OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

FINANCIAL AUDIT DIVISION REPORT

Department of Human Services

Healthcare Provider Payment Controls

Information Technology Audit

July 1, 2009, through April 30, 2010

November 4, 2010 **Report 10-34**

FINANCIAL AUDIT DIVISION
Centennial Building – Suite 140
658 Cedar Street – Saint Paul, MN 55155
Telephone: 651-296-4708 • Fax: 651-296-4712
E-mail: auditor@state.mn.us • Web site: http://www.auditor.leg.state.mn.us
Through Minnesota Relay: 1-800-627-3529 or 7-1-1

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OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

November 4, 2010

Senator Ann H. Rest, Chair
Legislative Audit Commission

Members of the Legislative Audit Commission

Mr. Cal R. Ludeman, Commissioner
Minnesota Department of Human Services

This report presents the results of our information technology audit of selected aspects of the Department of Human Services' Medical Assistance system (MMIS) for the period July 1, 2009, through April 30, 2010. We emphasize that we did not conduct a comprehensive audit of the department.

We discussed the results of the audit with the department on October 21, 2010. The audit was conducted by Amy Jorgenson, CPA (Audit Manager) and David Westlund, CPA, (Auditor-in-Charge), assisted by auditors Mark Allan, CPA, CFE, Carolyn Engstrom, CISA, CISSP, Sonya Johnson, CPA, CFE, Chau Nguyen, and Paul Thompson.

This report is intended for the information and use of the Legislative Audit Commission and the management of the Department of Human Services. This restriction is not intended to limit the distribution of this report, which was released as a public document on November 4, 2010.

We received the full cooperation of the Department of Human Services' staff while performing this audit.

James R. Nobles
Legislative Auditor

Cecile M. Ferkul, CPA, CISA
Deputy Legislative Auditor

Room 140 Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155-1603 • Tel: 651-296-4708 • Fax: 651-296-4712
E-mail: auditor@state.mn.us • Web Site: www.auditor.leg.state.mn.us • Through Minnesota Relay: 1-800-627-3529 or 7-1-1

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Report Summary

Conclusion

The Department of Human Services had generally adequate internal controls to ensure it made Medical Assistance payments for allowable procedures and at authorized amounts. However, the department's internal controls were not adequate to ensure it only paid eligible providers. We consider this to be a material weakness in the department's internal controls.

The Department of Human Services resolved one and partially resolved another prior audit finding relevant to the scope of this audit.[1] The department had not fully resolved a weakness related to limiting employee access to the Medical Assistance system.

Key Findings

- The Department of Human Services did not have adequate internal controls to ensure that it only paid licensed healthcare providers. (Finding 1, page 7)
- The Department of Human Services did not adequately separate incompatible duties in its process for enrolling service providers. (Finding 2, page 8)
- Prior Finding Partially Resolved: The Department of Human Services did not have sufficient controls to limit, monitor, or prevent incompatible or unnecessary access to the Medical Assistance system and the cash and food benefits system. (Finding 5, page 11)

Audit Objectives and Scope

The audit objectives were to answer the following questions:

- Were the department's internal controls in the Medical Assistance system adequate to ensure that payments were made to eligible healthcare providers for allowable procedures at the authorized price, in compliance with federal and state legal requirements?
- Were the department's internal controls adequate to ensure payments made by the state's accounting system agreed with payments authorized by the Medical Assistance system?
- Did the department resolve the two prior information technology findings that are relevant to the scope of this audit?

Our audit scope was July 1, 2009, through April 30, 2010.

[1] Office of the Legislative Auditor, Financial Audit Division, Report 07-14, *Department of Human Services: Medicaid Management Information Systems Security Controls*, issued June 7, 2007, Finding 1 partially resolved, Finding 2 resolved.

Department of Human Services

Healthcare Provider Payment Controls

Overview

The Minnesota Department of Human Services administers a variety of public assistance programs, including the state's Medical Assistance program.[2] The Medical Assistance program is a federal/state funded program that provides health care services to low income residents.

Through the Medical Assistance program and other publicly funded health care programs, eligible recipients receive medical care from healthcare providers. The healthcare providers then submit an electronic claim to the department for payment. The department's Medicaid Management Information System (MMIS) validates the claim against a variety of criteria to authorize the payment amount. Those criteria are intended to ensure that the department only pays eligible healthcare providers for allowable procedures provided to eligible recipients at the authorized price. The Medical Assistance system creates a payment file for the claims authorized to be paid and transmits that file to the state's accounting system for payment. The state's accounting system generates the payments to the healthcare providers. During fiscal year 2010, the healthcare providers received payments totaling about $8.5 billion through this process.

Objective, Scope, and Methodology

The audit objective was to answer the following questions:

- Were the department's internal controls in the Medical Assistance system adequate to ensure that payments were made to eligible healthcare providers for allowable procedures at the authorized price, in compliance with federal and state legal requirements?

[2] Medical Assistance is the state's name for the federal Medicaid program.

- Were the department's internal controls adequate to ensure payments made by the state's accounting system agreed with payments authorized by the Medical Assistance system?[3]

- Did the department resolve the two prior information technology findings that are relevant to the scope of this audit?[4]

These objectives parallel our responsibilities for auditing the state's compliance with federal program requirements under the Single Audit Act.

