There's high
[1:18:22] turnover. So a lot of the stuff
that case manager should be seeing on the front end
correcting reporting to the
[1:18:29] department. A lot of that stuff
is falling through the cracks. So I don't know if it's a
statue change a rule change
[1:18:35] funding change. But thinking
about Medicaid oversight is a shared responsibility, right?
We have counties player role
[1:18:42] the it just plays a role that
the federal government plays a role. The Legislature plays a
role, managed care organizations play a role.
We need to focus on how we can
[1:18:50] strengthen everybody's role
across that system because if we have areas of responsibility
that are falling short,
[1:18:59] we're going to continue
continue to see problems as in like not identifying these
issues on the front end with
[1:19:05] recipients that are receiving
services and making those quality tipsaw. I don't know if
it's a statutory change at an
[1:19:11] office rule, change a culture

change. We need to strengthen the county case management
system in this state because
[1:19:18] really they're really the front
line of of oversight in our in the Medicaid program. So I'm
happy to partner with you or
[1:19:25] anybody on that for ideas and
solutions. >> Representative Schultz last
one. Yes, thank you, Madam
[1:19:31] Chair. I'll just say it.
Another good comment. And I appreciate that, sir. Let's
work on that together. And also
[1:19:37] consider, you know, do we need
additional documentation? Does that documentation from a
county level need to be shared
[1:19:42] with you doesn't need to be
shared with the federal government, right? These are
all questions that I think that we really need to hone in on
for program integrity sakes.
[1:19:52] I'll just leave it at that.
Madam Chair. >> Thank you, members. I
appreciate this great discussion. I really do.
And we're going to quickly move
[1:19:59] through the next 3 very
quickly, because we do have a public test fires to want to
get to
[1:20:04] Representative Anderson, thank you very quick. We what what have you done?

[1:20:12] >> About looking at attendance
records because we saw what, for example, if even if you
chose fake names and you know,
[1:20:18] in this case, they have to have
a count that if something authorized to Medicaid. What's
and I appreciate we've heard
[1:20:25] from numerous county officials
about the pressure that they get to approve socially senior
care and sept the site that so
[1:20:34] it it's all fraudulent. But what have we
done about the fate, the attendance records because it
for only going out in every 2
[1:20:43] years and, you know, peeking to
see if they have, you know, something going out.
We don't know that they're
[1:20:48] actually spending 12 hours a
day or 8 hours a day at what used to be a senior center, you
know, years ago, some cases
[1:20:56] self. What are we doing about that
Sector, Clark? >> Thank you, Representative
Anderson. So reviewing
[1:21:03] attendance records is a part of
our licensing site visits, right? But like you said, those
don't happen every year,
[1:21:09] right? We have limited
capacity. We have not only adult day but thousands and

thousands and thousands right

[1:21:15] of of license Medicaid programs

in the state. So liason periodic licensing reviews

would be one way that we're

[1:21:21] looking at attendance records. Another way we would be looking

at attendance. Records would be

[1:21:26] if we are receiving tips of

fraud or potential attendance.

[1:21:34] Falsifications were receiving

those tips, then invest it, flipped fraud. Investigators

would go out and investigate

[1:21:41] providers. But I think what

you're getting at is we I mean, Medicaid also is it's a trusted

based system, right like you.

[1:21:49] We do not have the staff at

DHS. We do not have the technology to be looking over.

Everyone shoulder verifying

[1:21:56] every attendance record making

sure that every bill that submit to us is appropriate.

Right? We need to be able to

[1:22:03] trust the providers that they

are doing the right thing. So what can we do on the front

and to make sure that we weed

[1:22:09] out as many untrustworthy

providers as possible? That's where I think we need to be

focusing as a state because

[1:22:16] what you're getting at right is
like we're only doing licensing
reviews every couple of years, right number only responding to
tips like when we get them.
[1:22:24] So what what are what are we
missing? And a part of that is we just need to be able to
trust these providers that are
[1:22:31] entering our programs. So what
can we do to that to verify that these are trustworthy
businesses and individuals,
[1:22:38] that word that we're doing
business with us to stay so happy to partner with us.
She's too, but provider vetting
[1:22:44] on the front and is is where we need to be focusing
our efforts if we want to get
[1:22:50] ahead of fraud in our state. >> Thank you, Commissioner Ken,
thank you. Chair Robbins.
[1:22:56] I want to just add on to James
Inspector General. Clark's answer that. Also, this
enhanced prepayment review is
[1:23:06] going to be helpful for claims
of spotting trends in outliers and letting us know where to
look
[1:23:12] and then looking forward in the
future, perhaps the Legislature wants to consider electronic
visit verification or something

