Department of Human Services

Programs Selected for Statewide Audit For the Fiscal Year Ended June 30, 1995

June 1996

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Financial Audit Division
Office of the Legislative Auditor
State of Minnesota

96-22

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Representative Ann H. Rest, Chair
Legislative Audit Commission

Members of the Legislative Audit Commission

Ms. Maria Gomez, Commissioner
Department of Human Services

We have audited selected aspects of the Department of Human Services for the fiscal year ended June 30, 1995, as further explained in Chapter 1. The work conducted in the department is part of our Statewide Audit of the State of Minnesota's fiscal year 1995 financial statements. The Comprehensive Annual Financial Report for the year ended June 30, 1995, includes our opinion thereon dated December 1, 1995. This was not a complete audit of all financial activities of the Department of Human Services. The following Summary highlights the audit objectives and conclusions. We discuss our concerns more fully in the individual chapters of this report.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we obtain an understanding of management controls relevant to the audit. These standards also require that we design the audit to provide reasonable assurance that the Department of Human Services complied with provisions of laws and regulations that are significant to the audit. The management of the Department of Human Services is responsible for establishing and maintaining the internal control structure and compliance with applicable laws, regulations, contracts, and grants.

This report is intended for the information 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 June 7, 1996.

James R. Nobles
Legislative Auditor

John Asmussen, CPA
Deputy Legislative Auditor

End of Fieldwork: March 15, 1996

Report Signed On: May 31, 1996

SUMMARY

State of Minnesota
Office of the Legislative Auditor
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Department of Human Services

Programs Selected for Statewide Audit For the Fiscal Year Ended June 30, 1995

Public Release Date: June 7, 1996 No. 96-22

Background

The Department of Human Services (DHS) is the largest agency in state government, both in terms of the number of employees and total expenditures. DHS's main function is to administer various benefits programs to eligible Minnesotans. Maria Gomez has served as commissioner since December 1993. The department's current administrative structure includes a deputy commissioner and four assistant commissioners.

Audit Scope and Conclusions

Our scope was limited to those activities material to the State of Minnesota's Comprehensive Annual Financial Report for the year ended June 30, 1995, and the Single Audit for the year then ended.

The state spent nearly $3 billion for Medical Assistance, General Assistance Medical Care, and Minnesota Care during fiscal year 1995. The department's medical claims processing system, MMIS II, processed about 22 million claims during the year. The implementation of MMIS II greatly increased the department's medical claims processing capabilities. However, we found certain weaknesses and instances of noncompliance in the department's administration of these medical programs. We found that DHS made payments to medical providers on behalf of ineligible people during the initial change to a new eligibility verification system. We also found that the MAXIS and MMIS II systems contain discrepancies between eligibility status codes. Other problems included payment for medical procedures without verifying admission certification, inability to complete required federal reports, and setting certain rates not in accordance with statutory provisions.

We also found two weaknesses in the DHS computer security procedures. Some of the DHS security officers have more clearance than they need to perform their job duties. In addition, DHS has not deleted certain log-on IDs after one year. Finally, the Issuance Operations Center established an unauthorized bank account to pay for postage meter expenses.

Contact the Financial Audit Division for additional information.
296-1235

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Audit Participation

The following members of the Office of the Legislative Auditor prepared this report:

John Asmussen, CPA	Deputy Legislative Auditor
Jeanine Leifeld, CPA	Audit Manager
Cecile Ferkul, CPA	Auditor-in-Charge
Dave Poliseno, CPA, CISA	Team Leader
Janet Knox, CPA	Senior Auditor
Sonya Hill, CPA	Senior Auditor
Steve Johnson	Staff Auditor
Trent Usitalo	Student Worker
Chad Leiker	Intern

Exit Conference

We discussed the findings and recommendations in this report with the following staff of the Department of Human Services on May 16, 1996:

Maria Gomez	Commissioner
Dennis Erickson	Assistant Commissioner for Finance and Administration
Jon Darling	Financial Management Director
Larry Woods	Health Care Operations Director
Dave Ehrhardt	Internal Audit Director

Chapter 1. Introduction

The Department of Human Services (DHS) is the largest agency in state government, both in terms of the number of employees and total expenditures. DHS's main function is to administer various benefits programs to eligible Minnesotans. Minnesota Statutes Chapters 256 through 256G prescribe the types of aid the state provides and the eligibility criteria. Federal regulations and State Plans approved by the federal government also control program activity.

The department has undergone restructuring since Maria Gomez became commissioner in December 1993. The current administrative structure includes a deputy commissioner and assistant commissioners for the following divisions:

- Childrens Initiatives
- Economic and Community Support Strategies
- Finance and Management Operations
- Health and Continuing Care Strategies

Our audit scope focused on the 1995 revenues and expenditures of the department included in Tables 1-1 and 1-2. These financial activities were material to the state's financial statements and to the Single Audit objectives.

Table 1-1 Selected Revenue Programs
Fiscal Year 1995

Revenue Area	FY95 Revenues
Residential Treatment Center Cost of Care	$156,975,433
Medical Provider Surcharge	120,991,052
Chemical Dependency Cost of Care	13,782,232

Source: Derived from the Statewide Accounting System.

The primary objective of the Statewide Audit is to render an opinion on the state of Minnesota's financial statements included in its Comprehensive Annual Financial Report for fiscal year 1995. This includes determining whether the financial statements of the state fairly present its financial position, results of operations, and changes in cash flows in conformity with generally accepted accounting principles. As part of our work, we are required to gain an understanding of the internal control structure and ascertain whether the state complied with laws and regulations that may have a direct and material effect on its financial statements. The Comprehensive Annual Finance Report for the year ended June 30, 1995, includes our report, issued thereon, dated December 1, 1995.

The Statewide Audit is also designed to meet the requirements of the Single Audit Act of 1984, relating to federal financial assistance. The Single Audit Act established two additional audit objectives and requires us to determine whether:

- the state complied with rules and regulations that may have a material effect on each major federal program;

- the state has internal accounting and other control systems to provide reasonable assurance that it is managing federal financial assistance programs in compliance with applicable laws and regulations.

We did not review and evaluate county level controls established to ensure that DHS made payments only on behalf of eligible recipients. The Minnesota Financial and Compliance Report on Federally Assisted Programs for the year ended June 30, 1995, will include our reports on the supplementary information schedule, internal control structure, and compliance with laws and regulations. We anticipate issuing this report in June 1996.

Table 1-2
Selected Grant Programs
Fiscal Year 1995

Program Name	Federal	State	Total
Medical Programs			
Medical Assistance	$1,521,189,460	$1,186,140,972	$2,707,330,432
General Assistance Medical Care	0	154,742,378	154,742,378
Minnesota Care	0	60,069,013	60,069,013
Cash Assistance Programs			
Family Support Payments	245,678,142	278,746,491	524,424,633
Food Stamps-Cash Benefits (1)	12,664,194	0	12,664,194
Food Stamps-Administration	26,496,972	6,736,114	33,233,086
General Assistance	0	56,972,159	56,972,159
Work Readiness	0	11,897,767	11,897,767
Supplemental Aid	0	52,036,278	52,036,278
Other Grants			
Substance Abuse Preventive Treatment	17,890,413	0	17,890,413
Social Services	48,426,707	0	48,426,707
Community Social Services	0	15,930,264	51,653,380
Foster Care	40,994,780	4,751,189	45,745,969
Job Opportunities & Basic Skills Training	15,192,739	9,055,190	24,247,929
Child Support Enforcement	37,035,452	15,362,228	52,397,680
Child Care & Child Development	13,720,773	0	13,720,773
Consolidated Chemical Dependency Treatment	0	65,608,114	65,608,114

Note 1: In addition to the food stamps provided as cash benefits, DHS also distributed food coupons totaling $158,379,566 and electronic benefits totaling $64,062,903 during fiscal year 1995.