To answer these questions, we interviewed department staff, examined system documentation, and tested key processes and controls. To test whether healthcare providers were eligible, we examined the department's enrollment process and controls in the Medical Assistance system (MMIS). To test whether procedures were eligible and paid at the authorized price, we focused our testing on the 20 procedures that had the most dollar activity.[5] The scope of the audit was financial activity from July 1, 2009, through April 30, 2010, and we assessed controls as of April 30, 2010. We emphasize that this was not a comprehensive audit of the Medical Assistance system.

We conducted the audit in accordance with generally accepted government auditing standards. 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 used the guidance contained in the *Internal Control-Integrated Framework*, published by the Committee of Sponsoring Organizations of the Treadway Commission.[6] We used state and federal laws, regulations, and contracts and policies and procedures established by the Department of Management and Budget and the department's internal policies and procedures as evaluation criteria for compliance.

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[3] In addition to our primary objective stated above, we performed limited procedures to also determine whether the department's internal controls adequately ensured that it made payments only as authorized by the cash and food benefits system, named MAXIS. The department used this system to determine cash benefits paid for a variety of federal and state funded programs, including Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance programs. Similar to the process to pay healthcare providers, the cash and food benefits system creates a payment file for the authorized benefits. The department provided most of these benefits to recipients electronically; however, the department also provided some benefits by printing and mailing paper checks.

[4] Office of the Legislative Auditor, Financial Audit Division, Report 07-14, *Department of Human Services: Medicaid Management Information Systems Security Controls*, issued June 7, 2007, Findings 1 and 2.

[5] The department had nearly 28,000 procedure codes.

[6] The Treadway Commission and its Committee of Sponsoring Organizations were established in 1985 by the major national associations of accountants. One of their primary tasks was to identify the components of internal control that organizations should have in place to prevent inappropriate financial activity. The resulting *Internal Control-Integrated Framework* is the accepted accounting and auditing standard for internal control design and assessment.

To assess system controls, we used criteria contained in *Special Publication 800-53, Recommended Security Controls for Federal Information Systems*, published by the National Institute of Standards and Technology's Computer Security Division.

Table 1 shows the 20 procedures we tested. These 20 procedures accounted for approximately 25 percent of the payments to healthcare providers from July 1, 2009, through April 30, 2010.

Table 1
Top 20 Procedures
Paid through the Medical Assistance System (MMIS)
July 1, 2009, through April 30, 2010

Procedure Name[1]	Total Reimbursed
Residential care, not otherwise specified, waiver; per month	$401,324,708
Personal care services, per 15 minutes	352,143,744
Day habilitation, waiver; per diem	133,403,617
Targeted case management; per month	116,482,808
Foster care, adult; per month	113,255,192
Foster care, adult; per diem	100,473,516
Habilitation, residential, waiver; per diem	90,382,760
School-based individualized education program services, bundled	83,275,645
Specialized supply, not otherwise specified, waiver	77,309,071
Case management, each 15 minutes	56,490,169
Assisted living, waiver; per month	49,597,539
Registered nurse services, up to 15 minutes	40,036,034
Licensed practical and vocational nurse services, up to 15 minutes	29,954,563
Companion care, adult; per 15 minutes	28,934,518
Activity therapy, per 15 minutes	27,003,928
Alcohol and/or other drug treatment program, per hour	26,475,232
Attendant care services; per 15 minutes	25,158,829
Behavioral health; long-term residential	24,580,618
Skills training and development, per 15 minutes	24,428,004
Assertive community treatment program, per diem	20,791,702
Total	$1,821,502,197[2]

[1]The federal government defines these specific procedures in its Health Insurance Portability and Accountability Act (HIPAA) regulations. There are approximately 28,000 types of procedures.

[2]Payments for these 20 procedures totaled about 25 percent of the $7.3 billion paid through the Medical Assistance system from July 2009 through April 2010.

Source: Medical Assistance system.

Conclusions

The Department of Human Services had generally adequate internal controls to ensure it made Medical Assistance payments for allowable procedures and at authorized amounts. However, the department's internal controls were not adequate to ensure it only paid eligible providers. We consider this to be a material weakness in the department's internal controls.

The Department of Human Services resolved one and partially resolved another prior audit finding relevant to the scope of this audit.[7] The department had not fully resolved a weakness in its internal controls related to limiting employee access to the Medical Assistance system.

The following *Findings and Recommendations* further explain the department's internal control and compliance weaknesses.[8]

[7] Office of the Legislative Auditor, Financial Audit Division, Report 07-14, *Department of Human Services: Medicaid Management Information Systems Security Controls*, issued June 7, 2007, Finding 1 partially resolved, Finding 2 resolved.

[8] The findings in this report identify a material weakness (Finding 1) and significant deficiencies (Findings 2 through 10) in the department's internal controls over compliance with federal requirements for the Medical Assistance Cluster (CFDA 93.775 – 93.778).