[1:23:20] like that. >> Would be interested in
discussing that in the coming
[1:23:26] session. Thank you. Leap into
it. >> Thank you. Madam Chair.
I was going to say this for
[1:23:31] later, but sort of that them.
But as I heard additional comments from the members of
the majority of just was I want
[1:23:37] to bring this up. I've heard
folks mention multiple whistleblowers. And I heard I
heard you say that Madam Chair,
[1:23:43] Representative Anderson
referenced that. You know, we all know we know that
there's kickbacks. Representative Schultz, then
most recently brought up was
[1:23:50] the bars. I guess I just
perhaps this is a would be a question that I don't put the
agency in the spots. All the
[1:23:56] sort of press made this comment
you, Madam Chair members and remind the public the
whistleblower portal that the
[1:24:02] cherubs set up. Members of the
minority have not had access to members of the majority are
aware of even one whistleblower
[1:24:08] as information members have,
please get it to authorities going to folks who can

investigate and can act on it.

[1:24:15] And perhaps you've done that

and maybe it will. I just asked the question what to expect in

general. Are you aware of information provided by this

preference is to whistleblowers

[1:24:23] in kickbacks, knowledge of that

members of the committee? Are you aware of information

has been provided to members of the committee to you? And I

want to know the details,

[1:24:31] but have they pass that along

to you? Inspector General. >> Thank you, representative to

I am not aware of any

[1:24:38] information being forwarded to

me by the committee. If the committee has information about

fraud that I can use to suspend

[1:24:47] payments to providers, I am happy to meet at any time

like I im sick of Medicaid

[1:24:54] fraud. I want to shut off

payments to any provider that is stealing from us. So if we

have credible allegations of 4

[1:25:01] tips that can lead to credible

allegations of fraud, I can you can submit it through

our website, but I prefer them

[1:25:08] to come directly to me. When

things do get referred to us by elected officials, they

typically get race to my

[1:25:15] attention directly. And
Representative Hudson referred a reporter says some suspected
abuse a few months ago. I
[1:25:23] ensure that that got immediate
investigative assignment. So I'm happy to meet with
anybody on this committee
[1:25:31] privately over the phone so
that we can stop potential
[1:25:36] criminals from gaining access
to money. >> Thank you. I'd like to
respond to that. So we did
[1:25:41] receive your letter inspector
general asking us to share information with you.
Incredible whistleblower
[1:25:47] reports. And to date we have
not because there is no trust. As you might understand, this
fraud has been perpetuated on
[1:25:54] your watch. And the
whistleblowers who reach out to us within the department are
terrified and they feel that
[1:26:00] they've been retaliated against
already. They feel that they are very afraid. They're afraid
to reach out to us. And if they
[1:26:08] thought we were then turning
around and giving it to you, we would not have
whistleblowers. So we initiated

[1:26:14] a whistleblower portal last
spring in response to people who are afraid to come to you.
And that has received hundreds
[1:26:22] of tips. Belatedly. You also
put out a whistleblower report portal this fall, which I think
hopefully is also generating
[1:26:29] tips. But when I get credible
allegations of fraud from whistleblowers, we meet with
them. We interview them.
[1:26:37] We ferret it out as much as
possible. But as you know, legislators do not have access
to bank records, health
[1:26:42] records, subpoena power, the
swift payments system that the state uses to pay things.
So I can only get an
[1:26:48] investigation so far. But when
we get it, we go to the U.S. attorney, the FBI and the
Office of Legislative auditor
[1:26:55] who have access to all those
records. So our whistleblowers are being protected and they
are also being reviewed for
[1:27:01] further investigation. And I
would like to have a more collaborative relationship with
you. But I have to say, if
[1:27:06] whistleblower start, we were
turning everything over to you. It would stop. >> Madam Chair, I just just a

follow-up question then.

[1:27:15] Madam Chair, you I'm referring

a tips to law enforcement then

[1:27:20] into sort of implied by your

answer that you are if I can't have any been referred to law

enforcement multiple and Madam

[1:27:26] chair, in that case, the

members of minority have not seen a single nothing submitted

to that to that portal. It went

[1:27:32] to confirm is that gonna

continue to practice? Then if it's credible enough to hand

over to law enforcement, but you will not let fellow

legislators be aware of those

[1:27:39] of those attempts. >> I have not received requests

to see the trips are heading over to law enforcement.

But if you would like to be

[1:27:46] read and I would consider it.

But I want to protect my whistleblowers. That's what

they're afraid of.