Sources: Federal financial schedules and the state of Minnesota financial statements for fiscal year 1995.

In addition to these primary objectives, we reviewed certain aspects of DHS's program operations. Specifically, we examined portions of the medical programs' claims processing system and the department's oversight of the claims payment process. To address these objectives, we interviewed key department employees, reviewed applicable policies and procedures, and tested selected financial transactions.

In addition to the financial statement and Single Audit reports, we have developed audit findings and recommendations concerning the Department of Human Services. Chapter 2 discusses our review of DHS's administration of Medical Assistance and other medical programs. Chapter 3 describes some of the information systems operated by DHS and our concerns over various controls. Chapter 4 discusses the unauthorized bank account established by the Issuance Operations Center.

Chapter 2: Administration of Medical Assistance and Other Medical Programs

Chapter Conclusions

The state spent nearly $3 billion for Medical Assistance, General Assistance Medical Care, and Minnesota Care during fiscal year 1995. The department's medical claims processing system, MMIS II (Medicaid Management Information System II), processed about 22 million claims during fiscal year 1995, serving about 560,000 citizens. The implementation of MMIS II greatly increased DHS's medical claims processing capabilities. However, we found certain weaknesses and instances of noncompliance in DHS's administration of the medical programs. These include the following:

- *DHS made payments to medical providers on behalf of ineligible people during the initial change to a new eligibility verification system.*
- *The MAXIS and MMIS II systems contain discrepancies between eligibility status codes.*
- *DHS has not adequately controlled certain system edit changes.*
- *DHS pays for costly medical procedures without first verifying that they were approved.*
- *The MMIS II system does not yet have the full reporting capabilities to allow DHS to complete all required federal reports, nor provide internal users with all needed information.*
- *Certain rates are not set in accordance with statutory provisions.*

DHS administers three major medical programs:

- Medical Assistance - This is the state's Medicaid Program. Medicaid is a supplement to the federal Medicare Program. The federal government reimburses the state for approximately 54 percent of the Medical Assistance benefit costs.
- General Assistance Medical Care - This program extends similar medical benefits to certain people not qualifying for Medical Assistance. This program is 100 percent state funded.

- Minnesota Care - This is the state's health insurance plan for low income people with no other insurance. The state shares these program costs with the medical community and program participants.

The Legislature appropriates funds for these programs through open appropriations, meaning that whatever funds the program needs to meet its commitments are available for its use. DHS budgets its appropriations on a cash basis. The agency does not encumber or reserve appropriated funds at the time that the liability occurs, which is when the medical provider gives care to the recipient. Rather, DHS budgets based on the amount of cash expenditures it expects to make during a fiscal year. This resulted in a difference in accounts payable between DHS's budgetary reporting and the state's accrual basis of reporting at the end of fiscal year 1995 of nearly $100 million.

Medical Assistance and General Assistance Medical Care are state administered, county operated programs. The state works in partnership with the 87 counties to provide these benefits. The counties obtain information from program applicants to determine their eligibility status. Counties also maintain recipient files and determine program eligibility.

Since 1991, the state has taken over the counties' financial share of Medical Assistance and General Assistance Medical Care. The Legislature changed the funding methodology to relieve the counties of an increasing property tax burden. The state now funds these program costs rather than having each county pay for a part of the program costs incurred by its residents. DHS also operates Minnesota Care without county participation. Many features of these programs are the same; the main distinction is the clientele each serves. Table 2-1 shows the fiscal year 1995 program expenditures for these three programs. DHS estimates that approximately 560,000 citizens are served by these programs.

Table 2-1 Medical Programs
Fiscal Year 1995 Expenditures

Program	FY95 Expenditures
Medical Assistance	$2,707,330,432
General Assistance Medical Care	154,742,378
Minnesota Care	60,069,013
Totals	$2,922,141,823

Sources: Expenditures are derived from the Statewide Accounting System, on an accrual basis.

DHS's main function is to ensure that it makes payments in accordance with the federally approved state plan for the Medical Assistance Program, and in accordance with statutory provisions for the General Assistance Medical Care, and Minnesota Care programs. DHS uses two computer systems to assist it with medical program eligibility and claims processing. The MAXIS computer system determines eligibility for various cash assistance programs at the county level and facilitates eligibility determinations for the medical programs. The MMIS II system processes incoming claims for all of the medical programs administered by DHS.

Department of Human Services

Audit Scope and Objectives

We had two primary objectives in auditing the medical programs. The first objective was to determine whether state expenditures for the programs, as reported on the state's financial statements, were fairly stated in compliance with generally accepted accounting principles. Our second objective, required by the Single Audit Act, was to determine whether the department complied with rules and regulations relating to the programs and whether the department had internal accounting and other systems to provide reasonable assurance that it managed the programs in compliance with applicable laws and regulations. We did not review and evaluate county level controls established to ensure that DHS made payments only on behalf of eligible recipients. To reach our conclusions, we interviewed various DHS personnel, examined agency documentation, and tested selected transactions.

Eligibility Determination

Participation in the medical programs starts at the county level, where a potential program participant completes a Combined Application Form. This form gathers data common to many different programs administered by DHS, such as family size and income. The county financial worker enters the information from the Combined Application Form into the MAXIS computer system. MAXIS determines eligibility for the various cash assistance programs, facilitates eligibility determinations for the medical programs, and distributes cash assistance and food stamp benefits. Some of the cash benefit programs automatically qualify the person for Medical Assistance or another medical program. Approximately 55 percent of medical program participants qualify for these programs due to their participation in cash benefit programs such as Aid to Families with Dependent Children. If an applicant does not qualify for automatic medical assistance through cash benefits, the county worker determines whether the person qualifies for a medical program based on other information. In these cases, the MAXIS system facilitates the county worker in reaching this determination. Once the county financial worker determines eligibility on MAXIS, the eligibility status must be entered into the MMIS II system, which is the medical programs' claim processing system. Figure 2-1 shows the major steps used in the medical program eligibility determination process.

Claims Processing

The MMIS II system (Medicaid Management Information System II) processes claims for all of the medical programs administered by DHS. DHS developed this system in accordance with federal specifications and implemented it in June 1994, replacing a MMIS I system that had been in use for 20 years.