- A *material weakness* in internal control over compliance is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a federal program compliance requirement will not be prevented, or detected and corrected, on a timely basis.
- A *significant deficiency* in internal control over compliance is a deficiency, or combination of deficiencies, in internal control over compliance with a federal program compliance requirement that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

We have forwarded this report to the federal government. In addition, we will incorporate this report's findings in our Single Audit conclusions reported to the federal government in March 2011.

Findings and Recommendations

Finding 1

The Department of Human Services did not have adequate internal controls to ensure that it only paid licensed healthcare providers.

The department's Medical Assistance system (MMIS) authorized payments to healthcare providers even when the system's data indicated that the provider's license information was expired or missing. Although the license information in the Medical Assistance system did not necessarily reflect the healthcare providers' actual license status, department staff did not have an effective process to update provider license information. In addition, the department did not monitor the extent of payments to healthcare providers with expired license information nor did it address the increased risk of improper payments and fraud.

We consider what we found to be a material weakness in internal controls over compliance with federal and state Medical Assistance program requirements, which require certain healthcare providers to have valid licenses before being paid for services.[9] By not ensuring that health care providers had valid licenses, the department created an unacceptable risk that it paid ineligible providers.

As of April 30, 2010, the Medical Assistance system identified 11,489 healthcare providers requiring a license as having expired or missing license information – nearly 28 percent of the 41,529 healthcare providers requiring a license.[10] During the period from July 2009 through April 2010, the department's payments to healthcare providers with expired or missing license information totaled nearly $564 million. For example, the department paid $17,272,073 to 1,286 psychologists and $6,230,012 to 413 dentists who had missing or expired license information.

We compared the Medical Assistance system's license information for Minnesota providers in four of the healthcare provider categories (psychologists, dentists, physicians, and optometrists[11]) to the actual license information from the corresponding Minnesota health licensing boards. For these providers, we verified

[9] 42 CFR section 455.2 defines practitioners as "a physician or other individual licensed under State law to practice his or her profession." *Minnesota Rules* 9505.175 and *Minnesota Statutes* 256B.02 require certain providers to be licensed.

[10] Of these 11,489 healthcare providers, 11,180 had information indicating an expired license, and 309 providers had no licensing data in the Medical Assistance system.

[11] These four categories had 2,417 Minnesota health care providers with expired or missing license information in the Medical Assistance system and made up 21 percent of the total providers who had missing or expired license information in the Medical Assistance system.

that they had active Minnesota licenses and that the department had not made improper payments.[12]

In addition, the Medical Assistance system did not allow for recognition of more than one type of license for certain healthcare provider categories that may have several different licensing requirements. The *waivered program* category, which included a wide variety of home and community based services, had specific licensing requirements depending on the category of service provided; however, the system did not ensure that the license held by the provider matched the service provided.

Recommendations

- *The department should develop a process to update the Medical Assistance system's license information and prevent payments to providers who are not licensed or whose licenses are expired.*

- *The department should determine, for all types of health care providers, whether it made any payments to providers with expired licenses. If so, it should recover those payments and determine whether it needs to take any legal action against those providers.*

- *The department should refine its system controls or design an alternative way to ensure that waivered service providers have all appropriate licenses.*

Finding 2

The Department of Human Services did not adequately separate incompatible duties in its process for enrolling service providers.

The department did not adequately separate incompatible duties for 20 employees responsible for enrolling providers. Separation of incompatible duties is a fundamental internal control designed to ensure that no one employee or group of employees can perpetrate and conceal errors or fraud in the normal course of their duties. These employees could set up providers in the Medical Assistance system (MMIS), the state's accounting system, and the department's electronic claims submission interface. In addition, the same employees verified licensing information upon initial application. As a result, any one of these employees could set up an invalid provider and make fraudulent payments to that provider without detection. This weakness created an unacceptable risk of fraud.

[12] We did not verify the license status for the 1,936 providers in these categories who were licensed by other states.

Recommendation

- *The department should separate incompatible provider enrollment duties.*

Finding 3

The Department of Human Services did not establish standards to ensure the sufficiency of testing done for changes to the Medical Assistance system and did not adequately document testing and authorization for those changes.

The department did not ensure that program staff had adequately tested and authorized changes to the Medical Assistance system (MMIS) before information technology staff implemented the changes. The department frequently made changes to the system to improve business processes, comply with new legislative mandates, modify reports, or change edits. Testing of proposed changes is necessary to ensure that the changes worked as intended and did not result in unforeseen issues.[13] In addition, Office of Enterprise Technology[14] and National Institute of Standards and Technology[15] standards recommend that an appropriate individual must approve the changes before implementation.

Program staff within each of the 15 divisions that used the Medical Assistance system were responsible for developing their own testing practices for system changes. Generally, the department's information technology staff implemented changes based on e-mails from program staff authorizing the change. However, the information technology staff did not have information about whether the testing of the proposed change was appropriate or sufficiently rigorous to ensure that it worked as intended, and they did not know who had the authority to authorize the implementation of the change. The department's record of Medical Assistance system changes did not include information about who was responsible for the testing, what the testing approach was, or where, and for how long, employees should retain the testing results documentation. Also, information technology staff did not always retain e-mails authorizing the changes. Of the six change requests we tested, one did not have documentation of a test plan or of the test results and three did not have documentation of the authorization to implement the proposed change.