[1:27:52] >> Okay, Madam Chair, I I think

we had spoken previously about the minorities interest in

seeing the information and

[1:27:58] willful. After many months, the

whistleblower portal said that information would be shared

with members of the committee.

[1:28:03] We spoke recently. That's now

been changed. And that's being sure just for the record with
Republican members, which I appreciate the honesty of that.
But for many months, anybody
[1:28:11] submitting information to that
portal father does being shared with with the members of the
committee. That was not true.
[1:28:16] And you talk about a lack of
trust to my mind that is really generates a lot of lack of
trust that something people
[1:28:22] think is going to be acted upon
is just to the public and members. If you find it so
credibly going to law enforcement, we as policymakers
have no idea getting any kind
[1:28:29] of incitement, information that
portal see. I am I'm sorry if you did not think that before
now that we have an interest in
[1:28:35] that but service on the
Frontbench in committee means that we want to know anything
we can do to prevent fraud.
[1:28:40] Thank you, Madam Chair. >> Thank you. I would. I'm
sorry represent Alkins. I appreciate that. You have been
waiting in line for your second
[1:28:47] question. But we are going to
go to our public testifier. I would like to call up Nate
Olson and I could ask the
[1:28:54] commissioner and team to stay

because I do have a little presentation. I'm hoping to
provide that. I would like to ask you questions on afterward.
Thank you.
[1:29:00] Welcome to the committee,
Mister Olson. You have 2 minutes to get organized here.
[1:29:18] >> Madam Chair Committee to
Minnesota people. I've heard the commissioners and I'm
sorry. I just need you to state
[1:29:26] your name for the record.
I'm sorry if I'm sorry, ma'am. Madam Chair, I'm Danielle and
Olson. Disability advocate for
[1:29:32] the state of a Minnesota. I've heard the half
[1:29:37] commissioners and have that
apartment human services. But the one thing that I'm
freaking who worried about is
[1:29:43] this frickin fraud that is
happening over our state where there's 600,000 disability,
people in the state of
[1:29:49] Minnesota that could suffer.
And sadly, it's quite interesting that we have
Governor Waltz peak in the
[1:29:55] front of the state and saying
that this fog is nothing that's the side. But my people h*** o*
suffering more time with this
[1:30:06] fog. We're done with the
Department of Human Services coming up here in Saint.

All we're going to figure this out. This has been to ball and
the administration knew that
[1:30:15] this fog was coming. I talked
to families, parents, everyone have been reaching out to me
and say, whoa, this is what's
[1:30:22] happening to my child. This is
what's happening to my child growth of trade.
[1:30:28] We need to put aside this
difference as and we need to come together and put us to
this fraud.
[1:30:37] Our governor is not doing
anything to help us put step said here and that's it was to
blame Donald J the presence of
[1:30:44] United States. We have nothing to do with
this. There's a time to hold our
government accountable. And I'm
[1:30:53] not saying that this fog is out
for greatness
[1:30:58] and I'm very scared for my
little brother. If he goes into ice, yes, home. But right now
he's home with my parents.
[1:31:05] He's going to stay there
because I want to keep fighting for these disability people
because none of them are right
[1:31:10] here. I'm their voice. It is
time for us to say enough is

[1:31:16] enough. I'm Don and it makes me sad to see
what's happening to our state.
[1:31:24] This was a great state. It was. But all of this fraud that is
coming around here, all these
[1:31:31] excuses that it's happening
needs to stop.
[1:31:37] Minnesota needs to become a
great state again. Thank you and thank you guys for your
guys. It's hard work.
[1:31:45] >> Thank you for coming forward
and we appreciate your testimony.
[1:31:53] Representative Elkins, to want
to quick. Ask your next question by make my way to the
testifier table.
[1:32:00] Very quick. Thanks, Benji. >> I've spent spending a lot of
time with the county's the last couple of months. And what I
can say is the counties are
[1:32:10] suffering right now. The case
managers who get into this line of work because they want to
help people have been turned
[1:32:17] into glorified data entry
clerks just because of the clergy systems and in an awful
procedures that we put them
[1:32:24] through. And this is becoming a
crisis that we need to be addressing as well.
[1:32:50] >> Thank U next. We have a

presentation by Chair Robbins that arrogance.

[1:32:56] >> Thank you, Madam chair and

members. I know it's a little unusual for at me to come and

give a presentation

[1:33:04] when we don't have a bill in

front of us. But we've had multiple hearings for

many months and we have raised

[1:33:13] red flags after red flags

before with the department. We've tried to talk about

internal controls.

[1:33:20] And we've had months of being

told in this committee that things are getting better, that

they are changing processes and

[1:33:27] procedures that red flags are

being attended to.