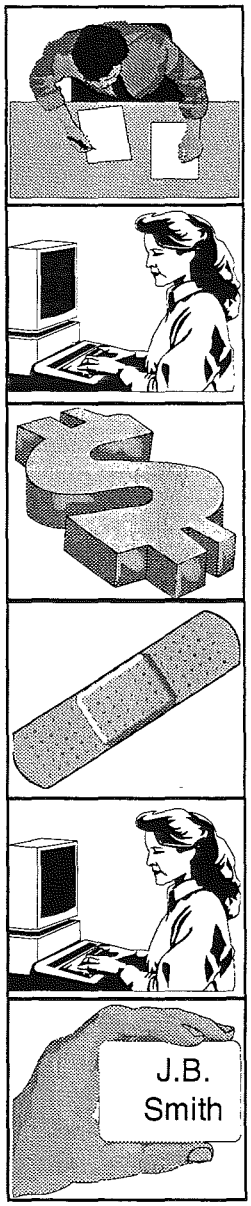
MMIS II has hundreds of edits to control claims processing and ensure compliance with intricate federal and state program requirements. These edits are designed to ensure that:

- DHS has approved the medical provider's participation in the program;
- the person receiving the medical benefit is an eligible participant of the program;

- the medical service is reimbursable under the program guidelines; and
- the amount reimbursed is in accordance with approved rates.

If a medical provider submits a claim that does not meet this criteria, MMIS II either "suspends" the claim until the provider resolves the problem or denies the claim.

Figure 2-1 Medical Programs Eligibility Determination Process



Applicant completes Combined Application Form and meets with county financial worker to determine eligibility.

County financial worker enters Combined Application Form information into the MAXIS System.

MAXIS determines eligibility for cash assistance programs. Eligibility in cash assistance programs qualifies applicant for medical program.

If applicant is not eligible for cash assistance program, county financial worker uses MAXIS to determine eligibility for medical program only.

County financial worker enters the medical program eligibility status into MMIS II. The eligibility status on MAXIS and MMIS II should be the same.

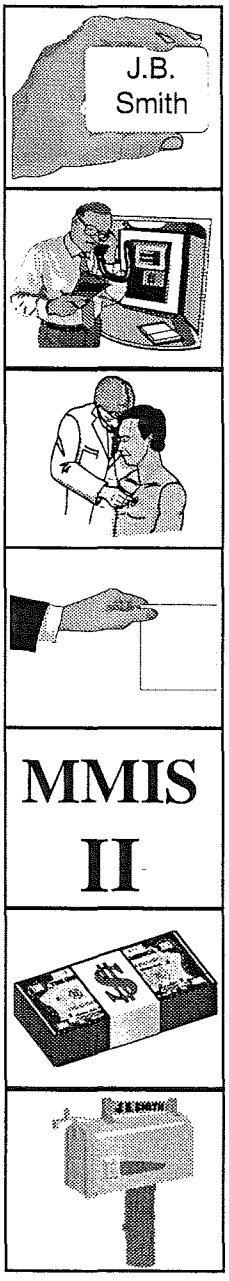
Eligible participant receives a Medical Benefits Card. The participant presents this card when requesting medical services.

Source: Auditor prepared.

Department of Human Services

The state generates warrants to medical providers for all valid claims. It also issues benefit statements to the recipients of the care. During fiscal year 1995, DHS processed roughly 22 million medical claims. Many claims are for small dollar amounts, such as prescriptions. Other claims are less frequent but for higher dollar amounts, such as in-patient hospital care. Still other claims are for recurring costs, such as monthly nursing home charges or health maintenance organization monthly fees. Figure 2-2 shows the major steps used for medical claims processing.

Figure 2-2 Medical Programs
Claims Processing



Program recipient presents Medical Benefits Card to a medical provider.

Medical provider calls the Eligibility Verification System (EVS) to determine the current eligibility status of the recipient. EVS uses MMIS II's eligibility status.

Medical provider gives care to the eligible recipient.

Medical provider submits reimbursement claim to the Department of Human Services.

MMIS II processes claim against recipient, provider, procedure, and rate edits.

MMIS II pays approved medical providers for allowable care given to eligible recipients at authorized rates.

MMIS II notifies recipients of payments made for medical services they received.

Source: Auditor prepared.

Department of Human Services

The implementation of MMIS II greatly increased DHS's medical claims processing capabilities. However, we found certain weaknesses and instances of noncompliance in DHS's administration of the medical programs, as described below.

1. DHS paid for medical services provided to ineligible people.

During fiscal year 1995, DHS paid for $574,983 in medical claims for ineligible people. DHS made the decision to pay the claims because of problems with its new Eligibility Verification System (EVS).

As part of the MMIS II implementation process, DHS began distributing universal medical benefit cards, without expiration dates, in June 1994. The universal cards replaced monthly eligibility cards for recipients, which were specific to the applicable medical program. Benefit recipients now use the same universal card for any of the medical programs, and the card is valid from the time of issuance. Use of this card reduced the cost of issuing monthly cards, allowed for easier access to services outside the county the recipient lives in, and improved the ability to monitor case activity. It also created the need for medical providers to verify currently active participation in a medical benefit program prior to providing medical care. To meet this need, DHS developed, as part of the MMIS II system, an Eligibility Verification System (EVS). Medical providers call a toll free number to access current MMIS II data about patient eligibility, along with information about claim status and payment.

In the first few months following implementation (June 1994 through October 1994) EVS did not function reliably. There were periods of time when EVS was not available to the medical community. Because of this, doctors and other providers of medical services could not always determine whether recipients were eligible to receive medical services. DHS, realizing the problems created by the unreliable verification system, decided to pay claims for services provided to ineligible people as long as they had been issued universal medical cards.

MMIS II suspended a total of 20,585 claims for June 1994 through October 1994 because of questionable eligibility. DHS determined that 5,508 of these claims were for people who had been eligible at some point during the period, but were not eligible at the time that they received medical services. DHS used state funds to pay the medical providers for these 5,508 claims, totaling $574,983. DHS concluded that "the service was legitimate, necessary care provided in good faith by the provider community, and payment was a reasonable exercise of public policy in an effort to maintain a viable provider community for a vulnerable population."

We question whether DHS had the legal authority to make payments to medical providers on behalf of people known to be ineligible. The open appropriation to DHS for the medical programs provides funds to pay benefits to people meeting the eligibility criteria established by the state Legislature and the federal government. DHS could have sought a special appropriation from the Legislative Advisory Commission to cover this unique situation.

After EVS's initial period of unreliability, there were less frequent, but still recurring, instances of unresponsiveness. DHS told medical providers to contact the DHS Help Desk whenever EVS was not available. However, the Help Desk is only available during normal business hours, even though many medical providers have evening and weekend appointments. In instances when

both EVS and the Help Desk were not available, DHS asked medical providers to submit documentation that they attempted to verify eligibility when submitting unverified claims. DHS paid properly documented unverified claims, regardless of the recipient's actual eligibility status. DHS has not monitored how often they have made these payments for ineligible people nor the value of these payments.

DHS exceeded its legal authority by paying claims that did not meet program criteria. It was not appropriate to pay those costs to the federal government without advance approval. DHS determined that the EVS difficulties were due to problems with the system hardware that an outside vendor maintains. DHS has subsequently rebid the vendor contract.