The department relies on the Medical Assistance system to review, assess, and validate most provider claims. The system processes almost 95 percent of all claims based solely on criteria established in the system. Because the department had not set its expectations for testing and authorizing changes to the Medical Assistance system, it unnecessarily increased the risk that changes to the system

[13] National Institute of Standards and Technology's 800-53 SA-11: Developer Security Testing.
[14] Office of Enterprise Technology Enterprise Security Operational Control Policy OP06.
[15] National Institute of Standards and Technology's 800-53 SA-10: Developer Configuration Management.

could result in errors in its financial or demographic data or in its processing of medical payment claims.

Recommendation

- *The department should document testing and approval standards for Medical Assistance system changes and implement monitoring activities to ensure compliance with the standards.*

Finding 4

The Department of Human Services did not log or monitor direct changes to critical Medical Assistance system files.

The department had not logged changes made directly to its Medical Assistance system (MMIS) files, including provider and recipient master files. Technical support staff at the department and the Office of Enterprise Technology could directly access data in these files without going through the security controls established within the Medical Assistance system. These technical staff needed direct access to the data to support the system's continued operation and availability. For example, they may need to fix processing errors or modify data that would be time consuming to correct through a system change. However, the department was not monitoring these employees' access or changes to the files.

The Office of Enterprise Technology's policy requires agencies to "log system events of critical information assets for the purposes of security monitoring, investigation, and compliance activities."[16] To ensure appropriate response to logged events, best practices require review of the log by employees independent of the changes made. Without logging and monitoring the logs, the department had no assurance that employees only made authorized changes.

Recommendations

- *The department should log changes to critical Medical Assistance system files.*

- *The department should independently monitor the critical file logs and investigate any unusual or unauthorized access to the files.*

[16] Office of Enterprise Technology Policy TC03.

Finding 5

Prior Finding Partially Resolved:[17] The Department of Human Services did not have sufficient controls to limit, monitor, or prevent incompatible or unnecessary access to the Medical Assistance system and the cash and food benefits system.

The department did not sufficiently limit access to the Medical Assistance system (MMIS) and the cash and food benefits system (MAXIS). The National Institute of Standards and Technology's access control standards include documenting the roles, responsibilities, and purpose of access controls, including identifying incompatible duties within and between roles.[18] Additionally, the department did not sufficiently monitor and manage system access to ensure it limited access to employees' job duties. The department had weaknesses in the following areas:

- The department had 25 employees with unnecessary access to create or modify data in the cash and food benefits system's warrant payment file. This file contained the data required for the department to print warrants for certain federal aid recipients.[19]

- The department had 13 staff with incompatible access to the Medical Assistance system. These employees could create or modify provider information, recipients, and claims for reimbursement. This combination would allow the employees to process fictitious transactions through the Medical Assistance system. The department had not detected this incompatible access because it did not have complete and accurate documentation for two of the Medical Assistance system's security groups. One security group had no documentation, and another had inaccurate information. Documentation of security groups is essential to ensure that the department limits employee access to the needs of assigned job duties and to prevent incompatible system access.

By not adequately limiting access to the systems, the department significantly increased its risk of fraud.

[17] Office of the Legislative Auditor, Financial Audit Division, Report 07-14, *Department of Human Services: Medicaid Management Information Systems Security Controls*, issued June 7, 2007, Finding 1.

[18] National Institute of Standards and Technology publication 800-53, AC-1, AC-5, AC-6.

[19] Although the department provided most federal food stamp and cash assistance benefits to recipients electronically through the cash and food benefits system, the department also provided some benefits by printing and mailing paper checks.

Recommendations

- *The department should eliminate unnecessary employee access to the cash and food benefits system's warrant payment file.*
- *The department should eliminate incompatible access to systems when possible or design effective mitigating controls.*
- *The department should ensure its security documentation is complete and accurate.*

Finding 6

The Department of Human Services did not reconcile its data warehouse to Medical Assistance system data.

The department did not verify that the financial activity recorded in its data warehouse included all claims authorized through the Medical Assistance system (MMIS). Rather than verifying that record counts and dollar amounts of transactions accurately uploaded from the Medical Assistance system to the department's warehouse, department staff checked to see whether the number of records increased by around the usual amount. Because the department used its data warehouse as its main source of payment information and as a basis for federal and state financial reporting, management may make decisions or prepare reports based on inaccurate or incomplete information.[20] State policy identifies reconciliations as a key control activity.[21]

Recommendation

- *The department should reconcile its data warehouse to the Medical Assistance system data to ensure accuracy and completeness of information.*

Finding 7

The Department of Human Services did not did ensure that the Medical Assistance system appropriately limited payments for personal care assistance services.

The department paid for some personal care services that exceeded statutory and policy limitations because it did not adequately monitor the effectiveness of changes it made to the Medical Assistance system (MMIS).