[1:33:32] I appreciate that progress is

being made. I really do. But based on the whistleblower

reports that come into our

[1:33:41] office and meetings I've had,

the meetings are researcher has had we continue to see these

networks of fraud,

[1:33:49] that concern me and that are in

multiple programs. So we first

[1:33:55] side in that feeding our future

and we saw it in to some centers that we side and

housing stabilization. And now

[1:34:02] today we're looking for the
first time at assisted living and adult day services members.
We do not have the time to do
[1:34:10] this for every single program.
So this is my attempt to show you what we have found in this
space to our research to then
[1:34:18] begs the department and the
others involved in these adult and assisted living to take
this on as their next project.
[1:34:26] But then also to look more
broadly at all of these services,
[1:34:32] it is incumbent on us to get a
handle on it. And when you see these networks, it's a huge red flag and it
doesn't seem to have been
[1:34:40] triggered in this space ship.
So we have several slides here that I'm going to walk through.
So the first 2 we've kind of
[1:34:48] address, I'm just going to talk
about it really quickly. The first slide here is talking
about that payments in assisted
[1:34:57] living and has was referred to
earlier, assisted living and customize living assisted
living licensure is done by the
[1:35:05] Department of Health. But the
customize living services are done by DHS. So it's sort of a
hybrid of responsibility.

[1:35:12] And what we are seeing in this
slide is in column one. The growth in the number of people
getting customize living
[1:35:20] services in assisted living
facilities has been double the growth in other wavered
programs. But more importantly,
[1:35:26] you'll see the rate of payments
for customized living services is 10 to 15 times the growth,
another waiver payments.
[1:35:34] So this is a huge concern
members. One of the many red flags we always see is the
growth in payments
[1:35:41] substantially. And we are
seeing this next slide. We've already talked about this quite
a bit in the department had
[1:35:48] this and one of their slides.
But the growth we have seen in the number of providers, we
talked about the number of
[1:35:54] providers in adult day care.
Now we're talking about the number of providers in assisted
living facilities. The growth
[1:36:00] has been really large and the
growth is interestingly from, if you just look at the
second part of the slide in the
[1:36:07] Provisional assisted licensing
facilities, that's the growth in new programs over the last

year because that provisional

[1:36:15] license, it's just good for one

month. One year, strikingly the growth is in

those with 5 or more or less

[1:36:23] for capacity. And why is that?

That is because the state put a moratorium on growth for 4 or

last a couple years ago.

[1:36:31] So they are just switched and

went into 5 or less members. This should be a red flag.

I don't know why this is not on

[1:36:39] people's radar. So they just

basically trying to avoid the moratorium, shifted 2, 5, And I

just think this is something

[1:36:47] that has to be addressed and I

want to raise it while the department is here so that they

can get back to us on that.

[1:36:52] All right. Next slide, big

picture. Here's that. Webb is that we have discovered and we

I want to give great

[1:37:02] thanks to our research, sir,

for members of the public who don't know. We are a committee

of 5 members and one researcher

[1:37:10] and our research or has done phenomenal work looking at publicly available

documents. I'm sorry.

[1:37:18] Members of the majority, we

have a committee of 8. I'm sorry, my my colleagues on the

other side, that leader

[1:37:24] researcher, you also have a

researcher on your side. So we have a majority

researcher, Majority minority

[1:37:29] researcher. So our researcher

has uncovered to publicly available documents. As I said

earlier, we don't have access

[1:37:37] to bank records, health

records, subpoena power. Any of the state payment system

does is just what we have

[1:37:42] discovered through

whistleblower reports and publicly available documents.

And it is a web of all these

[1:37:48] people who have multiple

relationships, multiple business, multiple ownership

interests that are involved in

[1:37:57] all of these Medicaid services.

And when you see a web like this, and this is just a tiny

one, this this is such a small

[1:38:03] sample of what we could have put out. But we do not have the

bandwidth to create a time like this

[1:38:10] and this should win. You can

create a web like this. It should be a red flag. So I want

to talk about specific pieces

[1:38:19] of the charts. Look over the

next chart really quickly. So members feeding our future

has been the largest scandal in
[1:38:27] state and national history from
COVID. As we will see in this chart,
[1:38:34] there is a feeding our future
defendant who is continuing to build this
state for assisted living
[1:38:41] services while awaiting trial
in the feeding our future scam. First, it is outrageous that
the department is still
[1:38:48] allowing a feeding our future
fraudster who has been alleged, you know, charged to still get
state money of any kind.
[1:38:55] The state statute explicitly
permits the state to stop payment where there are
credible allegations of fraud
[1:39:01] and my friends. If someone has
been indicted in feeding our future, that's a credible
allegation of fraud and they
[1:39:09] should not be getting state
money for any other program. So let me give you the back
story in February 2024, this
[1:39:15] person in the feeding our
future bubble was indicted in charge for 1.1 million in money
laundering in the feeding our
[1:39:23] future scandal. This same person was paid an
additional 49 million for other