Recommendations

- *DHS should consult with the Attorney General's Office to resolve the department's spending authority relating to the $574,983.25 in medical payments made to ineligible people.*

- *DHS should adequately inform the Legislature when unusual situations occur prior to paying claims.*

2. The MAXIS and MMIS II systems contain discrepancies between eligibility status codes.

A reconciliation between MAXIS and MMIS II identified discrepancies between recipient eligibility status on the two systems. Once a county financial worker determines a person's eligibility on MAXIS, the worker must separately enter an eligibility status (active or inactive) code into the MMIS II system. Whenever a recipient's status changes, the county worker must make the change in both systems. Because the worker must determine eligibility in MAXIS and separately enter the new status code in MMIS II, there is an increased potential for discrepancies between the two systems.

In September 1995, DHS compared the MAXIS recipient file to the MMIS II recipient file, reviewing 20 data elements for consistency. This was the first time DHS had performed such a reconciliation. One of the data elements that DHS compared was each person's eligibility status code on both systems. Based on DHS estimates, 9,141 of the 106,206 total discrepancies show that MAXIS correctly identified the recipient as ineligible while MMIS II showed the same recipient to be eligible. Since the eligibility code in MMIS II is the one used to verify incoming claims, DHS continued to pay any incoming claims for these ineligible recipients. Also, since the EVS relies on MMIS II data, medical providers received inaccurate eligibility information on these people.

DHS has not determined the value of fee-for-service benefits provided to these ineligible recipients. However, DHS projected that about 10 percent of the status code discrepancies were for participants in managed care programs, for which DHS pays monthly premiums of about $255 each. This equates to approximately $233,070 for the month of September 1995.

Reconciliations between MAXIS and MMIS II are an essential element of the control system. It is our understanding that DHS intends to perform this reconciliation on a quarterly basis, in accordance with federal regulations. Since the county financial workers maintain the recipient files and determine eligibility, they must resolve many of these discrepancies at the county level. We recognize that it will take time to investigate and resolve all of the status code discrepancies. A reconciliation performed in January 1996 showed improvement in the resolution of the status code discrepancies, but many still existed.

Recommendation

- *DHS should continue to perform quarterly reconciliations of the MAXIS and MMIS II recipient eligibility data. DHS should work with the counties to resolve discrepancies in a timely manner, giving priority to those discrepancies involving managed care participants.*

3. DHS has not adequately controlled certain system edit changes.

DHS has not adequately controlled system edit changes. The MMIS II claims processing subsystem contains roughly 900 edits designed to ensure that it pays claims in accordance with program criteria. For example, system edits verify that the service was performed by an approved medical provider.

Each edit has a status code. The edit status code determines the action taken on any claim that does not meet the edit criteria. Some edit codes allow MMIS II to process the claim even when the edit identifies a potential problem. Other edits result in the suspension or denial of the claim. Because the edit status code is a key control to prevent improper payment of claims, the codes should be closely monitored and only changed when authorized.

DHS did not adequately control status code changes. The claims processing supervisor is the only person within claims support who has the capability to change the status code of an edit. These changes are not documented. Also, DHS management has not used MMIS II reports to monitor code changes. The changing of a status code from "suspend" to "pay" or "deny" can affect the percentage of claims paid, as well as the workload of the Claims Processing Unit.

Recommendations

- *DHS should document all status code changes and authorizations.*
- *DHS should review the MMIS II edit change reports to ensure that only authorized changes have been made.*

4. DHS pays for costly medical procedures without first verifying that they were approved in advance.

The MMIS II system does not verify admission certifications before paying certain costly medical claims. DHS requires medical providers to obtain admission certifications before billing certain expensive medical procedures. The purpose of the admission certification is to confirm that the medical care or procedure is necessary and allowable. The State Plan requires these

admission certifications. Currently Blue Cross/ Blue Shield performs the "in-patient hospital care" admission certifications for DHS. When Blue Cross/Blue Shield authorizes the care, it issues an admission certification number to the medical provider. DHS requires providers to include these admission certification numbers on claims for these types of services.

However, the MMIS II claims processing system does not verify the authenticity of the admission certification numbers on incoming claims. Although this capability was part of the original specifications of the system, the final design did not include it. DHS plans to conduct tests of the admission certification claims processed over the past several years, and assess the extent that providers did not obtain proper authorization. DHS had conducted similar testing under the old MMIS system. DHS should take appropriate recourse against medical providers that it has paid for unauthorized care.

Recommendations

- *DHS should review the validity of the admission certification numbers.*
- *DHS should take appropriate recourse against medical providers who submitted claims with invalid admission certification numbers and should take any corrective action necessary to reduce future occurrences.*

5. The MMIS II system does not yet have the full reporting capabilities to allow DHS to complete all required federal reports nor provide internal users with all needed information.

DHS is not receiving the entire range of information it needs to totally complete its required federal report. In addition, other divisions within DHS have been unable to receive all critical data from the MMIS II system.

The Federal Health Care Financing Administration (HCFA) requires that DHS submit quarterly reports to the federal government detailing the nature of medical assistance expenditures by service type categories. DHS has not been able to provide all of the categorical information required for proper completion of the HCFA-64 report since the inception of MMIS II. The reports submitted for all quarters of fiscal year 1995 have shown most expenditures in the "Other" category. DHS is currently working on improving the MMIS II reporting capabilities. Once DHS is able to obtain the proper service type categories, it will need to submit revised HCFA-64 reports to the federal government.

Other DHS divisions, such as the Reports and Forecast Division and the Rates Division, have not received claims processing data critical to their functions. The Reports and Forecast Division requires timely data to use in projecting health care costs and recipient demographic changes. The Rates Division needs procedure usage information to monitor the need for rate revisions.

The Medicaid Fraud Division of the Attorney General's Office has also not received detailed provider claim history information from MMIS II. As a result, the Attorney General's investigation of some of its fraud cases has been impeded.

Recommendations

- *DHS should continue to improve the MMIS II reporting capabilities. When possible, DHS should issue revised HCFA-64 Quarterly Reports of Medicaid Expenditures for all quarters since May 1994.*

- *DHS should devote the resources necessary to ensure that users have timely access to information necessary to perform their jobs.*

6. Certain rates are not set in accordance with statutory provisions.

DHS does not follow the statutory provisions for rate setting when there are between five and ten claims for a particular procedure. Generally, DHS pays medical providers the lower of the actual amount claimed or the pre-established rate for the medical procedure. DHS establishes most commonly used rates based on the 50th percentile of a base year. Minn. Stat. Section 256B.0626 requires that at least ten billings are needed in order to set the rate for a procedure using this common method. When there are less than ten billings, the statutes require DHS to follow a more intensive rate setting process. The state plan, however, allows the use of the common rate setting method when five or more billings are available. DHS follows the state plan. The statute is not in agreement with the federally approved State Plan rate setting provisions.

Recommendation

- *DHS should comply with Minn. Stat. Section 256B.0626 rate setting provisions, or seek to amend the statute to agree with state plan provisions.*

Chapter 3. General Information System Issues

Chapter Conclusions

Although the security officers at the Department of Human Services are limiting access to critical computer resources and data, we found two weaknesses in the DHS computer security procedures:

- ***Some security officers in the department's Information Policy and Services Office have more clearance than they need to perform their job duties.***
- ***The department has not deleted unused ACF2 log-on IDs after 365 days.***

The Department of Human Services uses several computer systems to conduct its operations. DHS runs its computer systems on the state's two central mainframe computers. The Department of Administration's Intertechnologies Group (Intertech) operates the mainframe computers and manages the data center. Programmers at the Department of Human Services maintain the system software.