In January 2009, the Office of the Legislative Auditor's Program Evaluation Division issued a report on the department's oversight of personal care assistance

[20] The department's data warehouse is separate from the state's information warehouse.
[21] Department of Management and Budget policy 0102-01.

services.[22] The report identified instances in May 2008 when the department had paid for services exceeding 24 hours in a day. Fundamentally, a provider cannot work more than 24 hours in a day. In August 2009, to respond to this issue and implement other legislative and policy changes (including a monthly provider limit of 275 hours per month[23]), the department made changes to the Medical Assistance system intending to prevent payments to personal care service providers for more than 24 hours in a day and 275 hours in a month. However, in May 2010, a newspaper article reported that the department was still making these excessive payments to providers.[24]

Our analysis of data in the department's information warehouse for the period from July 2009 through June 2010 identified payments to personal care assistance providers totaling about $5,600 for hours exceeding 24 in a day and about $200,000 for hours exceeding 275 per month.

The inappropriate payments occurred because the system changes did not work as intended, and the department had not monitored the effectiveness of the changes. The department made additional changes to the Medical Assistance system in May 2010 that it believes correctly limited payments to personal care assistance services.

In addition, the department did not monitor personal care assistance claims it paid for services provided to a recipient (by multiple providers) for more than 24 hours in a day. In most cases, a recipient cannot receive more than 24 hours of services in a day but, under certain circumstances, *Minnesota Statutes* raised that limit to 28 hours, such as for a recipient on a ventilator.[25] However, the department programmed the Medical Assistance system to prevent payments for claims exceeding 31 hours. Our analysis of data in the department's information warehouse, for the period from July 2009 through April 2010, identified 40 claims where the department paid for more than 24 hours of personal care assistance services per recipient; 31 of those claims were for more than 28 hours of care. The department did not monitor the volume, frequency, or appropriateness of the payments to ensure that they complied with statutory criteria.

Recommendations

- *The department should recover the overpayments to personal care attendants.*

[22] Office of the Legislative Auditor, Program Evaluation Report, Personal Care Assistance, January 2009.

[23] *Minnesota Statutes* 2009, 256B.0659, subd. 11. The Minnesota Legislature established a 310 hour per month limit in statute; however, due to the Governor's unallotment in this program, the department lowered the limit to 275 hours.

[24] *Star Tribune*, "Overbilled? State Pays Anyway," May 26, 2010.

[25] *Minnesota Statutes* 2009, 256B.0652, subd. 7.

- *The department should validate the changes made in May 2010 to ensure that they prevent payments to personal care assistance providers for services exceeding 24 hours in a day or 275 hours in a month.*

- *The department should limit personal care assistance hours per recipient to the limits set in policy and statute or design effective ways to identify, monitor, and investigate payments for recipients receiving more care than allowed.*

Finding 8

The Department of Human Services lacked controls in the Medical Assistance system to prevent payments for Individualized Education Program procedures provided in the home.

The Medical Assistance system (MMIS) allowed payments for Individualized Education Program services provided in a recipient's home, in violation of department policy, which limits payment for these services to those provided in a school setting.[26] From July 2009 through April 2010, the department paid $104,200 for these services not allowed to be provided in a home setting. We asked department staff to review these transactions. They concluded that the providers had miscoded the transactions and should have identified the services as being provided in a school setting, which would have been an allowable cost. By not having adequate controls in the Medical Assistance system, the department could have incurred unallowable costs.

Recommendation

- *The department should implement system controls to prevent payments for Individualized Education Program services provided in a home setting.*

Finding 9

The Department of Human Services lacked adequate controls to prevent duplicate payments when a recipient claimed to have lost a check.

The department inappropriately paid $3,871 during the first nine months of fiscal year 2010 because it did not have adequate controls in place to prevent the cashing of checks reported as lost. When a recipient reported the loss of a benefit check issued through the cash and food benefits system (MAXIS), the department issued a replacement check on the same day it put a stop payment on the original check. However, in a few instances, the original check cleared before the stop payment took effect. If the department had delayed its issuance of the duplicate

[26] Department of Human Services' Individualized Educational Program – Technical Assistance Guide.

check until it was certain that the original check could not be cashed, it could have avoided these errors. Although the department identified these duplicate payments, it did not follow through to ensure that county social service workers took action to recover the duplicate payments from the recipient's benefits, if appropriate.

Recommendation

- *The department should implement controls to prevent duplicate payment of benefits.*

Finding 10

The Department of Human Services unnecessarily retained not public provider banking data.

The department retained not public banking information it obtained from providers as part of the enrollment process. The department received the banking information to allow the providers to receive electronic payments. It submitted this information to the Department of Management and Budget for entry into the state's accounting system; however, the department also scanned and retained the banking information electronically. Because the department had no reason to retain the banking information, it unnecessarily increased the risk that the data would be accessible to someone who could use it inappropriately. *Minnesota Statutes* require collection and storage of all data on individuals to be limited to what is necessary for the administration and management of programs.[27]

Recommendation

- *The department should not retain provider banking information.*

[27] *Minnesota Statutes* 2009, 13.05.

Minnesota Department of **Human Services**

October 28, 2010

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 of the internal control and compliance audit of the department's Medical Assistance System conducted by your office for the period July 1, 2009 through April 30, 2010. 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 David Ehrhardt, Internal Audit Director, at (651) 431-3619.