[1:39:29] state programs between 2019
2024, this person will have their
trial in April of 2026.
[1:39:37] The other key player in this
slide is real it or for our foreign the chart this person has shown up in our
records as being that most
[1:39:45] single largest buying agent for
single family homes that are converted to assisted living
from anyone that we have found.
[1:39:53] Our 4 and the feeding our
future defendant are interconnected in multiple
ways. Realtor for was the buying age
in from multiple properties by
[1:40:01] the feeding our future
defendant. If you look at the bubble just above our for its
assisted living facility 16,
[1:40:07] you will see this assisted living facility.
16 represents 3 separate
[1:40:13] properties owned by the feeding
our future defendant and operated under different
business by the defendant's
[1:40:20] wife assisted living facility
received over 2.3 million in
[1:40:25] state money last year. The wife of the feeding Rq
future defendant just recently
[1:40:33] purchased a force home that

will become part of assisted living facility 16 again, using
the litter for and was given a
[1:40:40] provisional license for this
facility in September members. What is going on?
This is a red flag and they
[1:40:49] just give them a provisional
license. Incredibly, the feeding our future
defendant changed his name just
[1:40:57] months before he was indicted
and he used that new name to purchase the homes that are
operated in assisted living
[1:41:05] facility bubble 17, 2 homes
that the state has paid currently in this talent in
this fiscal year $132,000,
[1:41:15] one of the homes purchased in
that setting for that facility was purchase using
[1:41:22] the same LLC that he's indicted
for money laundering in.
[1:41:28] It is unbelievable members. And and they were just granted
a new operating license for
[1:41:36] this facility earlier in the
year. So this is not hard to figure
out as Jim able or said,
[1:41:41] Senator Jim, a blur said back
in 2024. When this person was indicted, he said if it were
me, I do a strict audit of the

[1:41:49] last 5 years of this man's
business. People who are dishonest in one area may tend
to be dishonest in another.
[1:41:55] We have to be absolutely sure. Clearly his suggestion was
ignored.
[1:42:00] All of these homes purchased or owned by the
feeding. Our future defendant are currently enrolled in DHS
to deliver customized living
[1:42:09] services as late as October payments to the defendant's
wife had continued for services
[1:42:17] on her husband's properties for
2 years following his indictment and the payments to that
assisted Living 17.
[1:42:25] Those were founded, though, is
that property was founded after his indictment.
[1:42:31] We are not still getting the
attention of the department to do the basic due diligence that
we need. If they have not
[1:42:39] crossed, checked every member
of the feeding our future who have been indicted or convicted
and see what other services
[1:42:45] they are getting from the
state. They have failed and I'm asking them today to get that
done. Let's go to the next
[1:42:51] slide.
[1:42:56] Okay. This is another realtor

and the reason this is relevant is because you'll see in their ICs bubble. They they provide

[1:43:04] several services. This is the person where we had a testifier in September

[1:43:09] talking about how they were not provided services for dare ICS

[1:43:15] services by this provider.

So this real estate agent owns this ICS provider we talked about last month and payments

[1:43:24] have now apparently been shut down to this provider. But last year they got 1.6 million dollars from the taxpayer.

[1:43:34] He also owns 3 of these houses for assisted living.

So we've shut him down in

[1:43:42] integrated community supports,

but we have not shut him down for assisted living. Why is that?

[1:43:48] So 1.3 million and counting.

There are 2 other issues that I'm going to skip over for a time with Israel. It her.

[1:43:56] But it's important to know that this is just one example of how potential fraudulent activity is being allowed to continue in

[1:44:05] Minnesota. This lack of cross checking of different businesses is a basic failure of internal controls and it

[1:44:12] must stop. Now we're going to move on to
person one in person, too,
[1:44:18] from that far section of the
slide. So just just to level set up or
someone is related to real
[1:44:28] estate agent one, but it it's
not showing on here, but that was part of that larger web.
[1:44:33] So prison when he's been very
busy. They came to our attention from a whistleblower.
And then our staff later went
[1:44:39] to visit the commercial
building in Saint Paul that have houses about 100
healthcare companies.
[1:44:45] This building was named in the
FBI housing stabilization affidavit for the extensive
network, U.S. very similar
[1:44:52] network of fraudulently
providing housing stabilization service providers.
[1:44:58] This person story has an
interesting twist in the far left couple. They also own a restaurant that
was raided by the police for
[1:45:06] alcohol, tobacco and gaming
violations. And it was so egregious that the city of
Minneapolis polled their
[1:45:15] license and they are closed as
a restaurant. So I think this is another red

flag. If someone owns a

[1:45:22] business that's had multiple

legal gambling and liquor violations and their licenses,

Paul them, they're still

[1:45:30] getting a lot of other money

from the state. Maybe we should take more scrutiny there

[1:45:36] and also because the addresses

for their other businesses that are billing the state, the

address of the restaurant.