Three systems affected our fiscal year 1995 audit scope. They were the Medicaid Management Information System (MMIS II), MAXIS, and Long-Term Care.

- MMIS II is a complex, highly integrated claims payment and information retrieval system. MMIS II contains 14 interdependent subsystems. Each subsystem performs specific functions, but every subsystem relies on information that another subsystem collects and maintains. Within each subsystem, multiple files and records support specific kinds of information. Users have ready access to the information, yet the system maintains data security. The department uses MMIS II to pay the medical bills for health care program enrollees, help assure that quality care is being provided, assist investigators in detecting medical fraud, and maintain critical data. The department brought MMIS II on line in May 1994, retiring the original MMIS system used by the department for the previous 20 years.

- MAXIS assists counties in the determination of eligibility for various benefit programs, including Aid to Families with Dependent Children (AFDC), Food Stamps, and Medical Assistance (MA). DHS implemented the MAXIS system in May 1991. It uses family financial information to calculate the cash benefit a family should receive and whether the family qualifies for a medical program. MAXIS affects nearly 1 million Minnesotans through the eligibility determination process. It manages cases for public assistance clients and issues cash benefits for programs such as Aid to Families with Dependent Children and General Assistance, as well as food stamp coupons. There are about 7,000

MAXIS system users, primarily county workers. There are 66 different levels of security access to the system.

- The Long-Term Care (LTC) system reimburses long term care facilities (primarily nursing homes) for services provided to MA eligible recipients. DHS initially inputs long-term care facility claims into MMIS II, which validates the claims through a series of edits. MMIS II then interfaces with the LTC system, which pays the claims.

Intertech and the Department of Human Services jointly administer security for the human service computer systems. This joint responsibility is in conformance with Minn. Stat. Section 16B.40, Subd. 8, which states:

> In consultation with the attorney general and appropriate agency heads, the Commissioner of Administration shall develop data security policies, guidelines, and standards, and shall install and administer state data security systems on the state's centralized computer facility consistent with state law to assure the integrity of computer based and all other data and to assure confidentiality of the data, consistent with the public's right to know. Each department or agency head is responsible for the security of the department's or agency's data.

A software package called ACF2 controls access to the state's two central mainframe computers. ACF2 protects against unauthorized destruction, disclosure, modification, or use of data and computer resources. The software acts as an extension to the computer's operating system and protects all data by default. ACF2 will not permit a user to access data or use a computer resource unless a security officer or the data owner explicitly authorizes that access.

Audit Scope and Objectives

During our audit, we examined procedures for controlling access to DHS computer system data and computer resources. The following were our specific audit objectives:

- Is the department giving employees access to only the specific computer resources that they need to fulfill their job responsibilities?
- Is the department limiting access to DHS computer system data to only those employees who need access?

To answer these questions, we interviewed three of the department's security officers and reviewed ACF2 and application security records. We also interviewed members of Intertech's security services team.

The Functions of ACF2

ACF2 controls access at two levels. The software secures initial access to the system and it secures access to the human service computer systems such as MMIS II, MAXIS, and LTC. The application security programs secure access to the data and resources for each system.

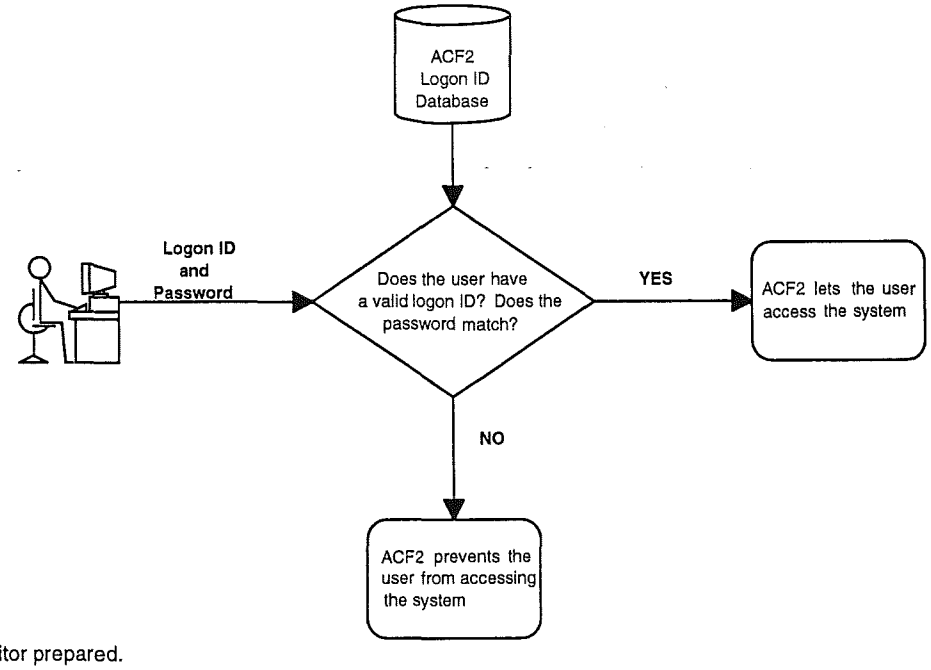
ACF2 uses unique log-on IDs and passwords to control access to the system. All users must enter their log-on IDs and passwords to access one of the state's central mainframes. ACF2 compares this user information to data stored in its log-on ID database. The software denies access to users with unknown log-on IDs or incorrect passwords. It also denies access to users with canceled or suspended log-on IDs. Figure 3-1 illustrates how ACF2 uses log-on IDs and passwords to control initial access to the system.

ACF2 uses rules to control access to data, computer resources, and the application systems. ACF2 makes either an allow or deny decision each time a user tries to access data, use a computer resource, or an application system such as MMIS II. The application security controls access to the various application resources such as a MAXIS on-line screen. In general, users cannot access any data or use computer resources unless permitted by a rule. However, some users with powerful "privileges," such as the security privilege, can bypass ACF2's rule validation process.

Controlling Access to the Human Service Computer System

Writing ACF2 rules for the DHS computer systems is a joint effort between Intertech and the Department of Human Services. Intertech writes the resource rules and the department maintains them. The department's security officers either write the data access rules or communicate the access decisions to the ACF2 security officer. The ACF2 security officer then writes ACF2 rules to implement those security decisions. Currently, the department has nine security officers. Each system has its primary security officer, and also security officers that perform backup duties. Six of these security officers have the authority to write their own rules.

Figure 3-1
ACF2 Controls Initial Access to the State's Central Mainframes



Source: Auditor prepared.

Department of Human Services

We recently released a report summarizing the results from our annual audit of the Department of Administration. One chapter in that report discusses how Intertech uses ACF2 to control access to data and computer resources. This chapter points out several weaknesses in the system used to communicate access decisions and write access rules. We found that:

- The state does not have any training guidelines for agency security officers. We found some security officers who do not have a sufficient understanding of ACF2 to make informed security decisions. Intertech's Security Services Team is not in a position to understand the technical intricacies of all systems residing on the state's two central mainframes. It also cannot judge what clearance agency employees need to fulfill their job responsibilities. Therefore, Intertech appropriately relies on decisions made by agency security officers. This reliance may result in problems, however, when the Department of Administration has not properly trained agency level security officers.