Sincerely,

Cal R. Ludeman

Cal R. Ludeman
Commissioner

Enclosure

Department of Human Services
Response to the Legislative Audit Report on the
Department's Medical Assistance System
For the Period July 1, 2009, through April 30, 2010

Audit Finding #1

The Department of Human Services did not have adequate internal controls to ensure that it only paid licensed healthcare providers.

Audit Recommendation #1-1

The department should develop a process to update the Medical Assistance system's license information and prevent payments to providers who are not licensed or whose licenses are expired.

Department Response #1-1

The department agrees with the recommendation. The current DHS Provider Enrollment (PE) process for enrolling and maintaining provider records includes verifying and entering license data at the time of enrollment, verifying license status for most of our currently enrolled providers as their license expiration date approaches, either manually or through an automated process, and processing notices of license actions from licensing boards.

We developed a programmed job in MMIS to more efficiently manage the maintenance of our 20,000 physicians and physician assistants. We receive a file from the Minnesota Board of Medical Practice on a monthly basis. The file is downloaded and the data is auto-populated into the corresponding provider records. Records where the Board has reported the license as expired, revoked, suspended or otherwise terminated are identified on a report. An enrollment specialist then manually terminates the enrollment status of each record identified on the report. An MMIS system's change request has been submitted to add a step to this job so that these records are systematically terminated so that manual intervention will no longer be required.

For the remaining 100,000 providers, a report is generated from MMIS on a monthly basis and distributed among the enrollment specialists according to their provider type expertise. The report identifies providers whose licenses are nearing their expiration date. The specialists verify the licenses and either manually update each record with new license expiration dates or manually terminate the enrollment status of those providers whose licenses have not been renewed.

Some licensing boards do not provide license expiration dates when specialists verify licensure. However, all Minnesota licensing boards provide PE with a copy of license action notices they send to their licensees. Enrollment specialists receive and process these notices as a part of their daily work, terminating enrollment status as appropriate at the time of notification.

All of the processes described above result in termination of the provider's record *after* the license is expired, revoked, suspended or otherwise terminated. Even the automated process is not a real-time process. To ensure recovery of claims paid for dates of service on or after the license action and corresponding enrollment termination, the DHS Operations Data Integrity (ODI) unit runs a weekly report to identify providers who have been terminated with a retroactive date and the associated claims, and a DHS Claims Specialist recovers those payments.

The manual license verification processes described above are labor-intensive and can be untimely if there is a backlog in the enrollment specialists' or administrative staff's work queues. PE is currently in the analysis stage of creating program jobs similar to the one described earlier for physicians and physician assistants for the 60-plus remaining provider types we enroll and maintain. PE has met with DHS Licensing to discuss jointly participating in the governor's E-License initiative as a means for connecting with other licensing boards and the Minnesota Department of Health.

This past summer, PE began implementation of Annual Re-enrollment, whereby all but our waiver service providers are asked to resubmit specific demographic information and sign a new provider agreement each year. License data is verified upon receipt of the new agreement. PE will terminate the enrollment status of providers who do not respond to the request for updated information.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: January 1, 2012

Audit Recommendation #1-2

The department should determine, for all types of health care providers, whether it made any payments to providers with expired licenses. If so, it should recover those payments and determine whether it needs to take any legal action against those providers.

Department Response #1-2

The department agrees with the recommendation. For all the providers identified, PE will request a bulk file from each licensing board, update each provider record with current license data including license number, license begin date and license end date

and use the established process described in the previous recommendation to recover payments as appropriate.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: January 1, 2012

Audit Recommendation #1-3

The department should refine its system controls or design an alternative way to ensure that waivered service providers have all appropriate licenses.

Department Response #1-3

The department agrees with the recommendation. We look to the Provider Enrollment and Provider Standards Initiative (PEPSI) project to address re-enrollment of our waiver service providers. The PEPSI project will develop a common provider enrollment business process across home care and waiver services with increased provider standards and verification. Among the objectives of the project are:

- Creating a consistent statewide waiver provider enrollment process with consistent and equitable provider standards and improved processes to verify standards
- Developing a directory of enrolled providers that will assure provider standards are met at initial enrollment and are verified on an ongoing basis
- Maximizing use of state resources by integrating existing provider quality assurance and oversight mechanisms and evidence of provider qualifications and performance generated via these mechanisms into DHS' provider enrollment system

In conjunction with the PEPSI project, we are creating a number of new license codes. Many of the Category of Service (COS) codes that are tied to Waiver billing codes actually represent a number of different types of services. And many of these services can be provided under the scope of multiple license types.

An example of this is the Foster Care COS (COS 103). It can represent *Adult Foster Care, Daily Adult Corporate Foster Care, Monthly Adult Corporate Foster Care, Adult Family Foster Care, Corporate Foster Care, and Child Foster Care*. To provide *Adult Foster Care, Daily Adult Corporate Foster Care* and *Monthly Adult Corporate Foster Care*, a waiver provider must possess an Adult Foster Care License

(License code LC). To provide *Adult Family Foster Care*, a provider must possess an Adult Foster Care License in which the home is the primary residence of thee license holder (license code AF). For *Corporate Foster Care*, a provider must have an Adult Foster Care License in with the home is ***not*** the primary residence of the license holder and which is licensed under Chapter 245B (license code EW). Finally, to provide Child Foster Care, a provider must possess a Child Foster Care License (license code CF).