[1:45:44] So this person has 3 different

assisted living facilities.

[1:45:49] I'm going to quickly run

through them. Assisted living facility. One is administered

by person one and has a

[1:45:55] capacity of for Betts. Despite this limited capacity,

they get 820. They had $826,000

[1:46:03] last year and they are on pace

to double that.

[1:46:09] We need to be concerned about

that assisted living facility to is operated by person.

One this home was purchased

[1:46:16] with cash, which is a red flag

because there's a lot of money laundering going on in these

spaces.

[1:46:22] It is also a homestead property

despite the fact that the owner already has a homestead

elsewhere. Members, we see this
[1:46:31] in multiple of these assisted
living facilities where they have homestead of the assisted
living facility while they have
[1:46:38] another property homestead,
that should be another basic internal control that is being
flagged. And I have not seen
[1:46:46] evidence of that being done by
the department later. A let's see
[1:46:54] tonight Tech, but they're
served one.
[1:46:59] This one is also on track to
double their payments in the next year. I'll just say
briefly, what's going on there.
[1:47:05] So the other interesting thing
about this is this person person, one is connected to
person, too,
[1:47:11] and a person to has an adult
daycare.
[1:47:18] Sorry. I'm looking for my notes
on that. The adult daycare bubble in
this chart
[1:47:25] received over 632 million
dollars. And 25 but it was I covered that
person, ones. Adult Day care is
[1:47:34] the former location of percent

whose adult daycare. So 2 adult
[1:47:39] day cares by person. One person
to run out of the same location, both billing the
state of Minnesota
[1:47:46] for 4 years. Those overlapping
payments just stopped
[1:47:52] and then percent who has a
separate assisted living facility. And there's more I
could save a person to, but we're running out of time.
So members, I bring this to
[1:48:00] your attention and to the department's
attention. Because despite months of
hearings,
[1:48:08] we continue to miss the most
basic internal controls,
[1:48:14] the most basic checks and
balances when we are enrolling providers. And I'm grateful
that the day before our
[1:48:21] hearing, they've now paused
enrollment for new providers in adult day services. Clearly,
that's essential.
[1:48:28] But we also have to pause.
I knew providers in assisted living facilities. And I hope
that we will do that.
[1:48:37] And I just want to quickly
highlight the red flags that that we've outlined in this one

network and members. This is
[1:48:44] just one network, our research or has
[1:48:50] multiple networks that we could
have discussed today. And I will be turning all of that
data over to the U.S. attorney
[1:48:58] after this hearing and
encourage them to look through it. But but the flags that I want
to highlight that have still
[1:49:06] not been addressed or the
explosive growth in providers and payments assisted living
[1:49:12] biz. So has at a minimum, any
business with ties to feeding our future indictments should
receive higher scrutiny.
[1:49:19] Any use of LL seeds or other
front companies. Houston
[1:49:25] feeding our future should be
scrutinized to see if they're also still getting other state
services. Any business owned by
[1:49:32] someone who has already been
stopped payments on in other programs. That was part of
person. One should get higher
[1:49:39] scrutiny. Any person who has had over
payments, they should get
[1:49:44] higher scrutiny about other
businesses they run. Any business
[1:49:50] owner should be checked to see

if the owner has a history of other violations at of at a minimum, do a Google search on these people who are
[1:49:58] owning businesses. I forgot to highlight some of the other things about person. One that one of them that's very
[1:50:04] intriguing is they have a mineral company in Africa.
[1:50:10] That license is unverified. So they claim that they're also providing license mineral services in Africa. That should
[1:50:18] be a red flag members. So we've highlighted this is all this is all information that the department
[1:50:25] claims they've cleaned up and it's ongoing. They are getting money today in other service areas. So I just want to
[1:50:33] highlight that the work of fixing basic internal controls has not happened.
[1:50:40] And we still need to make sure. And our job is to hold the agency accountable
[1:50:47] for making sure that they are buttoning this up. I am very thankful to see that these providers
[1:50:53] are not going to be allowed to enroll new providers in these programs, but we should do that not only for adult day care, we should