This weakness is apparent at the Department of Human Services, but it is not unique to the department. Rather, it is a statewide problem that the Department of Administration needs to address. Nonetheless, it is important to recognize that Minn. Stat. Section 16B.40, Subd. 8, clearly makes agencies responsible for the security of their own data.

We found effects of this systemic weakness at the Department of Human Services. For example, DHS requested ACF2 security privilege for three department computer programmers. It made this decision to provide a secondary level of backup for its three regular ACF2 security officers. Normally, the department's three regular security officers serve as backups for each other. The department's lead security officer did not realize that this privilege would let the programmers bypass ACF2 access rules.

Agency security officers and Intertech need to work together to address security officer training needs. Intertech needs to develop statewide training standards for agency security officers. The agency, on the other hand, needs to gain a better understanding of ACF2 and start actively managing its rules. Collectively, these efforts should help Intertech and state agencies administer security more effectively.

We found two additional weaknesses in DHS's general computer security administration.

7. DHS uses one broad ACF2 scope list for several of its security officers.

Five of the six decentralized security officers at the Department of Human Services have the same ACF2 scope list, named "DHS." However, all of the department's security officers have unique responsibilities. Therefore, it would be more appropriate to design a custom scope list for each security officer.

Scope lists are an important control because they limit the authority of users with powerful ACF2 privileges. Therefore, it is important to design scope lists that correspond with security officer's specific job responsibilities.

Department of Human Services

Intertech began, but did not finish, the process of designing unique scope lists for the Department of Human Services' decentralized security officers. In fiscal year 1995, Intertech developed a unique ACF2 scope list for one security officer. Previously, all six security officers shared the same scope list. However, DHS did not direct Intertech to change the original DHS scope list after designing this new list. As a result, the five security officers governed by the original DHS scope list still have more authority than they need. For example, the DHS scope list gives these five security officers the authority to write ACF2 computer resource rules. None of these decentralized security officers need this authority to fulfill their job responsibilities.

Recommendation

- *The Department of Human Services should restrict the scope of security officers to the minimum clearance necessary to fulfill their job responsibilities.*

8. The department does not delete unused log-on IDs after 365 days of inactivity.

The Department of Human Services does not delete ACF2 log-on IDs that have been unused for more than 365 days. The security officers assign ACF2 log-on IDs to agency and county users to access the computer system in order to perform their job duties. The security officers monitor the log-on ID usage with the aid of ACF2 security reports. The system records each time the user accesses the system and the length of time since the last log-on session. Intertech policies require that unused log-on IDs for 90 days be suspended and unused log-on IDs be deleted after 365 days. The security officers have the authority to suspend and unsuspend these log-on IDs as well as to delete them.

We reviewed various ACF2 security usage reports and found that many undeleted log-on IDs had been unused for more than 365 days. We found some of those log-on IDs had been unused for over 1,000 days. Most of the undeleted log-on IDs involve those that required MAXIS access. These log-on IDs remain in suspended status. The risk is that these log-on IDs could be unsuspended and used to make unauthorized transactions.

Recommendation

- *The Department of Human Services should delete unused log-on IDs after 365 days of inactivity.*

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Chapter 4. Unauthorized Bank Account

Chapter Conclusions

During our fiscal year 1995 audit of the Department of Human Services, an additional issue came to our attention:

- ***The Issuance Operations Center opened a bank account without proper authorization.***

9. The Issuance Operations Center (IOC) opened a bank account without proper authorization.

During fiscal year 1995, the IOC established an unauthorized bank account to pay for postage meter expenses. Postage costs are a significant part of the IOC's operating costs, since the IOC mails the cash benefit warrants and the medical benefit statements to DHS program participants. After the discovery of the account, DHS management notified the Department of Finance and the State Treasurers Office to determine the proper disposition of the account. The Department of Finance closed the account and returned the funds to state accounts. The Department of Finance conducted an investigation into the financial activity of the unauthorized account and determined the circumstances of its creation. Although they determined that account funds were used only for legitimate IOC postage costs, the state's exposure was significant. During the ten months that the account was active, it received over $3 million in state funds.

The Department of Finance issued a report on this matter in January 1996. The report cited various control weaknesses that allowed the IOC to establish the account and obtain state funds without detection. The report made several recommendations to help DHS and the state avoid similar problems in the future.

Recommendation

- *DHS should review its procedures and the recommendations of the Department of Finance concerning its Issuance Operations Center and make any necessary changes in its procedures.*

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State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

May 24, 1996

Mr. James R. Nobles
Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 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 financial and compliance audit conduct by your office for the year ended June 30, 1995. 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 (612) 282-9996.

Sincerely,

MARIA R. GOMEZ
Commissioner

cc: Jeanie Leifeld
Cecile M. Ferkul

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Audit Finding #1

The DHS paid for medical services provided to ineligible people.

Audit Recommendation #1

DHS should consult with the Attorney General's Office to resolve the department's spending authority relating to the $574,983.25 in medical payments made to ineligible people.

Department Response #1

DHS agrees with the recommendation and will consult with the Attorney's General Office to confirm the department's spending authority in situations where the health and safety of the recipient population may be jeopardized if action is not taken.

The Medicaid Management Information System (MMIS) was implemented in May 1994. A significant element of that conversion was development and implementation of an automated Eligibility Verification System (EVS) which provided real-time access to eligibility files via touch tone telephone. EVS operationalized a program decision to issue permanent identification cards without eligibility spans, in place of expensive monthly card issuance. The move to annual cards not only saved money, but allowed the department to issue a generic Minnesota Health Care Program card which reduced the stigma of the "welfare" card versus the Minnesota Care card.

The EVS system gave the provider community immediate response capability for verifying eligibility, third party information and benefit limits. Technical difficulties were encountered during the first three months of operation, and the system was not available during critical periods of service delivery. To ensure that clients were not denied critically necessary service, the department elected to honor selected claims for services provided during that period. If recipient history files confirmed that the client received a card in the month preceding service, thus enabling the client to present a card to the provider during periods of system down time, then claims were honored for those clients only. The service was legitimate, necessary care and provided in good faith by the provider. The department prudently acted to maintain integrity and continuity in administration of the programs. The issue clearly focussed on the health and safety of the entire population of recipients, and payment was a reasonable exercise of public policy in an effort to maintain a viable provider community for a vulnerable population.

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

August 1, 1996

Audit Recommendation #1-2

DHS should adequately inform the Legislature when unusual situation occur prior to paying claims.

Department Response #1-2

DHS concurs with the recommendation. Communication to the Legislature is reasonable and appropriate in those instances that are clearly contrary to the authority vested in the department to administer Medical Assistance, General Assistance Medical Care and Minnesota Care. However, the demands and dictates of administering a dynamic health care system may obviate the condition that notice is prior to payment.

Person Responsible:

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date:

Ongoing

Audit Finding #2

The MAXIS and MMIS II systems contain discrepancies between eligibility status codes.

Audit Recommendation #2

DHS should continue to perform quarterly reconciliations of the MAXIS and MMIS II recipient eligibility data. DHS should work with the counties to resolve discrepancies in a timely manner, giving priority to those discrepancies involving managed care participants.