We are creating license codes for each of the four scenarios described above, so that the provider's file clearly denotes the type of license that was verified by PE before adding the COS to the provider's record. This will prevent payment of claims for services where the provider does not have the appropriate license code and/or specialty code in their record for the specific date of service.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: January 1, 2012

Audit Finding #2

The Department of Human Services did not adequately separate incompatible duties in its process for enrolling service providers.

Audit Recommendation #2

The department should separate incompatible provider enrollment duties.

Department Response #2

The department agrees with the recommendation. PE is currently organized so that each specialist develops an expertise with specific provider types. There are over 70 provider types. There are eighteen enrollment specialists. Nine of them are dedicated to enrolling the 50,000-plus Individual Personal Care Attendants (PCAs) who work for the 800-plus personal care agencies in Minnesota. The other nine specialists have mastered the variety of enrollment requirements attributable to the remaining 70,000-plus providers.

While license verification is an important part of the enrollment process, there are a number of other elements, from the date of birth of an individual PCA to the names, addresses and Social Security Numbers of the owners and managers of a durable medical equipment provider, also required for enrollment. These elements vary from provider type to provider type. Some provider types' requirements, like Personal Care Provider Organizations (PCPOs), are more complex than others.

PE will meet the challenge presented by this finding by reorganizing the existing staff into two levels. The first level of staff will do the initial processing of documents submitted by new and currently enrolled providers, performing data entry and basic triage, and following up with providers who have missing or incorrect documents. The second level of staff will perform the necessary verification of requirements and activate, terminate or deny the provider's enrollment status. PE will work with Human Resources to determine if this change in structure will require changes to the job descriptions and job class.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: September 30, 2011

Audit Finding #3

The Department of Human Services did not establish standards to ensure the sufficiency of testing done for changes to the Medical Assistance system and did not adequately document testing and authorization for those changes.

Recommendation #3

The department should document testing and approval standards for Medical Assistance system changes and implement monitoring activities to ensure compliance with the standards.

Department Response #3

The department agrees with the recommendation. Changes will be made to the MMIS Change Request process. The process will now require documentation of the following:

- Testing strategy – A summary of planned testing strategies will be required. Change Requests will not be approved and forwarded to technical staff without this information.
- Test Plans – Test plans and results will either be attached or linked to the Change Request. This documentation will be a mandatory component of the Change Request closeout process.
- Identification of who (person or job title) can authorize moving the change to production – this will be a mandatory field in the Change Request submission process. Change Requests will not be approved and forwarded to technical staff without this information.
- A copy of the approval to move the change to production will be retained for 60 days.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: January 1, 2011

Auditing Finding #4

The Department of Human Services did not log or monitor direct changes to critical Medical Assistance system files.

Audit Recommendation #4-1

The department should log changes to critical Medical Assistance system files.

Department Response #4-1

The department agrees with the recommendation. All non-production update access to the files identified by the auditors, specifically, those generated by the claims warrant process and used by Minnesota Management & Budget, has been logged since June 8, 2010. All logged access is written to the DHS ACF2 daily security activity file and reported in the MMIS ACF2 Monthly Security report. The monthly security report is reviewed by both the HCO security supervisor and the HCO security team lead.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: Completed

Audit Recommendation #4-2

The department should independently monitor the critical file logs and investigate any unusual or unauthorized access to the files.

Department Response #4-2

The department agrees with the recommendation. See department response #4-1

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: Completed

Audit Finding #5

Prior Finding Partially Resolved:[1] The Department of Human Services did not have sufficient controls to limit, monitor, or prevent incompatible or unnecessary access to the Medical Assistance system and the cash and food benefits system.

Audit Recommendation #5-1

The department should eliminate unnecessary employee access to the cash and food benefits system's warrant payment file.

Department Response #5-1

The department agrees with this recommendation. Access for the 25 employees to the warrant payment file was removed July 2010.

Person Responsible: Kate Wulf, TSS Director

Estimated Completion Date: Completed

[1] Office of the Legislative Auditor, Financial Audit Division, Report 07-14, *Department of Human Services: Medicaid Management Information Systems Security Controls*, issued June 7, 2007, Finding 1.

Audit Recommendation #5-2

The department should eliminate incompatible access to systems when possible or design effective mitigating controls.

Department Response #5-2

The department agrees with this recommendation. For those staff whose job responsibilities require access which is potentially incompatible, e.g., the ability to pay claims and enroll providers, reports need to be designed, created and reviewed to audit their activities.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: December 31, 2010

Audit Recommendation #5-3

The department should ensure its security documentation is complete and accurate.

Department Response #5-3

The department agrees with this recommendation. The Health Care Operations security group documentation is complete and accurate.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: Completed

Audit Finding #6

The Department of Human Services did not reconcile its data warehouse to Medical Assistance system data.

Audit Recommendation #6

The department should reconcile its data warehouse to the Medical Assistance system data to ensure accuracy and completeness of information.