[1:51:00] do it for assisted living and
probably many other programs. And for those existing
providers,
[1:51:07] I personally think they should
all have to be verified. So members, I wanted to bring
this to your attention because
[1:51:14] the work of our committee, I think a lot of it the public
never sees. We have these
[1:51:20] hearings. Nobody understands
the networks. We're uncovering the things that are tremendous
staff has found and that
[1:51:28] hundreds of whistleblower
reports we are doing. And so I just wanted to make sure the
public understands we are
[1:51:35] making progress. And I
appreciate that steps the department has taken, but there
ongoing problems that have not
[1:51:42] been addressed and we need to do more to shut this down.
[1:51:48] And with that members, I'm
happy to take questions. But I also have questions based
on this testimony for the
[1:51:54] department. So I'm in a recent
we take my chair. Thank you
[1:52:01] and thank you while awaiting
Repsonded Green things.
[1:52:06] Thank you. Madam chairs. You know, I I wanted to raise a

concern which is.

[1:52:14] >> What I have heard the

inspector general say whatever heard others say is tips.

You can you can pass on tips.

[1:52:20] They don't have to have

personally identifying information. They can be

anonymous both directly and

[1:52:26] from us. So it is a concern to

me to hear this committee chair

[1:52:32] say not only are you not

passing on information to the inspector general, you're not

passing on information. I

[1:52:38] didn't hear you say the

attorney general and I heard you say the administration.

And so it sounds like to me and

[1:52:45] the concern I have and is a

partisan political concern. And here's why. Because you

talked about building trust,

[1:52:53] which I think is really, really

important. I think it's important that as government

we're building trust with our

[1:52:59] residents and our and the folks

who live here. But I think it

[1:53:04] is hard to build trust when you

have a committee, which one you referred to, I know it was a

slip, but as the committee of 5

[1:53:11] and their 8 of us. And so that
was the Republicans. You talked about the researcher. I assume
you're talking. You're not
[1:53:17] sharing this with, but you can
correct me if I'm wrong, are non-partisan research can
health suffering confidence? You're talking about your
partisan researcher. The tip
[1:53:24] line is a is a Minnesota House Republicans dot
com backslash Cristobal Porter.
[1:53:31] So it's not a government is not
a few. Didn't set up a legislative port all and with
with the rules that apply.
[1:53:38] It is a partisan political tip
line. And, you know, we have this
isn't this an election year and
[1:53:45] so the incentive structure is
not for it for you. Madam Chair, for others who are
running against the governor is
[1:53:52] not to fix. The problem is to
highlight and run on it. And I actually don't have a
problem with that. That is the
[1:53:57] politics we live in. But when
we talk about our work here and building trust with people, the
idea that this committee is
[1:54:05] collecting and not sharing with
the minority, not sharing with our nonpartisan infrastructure,

not sharing with the inspector
[1:54:12] general or the attorney general
and only sharing it with and the U.S. attorney who reports
to somebody who is directly
[1:54:19] coming after our governor and
who has said pretty terrible things is very partisan.
And I think you'd be hard to
[1:54:26] argue with that. And so I think
if we want to build trust, the way we start rebuilding
trust is by one sharing,
[1:54:34] if you can on a mice and share
that with every with the inspector general with the
attorney general's office,
[1:54:41] with the LA with the U.S.
attorney, but the behavior and
[1:54:46] the way that this committee has
been operating for the Republican majority on this
committee is not about building
[1:54:52] trust. You don't build trust
with the partisan website with a partisan angle and with not
sharing information with
[1:54:59] two-thirds of the government.
So I guess of that, I would ask Madam Chair, do plan on
changing the way now that,
[1:55:06] you know, that tips can be
anonymous, sharing some of that either with the part with the

minority or with the

[1:55:13] administration and with the

attorney General's office. >> Thank you, Representative

agreement. So to be clear,

[1:55:20] I share regularly with the I'm say that to be clear, I sure regularly

with

[1:55:29] office of Legislative Auditor,

I worked closely with our non-partisan research staff

[1:55:35] and it was on their advice that

we had to set up the cordle under the Republican side.

We tried to do it through a

[1:55:43] legislative bipartisan thing

and for reasons that are beyond my

technology, that was not

[1:55:51] possible. So we did we look

into that aggressively at the beginning. We were told the

best way to do it would be

[1:55:57] through a the the Republican

side. So we did try to do that.

And to your point, suggesting

[1:56:05] that sharing with the U.S.

attorney is inappropriate. The U.S. attorneys office under

[1:56:11] President Biden under Andy

Luger is the one who start started feeding our future.