Department Response #2

DHS agrees with the recommendation and intends to produce the recipient reconciliation discrepancy report comparing MAXIS and MMIS on a quarterly basis. Reports have been issued to counties in January and April of this year, with additional reconciliations planned for July and October. The department will support county staff as they work with the report. With each reconciliation, the three detailed status-related reports will be produced and made available to the Legislative Auditor.

TRENDS

Counties have made significant progress in reducing the number of discrepancies in status. The first reconciliation in September 1995 reported approximately **9,141** recipients who were inactive in MAXIS and active in MMIS. This figure dropped to **5,230** in the January 1996 reconciliation, and to **3,734** in the April 1996 reconciliation. This represents a **59%** decline in MAXIS inactive/MMIS active recipients in the seven months following the initial reconciliation.

We do not have detailed information from the September 1995 reconciliation regarding recipients who were reported as inactive in MAXIS and active in MMIS, and who were enrolled in Managed Care. We have observed progress in this area comparing the April 1996 to the January 1996 reconciliations. In the January reconciliation, **1,407** of the recipients with a discrepancy of this type were enrolled in managed care. In the April reconciliation, this total had declined to **1,036**. This was a **26%** improvement in three months.

DHS ACTIONS TO REDUCE THE NUMBER OF STATUS DISCREPANCIES

The ongoing issuance of the report is itself reducing the number of discrepancies between the MAXIS and MMIS systems. The department will continue to work with counties to resolve those discrepancies that are reported to them, as well as prevent others from occurring. The MMIS and MAXIS Help Desks provide user support to county staff as they work to resolve discrepancies. Instructions for resolution of discrepancies are available and continually updated by department staff in an on-line manual available on the MAXIS system. The department will monitor the reconciliation reports. The data will be used to target particular counties and workers, when appropriate, for corrective action in this area. County supervisors and management will be made aware of the scale of this problem through department staff attendance at statewide meetings.

Person Responsible

Kathie Henry, Director, Eligibility Division

Estimated Completion Date

Ongoing. We will provide the Legislative Auditor's Office with a report of the number of discrepancies in the status indicator on a quarterly basis. If counties have not made significant progress in reducing the number of discrepancies within one year, we will consider other alternatives.

Audit Finding #3

DHS has not adequately controlled certain system edit changes

Audit Recommendation #3-1

DHS should document all status code changes and authorizations.

Department Response #3-1

DHS agrees that there should be an historical record of changes and authorizations. All changes in disposition of a status code are automatically documented in the on-line screen for each edit. The system displays the date of change and the identification number of the staff person making the change. In addition, DHS has initiated a review and approval process that requires the signature of both the appropriate policy director and the Director of the Health Care Operation Division before the status of an edit can be changed. The administrative review and approval process will supplement the historical documentation contained in Cumulative Claims Exception Control Update Activity Report, report identifier PWMW3100-R9013.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed May 7, 1996

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Audit Recommendation #3-2

DHS should review the MMIS II edit change reports to ensure that only authorized changes have been made.

Department Response #3-2

DHS concurs with the audit recommendation. The status of all current edit dispositions will be reviewed.

Person Responsible

Larry Woods, Director, Health Care Operations Division

Estimated Completion Date

Completed May 23, 1996.

Audit Finding #4

DHS pays for costly medical procedures without first verifying that they were approved in advance.

Audit Recommendation #4-1

DHS should review the validity of the admission certification numbers.

Department Response #4-1

DHS agrees with the recommendation. The DHS Admission Certification Program requires providers of inpatient hospital services to obtain admission certification prior to billing for the services. The DHS medical review agent (MRA) screens admissions for medical necessity via a phone-in system and verifies admission certification or denial by letter. The MRA is required to perform retrospective reviews of approximately 20,000 paid claims per year. These reviews include comparing the information provided over the phone to the medical record to ensure accuracy and medical necessity. As part of the review, the MRA verifies the admission certification number. The DHS contract with the MRA also stipulates that retrospective medical record reviews are to be performed on

100% of transfers and readmissions, 100% of psychiatric admissions, 100% of obstetric admissions without delivery, 100% of out-of-state admissions, and 100% of outlier, short stay and long stay admissions (>59 days). These areas were selected by DHS for review because there is more potential for discrepancies as more denials occur within them.

Inpatient admissions of pregnant women who deliver during the admission and their newborns are not required to be certified because medical necessity is evident. The number of claims for these admissions fluctuates as a result of eligibility policy changes and expansion of managed care, and ranges between 30% and 40% of total claims in the years 1990 to 1995.

Most claims for admissions that require prior authorization such as transplants and investigative surgical procedures are checked against the prior authorization subsystem (both MMIS I and MMIS II), therefore editing for admission certification would be unnecessary. Also, claims for inpatient dental procedures and admissions approved by Medicare are not required to have admission certification numbers.

Between the claims reviewed by the MRA and the claims described above, we can account for 60% and 70% of total claims processed. Therefore, only 30% to 40% of inpatient claims are actually unverified and they are the types of claims with which we have experienced the least amount of discrepancies.

HISTORY

Although MMIS has always edited for the presence of a certification number, it has not verified the authenticity of the number because the certification numbers are run off the medical review agent's computer system (BCBSM). Attempts were made early in the program's existence to verify the authenticity of certification numbers by comparing BCBSM's certification data with DHS claim data but it was not possible due to an inability to match all components of an admission.

Recovery of payment for claims with duplicate/invalid certifications and double payments was initiated in February, 1990. The project included claims with admission dates on and after August 1, 1985 to claims paid as of November 3, 1989. The project's aim was to verify the authenticity of certification numbers by investigating claims with:

- Missing or invalid certification numbers
- Duplicate certification numbers on two or more claims submitted by the same hospital
- Duplicate certification numbers for the same recipient submitted by different hospitals
- Duplicated certification numbers for different recipients submitted by different hospitals

The MMIS II subsystem for admission certification that would automatically verify certification numbers at the time of claim payment was canceled because of the expansion to managed care. It was unlikely that the subsystem would be functional in the near future, and the resources expended would outweigh the resources saved for a shrinking fee-for-service system.

It was decided that our resources should be concentrated on post payment review of certification numbers. A project is currently underway to review claims with duplicate and invalidate certification numbers. It is similar to the one described above and is expected to be done on a continuous basis. A recovery process is being finalized and reviews will begin in May 1996.

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

January 1997

Audit Recommendation #4-2

DHS should take appropriate recourse against medical providers who submitted claims with invalid prior admission certification numbers and should take any corrective action necessary to reduce future occurrences.

Department Response #4-2

The Department agrees with the recommendation. See our general response to #4-1

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

January 1997

Audit Finding #5

The MMIS II system does not yet have the full reporting capabilities to allow DHS to complete all required federal reports nor provide internal users with all needed information.

Audit Recommendation #5-1

DHS should continue to improve the MMIS II reporting capabilities. When possible, DHS should issue revised HCFA-64 Quarterly Reports of Medicaid Expenditures for all quarters since May 1994.

Department Response #5-1

DHS agrees with the recommendation and will continue to give a priority to efforts to improve the reporting capabilities of MMIS for both federal reporting and for providing swift response to information requests from agency management and staff.