Department of Human Services
Response to the Legislative Audit Report on the
Department's Medical Assistance System
For the Period July 1, 2009, through April 30, 2010

Department Response #6

The department agrees with the recommendation. DHS staff will improve the reports to reconcile the data extracted for the warehouse with the source data and to reconcile the extracts with the data in the warehouse.

Person Responsible: Adrian Alexander, Healthcare Operations Director
Denise Moreland, Data Warehouse Manager

Estimated Completion Date: June 30, 2011

Audit Finding #7

The Department of Human Services did not did ensure that the Medical Assistance system appropriately limited payments for personal care assistance services.

Audit Recommendation #7-1

The department should recover the overpayments to personal care attendants.

Department Response #7-1

The department agrees with the recommendation. The Department is in the process of identifying overpayments made to Personal Care Provider Organizations (PCPOs) for services provided by individual Personal Care Attendants (PCAs) that exceeded 24 hours per day or 275 hours per month. Once we have fully identified all of the overpayments, we will begin the process of recovering the overpayments from the PCPOs.

Person Responsible: Alex Bartolic, Disability Services Director

Estimated Completion Date: January 1, 2011

Audit Recommendation #7-2

The department should validate the changes made in May 2010 to ensure that they prevent payments to personal care assistance providers for services exceeding 24 hours in a day or 275 hours in a month.

Department Response #7-2

The department agrees with the recommendation. The Department has thoroughly tested and has verified that the edits to prevent overpayments to PCPOs for services provided by individual PCAs that exceed 24 hours in a day or 275 hours in a month are working properly.

Person Responsible: Alex Bartolic, Disability Services Director

Estimated Completion Date: Completed

Audit Recommendation #7-3

The department should limit personal care assistance hours per recipient to the limits set in policy and statute or design effective ways to identify, monitor, and investigate payments for recipients receiving more care than allowed.

Department Response #7-3

The department agrees with the recommendation. The department will identify, monitor and investigate payments through a regular report of claims with over 24 hours of service provided to a single recipient with more than one assistant to assure that care was necessary and allowable for the needs of the recipient. This report will be added to a regular review of data that is currently conducted by the department, and payment will be recovered if claims are not supported by individual needs for that level of service.

Person Responsible: Alex Bartolic, Disability Services Director

Estimated Completion Date: December 31, 2010

Audit Finding #8

The Department of Human Services lacked controls in the Medical Assistance system to prevent payments for Individualized Education Program procedures provided in the home.

Audit Recommendation #8

The department should implement system controls to prevent payments for Individualized Education Program services provided in a home setting.

Department Response #8

The department agrees with the recommendation regarding payments for the following Individualized Education Program (IEP) services: personal care assistant services, assistive technology devices and special transportation. An edit has been added to prevent payments for these services when provided in a home setting. However, Minnesota public schools are responsible for providing covered "related services" to all eligible children under the age of 21 and there are situations in which schools may need to provide services in a home setting. Examples of such situations include: children who are home-bound for medical reasons, home-schooled, or young children (birth through age four) who do not yet attend school. Therefore, the following IEP services can be provided in a home setting: physical therapy, occupational therapy, speech-language and hearing therapy, mental health services, nursing services, and interpreter services.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: Completed

Audit Finding #9

The Department of Human Services lacked adequate controls to prevent duplicate payments when a recipient claimed to have lost a check

Audit Recommendation #9

The department should implement controls to prevent duplicate payment of benefits.

Department Response #9

The department agrees with the recommendation. The department has changed internal procedures and procedural direction to the counties to delay issuance of a replacement warrant until the day after a stop payment directive is entered into the system.

Person Responsible: Kate Wulf, TSS Director

Estimated Completion Date: Completed

Department of Human Services
Response to the Legislative Audit Report on the
Department's Medical Assistance System
For the Period July 1, 2009, through April 30, 2010

Audit Finding #10

The Department of Human Services unnecessarily retained not public provider banking data.

Audit Recommendation #10

The department should not retain provider banking information.

Department Response #10

The department agrees with the recommendation. Minnesota Statutes, section 16A.40 requires payees to supply their bank routing information to enable payments to be made through electronic funds transfer. The current process PE follows to comply with this statute was developed in conjunction with Minnesota Management and Budget (MMB). Providers are asked to complete and submit MMB's "Direct Deposit Authorization for Electronic Funds Transfer (EFT)" form along with their enrollment application materials. PE has access to MMB's vendor database, checks the database for an existing vendor number and if one exists, enters the vendor number on the provider's new provider record to enable the payment cycle to issue electronic payments. If a vendor number does not exist, PE forwards the form to MMB along with associated data from the provider record. PE performs routine checks of the MMB vendor database and when the new vendor number is created, enters it into the provider's record.

PE has approached MMB in the past to discuss transitioning the receipt of EFT forms back to MMB so that providers send the documents directly to MMB instead of sending them to PE. MMB has indicated they do not have the resources to resume this role. PE will continue to work with MMB in order to comply with the OLA's recommendation in this finding, so that we are no longer receiving provider's banking information. Until we are able to make this transition, PE will delete EFT forms from our repository after entering a vendor number in a provider's record.

Person Responsible: Adrian Alexander, Healthcare Operations Director

Estimated Completion Date: December 1, 2011