And we had a bipartisan meeting

[1:56:21] with the former U.S. attorney

[1:56:26] as a committee that everyone was invited to to
learn from him. And it was a very productive meeting.
[1:56:33] And now there has been a change
of government. But the person actually prosecuting these
cases in the U.S. Attorney's
[1:56:38] office is the same person and that person fantastic integrity and cares
about justice in cares about
[1:56:47] this state. And so I will I get
mad. I do not accept that. Referring things to the U.S.
Attorney's office is
[1:56:54] inappropriate. Madam Chair, I
just want to clarify because I didn't say that what I said.
He's only sharing things with
[1:57:00] U.S. attorney's office and not
sharing it with our Medicaid fraud control unit at the
attorney general's office. >> That's that's charged under
state and federal law with
[1:57:09] investigating this. Not sharing
it with the inspector general at the department. That's what
I said. It is not. I think you
[1:57:15] should be sharing these tips
and you can share anonymous with everybody. What I'm saying
is you're clearly make a distinction between places that
are controlled by Republicans
[1:57:23] in places that are controlled
by Democrats. And that to me does not you can choose to do

that. This is your committee

[1:57:29] that does not build trust in

what you're doing here and you raise the issue of trust.

And so that's what I'm saying.

[1:57:35] And so please don't

mischaracterize what extent. >> Thank you. You also said I

didn't refer to the LA I had

[1:57:41] worked with non-partisan staff

and I have done both and I continue to do both. But what I

will say to regarding why I'm

[1:57:47] not sharing currently with the

department and with the office of the Attorney general is

because of the trust broken

[1:57:56] with the whistleblowers that predates this committee by

year's end. The whistleblower's

[1:58:03] only felt comfortable coming

forward when they knew someone outside the attorney general's

office and the department was

[1:58:13] willing to listen to them

because they have tried repeatedly to share their concerns with

the department and with the

[1:58:22] attorney general's office and

have either been ignored or ghosted.

[1:58:27] They have been retaliated against surveilled

[1:58:32] and other problems. And so

because I'm first trying to build trust with the

whistleblowers.

[1:58:39] That's why we're not referring

back to the department because they are very afraid. If I

begin to feel like we can do

[1:58:46] that without violating the

whistleblower trust, then I would certainly want to share.

And I have had meetings with

[1:58:53] Commissioner Gandhi privately

in my office over the months and we have a good dialogue.

I also think that would build

[1:59:00] trust is responses to my

increase. After every hearing since June, I've sent letters

to the department asking for

[1:59:06] additional data. I've had one response and it

was after a press inquiry.

[1:59:12] So I have 6 outstanding data requests to the department

that I'm still waiting for

[1:59:19] information on. So would help

build trust if you would respond to me. So we will continue to work on

building trust.

[1:59:27] And I really mean that. But it has to be a two-way

street. >> Madam chair, just one thing

actually on the practicality

[1:59:34] because when you share with us

it with the inspector general, they can shut off payment.

The U.S. attorney and the I

[1:59:40] can't. So as it relates to
taxpayer dollars, if there are credible allegations that need
to even atomized need to go to
[1:59:48] the inspector general and you
are not turning them in is actually means that you are
preventing payments from being
[1:59:54] stop. And so again, I think
there is this. What I'm asking for is not that you only go to
them. What I am saying is that
[2:00:02] the inspector general has a
role to play here and they have been playing that role the oh,
LA has a role to play here.
[2:00:07] And I think we heard we have a
role to play here. But again, you have some humid,
[2:00:12] a lot of comments about a lot
of things happening, none of what you provided to the
minority. >> And so again, to build trust
with us. But also with the
[2:00:19] public, you have said a lot of
things. You have not put facts if there's allegations of
surveillance. You should bring
[2:00:25] that up, though, that that's a
potentially along for something. But just saying that
in a public hearing does not
[2:00:31] want to build trust and it also
doesn't bring our world our credibility. And that's I think

the stake we should all have in

[2:00:36] the U.S.. Thank you. >> Thank you. And my final

comment on that is we will continue to work together to

build trust

[2:00:44] and I will continue to protect

the whistleblower's. If you are watching, I have your back and you will

always be protected.

[2:00:51] And and I will continue to look

for ways to help provide

[2:00:57] information where we should

stop payment as appropriate. And I think I've given you

plenty of opportunity to look

[2:01:03] at things this afternoon where

I do think and I've recommended strongly we look at other

places to stop payment and I

[2:01:09] hope you'll take it seriously

that members were adjourned. Thank you