It is our belief that the MMIS system does have, and has had for some time, reporting capabilities which allow DHS to complete most required reports. DHS has not produced some complete versions of some reports due to issues in reconciling data converted from multiple sources and used in the original MMIS with production data from the new MMIS. This is, in big part, an age-old issue related to converting unlike data to like data.

A focused team, consisting of program policy and technical staff, have identified and resolved most or all of the data issues which have limited our reporting of complete data to the Health Care Financing Agency (HCFA).

Person Responsible

Dan Schivone, Director, MMIS

Estimated Completion Date

As of July 1996 the quarterly report (HCFA 64) will be completed. As time permits, revised reports will be reissued for reports generated since May 1994.

Audit Recommendation #5-2

DHS should devote the resources necessary to ensure that users have timely access to information necessary to perform their jobs.

Department Response #5-2

DHS agrees with the recommendation. Additional technical staff persons have been hired for the MMIS in order to support the reports producing activity within the MMIS. As they have become knowledgeable of all of the MMIS files, they are already contributing to the capability of DHS to provide timely information necessary to users to enable them to perform their jobs.

Person Responsible

Dan Schivone, Director, MMIS

Estimated Completion Date

July 1, 1997

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Audit Finding #6

Certain rates are not set in accordance with statutory provisions.

Audit Recommendation #6

DHS should comply with Minn. Stat. Section 256B.0626 rate setting provisions, or seek to amend the statute to agree with state plan provisions.

Department Response #6

Although we believe that the example cited in the report is in compliance, DHS agrees with the recommendation and plans to address the issues of specificity and inclusion of all rate methodologies in statute before next session. Based on Minnesota Statutes 256B.0626, we feel that the Department is in compliance for the example cited in audit finding #6 which states "DHS does not follow the statutory provisions for rate setting when there are between five and ten claims for a particular procedure."

According to 256B.0626:

"(a) The 50th percentile of the prevailing charge for the base year identified in statute must be estimated by the commissioner in the following situations:
(1) there were less than ten billings in the calendar year specified in legislation governing maximum payment rates....."

(b) When one of the situations identified in paragraph (a) occurs, the commissioner shall use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate:
(1) refer to information which exists for the first nine billings in the calendar year specified in legislation governing maximum payment rates; or...."

Person Responsible

Paul Olson, Director, Payment Policy Division

Estimated Completion Date

January 1, 1997

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Audit Finding #7

DHS uses one broad ACF2 scope list for several of its security officers.

Audit Recommendation #7

The Department of Human Services should restrict the scope of security officers to the minimum clearance necessary to fulfill their job responsibilities.

Department Response #7

DHS agrees with the recommendation. The report correctly states that at the time of the audit all DHS security officers had ACF2 scope list authorization that provided more clearance than necessary to fulfill their job responsibilities.

When this was identified by the Legislative Auditor, DHS staff scope authorizations were immediately modified. The "DHS" scope list authorization is now only available to the DHS security team leader and his two backups. Other DHS application security officers currently have scope list authorizations unique to the DHS system each officer supports.

Person Responsible

Ken Hasledalen, Director, Information Resources and Policy Division
Tom Rowland, MAXIS Division

Estimated Completion Date

Completed

Audit Finding #8

The department does not delete unused log-on IDs after 365 days of inactivity.

Audit Recommendation #8

The Department of Human Services should delete unused log-on IDs after 365 days of inactivity.

Department of Human Services
Responses to the Legislative Audit Report
For the Year Ended June 30, 1995

Department Response #8

Although DHS agrees in general with the recommendation, the entire security system of MAXIS would have to be rewritten before the inactive log-ons could be deleted. DHS has requested that inactive log-ons not be deleted from the ACF2 database. This request was based on the needs of the internal MAXIS "ADD" security system. ADD stores user information, and the ACF2 log-on is used within the system as the key identifier of all MAXIS system users. Federal regulations which regulate the retention of public assistance data require a historic record and audit trail of all actions performed on MAXIS cases for seven years. The AFC2 log-on identifies who made changes on a case at any time in MAXIS history.

While deletion of log-ons not used for 365 days may be desirable, the only easy way to determine if the log-on had MAXIS access in the past is to maintain information about the log-on ID in the ACF2 file. Within the ACF2 user profile, a code identifies if an ACF2 log-on ever had MAXIS access, as well as other system accesses. The code is stored in the USER ID string. When the code indicates a suspended ACF2 log-on has no history of MAXIS access, it can be deleted and reused. Only log-ons with MAXIS access cannot be reused. The practice of suspending ACF2 IDs was put into place as an aide to non MAXIS security officers to make them aware of log-ons that had previously been assigned MAXIS access.

The audit report states that suspension of an ACF2 log-on is of concern since all security liaisons can unsuspend a log-on thereby giving it new access. The report recommends deletion of ACF2 log-ons as a better choice. Since suspension is the area of concern, an alternative would be cancellation of the log-on, rather than deletion. Cancellation requests are controlled at InterTech. InterTech would never uncancel a log-on unless the request comes from the security officer of the system the original request was made from. No exceptions.

In 1989, DHS/MAXIS and InterTech managers agreed that ACF2 log-on ID's with MAXIS history would not be reused. Within the last year InterTech security has asked the MAXIS Division to review the need for this practice and to consider the reuse of log-ons with MAXIS history. While the LAC report states that "the risk is that these log-on IDs could be unsuspended and used to make unauthorized transactions", we understand the real concern to be about the increasing number of ACF2 log-ons that cannot be reused. In 1989, when InterTech supported MAXIS management's request not to reuse ACF2 log-ons with MAXIS history, MAXIS management believed that MAXIS would have about 2400 users. Instead, to date, over 8000 ACF2 log-ons have been assigned to

MAXIS.

MAXIS management has determined that a review of MAXIS log-ons and system security is important and must address issues such as the reuse of log-ons because of the practical issues involved. To incorporate the reuse of log-ons, all MAXIS system security will need to be rewritten, as well as much of the current system historical record keeping.

Person Responsible

Ken Hasledalen, Director, Information Resources and Policy Division
Tom Rowland, MAXIS Division

Estimated Completion Date

The MAXIS security team has been asked by MAXIS management to prepare an information document which summarizes and reviews all aspects of MAXIS system security. This workplan will be reviewed by MAXIS management during the summer of 1996. Upon completion of the management review a priority will be assigned to complete the functional user study and technical analysis necessary to rewrite MAXIS security. It is anticipated that a specification for the design of the technical architecture would be completed by the fall of 1997. At this time, it is estimated that the earliest completion date for this project would be early 1999. In effect this project would involve the reinstallation of the entire MAXIS online system.

Audit Finding #9

The Issuance Operations Center (IOC) opened a bank account without proper authorization.

Audit Recommendation #9

DHS should review its procedures and the recommendations of the Department of Finance concerning its Issuance Operations Center and make any necessary changes in its procedures.

Department Response #9

DHS agrees with the recommendation and several actions have been taken by the

Department in conjunction with the Department of Finance and the Office of the State Treasurer to safeguard the state's assets and to avoid similar problems in the future. The Department of Finance worked with Norwest Bank to open a secured account to pay for postage meter costs. DHS managers have reviewed the recommendations made by the Department of Finance and the Department's Internal Audits Office is reviewing IOC operations and procedures.

Person Responsible

Tom Rowland, MAXIS Division

Estimated Completion Date

Complete